

**The Unobserved Barriers in Undocumented Latina Women's
Reproductive Health Utilization: A Review of Health Policy Across Four
States**

*A thesis submitted to the Department of Sociology, Bryn Mawr College in partial
fulfillment of the requirements for the degree of Bachelor of Arts*

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ABSTRACT

This study examines the patterns of reproductive healthcare utilization of Latina undocumented immigrant women to contribute to a discussion of unequal health access for these women. The health-seeking behaviors of women were analyzed across California, New York, Minnesota, and Illinois to understand how state policy plays a role in preventing undocumented groups from receiving preventive services. The goal of this review is not to list patterns of reproductive health. Although it provides insight into prenatal and postpartum care rates for women. Instead, it deconstructs barriers in reproductive studies that prevent access to the health system. The undocumented Latina experience in the U.S is precarious compared to documented or U.S.-born Latinas. Undocumented women are subject to federal law that excludes them from receiving safety nets such as Medicaid. Based on a review of thirty-four qualitative articles on undocumented Latinas and health disparities, this thesis reveals how public health policy and cultural barriers influence care. The review adds to healthcare disparities for undocumented women by going beyond a mainstream model of SES barriers like income, and insurance status as determinants of health. The concept of unobserved barriers such as fear of deportation is used instead. The study is corrective to the thin literature on Medicaid policy by showing how state insurance has an intimate relationship with the undocumented. The findings reveal that undocumented women were receiving prenatal care at alarmingly lower rates than documented women or were receiving inadequate care. In all cases state sovereignty for public health was influential to the services women lacked. The prominent unobserved barriers were English proficiency, lack of knowledge, fear of deportation, and temporary coverage. The cases of California, New York, Minnesota, and Illinois reveal that to improve access unobserved barriers need to be taken seriously in the face of insufficient health policy.

Key Words: undocumented Latina women, health access, reproductive health, unobserved barriers, state policy, public health policy, Medicaid, postpartum care, prenatal care, SES barriers, networks of care

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The execution of this thesis couldn't have been possible without the last four years of working to develop a sociological imagination. The discipline that has an interest in migration, the intersectionality of race, and the critique of institutions seemed to bleed into my life and the low-income community I was raised in. During my time in sociology, the most significant challenge was finding a balance between the academic and the empirical experience that I had coming in. The experience I speak of is being raised in an immigrant community that some would only consider as a subject of study but was ingrained in my identity as a scholar. In this journey, I was willing to take the task of expanding my knowledge. I did so by not limiting myself to the perspectives I knew but by working with arguments that challenged my existing notions. The results are the following pages that transcend simplifications of the undocumented Latina struggle.

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INTRODUCTION

In recent decades, mainstream research surrounding healthcare disparities among racial groups has been an interdisciplinary effort made by medical anthropologists, psychologists, and public health academics. Sociology is no exception to this effort. The general concept of racial and ethnic health equity in the U.S has a history dating back to the 19th century. For example, American sociologist Dubois published his classic study the *Philadelphia Negro* where he concluded that poor health for Black people could be attributed to racial inequity in 1899. Thus, social science contributions have commonly discussed topics in healthcare with a critical or contributonal view towards medicine. In Weitz's book, *The Sociology of Health, Illness, and Health Care* she terms this distinction as sociology *in* medicine and sociology *of* medicine (Weitz 2019). The vast array of research on health disparities has swayed the sociology *of* medicine approach, a critical method that asks questions about the power dynamics involved in health outcomes and critiques the healthcare system. This approach is opposed to sociology *in* medicine which works with the health system. This approach asks questions about how to change a patient's behavior to comply with the doctor's needs. Instead of challenging medical facilities, this strategy aims to help existing social dynamics within them. Health disparity researchers use the former structure to point to a group's racial identity and utilize socioeconomic variables such as income, insurance, and education as explanatory variables for negative health outcomes.

Race and Socioeconomic Identifiers in Health Studies

The use of socioeconomic factors to explain racial inequity begs the question of why the sociological approach is so focused on viewing health disparities through a racial inequality lens. To exemplify, racial inequity in health has used income or education to explain why a specific group may not have access to care instead of looking at culture or health policy as explanations. To understand how the literature on health care disparities evolved to be about socioeconomic status (SES), health disparities and race must be first defined. In the breakthrough study by the Institute of Medicine (IOM), *Unequal Treatment*, published in 2002, a definition of health disparities is given and is attributed to differences in treatment for racial minorities. The definition is still very influential, positioning health disparities as racial and ethnic distinctions in healthcare quality (Smedley, Stith, and Nelson 2002). What healthcare quality means is basic

access to formal healthcare and positive health outcomes coherent with medical knowledge. The former excludes personal satisfaction by patients, clinical preferences, etc.

IOM's discussion on health inequity centers on racial and ethnic identifications as crucial to health inequity despite any differences found in morbidity and mortality rates within U.S. minority populations. The study declares that all minority groups like Latinos, Native Americans, Asians, and African Americans all have higher rates of mortality and disease, less access to care, and less access to insurance than whites (Smedley, Stith, and Nelson 2002). Aside from telling us that just being a racial minority equates to negative health outcomes, the study also addresses the growing interest in health disparities literature. The study states that in studies where socio-demographics were controlled (education, insurance, and clinical factors) racial differences in disparities might be reduced but never disappear. The IOM is not the first to notice this trend in health disparities that focus on racial identities. Public health studies also have pointed out that U.S.-based research tends to connect disparities to racial and gender inequality issues, which distracts from more focused groups like small immigrant communities. (Gervas and Mangin 2012). This manner of making health inequity almost synonymous with racial inequity has led many sociologists to add to the definition of health disparities by the IOM.

In this context, the Latino population has been featured heavily with this racial inequality lens for their negative health outcomes. The same framework of utilizing SES variables to explain health access is evident in studies from the 1980s and 1990s, which also discussed Black populations in the same vein. For instance, early studies in Latino health discuss coverage and undocumented status to explain the disparities between those with citizenship and those who lacked it (F. Allan Hubbell et al. 1991). Health coverage is among the most popular ways to understand health disparities shown by other publications that stressed the dramatic rate of uninsured Latinos, 39% compared to other races in the nation (Scott Collins 2000). More modern publications view SES variables as obvious contributors to health inequity and focus more on specific groups like Latina women while analyzing recurring morbidities among them (Ramos et al. 2010). The examples of Latino health studies listed above show different frameworks as one centered on socioeconomic variables to explain health disparities while the other takes those explanations as a given. Yet both take a critical approach to the health system.

The literature on health disparities during the 2000s discusses people's attitudes toward what constitutes quality healthcare outside the health system's view of care. Instead of focusing

on how health inequality can only occur if health is not positive from a medical standpoint, later studies look at preferential definitions of quality care rooted in patients' experiences. Sociologists like Cecilia Menjivar and Kathryn Pitkin Derosé expand on healthcare disparities by making the case for a system that is more preferential in healthcare quality to the needs of Latina immigrant women. They recommend integrating language services and more inclusivity. These more specific articles recognize the heterogeneity within minority populations.

Purpose of Study

There are many lines of reasoning in which the Latino population can be studied because of their heterogeneity and the many socioeconomic variables present in blocking access (insurance, English proficiency, etc.). My goal with this paper is to ask what patterns of reproductive healthcare utilization for Latina undocumented immigrant women reveal about health access across the studied states? While we know plenty about Latina women who are U.S born or have documentation, there is a gap in our understanding of the many sociodemographic factors that impact the health of undocumented women. Nevertheless, the data that has been compiled works as a starting point for understanding how variables such as location, and education play a pivotal role. The topic of reproductive health is precarious for undocumented women as they are subject to temporary insurance for situations like pregnancy (Maru et al. 2021). The types of care this group receives are contingent on the law and the public health programs offered by the location where they find themselves. Private coverage and out-of-pocket services are unattainable due to status and the likelihood of being low-income. The question first involves looking at a type of research that has taken the task of using interviews and surveys to ask women about their attitudes towards pap smears, prenatal care, mammograms, and postpartum. I am interested in secondary sources that are tailored to show patterns of utilizing reproductive health. (Betancourt S. et al. 2013; Maru et al. 2021; Nandi et al. 2008; Vargas Bustamante et al. 2010). These articles take into consideration undocumented status as a detriment of disparities in reproductive health but they go beyond this.

The goal of this review is to break down patterns of reproductive health usage that women show but also the barriers found for those patterns. The sources compiled deal with mainstream SES variables like coverage and income to explain underutilization but they also deal with unobserved barriers. Unobserved barriers is a concept inspired by the term unobserved

heterogeneity found in Bustamante et al. (2010). The term is defined as barriers to access that are too complex to reduce in large-scale surveys despite their relevance to health policy. Bustamante lists behaviors such as fears of deportation and lack of familiarity with the health systems. Unobserved heterogeneity differentiates unobserved from observed by factors that are non-measurable in surveys. On the contrary, the concept of unobserved barriers I will define also includes factors like English that can be measured in surveys. The idea of differentiation I use is more broad by making unobserved barriers, variables to health not typically discussed in mainstream health studies. These barriers have cultural components such as poor Spanish translation even if speaking English can be listed in a survey. A couple of examples of unobserved barriers I discuss are fears of deportation, lack of knowledge about postpartum care, and poor health capital. The aim is not to just list patterns of reproductive care but to ask how this type of care is revealing barriers that are more akin to this population and how it blocks access to the healthcare system.

The focus on reproductive health (RH) is also contingent on the second step in this analysis which is a comparison of states. RH has a special relationship with state locality for an underserved population who mostly gains access to delivery care, prenatal care, and other forms of testing through public health programs run by the state. Instead of just looking for patterns in RH, there will be attention paid to where those patterns occur to compare if undocumented women experience similar barriers. I will be looking at four states for this analysis starting from the traditional gateway immigrant destinations of California and New York and ending with Illinois and Minnesota. Large cities like NYC have been studied for their role as sanctuary cities. I will be looking at these cities when research on reproductive health is not available by state. Throughout these four states, data on maternal services is more prominent.

My analysis of RH will deal more with the side of prenatal care and postpartum care. Prenatal care is defined as preventive care that women receive during pregnancy and up to delivery. It entails medical check-ups, lab work, specialist visits, and hospital care during delivery. Postpartum care occurs in the first six weeks after birth and is a continuation of the care received during pregnancy. The studies I will analyze tie prenatal care to the hospital delivery period. Postpartum care is more elusive. Postpartum and Prenatal care are used as measures to access or points of comparison between services. The goal is also to focus on how the experience of being undocumented might present different obstacles to overall health access. Reproductive

health was chosen as the measure of access because of its relationship to state policy and the need for a more holistic definition of health disparities explained below.

Overview of Findings

In terms of the reproductive patterns studied on undocumented Latina women in the states of California and New York, prenatal care was being received by women mainly through temporary public coverage. In California, undocumented women were disproportionately accessing prenatal services in San Diego county compared to documented Latina women. The prenatal care undocumented women were receiving was inadequate by a medical definition that stresses care should begin during the first trimester. The prenatal care in Illinois was also inadequate but lack of research presents an incomplete picture of what coverage or in what conditions undocumented Latina's were receiving care. The situation in Minnesota was similar with a general Latina population receiving prenatal care but without context for the experiences of women. Postpartum care in California and New York was intimately tied to prenatal care in the form of public coverage such as Medicaid which provided or did not provide an extension of care post-birth. The result was that postpartum was viewed by women and granted by the state as an additional or luxury benefit that was not equally available to all. This is the case for CA and NY where some undocumented never received this type of care.

The most prominent unobserved barriers present across all states to explain these patterns were lack of English proficiency, poor cultural health capital, fear of undocumented status, and unequal health coverage. Unequal coverage such as temporary Medicaid showed up in three states except Illinois where a lack of research prevents any assumptions of undocumented health-seeking behaviors. Cultural health capital references poor knowledge of existing RH services by the state or public health. Poor adaptation to the bureaucratic health system was also noted which sometimes depends on the years of residency in the U.S.

The Latino Case of Health Disparities

Even within the diversity of minority groups, the case of healthcare for the Latino population is a unique case of disadvantage. The first reason is for the rates of unequal access to the formal health system they display and the second is because the Latino identity can be studied from different lines of health disparities. One line of reasoning to explain disparities is

looking at the difference between documented migrant status and undocumented status.¹ In the case of Latino health disparities, despite the famous Latino paradox that finds that a general Latino population has higher life expectancies and is healthier, being Latino does signify inequality in other areas of healthcare that aren't mortality or morbidity rates. The IOM book *Unequal Treatment*, in its section on minority group comparisons, stated that “The probability of being uninsured among Hispanic Americans is 35 percent, compared with 17.5 percent for the general population” (Smedley et al. 2002). Aside from being the minority with the highest uninsured rate in the nation, Latinos are the most likely not to receive regular care in the form of preventive care. In the book *Minority Health in America*, Latinas have higher rates of diabetes and heart diseases (Hogue, Carol J.R, Hargraves, Martha A., and Collins, Karen Scott 2000). Preventive care plays a major role in stopping these types of diseases from developing through early screenings, blood tests, and constant check-ups.

The disparity in preventive care is explained by the possibility of being an immigrant and impoverished. Latinos typically work in service jobs with no access to work insurance. In 2002, only 43% of a working-class population of 87% of Latinos had work insurance (Smedley et al. 2002). Latinos are more likely to face language barriers not compatible with other minority groups in the process of accessing health care.

Latina Gendered Disparities and Reproductive Health Framework

The gendered line of reasoning this study is building on is the health dichotomy between women and men. As well as the difference between documented immigrant women, citizens, and undocumented immigrant women. The Latino population as a whole constitutes 12.5% of the U.S population (Abraído-Lanza, Céspedes, and Daya 2011). Yet within this population female groups experience different disparities than men when it comes to mortality and morbidity and have different gendered needs. The life expectancy for Latina women is 71 years, eight years lower than a white woman at 79. They are also unequally impacted by these three deadly conditions: cancer, cerebrovascular diseases, and heart conditions.

Aside from these morbidity disparities, studies on Latina immigrant subgroups have found that despite disparities in access, women are three times more likely to seek a provider

¹ The word migrant will be used interchangeably with immigrant that applies broadly to an individual who moves to another country.

compared to men. The explanation here is that women's need for reproductive services such as gynecology forces women to seek out healthcare or find alternatives (Arijit Nandi et al. 2008). Reproductive health is very important among Latinas. Typically reproductive health involves unique health needs related to reproduction, maternal, and sexual well-being. Sexual reproductive health and maternal health are often linked together under a branch of reproductive health. This refers to tests for sexually transmitted diseases, prenatal care, and cancer screenings. While reproductive services are overlooked in the literature, there is a lot of data on them in other social science and public health fields (Ramos et al. 2010). On the contrary, what is more difficult to study due to a lack of data is undocumented immigrant women of Latino ethnicities.

There are 10.5 million undocumented immigrants living in the U.S as of 2021 with mainly Mexican origins (Pew Research Center 2023). While there are numerous studies documenting Latina populations and health (Ramos et al. 2010; Abraído-Lanza et al. 2010), there is less on undocumented women.

The Relationship between Undocumented Women and the Formal HealthCare System

Undocumented Latina women are even more of a unique case in Latino health disparities as they navigate the levels of disadvantages mentioned by the Latino and female identity while navigating undocumented immigrant status. While many early studies (F. Allan Hubbell et al. 1991 & Scott Collins 2000) looked more at immigration status as authorized status while sometimes mentioning unauthorized status, there is a difference between both. I define undocumented status as women who aren't authorized permanent citizens, who don't hold green cards or visas, or who have not qualified for refugee status. In terms of health disparities, the status of being undocumented in the U.S has proved to be a barrier to health coverage. Federal law is constructed to exclude people with undocumented status. The federal Work Opportunity Responsibility Act of 1996 prevented immigrants with citizenship from Medicaid for 5 years while excluding undocumented immigrants (Kaushal and Kaestner 2005). The implementation of the Affordable Care Act in 2010 was meant to expand access to Medicaid for states that approved it. It nearly closed the health insurance gap between U.S citizens and authorized immigrants, but it had almost no impact on undocumented groups (Jain et al. 2021). Under the restrictions placed by law, undocumented immigrant women experience their own sets of challenges in healthcare.

Numerous studies have found that undocumented women tended to be earlier arrivals, were less fluent in English proficiency, and were low-income, working in service jobs with no insurance (Chavez 1986 et al.; Menjivar 2002). All these socioeconomic variables impacted women's knowledge of health institutions and the facility in which they navigated services if they had access. Due to the fact that health policy is different depending on location, undocumented women aren't able to access full Medicaid coverage in the most flexible states like California. A study on undocumented Mexican women, for example, states, "These women aren't eligible for the safety net of other low-income people, which are programs like Medicaid" (Chavez, Cornelius, and Jones 1986:5). These policies vary and are multi-faceted across states. Undocumented immigrant women in contexts where they're only given temporary coverage for situations like pregnancy are vulnerable to reproductive disparities at higher rates than insured immigrant Latina women.

Thus, a comprehensive definition of health disparities for this Latina subgroup would lean more toward the preferential side of healthcare quality. It would recognize the disproportionate health outcomes that Latina undocumented immigrants have to healthcare. It would also take a holistic approach by including reproductive care. A preferential definition of health access approach would be better suited to advocate for more than access to basic health services. As discussed, this subgroup also experiences inequalities that are gendered and made worse by their undocumented status. Unauthorized status also means data is limiting. This is, of course, because data on undocumented status is difficult to collect. Most of these reasons have to do with medical confidentiality in clinics, and hospitals, fears of deportation by women, and more (Chavez et al. 1986). This review highlights the strides made within that gap.

Seeing Undocumented Immigrant Health Access through State Analysis

I have spoken extensively about the layers of disadvantages for Latina undocumented women. In particular how health disparities are tied to state policy. Yet another angle not as discussed as how public health policy is gendered. One of the most obvious ways states have made exceptions for Latina immigrant populations is for certain RH services. The role of states and by extension sanctuary cities have a historical relationship of using state law to expand health flexibility to sectors of undocumented immigrants. In California studies on how the Affordable Care Act (ACA) impacted coverage expansion for types of immigrant groups show

that undocumented immigrant women continue to be some of the only recipients of emergency Medicaid for reasons of pregnancy. Under an act that brought near equal coverage to documented immigrants, emergency Medicaid remains exclusive, “unauthorized immigrants ineligible for full Medicaid benefits...other than emergency Medicaid, which is limited to life threatening conditions and labor/delivery” (Porteny, Ponce, and D.Sommers 2020). Depending on the political climate state policy might collaborate with federal law for the exclusion of unauthorized migrants or move towards liberal reforms.

In large immigrant-receiving cities, the local functions to influence alternatives to exclusions for children and pregnant women. The NYC Health Insurance Access website promises women who are pregnant Medicaid, “regardless of immigrant status”. The Child Health Plus (CPIH) program for all children does the same. These publicly funded programs like Medicaid, and CPIH are of special focus to Latina undocumented women because they exist as some of the only pathways to access in a country where minorities are overrepresented in public coverage. Despite the exceptions that immigrant-receiving states create, public programs like Medicaid reflect the same levels of inequality that persist when looking at the health outcomes of Latina undocumented women. The states and cities like California and NYC, are characterized for their progressive and sanctuary attitudes towards immigrants. However, they are not immune from the criticism that their steps towards inclusivity are still subject to gendered and gradual steps. If health access progress is gradual in these regions what does the public health policy look like in areas not largely discussed for immigrant populations like the Midwest?

The Midwest offers an interesting middle ground between the sanctuary locations of the West and the East for the presence of cities like Chicago, which have historically received large undocumented immigrant populations. These cities also offer confidentiality for people seeking health and state services. However, there are also other states in the region like Minnesota that aren't typically researched for their immigrant populations because only certain counties within them qualify as sanctuary areas. The case of Minnesota is interesting because despite not being a popular immigrant destination it is estimated that by 2025 the state will have a Latino population of 296,00 people (Villanueva et al. 2005). That population also includes Latina immigrants who may face different challenges in a health system not equipped to receive them. This raises questions about how healthcare programs function across less popular immigrant destinations. What does this mean across the board for reproductive health services that might be conditioned

with state or county policies in mind? While not the main questions of this study these will be guiding questions to keep in mind while reviewing the data.

In California and New York, prenatal care which is extensively researched is accessed by a majority of undocumented Latina women at an adequate time. Yet in Illinois, prenatal care is seen as inadequate even when emergency coverage is offered. Postpartum care is an elusive topic across the studies I will be looking at. Barriers to these types of care might be specific to geographical context but they can be similar across different regions. Viewing undocumented immigrant women's health access through state analysis might reflect a broader scope of what blocks healthcare.

LITERATURE

History of Latina Undocumented Immigrant Women in Literature

The growing interest in attributing immigration to Latina health stems from a shift away from studying Latino populations through behavioral and cultural views of individual deficiency. As well as a response to the increase in immigrant arrivals. While migratory status and undocumented status for Latina women are experiencing a growing interest, such a focus is aligned with a more intersectional view of inequalities in access to healthcare. The more nuanced view, as explored above, places new emphasis on socioeconomic status, health insurance, income, and immigration status. In other words, for there to be an emphasis on undocumented immigrant women, immigration itself had to evolve to be considered a social detriment to health.

Yet, tracing three decades of research from the 1960s to the 1990s shows us that researchers viewed the growing Latino population as a growing homogenous mass. Immigration wasn't viewed as equally important as individual patterns of health utilization or cultural beliefs with underlying assumptions. The findings by Hogue et al. (2000) reveal that in the Commonwealth Fund Minority Survey of 1990, more than 70% of Latinos were U.S.-born compared to a minority of only 29% of immigrants. The data is a major contrast to a public health study in 2020 which identifies that 34% of the Latino population in the U.S are now immigrants (Ornelas et al. 2020). These statistics suggest that the Latino presence was initially viewed as a population with citizenship. Yet the consensus now is that this group is predominantly made up of immigrants. This shift in dynamic grew a need to explore the different outcomes of health disparities across immigrant status.

The framework for studying Latino health disparities and, initially, immigrant groups went this way; they studied health disparities with a behavioral approach to analyze individual choices among Latinos to attempt to explain health outcomes instead of focusing on the social context. This approach, as Heide Castañeda puts in her annual review of immigration prioritized a, “focus on personal responsibility, self-esteem, and self-efficacy as opportunities for changing health behavior within the existing context, rather than investigating contextual drivers of behaviors and the possibility for upstream change” (Castañeda et al. 2014). In other words, this approach places immigrant populations as responsible for fixing their attitudes towards health with suggestions like eating healthy, working out, and more.

A second approach, the cultural framework model, also overlaps with the individualism in the behavioral model. This approach focuses on a group's shared beliefs and customs tied to their ethnic identity. Researchers using a cultural approach end up categorizing culture as a determinant of health, using it to explain patterns of underutilization for immigrant groups. Instead of looking at the economic, social, and lawful barriers to access studies utilizing the cultural model rely on negative stereotypes of culture: “ Researchers may view Latino immigrants, for example, largely as a homogenous group instead of accounting for different histories and contexts of migration, class, legal status, SES...” (Castañeda et al. 2014). In the early decades of Latino health disparities, 1960s perspectives, as Hogue et al. (2000) put it, “considered health care behavior to be a consequence of cultural beliefs and demographic traits but more recent research on immigrant populations emphasizes low socioeconomic status, lack of health insurance coverage and barriers placed by the health delivery system...” (Hogue, Carol J.R et al. 2000). The research moved away from a more cultural approach that blamed health disparities on individual mishaps to one more rooted in viewing immigration as part of the explanation.

Studies in the 1980s and 1990s (F. Allan Hubbell et al. 1991; Chavez et al. 1986) began to distinguish between documented and undocumented immigrants. These studies were focused on large sanctuary states like California. While some were broad, merely looking at insurance and income as sources of access, others began to put more emphasis on Latina undocumented women in particular health areas like prenatal care. “Utilization of Health Services by Mexican Immigrant Women in San Diego,” written in 1986, begins by proclaiming that medical care for Mexican immigrant women was a topic of concern. Yet, data on Mexican immigrant women was even more limited than it is now. However, the consensus was that this group was less likely to receive reproductive care from studies done in the 1980s.

Moving forward, immigration and undocumented status have become a social determinant of health that intersect with gender. Numerous studies attempted to show the relationship between documented immigrant status which is defined by migrants reaching legalization and undocumented migrant status. This lens was applied to the use of health services for Latina women (Fuentes-Afflick et al. 2009; Ornelas et al. 2020) and how the public health policies and public health programs also impact maternal health for immigrant women (Jain et al. 2021). The discourse has become more intersectional in terms of analyzing undocumented

women and health disparities through explanation factors like health coverage, language barriers, etc. Others look at patterns of utilization women show and possible social explanations for those patterns. Some studies go beyond recognizing disparities and looking at how communities have dealt with them with cultural health capital. In accordance with a holistic definition of disparities in which undocumented women not only suffer unequal health outcomes, reproductive literature is more likely to discuss immigrant status as fundamental to its findings.

The Holistic Approach of Health Patterns of Utilization

In a context that is taking a more holistic approach to health disparities and views immigration as a determinant of health, analyzing broad patterns of reproductive health among undocumented immigrant women might seem like a step back. There are various reproductive health studies that focus on specific relationships between patients and providers, and satisfaction with reproductive services. However, a comparative broad approach to health utilization patterns such as the number of visits to a primary provider, access to PAP exams, and prenatal care doesn't necessarily mean that these analyses aren't equally as informative as those that choose to focus on one issue.

Instead, such studies that analyze health patterns usually yield multi-variable explanations that might not be as discussed in mainstream health literature. For instance, Betancourt et al. (2013) track down sexual reproductive healthcare patterns among Mexican immigrant women. Studies like Betancourt's produce knowledge about other factors impacting women's access to reproductive health that are less discussed such as the surprising lack of knowledge about free reproductive services in New York.

Aside from studying reproductive health patterns of utilization because they offer holistic discussions, research on health utilization among Latina immigrant populations is more limited than it seems. While multiple studies deal with the underutilization of health services it is a hard subject to broaden because of the heterogeneity of Latino groups. What applies to one undocumented immigrant population of women in one state or healthcare situation might not apply to the other. In Betancourt et al. (2013) it is admitted that "there is limited research that documents the variability of service utilization by various Latino immigrant subgroups in New York and the contexts that may explain observed differences" (Betancourt S, Colarossi, and Perez 2013). There are two issues addressed here, the first one of "variability", or a lack of

understanding of utilization among diverse Latino immigrant groups. The second is an issue of changing conditions due to locality.

Studies that take on the issue of locality at times are more focused on showing how patterns of service align with common barriers. These barriers like poverty and coverage are rooted in the research location (Chavez et al. 1986; Maru et al. 2021). They utilize lines of reasoning based on state policy. For instance, in an article by Sheela Maru on the use of postpartum care they frame NYC as important when it comes to explaining their findings, “Exclusionary health coverage policies, such as Medicaid ineligibility for some immigrant groups, also limit access to care. In NYC, nearly 18% of immigrants are uninsured...” (Maru et al. 2021). This emphasis on locality is important for addressing the heterogeneity of health access across the U.S.

Yet at times, the focus on mainstream determinants of health like income and coverage doesn't show unobserved determinants of health access. Especially if studies are concentrated on how mainstream variables work in one state because similar issues have been raised elsewhere. In research conducted by Vargas Bustamante on undocumented Mexican immigrants in California, he finds that the presence of outlier barriers might also be responsible for inequities, “12-13% of healthcare access and utilization disparities are due to “unobserved heterogeneity” (Bustamante et al. 2010). What he calls unobserved heterogeneity are barriers he didn't expect to find like fears of deportation and no social networks. These barriers aren't easily observed by analyzing health insurance statistics or conducting state-wide surveys with basic questions. This is not to say that the focus on framing health access through location is what is limiting. On the contrary, the focus on state location opens up the possibility of comparing the variability of health pattern utilizations across the U.S. For location analysis to be productive we also have to look at the “unobserved heterogeneity” that studies suggest or decide to focus on to complete the picture of health access.

The report *Unequal Treatment* circulates back to the idea that mainstream determinants of health like insurance don't always tell the full story. Insurance status as a predictor of care is important but not all insurance is equal, “The privately insured generally receive a higher quality of care than those who are insured through publicly funded sources (e.g., Medicaid)...” (Smedley et al. 2002). It's not just about the nuances of insurance but that minorities find it hard to navigate health with or without it. The existence of co-payments, the location of healthcare providers, and

transportation all exist as barriers that can't be easily accounted for. Literature that shows unexpected barriers like lack of knowledge of services, temporary insurance, and cultural factors do exist for reproductive care. And it is notably found in the holistic explanations of studies that look at service utilization.

METHODOLOGY

I conducted research for this review by compiling background information on Latino immigrants and health disparities in the form of secondary sources. I then moved toward more grounded academic articles on the reproductive health of undocumented Latina immigrant women. This first part of the research process involved a combination of thirty-four academic articles and book chapters on reproductive health for undocumented women and general Latino health disparities. The second part of this research was to identify information about the healthcare system and public health programs across the four states (California, New York, Illinois, and Minnesota) through the use of thirty-two government or state websites. I gathered statistics and sociodemographic information on Medicaid, public health programs, and immigrant eligibility using over thirty of these state or government websites. I also identified health reports made for the cases of Minnesota and Illinois that gave a broad picture of the health access of Latino demographics. The main literature for my findings is based mainly on the articles on reproductive health for women which are as follows: (Betancourt et al. 2013; Chavez et al. 1986; Maru et al. 2021; Nandi et al. 2008; Vargas Bustamante et al. 2010; Keller et al. 2021).

FINDINGS

CHAPTER 1

NEW YORK: The Determinants of State Policy on Maternal Services

“Immigrants in New York have more health insurance options than in many other states” (NYC 2024).

New York City is synonymous with its diverse immigrant community which is composed mainly of Latin American immigrants. In the early 2010’s Mexican immigration was outpacing migration from Latin America (Betancourt.S et al. 2013). In the context of its receiving capacities NYC is a hotspot for immigration politics and healthcare programs like Medicaid make it into discussions about welfare. These programs constitute some of the only points of access to maternal services for undocumented women. Due to publicly funded programs constituting such a major presence in NYC, they are at the epicenter of state analysis. The first step in analyzing unobserved barriers such as fear of deportation, and knowledge of services that differ from mainstream variables like income is to measure how limiting the public health situation is for this group.

The Immigrant Hierarchy of New York Public Health Programs

The state of New York boasts of offering a mix of federal and state programs for vulnerable populations such as children, low-income residents, and immigrants. These programs are Medicaid, Medicare, Child Health Plus (CHIP), and Family Health Plus respectively. For state-funded programs like Medicaid the state’s inclusion of any type of health care for immigrants regardless of status is generous. New York, compared to the extreme situation in Florida where immigrant children must be lawful residents for care, has structured its eligibility for its programs based on citizenship status. Medicaid which grants coverage to low-income citizens, pregnant women, families, and persons with disabilities holds immigrants to the extra burden of defining mixed immigrant status.

The state categorizes U.S. Citizens, nationals, and Native Americans as immigrants covered by Medicaid at similar levels of privilege as U.S citizens (Immigrant Eligibility 2004). At a glance, it seems like NY has made exceptions for pregnant women and immigrants. The state even ranks the highest for healthcare accessibility in a U.S News and World Report

compared to the other three states in this review. In a series of national surveys (Table 1) with 70,000 participants states were ranked across eight categories like access. Considering that access was measured by a mix of adults with no coverage, wellness visits, and visits by children with Medicaid, NY comes out on top as a provider for basic wellness visits.

Table 1. Health Care Access by State Ranking, 2023

New York	Illinois	Minnesota	California
*#10 in Health Care Access	#18 in Health Care Access	#21 in Health Care Access	#34 in Health Care Access

Source: U.S News and World Report. 2023. “Health Care Access by State Ranking.” Retrieved on October 22, 2023 <https://www.usnews.com/news/best-states/rankings/health-care/healthcare-access>.

*Data was collected using six metrics including population with no health insurance, child wellness visits by kids with Medicaid, child dental visits, adults with no wellness visits, and putting off visits due to cost.

The mentioned measures of access are typical for national surveys where income and coverage determine that people will at least have access to some form of primary care. Yet, quick breakthroughs of state health don’t account for nuances of coverage that create inequalities in care or don’t tell us about the gaps of who is susceptible to no visits. The ugly reality of public state health programs is that they are characterized by exclusions that cut their services in half by the lawful worth of immigrants prioritizing green card holders and refugees, a status difficult to achieve. This hierarchy of immigration implies that undocumented immigrant women are only left with emergency Medicaid and reduced costs for public hospitals and clinics. The other options constitute gendered needs such as the Prenatal Care Assistance Program (PCAP) under Medicaid and CHPlus B (Documentation Guide to Immigrant Eligibility 2004). While pregnancy continues to be an emergency of reproductive need, full Medicaid coverage remains exclusionary. Health insurance is not equal for everyone and health access is a complex web of gendered needs and cultural sensitivity that the state isn’t providing.

The Conditionality of Health Insurance

If Medicaid plays a major role in defining maternal health services this is most obvious in the data collected about undocumented women's sexual reproductive health services (SRH). Reproductive services are typically spoken about as contingent on maternal health for NYC immigrant women (Betancourt et.al 2013; Maru et al. 2021). I argue that the exclusions of health access for undocumented women are best analyzed by the relationship between prenatal care, which is offered through PCAP, and postpartum care which is not a state priority. These two types of care are not equally accessible for these women and a major factor has to do with undocumented status. The disparities in access created by health programs reveal that lack of knowledge related to education, unequal coverage, and years of residency are strong risk factors in deterring healthcare utilization. These barriers that aren't typically discussed as major predisposing factors are tied to unauthorized immigration and state policy that creates a hostile environment for women seeking reproductive care in public hospitals and centers.

When it comes to measuring reproductive health care utilization patterns for undocumented immigrants those measures and methods vary through the NYC literature. Yet health coverage always factors in as a point of content to lack of care. In a study, "Factors Associated with Sexual and Reproductive Health Care by Mexican Immigrant Women in New York City" they surveyed women to understand their utilization patterns for SHR services like prenatal care, mammograms, and abortion (Betancourt et.al 2013). The importance of this study comes in its ability to display the barriers to Mexican women receiving gynecological care beyond prenatal care in a geographical context. The researchers measured SHR utilization by asking demographic questions, most notably insurance and first pregnancy. The highest three barriers to care were the inability to pay for services, English language barriers, and difficulty obtaining care. (Betancourt et.al 2013). The highest obstacle was a topic related to insurance and costs associated with private doctors when insurance status was taken into account.

In a similar research approach, Sheela Maru et al. (2021) explore maternal health care from preconception, prenatal, and with a particular emphasis on postpartum. Although the data collected comes from the NYC Pregnancy Risk Assessment where immigrant women self-report maternal services, access was also measured utilizing a similar analytical stance to explain disparities in postpartum care. The type of insurance and other SES qualities like education

figured as covariates: “Covariates included insurance type during preconception, prenatal, and postpartum periods (private, Medicaid, or other public); race and ethnicity...”(Maru et al. 2021:714). Maternal Health in NYC is concluded to be lacking in the preconception and postpartum phase but the type of insurance figures as a strong explanatory variable for other barriers such as education and years of residency. Other researchers who are looking at Mexican undocumented immigrants with mixed gender demographics and with more emphasis on SES variables still take into account how insurance defines access (Nandi et al. 2008). With special attention to undocumented status, insurance is the major predisposing factor or SES variable that dictates primary care. Although insurance plays a role in all these analyses, it's how it's discussed as conditional to the quality of coverage that stands out for this social and cultural analysis of undocumented status. What are the barriers in the literature that reinforce the lack of coverage as a problem? The way insurance figures in themes of navigating NYC is crucial to comprehending why coverage is only one part of a more complex puzzle of health access.

New York: The Ultimate Prenatal Care Provider

The analysis of sexual reproductive services as a whole in NYC shows that at least among Mexican immigrant women there is a disconnect between what the healthcare system defines as access and the reality of undeveloped networks of health information and cultural space. The gap in healthcare reinforces typical SES barriers like coverage and low-income status as predisposing factors for the underutilization of services. In the NYC article measuring SRH service referenced prior, a health belief model is used to theorize how Mexican women will behave based on assumed benefits of services, knowledge of severity, and SES obstacles.² Models such as these give women agency in which their perceived knowledge and personal experiences in the U.S are used to assess if they choose to deal with the health system (Betancourt et al. 2013).

The most damaging unobserved barriers to SRH services for Mexican immigrant women were a lack of knowledge of health care services, poor information by the system, years of residency, and to an extent a fear of unauthorized status. A combination of these unobserved barriers that were either reinforced by lack of insurance or combined with negligent state

² The women in this study were recruited from the Mexican Consulate and CBOs where their undocumented status was not revealed but it is implied that participants are of mixed status. See Betancourt (2013) for demographics.

insurance (Medicaid) meant that women stopped receiving prenatal care. It is no surprise that these findings are related to education as Mexican immigrants have some of the lowest rates of education (Betancourt et al. 2013). Yet women's lack of knowledge of SHR is deeply connected to state policy and how New York institutions have excluded reproductive services from the gendered care they are willing to extend. A majority of Mexican women were reported to be uninsured (21 out of 151) and many became pregnant at relatively young ages. These two facts play a role in 88% of women receiving prenatal care paired with the disturbing results that some never had received PAP Smears or STI testing beyond maternal purposes (Betancourt et al. 2013). Prenatal care and delivery were the first points of contact women had with any reproductive service in the country despite the average participant having nine years of residency. The disparity between prenatal care and other reproductive services such as birth control/ PAP smears can be interpreted through the bureaucratic system's sufficient outreach of prenatal care through adequate information. This is opposed to the gap of knowledge that women have about reduced-cost programs in NYC that don't require authorized status.

In the breakdown of NY public health programs above, women with undocumented status are eligible for Prenatal Care Assistance (PCAP) as a right granted to anyone with a certain income (Immigrant Eligibility 2004). The need for contact with the healthcare system through the hospital and to receive prenatal care means that some women only learn they had this emergency right by childbirth. The PCAP is a benefit that is part of a half-cut measure of not providing full Medicaid but it's perhaps one of the most well-established programs under public health available to uninsured women. One woman recounts that her prenatal experience at NYC hospitals and clinics was easier to navigate than figuring out how SRH services work, "...And when you deliver, they tell you how to go to the clinic for pediatric care. But they don't tell you how to get health services for yourself or how to pay for it, like birth control or PAP exams" (Betancourt et al. 2013:329). This experience shows dissatisfaction with poor communication from providers about birth control or SRH outside of pregnancy. It also shows the gaps in knowledge women have about services that are convenient for their time and income.

The comment on the guidance of providers after delivery also shows how PCAP is structured to offer care for at least two months after delivery and care for the baby a year after birth (Richmond University Medical Center 2024). This structure prioritizes the female body mainly in childbirth and the child who is a naturalized citizen by birth. It's important to note that

in studies discussed so far prenatal care is described more as hospital care provided in the delivery stage. Yet a look at NY's PCAP benefits illustrates clearer the types of care women can receive under the state (Table 2).

Table 2. PCAP Program Benefits in New York State, 2010

Prenatal	Post-Pregnancy
Medical Check-Ups	Full Healthcare 60 days after birth for mothers ³
Lab Work	Access to WIC ⁴ and help applying for low or no-cost insurance for children
Access to specialists	
Hospital care for delivery	Healthcare for newborns for one year
Education on pregnancy	Family Planning Services
HIV Counseling and testing	

Source: New York State. 2010. "A Healthy Baby Starts with a Healthy Pregnancy." *ny. Gov.* Retrieved in April 2024 <https://www.health.ny.gov/publications/6000/>.

The PCAP program also seems to be the structure in which New York used to offer 60 days of postpartum care for women aside from the healthcare to their newborn. While the data in Table 2 dates back to 2010 it's important to note that the only thing that has changed in over twenty years is that healthcare for women after birth has recently been expanded by NY to up to one year as part of the American Rescue Act of 2021 (New York Immigration Coalition 2023). This state choice, although generous, only continues to offer postpartum care with time constraints. This presents an interesting angle to see the disparity between knowledge of services and the existence of said services.

Unlike this participant who details her experience, some women aren't even aware that such programs offer extended coverage after delivery or are reluctant to continue care after. This

³ Postpartum care under emergency prenatal care has moved from 60 days up to a year (New York State 2023). The table features data from 2010, with all benefits still available today except for postpartum care which has been updated.

⁴ WIC program serves pregnant women, infants and children up to age 5 by providing healthy foods, nutrition education and breastfeeding support for low-income women under Medi-Cal.

is true for a group of Mexican immigrant women in California in which 10.1% of undocumented women viewed their infant examination postpartum as unnecessary compared to 1.9% of documented mothers (Chavez et al. 1986). The hesitancy to deal with the healthcare system in the examples so far intersects with women's undocumented status leaving them only with prenatal care and unawareness. Mexican documented immigrant women who do qualify for coverage also express the need for better translation of NY public benefits. This is because knowledge about basic information for SRH services is lacking. At times the acculturation of women into the host country which is contingent on years of residency also adds to the misinterpretation of services.

Immigrant women who did access the healthcare system often didn't have a stable provider or references to SRH facilities. Those who had Medicaid coverage were only familiar with specific parts of their plan such as the easy guidance provided by the prenatal program during pregnancy. Yet when it came to topics of contraception women expressed unawareness of their plan's ability to cover it or their own ability to fund it (Betancourt et al. 2013). Education to fill the gaps of information for these programs requires a culturally sensitive and non-bureaucratic approach to language. The absence of such an approach has led many to wrongly assume that free medical services are paid: "Many women surveyed did not know that they could obtain free or low-cost SRH services in NYC (20%)" (Betancourt et al. 2013:330). Another percentage assumed that documentation was needed to obtain care, an assumption that could have been right if the locality wasn't New York. These two examples detail the gap in knowledge that women have based on documentation status, as one makes the other feel less entitled to care.

Adaptation to the complex health system in the U.S. involves time of social networking with migrant communities preferably women. The results of this study touched on how increased years of living in the state play a role when women in that category were more likely to have PAP test/ gynecologist (GYN) exams (Betancourt et al. 2013). Years of residency were also paired with the skills to navigate the rights they were entitled. However, language barriers and undocumented status are still a combination that produces fear in women. Even those who might know the limited access to of care they have aren't encouraged by the bureaucratic health systems of efficiency that provide underwhelming language translators. One of the only points of reproductive health contact for immigrant and undocumented women in NYC is prenatal care up

to the delivery stage. As mentioned above it's typical for women of both statuses to be eligible for PCAP as part of emergency Medicaid. Yet their knowledge about reduced programs under state coverage stops there with some not even knowing they have extended limited care post-birth.

These findings also implicate a gap between those who are the target receivers of Medicaid (low-income people, immigrants, etc.) and how the state has promoted those benefits. In 2023, Medicaid and CHIP, the children's program eligible to children of all status, had massive growth across California and Minnesota but not in New York. According to its own governmental statistics, as outlined in Table 3, the state had only an enrollment growth of 32% compared to California's immense expansion.

Table 3. Medicaid and CHIP Expansion by State, 2023

State	Individuals Enrolled	Net Increase Percent
California	*14,325,437	84.72%
Minnesota	1,401,089	60.48%
Illinois	3,863,904	47.09%
New York	7,535,276	32.70%

Source: Medicaid. 2023. "Medicaid and CHIP Expansion by State." *Medicaid.gov*. Retrieved in October, 2023 <https://www.medicaid.gov/state-overviews/state-profiles/index.html>.

*Data collected by Medicaid.gov as part of their "state profiles" report with information being up to date as of July 2023.

While states could have attracted enrollment for different policy reasons, what we do know is that there is a gap of mainly undocumented and immigrant women underusing certain aspects of Medicaid and other services to which they believe they are not entitled. It's also clear how the public health system and the reproductive health services offered by the state are not made with undocumented Latina women in mind. They are more adapted to a group of women familiar with the bureaucratic health system, who cultivate a sense of protection from citizenship rights, and who have facilitated access by language and cultural knowledge.

The gendered public health policies of maternal health care present in NY Medicaid have created a situation where prenatal care is one if not the first point of contact with the formal health care system. The accessibility of prenatal care isn't just opposed to a lack of reproductive services in general. As I've mentioned in the discussion on the inequality of coverage, the access to prenatal care reveals trends of exclusion for postpartum care. Within this form of exclusion, some of the same barriers (type of insurance, education, and minimal residential years) appear to shape the undocumented immigrant experience in a similar vein to SRH services. In a study on, "Utilization of Maternal Health Care..." immigrant women are observed for their self-reported utilization of prenatal and postpartum care to see how their responses differ from U.S.-born women (Maru et al. 2021). Although the ethnicity of these women was mixed, women from Central and South America showed some of the most glaring disparities in maternal health. While prenatal care might be adequate as provided by the state, postpartum care was more inaccessible to immigrant women compared to U.S.-born women in structural ways. Postpartum care is defined by the number of appointments or check ups women participate in to prevent future complications weeks after birth. Postpartum care for immigrants was shaped by the loss of temporary insurance most notably Medicaid.

Citizens and immigrant women had similar rates of postpartum utilization but it was in the process of gaining access that immigrant women had higher disadvantages to quick care. Immigrant women were left in a more vulnerable position as likely holders of temporary policies: 11% of migrant women lost insurance postpartum compared to only 1% of U.S. women. What is even more concerning is that the demographic being left without channels to postpartum care is Latina immigrants with a 95% rate of losing insurance postpartum (Maru et al. 2021). The glaring disparities mainly plaguing this group of women are deeply tied to public health insurance policies of the state as immigrant women figured as great users of Medicaid. In this sample of this study alone, 731 women were reported to be under Medicaid in their prenatal period with the majority being on private insurance after postpartum (Maru et al. 2021). If we interpret these results with the precarity of undocumented status and the strong priority that pregnancy has over other forms of preventive care in public health then it is safe to say that depending on status some women were only granted benefits during pregnancy. Some might even have resorted to enrolling in private insurance to receive some form of care post-delivery.

In fact, the study by Maru et al. (2021) also explains how the type of insurance plays a macro role in behaviors related to health utilization as not all insurance is equal. The most obvious evidence to support this fact is that as previously shown in the case of prenatal care for Mexican immigrant women, 88% had received this type of care compared to something like a mammogram (Betancourt et al. 2013). These statistics show that women of both statuses are more likely to receive maternal care when the state provides free and clear guidance for it. The type of insurance most used in “Utilization of Maternal Health Care...” reinforces this point as they clarify that most immigrant women, not just Latina migrants in NYC are covered by prenatal programs under Medicaid (Maru et al. 2021). Yet undocumented status makes it challenging for women who were once eligible for benefits to continue receiving them, “Undocumented women can enroll in Medicaid when they are pregnant, which gives them insurance access up to 60 days after the end of pregnancy. However, they cannot access Medicaid outside of pregnancy...” (Maru et al. 2021:722). These limitations for health services that appeared for Mexican immigrant women as well are also paired up with the idea that women need more access to education to navigate a hostile system not made with them in mind.

Throughout both case studies of SRH services, a form of knowledge tailored to a vulnerable group that is learning their way around a fragmented system is needed. When it came to a general immigrant female group in NYC women with less knowledge of preconception services were typically women with less than a high school education, no health insurance, and were Latina (Maru et al. 2021). Education factored greatly with health beliefs and behaviors but so did less duration in the U.S as another level of insecurity. The knowledge that immigrant women don't receive through the informal education system usually comes from empirical experience. Thus, it makes sense that a new immigrant status comes with higher risk differences for maternal services than a woman who is U.S-born. This is shown to be reduced once women are more integrated into the host country (Maru et al. 2021). Coverage for Latina immigrant women and for many minorities who suffer disparities is seen as a way of improving access and thus morbidity or mortality rates.

However, the relationship between prenatal care and postpartum care for Latina undocumented immigrant groups shows that health access is contingent on a localized and state perspective due to the uniqueness of their precarious status. It's important to acknowledge the type of insurance, and the barriers reinforced by the health system (lack of knowledge, increased

acculturation, etc.) because they reflect a group so economically and socially disadvantaged that it can only access emergency state insurance. Thus one of the first steps in improving health access should begin by looking at public health programs like Medicaid instead of simply stating if women are insured or not. Or bunching up different types of insurance. The reality is that most women based on the literature are likely to have public insurance above private coverage. From that standpoint, improving public health programs by breaking language barriers, training health providers with a Latino health perspective, and getting rid of legal barriers to coverage is a better approach.

Duration in the U.S and State Policy Matter

In addition to the relationship between different reproductive systems, another vantage point in which to situate access in NY is by analyzing how the immigrants fare under anti-immigration laws. These laws helped shape the way undocumented Latino immigrants adapted to the health system, and how gendered differences continue to matter in anti-immigrant climates. In, “Access to and Use of Health Services Among Undocumented Mexican Immigrants...” Arijit Nandi et al. (2008) tests health service access solely on an undocumented Mexican population, This study has co-ed participants but its consideration of gender details showcases attitudes towards health that are specific to gender.

Family and social networks can be deterrents or motivators of health. The same principle applies to women who, faced with the limits of services, would rather prioritize the health of their children. (Betancourt et al. 2013). It was found that in some cases gender enabled Mexican women to seek out a regular provider at higher rates than men. This is due to women being the first to step into the healthcare system for the sake of their families (Nandi et al. 2008). Undocumented Mexican women were at times more motivated to seek services to build family knowledge. Menjivar (2002) expresses how women are responsible for family health by transmitting information between mothers and daughters. Women in this study had more positive health access than men but this was due to some undocumented migrants having years of acculturation, higher incomes, living with few adults, sending no remittances to Mexico and having a social support network. (Nandi et al. 2008). These women have more advantages to new Mexican immigrants in the informal economy and predominantly immigrated before the 1996 Work Opportunity Act.

The Act restricted documented immigrants from applying to Medicaid for 5 years if they entered the country before 1996 at a federal level. The results of this study suggest that people who entered the country before 1997 had more access to a regular health provider and women were leading in this category (Nandi et al. 2008). It's important to note that the women in this sample are undocumented thus, the law didn't restrict any Medicaid eligibility as this was already denied. Most of these women were more acculturated, had fewer children to take care of and possibly had access to reduced cost health centers if access is determined by having a regular provider. The duration of time in the U.S (before 1997) might also imply that this group of women inhabited a political space that could be debated to be less anti-immigrant by law, while newly arrived immigrants after '97 were greeted with more restrictions. It's also important to note that while this law was at the federal level states had a choice of how to implement it. California and Illinois continued to restrict undocumented migrant coverage but created quasi programs for documented immigrants as a loophole for the 5 year wait. On the other hand Florida jumped at the chance to enforce it fully (Kaushal and Kaestner 2005).

The example of how a group of undocumented Mexican women might have better access because they are more economically advantaged, have more years of residency, and don't have families shows how some of these continue to be barriers for newly arrived women. This case also reinforces the idea that state actors are key in immigration politics as seen by the slightly progressive approach of California as it refused to cave under the pressure to legalize anti-immigration.

Discussion

The case of New York shows how state and public health policy has an impact on the vulnerable undocumented population of Latina immigrants. While other populations like documented immigrants or Latinx born citizens might have more insurance options and knowledge via cultural capital, undocumented women are more dependent on free and reduced services than most marginalized groups. At least in terms of maternal services women showcased a major use of Medicaid and PCAP programs (Betancourt et al. 2013; Maru et al. 2021). Instead of viewing any type of insurance as a possible gateway for access in NY, research should recognize that not all insurance is equal as extensively described by the emergency policies that enabled women specific reproductive care while posing a barrier to others.

Even when acknowledging the nuances of state and federal insurances like Medicaid another aspect is the need for increased cultural capital for public programs. While diverse state's like New York are likely to have Spanish translators in clinics or hospitals, the space for more trained health professionals with cultural knowledge and a Latinx background is still needed. For example, immigrant women reported that despite translators they felt ostracized for their Spanish and as if their questions weren't being taken seriously (Betancourt et al. 2013). These unobserved barriers which I have defined as determinants that typically aren't widely discussed, suggest that both a community based approach and state regulation is necessary. While immigrant community organizations can help spread SRH and Public program education, the health system can also collaborate by making knowledge accessible. Health providers should be expected to provide the same digestible guidance that they do for prenatal care for other forms of reproductive care and staff need to do better at helping women communicate with their insurance on eligibility.

The state has made small strides in moving away from policy that dictates a loss of insurance after postpartum as studies have noted. The introduction of the American Rescue Act which extends coverage for up to 12 months for postpartum care under PCAP is a federal act for states who wish to implement it (Immigration Coalition 2023). New York showed willingness to move forward with its application of it. Yet the impact of the policy has yet to pan out with inclusion being only a year old. To those who suffer from such disparities the law seems to be gradually taking steps while dancing around full coverage. Ideally speaking, New York would use its right to make decisions over state-federal programs like Medicaid to expand coverage to all immigrants despite undocumented status.

CHAPTER 2

CALIFORNIA: The Evolving Project for Undocumented Health Access

“Although undocumented women have the right to access emergency and prenatal care, often they are unaware of these rights or feel intimidated about seeking health care.” (Zavella 2016:36).

California is the golden state of progressivity from its push for green policies, migrant friendly programs, and health care. The vast network of Latino communities that call cities like Los Angeles home make it a popular destination for immigrants to settle down. Across ten states, “California holds the highest concentration (37%) of the Mexican immigrant population” (Bustamante et al. 2010). The situation of health policy and public health programs for decades was similar to the immigrant hierarchy in Medicaid or Medi-Cal as it is known in California. Medi-Cal is also shaped by the documented and undocumented immigrant divide and it has worked around federal law to make their programs available to both. The state notoriously has blocked full Medi-Cal coverage specifying that undocumented adult immigrants could only receive emergency coverage. Undocumented pregnant women were also only eligible for temporary coverage under a pregnancy only coverage similar to PCAP in NY (Department of Covered California 2023).

Despite these points in undocumented immigrant coverage or lack thereof, the state can’t be completely comparable in its Medi-Cal decisions to New York. CA’s expansion plan for public health has been based on age of individuals more than it has on immigration status. This is not to say immigration status has not played a role in access to public programs as California can also be criticized for prioritizing documented immigrants. In the discussion of the Work Opportunity Act, documented migrants kept some benefits through state intervention. People in specific circumstances, like DACA students who qualify for deferred action against their status for their entry as children, were given priority over undocumented immigrant adults. Yet, California has rolled out Medi-Cal expansion through a hierarchy that is categorized by age and health of individuals. Unlike New York, its principal aim has been an ambitious move to provide all low-income adults despite status with coverage (PPIC 2024). This goal of California policy implies that the unobserved barriers that will be presented for this case need to be looked at through the lens of the gradual development of low-income undocumented women. Especially

since most studies that deal with utilization take insurance type, public health programs, and changes in public health as essential to their analysis of overall health access. The determinants for RH must also be described in the context of locality even if they overlap with New York findings.

The Rocky Road to the First-in-Nation State Law for Full Coverage

California boasts of the largest Medi-Cal program not just across four states but in the nation with an impressive 15.3 million people covered (Health Insurance 2023). These numbers only tell part of the story of health access for undocumented women and were only made possible with a combination of federal law and state expansion for those who were predisposed to qualify. The passing of the ACA in 2010 was the start of a long gradual road to full state universal coverage for all income groups regardless of status. Unlike many states that implemented ACA by 2014, California showed its trailblazing attitude by having it take effect as early as 2011 in some counties. The effect of ACA on Medi-Cal benefited mainly documented immigrants in the 2010s and almost all low-income populations while the undocumented were not considered (Porteny et al. 2022). With this rocky start in which the situation for undocumented women remained the same as it does in New York, California took small steps for undocumented immigrants by prioritizing the young and healthy and ending with the vulnerable.

In 2016, undocumented immigrant children achieved full Medi-Cal coverage with young low-income adults younger than 26 achieving the same milestone by 2020. While New York is characterized by prioritizing documented immigrants and half-backed emergency policies, CA is best described as an evolving project for full coverage that brought long waits to undocumented adults and elderly people. By May 2022, CA had switched its strategy granting the same eligibility to undocumented adults of 50 years. By 2024, California was ready to be the first state to implement a first-in nation state policy that opened up Medi-Cal to all undocumented immigrants regardless of age (PPIC 2024). The initiative funded mainly by state tax dollars has promised full coverage to everyone and is viewed as a milestone for states like Minnesota who plan to implement their own vision of full coverage.

However, the non-linear road to meet this goal has created conditions in the Latina undocumented population that resemble NY's lack of access. In terms of unobserved barriers, full coverage was only a possibility starting with the ACA in 2010 and was practically

unthinkable before that. Women struggle with the same issues of unequal emergency coverage, have similar fears of deportation, and knowledge of services in some CA contexts is limited and attached to the duration of residency. For reproductive health NY and CA have similar issues with prenatal care and postpartum care that will be elaborated on in the next two sections. I will analyze California with these recurring issues and depict them as starting points for the state to address in order for its new policy to reach as many undocumented women as possible. While reinforcing the notion that more than state insurance is essential to women's health access. I will also turn my attention to older research that details the situation for immigrants ending with new findings that show how nuanced the path to access has been.

Social Invisibility, Poverty, and Hazardous Jobs

California's generous attitude in the last two decades does not make it exempt from years of disparities in Medi-Cal. Research of undocumented women displays similar SES explanations for the underutilization of preventive, postpartum, prenatal, and even forms of RH care. Studies dedicated to undocumented Mexican women and their underutilization of preventive care show the triple disadvantage that women have in immigrant destinations areas such as San Diego. These women don't just have to deal with figuring out their special needs as women with immigrant status but live in unauthorized status which adds a level of uncertainty to the ordeal. In Chavez et al. (1986) the health situation of this group was analyzed by asking women by status about maternal health. Such early initiatives into this particular disadvantaged formed the sociodemographic picture in CA that is still reinforced by later research. The most obvious is that undocumented women were part of a low-income group and were almost always unlikely to have access to private health services.

Undocumented Mexican women in San Diego were 63% more likely to be working and concentrated in service sectors compared to their documented counterparts (Chavez et al. 1986). Domestic service jobs are physically demanding, low-paying, and lacking the protection of labor laws against exploitation afforded to U.S citizens. In these conditions, work insurance is not a reality and it was documented women who had higher rates of private insurance and usage of state programs. Undocumented women's restrictions to work insurance make them more at risk if we put into context that employer benefits were once the main avenue for healthcare. To exemplify how large this disparity is for undocumented women, in the 1980s, 80% of the

nation's population was under private insurance they could only afford by employers. (Chavez et al. 1986). While the types of coverage that undocumented women had if they weren't granted work insurance is unclear it's likely they had emergency coverage as part of Medicaid or other cost-effective insurances.

The 2010s held promise for expansion not just for public coverage, but for the ability to purchase insurance by premiums and subsidies for citizens but not for undocumented women. Nearly thirty years apart from foundational research the Mexican undocumented population continued to display the same SES disparities. Access to doctors, and primary sources of care remained restricted to authorized status with similar explanatory variables of education, sex, income, and health insurance (Bustamante et al. 2010). The current climate of change in California yet to impact the undocumented. This made it clear that women were still subject to policies of emergency that were magnified by their position of socio-economic marginality in which they weren't even viewed as second-class citizens but with invisibility.

The Mechanisms of Unequal Reproductive Care at the Height of Emergency Coverage

The patterns of underutilization of reproductive services and preventive care for undocumented women across California reveal how undocumented status was a greater predictor of blocked access because of how it played off of fears of deportation, unequal insurance, and location of services, compared to NYC. The developing policies that moved towards offering most low-income citizens in coverage were continued discussion points in most undocumented immigrant literature (Bustamante et al. 2010; Porteny et al. 2022) indicating that utilization of reproductive services were described through the lens of who was starting to receive coverage, who was left out, and what other observations impacted status in relation to the services being offered. For instance, in Chavez et al. (1986), there was less of a focus on if undocumented women received prenatal care and more on how that quality of care compared to their documented counterparts.

Generally speaking across the board the unobserved barriers that seemed to block access to quality reproductive and preventive care were irregular status, fear of deportation, duration of residency, English proficiency, the need for knowledge, and at times location of services. In San Diego in the 1980s, undocumented Mexican women were accessing prenatal care but at slower rates than documented women and with no private insurance. The percentage of

undocumented women (21%) not accessing prenatal was greater than that of authorized women at 13% (Chavez et al. 1986). This is not to say that California had fewer women accessing prenatal than New York per se. This is simply stating that in the Chavez study the 247 undocumented women out of 309 receiving care in this sample were being outpaced by documented Latinas (1986). The structure of free prenatal care in California was mirrored by the one in New York for which undocumented women were only allowed to receive emergency prenatal care before 2024. This approach was known as Medi-Cal for pregnancy as full coverage Medi-Cal automatically included prenatal and postpartum services. Medi-Cal for pregnancy compared to emergency care in NY has slight differences in services. Unlike NY it includes services like mental and vision. (Table 4).

Table 4. Medi-Cal for Pregnancy in California, 2024

During Pregnancy	Post-Pregnancy
Prenatal Care	Full coverage for a year with continuation of exact benefits
Hospitalizations	
Prescriptions	
Newborn Care	
Vision	
Mental Services	

Source: Department of Health Care Services. 2024. "Pregnancy". *dhcs.ca.gov*. Retrieved in April 2024 <https://www.dhcs.ca.gov/Get-Medi-Cal/Pages/pregnancy.aspx>.

The article by Chavez et al. (1986) does not state if Medi-Cal was a source of prenatal care for these women but it does acknowledge that Medicaid remained exclusionary, or at least the full version of it. Yet the most popular location for prenatal care were public hospitals with 29% of women attending. Public hospitals are also structured with state programs in mind and are equipped with receiving Medi-Cal and state coverages. This makes it possible that the undocumented women who couldn't receive full coverage might have received free prenatal

services by the state. Thus, if women do have some form of prenatal coverage by the state, it begs the question of why they seem to be underusing that service more? The same could be said about postpartum care which showed massive disparities between documentation with 16.3% of undocumented women not going back for post-delivery exams compared to 5.3% of documented Latinas who forfeit this exam (Chavez et al. 1986).

In the context that limited pregnancy coverage does offer postpartum for up to a year unlike the recent introduction of this extension by NY, it is interesting to view similar levels of underutilization for postpartum. However, the research for California indicates that legal status is more of a powerful contributor or at least it's highlighted more in the attitudes of women. Undocumented women in the study tended to be newly arrived in the U.S while documented Latina's were long-term residents. Long-term Latinas with regular status showed more English proficiency while their counterparts tended to struggle (Chavez et al. 1986). Although in NYC language barriers were present and duration of stay was paired with knowledge, California is more of a case where postpartum and prenatal care are measured by quality instead of access which is where those barriers play a part. While NY maternal services are generous, California's services were more expansive making it probable that women were accessing services and that research on California has more of a focus on the process of said services. California undocumented women showed more hesitancy towards parts of prenatal and postpartum care while in NYC women tended not to know about said services or underutilize them. It is in the process of receiving or not receiving postpartum and prenatal that English proficiency and years of residency play a role.

If undocumented women were new arrivals their first contact with the healthcare system was also pregnancy and in labor (Chavez et al. 1986). Prenatal care attitudes for women are contingent on status and shape the type of prenatal experience they had. Inadequate prenatal care is defined as care that begins in the third trimester instead of in the first. Undocumented women were 6.8% more likely to delay prenatal care than 1.9% of regularized women (Chavez et al. 1986). When women do access services, delays impact the quality of those services. English proficiency and years of residency are explanatory factors in why women were more likely to delay care especially when prenatal care was dependent on hospital visits.

Undocumented women are less familiar with public hospitals such as the UCSD Medical Center in San Diego where most of the women in the mentioned study were receiving care. Most

notably those delaying prenatal care were women who had given birth in the U.S not in Mexico like other women in the sample. As newly arrived women with more knowledge of the Mexican system they possibly displayed hesitancy towards accessing prenatal programs in the first stages of pregnancy. The most crucial stages like the trimester and delivery showed signs of utilization as they were deemed the most necessary by women.

English proficiency is another strong barrier that plays into unfamiliarity. Undocumented and documented women had similar levels of education but 60% of the former can't speak English and 68% can't read English compared to 40% of the latter who lacked speaking skills (Chavez et al. 1986). To put into context how this barrier might cause non-access, hospitals often require paperwork with signatures, the use of translators to piece together information, and reinforce practices of quick discharge to not overwhelm the system. The lack of English skills in both areas can also make women feel stigmatized and uncared for as women did express fear of U.S doctors and recommendations of procedures they were not familiar with (Chavez et al. 1986). English proficiency and years of residency not only led women to seek prenatal care much later but also figured into attributes of rejected postpartum care.

While delivery and care into the third trimester are interpreted by undocumented women as necessary services, post-delivery shows a different picture of rejecting this post-partum altogether. We've discussed how undocumented women were less likely to receive postpartum checkups but the reasoning for this was not because of non-access that was aligned with coverage. Instead, 53% of both women believed they didn't need to attend a postpartum checkup because they were healthy with only a small minority of 8% listing cost as a barrier. The above indicates that across status Mexican women viewed postpartum exams as unnecessary (Chavez et al. 1986). Even so, the higher rate of undocumented women without this type of exam is similar to the attitude taken for prenatal care which was only used during labor or a couple months before.

The rejection of a postpartum exam reinforces the notion that if women don't have to deal with the public health system they simply won't. There is a clear disconnect between how the state offers postpartum care for up to a year post-pregnancy (see Table 4) to how women understand their needs in the context of an unwelcoming system. Undocumented women in other locations tended to prioritize the health of children (Betancourt et al. 2013) above their own or in this example believed that once the child had been delivered healthy they didn't feel the need

to prioritize their bodies. Especially if that priority indicated intimidation by the system and fears of detection.

The attitude towards C-sections can also be interpreted by women holding beliefs about how to handle their own bodies that differ from Western interpretations of C-sections that view them as low risk. As well as the likelihood of having low-income status. In the Chavez et al. (1986) article, women who had less duration in the country were also less likely to submit to procedures that they considered to be more risky such as C-sections. Only 17% of undocumented women chose to deliver using C-sections when they were offered under non-emergency conditions. This is compared to 33% of documented women who showed a strong preference for the surgery (Chavez et al. 1986). Interestingly, the percentage of undocumented women who went through with the procedure was similar to the rate of women who had chosen to get a C-section in Mexico before immigrating. The similarity indicates that women who are familiar with the surgery in their home countries will undergo it again in the U.S. Yet, this type of delivery was not popular among this group anyway meaning that most might align with the explanation that newly arrived Mexican women view C-sections negatively and with fear and prefer, “natural or vaginal deliveries” (Chavez et al. 1986:16). Aside from women feeling more comfortable with natural delivery, low-income status can also explain why many would find an expensive surgery less attractive than what they deemed a more safe and inexpensive option. Documented women in this San Diego 1980s context were at the height of having more ability to pay and were of course for full public coverage showing an ability to choose that is exclusive.

Thus, maternal services at the peak of an era where Medi-Cal was exclusive to documented women show similar patterns of underutilizing postpartum as NYC but also showed nuances in the attitudes of women who made difficult decisions to delay care. In California, prenatal care is viewed not just by access but by its completion, and postpartum at times was rejected. Both these patterns are reinforced by undocumented determinants like English barriers, fears of detection in public spaces, and fewer years in the U.S making them more familiar with the Mexican health system.

If the new coverage law in 2024 aims to reach as many women regardless of immigration status it should first begin by initiating discussions of its open eligibility in immigrant communities, especially immigrant activists and non-profit groups that can expand information in Spanish. The establishment of open Medi-Cal eligibility should then be followed

by measuring how attitudes over public health spaces have changed over the years. With the evolution of many community health centers and hospitals in low-income migrant communities in CA it would be helpful to know if women still feel like language poses a barrier to services or if the quality of Spanish translation is still lacking. Women who are new arrivals are in the most precarious position as they are most likely to rely on long-term resident Latinas for knowledge acquired in the healthsystem. The more that women are informed of entitlement rights under state policy, paired with reduction of unobserved barriers, the more they are equipped to strengthen their own social networks that might include newly arrived women with said knowledge.

Unacknowledged Undocumentation Status in the 2010s

The picture of health for undocumented women during a time of state-federal restrictions on public coverage shows that even with the few openings for women to access the system they preferred at times to remain outside of it. California's path to full in-state coverage for all low-income individuals starting with the primary development of the ACA continued to raise discussion in immigrant politics. The 2010s influenced all immigrants in the public health system despite status, but how did it shift attitudes toward utilization of services and coverage access? In Bustamante et al. (2010) a similar approach is taken to analyze utilization patterns to sources of care across statuses for a mixed Mexican group. The timing of this study in 2010 coincides with the real-time enactment of the ACA. The study depicts how powerful legal status continues to be in determining poor health access. These findings will also be used as a point of comparison for the aftermath of the Affordable Care Act.

The study, Bustamante et al. (2010) has more of a focus on preventive health mainly in the form of primary sources of care and the number of doctors visits. Yet what makes this study compelling is that it separates what they call observed and unobserved heterogeneity in the overall access to preventive services. Unobserved heterogeneity is defined as, "behavioral and idiosyncratic factors that are often difficult to measure in large-scale surveys although they remain important policy targets" (Bustamante et al. 2010:153). Unobserved heterogeneity are behaviors that seem "idiosyncratic" such as unfamiliarity with the U.S health system. These topics aren't discussed easily with reducible points in the way income or education status can be listed in a survey to quickly tell us something about a group's disadvantage. In this comparative

analysis we have discussed how these factors function under state programs and insurance to block full and quality access.

The blockage of preventive care such as doctor visits, primary care visits, and efficient prescriptions remained contingent on legal status in 2010, a situation that was shaped mainly by observed factors. In comparison to documented immigrants, documented Mexicans were only 60% likely to report seeing a doctor in the past year compared to 76% in the latter group (Bustamante et al. 2010). Undocumented immigrants don't have the equal access to simple care like a one year round doctor check up due to explanations of poverty, health insurance, education, and marital status. Other explanations such as English and time in the U.S were categorized as “observed factors” in this study as they could be reduced to numbers and measured as categories in a table. For other forms of preventive care undocumented Mexicans were at a disadvantage with 52% of them having a source of care compared to a majority of the documented at 73% (Bustamante et al. 2010). Undocumented migrants expressed not having a fixed place to go when they were sick compared to documented migrants who had more sources available to them. These disparities are part of the same complex relationship between legal status and the prominent use of the public health system that serves millions in California. The system that blocks access to most care that isn't emergency or life threatening based care.

The fact that 88% of health utilization disparities across status were because of observed factors in the form of socioeconomic differences is not a coincidence. The public health system of the 1980s in California had undergone massive shifts due to federal law and state decisions with the passing of the ACA. The ACA only had low-income citizens and those protected by legal status in mind by also denying forms of coverage that weren't Medi-Cal, “undocumented immigrants are exempted by the mandate to have health insurance coverage and are they are not eligible to purchase insurance through the health insurance exchanges or to receive subsidies” (Bustamante et al. 2010:153). The above exemplifies that federal law doesn't recognize the presence of undocumented people and by extension their health by not requiring them to comply with the rule that everyone has to be enrolled in coverage or be exposed to a fine. Instead the private and public insurance market was reformed by providing citizens with exchanges and subsidies to purchase insurance or receive free coverage through their state's expansion. The ACA was designed to work for the current health system and was not an alternative to it. The act was not revolutionary at all for undocumented populations.

In the text *Slow Violence...* by Nixon (2011) he attributes the gradual effects of climate change and its impact on poor communities as slow violence. Slow violence is opposed to explicit and quick violence from manmade wars or persecution. The concept can be used to describe inequalities like poverty and poor health access that minorities suffer at the hands of the state or macrosystems that condemn them to slow deaths. The exclusion from ACA is a form of slow violence in which CA was able to continue its emergency exceptions for undocumented people. While the ACA didn't even recognize the existence of this community. This led health inequity to remain practically the same while subjecting people to the same morbidity rates that were common for Latinas who didn't receive preventive services. Although the study (Bustamante et al. 2010) displays findings before the year the act was fully in effect the next section will demonstrate how utilization patterns continued to show disparities years after full implementation. We have seen that coverage is part of these observed factors that make up the majority of socioeconomic reasons why undocumented migrants are more subject to access disparities and how public access continues to be outdated despite the updated system for the rest of the low-income population.

Nevertheless, poverty and education were also key players also referred to in the analysis of women who were low-income and whose unskilled jobs didn't allow them any benefits due to status. Education related to English proficiency also present in the 1980s continued to play a role in 2010 utilization patterns suggesting that Spanish translation, or lack of it, remained a problem in healthcare settings when this group was able to access doctors or services. Although usually categorized as an observed variable, English proficiency is described in this analysis as having a prominent role in how it plays out in settings like clinics, ED rooms, and health centers with health workers not culturally and linguistically trained to deal with questions and health explanations for this group. Most importantly, this barrier is contingent on unobserved factors like a fear of deportation. As well as a lack of familiarity with the U.S healthcare system and the absence of strong social networks for better knowledge, a barrier that will be further explored at the end of this analysis. While 88% of health disparities between Mexican groups could be explained with SES factors, 12-13% of those disparities could only be explained through unobserved variables (Bustamante et al. 2010). The unobserved barrier of fear of deportation produced similar responses for undocumented Mexicans in this study as it did for uncommented women in San Diego.

The women in Chavez et al. (1986) would delay prenatal care and reject postpartum checkups when they felt that they were unnecessary because they had internalized the public health logic of only accessing care in emergency situations. Legal status was a barrier that held up this attitude as women who were undocumented were less likely to speak English, feared questions of their status, and were intimidated by western procedures of medicine. Bustamante et al. (2010) found that fear of deportation was the strongest unobserved factor that made people reconsider getting healthcare. Yet, this detriment to get help was not as strong when immigrants needed treatment for critical health conditions that led them to the emergency room. In this pattern of behavior, there is a constant negotiation of health conditions as dire enough to access the system and those that are seen as minimal to reject preventive care if it means not dealing with these fears. Thus, in behavioral contexts unobserved barriers still play a significant role in undocumented Latino populations getting care and are much harder to explain because they might look differently across different ethnicities of women, or gender. The overall consensus at the dawn of ACA was that undocumented immigrants would continue to face the same disparities unless coverage and unobserved barriers were taken into consideration.

The ACA: An Enabler of the Health System

The passing of the ACA excluded the use of funds at the federal level for undocumented immigrants. Still undocumented immigration is also regulated by the discretion of the state to distribute funds. California is an exceptional case as it hosts the largest immigrant population in the nation (Porteny et al. 2022). Thus, its application of the ACA can't just be analyzed through a black and white divide of granting documented and not undocumented immigrants access. Instead everyone including the undocumented saw some change due to the new law. Yet that change remained the most unequal for adult undocumented immigrants. The state once again prioritized documented residents followed by certain age groups and DACA recipients. Previous attempts by federal law like the 1996 ACT had California rejecting the five year wait for regularized migrants, meaning that the 2010 ACT created a situation in which they were immediately entitled the same rights for public and Marketplace insurance as U.S born citizens. When it comes to health states also are able to make their own exceptions for those excluded from the law and the state did so for those it defined as worthy of coverage, "DACA designees are eligible for full scope Medicaid funded by the state and since 2016 the state covers all

qualified children ages 0-18 in Medicaid regardless of status” (Porteny et al.2022:87). The steps that California was taking for better immigrant access weren’t too radical in the early 2010’s and were full of gradual waits. Those who suffered the state’s indecision were undocumented adults.

While the state only expanded unequal Medicaid coverage, irregular migrants showed similar levels of disparity in health access more than ten years after the Bustamante et al. (2010) study⁵. From the dates of ACA’s full implementation (2014-2016) all three groups of U.S citizens, documented immigrants, and undocumented immigrants experienced a drop in uninsured rates. Medi-Cal/ CHIP coverage was increased for all three groups with the lowest increase going to undocumented immigrants who only went from a 22% rate of coverage to 32% (Porteny et al. 2022). The most obvious disparity was for undocumented groups shown by the fact that the ACA resulted in the gap of uninsured to widen between documented immigrant and undocumented immigrants. While the disparity between U.S born citizens and undocumented immigrants almost disappeared. The documented population went from having an uninsured rate of 32% to an impressive drop of 18% (Porteny et al. 2022). These changes were mostly from receiving full Medi-Cal as changes in private insurance were modest. Thus showing how California’s health protections towards documented immigrants in the past made them automatically eligible for Medicaid without any waiting periods in between.

The positive improvement for undocumented immigrants was mainly due to county and local policies who decided to extend coverage they had been denying. In Porteny’s explanation of this small improvement, which they reason can’t be due to undocumented children gaining coverage because they were also analyzing the years before 2016, they conclude that, “an increased number of individuals eligible for Emergency Medicaid due to the ACA expansion and local programs...10 county programs in California, such as my Health L.A provide non-emergency care for the unauthorized” (Porteny et al.2022:92). The modest gains after the ACA for undocumented immigrants came from counties that expanded emergency coverage to immigrants and local programs who already provided full care. These gains came before the 2016 coverage for children. These changes were at the local level and show that in terms of the observed barrier of coverage the ACA was not reformatory for undocumented immigrants. Considering that in pre-ACA years undocumented Mexicans suffered health access disparities

⁵ It's interesting to note that (Bustamante et al. 2010) and (Porteny et al. 2022) use the same survey method, the California Health Interview Survey based on the years they were measuring access and the ACA coverage expansion.

mainly to observed barriers including coverage this is worrisome as the lack of any undocumented immigrant reform actually widened disparities. These disparities in health would have continued in a mainly negative path if the 2020's didn't begin with a report by Governor Newsom and state representatives for a path to universal coverage. Yet, such a policy is so new only coming into effect in January 2024 that future research is necessary to determine whether full coverage improved the gap between documented immigrants and undocumented immigrants. In addition the rate of immigrants accessing Medi-Cal services to their fullest capacity would also have to be accounted for. Such a study would have to take an interest in California as nationally full-coverage for undocumented people despite age is rare.

Reproductive Justice Education in Los Angeles for Undocumented Latina Women

In terms of the observed barrier of coverage the start of the new decade brought with it changes that have yet to pan out fully but what remains true is that unobserved factors can also account for undocumented women not utilizing free services they are eligible for. Undocumented women are pressured by external factors of legal status, English proficiency, education and more to refuse services in an coercive manner by these stressors. In these conditions the only motivators for utilizing applicable services are in emergency situations. The same behavior was observed in the study of Bustamante et al. (2010). The behavioral pattern of putting off available services or refusing them can also be explained with similar unobserved barriers also found in the case of NY women for reproductive care. Those being a lack of knowledge about services found in undocumented Latina women in Los Angeles and common fears of intimidation for navigating public health settings.

The study by Zavella (2016) is an ethnography that was conducted in a state-wide organization for reproductive justice for undocumented Latinas called California Latinas for Reproductive Justice (CLRJ). This organization created an institution based in L. A for Spanish-speaking women called el Instituto de Autonomía y Justicia. The main question this study grapples with is asking if this type of organization based on reproductive justice with an intersectional lens actually has an impact on participants. Zavella (2016) also points out that undocumented Latina women in L.A struggle with the knowledge of reproductive services. Like Latinas in NY, undocumented women were likely to assume they don't have emergency and prenatal care as state rights or felt intimidated seeking out care in public spaces. These fears were

also strengthened by SES characteristics of poverty, health insurance, and other barriers like transportation.

Latina women who do access reproductive services were reported feelings of subjectification and intimation for western notions of healthcare. This is similar to women in San Diego in the 1980s study where Mexican undocumented women viewed C-section surgeries with skepticism and fear. Aside from telling us that these observed and unobserved barriers continue to exist in cities with large immigrant populations, this ethnography also shows us that engaging in reproductive justice with an intersectionality lens can be successful. The success of this approach comes from knowledge it produces of services. This health capital was built through health literacy in Spanish with an emphasis on immigrant rights.

The CLRJ noticed that undocumented Latinas had a gap in knowledge about how to access reproductive health, in particular young adult women who didn't know they could access contraception and other sexual health services from doctors without parental consent (Zavella 2016). These gaps in knowledge were not just met with basic reproductive health service information and sex education by the organization. Instead a series of focus groups that lasted a couple days with a community and social justice framework run by Spanish Latina staff, some of which were formerly undocumented themselves. In these sessions, women learned about the female body, the rights they were entitled to, reproductive justice, and political theory totaling thirteen hours of instruction.

This type of organizing was successful as it combined a praxis outreach of reproductive justice education and provided information about rights and services. Many commented on the success of the workshop, "... it was very interesting and very well done (muy bonito)" (Zavella 2016). The case of this ethnography serves to strengthen the argument that undocumented women need education through social support networks about health services that aren't patronizing. This works best if it's done through people who are trained in immigrant rights, and Spanish health literacy, or even share the experience of once having been undocumented. Through this type of organizing and with the help of state policy more undocumented people could be reached.

Discussion

The most surprising findings in California have to do more with how unobserved barriers play a role in the process of undocumented women receiving reproductive or preventive services. NY showed a precarious situation for undocumented women in which barriers like knowledge of SRH services blocked access, and the emergency Medicaid policies made it impossible for women to receive postpartum care that wasn't prenatal. While California showed overlaps with its emergency Medi-Cal policies, its goals for full universal coverage impacted the way researchers have reviewed access in the immigrant-friendly state, and those policies in turn impacted women's attitudes towards free care. The strongest unobserved barriers were fears of unregularized status, followed by English proficiency, education, and a lack of familiarity with a Western health system. As well as other SES barriers like income that were reinforced by the lack of legal status. The above-impacted women's delay in prenatal care and their rejection of postpartum care with preferences to only receive care in emergency situations like childbirth.

Latina undocumented immigrants also struggled with unequal insurance while it seemed like most of the low-income population including their documented counterparts were being granted full Medi-Cal under the ACA. If the new policy of full coverage is to have an impact on undocumented Latina women the state should distribute Spanish information in prominent Latina communities about the existence of full coverage as women might still be under the impression that the old emergency policies still apply. They could also partner up with organizations like CLRJ that have a more social justice framework to them to help women apply to Medi-Cal as the public health system can be intimidating for newly arrived women. Latina volunteers from immigrant organizations are also crucial in spreading a reproductive justice framework that isn't just about informing women but also empowering them.

California is debatably the closest thing to an ideal case for improving immigrant health access because full coverage is a reality, not an unfulfilled realized plan. The state also has statewide organizations that are made up of Latinas working on aspects of unobserved barriers like knowledge in major receiving cities like L.A. The potential for this state is favorable but the picture of health access becomes more murky for the undocumented women in the next two states Minnesota and Illinois.

CHAPTER 3

MINNESOTA: The Determinants of a New Immigrant Destination

“They tell you look here, they can help you but we live in isolation where we barely talk about health issues” (Smaida et al. 2002:14).

A Non-Desirable Immigrant Destination

The political climate of anti-immigrant sentiment on tides of Latin American immigrants coming in through states like Texas is mainly directed on desired destinations such as New York. These states are envisioned as having influxes of immigrants coming in for their sanctuary and democratic values. There is a similar focus on the East and West Coast by immigrant scholars who view desired destinations as worthy of research for their prominence. Still, the Midwest region contains democratic states like Minnesota whose Latino immigrant population is rarely featured in discussions for irregular status of migrants.

Research in California in the 1980s was showing that undocumented Latina women were early low-income arrivals and were prospective long-term residents. The Latina community was established as having the qualities of prospective long-term residency. In contrast, 1990s historical research on Minnesota Latino immigrants, mainly Mexicans, depicted a seasonal picture of migration and patterns of immigration made up primarily of blue-collared workers in cities (Villanueva et al. 2005). These observations show that the Latino immigrant community was viewed in a framework of the past and for their history of temporary workers that weren't expected to overstay their welcome. Yet, in the early 2000s, the attitude towards immigration began to shift as the new century didn't promise a decrease in Latinos. The general Midwest region experienced a new phase of ethnic diversity of Latino cultures and was met with policy analysis and research to understand demographics and pull factors.

The early 2000s saw Latino immigrants move outside large cities to rural and small town areas. A study by Villanueva et al. (2005) breaks down the increase of national diversity as migrants went from cities to towns: “...residing outside the Twin Cities metropolitan area in 2000 include 95, 6222 Mexicans, 1,579 Puerto Ricans, 1,000 Cubans...”(p.1). The move involved pull factors like job openings in job processing. The shift from urban to rural is distinctive for a minority group that is envisioned nationally to be concentrated in large urban

areas such as New York and L.A. Thus, it is from this rural shift that I will analyze the Latina undocumented immigrant perspective. Due to how Minnesota's immigrants have been analyzed through the perspective of a non-receiving state the research on undocumented Latina women in terms of reproductive health is incredibly limited as if to say almost non-existent. Studies that do mention Latina immigrants do so under the guise that undocumented immigration in rural areas is part of a new shift in movement towards new immigrant destinations (Keller et al. 2021). There are various health reports that provide information on reproductive services for women across states but these are typically reduced to a couple data points on Minnesota (Hasstedt et al. 2018). There is of course research done on health disparities in the Minnesota and the Midwestern region, especially a focus on the rural.

Yet these articles usually analyze a homogenous Latino population in healthcare (Blewett et al 2008). More recent research has focused on determinants that changed the public health landscape like the impact of Covid-19 in minority groups in Minnesota (Field et al. 2020). With this in mind, this chapter will be based on limited research done on Latina immigrant women in Minnesota rural areas. I will combine that research with health reports on minorities that give an image of reproductive health in the state. While at the current moment the literature on undocumented Latina women is limited, it is reported that 95,000 undocumented immigrants reside in Minnesota with Mexicans making up 50% of that group (Pew Research Center 2019). The relevance of this growing population implies that it's worth the effort to highlight undocumented status in areas of health care where it's not as extensively understood as it is in popular urban centers.

Viewing Coverage Expansion through a Racial Equity and Intersectional Lens

Although not a desired immigrant destination by the media and even by Latino immigrants who reside mainly in popular cities, Minnesota's public health programs may undergo noticeable changes as they grapple with the existence of their undocumented immigrant population. In California and New York health access for undocumented immigrants revolves around insurance like Medicaid and unobserved barriers work around the lack of coverage. On the other hand, Minnesota has its own unique public health programs that work to block undocumented health access that rival the importance of Medicaid in the two previous states. The state is not exempt from the rule of undocumented immigrants being denied preventive

healthcare that is not coverage of emergency services. Especially for a location that has not characterized itself throughout its history as a receiving or even desired destination.

However, Minnesota has displayed more effort to incorporate expansive public health programs for low-income people mainly benefiting citizens. While not as radical in its goals like California it has used state-federal funds to create programs aside from the Medical Assistance (MA) program which is the name for Minnesota's Medicaid. Another of its prominent public health programs is MinnesotaCare which provides low-cost insurance to employed uninsured residents who are low-income (MNDH 2023). The recipients of this program are still required to pay monthly premiums based on economic situations.

These two programs, Medical Assistance, and MinnesotaCare are at the heart of the discussion of blocked policies for undocumented immigrants. In addition to a temporary form of coverage known as Emergency Medicaid Assistance (EMA). The complexities of how each one works will figure as another barrier for undocumented women that shows how immigrants not only find the general health system intimidating but view public health programs as disorganized and uncommunicative to their needs. I have summarized the eligibility of undocumented women for the three programs (see Table 5). Minnesota has more of an emphasis on its low-income citizen and documented population as seen by the creation of MinnesotaCare for which it makes certain exceptions for special cases. The addition of EMA is but another extension of the gendered policy of Medicaid. Both reinforce the notion that undocumented women are only worth aiding when they are birthing a child and a potential citizen of the state.

It can be argued that the state is generous for giving undocumented who do have coverage another free avenue for prenatal care that is not a form of Medicaid; these additions come with limitations of their own. For example, while NY hasn't made the significant changes in coverage that CA has, it has taken small steps under the Biden administration. NY is allowing women a year of postpartum care compared to its insufficient sixty days. Minnesota is unmoved to change the exceptionality of its emergency care for women.

Table 5. Eligibility for Undocumented Immigrants Across Public Health Programs, 2019

Public Health Program	Undocumented Eligibility
Medical Assistance (MA)	<p>Undocumented individuals are eligible for emergency services like pregnancy and delivery with criteria.</p> <p>Undocumented women can't be insured to qualify. Covers the period of pregnancy and 60 days postpartum as part of CHIP.⁶</p>
MinnesotaCare	<p>Immigrants with lawful presence in the U.S are eligible for state or federal care Undocumented individuals are not eligible.</p> <p>State-funded care is available for DACA recipients.</p>
Emergency Medical Assistance Program (EMA)	<p>Undocumented individuals who meet MA income criteria but can't apply due to status.</p> <p>Undocumented pregnant women who are ineligible for CHIP-funded MA due to existing insurance. Covers labor and delivery costs.</p>

Source: MN House Research. 2019. "Eligibility of Noncitizens for Health Care and Cash Assistance Programs." Retrieved on April 15, 2024

<https://www.usnews.com/news/best-states/rankings/health-care/healthcare-access>.

⁶ CHIP is the Children's Health Insurance Program under Medicaid.

That notion of exceptionalism in the fine print of these public health programs sends the message that the state is giving welfare designated for more valuable populations to an undeserving population. In that context, it feels entitled to be applauded for giving the bare minimum. The attitude towards reforming public health in NY and CA is one that is moving towards recognizing the intersectionality of minority groups that suffer health disparities. Despite New York's gradual steps, its decision to expand postpartum is a socially conscious one under the Maternity Care Action Plan aimed at disadvantaged groups. The Immigrant Coalition (2023) frames the move as one to, “reduce racial inequality in connection to postpartum morbidity and mortality...”(p.1). New York and California recognize that these reforms that they are undertaking by either expanding coverage or revising aspects of their policies are due to state-federal law contributions to the morbidity and mortality rates of minorities. On the other hand, the reforms by Minnesota are framed with an attitude that doesn't acknowledge the intersectionality of undocumented groups. The political rifts between democrats and republicans also make its solidarity appear questionable.

The Limits of the MinnesotaCare Buy-In Expansion

The planned reform I speak of is the signing of a law in 2023 by Governor Tim Walz to allow all undocumented immigrants to enroll in MinnesotaCare. The bill known as MinnesotaCare buy-in will go into effect in 2025. From its very proposal the bill faced challenges from democrats, the governor, and citizens who were “concerned with costs” (Minnesota Reformer 2023). Instead, the proposed future for Minnesota was one where the governor only granted undocumented children care. The proposal was finally signed but granted with an air of reluctance and was justified by supporters who pointed to the sacrifice of undocumented workers during the COVID-19 pandemic. Although important to recognize the disparities that the pandemic highlighted for the Latino community, these were already pre-existing but not viewed as worthy of preventive and specialist care before.

The expansion of MinnesotaCare is also an interesting choice when Medical Assistance is the largest publicly funded health program in the state. The choice of Medical Assistance seems obvious since it grants free full coverage to those eligible. It's also through Medicaid that the only other state that has allowed undocumented eligibility for public insurance has carried out its law. Yet, MinnesotaCare as depicted in Table 5 has the most restrictive availability for

undocumented people of them all. A part of this is due to the fact that it's not free coverage but low-cost insurance. Under MinnesotaCare low-income people must still undergo a system of premiums including deductibles and copays. The 2025 law won't alter this rule even when it's targeting one of the most low-income and exploited groups as reports state that the program will be the same for unauthorized groups with expenses attached (MPR News 2023). The following supports the notion that Minnesota isn't ready to be fully reformative or lead with an attitude of intersectionality that acknowledges how low-income and unprotected by law undocumented Latinos are. If this was the case it would have granted full MA coverage free of cost to all low-income residents in California. The disregard for the population they are targeting and their history of health disparities also presents an issue in the path of health access for undocumented women.

If insurance continues to not be equally distributed then unobserved barriers like lack of knowledge about financial information, premiums, and language barriers will continue to play off of this disparity. The existing Minnesota public health system also seems to be complicated with the inclusion of MinnesotaCare which many wouldn't know the difference between this type of program versus the well-known Medicaid. The history of Minnesota's reluctance to categorize itself as an immigrant state, though it hosts a considerable population also means that social marginalization for Latinas might be a larger issue there. Cities like LA or NYC have the advantage of being Spanish-speaking dominant places. These are all aspects of Minnesota's unique system I will cover more in depth in the next section with the limited information available on women's experiences.

The Gap in Reproductive Health for Undocumented Latina Women

The limits of undocumented Latina research have been discussed as women are reluctant to share their precarious status and for settings like health centers and hospitals that don't require it for care. On top of these challenges, Minnesota is not a state that has yielded much research on the undocumented experience, and when there is interest it's not in the reproductive area. Thus, health reports that work closely with the Minnesota Department of Health on women's health will give the most reliable picture of reproductive health for a Latina population with a mixed demographic (Minnesota Women's Health Report 2022). I will analyze this information with the consideration that undocumented women might not be equally represented in these reports for

reasons of fears of undocumented status and for the heterogeneity of the demographics that might include documented and U.S.-born Latinas.

In the report, “2022 Minnesota Women’s Health Report Card” compiled by the University of Minnesota” the data on women’s health is broken down to the best extent using racial and ethnic identifiers but it quickly noted that, “One of the limitations of the data sources is that some data reported were not broken down by gender and race/ethnicity” (p.1). With this in mind, when looking at a heterogeneous Latina population most recent data points to SES characteristics in the state being mainly favorable. In terms of potential barriers, Latina women ranked high as participants in the labor force with 73% of women employed in 2019 making them the second highest group after Black women. This might imply some stability in terms of income but more information would be needed to know the types of labor force jobs done. The type of employment could either block coverage, enable it, or in the case of undocumented women create unhealthy results depending on the loose work restrictions.

In terms of preventive care the state was achieving pretty favorable results for minority women when measured by the Healthy People Targets.⁷ The most impressive of these goals in preventive care reached was for mammogram services. The percentage of women receiving mammograms in 2020 was 79% while the target for 2030 was 80% showing that across race and ethnicity, women were mostly receiving these services (MWHR 2022). These forms of cancer screenings are mainly not considered emergency care, making it possible that mainly documented Latinas with insurance or undocumented women with some form of private insurance were accessing them.

Prenatal and Reproductive Health

While the more detailed cases of New York and California depicted an image of adequate prenatal care through the state and access to prenatal care with negative attitudes surrounding the process, Minnesota seems to be offering adequate care. In 2020 across races and ethnicities of Latina, Black, Asian, White, and Native women 79% of pregnant women received prenatal care in the most crucial stage of the first trimester (MWHR 2022). The former is likely due to Minnesota’s open options for emergency prenatal care under EMA making women who have

⁷ A model that provides health goals to strive for by a certain year and compares the current state of health to the desired target. This model the report refers to references data from the year 2020 and compares it to goals for 2030.

insurance or earn too much for MA still be eligible for covered prenatal care. As well as the fact that both MA and EM are available to undocumented Latina women. Although the process of Latina women reaching out for prenatal care is unknown from the cases of New York and California women were more inclined to navigate the health system during pregnancy or for the sake of their children.

From the years 2018-2020, Latina women in general were reported to not account for too many births with only eight percent of Latina women pregnant compared to sixty-eight percent of White women (MWHR 2022). These statistics go against the stereotype that Latina women are flooding hospitals with pregnancies and taking away public funds. It's interesting to note that 20% of births during this period were by foreign-born mothers from Mexico, Ethiopia, and Somalia. This indicates that it is possible that Latina immigrant undocumented women figured into these births. We have also seen that undocumented women are less inclined to deal with the healthcare system from cases like California where only delivery might motivate them to do so (Chavez et al. 1986). In terms of quality prenatal care women weren't only getting care during the first trimester but they were also giving birth to regular weight babies. Thus from a medical standpoint, women were seen as getting full prenatal and quality care up to delivery. Across race and ethnicity, 84% of women gave birth normally with 7% giving birth to low weight babies (MWHR 2022). However, since this is not divided by ethnicity and race the ethnicity or race of the women giving birth to low weight babies is unknown.

Postpartum depression, although not mentioned by other studies, did figure in this report with 14% of mothers responding they felt symptoms after giving birth (MWHR 2022). The unexplored mechanism of postpartum depression raises questions of how undocumented women experience depression or navigate it if women are disproportionately denied physical care to begin with. A study on this especially in a non-traditional immigrant state would add to the mental health disparities that Latina women also experience. While the data presented isn't as revealing as the cases of NY and CA where attitudes and the process of reaching out for help was more discussed it does reveal that Minnesotan women including a general Latina group is using prenatal services. However, how the health system and public health programs work in Minnesota can reveal more specific barriers and attitudes that Latina immigrant women face even if they are not receiving reproductive care. With this general reproductive picture in mind, I will analyze the experiences that undocumented immigrant Latinas face when trying to use

public health programs and interact with a social welfare structure in Minnesota that is not well equipped to their needs.

The Barriers for HealthCare Integration in a Non-Traditional Immigrant Region

For immigrant Latina women moving into non-traditional rural areas, confronting a dominantly white homogenous, and culturally untrained health system has become the norm. In cities like New York and Los Angeles, there seems to be systems in place that provide Spanish translators with different degrees of adequacy and representation. In terms of state demographics, the Minnesota health system lacks any basic surface-level representation within social services like medical ones. In fact, Latina immigrants in the Midwest are more likely to be receiving services from non-Latina providers creating rifts between service providers and new immigrant communities that are just starting to emerge (Villanueva et al. 2005). The greatest unobserved barriers for women in accessing social services and medical programs in rural Minnesota were lack of information, English barriers, due to a lack of education, followed by a lack of understanding. The cultural divide between Latina attitudes on health and social service providers was also noted to impact how these barriers played out when women made efforts to access services.

While these barriers might overlap with the attitudes found in the two locations, Minnesota Latinas must be viewed in a context where they are in a process of integration and where the health system is more likely to ignore their experiences creating stronger cultural barriers. For example, NYC and L.A have Latina populations that have undergone decades of integration into these areas and the policies in public facilities have grown to recognize the dominance of Spanish for communication. While one can make an argument for the exclusion of this population there it's still important to recognize these cities still hold more physical representation in demographics and superficial integration, sometimes assimilation by Latinas themselves in the dominant cultures there. The fairly recent move of Latina immigrants to rural areas indicates that Latinas are more likely to rely on their social networks to navigate social and medical services which become more crucial without the mechanisms explained above.

The study by Villanueva et al. (2005) aims to answer foundational questions about Latina attitudes and interactions with government agencies, and private, and nonprofit services serving the immigrant population. These agencies and services of course involve the public health

system that receives state-federal funds to support programs like MA and Minnesotacare. The main question answered in this study also relates to barriers blocking a more general type of access to social services by asking Latinas and the providers who serve them what they identify as the most crucial linguistic and cultural barriers to social help (Villanueva et al. 2005). The perspective of social service workers will also give insight into how English proficiency and lack of knowledge are also related to misunderstandings between those working in health and those receiving poor services. In the cases of NY and CA the way linguistic barriers figure into hesitancy of reaching for available services is also because of how the health system is uninviting to women who feel stigmatized, looked down upon for their Spanish, and because health bureaucracies work towards efficiency not for personalized quality care.

In Villanueva et al. (2005), there is a recognition that communicative models that stress empathy and a more personal connection between two people is what is preferred for Latinas in general. This is contrasted to the approaches of quick information and help that social service providers extend under, “the bureaucratic constraints of bureaucratic forms of organizations...information is provided under the expectation that individuals will act on information based on their own rational self-interest...” (Villanueva et al. 2005: 2). Yet from the cases of undocumented Latina women in California and New York as women who gave birth normally canceled postpartum checkups and women who didn’t understand the RH services available would rather learn about their children’s eligibility. These two cases are examples of going against one’s interest and focusing time to learn about services for their families while neglecting personal needs. There are similar “irrational” behaviors by Latina immigrants in the case of Minnesota explained better by the English barriers and lack of information about public and private services.

Throughout the Latina immigrant population studied in Villanueva et al. (2005) in the towns of Cold Spring, Melrose, St. Cloud, and Long Prairie women were asked about what they believed the most pressing sources for their integration were.⁸ These included medical, services, legal aid, English courses, public transport, and employment. This revealed that the highest social need for Latinas that would contribute to general awareness of public services were English courses (28%) followed by the desire to access more medical services (27%) (Villanueva

⁸ The study (Villanueva et al. 2005) uses a non-random population of Latina immigrants without disclosing their status. Many are immigrants from Latin America others consist of internal immigrants. There is an intergenerational element with second-generation Latinas included.

et al. 2005). These needs were considered the most urgent by women themselves. The lack of linguistic proficiency and the need to access medical services go hand in hand. As established in previous studies, English speakers tend to have more awareness of what is being offered to them by the state, what they are eligible for, and what they are denied. On the other hand, in a second ranking that reduced need to the top five most crucial 77% of immigrants expressed the urgency of information on services (Villanueva et al. 2005). Thus above, the barrier of English is the barrier of lack of knowledge where women don't even have a basis in which to try to translate health information.

Latina immigrants in Minnesota had a low tendency to utilize social welfare and other free services provided by the city, county-governments, nonprofits, and at times by private entities. The results showed that 43% to 75% of immigrant women weren't aware of eighteen prominent social services (Villanueva et al. 2005). From that list of services Medicaid, WIC, MinnesotaCare, women's health clinics, and private doctors were all accounted for. The lack of awareness coupled with the largest need being more information to services indicate that Minnesota immigrants are even more at a disadvantage than women who at least knew about prenatal care or choose not to continue care due to English skills or fears of status. In fact, 68% of the immigrant's in this 2005 study weren't even using social services at all.

It's important to note that some of these services are only available to documented Latina immigrants like MinnesotaCare but that is something that many might not know due to poor distribution of Spanish information and the confusing process of applying for MA and MinnesotaCare. For instance, only 59% of service providers, many of whom worked in healthcare reported speaking no Spanish in this sample (Villanueva et al. 2005). These unobserved barriers show a different level of accessing public and at times private health services that can't just be reduced to women having low-income positions and not having coverage that facilitates access. Instead, when immigrant women do seek out services in Minnesota they report a cultural divide and patronizing tones between the system and their attempts of utilization. For instance, a significant amount of immigrant women reported that providers don't understand people who are from a culture that is not the mainstream U.S culture. Other Latina's reported feeling embarrassed while attempting to communicate with unemphatic providers (Villanueva et al. 2005). However, among all the eighteen social services listed

immigrant women did show more awareness of education and health service programs regardless of these issues when trying to access care.

These programs were WIC, Medicaid, school lunch programs, and public libraries. The services are more oriented towards the education, health, and cultural capital of children. There is a trend of immigrant women prioritizing the needs of their children in health. In this study, women showed this through interest in education, public libraries, free school lunches, and WIC which is a service for infants too. The above is supported by the fact that 79% of immigrant Latinas are mothers in this study. There is also the recurring theme of women feeling more entitled to ask for pediatric services while putting off their own health in NYC studies. (Betancourt et al. 2013). Latina immigrant women in general are considered to be the main heads of health knowledge for their families due to gender roles and cultural perceptions of stay at home motherhood. These factors of English proficiency, lack of empathy by providers, and unawareness all are part of underutilization of health services that don't fit the bureaucratic health system's definition of people putting their own self-interest first. The way the health system and public health programs like MA and MinnesotaCare carry out outreach is also another issue detailed in the next section.

The Bureaucratic Disconnect between Health Programs and Targeted Communities

Latina immigrant women aren't accessing programs like Medical Assistance and MinnesotaCare at high rates but those who do have some form of coverage or are granted certain aspects of these programs might find it difficult to navigate them. In a study by Smaida et al. (2002) on disparities in health regarding a general Latino population participants expressed confusion about the services provided under public insurance and defined insurance coverage differently from the state. The Latino community interviewed was of mixed status and were potentially documented or native-born Latinos but still struggled with Spanish and cultural barriers in a similar fashion that immigrants did. Latinos interviewed expressed confusion at terms such as co-pays, deductibles, and premiums under MinnesotaCare which is only eligible to documented working-class people. Many expressed discontent at the state-federal limits placed on public care as they perceived insurance as a right that should include full coverage for all individuals who pay taxes (Smaida et al. 2002). The assumption that all public insurance is free for those who do qualify is one that is easy to make when other states like California typically

give free healthcare coverage to those who qualify under Medi-Cal. As well as the fact that many states don't have additional programs like MinnesotaCare they mainly fund Medicaid.

The lack of understanding for bureaucratic and financial terms like co-pays, and deductibles for what is presumed to be a documented Latino population if they are accessing MinnesotaCare adds to the lack of thought put into the 2025 expansion. If a Latino documented population is already dealing with not understanding payments and logistics the disparity might be wider for undocumented groups when only MinnesotaCare expands. Undocumented Latinos are more likely to be low-income and might be pushed back by the fact that expansion comes with financial strings attached. The likelihood of English barriers for newly arrived immigrants might also make payments and billing more difficult to deal with.

These concerns are aggravated when Smaida et al. (2002) report that even documented Latinos with incomes that don't qualify as low-income still struggle with cultural barriers that serve as push factors in accessing public insurance. In both rural and urban centers, Latinos expressed knowledge-based concerns about insurance and the need for more Spanish-speaking providers and staff like nurses. One interviewee didn't understand why Medical Assistance enrollment information couldn't be translated in Spanish, "They send us a book of all the benefits and services that are available to us, but it's all in English... Well, I am Hispanic, and it would be great if they could send it to me in Spanish so that I could truly understand what it is that I am receiving..." (Smaida et al. 2002:14). These experiences reinforce the idea that language barriers make it harder to read the fine print that public programs like MA come with, especially those that don't fully cover everything. This lack of regard by public health programs for the communities they are targeting is discouraging for the future of expansion. The Minnesotacare rollout should prioritize these issues firsthand if it even hopes to inform undocumented Latinas that they are now eligible.

Unempathetic Health Service Providers

Another angle not frequently touched upon in studies that focus mainly on health utilization patterns is an in-depth look at the human relationships between service providers and Latina immigrants. These interactions provide insight on how cultural divides play out in attempts to access services that are blocked by delivery of poor information and linguistic barriers. The idea of facing unemphatic service providers when claiming services has led to

uncomfortable situations in which women disqualify themselves from the health care they're eligible for. Both a Latino population and immigrant Latinas have expressed frustration of staff's inability to speak Spanish and to misunderstand cultural attitudes in health. Instead, providers deliver information in English and with little guidance prioritizing individualism (Smaida et al. 2002; Villanueva et al. 2005). It can be argued that social service providers are only following the bureaucratic requirements of their jobs that demand them to offer written documents and generalized instructions for guidance. However, providers are not exempt from showing biases towards immigrant women.

In the Villanueva et al. (2005) study measuring attributes between immigrants and service providers, the majority of staff interviewed worked in healthcare with 26% working in hospitals. These providers who often served Latinas shared different attitudes than immigrant women in terms of what the needs and priorities of women were when accessing health services. For instance, when asked about education or the overall desire to pursue higher education 85% of immigrant women agreed that education was an important personal goal. While only 29% of providers believed that Latinas would be interested in education and believed that Latinas were most likely uneducated. (Villanueva et al. 2005). Ironically, providers were more inclined to believe that women came from large families and had many people to care for than they were disposed to believe women could reach for college education. These attitudes have to do with the cultural and social aspects that play a role in the ritual of asking for help. The perception of providers demonstrates stereotypes that affect how they might deliver information to immigrants who they view as uneducated creating an imbalance of knowledge.

The assumption that women are overburdening social service systems with large families they advocate for also creates negative images that resemble rhetoric of immigrants taking away welfare and resources. Ironically, some women in Villaneuva's study are of second generation or are possibly documented Latina's making it likely that they are educated despite these assumptions. The aforementioned interest that Latina immigrants also have for English courses also shows a misconception of providers who assume women don't have the urge to learn or adapt to bureaucratic forms of accessing information. The relationships between health providers and undocumented Latina immigrant women isn't one that is too looked upon with the exception of studies that focus more on primary caregivers, doctors, and specialist over office staff. Despite

the fact that office staff and social service workers in Medicaid programs are one of the first contacts women make when applying for coverage or entering a medical facility.

The new immigrant destinations that rural towns represent for Latina immigrants also indicate that the social integration in these towns fall short. Unlike metropolitan areas or popular destinations like L.A., these towns are in the process of developing formal Latino immigrant organizations that work on social justice issues or even strong social network ties between immigrants. These are different from groups that work on general Latino rights as undocumented status is a detriment of its own. The sources used in this chapter like the “Disparities in Health Access report...” by Smaida et al. (2002) shows there are already existing organizations like HACER advocating for Latino research in the Midwest but not with specific aims at undocumented Latino advocacy. Thus, with a combination of a strong immigrant presence growing and a health system not willing to understand that cultural context, many women have turned to relying on cultural capital among other women.

Latina immigrant women shared that their main knowledge of social services including health came from word of mouth or social networks made up of other Latinas. Other interesting sources of information included Spanish TV networks in the U.S and church members (Villanueva et al. 2005). These networks made up of Spanish speakers and Latina women are not unusual for immigrants, more particularly undocumented immigrants. Especially since fears of deportation indicate that others who share that status offer safer spaces to know what services are available to them. English barriers and low levels of education also mean that listening to Spanish news reports with digestible information provide a better alternative than packets of English information with jargon health terminology.

The pattern of immigrants, particularly undocumented women utilizing social networks or “networks of care” as a form of health cultural capital, is present in popular destinations like California as well (Derose 2000; Menjivar 2002). Nevertheless, the new immigrant destination that Minnesota represents means that these networks of care and information might be even more crucial to navigating even the most basic of emergency services for women. Minnesota is not a new immigrant destination only because it had a surge in Latino population growth in the early 2000s but because historically and has considered itself as a temporary migrant state. This impacted the attitudes towards Latino immigrants only recently politically recognizing them more. These socio political and historical circumstances make Minnesota a case to watch to

understand how the state's recognition of the undocumented population will change the public healthcare system. That change may or may in turn affect access to health services for undocumented immigrants who are still impacted by a less culturally comprehensive health system than their counterparts in popular migrant locations.

Discussion

The immigrant Latina women in rural Minnesota struggle unequally with poor information delivered by health providers, English barriers, and lack of knowledge over public insurance. Unlike the California and New York cases where unobserved barriers were revealed measuring reproductive health access, Minnesota has less concentrated research on undocumented Latinas and RH. Instead, it's in the context of Minnesota's health system in the form of their public insurance programs and experiences by Latina immigrants with providers that unobserved barriers can be deciphered. The strongest of these barriers is the poor deliverance or absence of information for Latinas hindering their knowledge of basic health services offered by the state (Villanueva et al. 2005). These barriers were detected in the early 2000s and were analyzing what prevented women from receiving general social services. However, a brief report by Hasstedt et al. (2018) shows that immigrant women still don't seek coverage for reasons of lack of knowledge (28%) across thirty-four states including Minnesota. The brief is specifically looking at barriers for sexual and reproductive health indicating that across these states immigrant women couldn't access coverage for SRH due to knowledge.

From the perspective of the public health system, poor delivery of information, English barriers, and lack of knowledge clashed with the bureaucratic model of communicating information by health providers. The communicative model preferred by immigrant Latinas is one that is empathic and more akin to social networking as shown by their use of word of mouth. Instead, the health system is built upon bureaucratic forms of organizing that provide written information in English, promote efficiency over care, and have providers strategizing what the most rational ways to provide services are. In Villanueva et al. (2005), they created focus groups with Latina and bilingual providers who mainly worked in the health sector. These women recommended approaches to changing the system gradually by making Spanish a job qualification in health services. They also recommended putting more public emphasis on the Spanish required for such positions. They also recommended a more macro change to the system

where instead of clients going to the provider the provider should come to the client (Villanueva et al.2005). In this way, providers would start conversations about health instead of having women initiate interactions that are stigmatizing and hold linguistic barriers. Providers would be required to be Spanish-trained to provide information to women in a more empathic manner.

In terms of Minnesota's expansion of MinnesotaCare, it can't be comparable to California's expansion of Medi-Cal. Undocumented Latinos in general have figured in discussions of public coverage with invisibility in both states. With the exception that California's more liberal and larger Latino population indicates that visibility of social justice groups, and organizations exert pressure on the state's path to universal coverage. Minnesota's new destination character is an unfolding project that at least on paper seems to be extending towards recognizing the undocumented Latino population. Nevertheless, the unobserved barriers displayed by women in Minnesota have more weight to them in a region with less cultural sensitivity and adaptation to the Latina presence.

CHAPTER 4

ILLINOIS: A Pressing Case of Undocumented Health Care in the Midwest

“The decision by Governor Pritzker to cut off health care enrollment for immigrants is wrong and will have life-and-death consequences” (wttw News 2023).

The Midwest continues to offer a paradox between states who appear to accept Latino immigrants and those who don't consider them as political agents. Yet it is those states with more demographic representation of undocumented immigrants that hold more austerity measures in health. Illinois has the largest Latinx population in the Midwestern region at over two million people (Anderson 2016). In terms of immigrants, Chicago has historically been one of the largest receiving cities in the nation. It boasts the second largest immigrant population from Mexico only second to Los Angeles (Misra 2014). The vibrant Latinx migrant culture in the city can be said to be due to the existing migrant networks, and the overall friendly migrant policies. However, when it comes to health coverage Illinois has not lived up to its title of a state with sanctuary areas compared to the other two large receiving states. The state has practiced similar policies to those of New York while at the present threatening to take steps back. At a glance, Illinois seems to be creating less pathways to undocumented immigrant access than Minnesota, which is not heavily represented in the national imagination. The latter is due to the political rifts of those in power. While public coverage is not all there is to health access it has served as the most affordable pathway for low-income undocumented women to receive basic prenatal and postpartum care. When it comes to public health coverage and reproductive health access the picture for undocumented Latina women is everything but clear.

The Need for an Intersectional Lens on Latina Health in Illinois and Chicago

As aforementioned the Latinx population should be studied with an intersectionality lens. Undocumented Latinas are one of the more challenging populations to gather data on. The mix of this precarious status with an emphasis on patterns of RH is difficult to study. In Chicago, there has been an emphasis on studying the Mexican immigrant community in public health. There are a variety of articles that look at city Mexican immigrant enclaves to assess how health is impacted at a local level (Beirne et al. 2018). Sociology research has been done in the Midwest prioritizing the gap of information in states like Kansas and Indiana in Latina health access and

sexual reproductive behaviors (Cervantes and Menjivar 2002; Reyes et al.2021). These articles tell us important factors at the local level by showing that barriers like the organization of the health system, language, and fear of deportation are present in this region. Still, there is a lack of research for undocumented Latina women in Illinois, the largest Midwest state with Latinx people. There seems to be a great focus on the Mexican immigrant community which is natural as Chicago has such a prominent Mexican presence.

However the focus on one community and the general consensus that Chicago and Illinois already has a large body of Latinx research has created less of an emphasis on undocumented status as a detriment for health. Especially when it concerns women's reproductive health. All layers of disadvantage have to be considered to get a good snapshot of the barriers impacting this group of women in Illinois. The studies above on Latina's in the Midwest are the closest to understanding how similar barriers impact undocumented Latinas (Cervantes and Menjivar 2002; Reyes et al.2021). Yet they don't tell us if Chicago women share the same barriers or if location is more influential in shaping the health system and their health access experiences. The importance of locality has been seen with the cases of Minnesota also in the Midwest where public programs like MinnesotaCare pose a challenge for accessing basic services. There are also unique cases like California that are ahead of many in terms of coverage and who vary in their quality of maternal health. Instead of generalizing the Midwest region, there should be greater focus on Latina undocumented women and their reproductive health seeking behaviors and patterns is needed in Illinois.

Thus, this chapter will report on the limited data that is known by ethnicity on the topics of postpartum care and maternal health for Latinas in the hopes that more research will be built upon the undocumented determinant. This would be a simple transition since Chicago hosts such a large Mexican immigrant population. Thus it can easily focus its interest on undocumented Mexican women and their SRH. The need to analyze undocumented women is even more pressing at the current moment as the state moves to restrict the public healthcare arena.

Illinois Takes Steps Back for Undocumented Health Coverage

Throughout most states, undocumented immigrants have carried the weight of severe restrictions on state-federal public health programs with insufficient options. The federal restrictions placed on undocumented groups are also supported by Illinois with the exception that the state has taken an unexpected route in immigrant policy. Similarly to the three previous states Illinois has its own medical programs under Medicaid for pregnant women. These are forms of emergency services for women who can't care and are extended temporary prenatal and postpartum care. Yet instead of one program like PCAP or MA that ties prenatal and postpartum care together, Illinois covers women through two separate programs if they wish to receive both types of care. These are Medicaid Presumptive Eligibility (MPE) and Moms and Babies. Under these programs, Illinois has been relatively generous. For example, MPE is an outpatient service program that provides prenatal care. Yet it goes beyond prenatal checkups. It includes dental, vision, and even transportation to medical facilities, a noted barrier by some Latina women. I have outlined the different services provided to pregnant women despite status (Table 6). MPE is temporary coverage for outpatient services while the ideal is Moms and Babies. Moms and Babies covers both outpatient services like prenatal and postpartum including hospital deliveries.

Table 6. Programs for Pregnant Women in Illinois, 2024

Medicaid Presumptive Eligibility (outpatient Services)	Moms and Babies (outpatient and inpatient hospital services)
Prenatal Checkups	Outpatient Services by MPE
Prenatal Vitamins	Hospital Services
Doctor Visits	Labor and Delivery
Eye and Dental Care	12 months of postpartum for mothers
Mental Health Care	12 months of care for babies
Transportation to medical care and other services	

Source: Illinois Department of Healthcare and Family Services. 2024. “Moms and Babies, Programs for Pregnant Women.” Retrieved on April 20, 2024

<https://hfs.illinois.gov/medicalprograms/allkids/momsandbabies.html>.

The separation of these can be confusing as Moms and Babies covers what MPE does and more. Yet, the system utilizes MPE as a temporary cover while women wait for their applications to be reviewed for full coverage. These intricacies of bureaucracy procedure can prove challenging to undocumented women who may not know they are entitled to both programs or assume wrongly that both cover hospital deliveries. They also show that not all public health programs are interchangeable by state as seen by the case of Minnesota which has low-income programs aside from Medicaid. Despite their confusing nature, the services under Mothers and Babies show a willingness by Illinois to extend services for an undocumented population of women that aren't just prenatal checkups and doctor visits. Unfortunately, these exceptions are gendered and contingent on pregnancy as the state of public health programs for most undocumented adults has taken some rough turns.

Illinois, like California, was on a path to expanding undocumented coverage to all adults, a step that seemed natural for its large irregular immigrant population. The first indicators of this came when the state expanded Medicaid coverage to undocumented children eighteen years and younger under the All Kids Program. These shifts were the start of a path to undocumented adult coverage. The state granted insurance to undocumented seniors in 2020 under the Health Benefits for Immigrant Senior program. In 2022 it declared that it was committed to provide insurance to adults forty-two to sixty four despite immigrant status (HFS 2024). The gradual expansion of adults had created hope for Latino immigrant advocates and lawmakers who viewed this as a first step to providing full undocumented adult coverage for all ages. Nevertheless, instead of this being the start of Illinois path to universal coverage, it began to take steps backwards by reversing its expansion under the 2020 Health Benefits for Immigrant program (wttw News 2023). The program accepted applicants and provided care for a year but is now under a so-called temporary enrollment pause for the foreseeable future.

The decision made by Governor J.B. Pritzker is fueled by a rise of anti-immigrant sentiment originating from the republican side of the state. The right argues that undocumented preventive care is too costly, likely to take away funds for the care of “vulnerable” citizens, and

that the responsibility should be pushed onto the federal side who supports open borders. (wttw News 2023). The above is an example of how anti-immigrant rhetoric and the right impacts state policy first hand. The political climate in Illinois has fueled false narratives of undocumented immigrants taking away care for citizens that already have a pre-existing mechanism of coverage reserved for them. The blockage of undocumented access also ignores the fact that preventive care fuels less costs for emergency services. The rift between the right and Latino advocates and activists for universal coverage has impacted health access for undocumented women.

Not only do these restrictions pose a risk to existing available services for undocumented immigrants, but they are also attacking a low-income population. The restrictions demand pay for services under the Immigrant Senior program that were once free. The case of Illinois public health shows that physical demographic representation does not equate to rights under state-federal law. The paradox between Illinois and Minnesota shows that while democratic state actors are pushing back against hesitation for coverage in one state, the popular destination of Illinois is having trouble dealing with the anti-immigrant threat of the right.

Immigrant Women in Illinois

Despite the limited amount of research done on Latina undocumented women in general demographics from Illinois show that undocumented immigrant women hold a large presence in the state. Overall Illinois is home to 425,000 undocumented immigrants with the top country of origin being Mexico (MPI 2024). A large minority of immigrants of mixed status are actually women. In fact this group numbers 8666,95 women calling the state home. The majority of these women are also migrating from Mexico. The strong Latin American female presence in the state means that reproductive health services are an important part of the discussion of Latino health disparities in the state. While the state provides generous emergency pregnancy services regardless of status, the immigrant population in Illinois might still find non-mainstream factors impacting access to services.

The immigrant composition of Illinois is not clear in terms of irregular status. Yet a report by the American Immigrant Council claims that almost half (52%) of the immigrant population is naturalized. There seems to be more of an intergenerational component in the immigrant population showing that a second generation has already grown up as U.S citizens with undocumented migrants more likely being parents or family members. In fact, 395,179 U.S.

citizens were living with one undocumented family member between 2010 and 2014 (American Immigrant Council 2020). This second-generation component is interesting as education seems to be more of a pressing disparity for Latino immigrants in the state with 35% of Latinos not having a high school education (Halloway et al. 2020). This indicates that education might not be equally distributed from immigrants of other ethnicities which this report incorporates. The lack of education might offer a possible explanation to how Latina women experience care combined with the picture of public health from the state.

Inadequate Prenatal Care for Latina Women

In a report released by the Illinois Department of Public Health Latinos on health disparities, the Latino population was still the most disadvantaged in insurance coverage with 18% having no coverage in 2015. These statistics have seen little decline over the years with Latinx people having the highest rate of uninsured since 2009 across race. The report lists that barriers like fear of deportation, the health system, English barriers and culturally insensitive providers might account for the high (Halloway et al. 2020). In regards to the health system, Illinois had been working towards these disparities by the early 2020s by opening up coverage to undocumented people until the process was halted.

In the case of Latina immigrant women, fear of deportation and possible lack of knowledge reinforced by language might complicate accessing the system. In particular when it comes to the right of prenatal and postpartum care under the programs listed in Table 5. Women might not be aware that they are eligible for both, may only receive temporary coverage, and find it harder to communicate with providers who could help them distinguish the difference. In fact, prenatal care for Latinas in the state does lean towards an inadequate definition of care. As aforementioned, inadequate prenatal care is care received after the first trimester. Between 2014 to 2015 inadequate prenatal care improved across all races but remained relatively unequal for Latinas. Only 7% of white women were getting late care compared to 10% of Latinas (Halloway et al. 2020). The rate of inadequate prenatal care might also be impacting complications during delivery. While there was a reduction of babies born with low weight across race Black and Latina women experienced the lowest reduction. In the early 2010s, 6% of Latina were still giving birth to low weight babies (Halloway et al. 2020). The rate of inadequate prenatal care might also be impacting complications during delivery. These maternal disparities show that

women might be facing complications to accessing programs like Moms and Babies and MEP considering these offer prenatal care.

The social determinants named by the report including fears of deportation, language barriers, and culturally insensitive providers can also apply to navigating free prenatal care. In research for undocumented Latina women in other locations, these barriers are exacerbated. From the data in Illinois, the overall population struggles with English proficiency with 34% reporting that they don't speak the language well (Holloway et al. 2020). The gap in English and the low high school education rates might influence Latinas, especially if they are undocumented negatively when seeking out pregnancy programs. A majority might not feel comfortable communicating with public health workers, might misunderstand when coverage is temporary or might enroll in the wrong maternal programs. Nevertheless, immigrant status for Latinas should be utilized to uncover the specific unobserved barriers that are most prominent for inadequate prenatal care. These might involve the Illinois health system, and English barriers that are part of the general Latino population, or these might not be as influential as they are in other states.

Discussion

The case of Illinois displays an alarming detachment from its Latinx immigrant population and its limited research on undocumented Latina women in areas of reproductive health. The sanctuary city of Chicago has attracted many in the public health and sociology fields to the vibrant Mexican immigrant community and Latinas will show up in articles on health disparities in Chicago suburbs and community contexts. For example, Beirne et al. (2018) study an enclave named "La Vitta" to assess health at a community level. While these articles acknowledge immigrant status for a general Latino or Mexican population there has yet to be many solely on undocumented women and their patterns of health access in the city or in state.

The public health programs in Illinois complicates the picture of health access for undocumented women as restrictions to coverage are now reversing into austerity measures against immigrant status. This is a pressing time for the health of undocumented immigrant women who depend on state-federal law to take on a progressive stance and acknowledge them as deserving of equal protection as other low-income citizens and documented immigrants. In an ironic twist of events, the opposite is occurring in Minnesota which displays gradual moves to some form of coverage, be it with strings attached. The move to secure public health coverage

for undocumented Latina women in Illinois will take a shift in political attitudes at the state level and a coalition of strong Latinx organizations, advocates, etc. to change the tides of the growing anti-immigrant sentiment.

Nevertheless, a general analysis of Latinas in the state show that even under exceptions like pregnancy and with free coverage available women still are not receiving adequate prenatal care. The unobserved barriers that impact Latinas were found to be similar to those in Minnesota mainly the lack of English skills that might impact outreach to the health system. In the context of pregnancy programs and public health programs that aren't simple to navigate, this might pose a barrier to Latinas with little English skill and low education to understand the difference between publicly funded opportunities. Yet health access is not just about finding similar barriers between states but analyzing how those play out in the context of location and even how women define their experiences. There needs to be a growing body of research in the social sciences looking at determinants in health access for undocumented women in a local context. This might reveal attitudes women have while seeking out Illinois public programs, their interactions with health providers, and their knowledge of sexual reproductive services. The lack of information makes it challenging to state any specific barriers for undocumented Latina women in Illinois. Still, the existing body of Latino literature in Chicago still holds promise to take on the task of giving undocumented women more focus.

CHAPTER 5

LOS ANGELES: Obtaining Health Capital through Social Networks of Care

“Sometimes you ask one woman but for one reason or another, she can’t help, then you ask another one, and like that. The point is to ask around; one needs to informarse” (Menjivar 2002).

The literature review at hand has explored how undocumented Latina immigrant women are subject to slow violence by U.S federal law that refuses to recognize the existence of their health needs. The state’s exclusion has contributed to the morbidity rates of women in an act of violence against this group. While it can be argued that states are restricted by law, federal changes have not led to state sovereignty stepping in to aid undocumented women for decades. The comparative analysis of the unobserved barriers found in the utilization of RH services across four states shows how public health care is crucial to low-income undocumented women. Within this vantage point, undocumented Latina women in all four states are living and have been living for decades with insurance for only emergency care for life-threatening emergencies and pregnancy. The exception to this would be undocumented women who have private insurance or don’t use public services which is not common. With only recent changes in some states, this implies that women have been working around unobserved barriers (English proficiency, lack of knowledge, status, etc.) to get any basic low-quality care.

While the formal health system has excluded undocumented immigrant women, they have shown a great deal of agency to provide medical alternatives for them and their families outside the health system or within it. I aim to explore how undocumented Latina women use the phenomenon of networks of care and social ties. The term networks of care is defined by Derose (2000) as groups of solidarity made up of family, friends, and acquaintances to obtain the preventive care denied by the health system. This strategy also helped women carry out diagnosis or treatment recommendations. Similarly Menjivar (2002) coins social ties as informal networks through which immigrant women reach treatment for themselves or their families. Women either reach for formal medicine-like perspectives or traditional healing alternatives. Whether women tap into networks to receive formal or informal care their participation in networks is crucial for their families. Women typically play caregiver roles that make them “anchors of family and community life among immigrants and to be primarily responsible for

family health” (Menjivar 2002:439). Women occupy a place dominated by gender norms within Latino families making them mediators of what knowledge they acquire of health.

What is Cultural Health Capital?

I have explained networks of care or social ties as ideas by Derose (2000) and Menjivar (2002) as practices that build knowledge. These two concepts aid women to access some aspect of the health system or to receive alternatives for treatment. These networks of care produce cultural capital. However, the type of capital they produce might not be valued by the dominant society as valuable but remains integral to women’s health needs. These forms of capital would be knowledge passed down by other women, herbal treatment, botanicas, or even information on public health programs. Yet, women’s networks of care are cultural capital acquired on the basis of health so they are more akin to health capital. In a study by Madden (2015), they define cultural health capital as health knowledge that goes beyond the medical knowledge rewarded by the dominant healthcare system. I will analyze two studies that showcase how Latina immigrants use networks of care in Los Angeles in the middle of exclusionary policies on public health and Medi-Cal.

In Menjivar (2002), she analyzed how Guatemalan immigrant women use strategic social ties to secure treatments from botanicas, prescription drugs, and knowledge of the health system. She works more with women who are attempting to work around the health system due to their exclusion through informal cures and transnational relations. On the other hand, Derose (2000) interviews women who are attempting to access the formal healthcare system to analyze how they overcome the unobserved variables of lack of knowledge and linguistic barriers through strong bonds to their fellow Latinas, intermediate families, and others.

Social Ties Among Undocumented Guatemalan Women

In Menjivar’s (2002) study, she interviews mainly undocumented Guatemalan who are new arrivals and who are in a more precarious position in terms of knowledge and adaptability to the host country. These women also are also more likely to experience the disadvantages that other undocumented have experienced through this review like no insurance to access the U.S healthcare system. Undocumented Guatemalan women utilized informal networks of family and friends at times with immigrant women with more residency time to create packages of Western

and traditional medicines (Menjivar 2002). Western medicine is usually acquired by friends or family who work in hospital or private clinic settings. Traditional medicine is referred to as herbal or natural treatments. Yet these informal networks don't just provide women with physical solutions to temporary sickness or more serious illness but they provide newly arrived women with knowledge of health centers, local hospitals, or curanderas. Another unobserved barrier not found in the reproductive service utilization sources used in this context but found among other health service access analyses is the problem of transportation. These networks also provide avenues to transportation to medical facilities by friends who are more established. For example, an undocumented Guatemalan indigenous woman named Hermelinda treated a non-emergency illness for her child by going to a curandero recommended by another Guatemalan woman (Menjivar 2002). She was able to get tea and a prescription she could buy over the counter to solve the problem. In these practices, women show that they are not passive in their exclusion by the state and federal law. They are very much invested in regulating their health and the health of their families. Such a point has also been expressed before for the way women will put their own children's needs above their own.

Women as Health Knowledge Mediators for their Families

Immigrant women in Menjivar's (2002) study participated in social networks that were exclusively female or in what she coined as "kinship work". Kinship work is a form of building female center networks and they "connect people and initiate and maintain networks through which people migrate and settle..." (Menjivar 2002; 442). Kinship does not just involve building connections to help other women integrate, it's initiated with the intention of gaining knowledge to pass down to one's immediate family. Women are the main caretakers of their homes and this means they are the bridge to the medical system and their families. When women do acquire knowledge of services they are entitled to either through duration in the U.S. or through networks they act as providers to their families. They are the link to the medical bureaucracy in which knowledge is passed down.

Thus the role that undocumented women play in Latino homes should not be underestimated as caregivers for they are the main path for health knowledge and services to others. This makes it more crucial that women know about what programs are locally available

and this role should be taken into consideration by policymakers and organizations that aim to reach Latino communities.

Female Networks to discuss “Women’s Things”

Yet, it's not just the traditional gendered role of women as caregivers that makes them mediators of health for their families or motivates them to participate in female networks. In Menjivar (2002) women expressed feeling more comfortable talking about their sexual reproductive health such as birth control pills with other women. Others commented that culturally men tried to be less informed about health information. Men performed gender roles in ways that made them view sickness as a weakness at times or were less interested in medicine talk. One woman commented “Women have experience in these things. Men don’t” (Menjivar 2002; 452). These findings suggest that in some contexts women prefer other networks of women to speak on reproductive health issues and find more solidarity between each other.

The notion that women just knew more about health is also shown with women who kept transnational ties in Guatemala with mothers and sisters. Women who could not migrate back and forth receive packages of drugs that are only allowed with prescription in the U.S, or a combination of traditional remedies. For instance, a woman named Nora describes how her sister never fails to send her penicillin, painkillers, and other pills not available in the U.S without a prescription (Menjivar 2002). These transnational ties help women receive resources to cure unserious illnesses they wouldn’t be able to afford in the U.S with the lack of coverage and out-of-pocket expenses. Among these experiences, women go to other women for intergenerational knowledge on medicine either Western medicine or traditional medicine.

The case of Menjivar (2002) shows women’s resilience and strategies to survive when they are excluded from the health system and have to work around it. While it's important to acknowledge the role of women as caretakers of their families and as builders of social networks that help others acquire health knowledge, it's also crucial not to romanticize these networks. Social care networks are usually a last resort for women who are in a very precarious position and their success in non-emergency situations should not be used to justify the prevention of healthcare access for undocumented women. While social networks among women will remain strong, state intervention and law should make way for easier health access.

The Emergency Room in Los Angeles

In Derose (2000), she studies a Latina immigrant population who attempts to access emergency services at a public hospital in Los Angeles. The setting of a hospital is relevant as undocumented women throughout the first two decades of the 2000s only had access to emergency care in California. This study also aims to analyze how barriers to English, and education plays a role in the main issues immigrants face when accessing care. Similarly to Menjivar (2002), women are found to be the “main point of contact between the health care system and family members” (Derose 2000:80). When women put themselves out there they do so with the help of what Derose coins, “social networks of care” from their friends, family and connections within the health system.

Navigating the English Barrier

One unobserved barrier that came up as women visited the ER was the English barrier for Spanish-speaking women. At times nurses refuse women emergency services they were entitled to if translators were not available to check them in and sign documents. The example of Manuela discussed by (Derose 2000) shows how intimidating hospitals can be when they are equipped with poor Spanish translators. Manuela is not bilingual nor can she write Spanish well. When she was asked to sign a document she froze and was unable to do it until a girl volunteered to sign it for her. She described everyone staring at her (Derose 2000). These experiences detail how women aren't supported by the public health system as Manuela had to rely on a girl who volunteered to help her while the hospital only employed one professional Spanish speaker.

Yet, women navigated English barriers with networks of English-speaking family members, friends, or acquaintances. The most common strategy was to use family members to communicate with providers, and to simplify instructions after a diagnosis (Derose 2000). Acquaintances and other Latina community members also played a role in closing knowledge gaps. For instance, a woman named Maria recalls a chance meeting at a store with a Latina who offered to take her mother to the ER. The woman talked to her about the ER procedures of signing documents, and how to access transportation, and even made a follow-up appointment for her. Overall, women relied on other English-speaking Latinas mainly their daughters but at times strangers, to help them assimilate to the bureaucratic processes of the ER. In most of these

experiences, women are aided by women in their informal networks or Latinas with prior knowledge. While health providers do their job with rude to discriminatory attitudes.

Social networks of care have served as one of the main strategies for decades for women who can't access the health system or have trouble navigating the services they are entitled to. They speak to the agency of women to reach out to empathic Latinas and work as medical resources for their families. The Los Angeles case reinforces the notion that Latina immigrants prefer an intersubjective form of communication better when delivering information and that women are interested in educating themselves about health. These two examples show how unobserved barriers play out even in cases where emergency care is available by law but not by societal and cultural constraints.

DISCUSSION

I have analyzed undocumented Latina women's reproductive health and its tumultuous relationship with state policy that reflects a greater issue with the structure of federal law that excludes the undocumented body from the same health opportunities that it affords to others. In my critique of state policy and the health system, I employed a sociology of medicine approach to inquire about the patterns of utilizing health services by these women. I did this with an interest in revealing what these patterns say about the macro picture of health access for these women that is known to be disproportionate and deadly when it comes to morbidity and mortality rates. In the sources utilized for this review, women's voices didn't figure much into reproductive health utilization. Instead, their health-seeking behaviors and attitudes towards services are recorded to move forward pre-existing research on the barriers that prevent access to RH or preventive health. However, when the literature emphasizes women's voices such as in Derose (2000), undocumented Latinas show that they are aware of their exclusion and they have created networks of language, female solidarity, and communicative health knowledge.

The existence of these networks of care attests to the strength of traditional gender roles in Latinx families where women occupy a mediator role between medical bureaucracy and family well-being. While the reproductive sources across four states to a degree display patterns of fears of deportation and a gap in health capital, women are still avid critics of the health system. They don't passively accept deliberate attempts from providers to deter them from seeking applicable services. The interactions between actors in the health system (physicians, service workers, nurses, and office staff) and immigrant women don't occur in a vacuum. The bureaucratic organization of the health system across states stresses efficiency and impersonal relationships with provider and client models. Yet it's what occurs with these impersonal relationships that define the attitudes of women towards health and is decisive to their seeking behaviors. In Derose (2000), Esperanza summarizes the emotional labor that women have to do to fill the gaps in the knowledge and negligence of cultural networks, "Right now I am trying to make a decision about family planning. I do want to get it but I would like them to explain very clear to me. Because just giving me a paper is not the same as an explanation..." (p.84). Women have to be emotionally and actively engaged in filling up blanks of information with non-existent clues from insurance documents given to them for the sake of their families.

These health-seeking behaviors of women involve a great amount of mental strife as unobserved barriers of cultural stigmatization, fears of deportation, and English barriers play out in the social world through experiences of microaggression and discrimination. Derose (2000) also details how women speak up for the sake of their children even when they are faced with providers who refuse to treat them with dignity: "...he had the nurse tell me to go home and he would see my son another day... So I asked the clinic boss. And yes they took care of my son. Not just because the doctors said, "I will not see them today," was I going to remain quiet..."(p.84). Despite the internalization of fear and being constantly shown through law and social attitudes that they are not entitled to similar health rights, women navigated these obstacles with attitudes of entitlement when their family's health was at stake. Women's active participation in combating attitudes of exclusion in the system does not imply that the mechanisms of inadequate commutative models, language barriers, and outright discrimination disappear when navigating the limited services women have available. The fact remains that some undocumented women like in NYC are unaware they can access affordable Medicaid or CHIP services (Betancourt et al. 2013). Nevertheless when showing women's disadvantages in the face of state public policy should still be viewed as actors facing very unique circumstances for their undocumented status by context.

The idea of this thesis was born out of a need to recognize that undocumented Latina women are in a more precarious position than documented Latinx people. In the face of public health and social science studies that merge both statuses together, or that use simplified measures of access such as "had insurance" or "saw a doctor in the last year", I recognized a need for a more qualitative approach that was rooted in intersectionality. For instance, while it is true that undocumented Latinas are less likely to have insurance, they are also more likely to depend on public insurance provided by the state. In Hogue et al. (2000), Latina women were overrepresented in public health insurance with 63% of women in a national sample obtaining coverage through Medicaid. For the undocumented, this is exacerbated as they are shown to be the majority of those who depend on Medicaid policies and federal law.

Women are also more likely to be treated in emergency rooms and in public health centers (Hogue et al. 2000). The dichotomy between public and private coverage that women are subject to is rarely acknowledged as a point of analysis. In fact, it was surprising how few studies used Medicaid as a starting point to discuss how undocumented women are subject to different

rules under state-federal law. There should be more emphasis put on conducting qualitative studies like ethnographies in public health clinics and hospitals. Undocumented women are more likely to come in contact with these free services when they do know about them in these settings. There should also be more research on how Medicaid service providers and undocumented Latina providers interact such as the report by Villanueva et al. (2005) which did so successfully by showing how biases plague the bureaucratic health system in rural Minnesota. That report showed that stereotypes held by general health providers impacted the quality of information women were given about services. The assumption that women were uneducated can lead providers to disregard women's rights or abuse their knowledge of the system. As aforementioned interactions in health services don't occur in a vacuum and this would be an opportunity to see how unobserved barriers impact or don't impact some undocumented women.

The harsh reality of state-federal law is that its emergency exceptions for undocumented women also mean many don't know or would rather not deal with hostile systems. The reasons for this which range by context like limited knowledge on Western systems and adaptation to the host country are more akin to undocumented immigrants. I noticed that a general Latina literature on health disparities never fleshed these reasons out if they were mentioned (Ornelas et al 2020; Ramos et al. 2010). Unless the purpose of said studies was to display women's attitudes through methods like interviewing them firsthand or they are making the case for certain SES barriers. The literature that deals best with the restrictive public coverage that undocumented women are subject to while addressing unobserved "heterogeneity" is on RH health access. A similar recognition was found in studies of changing policies under the ACA that impact health behavior (Betancourt et al. 2013; Chavez et al. 1986; Maru et al. 2021; Nandi et al. 2008; Vargas Bustamante et al. 2010). The former was due to the idea that maternal and RH services have a strong relationship with state-federal policy.

Beyond Generalization of Unobserved Barriers and Unexpected Findings

The thesis at hand contributes to the limited undocumented Latina literature on health access by highlighting unobserved barriers or what Bustamante et al. (2010) call unobserved "heterogeneity". Corrective to the literature that views mainstream SES barriers such as income, insurance status, and employment as the main predisposing factors of health access, I explore less analyzed determinants of health utilization. These include a lack of bureaucratic knowledge,

fear of deportation, and inadequate Spanish translations. The following behaviors are not patterns that can be explained fully without an intersectional lens that recognizes undocumented status and is culturally sensitive to how these experiences work. Instead of generalizing these unobserved determinants by using a variety of health access papers on undocumented Latinas a state analysis approach was used. The reasoning behind this was to address the gap in recognizing that undocumented women have mainly accessed public health through state-federal policies like Medicaid and in public and community medical facilities that vary by location. Reproductive health, also worsened by documented status, was the obvious choice for health policies that view maternal health as the only worthy care afforded to non-citizens almost nationally. How these barriers play out by location was more important than just listing them out, as existing literature already does this well enough.

I went into this thesis expecting that undocumented Latina women would face harsher obstacles when navigating public health settings and maternal services in almost all locations despite migrant-friendly attitudes. Yet, I was surprised to find out that not all women knew about this exclusive relationship between health state-federal policy and maternal health. Some women weren't even navigating public health or temporary Medicaid coverage at all. These findings implicate an even more vulnerable picture of health access not just for reproductive health but for preventive health across the board. If we were to generalize the findings on unobserved barriers across the four states, the strongest barrier was English proficiency, which showed up in all cases, followed by a lack of cultural health knowledge, education, and fear of unauthorized status. These were either stronger or weaker depending on the women's duration in the host country.

Perhaps the most decisive unobserved barrier was temporary Medicaid coverage or unequal public insurance that influenced the ways in which health-seeking interactions took place in California and New York. Due to the limited research in Minnesota and Illinois on health access for undocumented Latina women in general there is little understanding of how Medicaid emergency policies in the outreach for maternal or health services impact women or doesn't. Thus it's not safe to assume that temporary insurance impacts women in these states the same way it does in popular immigrant destinations. However, there is research on how a Latino population struggles with Medical Assistance coverage in Minnesota which makes it likely that the cultural health capital for immigrant populations is also lacking. The combination of

emergency public policies and the lack of entitlement that women have to the system is an explosive one when it comes to reaching for basic care if women do know about services.

Nevertheless, these generalizations can only take the research on health access for undocumented women so far. Just as the health access for undocumented Latina women can't be understood by looking at a heterogeneous Latino population, neither can unobserved heterogeneity that has different implications for health access by location and depending on the services women are seeking. The focus of this review is on SRH services which have mainly been discussed in terms of maternal health and whose health-seeking behaviors are shaped by nuances of state policy. The listing of unobserved barriers across states doesn't tell us how social interactions play out when trying to seek reproductive or preventive health care in a public setting, the lines of reasoning women use to deter their access, or what RH services are more prominent. This is why I decided that analyzing case by case could shed light on the importance of these barriers in a way that portrayed women as dignified rather than just subjects to measure basic access.

The approach showed subtle to large differences by state for reproductive health access. For example, while undocumented women in California and New York were receiving prenatal care CA Mexican undocumented women were receiving inadequate care. There was a lack of knowledge about reproductive services especially when it came to postpartum but even the type of knowledge was different. While Mexican undocumented women in CA seemed to know about postpartum care they could access for a year after birth their lack of knowledge came from a cultural standpoint. Newly arrived Mexican women didn't find the Western system in the U.S. as welcoming as they did the one in Mexico and unauthorized status deterred them from pursuing post-pregnancy care. The immigrant women in NYC had a lack of bureaucratic medical knowledge in the form of dominant health capital in which they didn't know about postpartum services under Medicaid programs. Even if they did know about these services they would have been met with temporary coverage only lasting sixty days as shown by Maru et al. (2021).

Prenatal care in Illinois was also inadequate for a Latina population like in CA but there is less of a vivid picture of how programs such as Moms and Babies which offer generous, albeit temporary coverage packages impact this trend. The reports on maternal health for Minnesota Latinas likely don't target undocumented women fully but give a glance at prenatal care. For the most part prenatal care was medically adequate for both the mother and child. Across all four

locations, state sovereignty for public health decisions and the social context on immigrant attitudes were influential for the quality of care women were receiving. For instance, Minnesota's state apparatus can't be compared to California's even when they were both making coverage decisions for the undocumented when the research for this paper began. Minnesota's non-immigrant destination character has played a role in its passivity for creating culturally sensitive health coverage models with an equity lens. The future of its MinnesotaCare expansion might or might not have similar consequences for undocumented people the same way California's free coverage might.

The subtleties of state bureaucracy, public health policy, and attitudes toward immigrant women can't be reduced in a simplification of unobserved barriers across states. They must be analyzed for how they impact local undocumented populations. While some might argue that state policy and by extension public policy is bound to change and generalization is a more apt tool, the previous decades have shown a stubbornness towards this. The largest changes in health access in the nation such as ACA in 2010 came after decades of denying humanity to undocumented Latinos by preventing them from receiving services. The exclusion was done despite research that shows they suffer more from serious diseases that could be prevented by primary care. In a cruel twist of events, ACA's initial implementation did close to nothing for undocumented populations. Since then state public health has taken gradual steps with some more successful than others. For undocumented populations, unobserved barriers have a strong relationship with temporary coverage making this research relevant.

Limitations

The general consensus is that undocumented Latina women are a difficult group to study because of irregular status. This has to do with confidentiality in medical settings like public centers and hospitals, as well as a reluctance to be represented in public research for fear of detection. Other explanations for this are due to confidentiality measures by educational institutions to protect human subjects. Within this limit, I worked with papers like Villanueva et al. (2005) which don't emphasize undocumented status but work with immigrant populations that don't reveal their status. For states such as CA and NY, I found the most emphasis on undocumented status. Yet when I controlled the search for undocumented Latina women and RH access the options shrank. In response to this, I used studies like Betancourt et al. (2021) and

Maru et al. (2021) which referred to Latina immigrants as opposed to undocumented immigrant women. This gap means that some of the findings pertain to mixed-status women instead of ideally only undocumented women.

The ethnic diversity of undocumented Latinas is also not mentioned or plays an appropriate role in some RH studies. The majority of research focused on Mexican undocumented immigrants when it did mention ethnicity. The prominence of this group means that other ethnic groups are less likely to have research done on them on specific topics like reproductive health. The exception in this paper was Menjivar (2002) who studies Guatemala and indigenous women for social ties. For the sake of compiling specific state data and combining it with hard-to-find undocumented women's research, I looked at a general undocumented Latina population.

Importance

The findings of this review are not just alarming for the widening disparity of health access between undocumented women and their documented counterparts. They are alarming because they tell us something about the bare life status of undocumented Latinas who don't figure into the political and social imagination of the nation by dominant powers. Health access is one of the most debated topics with many not agreeing on universal coverage. While coverage might not be the final solution to all health disparities among the Latinx community for the undocumented it has a strong relationship to how health-seeking experiences function in the real world. If Latina women feel entitled to coverage, they can navigate the system with more confidence, and if they become aware of services they are more likely to acquire health capital.

However, while debates go on about the worthiness of those who deserve coverage, Latinas suffer the consequences of indecision with their bodies and their mental health. Latinas as a group have mortality rates caused by chronic diseases like diabetes that could be prevented through preventive care such as constant doctor visits and bloodwork. In the reproductive health area, Latinas disproportionately experience higher rates of maternal mortality than white women with more than 25% not receiving prenatal care (Ramos et al. 2010). These statistics, while important, aren't all there is to know about women's experiences. Despite their exclusion from the formal health system, undocumented women have an intimate relationship with the system,

their health, and treatments outside Western medicine. In other words, they should not be reduced to passive victims unaware that the system has faltered to treat them with dignity.

While I was interested in the formal gaps of research on undocumented barriers such as Medicaid and state-federal policy, ideas for this thesis also came from empirical observations. The personal experience I have living in an immigrant community where health issues are prevalent showed that women were at the heart of health-seeking and at the mercy of poor diagnoses, fatal diseases, and frustrating long waits. I had also come to realize that the Medicaid systems they were navigating weren't the normal public health orders citizens were subject to. Their temporary health coverage involved jumping through hoops and working through emotional pain as a response to poor care. Despite these obstacles, immigrant women showed a willingness to continue navigating the system and finding their way through poorly funded community centers. Thus, I began to wonder why there wasn't more existing research on the experience of women living in a perpetual state of emergency care. Or why was the imagination for undocumented Latinas so limited to mainstream barriers that don't say much about the daily struggles of health that are more akin to status? The research I conducted made it clear that the public health system was not made for undocumented women but for women who were protected under citizenship and were active participants in impersonal language and behaviors.

Overall, the aim of this thesis is to highlight the exceptionality of the undocumented Latina case in a way that produces more discussion about the unforeseen consequences of living in a state of fear. The experience involves being subject to state-federal law that deems one unworthy. While also shedding light on the agency that women take in response to that plight.

Concluding Remarks

The comparative state analysis shows that progress towards health access has a gradual character and involves a coalition of actors from the state, government, Latinx social justice groups, and allies. While state-federal law proceeds gradually micro solutions for the progress of health care are equally as important. Across studies for the undocumented like in Ornelas et al. (2020), it is recognized that this group is more concentrated in community clinics. The efforts to integrate Spanish and cultural training should then be focused in public settings. Undocumented women mention multiple times they prefer *promotoras* who are volunteer health advisors equipped with Spanish-speaking skills, and natural forms of delivering information and are

trained by community organizations (Betancourt et al. 2021; Derose 2000). Large community centers and hospitals could implement this model more fully with their own staff instead of relying on Latinx organizations and networks. Especially in areas such as Minnesota where these networks aren't as developed.

The state can also play a part in this by creating channels to speak to undocumented populations about their rights under state policy through a program model. The latter would involve a more community approach than the impersonal models in medical facilities. California with its strong Latina community organizations and its progressive ideals can be a cornerstone for programs that reach families for these purposes. The example of CLRJ shows that applying not just an undocumented perspective but a reproductive social justice lens is successful in reaching women. These practices can be embedded into state-federal programs to some degree. The state already performs outreach with programs such as WIC that spread nutrition information. WIC is successful at having locations in low-income areas with immigrant populations. California is a model state for others and would possibly incentivize many to do the same. For health access to be successful it must not just get rid of unobserved barriers but states would ideally use their right to use funds in public health to spread universal coverage. The future of undocumented Latina women, unfortunately, relies on attitudes toward immigrants as well.

I have spoken extensively about the role that social science research can take on undocumented populations under barrier generalizations. Public health can also opt-in to provide research on how Minnesota and California's undocumented coverage expansions have changed access. This of course would require the passage of time to have a broader perspective of how local communities have reacted to such policies. The future of undocumented Latina women's health access is more hopeful in some states than others and has ironically taken steps back in some sanctuary areas. These paradoxes and intricacies of state-federal bureaucracy all shape the complex picture of health access that makes up the precarious world of undocumented Latinas.

Yet the greatest challenge of them all is finding a common agreement for equitable health practices that recognize intersectionality, and humanity, and let go of desensitization towards the slow violence that undocumented women experience.

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