

April 2023

Impact of the COVID-19 Pandemic on Immigration-Related Stressors, Pregnancy, Birth, and Post-Partum Experiences of Women Living Along the US-Mexico Border

Isabela Solis
University of South Florida

Follow this and additional works at: <https://digitalcommons.usf.edu/etd>



Part of the [Other Social and Behavioral Sciences Commons](#)

Scholar Commons Citation

Solis, Isabela, "Impact of the COVID-19 Pandemic on Immigration-Related Stressors, Pregnancy, Birth, and Post-Partum Experiences of Women Living Along the US-Mexico Border" (2023). *USF Tampa Graduate Theses and Dissertations*.

<https://digitalcommons.usf.edu/etd/9929>

This Thesis is brought to you for free and open access by the USF Graduate Theses and Dissertations at Digital Commons @ University of South Florida. It has been accepted for inclusion in USF Tampa Graduate Theses and Dissertations by an authorized administrator of Digital Commons @ University of South Florida. For more information, please contact digitalcommons@usf.edu.

Impact of the COVID-19 Pandemic on Immigration-Related Stressors, Pregnancy, Birth, and
Post-Partum Experiences of Women Living Along the US-Mexico Border

by

Isabela Solis

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
Department of Anthropology
College of Arts and Sciences
University of South Florida

Major Professor: Heide Castañeda, Ph.D.
Carina Heckert, Ph.D.
Nancy Romero-Daza, Ph.D.
Dinorah Martinez-Tyson, Ph.D.

Date of Approval:
April 14, 2023

Keywords: health, social, political, crossing, individual

Copyright © 2023, Isabela Solis

TABLE OF CONTENTS

List of Tables	ii
Abstract	iii
Chapter I: Introduction.....	1
Research Setting and Background	4
Broader Impact.....	6
Chapter II: Background and Literature Review	7
Border Closure And Immigration Policies Disruption To Maternal Health Support	7
Immigration-Related Stressors.....	10
Covid- 19’s Effect on the U.S.-Mexico Border Region Resulting in Economic Insecurities	17
Theoretical Framework.....	19
Chapter III: Method	24
Recruitment.....	27
Coding.....	27
Ethical Considerations	28
Chapter IV: Results.....	30
Border Closure and Immigration Policies Disruption to Maternal Health Support.....	32
Family Separation and How That Impacted Women’s Emotional Well-Being	40
Provider/Legislative Interview Discussion	51
Chapter V: Discussion	60
Legal Violence	60
Stress and Embodiment.....	63
Chapter VI: Recommendations and Conclusions	68
Recommendations.....	68
Conclusions.....	70
References.....	72
Appendix A: Online Informed Consent.....	79
Appendix B: IRB Approval for Study	80

Appendix C: S Semi-Structured Interview Guide81

Appendix D: Background of Participants82

LIST OF TABLES

Table 1:	Comparison of Texas’s Publicly Funded Prenatal Care Programs	5
Table 2:	Background of Participants	30

ABSTRACT

The COVID-19 pandemic coupled with immigration-related stressors had a profound effect on women who lived on the U.S.-Mexico border and their pregnancy, birth, and post-partum experiences. This project focused the experiences of 17 women living in El Paso, Texas and how border closure, economic insecurities, and family separation during the COVID-19 pandemic shaped women's experiences. This research included interviewing maternal and child health experts to propose recommendations geared towards policy change. Finally, this project highlights the vast complexities that go into the pregnancy, birth, and post-partum period for women living on the U.S.-Mexico border, and how these experiences shape maternal and child health outcomes.

CHAPTER I: INTRODUCTION

This project focused on women in El Paso, Texas, which borders Ciudad Juarez, Mexico. El Paso is a major port of entry to the United States; therefore, border city health disparities and influences on access to care are imperative to the questions this research posed. El Paso is a city comprised of a population that is 83% Hispanic, requiring a focus on immigrant and Latino disparities (United States Census, 2019). There are many components that factor into adverse health outcomes in pregnant immigrant women, especially preterm birth and low birthweight. Factors such as access to care, social support, immigration-related stressors, everyday stress, and legal violence all impact health outcomes and become exacerbated in minority populations.

In recent times, El Paso has been a target for harsh immigration policies due to its proximity to the border. For example, the Governor of Texas, Greg Abbott, introduced an executive order that would allow state troopers to stop vehicles suspected of transporting migrants (Oxner, 2021). This order could potentially lead to overcrowding in migrant shelters and delay of access to health services. Additionally, in 2017, the El Paso Border Patrol sector became a testing ground for separating children from their families before this became commonplace along the border. Restrictive immigration policies and practices such as these can contribute to a heightened stress of vulnerability and stress for undocumented immigrants. They also bring into question who deserves access to care and subsequent health services (LeBrón et al., 2018).

Since the 2016 presidential election, researchers have examined the detrimental effects the rhetoric communicated by administrations can have on pregnant women with precarious

immigration status. For example, Callaghan et al. (2019) sought to understand factors that exacerbate barriers to health care access for this population during the 2016 presidential election, discovering that fear limited access to health services during the Trump administration as people were concerned of being deported or detained by immigration officials (Callaghan et al., 2019). Another key theme that arose was misinformation as a barrier to care, with participants stating that the administration's rhetoric and harsh proposed policies complicated their access to care (Callaghan et al., 2019). Having limited mobility or being fearful of seeking care due to anti-immigrant rhetoric can pose significant barriers to access to care. This, coupled with stress and hypervigilance, can result in adverse health outcomes, especially for pregnant immigrant women, who are especially vulnerable.

There are many complex factors that influence access to care among the U.S.-Mexico border. This project focuses on the factors that may influence access to care in first- and second-generation immigrant women. Additionally, it explores how COVID-19 has affected access to care and family planning services. Key themes that are presented in this research are the border closure and immigration policies disruption to maternal and child health, COVID-19's effect on the U.S.-Mexico border region resulting in economic insecurities, and family separation and how that impacted women's emotional well-being. Themes throughout this project will be labeled as border closure, economic insecurities, and family separation for short. This project sought to explore the emotional pathways of stress that pregnant and postnatal women experience due to immigration-related stress and how that can result in physiological changes associated with adverse health outcomes.

The primary research questions were to explore how the pandemic impacted pregnancy, birth, and post-partum experiences for women living on the border; in what ways has the

pandemic exacerbated immigration-related concerns; and how women feel these stressors have impacted their health during the pregnancy and post-partum period. Another important facet of this project was to explore how this research can impact state level policy and be disseminated most effectively. This was done by using interviews as part of a larger study conducted in El Paso, Texas. This broader study was done through the University of Texas at El Paso that looked at the emotional distress and pathways of embodied maternal health vulnerability among immigrant women on the US-Mexico Border. Interviews were transcribed and read through in order to find preliminary themes that emerged in the data based on the research questions outlined above. To do so an inductive approach to coding was used in order to identify codes that were presented in the data. Themes were identified that focused on how the pandemic shaped women's pregnancy and postpartum experiences while living on the U.S. Mexico border.

Another component of this research was speaking to providers and people who were informed in policy. This was done by interviewing someone who sat on the Texas Maternal Mortality Review Board and provider who sat on the Florida Maternal Mortality Review Board. This was to gauge the recommendations they had moving forward with the research and how to make the biggest impact in terms of policy change.

Interviews with the women who are a part of this study highlighted issues that impact women's health on the U.S.-Mexico border, including the border closure, economic insecurities, and family separation, all of which were fueled by the pandemic. Recommendations for future policy change and better maternal and child health outcomes include, addressing the gap in data for women on continuity of care, expanding Medicaid, a shift in the way we see immigration and borders in the U.S., and refocusing the need for maternal care.

Research Setting and Background

El Paso, Texas has a population of 680,000 people. Additionally, 20 percent of the population in El Paso is below the poverty level (U.S. Census Bureau, 2021). Texas Health and Human Services estimates that rates of poverty are starkly higher along the border areas in comparison to the rest of Texas. The Texas-Mexico border area has seen an increase in population and is likely attributed to an increase in migration patterns from Mexico (Texas Health and Human Services, 2017). On the Texas border there is a 25 percent rate of people who are uninsured compared to 18% for the rest of the state (Texas Health and Human Services, 2016). This number is slightly higher for women of childbearing age with 26.3% of women being uninsured in the state of Texas (United Health Foundation, 2022). This would mean that over 1 in 4 women are uninsured in the state of Texas and on the Texas-Mexico border. This lack of coverage for women may be why Medicaid covers over half of the births in Texas (March of Dimes, 2020). The impact of COVID on the El Paso region is an important aspect of this project and is further discussed in the later section of “COVID-19’s Effect on the U.S.-Mexico Border Region resulting in Economic Insecurities”.

Texas has the highest rate of uninsured people in the country at 18% and is also among the 12 states that chose not to expand Medicaid (U.S. Census Bureau, 2019-2021; Krisberg and Leffler, 2022). An important detail here is that in the Texas Health and Human Services, “illegal aliens are only eligible for Medicaid for treatment of an emergency medical condition if they meet all other eligibility criteria, including residency requirements” (Texas Health and Human Services, nda). Alternatively, CHIP perinatal covers immigrant children with precarious immigration status during the first 5 years in the U.S., it only covers the child not the mother (Dunkelbreg, 2016). It is important to look at Texas as a whole in terms of coverage, laws, and

policies as state regulations trickle down to individual cities and impact particular populations. It is important to highlight the difference in coverage between Medicaid and CHIP perinatal, seeing as we can see there is stratified access based on immigration status. Table 1 illustrates the differences in coverage by program.

Table 1: Comparison of Texas’s Publicly Funded Prenatal Care Programs

Program	Immigration Requirements	Income Coverage	Requirements
Medicaid for Pregnant Women	US Citizenship or at least 5 years of legal permanent residency	198% FPL	Comprehensive care during pregnancy, the birth, and 60-days postpartum
CHIP Perinatal	Evidence of living in Texas, but no exclusion based on immigration status	202% FPL	Prenatal appointments and coverage for conditions defined as posing a risk to the fetus Delivery, but not false labor Up to 2 postpartum visits, but no coverage for additional services that may be needed

Credit: Heckert, C. (in progress). Birth in Times of Despair

Health care coverage is a significant part of this research and therefore important to understand the coverage afforded to certain groups and not others. Mulligan and Castañeda (2017), argue that while the Affordable Care Act (ACA) extended coverage to approximately 20 million individuals it excluded or “stratified” immigrants and created unequal coverage. There is also an impact on who Mulligan and Castañeda (2017) talk about as mixed-status families in which for example some family members may be able to apply for Medicaid while other undocumented family members may not. Under the ACA access to certain services was reduced

further stratifying immigrants and limiting their access to health care services, further marginalizing certain groups (Mulligan and Castañeda, 2017). Additionally, under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) there was an emphasis on how your immigration status can impact the federal benefits that can or cannot be received (Mulligan and Castañeda, 2017). Therefore, we can see how through policy and further through legal violence certain groups of people can become further marginalized and have heightened vulnerability. In this case, how access to care may become less accessible to certain groups of people due to policy enactment.

Broader Impact

The purpose of this research is to understand how the pandemic has shaped experiences of women on the border in terms of pregnancy, birth, and post-partum. In addition, a key interest is to understand how the pandemic has exacerbated immigration-related concerns. This would allow us to understand how immigration-related stressors, the pandemic, and health are interwoven to create a unique experience for women living along the border. Raising awareness of these issues are imperative to guaranteeing access to care for all.

This project then focused on three key themes that arose through the experiences of the women interviewed which included, the border closure, family separation, and economic insecurities. These broader themes highlight how the pandemic coupled with immigration-related stressors impacted women's pregnancy, birth, and post-partum experiences and potentially result in negative health outcomes. Additionally, recommendations will be explored based on this research and the literature to help inform policy geared towards improving these outcomes.

CHAPTER II: BACKGROUND AND LITERATURE REVIEW

There are many components that factor into adverse health outcomes for pregnant immigrant women, such as preterm birth and low birthweight. Factors such as the COVID-19 pandemic, access to care, social support, immigration-related stressors, everyday stress, legal violence, can impact health outcomes and become exacerbated in minority populations (Cervantes and Menjivar, 2020; Stafford et al., 2022; Page-Reeves et al., 2022). The pandemic shut down the U.S.-Mexico border to Mexican citizens travelling to the United States, which had potential unintended consequences for pregnancy and post-partum experiences in the border region. With the border closures, there may have been lack of social and familial support for women living along the U.S-Mexico border, in addition to a limit on movement for non-U.S. citizens and potential lack of access to care due to the closures. With the media attention tuned to COVID-19, there was little to no coverage on the issues facing the U.S.-Mexico border at the time (Blue et al., 2021). The Trump administration used COVID-19 to push the agenda and limit immigration and limiting mobility for asylum seekers, which included forcing expulsion from the U.S. side of the border. Therefore, there are various unintended consequences and political agendas that can exacerbate post-partum and pregnancy experiences on the border.

Border Closure And Immigration Policies Disruption To Maternal Health Support

Border closures can also exacerbate anxiety in people living in border regions and are often not proven to reduce the spread of COVID-19 (Kenwick and Simmons, 2020). Kenwick and Simmons (2020), argue that politicians and the public have been contributing to this border

anxiety by using the narrative of the “dangerous others” and the pandemic has been an example of this phenomena. Therefore, by justifying the border closure with the idea that it will be safer against the spread of COVID-19 is unsupported by the literature and has unintended consequences for people living on the border (Kenwick and Simmons, 2020; Boyd et al., 2020; Emeto et al., 2021; World Health Organization [WHO], 2020).

It is important to note how the pandemic affected the amount of border crossing and the unintended consequences that followed the border closure, such as a economic hardships and job losses. This is due to the El Paso and Juarez being economically interdependent. The amount of border crossings before and during the pandemic reflect a loss in economic stability between the two cities. For example, in 2019 before the pandemic hit over 7.5 million people crossed between the two cities (United States Department of Transportation, 2019). When the pandemic hit border crossings were at a historically low 2,981,773 people crossing (United States Department of Transportation, 2021). Prior to the pandemic the economic interdependence between the two cities was reflected in the high volume of congested traffic along the 5 ports of entry in El Paso (Staudt, 2020). This high volume of traffic included people crossing to shop, work, visit family, etc. (Staudt, 2020). With the 20-month border closure the inability for people to cross to shop contributed to the economic hardships and job losses in El Paso for an extended period of time, when other parts of the country may have quicker economic recoveries.

The importance of the border being open is particularly important when talking about exclusion and inclusion (Castañeda, 2019). During this 20-month border closure, only U.S. citizens were allowed to cross back and forth, which propelled this exclusion criteria further by excluding Mexican citizens from crossing. Castañeda (2019), talks about “borders represent the ultimate regulation of mobility, creating uneven landscapes of movement (p. 23). With this

border closure, the ultimate regulation of mobility was imposed. Castañeda (2019), talks about how “border enforcement plays a critical role in maintaining global inequalities by producing separate social, political, and economic spaces, and by restricting the ability of impoverished residents to move from one region to another” (p.28). I would argue that this 20-month border closure did just that, and further produced inequities for certain groups. This then further exacerbated legal violence, family separation, and economic concerns as highlighted in the rest of this thesis.

Casaglia (2021), argues that the pandemic has already affected people who are most vulnerable and experience inequalities putting people with precarious immigration status the crossroads of multiple inequalities that are a result of the border closure. Some of these intersections of vulnerability lie in a potential lack of access to healthcare, exclusion from welfare programs, and socio-economic disparities (Casaglia, 2021). It is also the case that some people may have access to welfare programs but may not choose to apply because of the likely public charge rule. A likely public charge meaning that if a non-citizen is deemed a likely public charge meaning “primarily dependent on the government for subsistence” they can be denied residence or a green card (Homeland Security, 2022).

There is a lack of inclusion in Medicaid programs, federal housing assistance, food stamps, etc. for non-citizens further contributing to already existing vulnerabilities for this population. There has since been a revision to the likely public charge rule that Supplemental Nutrition Assistance Program (SNAP), Medicaid, Children’s Health Insurance Program (CHIP) and housing benefits would no longer be considered as a public charge (Homeland Security, 2022). This change came into effect December 2022 and therefore did not apply to the women who were a part of this study. Makhlouf (2019) argues that this public charge rule can be seen as

health policy as it directly excludes people from programs like Medicaid that serve as healthcare. This can also create fear when it comes to applying for programs that a person qualifies for regardless of immigration status, such as CHIP perinatal and WIC. With the border closure lack of access to care was exacerbated further as non-citizens would no longer be able to go to Mexico to access care, that is often more affordable than that of the care in the U.S., especially for those who are uninsured. Prior to the pandemic people lacking legal status were unable to cross. During the pandemic people with border crossing cards and student visas, who would previously been able to cross, could no longer do so. Additionally, U.S.-citizens were not supposed to cross for non-essential purposes though there was no way to enforce this seeing as they had a legal right to reenter the U.S.

Immigration-Related Stressors

There are many ways pregnant women experience immigration-related stress, but a major issue that stands out in the literature is being constantly policed. For example, women with precarious immigration status may have high levels of stress, emotional responses, and even physiological responses to enforcement activities (Solis and Heckert, 2020). Heightened stress during a pregnancy has been linked to adverse birth outcomes in women (Federenko and Wadhwa, 2004; Phelan et al., 2015). Exposure to acute and chronic stress can also factor into likelihood of having infants born preterm (Behrman and Butler, 2007). Stress in both the individual level and residence level can affect preterm birth in terms of the mental and emotional well-being of the mother. This can be in the context of everyday stress, immigration-related stress, assimilation stress, etc. This is particularly important since there are clear associations with preterm birth and low birthweight contributing to maternal stressors and are leading causes

for infant and maternal mortality and morbidity (Rondó et al., 2003). Rondo et al. (2003) found a clear link with maternal distress and low birthweight and preterm birth. This leads to mothers' emotional and mental well-being an important factor to preventing adverse health outcomes such as low birthweight and preterm birth.

Findings show that a mother's mental health can impact the overall health of the fetus (Federenko and Wadhwa, 2004; Phelan et al., 2015). The responses to being constantly policed can result in hypervigilance and perceptions of immigrants as underserving of residing in the United States, even temporarily (Quesada, 2011). Often, Latino migrants have to navigate negative perceptions that have been heavily produced by the media. For example, Latino immigrants have often been portrayed in the media as being a threat to the United States (Reny & Manzano, 2016). Another important piece of how Latino immigrants are perceived in the media is this categorization of "illegal alien" that came about in the 1920's (Reny & Manzano, 2016). This term allowed for immigration to be thought of as harmful, undesirable, and a threat to American traditions and the law (Reny & Manzano, 2016). This can lead to hypervigilance and imposing limitations on one's movement and fear (Rodriguez et al., 2017, Solis and Heckert, 2020, Quesada, 2011) that can result in limitation of access to health care services.

It is also important to highlight the spillover effects of immigration policy on families. Castañeda (2019), talks about how immigration policy often not only impacts the immigrants themselves, but also their U.S. born children. "Illegality" thus permeates into opportunities and resources for other members of the family (Castañeda, 2019), requiring us to look at the spillover effects beyond just the individual in order to see how immigration policy, law, and border militarization have all affected both undocumented and documented individuals.

Hyper-vigilance and self-imposed limitations of movement can manifest in many forms. For example, women with precarious immigration status describe police surveillance and traffic-related encounters resulting in assumptions of the driver or passenger's legal status (LeBrón et al., 2018). If movement can result in police interactions where legality of residence is questioned or assumed, immigrant women may turn to self-imposed limitations. Lebrón et al. (2018) found that immigrant women, in order to avoid unnecessary interaction with police or immigration officials, would self-surveil their movements. This hypervigilance and stress could deter women from seeking health-promoting resources (LeBrón et al., 2018). Women who had family members with undocumented statuses also engaged in hypervigilance and self-surveillance (LeBrón et al., 2018).

Restrictive immigration policies can also increase levels of insecurity and heightened stress. Policies such as Arizona's SB1070 law, which allowed officers to ask for documentation of immigration status at routine traffic stops, lead to racial profiling concerns (Morse, 2011). A similar law was proposed in the state of Texas by Governor Greg Abbott, which allowed state troopers stop vehicles suspected of transporting migrants (Oxner, 2021). These are examples of how restrictive immigration policies can contribute to heightened stress and vulnerability for undocumented immigrants. Restrictive immigration policies also question who deserves access to care and subsequent health services (LeBrón et al., 2018). If the narrative is one where immigrants are taking resources and jobs from citizens, are viewed as criminals, then they are deemed undeserving of the access to care in comparison to their citizen counterparts.

Access to care for immigrants with undocumented or precarious status is viewed as a privilege and not a right. Vanthuyane et al. (2013) conducted a survey on ethical and professional dilemmas regarding pregnant women with precarious immigration status who are

uninsured or partially insured. Healthcare workers in this study viewed the uninsured as undeserving of care or healthcare as a privilege. This would put pregnant immigrant women, who are already hypervigilant and limited in their movement, at risk for not being covered by health care services because they are seen as undeserving. Another study found that undocumented Latinos are concerned about their ability to get health care services due to their status (Berk & Schur, 2001). This can be attributed to changes under the 1996 welfare program where changes on eligibility on who can receive care based on immigration status were resurfacing at the time (Berk & Schur, 2001). Therefore, there may be some confusion or concern over what services are available for undocumented Latino immigrants in terms of access to care.

A study conducted in Alabama examined in-depth interviews with Latina immigrants and their U.S. born children about their access to health care after a new law (White et al., 2014). The law prohibited “illegal immigrants” from accessing any public benefits and would not allow them to attend any public college/university (Morse, n.d.). Another study looked at the restrictions in the law for publicly funded programs and women with precarious immigration status reported a heightened sense of discrimination and potential impacts on health due to lack of access to services (White et al., 2014). This can have serious implications for women’s health, especially pregnant immigrant women, with implications for availability of health services, affordability of services, accommodation, acceptability, and accessibility. Women were hesitant to visit local clinics or hospitals for care and were unaware of specific stipulations of the law under what services may be exempt from this law. They were also afraid they would be unable to pay for high medical costs and had fears associated with future costs (White et al., 2014). Most indicated feeling uncomfortable or being discriminated against at local clinics, which in turn

affected the acceptability of these local health services. Regarding accessibility, most participants reported limiting their movement after the law was passed to reduce their interactions with police and possible detainment (White et al., 2014).

Harmful immigration laws and policies at the federal, states, and local level can result in adverse health outcomes for immigrants with precarious immigration statuses (Kline and Castañeda, 2019). Increased border security, increase in the number of officers at the border, and more specialized surveillance technology have exacerbated the risk of crossing the border (Kline and Castañeda, 2019). This can lead to increased stress and hypervigilance which can result in negative health outcomes, especially for pregnant women. There are real health impacts when it comes to Latinx immigrants such as exacerbating already existing health concerns and creating new health concerns which can be linked to immigration enforcement policies (Kline and Castañeda, 2019). It is important to consider how laws and policies can impact the health of immigrants. For example, Kline (2022), found that in Georgia due to their harsh immigration enforcement laws, undocumented immigrants would be denied care by private hospitals and instead be routed to a public hospital. This denial of care could perpetuate existing health concerns and is seen as unethical to deny care to anyone based on the status of their immigration (Kline, 2022). These are all key examples of how laws and policies can contribute to adverse health outcomes for a targeted population, in this case Latinx undocumented immigrants.

Arizona's SB1070 and Alabama's omnibus laws illustrate the damage that harsh immigration policies can have on not only pregnant immigrant women but also their U.S.-born children. Denying access to care or implementing fear of engaging in everyday activities leaves people in a particularly vulnerable place and therefore can contribute to adverse health outcomes, including preterm birth and low birthweight. Laws are not the only barriers to health care, in

some instances, politics and who holds office can impact health outcomes in Latina women and their subsequent U.S.-born children.

Following the 2016 presidential election, researchers have examined the detrimental effects of the rhetoric on pregnant women with precarious immigration status. Callaghan et al. (2019) found that fear limited access to health services during the Trump administration over concerns of getting deported or detained by immigration officials. Misinformation was also listed as a barrier in focus groups, due to participants deciding whether or not to seek health services based on the available information (Callaghan et al., 2019). Having limited mobility or being fearful of seeking care due to such rhetoric can pose significant barriers to access to care. This coupled, with stress and hypervigilance, can result in adverse health outcomes, especially for pregnant immigrant women, who are especially vulnerable.

Part of the harmful rhetoric included threats the administration was making to implement new policies that would reduce access to care. During the Trump administration, a new plan was implemented regarding who would become a “likely public charge,” which would allow the denial of residency applications if there was concern that the applicant would be utilizing publicly funded programs (Solis and Heckert, 2020). CHIP perinatal offers women access to prenatal care regardless of immigration status and often is the only time immigrant women can access care or have coverage (Heckert, 2020). While these programs did not fall under the “likely public charge” rule Heckert (2020) found that there was some provider uncertainty on how these programs would affect immigration applications. This uncertainty was enough to instill fear and stray women away from applying to CHIP perinatal and opting out of that coverage (Heckert, 2020).

A likely public charge is rule that can be used to deny a person's application on the grounds that they may become reliant on publically funded programs. This assumed that it would deter immigration and affected thousands of applications. This likely public charge could also have implications on immigrant and Latinos residing in the U.S. on the use of publicly funded programs. In 2018, the Department of Homeland Security proposed making revisions to the public charge rule which included expanding the public benefits that would put immigrants in the "public charge" category at a significantly higher rate and therefore deter more immigrants from receiving admission into the U.S. (Horton et al., 2018). This expansion of services that are deemed under the category "public charge" included Medicaid, insurance purchased through the American Care Act (ACA) and food stamps, etc. (Horton et al., 2018). This is particularly important to consider when 23% of the population in El Paso are uninsured which is more than double the national average (United States Census Bureau, 2020). This public charge rule went into effect in February 2020 and has had detrimental effects on immigrants who have sought or are seeking public assistance (Dunan et al., 2021). This public assistance which included programs such as Medicaid and food stamps were vital to this population during the COVID-19 pandemic (Dunan et al., 2021). Therefore, if people are refraining from seeking Medicaid and other government assistance programs, border closures may prevent people from seeking cost-effective healthcare, and the uninsured rate is more than double the national average, women living alone the border may be experiencing compounding barriers in access to care.

Another study looked at preterm births among Latina women during the 2016 presidential election and found an association between preterm births and heightened levels of psychosocial stress and anxiety (Gemmill et al., 2019). This implicated not only Latina women but family and community members as well. Low birthweight and preterm birth are of concern throughout the

United States but especially in El Paso seeing as this community has higher rates than the national averages. For example, the national rate for preterm births is 10.1% while El Paso has a rate of 12.1% (Centers for Disease Control and Prevention [CDC], 2020; Paseo Del Norte, 2017). Additionally, the years that Ciudad Juarez the city that borders El Paso was named the most dangerous city in the world in 2010, coincidentally the year with the second highest preterm births since 2018. While there may have been many factors contributing to preterm birth rates being high, stressful interactions at the border and within the city should be explored. Since 2012 preterm births and low birthweight rates have been steadily decreasing with numbers rising back up in 2016 (Healthy Paso del Norte, 2015; 2017).

Covid- 19's Effect on the U.S.-Mexico Border Region resulting in Economic Insecurities

An important unintended consequence for the pregnancy and post-partum experience during the COVID-19 pandemic is the impact of the pandemic on family relationships of Mexican Americans on the U.S. Mexico border. A study looked at familial relationships of Mexican Americans living El Paso and found people who reported a negative change in familial relationships had higher rates of reported depression and anxiety (Volpert-Esmond et al., 2022). Family disruption can come in many ways along the U.S. Mexico border such as threats of deportation to family members or partners and economic concerns driving partners to find work far from home (Maldonado, 2022). Additionally, the U.S.-Mexico border had higher mortality rates than non-border areas (Filosa et al., 2022) further contributing to disruptions in familial relationships and support.

Another study examined the COVID-19 and its effects on the border region in terms of health and the economy and found that the closure of international borders had an association

with economic insecurities, job loss, decreased income, and physical and mental challenges (Silva-Sobrinho et al., 2021). These consequences of both the border closure and the pandemic have likely impacted women's pregnancy and post-partum experiences. Women living on the U.S. Mexico border can experience economic insecurities, lack of access to care, anxiety, lack of support etc. For example, Silva-Sobrinho et al. (2021) found that social isolation and the border closure had a profound effect on the health of people living on the border and negatively affected the region's economy. Another study suggests that both sides of the border have a profound effect on each other and cessation of these relationships, with for example the 20-month border closure, could potentially do more harm than good (Filosa et al, 2022). This study also suggests the importance of policy, policymakers, and public health officials are key to avoiding the consequences in the early pandemic that were spearheaded by these severed relationships (Filosa et al, 2022).

There are benefits to both sides of the border economically, for Mexico it is the U.S. tourism while for the U.S. it is the availability of Mexican workers. Border closures can magnify economic insecurities by cutting off that economic interdependence for extended periods of time (Donelson and Esparza, 2010). Economic insecurities have been exacerbated by the pandemic as evidenced by the fact that just in the month of May in 2020 almost 50 million people in the U.S. were unable to work leading to other potential unintended consequences such as family separation (U.S. Bureau of Labor Statistics, 2020). Another important factor that could contribute to economic insecurities in that Covid Aid, Relief, and Economic Security (CARES) does not provide relief to people with precarious immigration status, further contributing to their economic insecurities (Wilson and Stimpson, 2020).

Immigrant populations and Mexican Americans have been disproportionately affected by the COVID-19 pandemic. The spread of COVID-19, economic impact, policies, prevalence, hospitalizations, and death have all contributed to a heightened vulnerability for immigrant populations. Wilson and Stimpson (2020) discuss the economic and legal barriers in accessing care for undocumented immigrants and the border closures due to the pandemic, which can be detrimental to women who rely on the healthcare they receive on the U.S. side of the border. When the border was closed to non-essential travel, immigrants who resided in the U.S. were no longer able to seek the less expensive care in Mexico and were more likely to rely on emergency medicine (Wilson and Stimpson, 2020). U.S. citizens would also frequently cross to Mexico for more affordable care.

It is important to understand the experiences that shape pregnancy and how the pandemic has contributed to those experiences. Additionally, as we see in the literature review, it is important to consider how the pandemic has impacted pregnancy, birth, and post-partum experiences for women living on the border. This can include policies that target immigration at the border with unintended consequences for women accessing care. It is important then to consider how the pandemic exacerbated immigration-related concerns.

Theoretical Framework

There are a few foundational concepts that helped guide this research. Hyper-vigilance, immigration-related stress, everyday violence and maternal stress can be linked to embodiment. Embodiment refers to the process in which social structures, race, individual-level experiences, and social interactions can generate biological patterns (Kreiger, 2001, 2016; Gravlee, 2009). We can then think about the links of stress to embodiment and how stress can impact the body. In

this way social structures, social interactions as forms of institutional racism, etc. can produce negative health outcomes for Mexican-origin individuals in the U.S. (Martinez et al., 2018). As an example, embodiment can explore the ways in which harmful immigration policies can result in adverse health outcomes in Mexican-origin individuals. Immigration enforcement policies can have consequences for individuals living with undocumented relatives by exacerbating fear and producing stress for the people with precarious immigration status (Martinez et al., 2018).

Gravlee (2009), sought to explore how race become biology, specifically how systemic racism becomes embodied through the individual. Race has historically played a role in Anthropological studies and at the turn of the 20th century most anthropologist had rejected the concept of race as biology (Gravlee, 2009). Instead, we pivoted as anthropologists to discussing race as a social/cultural construct (Gravlee, 2009). Embodiment can aid this research in providing a critical lens into the ways women internalize stress, institutional racism, social structures and individual-level experiences.

Another key part of the foundational concepts to this research is the way stress is linked to adverse health outcomes for women such as preterm birth and low birthweight. This is an important part of embodiment as we can look at the way stress and health can be linked to embodiment. Preterm birth and low birthweight can be linked to maternal stress and in turn cause infant morbidity and mortality (Dunkel & Glynn, 2011; Grote et al., 2010; Rondó et al., 2003). In a city, such as El Paso that borders Mexico so closely, immigration-related stress is prevalent among immigrants and Latinos. This immigration-related stress can exacerbate adverse health conditions. A study looked at the effect of immigration raids in Pottsville, Iowa on 52,344 U.S.-born non-White Latinas (Novak et al., 2017). The goal of this research was to look at the spillover effects in 2008 in which Pottsville at the time the largest “single-site federal

immigration raid (Novak et al., 2017). For example, researchers found that following an immigration raid Latinas had a greater risk of having babies preterm and with low birthweight (Novak et al., 2017). Grote et al., (2010) found that maternal stress and low birthweight can be linked and have adverse health outcomes. Having an environment that constantly polices for immigrants with precarious immigration status can cause added stress for mothers, even if they are here legally. Therefore, while there may be other factors that can contribute to negative health outcomes in mothers and children, we must also consider the social structures that are creating added harm. Additionally, a study conducted about birth differences in Texas found that mothers who were US born but with Mexican origin had a higher possibility of having preterm births and infants born with low birthweight than US born white mothers (Sullivan et al., 2011). It is clear that we must take into consideration race, ethnicity, and immigration status into consideration when looking at preterm births and low birthweight rates in Texas.

Hypervigilance, self-imposed limitations on movement, and harmful immigration policies are not the only contributors to lack of access to care. Hacker et al. (2015) found that barriers to health care are not simply found in policy but can also be influenced by factors such as financial limitations and fear of deportation. National policies that aim to exclude undocumented immigrants from receiving care are common. In addition, health systems can be difficult to navigate, costly, and often stressful. High healthcare costs can be detrimental, especially related to pregnancy, and can become a barrier in seeking care. Cost to the individual, discrimination in the healthcare system, and even external barriers such as work obligations can serve as barriers to access for this population (Hacker et al, 2015).

Another framework at the intersection with embodiment is legal violence. Legal violence refers the ways laws can perpetuate harm in individuals or group of individuals targeted by the

law (Menjivar and Abrego, 2012). Therefore, the ways in which policies and laws can target individuals or groups of individuals can be seen through embodiment. Legal violence is particularly useful in immigration-related research as it provides a theory for the unintended consequences the law can perpetuate (Menjivar and Abrego, 2012). Moreover, exploring the ways laws can perpetuate harm on individuals can give insight into how women embody the stress caused by these laws.

Another important component of legal violence is the ways it limits mothers' ability to mother (Abrego and Menjivar, 2011). For example, immigrant women often face lengthy separations from their families due to their precarious immigration statuses (Abrego and Menjivar, 2011). Another component of this is that even if the undocumented mother is home with her children the home is filled with stress and tension as the threat of deportation is constant (Abrego and Menjivar, 2011). It works the same way when the mother migrates to the U.S. in search of work leaving their children and family for extended periods of time (Abrego and Menjivar, 2011). In most cases mothers are simply trying to provide for their families, work, and generally make a better life for their families and children but are often faced with legal barriers.

Legal violence has the potential to impact individuals but also communities that experience restrictive immigration laws or immigration-related stressors. Abrego and Menjivar (2011), make the argument that workplace or home raids, restrictive immigration policies, and family separation all contribute to instilling fear in whole communities and are a form of legal violence. Legal violence can often be referred to as unintended consequences of the law while Abrego and Menjivar (2011) take it a step further by explaining legal violence as the ways the laws that are supposed to control or protect the general public end up causing harm to certain groups of people putting them at risk for further forms of "unintended consequences". This can

be done by extending the scope of laws or policies that specifically impact immigrants which has become more popular along the border. Immigrants, either documented or undocumented, still face certain barriers such as treatment by authorities or employers, levels of suffering, and harmful rhetoric that positions documented or undocumented immigrants as suspects, criminals, and deserving of punishment (Abrego and Menjivar, 2011). Therefore, in the public eye the narrative has shifted from immigrants being people who steal our jobs to being dangerous criminals and terrorists (Abrego and Menjivar, 2011). Background into how legal violence affects not only undocumented immigrants but documented immigrants as well will be useful in how this has affected women living on the border.

There is still a problem that needs to be addressed in this community for Hispanic and Latina women in terms of birthing and post-partum experiences on the U.S.-Mexico border. Interview data from this project provides insight into the ways legal violence, embodiment, social structures, and individual-level experiences all affect the women living on the U.S.-Mexico border. Women in this study described actions that reflect hypervigilance or talked about ways different types of concerns that they have manifest as stress, tension, or anxiety. It is important to explore the ways in which every day experiences surrounding living on the U.S.-Mexico border manifest into potential adverse health outcomes.

CHAPTER III: METHODS

The interviews for phase 1 (subset of 17 interviews) were conducted by Dr. Carina Heckert, a professor at the University of Texas at El Paso (UTEP). This larger study from UTEP looked at the emotional distress and pathways of embodied maternal health vulnerability among immigrant women on the US-Mexico Border. Dr. Heckert sought to look at the emotional pathways that connect the social context to biological responses and the similarities and differences in these pathways based on different types of immigration-related concerns. The questions were explored using a multi-phased design that will include survey data, cortisol testing (a stress biomarker), health records, and in-depth interviews. Women living at the U.S.-Mexico border were recruited to share their experiences of pregnancy and post-partum. This included looking at how the pandemic has exacerbated these experiences for women, coupled with immigration-related concerns. Women were recruited from food pantries, flyers, word of mouth, and birthing centers. Inclusion criteria included women who had post-partum interviews.

Interview data consisted of 17 participants, for 12 of these individuals there were pregnancy and postpartum interviews. The remaining 5 participants only had postpartum interviews, a collective sample of 17 participants. These 17 interviews were under the study mentioned above “Emotional Distress and Pathways of Embodied Maternal Health Vulnerability among Immigrant Women on the US-Mexico Border”. These interviews were conducted both in English and Spanish and were transcribed accordingly. Therefore, some of the quotes that will appear throughout this project may have originally been in Spanish and were translated. This subset of 17 interviews were included in this project because they all had post-partum interviews

and was phase one of this project. The goal of this project was to capture how the COVID-19 pandemic has affected pregnancy, birth, and the post-partum period, in order to capture the pregnancy, birth and post-partum period the women would have had to have a post-partum interview. All 17 interviews were transcribed and read through multiple times to find preliminary themes that emerged in the data based on the research questions. Therefore, an inductive approach to coding was used to identify codes that were presented in the data. All data was de-identified and all names are pseudonyms to ensure confidentiality. Themes were identified that focused on how the pandemic shaped women's pregnancy and postpartum experiences while living on the U.S. Mexico border. The border closure was coded if the women identified the border closure affecting their birth, pregnancy, and post-partum experiences. Family separation was coded for if the women identified their partners or loved ones being unable to be a part of their birth experience due to the pandemic. Economic insecurities were coded for if the women identified economic insecurities affecting their experience and health.

Phase two of this project consisted of conversations I had with a provider and a person on the Texas Maternal Mortality Review committee about how these findings can be applied to make a case for specific pieces of legislation and help maternal and child health outcomes. I conducted one interview with a provider and researcher in maternal and child health who served on a Florida Maternal Mortality Review committee and a researcher who sits on the Texas Mortality Review Committee who is also in maternal and child health. The selection for this legislative office was based on the most amount of impact this research can make at the state level versus national-level policy. The goal of these interviews was to explore how this research can impact state level policy and be disseminated most effectively. Providers are key in terms of their knowledge base in existing data on birth outcomes as it relates to type of coverage. Both

members sitting on Maternal Mortality reviews had key insights into the gaps in data for maternal and child health and gaps in care for maternal and child health. These interviews gave key insights to inform policy change and health interventions.

I conducted both interviews via video platforms and emailed questions and verbal consent forms before the interviews took place. The recruitment was done via email and was targeted for people in maternal and child health positions and policy knowledge. I should note that I emailed or contacted every person on the Texas Maternal Mortality Review Board but only the person I interviewed got back to me. For confidentiality purposes I will be referring to the physician as Michael and the second interviewee as Samantha.

Phase two of this project was primary data collection and subsequent analysis that was conducted to help inform the discussion and future directions part of this project. This was done by giving a brief summary of the findings from part one and asking questions about how to best disseminate the findings to help inform policy. These interviews were conducted, recorded, and transcribed to help inform future directions and recommendations. Recruitment for this part of the project was targeted as participants were included because of their maternal and child health experiences, contribution to policy, and seat at maternal mortality review boards. Participants for these semi-structured interviews were given verbal informed consent and a copy of the informed consent and questions was sent to them via email before the interview. Questions for this part focus on the project background, data, and their experiences. These questions can be found in Appendix C.

Recruitment

Phase 1: For this project, I drew on interview data that is part of a larger study conducted in El Paso, Texas. The larger study is being funded by the National Science Foundation and the Principal investigator is Dr. Carina Heckert a professor at the University of Texas at El Paso. The title of the study is titled “Emotional Distress and Pathways of Embodied Maternal Health Vulnerability among Immigrant Women on the US-Mexico Border”. This bigger project focuses on the emotional experience of pregnancy among Mexican-born immigrant women and US-born Hispanic women on the US-Mexico border. This research will address the emotional pathways that connect the social context to biological responses and the similarities and differences in these pathways based on different types of immigration-related concerns. This subset of interviews were selected as all of these 17 women had postpartum interviews. These are de-identified interviews that were conducted through UTEP. Participants were recruited through a clinical context at Texas Tech University Health Science Center El Paso. Therefore, USF did was not involved in any recruitment for these interviews.

Phase 2: Recruitment happened via email and connections have been established through earlier research and networking. I emailed both participants asking if they were available for an interview and set those interviews up via Teams.

Coding

Coding for phase 1 of this project used an inductive approach. The first step was to comb through the data and transcribe some of the interviews. Interview were selected if there were postpartum interviews. Some women had both pregnancy and post-partum interviews (n=12) and some women had just post-partum interviews (n=5). This was because I was interested in seeing

how the experiences of birth went. After this step I went through the data once more and did open coding. This helped make sense of the data and move to the next step which was to develop themes and findings. This was done by transcribing, reading the transcripts several times, and identifying themes that were salient in the data. All interviews were then printed and used to hand code each of the themes that were identified in the preliminary coding phase.

Three themes emerged from the data and the research questions which were border closure, economic insecurities, and family separation. Each theme was hand coded with a color in the transcripts using colored post-it tabs. Pink post-it tabs were used for “border closure”, orange post-it tabs are used for “family separation”, and green was used for “economic insecurities”. While themes were being identified and labeled in the data there was also in vivo coding that was being identified. This was done by identifying quotes from the data to support the findings and using colors that matched the theme colors to highlight quotes from participants. When there was a relevant quote for the theme border closure in the data it would be highlighted in the same color, in this case pink. I used a systematic approach that is best described by Bingham and Wikowsky (2022) as data organization which includes the transcribing and primary read of the data, open and initial coding which identifies themes in the data, then identifying themes and findings to finding relevant quotes that support the themes identified, and finally applying theory to explain the findings.

Ethical Considerations

The first part of this project is secondary data and therefore ownership of the data can become an ethical consideration. This project was done in collaboration with a professor at the University of Texas at El Paso (UTEP). Interview data for the 17 women who are presented here

are pulled from data collected by Dr. Carina Heckert at UTEP. The analysis I conducted on this subset of 17 women contributes to academic literature and provides recommendations for policy change that could help maternal and child health outcomes. This larger-scale project has IRB approval through Texas Tech University Health Science Center-El Paso and the part of the project (which covers multiple follow-up interviews for a subsample) have IRB approval through UTEP. How this data would be disseminated should be in accordance with the original researcher's agreement with participants and other Universities. Another ethical consideration is this phase one research was collected with different research questions in mind, while they were similar, they are not identical (Tripathy, 2013). Though, the questions were similar enough that the data was central to answering my research questions. Lastly, pseudonyms were used in this research for all participants involved. Confidentiality was strictly enforced and therefore, participants should not be able to be identified.

CHAPTER IV: RESULTS

The following experiences and narratives of mothers living on the U.S.-Mexico border during the pandemic will outline how the 20-month border closure coupled with immigration-related stressors, economic insecurities, and family separation affected their pregnancy, birth and post-partum experiences. As mentioned above this study identified three key themes as part of this research, the border closure, family separation, and economic insecurities. Table 2 introduces the subset of women, the themes that were present, and immigration-related stressors.

Table 2: Background of Participants

Pseudonym	Country of Birth	Type of Disruption (Themes)	Immigration-related concerns
Anamaria (36 years old and second baby)	US	Family Separation	
Carmen (26 years old and first baby)	Mexico	Border Closure and Family Separation	Extended Family Members
Sandra (34 years old and third birth)	Mexico	Border Closure, Economic Insecurities, and Family Separation	DACA & Husband Undocumented
Salma (38 years old and 3 rd child)	US	Border Closure, Economic Insecurities, and Family Separation	Undocumented Mother and Sister & not seeking care because of documentation status
Janeth (31 years old and 3 rd child)	US	Border Closure, Economic Insecurities, and Family Separation	Second-generation, family members who were seeking asylum and deported, in-laws in process of adjusting status

Table 2: (Continued)

Virginia (22 years old)	US	Family Separation and Economic Insecurities	Extended Family Members
Alma (7 th child and 31 years old)	US	Family Separation and Economic Insecurities	Second-generation
Eliana (36 years old and 1 st child)	US	Family Separation and Economic Insecurities	Second-generation
Brisa (25 years old)	Mexico	Border Closure, Economic Insecurities, and Family Separation	Undocumented
Itzel (28 years old and 4 th child)	US	Border Closure, Economic Insecurities, and Family Separation	Born in US, grew up in Mexico, returned as young adult, unable to get passport because born in birth center
Yvonne (30 years old and 1 st child)	US	Border Closure, Economic Insecurities, and Family Separation	Second-gen, born in US, grew up in Juarez, returned with family at 21 (petitioned for parents)
Flor (23 years old)	Mexico	Border Closure Economic Insecurities and Family Separation	Undocumented as child, came at age 12, became PR in 2015, concerns for immediate family
Liliana (18 years old)	Chile	Border Closure, Economic Insecurities, and Family Separation	Came with student visa and became PR via marriage before visa expired, father deported in past (coming from Chile -- reason the family ended up in Juarez)
Anessa (21 years old)	Mexico	Border Closure, Economic Insecurities, and Family Separation	Undocumented, came on tourist visa, in process of adjusting status via marriage
Talia (24 years old)	US	Family Separation	

Table 2: (Continued)

Jazmine (3 rd child)	US	Border Closure, Economic Insecurities, and Family Separation	Second-gen, mother and older sister were undocumented but have been able to adjust status
Lorena (3 rd child)	US	Economic Insecurities	

“Well at first, I was somewhat stable but right now with the pandemic it was a tremendous lack of control. Also because of my undocumented status. My pregnancy is something beautiful, but it has been very difficult.” – Brisa

Border Closure And Immigration Policies Disruption To Maternal Health Support

This part of the chapter focuses on the border closure and immigration-related stressors and how they have impacted women’s pregnancy, birth, and post-partum experiences. Other parts of the chapter will focus on economic insecurities and family separation and how that has also impacted these women’s experiences. Though, throughout the chapter there will be times when these themes overlap, creating a bigger picture insight into how the pandemic has shaped the experiences of these women.

As Table 1 above illustrates, 11 out of the 17 women were born in the U.S. and are second generation immigrants. Although they were born in the U.S, some of these women did discuss the border closure and immigration-related stressors as part of their narratives. These firsthand accounts into how these women felt that the border closure and immigration-related stressors shaped their pregnancy, birth, and post-partum experiences can help us understand the negative consequences that can come from harsh immigration policies and laws.

Brisa, 25 years old, was an undocumented immigrant who came from Mexico to the U.S., whose quote at the beginning of the chapter illustrates how both the pandemic and her

undocumented status impacted her pregnancy, which she states should be a beautiful time in her life but instead had been very difficult. Brisa had high blood pressure, maternal stress, and preeclampsia during her pregnancy as well as hemorrhaging during birth. She talks about first arriving in El Paso and the stress and anxiety it caused her to live near the border, which is constantly policed by immigration agents, as she expresses here

And when I arrived in El Paso the apartment where we arrived of housing or something like that was along the border like all the time that I would look out the window you could see Mexico. And you see immigration patrols there all the time. I mean, it was a fear like that of... I mean, I dreamed that I arrived and ran into immigration. That is, with the immigration vans. Or that we go on the border and run into immigration.

This constant fear of running into immigration created a sense of anguish for Brisa. She goes on to talk about how she would not drive at all in El Paso because she feared being stopped by immigration and sent back to Mexico. She felt uneasy leaving the house and would only do so when it was absolutely necessary, such as doctor's appointments or anything related to the baby. Even when Brisa's doctor suggested that exercise would be good for her, the constant fear of immigration policing kept her from walking during her pregnancy.

Everything to do with immigration. That is where the helicopters are and the vans, the buildings are there and border patrol is constantly leaving. So in terms of walking there I don't have security or confidence. The doctor told me to go out and walk like half an hour so I could exercise that it would do me good but for those reasons I am scared because for example immigration is there.

These concerns also extended to other people close to the mother. Immigration-related stressors can impact immediate family, extended family, and even in-laws. Castañeda (2019, p.16) talks about this in her argument that "families and individuals actively contest their exclusion and develop a set of strategies in response to limitations that arise." Therefore, it is particularly important to consider how immigration policies and laws affect not only the individual that is undocumented but their family as well. This was evident in Janeth's case where she expresses

her concern about immediate family's immigration status. Janeth was 31 years old at the time of her interview, a second-generation immigrant with three children. She had post-partum depression and recounted her birth experience. At the time of her pregnancy she had gestational diabetes, high blood pressure, and maternal stress. In terms of immigration-related stressors, Janeth talked about the events that transpired with immediate family when asked if any of them had ever been deported or detained:

It it was pretty traumatizing because it was it was my grandpa, my aunt, and my aunt's husband, and also my grandma but it was a bit traumatizing because they were seeking they came here to seek asylum and they did give it to them but it was just for a short period of time well my uncle he had to stay detained he had stayed in in like a jail facility type of place but when it was time for him to go back it was through a deportation

Janeth talked about how stressful this experience was for her and how her grandfather had died that same year. While it was not her who had immigration-related concerns, nor her partner, she worried about her family and had seen them be detained and deported. She also added that because of the pandemic her pregnancy was lonely and isolating. The ways in which immigration-related stressors for family members impacted the physical and emotional well-being of these mothers is seen in Salma's case as well. Salma was 38 at the time of her interview, had three children, and had been living in Texas since she was born. Salma was a diabetic and had asthma at the time of her pregnancy; she also tested positive for COVID during the birth. Additionally, Salma's mother and sister were undocumented, and she talked about how specifically her sister's status affected her:

She's never gotten her documentation fixed. My stepdad was supposed to fix it for her and he never did so there's just a lot of like you never could talk to her. You never know where she is. You're always worried about her cause she's just had a terrible life

When asked about her post-partum issues or stressors Salma lists her sister's situation as a stressor.

One that kind of made me a little bit depressed I guess and I wasn't expecting it. I don't have the best relationship with my older sister. She's an immigrant, she hasn't been able to fix her papers. For her, she's like, if I get pulled over, I don't know that I won't get taken away from my kids and I'm like, I get it. That kind of stuff bums you out cause you realize how much privilege you have just for the location on a map that you were born in at that time. That kind of stuff worries me

While Salma herself is not undocumented, she has immigration-related stressors through immediate family that cloud over her. This stress, worry, and anxiety can manifest physically, as it did with Flor. Flor, 23 years old at the time of her interview, was an undocumented immigrant as a child and came to the U.S. from Mexico when she was 12. She became a permanent resident in 2015. When asked how her migration status affected her health, Flor says:

Ah, for example, indirectly I think I feel my self-esteem is very low. So that causes stomach aches and constipation. When I arrived I began to suffer from constipation, uncertainties and this anxiety. I have a lot of this problem that I grind my teeth at night and even though I no longer have that stress, I feel that it stayed there mentally

Flor attributed her stomach issues and grinding of her teeth at night to the stress she had when she was undocumented.

Another component of immigration-related issues was the border closure related to COVID. The border closure affected women's pregnancy, birth, and post-partum experiences in terms of not having who they wanted at the birth, family members not being able to cross, and feelings of isolation. It may also be the case that people residing in the U.S. have precarious immigration status and cannot cross to Mexico to maintain those familial ties. When the pandemic hit and the border closure was implemented those with a Border Crossing Visa were unable to cross the U.S.-Mexico. This could hinder women from being able to seek cheaper health care access in Mexico or get the social support they may have needed during their pregnancy experiences. The border closure had a profound effect on family unity which is central to Mexican families. Anessa shared her experience of the border closure and how it

impacted her pregnancy. She was 22 years old at the time of the interview and was born in Juarez. She was in the process of adjusting her status via marriage, following arrival on a Border Crossing Card and overstaying. Anessa also had high blood pressure at the time of her pregnancy and COVID during the birth. When asked how she felt about the pregnancy, she stated that the first three months she fell into a depression. She attributes it to her family not being able to cross because of the border closure.

Well, it was what I thought because I felt very sad at that time and more for not being with my family as I wanted to enjoy this pregnancy with my mother, my parents and my brothers, so far, if it was something that at first it kept me kind of sad. But my mother and sister have not been able to cross, they cannot cross because of the pandemic situation.

Because of Anessa's immigration status, she was not able to apply for Medicaid and could only apply for CHIP perinatal, which covered anything that was related to the baby but did not cover the mother. She had been unable to schedule an appointment for prenatal care since she had not yet been approved for the CHIP. She states :

Yes, actually, I was getting desperate, I even wanted to look for an appointment already outside [of the health insurance], that is, so that they would tell me that everything was fine or like that because I had not had any appointments, and I was about two months more or less far along

After Anessa gave birth, she ended up getting mastitis, which is essentially a clogged and inflamed milk duct, and could not get care for it because she was uninsured. Anessa mentions not being able to get care at the hospital for her mastitis:

Yes, but that was also a problem the hospital would not help me, they would not help me economically, and they would not take me in without health insurance and so I had to look for a surgeon outside the hospital

Anessa attributed having post-partum depression to being unable to treat her mastitis and her husband working out of town. She ended up going to a surgeon in Juarez for care but had to go another week without care and the painful mastitis. Anessa also was only able to cross to Juarez

since the border had reopened, had the border closure still been in effect she could not have crossed. Anessa could not have crossed since she did not yet have resident and she only had a border crossing card, which we have established was not enough to cross the U.S.-Mexico border during the border closure. Another consequence of being undocumented is that when asked if she had concerns about applying for residency, Anessa talks about her concern of being a likely public charge (“they tell me that only if you are a burden to the government”); therefore, she needed a sponsor in her application process in order to be not deemed a likely public charge and denied in her application process. It is important to note here that the reason she needed a co-sponsor was because her husband did not make enough money to be the sole sponsor. Otherwise, it is possible for a petition to be sponsored only by the spouse for marriage-based applications. Anessa, then, was unable to have the support she wanted during the birth because of the border closure impeding her family from crossing, was unable to get care because of her status, and this all made the application process for residency trickier as she needed a sponsor in order to not be deemed a likely public charge. Her family was able to cross at the time of birth, but because of COVID policies in the hospitals, only her husband could be with her for the birth. Most of her pregnancy though the border was closed and she was separated from her family. When talking about her family not being able to be there during the pregnancy because of the border closure, Anessa says, “It was like every day I was sad, every day I was, like I didn't even want to shower, I just wanted to be in bed all day.”

Brisa had similar experiences to Anessa, with lack of care or attention because of her immigration status. She recalls how she felt in terms of access to care because of her status: “I felt that because of my undocumented status less valued and like they wouldn't treat me the same as they would treat others. Like I wasn't important because of my legal status.” Brisa also talked

about the constant anguish she felt when leaving the house, as she recounts in her experience living in El Paso.

It is very distressing, not having papers, knowing that a border is in the way. In El Paso well it was the immigration, the immigration [status] was my panic, I didn't want to go out because of immigration [patrols]. All of El Paso was immigration policing, to walk or to go out and walk I didn't want to go out and walk. Outside I don't know I feel anguish like I want to get home for the same reason or when I see a van or an agent.

Brisa had her own immigration-related stressors but also that of her immediate family who could not cross over, as some of her siblings were undocumented, and others had DACA. Her parents could not cross over because of the border closure. Her mother on the other hand was in San Antonio but could not travel due to internal border check points and that kept Brisa and her mom separated. When talking about applying for residency via marriage, Brisa states how the process has been for her,

Well, uh, it feels horrible, it's tremendously frustrating because uh, my husband has told me to start saving to start a migration process, so I know that it's also something like, having problems with the police, having problems with, well, it's also more difficult, but apart from that I know that here in the United States, it's to pay lawyers.

This was a frustration for other women as well: the expense of having to go through lawyers to petition for residency, lawyers committing fraud, or that adjusting status simply did not seem like a priority when they had more pressing financial needs. Anessa, for example, talked about why she has not yet petitioned for residency, saying: "I was worried because it was expensive and then a lot of people told me that there are lawyers who commit fraud". Even those who are natural-born US citizens had problems getting a passport if they were born outside of the hospital system. This is important as the U.S. has been known to denying passports Americans born on the border, by doing so the U.S. is putting their citizenship in question (Sieff, 2018). This was the case with Itzel, who was 28 and on her 4th child at the time of the interview was

born in the U.S. to midwives. Additionally, both her parents are Mexican nationals who reside in Juarez. Itzel grew up in Juarez and came back to the US as an adult. Her inability to get a passport means she had to rely on her parents being able to cross with border crossing cards, and they were unable to cross during the border closure. Itzel also had trouble getting prenatal care early in her pregnancy because she had gotten COVID and had gestation diabetes during her pregnancy. Itzel was unable to obtain a passport, though in her interview it is unclear why; she was born in a birthing center to midwives, and attributes this to being unable to apply for a U.S. passport without hiring a lawyer. It is true that, in some cases, births with midwives are not registered, but she has been able to obtain a valid ID and social security card, so it may be due to other factors. In any case, Itzel says, “I’d rather leave it like that because if I invest in fixing it they are charging me 10,000 US dollars to do so.” When asked how she thinks this has affected her life, she says:

So I think that it has affected me in various situations in my life and apart from the fact that you are always afraid that one day they tell you you know what you can no longer use your ID, you can no longer be using your Social Security so you’re always with the fear that something like that can happen to you, even though you know you were born here

Since Itzel does not have a passport, she is unable to go to Mexico. As she says, “Like now my parents and a lot of my family cannot come to the U.S. because of the pandemic situation,” that is, her family cannot cross to the U.S. because of the border closure. We see then that in many complex ways, the border closure, and immigration-related stressors, either personally or for family members, have impacted the pregnancy, birth, and post-partum period.

Family Separation And How That Impacted Women's Emotional Well-Being

Another important facet to pregnancy and post-partum experiences was the theme of family separation. This meant the moms were unable to have their partners, family, or whoever they wanted to be a part of the pregnancy and post-partum experience. This was often due to the woman's partner working elsewhere or simply not being able to be there because of COVID. This next section of the chapter will focus on how family separation impacted the pregnancy, birth, and post-partum experience.

sighs I wish I had my mom there, so that was hard - Flor

While different hospitals had different COVID regulations for who can be in the delivery room, what the procedures are if you or your partner have COVID, who, if anyone, could be present during pregnancy appointments, it is clear that these regulations have affected the pregnancy, delivery, and post-partum experiences for the women who were a part of this project. Flor's quote at the beginning of this section illustrates the frustration, sadness, loneliness, and isolation these women felt not being able to have who they wanted be a part of the birth, pregnancy, and post-partum experience. Flor talks about having her baby in the pandemic and compares it to her earlier pregnancies, where both her mom and mother-in-law were able to be a part of that.

I was sad that my mom couldn't be there because for my first child both my mother and my mother-in-law were there that was before the pandemic and none of my moms couldn't be there so I was sad about that but I thought it was I thought it went really well like I guess I set my mind that I wasn't going to have them and that was the hard part I really wanted my mom to be there my husband and my mom obviously I had to choose only one

She then goes on to talk about how this made her feel, not being able to have her mom there during the birth because of COVID: "It was emotional actually yeah not having my mom there because my mom saw the first one being born so I **sighs** I wish I had my mom there so that

was hard.” Alma, who was 31 and had 7 children at the time of her interview, felt the same when asked how the pandemic affected her birth experience

I mean simply because it was just me and my husband. Usually, I have my mom there as well. I always needed my mom there for that extra support and just with the pandemic I wasn’t able to have 2 people with me so it was just hard not having her there.

Having her mom there was particularly important to Alma because she says:

I mean it was sad especially because I was having—I knew that I was having the hysterectomy I had a high risk delivery (inaudible) I needed her there and it was just I think that I was how can I say it I think I was extra worried. Just stressing that I guess I can say stressing because I was just thinking what if something happens and she’s not here

Having that support from her mom or the people she would want as a part of the delivery is important to ensure the mother feels comfortable, safe, and supported during this time. Likewise, Anamaria a 36 year old with 2 children, said the pandemic affected her birth experience in the following way:

I mean it was kind of sad that my mom couldn't be there cause I wanted my mom to be there with me. But no, only one person could be there with you, well there at the hospital with me, I don't know the other hospitals, but only one person could be there. So that was sad, you know, nobody could like visit you or send you, you know gifts and stuff like with that I think it was different

This feeling of being alone during this period because of family separation was not only felt during the birth but also during the pregnancy period. Yvonne was 30 years old and on her 2nd child at the time of her interview, described her experience of living on the border as “my whole life has been an in between the two cultures.” Yvonne was born in the U.S. but grew up in Juarez since her parents had precarious immigration status. They returned to the U.S. when she was 21 and petitioned for her parents’ residency then. Yvonne described how she felt during the pregnancy and how family separation affected her pregnancy and post-partum period.

And I think it's hard like if you're in a situation to have to go to the doctor by yourself, I mean unless it's something simple but when it's, you're facing a situation like that and to

be able to have someone by your side uh I don't, like it's, it's too hard, its, its hard on everyone

She talked about how “it was a very stressful pregnancy” and a high-risk one as well. Yvonne remembers a specific moment when she wished her husband was able to be with her during the appointments:

And then, that's when we found out it was a high-risk pregnancy and the doctor was, I'm sorry but he was an asshole about it, he was just so cold, he, he was like, he, I mean because of COVID, he didn't let my husband in so it was just me and him in a dark room

In addition to being able to be present during the appointments Yvonne's husband worked out of town for economic reasons, and she spoke on how this separation has affected her post-partum period. Her husband left to West Texas shortly after the baby was born because he was unable to find work in El Paso.

And then when he was born and like maybe after week or so that he was born, my husband was like you know what we need the we need money so he went back to work in the oil fields so he left to west Texas and so that added. I mean it's hard I'm not going lie it's hard especially when you know when we're first you know we're new we're new parents so it's hard for him

Yvonne was alone during her pregnancy appointments, when she felt she needed the support and felt alone after the baby was born, since her husband was unable to find a job in El Paso and instead had to go out of town to provide for the family. Anessa was in a similar situation, where her partner was working out of town and her mother could not be there as part of the birth. Anessa talked about her worries for the birth: “So I do get scared for the fact that my mom cannot be there telling me what to do”. Carmen who was 26 years old at the time and having her first child, shares this experience of being without family during the delivery because “they only accepted one person” but does not elaborate on who was a part of the birthing experience. It was important for Carmen to have her aunt there as she describes her “like my second mom” but her aunt could not cross because of the border closure.

Brisa recounts also not being able to have the people she wanted during the birth because of the pandemic and how that impacted her experience.

And well because of COVID they told me that the person who would come in would be the only person that could be there and that no one else could come in or take turns and for four days practically well we couldn't receive any help from anyone else other than the nurses and the doctors and for the same reason for the pandemic

This was coupled with the fact that Brisa had experienced family separation since the pregnancy started, since her family could not cross because of the border closure and their undocumented status. She talks about how this affected the post-partum period as well: "Yes, you miss that part like with family you have more trust of asking for a favor when I feel sick I feel bad I feel alone." Family separation was also felt by Jazmine because of the pandemic. Jazmine who was on her 3rd child, is a second-generation immigrant, whose mother and sister were undocumented but have since been able to adjust their status. Jazmine's pregnancy began when the pandemic started, and she states "so it's been challenging you know not being able to see family as much". In addition to this, Jazmine was unable to have the father be a part of the doctors' appointments at the beginning of the pregnancy:

Uhm thankfully my husband was able to go in now to my appointments and he wasn't before so that's nice but it's stressful not being able to have anyone in other than my husband. My daughter couldn't visit us at the hospital to see her brother or anything so that was stressful

When talking about how else the pandemic affected her pregnancy, she talks about having COVID early on in the pregnancy and not knowing she was pregnant because of it.

I did terrible with her I don't know maybe it was lack of exercise or stress I was definitely a lot more stressed when I was pregnant with her. It's stressful being pregnant on top of having little children that can be exposed to it [COVID]

Since Jazmine had COVID early on and was unaware that she was pregnant because she could not distinguish the symptoms, she was unable to get prenatal care until about 22 or 23 weeks into

the pregnancy. Jazmine's husband also works out of town and she explains how this has been difficult during her post-partum period: "he's gone most of the week and it's been very difficult but it's at that point where that is the job that you are able to get right now." This family separation has made her post-partum period even more challenging. Janeth who was 31 and on her 3rd child, felt this family separation because of the pandemic during her pregnancy as well.

Yes, I do think it made it worse because my husband was not able to be with me for a lot of this last pregnancy, so I lived it alone. I think it was sad because my husband wasn't able to be there for anything just the birth, just the day that I gave birth. But he wasn't able to experience the whole pregnancy with me no sonograms, no heartbeat, or no doctors' appointments, nothing.

Liliana who was 18 years old at the time of the interview, came to the U.S. from Mexico, but is originally from Chile. She arrived on a student visa and became a permanent resident via marriage before her visa expired. Liliana's father had been deported in the past since he had crossed illegally: "Illegally but he got deported. He was found actually with a bunch of people in the desert." Liliana has siblings who are in Mexico and are unable to cross because of the border closure contributing to her family separation.

I don't have family close by like my parents are in other states of the US and my sister and my brother they're in Mexico and with the pandemic they closed it so they can't cross, they can't help me you know

Another source of family separation is that her husband works out of town. She says, "My husband works out of town I was alone most of the time and just out of the hospital."

Additionally, their baby was born and had to go to the NICU. Liliana says, "there was only one person at a time so it's either me or my husband but not both together," when talking about seeing the baby in the NICU.

Talia who was 24 at the time of her interview, had preeclampsia at the time of the birth and shared this sentiment of experiencing family separation when she delivered

It's not like the movies I don't know I actually had a bad experience because um I had pre-eclampsia aha and so they had admitted me early and uh my baby's dad before the same day before they admitted me he got COVID and I was I delivered two weeks early or three weeks early well when I was 37 weeks so yeah that was really hard for me I wanted him to be there

Virginia was 22 at the time of her interview and was born in the U.S. Virginia also shared her experience during her pregnancy and how family separation because of COVID impacted her pregnancy and even how she decided to give birth.

It's it's my first pregnancy and dealing you know with uhm you know COVID and the appointments going in alone it's uhm sad it's sad. They kinda gave me the option uhm of doing a natural or C-section so uhm I'm I'm considering that but uhm I have heard from recent moms how would you deliver anticipate which one you doing it's either one person allowed or two. Yeah and then of course during was you know my significant other couldn't go to my go into the doctors' appointments with me

Virginia not only felt alone during her pregnancy because her partner was unable to go into appointments because of COVID but was considering giving birth in a specific way in case they let more than one person into the delivery room if she had a cesarian or natural birth. We see then, though the narratives and experiences of these women, how family separation because of COVID has impacted their pregnancy, birth and post-partum care/experiences. The last section of this chapter focuses on economic insecurities felt by these women.

COVID-19's Effect on the U.S.-Mexico Border Region Resulting in Economic Insecurities

“It's stressful enough having a baby with all the other things you have to worry about and on top of that having to worry about if your baby is going to be able to eat or not.”

Jazmine's quote above illustrates the challenges and stress that come with economic insecurities during this time. When asked if Jazmine had any type of postpartum support, other than postpartum appointment she talks about struggling with the paperwork to receive government assistance:

Uh no actually I had um, I did have food stamps but, again, I've always struggled. This past year actually I had struggled so much with all the paperwork

It was frustrating and stressful for Jazmine not only to have to worry about feeding her kids but in being delayed in the process of applying for government assistance. There was a wave of people losing their jobs because of the pandemic, and some of the women talked about how this affected their experiences. Often these experiences also overlapped with family separation, in that the partners would have to find work outside of the city to have an income. Yvonne is a perfect example of how her and her husband's economic insecurities fueled their family separation and how it impacted her birth and post-partum experience.

And then when he was born, my husband couldn't find a job so and I wasn't working and so money was another issue. And then when he was born and like maybe after week or so that he was born they, my husband was like you know what we need the we need money so he went back to work in the oil fields so he left to west Texas and so that added too

Liliana's husband also lost his job and Liliana left her job at the beginning of the pandemic both of which fueled their economic insecurities

Well right now I feel a little bit better but beginning of my pregnancy I was really stressed because of economical issues many times so he got one here [realtor job] in El Paso so he was able to stay with us, me and my baby. But then he left again so the work that he had closed or it went to bankruptcy And he stopped working because he got sick so he already was behind on bills and everything so he was like I can't come back and still wait you know to, to get paid

When Liliana was asked how the economic stress had affected her pregnancy she replied

Uh really bad I guess. I think it was worse with this pregnancy yeah because I don't know it's, I don't know I feel it's hard because I'm also dealing with my baby so before that she [her daughter] was the only one so I will have to just focus on, on her and the stress you know and now focusing on this stress the baby and now the pregnancy so little bit more

Alma's husband also lost his job during the pandemic, and Alma was not working at the time.

She shared how this has fueled her economic concerns

We always have that economic concern because my husband is the only one that works. My husband wasn't working for a while and we were struggling a lot with money

because he wasn't working and then I think it was like a little after the income tax season because our income tax was held back so he lost his job and then we had I think two pay checks saved up and then after that we were borrowing money from my mom, my parents, his parents, so it was just really really difficult for a while

Having these economic insecurities be exacerbated by the pandemic added a component of maternal stress to the pregnancy period, and stress in general to the post-partum period. Janeth is a perfect example of the stress that economic insecurities can have on a mom. Janeth also had a component of family separation intertwined with her economic insecurities as her husband had to work in the oil fields of West Texas.

My husband got unemployed, and it was very very stressful and with the pregnancy. I was at risk I want to say because I was having suicidal thoughts during the pregnancy. He got a job in Odessa which was a lot more money but then he got laid off because of COVID

Virginia also shared these economic concerns when her significant other had lost his job: "It was already hard, and my significant other lost his job and was without for a few months."

Eliana and Sandra both experienced economic insecurities in not being able to work themselves. Eliana was 36 and had her first child at the time of her interview, was a second-generation immigrant. She had tested positive for COVID during the birth. Sandra was 34 years old and on her 3rd child at the time of the interview was born in Juarez; her husband was undocumented, and she was a Dreamer (that is, she was a DACA recipient). Sandra had preeclampsia and gestational diabetes during her pregnancy. Eliana's economic insecurities were fueled by her job not offering maternity leave.

It is super frustrating to be that short of money especially as a single mom and I don't know. There's times where I feel very umm frustrated or stressed because of the money. Where I am working now they won't pay maternity leave and people have debts like people have bills to pay

Eliana mentions that even if she would go back to work after her unpaid maternity leave is over, she would have to find childcare and that is an uncertainty since she says the daycares are full.

Sandra shares a similar experience with economic insecurities fueled by the pandemic and a lack of childcare.

It was hard for me to get a job being pregnant and with the pandemic and it was, it was just hard, so I had to have been on unemployment. If I was to start looking for a job now, it would, it would be hard to get childcare.

Additionally, her economic insecurities were exacerbated by her husband's undocumented status.

She mentions, "he's not I guess legal so it's hard it's hard too like if I'm not if I don't have a set job and him not finding a job either." Her inability to find a job while pregnant and because of the pandemic, coupled with her husband's legal status, exacerbated her economic concerns.

Brisa also had economic insecurities linked to her illegal status. She mentions how she cannot receive government help because she is undocumented and how the financial situation impacted her mental and emotional well-being.

Well actually a lady had told me about food stamps but they told me I can't apply because they were only for U.S. citizens. That these kinds of government assistance were only for those that were U.S. citizens and because of my illegal status well I couldn't receive that kind of help.

Her undocumented status makes her ineligible to receive government help, including Medicaid.

This meant that Brisa could only receive CHIP, which only covers the fetus, as well as anything related to the well-being of the baby, but does not cover the mother. Brisa comments how being undocumented made her feel and how it fueled her economic insecurities.

Well right now I don't have a job and that keeps me up at night like what am I going to do I'm going to at the post-partum period and well my legal status doesn't help me much either. I can't find a way out I still have nothing, no job, and leaving my baby is super anguishing for me. The financial situation is difficult.

Brisa talks about how she would need a work permit to find work and that without it she would have to work long hours for little pay. She also comments on how because of her immigration status she feels less valued for her work and they work her more with less pay.

Every time it is more difficult to work illegally here because I did come with a visa but after it did expire. A lot of places ask for you to have, what is it called, work permits and the jobs I can find are very hard and pay very little. The economical for example the, how do you call it, my immigration status and all of that well one feel less than like they don't value like the same work like more work and less pay it feels ugly but at the same time I understand.

In terms of how the pandemic has impacted her ability to work, Brisa talks about how she used to clean houses for income but both the pandemic and the baby have impacted her ability to work in that setting. Brisa was asked how the pandemic had affected her economic situation to which she replied:

No well the pandemic did affect me in everything because, well work since the pandemic started the people I worked for were elderly and there was that fear. It's difficult to work here with a baby that I cannot take to the houses I am cleaning. Because if you are not working in the U.S. it is not possible here.

For Brisa, there were multiple ways in which the pandemic and her immigration status fueled economic insecurities. Much like the narratives presented already, Lorena, who was on her 3rd child, talked about economic concerns as stressful during her post-partum period "Definitely with money we've been concerned because everything is so expensive, so just yeah, like, but economic and financial."

Itzel had worked through her pregnancy but was unsure how quickly she wanted to return to work, since she did not want to leave her baby in daycare when he was recently born. She only had three weeks of maternity leave and talked about how, because of financial reasons, she might have to go back regardless. These economic concerns even bled into the birthing process, since

she wanted to have a natural birth instead of a C-section in case she had to return to work, since natural birth has a quicker recovery.

I was worried that with this baby for one reason or another they would want me to have a cesarian. And then it would be more difficult for me to take care of my other children and then I would have to go back to work quickly and with a cesarian the recovery time is longer

Itzel talked about her thought process in her decision whether or not to return to work and how the pandemic factored into this decision-making process:

Well it also gave me some sort of worry because I know that maybe when I make the decision of how quickly to go back to work and if I am going to work at the same place where I work now. Or if I am going to look for a new job I am scared because right now there is not a lot of work. For the same reason because of the pandemic

Itzel's case was explored above; she attributed her inability to get her passport to being born to midwives in a birthing center and it was 10,000 dollars to fix this legally. Itzel talks about her barriers in accessing care both because of her economic insecurities and because she cannot go to Mexico. Ideally, she could go to Mexico for cheaper care.

I think that health care services in terms of insurance are super expensive. I do not earn enough to have that extra bill a month. So if I was very sick or something I would send someone to go to Mexico or ask someone to bring me medication from Mexico perhaps. Because we are on the border

Itzel talked further about how her economic insecurities came about and how that affected her

I also got behind economically at that time because the baby's dad also stopped working so obviously when they laid him off from work he stopped making money and obviously he couldn't give me money because of the fact that he had lost his job when COVID started. So I now feel more worried, you can say perhaps that is the word, like I feel worries every day because I have no idea how I'm going to do it

Ultimately, Itzel decided not to go back to work, because they asked her to come back three weeks after the baby was born and she did not feel comfortable leaving the baby in daycare that

small. She felt the baby's immune defenses were too low, and with the pandemic she did not want to risk putting the baby in daycare.

And then and me with everything that is happening I haven't gone back to work because they wanted me to go back to work when my baby hadn't even been born for a month and sadly I had to say no because the baby was too small and I didn't want to risk it with everything that is happening with the pandemic and more importantly risk my baby to return to daycare and well I don't know I feel that his immune system is still weak

We see then how the pandemic, the 20-month border closure, and immigration-related stressors, family separation, and economic insecurities have all shaped women's pregnancy, birth, and post-partum experiences on the U.S.-Mexico border. The next chapter will focus on how these themes both individually and together worked to impact the experiences of the pregnancy and post-partum experiences for both first- and second-generation immigrants living in El Paso, Texas. It will also focus on how future directions and potential policy solutions can improve maternal and child health experiences for women living along the border, but also women across the U.S. more broadly. Interviews with providers and people who sit on Maternal mortality review boards will help inform this next piece. These next interviews focused on how this research can make the most impact for maternal and child health, best ways to disseminate this information, and addressing the gaps in data to better understand maternal and child health outcomes.

Provider/ Legislative Interview Discussion

Phase Two of this project was aimed at gathering data for policy recommendations moving forward. The goal of this phase was to find the best ways to disseminate information and help inform policy. To do this, I had conversations with people who both had a background in maternal and child health and policy experience. The first person, Michael, I interviewed was a

physician, epidemiologist, professor in maternal and child health, who also sat on the Maternal Mortality Review Board in Florida, among other things. The second person, Samantha, examined maternal deaths and was also a member of the Maternal Mortality Review Board in Texas. In order to protect confidentiality, I will not disclose what this person does for a living as it could help identify them. This person was selected to be interviewed due to their extensive maternal and child health experience and knowledge. I had known this person previously due to networking and reached out via email to see if we could schedule an interview. The interview was done over teams and recorded with just audio recording. Questions that were asked during this interview are in Appendix C.

As a part of the interview, I shared key findings from the project thus far and asked them a series of questions on how best to disseminate the results that would be conducive for policy change. These key findings I presented to Michael and Samantha included an overview of the project, key findings, and the themes I have outlined throughout this paper. The goal of these interviews was to find people with extensive maternal and child health knowledge and gauge how we can improve those outcomes with policy change. The two interviews were selected based on that maternal and child health knowledge base. This would entail creating recommendations geared towards policy change. I asked Michael “in your work/ experience with maternal and child health where is the biggest gap in missing data? And how this would be useful to improving maternal and child outcomes”. He replied that in Florida, they are missing the big picture in terms of maternal and child health data. He said,

And then with other insurance companies, there's no mechanism, you have to approach each one separately to figure out what's going on, since you can't really see what medications, they have access to what their healthcare utilization patterns are. And so you can't really tie that to outcomes very well, because you just don't have that level of information. And that information is not sufficient, it doesn't always tell us about the characteristics of the mom and baby doesn't always tell us not just social determinants but

doesn't always tell us a lot of their health behaviors or other information. And so from a data gap perspective, we really have only snapshots of what's really happening in a continuous system of care

This question was particularly important to understand what was missing from the data in order to present that information to people in positions to make change happen. The idea here being that in order to really understand maternal and child health outcomes we needed more of the data than what is available. For example, instead of just knowing women's outcomes during pregnancy we want to know what happened before and after pregnancy as well. What Michael is suggesting here is that we are missing data in the continuum of care as well as other information that may not be discussed in the birth. This can include social determinants of health, living situation, continuum of care, etc. on what would be an essential part of getting someone the care they need.

When asked how we address this gap Michael talked about

Well, if we knew more about care patterns, we could do a better job of evaluating how well our services are working, not working and coordinating, providing quality of care, and terms of how things could be better organized to address outcomes. And if we knew more about the families, we could then also do a better job of trying to integrate the other community services and specialty services that are needed to help families with their health-related issues.

In order to understand why women, particularly this population, are having negative health outcomes and negative birthing experiences, providers need to have the full context. By context I mean more information about the women beyond just their pregnancy period. What Michael is implying here is that providers and researchers may only be getting a snapshot when we need the full picture and as a result, women may be having negative health outcomes and negative birthing experiences. That is where providers and researchers are missing the biggest data and potentially failing women in their healthcare diagnosis and preventative care. This plays

into evaluation of programs to see if they are working and how effective and efficient these are. Often there is a lack of evaluation with programs such as CHIP perinatal and that add to the gap of knowledge we have for pregnant women and their subsequent health outcomes. This is precisely what Michael is saying in the quote above. We need to do better in evaluating these programs to find what is not working and change it to improve health outcomes, not only for this population but across the U.S. Another important aspect of missing data that Samantha gets at in the quote below is how often in birthing centers we have missing data.

Samantha answered similarly in response to these questions:

There's data missing, as far as care, she might have received outside emergency rooms, like urgent care centers, okay. Or birthing centers Sometimes we don't have that data. Yeah, there's a lot of missing pieces of information. But I think the key thing is a key informant interviews.

Therefore, in terms of data gaps for both Texas and Florida we see that we are missing data for women who have children outside of hospital settings, we are missing insurance information prior and post birth and missing information on social determinant of health that could impact women's experiences. A good solution to this would be to have information about women's continuity of care, key informant interviews, and other data, not just hospital records. Samantha expresses how we do not have the full story. Key informants in this case would refer to people sharing their experiences of birth or, if the mom has passed, people who were close to her to share their story. Samantha was asked "in your work/ experience with maternal and child health where is the biggest gap in missing data? How would this be useful to improving maternal and child outcomes?" to which she responded:

Well, one, we don't know all the full story. So we don't know, for example, the role. I mean, we do know that we were reviewing medical records, so you're not always going to be able to see racism in the records, for example, we know that racism plays a role in maternal and child health outcomes, and systemic racism and implicit explicit racism

how the woman might have been treated during her course of either delivery of prenatal care, post-delivery, and would identify other areas of opportunity for change

The second part of the interview focused on how this research would be not only geared towards policy change but what recommendations would be the most effective in creating change.

Michael talked about what would be interesting to people on the Maternal Mortality Review Board who often push for policy and legislative change, stating that:

They're going to be very interested in how COVID and other things may have impacted the services of those women who had those higher risk conditions, your stories about women and their access to care problems, we don't have that condition, you could still say are suggestive of those who might have had those conditions. I think the key with legislators are to be able to identify key issues that need to be addressed. But then what's more effective with the legislature is in tying a story to that issue that can drive it home, because the legislative staff are going to be more interested in the data. But the legislative leaders and others are going to be interested in the stories.

Michael is suggesting that in order to spark change at the legislative level, it is important to present both the stories and the data. This would likely be a mixed-methods approach that highlights why women think these conditions are happening or being exacerbated coupled with the data to show this as well. It is important to have the quantitative data component but the experiences of these women are also very real and can contribute to the bigger picture. Here, I would argue that the stories are just as important as the numbers. They illustrate what barriers these women faced in accessing care, having a positive birthing experience, and accessing the resources needed. In the case of the women above the border closure, family separation, and economic concerns intersected to impact their pregnancy, birth, and postpartum experiences.

Michael and Samantha both had the same recommendations for the ways in which this research could have the most impact in terms of policy change.

And that, that tells you from a legislative perspective, you need to find people who are interested in your issues, who will then push it. So the key gets to be it's almost you need to know your legislature and know who is interested in what issues and have a

relationship with them, and then provide the data and information they need to support that to create a momentum does that make sense? - Michael

Well, the evidence is there. So the science has done a good job. I think what's lacking is political will. And I think that's going to take more grassroots involvement, to get those things, those things done. But there hasn't been the will to do it. So I think without the political will, I don't think that these things can be changed. And without the demand at the grassroots level for these changes, I think, I don't think the evidence in the data and the science is going to do it. -Samantha

There is general consensus between Samantha and Michael, from these two points above, that policymakers have to be interested in an issue for change to happen. For example, in order to expand Medicaid, as I will discuss in the next chapter, individual states and politicians need to be interested in the topic. Another important component of making change is knowing your audience and catering to this audience. This would mean potentially writing a policy brief to present these findings to legislators and policymakers. Writing this research for the general public might involve something less technical in order to make it accessible. Samantha takes this a bit further by suggesting that the evidence alone is not sufficient to creating change but with political will, data, and grassroots efforts there is a better chance for change. The key to really changing the policy, then, according to these two participants, is to have the legislative or political recognition that these issues are important, pressing, and in need of change. As Samantha and Michael highlight, it is important to know the policy makers and provide them with the data that highlights why these issues are important.

Another important aspect of these interviews were the differences in coverage for immigrants and U.S. citizens and the type of care they are entitled to (CHIP vs Medicaid). Both Samantha and Michael agreed that a better form of continuity of care would be a good step into helping improve maternal and child health outcomes. Another would be the expansion of

Medicaid in both Florida and Texas. I asked Michael how the Medicaid expansion would be beneficial to maternal and child health outcomes, and he answered:

The biggest help that expansion of Medicaid would do would be we wouldn't have this cycle of women being on insurance and off insurance that women would have access to women health services throughout. And that would especially impact those who have chronic conditions. Not just medical conditions, but mental and behavioral conditions. And so that we could do a better job of providing continuity of care to women across the lifespan

Therefore, we address the gap of women who covered under Medicaid only when they are pregnant. It is important that women have access to care before and after they decided to get pregnant in order to have preventative care and address some of the adverse health outcomes we see. Samantha talked about how CHIP was not women's health care since it covers only the fetus and not the mother. Samantha also expressed the importance of continuity of care and preventative care

Yeah, so CHIP perinatal of course is, is, when it was first introduced, a great tool, however, resource, it didn't have to, it could have been better. You know, it really covers the fetus, and the only care is as it relates to the fetus. So it's really not women's health care, it's about the fetus. And so that's really limited, because women have a lot of different conditions that may impact the pregnancy may not be directly but certainly impacts her quality of life. And for many women, this is only care that they receive. So I think that that it's structured that way is problematic, and is an area for policy change. Also, the expansion, the biggest, the easiest thing to do, would be to expand Medicaid. And so you would have women, not everyone would be eligible, but a larger chunk of women would be eligible to get care before they became pregnant. So then any kind of conditions that they had, that maybe had never been identified could be identified and treated prior to going into pregnancy

It is important to highlight that CHIP perinatal varies by state and what is covered also may vary depending on the state. CHIP, in Texas, covers only the fetus or anything with the mother that is related to the fetus. It may be the case that this brief period of coverage is the only coverage these women may have and therefore it is important to have better comprehensive care. In this case, expanding CHIP to cover both the mother and the child may address some of the

negative health impacts and improve outcomes. An expansion for Medicaid would also be extremely beneficial as it would provide better comprehensive care as well as, improving the continuum of care. This would mean that, as Samantha suggested above, women under a Medicaid expansion would be covered before and after pregnancy allowing for better access to care and improving health outcomes for the mother and child. Pre-pandemic CHIP and Medicaid were only covering the mother and fetus 2 months postpartum and adverse health conditions for women after that 60-day period. Michael mentioned this in his interview and said that in his experience reviewing maternal death they often happen after those 60 days post-partum. A Medicaid expansion would help mothers get the access to care throughout their lifetimes and not just during pregnancy.

Samantha mentions that “a clear policy change that could be made that would really make a big impact on maternal and child health.” When I asked Michael how we address people who are undocumented who fall into a gap, where there is less or lack of access to care he responded with

Oh, my first response would be better off getting rid of the five-year limit for Medicaid and having him [an example of some people who relied on cheaper or better access to care in Mexico who were unable to get it because of the closure] on Medicaid. So the mom and baby is are covered by the same insurance and you don't have that split. Not only for undocumented, but that's true for refugees. Although the US government accepts them, we won't let them go on Medicaid for five years. Which is crazy. If you're here illegally in the United States, you should have coverage.

The last important piece that I want to drive home is how the border closure and family separation has impacted women in their pregnancy, birth and post-partum experiences. Michael talks about how he has found the pandemic affected the birth experiences for women

And then of course, a big thing was you could not bring in support people was a time of delivery. You couldn't bring in your doula or if you could you could bring you there your doula or your family member, but you couldn't bring in both? Right. You know, that was

the they would have only one person in the NICU at all. So I mean, there's so clearly access to family and family support and other things were greatly curtailed

Through the narratives and experiences of these women living on the U.S. Mexico border and the conversations with Michael and Samantha, I will highlight in the next chapter a few recommendations that I found particularly useful, important, and practical for policy change and ultimately to improve maternal and child health outcomes.

CHAPTER V: DISCUSSION

This chapter will focus on how these women experience of the border closure and immigration-related stressors, economic insecurities, and family separation contribute to their pregnancy and post-partum experiences during the pandemic.

Legal Violence

Legal violence was at the center of these women's lives when it came to the border closure and immigration-related stressors. Legal violence is the ways in which the law and policies perpetuate harm for individuals (Abrego and Menjivar, 2011). Legal violence takes unintended consequences of the law designed to protect the "general population" a step further by using this term to describe the further marginalization of certain groups (Abrego and Menjivar, 2011). In terms of the border closure, we see that this closure was implemented to prevent COVID-19 from further spreading into the U.S. Justifying the border closure with the idea that it will be safer against the spread of COVID-19 is unsupported by the literature and has unintended consequences for people living on the border (Kenwick and Simmons, 2020; Boyd et al., 2020; Emeto et al., 2021; World Health Organization [WHO], 2020).

Over half of the women included in this project were affected by the border closure and immigration-related stressors. The border closure did not only have implications for Mexican citizens, undocumented immigrants, documented immigrants, who were unable to cross into the U.S., but also their U.S. counterparts. There is an overlap in the ways these women experience the border closure and immigration-related stressors. Often these immigration-related stressors

and the 20-month border closure bleed into the other themes present in this project. For example, the border closure and immigration-related stressors can often contribute to family separation and economic insecurities and vice versa.

Border closures can also exacerbate anxiety in people living in border regions and are often not proven to reduce the spread of COVID-19 (Kenwick and Simmons, 2020). The border closure serves as a form of legal violence for these women. Though this implementation, that was intended to protect the general population, we created harm for individuals living on the U.S.-Mexico border. Through the narratives of the women, we interviewed we see the border closure had consequences for the pregnancy and post-partum period of both U.S. born Latina women and immigrant women. For Anessa the border closure did not allow her family to be a part of her pregnancy. Anessa lacked that social support she desperately wanted and needed in this period of her life. Anessa talked about falling into a depression the first few months of her pregnancy which she attributed to not being able to have her family with her. Her family was unable to cross, since the border was closed to non- U.S. citizens. For Anessa having her family be a part of her pregnancy, delivery and post-partum experience was central to her well-being. When she was unable to have her family be a part of that because of the border closure she fell into a deep depression. Additionally, Anessa's undocumented status contributed to immigration-related stressors. Due to her undocumented status Anessa was unable to apply for Medicaid and could only apply for CHIP perinatal. In this time where she was applying for CHIP perinatal but had not received it there was a gap in care for her and she was unable to receive prenatal care early in her pregnancy.

“Yes, actually, I was getting desperate, I even wanted to look for an appointment already outside [of the health insurance], that is, so that they would tell me that everything was fine or like that because I had not had any appointments, and I was about two months more or less far along”

This border closure and her undocumented status was fueled by the legal violence of the border closure and the lack of health coverage for immigrants in the U.S. The border closure which was intended to prevent the spread on COVID further propelled Anessa into a state of depression and contributed to her lack of care. Anessa also experienced this lack of care post-partum when she developed mastitis and did not have health insurance to cover the surgery. Anessa mentions her struggles with getting care due to the hospital in El Paso not seeing her on the basis of her not having health insurance.

Another form of legal violence Anessa experienced was the inability to get government funded help, since it would label her as a “likely public charge”. Because the U.S. can deny a residency application on the basis of deeming someone a likely public charge, this was stressful for Anessa as she had to get a sponsor for her residency. This likely public charge rule can impede people seeking residency from getting the help they need to have a better pregnancy furthering the legal violence felt by this marginalized group. A perfect example of how impeding immigrants from using publicly funded programs is Brisa. Brisa was also an undocumented immigrant who had immigration-related stressors and was impacted by the border closure. Brisa had economic concerns but could not receive government help she needed because of her illegal status. Brisa talks about her inability to receive this help and how it impacted her mental and emotional well-being

“Well actually a lady had told me about food stamps but they told me I can’t apply because they were only for U.S. citizens and because of my illegal status well I couldn’t receive that kind of help. One of them that went at the beginning they took me to [redacted] she’s called a social worker and there she told me that they couldn’t help me that the help was for people who are from here.

Brisa like Anissa was unable to receive Medicaid because of her status and could only have CHIP perinatal. Brisa's commented on how she felt her status affected the way she was being treated "I felt that because of my undocumented status less valued and like they wouldn't treat me the same as they would treat others. Like I wasn't important because of my legal status." Much like Anessa the border closure affect Brisa as she wanted to see her family and have them be a part of the pregnancy, birth and post-partum experience but they were unable to because of the border closure. Itzel also suffered from the border closure when talking about how the pandemic has affected her experiences "like now my parents and a lot of my family cannot come to the U.S. because of the pandemic situation." The border closure and lack publicly funded support acted as a form of legal violence for these women and ultimately impacted their pregnancy, birth and post-partum period.

Stress and Embodiment

Stress is linked to several adverse birth outcomes in women (Federenko and Wadhwa, 2004; Phelan et al., 2015) which can be further amplified by immigration-related stressors (Loomans et al., 2013; Solis and Heckert, 2020; Quesada, 2011; Kline and Castañeda, 2019). Immigration-related stressors can lead to hyper-vigilance, self-imposed limitations on movement, embodiment, and eventually adverse health outcomes (Hacker et al, 2015; LeBrón et al., 2018 Federenko and Wadhwa, 2004; Phelan et al., 2015; Rodriguez et al., 2017, Solis and Heckert, 2020, Quesada, 2011). Immigration-related stressors can impact the pregnancy and post-partum period. Though, immigration-related stressors do not have to directly impact the individual to have unintended consequences, they often are out of concern for family members or partners.

Immigration-related stressors are not the only ways in which women can experience maternal stress. Through interviews with women, we found that stress can manifest in economic insecurities and family separation. These economic insecurities and family separation can be further exacerbated by the pandemic, as was the case with women in this project. For example, Martinez et al. (2018) found that social structures, social interactions as forms of institutional racism, etc. can produce negative health outcomes for Mexican-origin individuals in the U.S. Preterm birth and low birthweight can be also linked to maternal stress and in turn cause infant morbidity and mortality (Dunkel & Glynn, 2011; Grote et al., 2010; Rondó et al., 2003). Grote et al., (2010) found that maternal stress and low birthweight can be linked and have adverse health outcomes. A study that looked at the association between social support and maternal stress with preeclampsia (Dawson, 2022). This study looked at 110 multipara women, 55 who had preeclampsia and 55 who had normal pregnancies (Dawson, 2022). Social support or lack thereof can also be associated with negative health outcomes such as preeclampsia (Moafi et al., 2013). Preeclampsia is a complication that can happen from having high blood pressure during pregnancy (Dawson, 2022). Preeclampsia happens when a woman, who previously had normal blood pressure suddenly has high blood pressure during pregnancy usually after 20 weeks of pregnancy (CDC, 2023). Five of the 17 women in this study developed preeclampsia while pregnant. A study found that social support had an effect of incidence of preeclampsia in pregnant women (Moafi et al., 2013). Another study included 50 pregnant women with preeclampsia and 50 who had normal pregnancies who gave birth in public hospitals in Iran (Sarmasti et al., 2019). Additionally, the goal of this research was to compare social support and perceived stress in women with healthy pregnancies and pregnancies with preeclampsia. This

study found that pregnant women with preeclampsia had more stress and less social support than their healthy pregnant women counterparts (Sarmasti et al., 2019).

Maternal stress was evident in Brisa's case who had all three stressors, border closure and immigration-related stressors, family separation and economic insecurities present in her pregnancy, birth, and post-partum experiences. Brisa also experiences hyper-vigilance and imposed limitations on movement because of her immigration status. Brisa self-imposed limitations on movement due to immigration-related stressors she felt while living on the border and being pregnant

Outside I don't know I feel anguish like I want to get home for the same reason. Everything to do with immigration. There is where the helicopters are and the vans, the buildings are there and they are constantly leaving. So for walking there I don't have security or confidence. The doctor told me to go out and walk like half an hour so I could exercise that it would do me good but for those reasons I am scared because for example immigration is there. The doctor also told me well when I asked her why I felt that desperation in my hands and feet she also told me that this could be part of the same thing

Even though Brisa's doctor recommended she walk during her pregnancy because it would be good for her, Brisa would not leave the house due to her stress of being constant presence of immigration officials on the border. Brisa's stress also manifested physically in her swollen hands and feet because of the constant anguish and worry she felt leaving the house. Her constant state of distress and anguish when leaving the house contributed to her embodiment of stress physically. Brisa describes how she embodied her stress in frustration and anguish "well, uh, it feels horrible, it's tremendously frustrating". Brisa describes how stressful a situation was when running into border patrol officers at a job interview for a restaurant

"Or, for example, one day I went... I remember that I was looking for a job and I went to a restaurant for an interview and the immigration officers were there eating and I felt as if I couldn't breathe, and I wanted to leave because they were there the immigration officers and well here there is a lot of immigration activity."

Brisa also felt this stress in her everyday life because of her economic insecurities. She expresses how being financially stuck has made her feel “I can’t find a way out I still have nothing, no job, and leaving my baby is super anguishing for me.” Due to her inability to get Medicaid she also expressed her economic insecurities due to hospital bills “I worried about the bill because I know they are expensive for hospital bill.”

Much like Brisa, Flor embodied her immigration-related stressors physically. When talking about how her status makes her feel she says

“Ah, for example, indirectly I think I feel my self-esteem is very low. So that causes stomach aches and constipation. When I arrived I began to suffer from constipation, uncertainties and this anxiety. I have a lot of this problem that I grind my teeth at night and even though I no longer have that stress, I feel that it stayed there mentally”

The anxiety of being an immigrant in El Paso had manifest physically and Flor had embodied the stress, leading to anxiety, constipation and grinding her teeth at night. Janeth is another example of how all the three themes interacted to fuel her maternal stress and potentially cause her preeclampsia. Janeth talked about how the pandemic had affected her because her husband was unable to be there during the pregnancy “yes, I do think it made it worse because my husband was not able to be with me for a lot of this last pregnancy, so I lived it alone.”

Itzel was another example of how maternal stress was amplified by the border closure, economic insecurities and family separation. Itzel talks about how her family was unable to be there for the birth because of the border closure and this contributed to her family separation. Itzel also talked about her decision of leaving or not leaving her job because it would further her economic insecurities and how that made her feel “so I now feel more worried, you can say perhaps that is the word, like I feel worries every day because I have no idea how I’m going to do it.”

Through the border closure and immigration-related stressors, economic insecurities, and family separation these women experienced legal violence, stress, embodiment of that stress, self-imposed limitations on movement, and legal violence. There was often a lack of continuity of care these women experienced by not getting prenatal care early on, not having social support, and not being able to address their concerns that manifested into stress. The next chapter will focus on how we can address these issues to improve maternal and child health outcomes.

CHAPTER VI: RECOMMENDATIONS AND CONCLUSION

Recommendations

1. **Addressing the gap in data for women on continuity of care.**

Addressing the gap in data for continuity of care would entail better records on birthing centers, post-partum care, preventative care, data on prenatal care, health insurance, key informant interviews etc. Additionally this would address gaps in the information we are missing to paint the bigger picture. Currently we tend to highlight quantitative data and it is limited to hospital records. With a boarder understanding of what impacts maternal and child health there may be a shift in the way we provide maternal and child health services and potentially improve outcomes. Addressing the gap would also provide better mental health services for women who coping with stress during their pregnancies. Addressing the gap includes the impact the pandemic had on lack of social support due to family separation and the exacerbation of economic concerns for these women. Having a continuous form of care would have alleviated stress that women who lacked coverage had. Additionally, having the right resources to deal with lack of social support and economic insecurities would help ease some of the frustration and anguish felt. As Samantha mentioned, sometimes pregnancy is the only time a woman has access to health care, and this is particularly salient in women with precarious or undocumented status. Ensuring a continuum of care and providing women with coverage throughout the life course would significantly help with maternal and child health outcomes. Not allowing women to have full health coverage based on their immigration status is unacceptable. Women should be able to have safe and healthy deliveries all while having access to the care they need before and after pregnancy.

2. Expanding Medicaid

As was highlighted in the interviews expanding Medicaid would be greatly beneficial to maternal and child health outcomes. This would ensure women would be covered before and after pregnancy. It would ensure preventative services were offered and help with continuity of care. These interviews highlighted that pregnancy is often when women are getting the care they need, when it should be across the lifespan. Expanding Medicaid would allow for coverage outside of pregnancy for better reproductive care. Additionally, covering undocumented immigrants and refugees should be a priority as we see there is a lack of care for this population, stemming from the U.S. only covering the U.S. born fetus. It is important to highlight that the recommendation here is not *extending* Medicaid, as was done during the pandemic as part of the American Rescue Plan but *expanding* Medicaid. Expanding Medicaid would be a component of the first recommendation to ensure continuity of care while extending Medicaid would just give women a bit more time in terms of coverage.

3. A shift in the way we see immigration and borders in the U.S.

While this recommendation seems far-fetched it would greatly ease a lot of stress for both immigrants and people living on the border. The 20-month border closure had a profound effect on immigration, economic stability, and family separation. Borders are socially and politically constructed and have historically been used for exclusion and inclusion criteria. We see through these women's narratives, policy and providers testimony, and the literature, the harmful effects of closing the border. Additionally, the border closure allowed U.S. citizens to cross back and forth through the U.S.-Mexico border while Mexican nationals were essentially excluded from this ability. This effect was not only felt by immigrant women but also U.S. born Latinas.

4. Refocusing the need for maternal care.

It is important that law and policy makers place importance on maternal care for change to begin. This would include having data on CHIP perinatal and an evaluation of both Medicaid and CHIP. Interest in outcomes, who is covered, and how efficient the programs are is an important component of this recommendation. This would also mean shifting the focus to outcomes in women who give birth past the 60 days of coverage, for Medicaid and CHIP. This data would allow both policymakers and people in MCH fields to have the “full picture” data from before and after pregnancy. Shifting the way we see maternal care could potentially help mothers in terms of where mothers feel they need the most support. Another important piece of data that we are missing that would help refocusing the need for maternal care are social determinants of health, and collecting data on income, health coverage before and after pregnancy, education, living conditions, etc. This would illustrate how other factors can influence health in women, before, during, and after pregnancy. For the women that were a part of this study this would include, the border closure, family separation, and economic insecurities.

Conclusions

During this project I examined how the pandemic has shaped the experiences of women living on the U.S.-Mexico border during their pregnancy, birth, and post-partum time. Research on this topic in El Paso, Texas requires the examination of immigration-related concerns that have always been present for both undocumented and documented immigrants and often even U.S. citizens who are of Mexican origin. Interviews with the women who are a part of this study

highlighted issues that impact women's health on the U.S.-Mexico border, including the border closure, economic insecurities, and family separation, all of which were fueled by the pandemic.

These themes highlight other barriers that can impact women's health along the border. Hyper-vigilance, self-imposed limitations on movement, heightened levels of stress, lack of social support, and legal violence can all work through these bigger themes as symptoms to exacerbate negative health outcomes for women. These symptoms (hyper-vigilance, heightened levels of stress, etc.) can be a result of harmful immigration policies and the way we see immigration in the United States. The women who shared their experiences as part of this project showed how different forms of social structures can interact to produce negative health outcomes. Through the border closure we see women who were unable to have social support during their pregnancy. This could lead to heightened level of stress, economic insecurities which may become embodied during pregnancy.

Interviews with women about their experiences was one source of data, while the second piece was speaking to provider experts in maternal and child health in order to guide future interventions. This allowed for recommendations to achieve potential changes for maternal and child health outcomes and are based both in the literature and in the data from this study to provide the best possible recommendations for policy change. A greater focus on maternal and child health outcomes and a shift in the way we see immigration has the potential to pave way for a better continuum of care.

References

- Abrego, L. J., & Menjívar, C. (2011). Immigrant Latina mothers as targets of legal violence. *International Journal of Sociology of the Family*, 37(1).
- Behrman, R. E., & Butler, A. S. (2007). *Preterm birth: Causes, consequences, and prevention*. National Academies Press.
- Berk, M. L., & Schur, C. L. (2001). The Effect of Fear on Access to Care Among Undocumented Latino Immigrants. *Journal of Immigrant Health*, 3(3), 151–156.
<https://doi.org/10.1023/a:1011389105821>
- Bingham, A.J., & Witkowsky, P. (2022). Deductive and inductive approaches to qualitative data analysis. In C. Vanover, P. Mihas, & J. Saldaña (Eds.), *Analyzing and interpreting qualitative data: After the interview* (pp. 133-146). SAGE Publications.
- Boyd, M., Baker, M. G., & Wilson, N. (2020). Border closure for island nations? analysis of pandemic and bioweapon-related threats suggests some scenarios warrant drastic action. *Australian and New Zealand Journal of Public Health*, 44(2), 89–91.
<https://doi.org/10.1111/1753-6405.12991>
- Callaghan, T., Washburn, D. J., Nimmons, K., Duchicela, D., Gurram, A., & Burdine, J. (2019). Immigrant Health Access in Texas: Policy, rhetoric, and fear in the trump era. *BMC Health Services Research*, 19(1). <https://doi.org/10.1186/s12913-019-4167-1>
- Castañeda, H. (2019). *Borders of belonging: Struggle and Solidarity in mixed-status immigrant families*. Stanford University Press.
- Centers for Disease Control and Prevention [CDC]. (2021). Reproductive health: preterm birth. Retrieved from: <https://www.cdc.gov/reproductivehealth/features/premature-birth/index.html>
- Centers for Disease Control and Prevention [CDC]. (2023). High blood pressure during pregnancy. Retrieved from: <https://www.cdc.gov/bloodpressure/pregnancy.htm>
- Conway, D., Mykyta, L. (2022). Uninsured Rate Declined in 28 States 2019-2021: U.S. Census Bureau. Retrieved from: <https://www.census.gov/library/stories/2022/09/uninsured-rate-declined-in-28-states.html>
- Dawson, E. (2022). Preeclampsia, Genomics and Public Health: Centers for Disease Control and Prevention. Reterived from: <https://blogs.cdc.gov/genomics/2022/10/25/preeclampsia/>

- Department of Homeland Security. (2022). Public Charge Ground of Inadmissibility .*The Federal Register*. Retrieved from <https://www.federalregister.gov/documents/2022/09/09/2022-18867/public-charge-ground-of-inadmissibility>
- Donelson, A. J., & Esparza, A. X. (2010). Part 1. In *The colonias reader: Economy, housing, and public health in U.S.-Mexico Border Colonias*. essay, University of Arizona Press.
- Dunkelberg, A. (2016). Immigrants' Access to Health Care in Texas: An Updated Landscape. Retrieved from: https://everytexan.org/images/HW_2016_ImmigrantsAccess_FullReport.pdf
- Duncan, W., Horton, S., Yarris, K. (2021). COVID and Coraje: Negotiating Latinx Immigrant Experiences of the Pandemic.
- Dunkel Schetter, C., & Glynn, L. (2011). Stress in pregnancy: Empirical evidence and theoretical frameworks to guide interdisciplinary research. In R. Contrada & A. Baum (Eds.), *The handbook of stress science* (pp. 320–343). Springer.
- Espino, V., R. (2007). Women sterilized as they give birth: population control, eugenics, and social activism in the twentieth-century United States. Dissertation. ProQuest Publishing.
- Emeto, T. I., Alele, F. O., & Ilesanmi, O. S. (2021). Evaluation of the effect of border closure on covid-19 incidence rates across nine African countries: An interrupted time series study. *Transactions of The Royal Society of Tropical Medicine and Hygiene*, 115(10), 1174–1183. <https://doi.org/10.1093/trstmh/trab033>
- Federenko, I. S., & Wadhwa, P. D. (2004). Women's mental health during pregnancy influences fetal and infant developmental and health outcomes. *CNS Spectrums*, 9(3), 198–206. <https://doi.org/10.1017/s1092852900008993>
- Filosa, J. N., Botello-Mares, A., & Goodman-Meza, D. (2022). Covid-19 needs no passport: The Interrelationship of the covid-19 pandemic along the U.S.-Mexico Border. *BMC Public Health*, 22(1). <https://doi.org/10.1186/s12889-022-13513-1>
- Gemmill, A., Catalano, R., Casey, J. A., Karasek, D., Alcalá, H. E., Elser, H., & Torres, J. M. (2019). Association of preterm births among US latina women with the 2016 presidential election. *JAMA Network Open*, 2(7). <https://doi.org/10.1001/jamanetworkopen.2019.7084>
- Grote, N., Bridge, J., Gavin, A., Melville, J., Iyengar, S., & Katon, W. (2010). A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. *Archives of General Psychiatry*, 67(10), 1012–1024. <https://doi.org/10.1001/archgenpsychiatry.2010.111>

- Hacker, K., Anies, M. E., Folb, B., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: A literature review. *Risk Management and Healthcare Policy*, 175. <https://doi.org/10.2147/rmhp.s70173>
- Healthy Paseo Del Norte (2015). Babies with low birthweight. Community Dashboard. Retrieved from: <https://www.healthypasodelnorte.org/indicators/index/view?indicatorId=172&localeId=2645>
- Healthy Paseo Del Norte (2017). Preterm birth. Community Dashboard. Retrieved from: <https://www.healthypasodelnorte.org/indicators/index/view?indicatorId=380&localeId=2645>
- Heckert, C. (2020). The bureaucratic violence of the health care system for pregnant immigrants on the United States-Mexico border. *Human Organization*, 79(1), 33–42. <https://doi.org/10.17730/0018-7259.79.1.33>
- Homeland Security. (2022). DHS Publishes Fair and Humane Public Charge Rule. Retrieved from: <https://www.dhs.gov/news/2022/09/08/dhs-publishes-fair-and-humane-public-charge-rule>
- Horton, S., Duncan, W., & Yarris, K. (2018). Immigrant communities and the public charge rule. *Anthropology News*, 59(5). <https://doi.org/10.1111/an.1015>
- Jardim, D. M., & Modena, C. M. (2018). Obstetric violence in the daily routine of care and its characteristics. *Revista Latino-Americana De Enfermagem*, 26. <https://doi.org/10.1590/1518-8345.2450.3069>
- Kenwick, M. R., & Simmons, B. A. (2020). Pandemic response as border politics. *International Organization*, 74(S1). <https://doi.org/10.1017/s0020818320000363>
- Kline, N. (2022). Health and Immigration Systems as an ethnographic field: Methodological lessons from examining immigration enforcement and health in the US. *Social Science & Medicine*, 300, 114498. <https://doi.org/10.1016/j.socscimed.2021.114498>
- Kline, N., & Castañeda, H. (2019). Immigration enforcement policies and Latinx Health: State of knowledge. *New and Emerging Issues in Latinx Health*, 253–269. https://doi.org/10.1007/978-3-030-24043-1_12
- Krisberg, K., Leffler, D. (2022). Why Texas Republicans still oppose Medicaid expansion: Texas Tribune. Retrieved from: <https://www.texastribune.org/2022/11/07/texas-medicaid-expansion-republicans/>

- LeBrón, A. M., Schulz, A. J., Gamboa, C., Reyes, A., Viruell-Fuentes, E. A., & Israel, B. A. (2018). “they are clipping our wings”: Health implications of restrictive immigrant policies for Mexican-origin women in a northern border community. *Race and Social Problems*, 10(3), 174–192. <https://doi.org/10.1007/s12552-018-9238-0>
- Loomans, E. M., van Dijk, A. E., Vrijkotte, T. G. M., van Eijsden, M., Stronks, K., Gemke, R. J., & Van den Bergh, B. R. (2012). Psychosocial stress during pregnancy is related to adverse birth outcomes: Results from a large multi-ethnic community-based birth cohort. *European Journal of Public Health*, 23(3), 485–491. <https://doi.org/10.1093/eurpub/cks097>
- Makhlouf, M. D. (2019). The public charge rule as Public Health Policy. *Indiana Health Law Review*, 16(2), 177–210. <https://doi.org/10.18060/23295>
- March of Dimes. (2020). Health insurance/income. Retrieved from: <https://www.marchofdimes.org/peristats/data?reg=99&top=11&stop=154&lev=1&slev=4&obj=1&sreg=48>
- Martínez, A. D., Ruelas, L., & Granger, D. A. (2018). Household fear of deportation in relation to chronic stressors and salivary proinflammatory cytokines in Mexican-origin families post-SB 1070. *SSM - Population Health*, 5, 188–200. <https://doi.org/10.1016/j.ssmph.2018.06.003>
- Menjívar, C., & Abrego, L. (2012). Legal violence: Immigration law and the lives of Central American immigrants. *International Journal of Sociology of the Family*, 37(1), 9–26. <https://doi.org/10.1086/663575>
- Moafi F, Dolatian M, Keshavarz Z, AlaviMajd H, Dejman M. Association between social support and maternal stress with preeclampsia. *Soc Welfare Quart*, 2013; 13(48):151-70
- Morse, A. (n.d.). Immigrant policy project: Omnibus immigration Legislation. Retrieved from <https://www.ncsl.org/research/immigration/omnibus-immigration-legislation.aspx>.
- Muñoz, S. M., & Vigil, D. (2018). Interrogating racist nativist microaggressions and campus climate: How undocumented and Daca College students experience institutional legal violence in Colorado. *Journal of Diversity in Higher Education*, 11(4), 451–466. <https://doi.org/10.1037/dhe0000078>
- Mulligan, J. M., & Castañeda, H. (n.d.). *Unequal coverage: The experience of health care reform in the United States*. New York University press.
- Novak, N., Geronimus, A., & Martinez-Cardoso, A. (2017). Change in birth outcomes among infants born to Latina mothers after a major immigration raid. *International Journal of Epidemiology*, 46(3), 839–849. <https://doi.org/10.1093/ije/dyw346>

- Oxner, R. (2021). Federal judge temporarily blocks gov. Greg Abbott's order to pull over vehicles with migrants, which drew racial profiling concerns. *The Texas Tribune*. Retrieved from <https://www.texastribune.org/2021/08/03/texas-greg-abbott-migrant-order-blocked/>.
- Phelan, A. L., DiBenedetto, M. R., Paul, I. M., Zhu, J., & Kjerulff, K. H. (2015). Psychosocial stress during first pregnancy predicts infant health outcomes in the first postnatal year. *Maternal and Child Health Journal*, *19*(12), 2587–2597. <https://doi.org/10.1007/s10995-015-1777-z>
- Quesada, J. (2011). No soy welferero: Undocumented Latino laborers in the crosshairs of legitimation maneuvers. *Medical Anthropology*, *30*(4), 386–408. <https://doi.org/10.1080/01459740.2011.576904>
- Reny, T., & Manzano, S. (2016). The negative effects of mass media stereotypes of Latinos and immigrants. *Media and Minorities*, 195–212. <https://doi.org/10.13109/9783666300882.195>
- Rodriguez, N., Paredes, C. L., & Hagan, J. (2017). Fear of immigration enforcement among older Latino immigrants in the United States. *Journal of Aging and Health*, *29*(6), 986–1014. <https://doi.org/10.1177/0898264317710839>
- Rondo, P., Ferreira, R., Nogueira, F., Ribeiro, M. C. N., Lobert, H., & Artes, R. (2003). Maternal psychological stress and distress as predictors of low birth weight, prematurity and intrauterine growth retardation. *European Journal of Clinical Nutrition*, *57*(2), 266–272. <https://doi.org/10.1038/sj.ejcn.1601526>
- Sarmasti, N., Ayoubi, S. H., Mahmoudi, G., & Heydarpour, S. (2019). Comparing perceived social support and perceived stress in healthy pregnant women and pregnant women with preeclampsia. *Ethiopian Journal of Health Sciences*, *29*(3). <https://doi.org/10.4314/ejhs.v29i3.9>
- Sieff, K. (2018). U.S. is denying passports to Americans along the border, throwing their citizenship into question. *The Wall Street Journal*. Retrieved from: https://www.washingtonpost.com/world/the_americas/us-is-denying-passports-to-americans-along-the-border-throwing-their-citizenship-into-question/2018/08/29/1d630e84-a0da-11e8-a3dd-2a1991f075d5_story.html
- Silva-Sobrinho, R. A., Zilly, A., Silva, R. M., Arcoverde, M. A., Deschutter, E. J., Palha, P. F., & Bernardi, A. S. (2021). Coping with covid-19 in an international border region: Health and Economy. *Revista Latino-Americana De Enfermagem*, *29*. <https://doi.org/10.1590/1518-8345.4659.3398>
- Solis, I., & Heckert, C. (2020). Case studies of intimate partner violence, immigration-related stress, and legal violence during pregnancy in the U.S.-Mexico Border Region. *Affilia*, *36*(1), 27–42. <https://doi.org/10.1177/0886109920939056>

- Staudt, K. (2020). The central u.s.–mexico borderlands during the 2020 pandemic. *Borders in Globalization Review*, 2(1), 104–108. <https://doi.org/10.18357/bigr21202019835>
- Sullivan, K., Raley, R. K., Hummer, R. A., & Schiefelbein, E. (2011). The potential contribution of marital-cohabitation status to racial, ethnic, and Nativity Differentials in birth outcomes in Texas. *Maternal and Child Health Journal*, 16(4), 775–784. <https://doi.org/10.1007/s10995-011-0801-1>
- Texas Health and Human Services. (nda). Medicaid and CHIP. Retrieved from: <https://www.hhs.texas.gov/services/health/medicaid-chip>
- Tripathy, J. P. (2013). Secondary data analysis: Ethical issues and challenges. *Iranian journal of public health*, 42(12), 1478.
- United Health Foundation. (2022). Trend: Uninsured Women in Texas, United States. Retrieved from: https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/Uninsured_women/state/TX?edition-year=2022
- U.S. Bureau of Labor Statistics. (2020). Labor Force Statistics from the Current Population Survey: Effects of the coronavirus COVID-19 pandemic (CPS). Retrieved from:
- U.S. Census Bureau. (2019). Quick Facts: El Paso County, Texas. Retrieved from: <https://www.census.gov/quickfacts/elpasocountytexas>.
- U.S. Census Bureau. (2020). Quick Facts: El Paso County, Texas. Retrieved from: <https://www.census.gov/quickfacts/fact/table/elpasocountytexas/BZA010220>.
- Vanthuyne, K., Meloni, F., Ruiz-Casares, M., Rousseau, C., & Ricard-Guay, A. (2013). Health Workers' perceptions of access to care for children and pregnant women with precarious immigration status: Health as a right or a privilege? *Social Science & Medicine*, 93, 78–85. <https://doi.org/10.1016/j.socscimed.2013.06.008>
- Volpert-Esmond, H. I., Marquez, E. D., & Camacho, A. A. (2022). Family relationships and familism among Mexican Americans on the U.S.–Mexico border during the COVID-19 Pandemic. *Cultural Diversity and Ethnic Minority Psychology*. Advance online publication. <http://dx.doi.org/10.1037/cdp0000547>
- White, K., Yeager, V. A., Menachemi, N., & Scarinci, I. C. (2014). Impact of alabama's immigration law on access to health care among Latina immigrants and children: Implications for national reform. *American Journal of Public Health*, 104(3), 397–405. <https://doi.org/10.2105/ajph.2013.301560>
- Wilson, F. A., & Stimpson, J. P. (2020). US policies increase vulnerability of immigrant communities to the COVID-19 pandemic. *Annals of Global Health*, 86(1). <https://doi.org/10.5334/aogh.2897>

World Health Organization (2020). Updated WHO recommendations for international traffic in relation to COVID-19 outbreak. Retrieved from: <https://www.who.int/news-room/articles-detail/updated-who-recommendations-for-international-traffic-in-relation-to-covid-19-outbreak>

APPENDIX A: ONLINE INFORMED CONSENT



Script for Obtaining Verbal Informed Consent

Information to Consider Before Taking Part in this Research Study

Title: Impact of the Pandemic on Immigration Related Stressors, Pregnancy, Birth, and Post-partum Experiences of Women Living Along the Border.

Study # STUDY004467

Overview: You are being asked to take part in a research study. The information in this document should help you to decide if you would like to participate. The sections in this Overview provide the basic information about the study. More detailed information is provided in the remainder of the document.

Study Staff: This study is being led by *Isabela Solis* who is a *student at/in University of South Florida*. This person is called the Principal Investigator. *Isabela Solis* is being guided in this research by *Dr. Heide Castañeda*. Other approved research staff may act on behalf of the Principal Investigator.

Study Details: This study is being conducted in El Paso, Texas. The purpose of the study is to *understand the emotional experiences of women who gave birth on the U.S.-Mexico border and how other influences such as stress, immigration-related concerns, doctors, etc., affect the women's experience.*

Subjects: You are being asked to take part because *you have worked with this population of women, in this field of knowledge in maternal and child health, or are in a position that influences policy.*

Voluntary Participation: Your participation is voluntary. You do not have to participate and may stop your participation at any time. There will be no penalties or loss of benefits or opportunities if you do not participate or decide to stop once you start.

Benefits, Compensation, and Risk: We do not know if you will receive any benefit from your participation. There is no cost to participate. You will not be compensated for your participation. This research is considered minimal risk. Minimal risk means that study risks are the same as the risks you face in daily life.

Confidentiality: Even if we publish the findings from this study, we will keep your study information private and confidential. Anyone with the authority to look at your records must keep them confidential.

Why are you being asked to take part?

You are being asked to take part because you have worked with this population of women, in this field of knowledge in maternal and child health or are in a position that influences policy.

Study Procedures:

During the interview you will be asked questions about your area of knowledge (provider or legislative office) on what contributions you have to the results of the study. How best to spread the results, how best to make the most change with the results, and how you see there can be a change given your profession. These interviews will take anywhere from 1-2 hours.

Version 1 (8/17/2022)

APPENDIX B: IRB APPROVAL FOR STUDY



EXEMPT DETERMINATION

August 19, 2022

Isabela Solis

Dear Isabela Solis:

On 8/18/2022, the IRB reviewed and approved the following

protocol:

Application Type:	Initial Study
IRB ID:	STUDY004467
Review Type:	Exempt 2
Title:	Impact of the Pandemic on Immigration Related Stressors, Pregnancy, Birth, and Post-partum Experiences of Women Living Along the Border.
Funding:	None
Protocol:	• IRB IS_8/17/22 No Consents

The IRB determined that this protocol meets the criteria for exemption from IRB review.

In conducting this protocol, you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Please note, as per USF policy, once the exempt determination is made, the application is closed in BullsIRB. This does not limit your ability to conduct the research. Any proposed or anticipated change to the study design that was previously declared exempt from IRB oversight must be submitted to the IRB as a new study prior to initiation of the change. However, administrative changes, including changes in research personnel, do not warrant a modification or new application.

Ongoing IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about

Institutional Review Boards / Research Integrity & Compliance

FWA No. 00001669

University of South Florida / 3702 Spectrum Blvd., Suite 165 / Tampa, FL 33612 / 813-974-5638

Page 1 of 2

APPENDIX C: SEMI-STRUCTURED INTERVIEW

Semi-Structured Interview for Providers/Maternal Mortality Board

Background:

1. Can you tell me about your work and what you do in relation to maternal and child health (as part of the maternal mortality review)?

Data and experience

1. In your work/ experience with maternal and child health where is the biggest gap in missing data? How would this be useful to improving maternal and child outcomes?
Probe
2. After hearing about our preliminary findings what could I share that would be useful?
3. What type of data is useful to assist with legislative and policy changes?
4. Have you found there was a perceived lack of coverage among women during the pandemic?
5. How have you seen the pandemic has impacted care or quality care for maternal and child health?
6. Have you seen in your work that structural inequalities in healthcare impact minorities? If so, how? And what can we do to improve outcomes? (stratified access)
7. How would a Medicaid expansion impact maternal and child health outcome?
8. How would more comprehensive coverage under CHIP perinatal impact maternal and child health outcomes?
9. What conversations have there been about expanding chip perinatal and who gets to decide what is covered by CHIP perinatal? Are there differences at the state level
10. What types of policy changes do you think would best promote better maternal health?
11. What do you think is needed for these changes to take place?
12. What do you see as the biggest challenges in providing care for maternal and child health populations?

APPENDIX D: BACKGROUND OF PARTICIPANTS

Pseudonym	Country of Birth	Type of Disruption (Themes)	Immigration-related concerns
1 (Anamaria) PP	US	Family Separation	
2 (Carmen) PP	Mexico	Border Closure and Family Separation	Extended Family Members
9 (Sandra) PP	Mexico	Border Closure, Economic Insecurities, and Family Separation	DACA & Husband Undocumented
45 (Salma)	US	Border Closure, Economic Insecurities, and Family Separation	Undocumented Mother and Sister & not seeking care because of documentation status
47 (Janeth) PP	US	Border Closure, Economic Insecurities, and Family Separation	Second-generation, family members who were seeking asylum and deported, in-laws in process of adjusting status
50 (Virginia)	US	Family Separation and Economic Insecurities	Extended Family Members
57 (Alma) PP	US	Family Separation and Economic Insecurities	Second-generation
64 (Eliana)	US	Family Separation and Economic Insecurities	Second-generation
72 (Brisa)	Mexico	Border Closure, Economic Insecurities, and Family Separation	Undocumented
105 (Itzel)	US	Border Closure, Economic Insecurities, and Family Separation	Born in US, grew up in Mexico, returned as young adult, unable to get passport because born in birth center
142 (Yvonne)	US	Border Closure, Economic Insecurities, and Family Separation	Second-gen, born in US, grew up in Juarez, returned with family at 21 (petitioned for parents)
149 (Flor)	Mexico	Border Closure and Family Separation	Undocumented as child, came at age 12, became PR in 2015, concerns for immediate family
157 (Liliana)	Chile	Border Closure, Economic Insecurities, and Family Separation	Came with student visa and became PR via marriage before visa expired, father deported in past (coming from Chile -- reason the family ended up in Juarez)
171 (Anessa)	Mexico	Border Closure, Economic Insecurities, and Family Separation	Undocumented, came on tourist visa, in process of adjusting status via marriage
173 (Talia)	US	Family Separation	
220 (Jasmine)	US	Border Closure, Economic Insecurities, and Family Separation	Second-gen, mother and older sister were undocumented but have been able to adjust status
230 (Lorena)	US	Economic Insecurities	