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Navigating Aid: Latinx Immigrants Accessing Services in a Post-Welfare Reform Era

By

Daniela Cristina Carrillo

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requirements for the degree of

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in

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Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Irene Bloemraad, Chair

Professor Cybelle Fox

Professor Cristina Mora

Professor Carolina Reid

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Abstract

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Professor Irene Bloemraad, Chair

How do immigrants access social services in a nation that has increasingly restricted its aid to them? Analyzing 85 interviews that I conducted with low-income, Spanish-speaking immigrants and 12 staff members at immigrant, non-profit organizations (NPOs), combined with two years of participant observation in NPO settings, I find significant barriers to aid-seeking – ones that some immigrants mitigate through gendered social networks. *Navigating Aid* unveils how access to services varies between women and men, and how differential access is shaped and reinforced by networks based on caring for family or, alternatively, working for pay. Adding a qualitative component to the recent research on suburbanization of poverty, my research also examines how urban versus suburban settings can influence access to resources. In a smaller network of service providers, organizations have the potential to cohere more tightly and make the process for accessing a variety of services more streamlined for their clients. Furthermore, while resources were scarcer in the suburbs, the pathways to accessing them remain largely the same.

Navigating Aid complicates past welfare state literature that discusses the benefits afforded to men in contrast to women by showing how, when legal status is taken into account, undocumented men are left with no public safety net. Moreover, it exposes how heteronormative and familial norms are reinforced when women's main access to services is through their assumed motherhood. In contrast to other studies on welfare programs that focus on the experiences of native-born citizens, *Navigating Aid* delicately unpacks the intersection of poverty, race and legal status in understanding undocumented Latinx immigrants' paths to accessing services. In exploring immigrants' challenges and coping mechanisms, this dissertation opens a conversation about much more than immigrants' access to social services and public programs; it viscerally exposes the contradictions and changing contours of a thinning welfare state.

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INTRODUCTION: GENDERED PIPELINES INTO SERVICES

When Mari was just ten years old, her two older brothers made the move to come to the United States and earn money to help support her and her parents. Mari had a sense she would come North soon; it was only a matter of time before the wages from working on the fields in rural Mexico would be unsustainable. Sure enough, when her twenty-fifth birthday rolled around, her mother and she packed their bags and made the journey North to reunite with their family in Oakland. Soon after arriving with her brothers, Mari found a job in a factory where she met her future spouse. She became pregnant with her first child a couple of years later, and her sister-in-law showed her the ropes as she guided her through the public medical assistance program for mothers and later on, through the public schooling system for her children. Although navigating the bureaucracy of schools and medical institutions still proves difficult for her as an undocumented, monolingual speaker, she has the backing of her networks to support her through the challenge.

Tomas didn't grow up in such a stable home, and in fact, he had very little support from his family. His father left his family as a child, and his mother was overburdened raising him and his six younger brothers. He left his home at a young age to work odd jobs in the capital of Mexico. When his acquaintances informed him of an opportunity to come to the United States, he immediately took it. He had the housing support of an acquaintance he traveled North with, and by talking to his acquaintances and other men who had migrated to the U.S., he learned where to search for day labor on street corners. For many years, he worked at a below-minimum wage, and he had no support in terms of social services. It was only when his friend connected him to a non-profit organization five years ago that he was finally able to receive medical services in Oakland. Having access to a county health program helped him check his eyes and get a bridge for his teeth, but he still felt uncomfortable asking for food at pantries. He wasn't raised to take things, he says; he was raised to earn them. Even though Tomas makes enough to get by in Oakland, he worries about his unsteady income. As an undocumented male migrant laborer, his safety net and social network is highly limited. He has few public programs to turn to and no private network to provide him with financial or emotional support as he tries to make ends meet.

Both Mari and Tomas face challenges as undocumented, Latinx immigrants, but the difference between them is that while Mari has found some support through her networks and in the form of social services, Tomas has a more limited safety net and social network. In this dissertation, I argue that the pathways and forms of access to social services for disadvantaged Latinx populations are distinctly gendered, with a broader institutional opening for mothers and a minimal, narrow institutional opening for men. While most studies to date on accessing services have focused on women and in particular, mothers, few studies have deeply explored the question of how this process plays out for men. Past research has documented how the U.S. safety net has been racially exclusionary, gendered, and has generally cast out non-white immigrants. However, few studies have approached studying the welfare state from a more intersectional lens.

In this dissertation, I show one's immigrant identity and legal status intersects with gender to form different pipelines for undocumented Latinx immigrants. I use the term pipeline because it highlights the restrictive nature of federal immigration policies in the United States. A pipe is continually bounded, but much like immigration policies in the past century, it can expand and contract with changes in political climate (and labor needs). Pipes can also come in

many shapes and sizes. The pipeline to services is narrow for all respondents I spoke to, but there are institutional mechanisms and network structures that make the pipeline to social services wider for mothers. As I will show in this dissertation, women with children often benefit from “guiding figures,” or other women who help them navigate a limited social service infrastructure and inform and literally help transport women to different institutions. Men, on the other hand, often come as sole laborers with limited, predominantly male ties who offer support in the way of work and housing, but do not openly engage in information sharing on social services. This limited information sharing stems in part from their even more restricted access to public programs, and from a culture of masculinity that emphasizes one’s labor over one’s health and well-being. This leaves many men and non-mothers excluded from key services with important consequences for their health and well-being.

Despite the obstacles individuals are up against, however, they still persevere in their quest for resources for themselves and their children. Even though the state uses racially coded rhetoric to exclude immigrants from services and stigmatize participation in public aid programs, not all immigrants internalize the negative rhetoric used against them to restrict their use of services from the state. In other words, they outwardly denounce the labeling of immigrants as “illegal,” “criminals,” and “parasites”; instead, they emphasize their own legality, contribution to the state, and equality to others. The state’s rhetoric doesn’t determine how undocumented Latinx immigrants see themselves. By studying access to the safety net from an intersectional lens, I illuminate how the state sustains and reproduces gendered pipelines, but I also show how individuals adapt to these pipelines and challenge the rhetoric that helps produce and reproduce these narrow, exclusionary paths to services for those in need.

Contextualizing the Safety Net and Welfare State: The Case of the United States

By and large, the United States has a limited safety net when compared to other Western countries including France, Germany, and Nordic countries which are known for their generous safety net and robust welfare state. Most notably, the United States has limited re-distribution of taxes, no universal health insurance, an outdated measure of poverty that largely underestimates costs of living, and a stick-driven system for cash aid. This is important to keep in mind because the welfare state not only restricts its aid to immigrants, the nation also restricts its aid to the general population at large. By pitting populations against each other to vie for different services and by stigmatizing the use of state resources to provide for one’s self and/or one’s family, the state deters individuals from accessing key resources in the first place. The neoliberal state has stealthily shifted the rhetoric of decent housing, food, and healthcare as a privilege and not as an entitlement afforded to those in need.

Given the limited scope of federal aid, the United States has historically had a voluntary third sector in the form of non-profit organizations including religious institutions that have taken on food assistance and other forms of material relief for populations in need. Especially since the turn of the 1970s, the federal government has delegated aid and social service provision to non-profit organizations through Community Development Block Grants (CDBGs). These grants are given to local levels of government which in turn distribute some of the funds to community-based organizations that must apply for funding. While federal funding for public programs is limited overall, there is wide variation in the services offered at a sub-national level through states and local governments, particularly for immigrant populations, which I describe more in detail in next chapter. Suffice to say that the U.S. safety net is comprised of public and

private institutions, is means-tested and relatively limited in scope, and there are considerable differences across states, counties, and cities in the amount and variety of services that are offered to those in need.

A Racially Exclusive and Gendered Welfare State

Given that there is limited funding to go around for different forms of social services, how are these services allocated? Two major dimensions along which U.S. public programs have been historically delimited are through race and gender. In other words, the U.S. welfare state has generally been racially exclusive towards non-white populations, and it makes gendered assumptions in the way that public programs are prioritized and set-up.

The practice of excluding racial and ethnic minorities from public programs has been long-standing in the United States. When the Social Security Act was first established in 1935, the state did not exclude any racial or ethnic group by law, but it did exempt agricultural workers and domestic workers from Social Security and Unemployment Benefits. Because a majority of the African American and Mexican population worked in agriculture and domestic service, this led to many of them being cast out of these social insurance programs in practice (Katznelson 2005). During the New Deal Era, African Americans and Mexican immigrants were legally eligible for food assistance and assistance for the elderly, but they were largely discriminated against at aid offices. Furthermore, cities with larger populations of African Americans lowered their aid distribution compared to states with larger populations of White, European immigrants, solidifying the racially coded and exclusive nature of aid redistribution in the United States (Fox 2012).

Following World War II, African Americans were largely denied many of the provisions for veterans including mortgage assistance and funding for higher education through the GI Bill (Katznelson 2005), and it is possible, even likely, that other veterans of color were denied these provisions as well. Even if racial minority populations were eligible for programs like Aid to Dependent Children, through the 1960s, women of color were subjected to “midnight checks” where caseworkers would come into welfare recipients’ homes in the middle of the night to ensure that they were not involved with any man who could potentially be providing for her children. Women of color also faced pervasive discrimination from caseworkers who were more punitive with black and Latina mothers – a practice that is still documented to this day (Reese 2011, Schram et al. 2009). The racially coded welfare state has in many ways contributed to the current racial wealth gap.¹

Beyond discriminating by race and gender, the American safety net has also excluded people based on their citizenship or legal status, although legal exclusion of non-citizens from public benefits is a more recent development. Prior to the 1970s, the federal law on the books often included non-citizens in the U.S. welfare state, even as non-white immigrants were historically excluded in practice (Fox 2012). However, as I describe in the following chapter, the welfare state has become more legally restrictive towards immigrant populations since the 1970s, which contributes to a widening of the financial and social inequality between citizens and non-citizens in the U.S.

¹ According to the Urban Institute (2017), in 2016, the average wealth of White families (\$919,000) was seven times greater than the average wealth of Black families (\$140,000), and five times greater than the average wealth of Latino families (\$192,000). This is higher than the racial wealth gap in 1963.

In gender analyses of the welfare state, scholars are generally divided between two lines of thought. On the one hand, public aid programs often assume men as breadwinners and women as dependents, which reinforce heteronormative, patriarchal norms. That is, men have historically had ample government benefits through their role as laborers and women have historically had access to benefits through their motherhood. On the other hand, scholars have also documented how welfare programs can serve as a leveling mechanism when the state provides aid for mothers and their children, independent of their marital status. Past work by Skocpol (1992) has also documented how women used the status of their motherhood to leverage more resources from the state. In the early twentieth century, women who did not even have the right to vote, advanced campaigns to forward widow's pensions as state protections for mothers. One popular women's magazine, *The Delineator*, launched a campaign for mothers' pensions with an article entitled, "Four Counties that Prefer Mothers to Orphan Asylums" (Skocpol 1992: 435). Later in the series, one article advocating for widow's pensions read the following: "set the children free! [...] Let the mothers earn their living from the State by doing the most useful thing they could possibly do – bring up their children!" (p. 437). The rhetoric behind the campaign was far from feminist, but it helped activate women to get politically involved for welfare rights.

Whether critiqued as patriarchal or held up as an access pathway, mothers' access to cash benefits generally comes front and center in analyses of the welfare state, which leaves many men left out of the welfare state literature. When men are discussed in the literature, the focus is on their roles as breadwinning fathers, not as caregivers (Curran and Abrams 2000). Connell (1995) further makes the argument that the state exerts symbolic violence upon men who are marginalized along class, race, and sexuality by reinforcing a "hegemonic masculinity" through assuming their roles as breadwinners and fathers. Indeed, research on single, custodial fathers indicates the challenges they face at welfare offices and with subsidized childcare programs, as caseworkers raise suspicions around their caregiving role (Hamer and Marchioro 2002).

With the passage of welfare reform, the state rhetoric around fatherhood did slightly shift to take caregiving into account with the emergence of parenting programs for fathers. However, the fatherhood programs still have women as intermediaries between men and the state (Geva 2011). Even though the welfare state has now acknowledged the wage-earning power of women and, to some extent, the caregiving capacities of men, it is still under the assumption and project of maintaining heterosexual, two-parent families with children.

Indeed, most scholars of the welfare state do not closely examine other programs that exist for low-income individuals. Such programs include food assistance, health care, elderly assistance, unemployment benefits, and subsidized housing. Scholarship on accessing food assistance programs and public health care coverage either focus solely on women (Kaiser 2008) or are generally gender neutral and focus on households as a unit of analysis (Algert, Reibel, and Renvall 2006). Public programs for veterans do generally enroll more men than women, and in this line of research, scholars note the information and stigma barriers that limit veterans access to such programs. However, they also note the importance that trusted ties play in encouraging veterans to seek disability assistance for post-traumatic stress disorder (Sayer et al. 2011). Yet, more focused, qualitative research on men's experiences navigating public programs remains to be explored.

Bridging Immigration Literature with Gender Analyses of the Welfare State

In the immigration literature at large, scholars are often focused on what factors influence immigrants' adaptation into U.S. society. Their focus is often on the second generation, the children of immigrants, as the appropriate focus for integration or 'assimilation.' When scholars examine the adaptation of the adult first generation, they often focus on employment. When it comes to gender, such research often describes the gendered labor markets that dominate the U.S. landscape. Immigrant women may be more prone to take on jobs in private spaces (e.g. housecleaning and/or caretaking), while men may be more prone to take on jobs in public spaces (e.g. construction and/or restaurant work).

Beyond the workplace, scholars have also been attuned to the role of gender in shaping immigrants' involvement with public institutions like schools and hospitals. In their role as mothers, women are more likely to have more contact with social service institutions as they vie for resources for them and their children. Indeed, more recent immigration literature has described how undocumented mothers navigate different public programs for their young U.S. citizen children (Yoshikawa 2011), how undocumented Latina women became empowered through their involvement with NPOs in San Francisco (Coll 2010), and the lack of deservingness that undocumented Latina women may experience as they receive different services at different non-profit organizations in San Francisco (Gast and Okamoto 2016). While these important studies document the challenges and rewards that may come from the social service seeking process, they are all focused on the experiences of immigrant women, and in particular, mothers. This is not that different from the general literature on the welfare state in the United States and disadvantaged individuals' use of the safety net. What do we make of the experiences of immigrant men?

My work takes on an intersectional lens as I examine how immigration status and gender intersect to shape the pipelines and access to services for Latinx men and women. I find that while both men and women are often subjugated to informal labor markets that render them with no health insurance, no unemployment benefits, and no worker protections, women are able to use their status as mothers to gain access to public programs, at least temporarily, through the county and state. Men, on the other hand, have little recourse to public programs, and require more targeted interventions to get access to services they qualify for, as limited as they may be. However, even as men and women navigate services, they must still confront discrimination, bureaucratic barriers, and other information barriers, which can hinder their physical and emotional health. Some people persist and garner the resources they need, but at what price?

Methods

To understand how gender and immigration status influence social service access, I draw on three data sources: informational interviews with twelve social service providers in urban and suburban locations, semi-structured in-depth interviews with eighty-five, low-income Latinx immigrants who had immigrated to the United States as adults, and participant observation in several settings where disadvantaged immigrants find formal and informal help. I served as a bilingual intake volunteer at a multi-service non-profit organization; I taught English and citizenship classes at a community-based organization; I volunteered at citizenship workshops; I participated in a Spanish-speaking prayer group; and I volunteered as a Spanish interpreter at a free medical clinic.

Below, I further describe my interview samples, recruitment methods, and site selection, but for confidentiality purposes, I do not provide extensive details of the fieldwork sites. I volunteered and prayed in these sites because I wanted to gain a better sense of the spaces respondents went to seek material, psychological and spiritual help, and to put the interview material into the perspective of actual experiences and activities. However, I did not want to compromise the sanctity of private spaces, like prayer groups or medical clinics, by asking for permission to write down notes for my fieldwork. For public events, like citizenship workshops, I wrote extensive field notes on how they operated and where they took place. The analysis in this dissertation thus is informed by my participant observation, even if I do not always note specific details or events that took place.

Descriptive Data on Cities and Suburbs

My research focuses on NPOs and residents located in Oakland, California (in Alameda County), and two suburbs in eastern Contra Costa County – Concord and Antioch.² (See Figure 1.)

[Insert Figure 1 Below]

I selected these study sites because they have roughly similar racial compositions and proportions of immigrants, but whereas Oakland is a traditional dense urban city, Concord and Antioch are suburbs of Oakland. The urban/suburban comparison in my project allows me to gain a qualitative portrait of how significant demographic changes on the national landscape affect people's service access. More specifically, starting in the 1990s, and really taking off at the turn of the millennium, the poverty levels in the suburbs have significantly grown, and now a majority of people experiencing poverty live in the suburbs (Kneebone and Berube 2013). At the same time, migration patterns have drastically changed as more international immigrants are directly migrating to the suburbs and other new gateway destinations (Singer et al 2008).

The shifting geography of poverty and immigration to the suburbs leaves social service providers in the suburbs with increased demand for services, but less resources and infrastructure to meet this demand (Allard 2008, Weir 2011, Murphy 2010). Academics term the uneven match between services needed and services available in the suburbs as a spatial mismatch, which is even more pronounced for immigrant populations in finding culturally and linguistically competent service organizations and providers (De Graauw, Gleeson, and Bloemraad 2013; Joassart-Marcelli 2013; Panchok-Berry, Rivas, and Murphy 2013, Roth and Allard 2016). While researchers have quantitatively documented the spatial mismatch between social service organizations and individuals in poverty in the suburbs, less research has been devoted to understanding how low-income, and specifically immigrant populations access and receive services in the suburbs.³ My project begins to fill in this gap by comparing the service seeking processes of residents living in Oakland to that the inner ring of Concord and the outer ring suburb of Antioch. I provide demographic characteristics of three study sites in Table 1 below.

[Insert Table 1]

² While I conducted most interviews with residents of Antioch, I also spoke to four respondents from neighboring suburbs including Pittsburg, Martinez, and Bay Point.

³ One notable exception to this is Roth, Gonzalez, and Lesniewski (2015) which surveys immigrant-serving organizations in the Chicago region on the challenges and strategies for providing services to immigrant populations in the suburbs.

Oakland

Oakland is one of the closest, and by far the largest, city east of San Francisco; it had approximately 420,000 residents in 2016. Like other major cities, Oakland is very dense – it had about 7,000 residents per square mile in 2010, and its poverty levels have remained relatively high but constant since at least 1990 (hovering around 19-20% in the past three decades). Oakland's population has historically been racially diverse, and according to 2016 American Community Survey estimates, 24% of its population was African American, 16% was Asian, 5% was multiracial, 27% was Latinx, and 27% was non-Hispanic White. About 27% of the population was foreign born and 15% were non-U.S. citizens (ACS 2016). Thus, it has many of the markers of an urban space (large size and high density), and urban place (a central socio-political location with a history of poverty and immigration).

In comparison to its suburban counterparts, Oakland has a robust public transportation system, which consists of several stops along the Bay Area Rapid Transit (BART) line, a high-speed rail system that extends into multiple counties in the Bay Area region. Oakland also has multiple bus lines running through the city, which connect to places like San Francisco and Berkeley. The robustness of the public transportation system has implications for service access because it can facilitate people's access to different organizations, particularly for those with no private vehicles. In terms of industry and employment, the manufacturing industry has been historically prominent in Oakland, but with the advent of deindustrialization starting in the 1960s, Oakland's manufacturing sector has slowly lost its stronghold as Oakland's economy gave way to a more jobs in healthcare and education. Kaiser Permanente, for example, has its roots in Oakland and is the top employer in the city (City of Oakland website). Other prominent employment sectors include the scientific and technical services, the retail industry, and to some extent, manufacturing and construction (ACS 2016).

In terms of Oakland's immigration past, the city has historically had a large and diverse immigrant and refugee population hailing from countries all over the world. For example, Chinese immigration to Oakland dates back as far back as the 1850s, when they participated in building California railroads, among other public works projects. As far back as the 1960s, about 20% of residents in East Oakland were reported to have Spanish surnames (this is before the Hispanic category was invented), and 8% of the population in Alameda County was born in Mexico, though presumably, the percentage was higher in Oakland (Social Explorer Data). According to 2016 American Community Survey estimates, 46% of the foreign-born population comes from Latin American countries, compared to 41% of the foreign-born population hailing from countries in Asia. Approximately 46% of the Hispanic population is foreign-born, which implies that roughly half of the Latinx population is first generation, while the other half is second generation or higher.

Concord

Concord is a medium sized-suburb in Contra Costa County with nearly 129,000 residents in 2016, and a density of 4,000 per square mile compared to 7,000 in Oakland. It has had relatively low, but growing rates of poverty (8%-12% from 1990 to 2016). In 2016, 27% of its population was foreign-born, and 15% of the population was not naturalized. According to ACS estimates from 2016, 4% of its population was African American, 11% was Asian, 4% were multiracial, 31% were Latino, and 49% were non-Hispanic Whites.

Concord is the largest city in Contra Costa County, and since 1973 it has been the terminus for the Bay Area Rapid Transit (BART) system that quickly connects it to other cities in the region. It also has county buses, which run through the city and connect it to other nearby suburbs in Contra Costa County. This said, the public transportation system is less developed than that of Oakland, this is despite its standing as commuter town. According to Concord's 2016 Comprehensive Financial Report, the top four employers in Concord include Bank of America, John Muir Medical Center, PG&E, and Mount Diablo Unified School District (139). Nearly a fifth (19%) of Concord's employed population reported spending at least an hour commuting to work in 2016, compared to 14% of employed Oakland residents (ACS 2016); longer commutes can exacerbate time constraints for those who are employed to seek social services outside of work hours.

In terms of immigration, Concord has a more recent immigration history than Oakland – most growth in the foreign-born population was during the 1980s when the foreign-born population doubled in western Concord from comprising around 10% of the population in 1980 to 20% of the population in 1990. The city, as a whole has had about a quarter of its population been foreign-born since 2000 (Social Explorer Data). The foreign-born population has historically been majority Latinx, although a substantial Asian immigrant population has been present as well. Currently, 52% of the foreign-born population hails from Latin American countries, with 33% of the foreign-born population hailing from countries in Asia. Approximately, 46% of the Hispanic population in Concord is foreign-born indicating a slight majority of second generation Latinx immigrants, or higher (ACS 2016).

Antioch

Antioch is an increasingly racially diverse suburb about 40 miles east of downtown Oakland, and about 16 miles east of Concord. In 2016, it had nearly 111,000 residents, and it had a density of 3,600 residents per square mile, roughly half that of Oakland. Slightly over a fifth of its population (22%) was foreign-born in 2015 ACS estimates, and 11% of its population was not naturalized according to those same estimates. The most recent American Community Survey estimates indicate the following representation of different ethnic and racial groups in 2016: 19% African American, 10% Asian, 5% identified as multiracial, 33% Latinx, and 31% non-Hispanic White.

The suburb of Antioch has recently been in the spotlight for researchers focusing on the suburbanization of poverty (Kneebone and Berube 2013), and recently, it gained media spotlight as the National Public Radio (NPR) station did an entire series on the changing suburb.⁴ According to ACS estimates, 14% of people lived in poverty in 2016, this is compared to 8.5% in 2000. Other major demographic change includes a near doubling of the foreign-born population from comprising 14% of the population in 2000 to 22% in 2016. Due to the doubling of those in poverty and of the foreign-born population, service providers may be particularly hard-pressed to meet growing needs. Moreover, suburban residents may face more exacerbated constraints to services than Concord given its more limited public transportation infrastructure, which may make it hard to access organizations without a private vehicle. Long commuting times may also cut into their availability to set and make social service appointments; a full third of employed residents (33%) report spending at least an hour commuting to work. Like Concord, Antioch has limited employers based in the suburb. According to the City of Antioch's website,

⁴<https://www.kqed.org/news/series/american-suburb-podcast>

the top three employers in 2016 were Kaiser Permanente, Antioch Unified School District, and Sutter Delta Medical Center.

Surprisingly, Antioch has a longer history of Latinx immigration countries than Concord. In 1960, about 15% of residents in central Antioch were reported to have Spanish surnames, and 11.1% of the population in Contra Costa County was born in Mexico, though presumably, the percentage was higher in agricultural regions in the eastern part of the county. According to 2016 American Community Survey estimates, 50.4% of the foreign-born population comes from Latin American countries, compared to 37.4% of the foreign-born population hailing from countries in Asia. Approximately 33.7% of the Hispanic population is foreign-born, which implies that a large majority of the Latinx immigration population is second generation or higher. Thus, compared to Oakland, Concord historically has had relatively low levels of poverty and more recent experience with immigration. Antioch, by contrast, has had a more established presence of Mexican American populations than Concord, but has only more recently experienced a surge in international migration and poverty in the past fifteen years.

Informational Interviews with Organization Staff: Suburban/ Urban Nonprofit Infrastructures

To situate my research, I first wanted to gain a better sense of the social service infrastructure for immigrants in Oakland and its suburbs. To this end, I interviewed eight non-profit directors, attorneys, and program coordinators at each of the seven NPOs that provide legal aid to low-income immigrant communities in Oakland and Eastern Contra Costa County.⁵ I also interviewed four program coordinators from four other suburban multi-service NPOs that work with low-income Latinx immigrants in Contra Costa County after they were referred to me by suburban legal aid providers who were working extensively with these organizations. My interview questions focused on the organization's history, the demography of their clientele, and the processes of obtaining and retaining funding. I also asked questions about governmental ties and organizational partners to get a sense of their visibility and range of collaborative efforts. I analyzed the interview data using the qualitative data analysis software Atlas.ti with several deductive themes (e.g. funding difficulty, organizational ties, and challenges) and themes that arose inductively from the data (e.g., effect of funder on services, and cooperation with police departments).

In-depth Interviews of Latinx Immigrants: Resource-Seeking Processes

The second part of my research design comprised of eighty-five in-depth interviews with low-income immigrants. Because the majority of the foreign-born population in the United States, and in California, is Latinx, I focused on recruiting Latinx immigrants for my interviews. I recruited respondents through non-profit organizations that worked closely with low-income populations, including a food pantry, multi-service organization, an organization for parents with young children, and day labor centers. I also recruited respondents through churches, flea markets, and through other respondents. Most respondents (80%) in my sample grew up in Mexico, while the rest of respondents came from Central American countries including

⁵ I interviewed all the immigration legal aid NPOs in eastern Contra Costa County, and I interviewed all but one in Oakland – the Immigration Center for Women and Children, which is a more specialized legal service NPO.

Guatemala, Honduras, Nicaragua, and El Salvador.⁶ I only interviewed first-generation, adult immigrants (i.e. those who arrived in the United States at the age of 16 or older) because they did not grow up in a U.S. context and thus had to undergo a critical transition to new institutions upon coming to the United States. I did not screen participants for documented or undocumented status due to the sensitive nature of this question. I similarly did not pre-screen participants on their income, but rather, asked about their income as a demographic question at the end of the interview. Because I recruited many respondents through social service organizations that catered to low-income populations and flea markets and churches located in lower income neighborhoods, most respondents did fit the sample characteristics, with a few outliers, which I omitted from my sample.

The interviews lasted anywhere from forty-five minutes to two hours, with most lasting about an hour and a half. All but three of these interviews were conducted by myself in Spanish; the remaining three were conducted by a research assistant who also identifies as Latina and is a native Spanish speaker. Seventy-one percent of interviews were tape-recorded; I wrote down detailed notes for respondents who preferred not to be recorded. At the end of the interview, I collected demographic information on a participant's age, years in the United States, income, and household and family composition, which included the age and number of children they had inside and outside the United States – all factors that could affect respondents' access to resources. I provide a more detailed description of my experience recruiting and interviewing respondents, and how my positionality may have affected this overall process in a methodological appendix (see Appendix A).

For the interviews, I asked respondents about their migration histories, and their experiences accessing resources such as housing, employment and services including health care, food assistance, education, and low-cost legal aid. I also probed about how their legal status affects their day-to-day lives, including how it impacts their access to different resources and services. I analyzed all the data using a series of inductive and deductive codes in the qualitative software program, Dedoose. I was assisted in coding by five research assistants who provided valuable input in the coding process and helped clarify and strengthen the operationalization of themes in the codebook. For example, in the initial rendition of my coding, I asked research assistants to code transcribed interviews for any mention of service seeking activity (e.g. going to food pantries or free medical clinics), but we soon realized that we needed to create a more detailed code that specified which service they were seeking (e.g. food assistance vs. medical service). For the first three or five interviews that research assistants coded, I conducted quality checks to ensure all appropriate phrases were coded and to discuss any questions on the process. When few discrepancies arose during the quality checks, I stopped the quality checks and instead, research assistants brought up any questions or concerns about coding during our weekly meetings. Overall, research assistants coded forty interviews, while I coded the remaining forty-five.

Mexican Migration History Redux

Because the vast majority of respondents in my sample (80%) are Mexican immigrants, I want to provide a bit of historical context to situate the respondents' biographies and migration histories. The history of migration between Mexico and the U.S. is longstanding. Most of the

⁶ I had two respondents who were raised in Nicaragua and Honduras, but most Central American respondents I spoke to came from Guatemala and El Salvador.

present-day U.S. Southwest, including California, was Mexican territory prior to late nineteenth century. However, when the Treaty of Guadalupe Hidalgo passed in 1848, Mexican nationals legally became foreigners in their own land. Most of the Mexican nationals were wealthy landowners who enslaved indigenous tribes to work on their land, and as such, the Mexican population was sparse in the Southwest in 1848 (estimates range around 50,000) (Jiménez 2010: 33). However, the migration from Mexico to the United States quickly grew in the early twentieth century with the onset of political revolution and the subsequent commercialization of agricultural production in Mexico, technological advances that facilitated ease of travel between the two countries, and with labor shortages in the United States that were ameliorated, in part, by Mexican laborers (Henderson 2011).

Some key historical moments that have defined Mexican American migration through the decades include: the Bracero Program, which ran from 1942-1964 and mostly employed male migrants to take on seasonal labor on farms; the Hart-Cellar Act in 1965, which facilitated family reunification in the United States, and the Immigration Reform and Control Act (IRCA) in 1986 that simultaneously increased enforcement at the Mexican border and granted amnesty to pre-existing immigrants in the U.S. The North American Free Trade Agreement (NAFTA) in 1994 also incentivized South to North migration as the agricultural industry in Mexico became even more commercialized and pushed farmers in Southern Mexico to the U.S. for work. Particularly during the 1990s, more restrictive immigration policies became implemented at a national level which affected migration flows. Notably, the Immigration Reform and Immigration Responsibility Act (IIRIRA) in 1996 increased funding for border control and enforcement, and toughened penalties for smugglers and undocumented immigrants, among other more restrictive policies. Throughout the century, we see a trend of pulling Mexican nationals in to meet labor demands in the U.S., and simultaneously pushing Mexican nationals away from becoming politically integrated in the nation state.

Central American History Redux

Apart from Mexico, respondents in my sample came from two main Central American countries with more recent immigration flows to the United States: Guatemala and El Salvador, countries which along with Honduras, are commonly referred to as the Northern Triangle. According to a report by the Migration Policy Institute, in 2015, eighty five percent of Central American immigrants came from Northern Triangle countries, and they comprised eight percent of the U.S. foreign-born population. As highlighted during the influx of unaccompanied minors in 2014, many Central Americans are fleeing political violence, which stems, in part, from civil wars which plagued Guatemala from 1960-1996 and El Salvador from 1979-1992. Even though Honduras did not undergo a formal civil war during this period, it has experienced high political instability as well. In all three countries, the United States government was involved in political affairs by helping fund and arm more centrist parties to fight leftist rebels (Leogrande 1990).

In 1998, the United States government granted Temporary Protected Status (TPS) to residents in Honduras following Hurricane Mitch, which allowed Honduran nationals an opportunity to live and work in the United States with a temporary, renewable permit that exempted them from deportation. Three years later, in 2001, two major earthquakes hit El Salvador, and the U.S. granted TPS to Salvadoran nationals as well. Although several Central American respondents I interviewed had TPS at the time of the interview, the status is due to be suspended in July 2018 for Honduran residents and September 2019 for Salvadoran migrants due

to federal administration changes.⁷ This is despite the fact that the U.S. Department of State has issued travel warnings for all three countries because of their high homicide rates and crime rates. In fact, according to a 2017 Doctors Without Borders report, 39 percent of migrants from Northern Triangle countries reported migrating North through Mexico due to “direct attacks or threats to themselves or their families, extortion, or gang-forced recruitment;” “44 percent had a relative who died due to violence in the last two years;” and, 55 percent of Salvadorans reported being the victim of blackmail or extortion with 56 percent having a relative die due to violence in the past two years.

Gendered Migration Patterns

Due to ebbs and flows of immigration laws through the past century – and an increasingly more globalized economy, the gender composition of migrants has changed over the past few decades in the United States. Starting in the 1970s and intensifying in the 1990s, the increased border control and criminalization of immigrants reduced circular migration patterns that had previously existed, especially with seasonal laborers, like farmworkers and braceros. Instead of migrants having more flexibility in returning Mexico to see their networks and/or work, undocumented immigrants began to settle in the U.S. more permanently. The settlement of Mexican migrants in the U.S. then helped facilitate migration of friends, families, and hometown acquaintances North, and as illustrated in the international migration literature, this model of pioneer versus family reunification migration took on gendered patterns. Men were more likely to be the first in their families to migrate to the United States, with women, including wives and children following after (Garip 2012).

In the 1990s, international migration became more feminized as women left their families to economically sustain them. However, contrary to men, Mexican women migrants were more likely to have pre-established networks in the United States to help facilitate their transition into the United States. Although as Menjívar notes with Central American immigrants, the support levels from these ties was limited (2000). As such, the migration histories of my respondents reflect these gendered patterns. Eighty-three percent of men in my interview sample were the first in their families to migrate North and had weak ties, if any, upon arrival in the U.S. This was in contrast to the fifty-seven percent of women in my sample who immigrated to join their spouses or other family members in the United States. As shown throughout this dissertation, these gendered migration patterns hold important implications for their access to social services. More detailed demographic information on respondents, broken down by gender, is shown in Table 2 below.

[Insert Table 2 here]

For the women in the study, approximately fifty-nine percent were undocumented at the time of the interview; the remaining forty-one percent had either legal permanent residency, had been granted asylum status, acquired U-visa status, or had become U.S. citizens.⁸ All, but five of

⁷ Other TPS countries are due to have suspensions, including Nicaragua which was granted TPS status in 1999 after Hurricane Mitch.

⁸ Respondents who are legal permanent residents have a green card, which grants them long-term residence and allows them to seek formal employment in the U.S. After five years, they may apply for U.S. citizenship. Those who are granted asylum status are allowed to stay in the U.S. as long as the country of origin is still deemed dangerous to return to by the U.S. government. After one year of asylum status, individuals can apply for a green card, or legal permanent residency status. U-visas are designed for victims of domestic crime, and they initially allow respondents

the women in my sample were undocumented in the United States at one point of time, but of those previously undocumented, ten women subsequently acquired legal immigration status through their spouses or through seeking political asylum. The average age for women in my sample was 42 years old, and they had lived in the U.S. an average of 15.5 years. Approximately fifty-five percent of women had received less than a high school education, while twenty-five percent of women received a high school diploma. Nearly twenty percent of the women in the sample had received some form of college education from their country of origin. The fact that over half of the women did not have the opportunity to finish high school reflects the limited educational opportunities many confronted in rural villages living in households that faced severe economic hardship. Those who had some college in their country of origin did come from more economically advantaged backgrounds and most of them came to join their spouses or husbands in the U.S.

About half of the women in my sample were homemakers while about a quarter of them worked as house cleaners or janitors and the other quarter worked as caregivers, vendors, or in retail. Only two women were unemployed at the time of the interview. Three-quarters of the women in the sample had a child under the age of eighteen at the time of the interview. Of the 51 women I interviewed, 18 (or around 35%) resided in Oakland, 12 (or around 24%) resided in Concord, and 21 (or around 41%) resided in East Contra Costa County, with all but two of them residing in Antioch, California.

Reflecting the gendered migration patterns discussed in the previous section, a majority of women (57%) had come to the United States to join their spouses or other family members; over one third of women (37%) came to the United States for better economic opportunities for themselves and their family; two women (4%) came to flee political violence. While about 9 percent of women left their spouse and/or children behind to come to the United States, most women in my sample either had spouses they were joining in the United States, or met their spouses and formed families in the U.S. I recruited fifty-one percent of women through non-profit organizations that offered food assistance or were directed towards low-income mothers, and I recruited twenty-four percent through different local churches. Nearly eight percent of respondents were referrals from interviewees; nearly four percent were recruited from worker centers. The remaining fourteen percent of respondents were recruited at local flea markets, schools, and referrals from other interview respondents.

Of the 29 men in the interview sample, 20 of them, or (67% of them) were undocumented at the time of the interview. An additional man was previously undocumented before acquiring visa status. The remaining ten men in the sample had either legal permanent residency or had acquired temporary protected status soon after arriving in the United States, so they had never lived without papers. Men, on average, were 47 years old, and had spent an average of 15 years in the United States. Nearly half of the men, or 48 percent, in the study had less than a high school education; while 28 percent of men had a high school education, and 24 percent had some college education. Again, the fact that three quarters of the men in my sample had a high school education or less is telling of the difficult economic circumstances they were in – many of them worked from a young age to help support their families and had limited educational opportunities

to access some public benefits, work legally in the United States, and after three years, they may apply for legal permanent residency status. This visa status contrasts the Temporary Protected Status (TPS), which some respondents held, because TPS does not allow a path towards permanent residency or citizenship. TPS has to be renewed (at a costly price) every year. Moreover, it can be terminated at any point, rendering former TPS recipients as undocumented.

in more rural parts of their countries. The men who did have some education beyond high school often came from larger cities and came to United States in the hopes of making more money. Nearly 14 percent of men in the study worked in construction or landscaping, 64 percent worked as day laborers, and the remaining fifth worked in the restaurant sector or in other industries. Only one man was unemployed at the time of the interview.

Nearly 60 percent of men in the study resided in Oakland, 35 percent resided Concord, and only two men resided in East Contra Costa County. Nineteen men (or 66% of the sample) grew up in Mexico, while the rest had grown up in Central American countries. Almost all of the men in the sample came to the United States for better economic opportunities for themselves or their families, with the exception of three men who came to join a spouse or parent and two men who sought political asylum in the United States. Nearly forty percent of men (37%) left their families, including their children in their country of origin, with some forming new families in the U.S.; a fifth were single with no children; and about forty percent (43%) had only formed families with children in the United States. Men's family situations had implications for service-seeking. Because some men left their spouses and children in their country of origin in order to better provide for them, they had limited networks coming into the states who could inform them of services. However, even those with a spouse and/or children in the United States were less informed of services than the women in my sample. I recruited 65.5 percent of men from worker centers, 14 percent of men from church, and about a fifth of the men interviewed were referrals from other interviewees.

In terms of differences in the demographic composition of respondents across study sites, I find that compared to larger, urban cities, like Oakland, those in suburbs more often migrated to join their family members there. More specifically, I found that over eighty percent of respondents in Antioch described migrating primarily to join their family members, compared to about half of respondents in Concord, and about a quarter of respondents in Oakland. Most respondents did have somebody that they knew coming upon to the U.S. – although some of those ties would come apart, or the support would be limited. However, the fact that most people in Oakland came for economic or safety/political reasons and reached out to family members ad hoc, meant that the obligation to those family members was less bounded. If one came primarily to join one's family, that meant a strong, robust support system was already in place to receive them. This had important consequences for the information and services they were then connected to as well.

A Moment in Time: The Role of Political Timing in Interviews

All of the interviews were carried out from the Summer of 2015 through the Fall of 2016. As such, they reflect the respondents' experiences in a specific point and time when local and national policies, on the whole, seemed to moving in a favorable direction for immigrants. People described the relief they felt from the passage of the AB60 bill, which allowed local residents to apply for state driver's licenses irrespective of legal status, and they also described the tremendous difference the Deferred Action for Childhood Arrivals (DACA) program made in their lives as their children could now work and attend institutions of higher education. While the presidential election did come up with some interviews with immigrants, the ramifications of the policies enacted since January 2017 are not captured in my research. Some might thus conclude that the experiences reported here represent a moment of greater access than since the election of Donald Trump. Yet, California has seen strong continuity in the services offered at the local

level, even as the federal government takes the state to court over immigration issues. More generally, my findings hold relevance for academics, service providers, and policy-makers on the crucial processes for accessing social services among politically vulnerable populations. My hope is that with a more informed understanding of the barriers and facilitators towards services and care, institutions can support mechanisms that allow low-income populations to be informed about and access crucial services.

Chapter Lay-Out

In the chapters that follow, I describe the multiple and overlapping barriers that Latinx immigrants may face in accessing social services. Chapter one provides a policy overview and detailed description of different social service programs available to recent and undocumented immigrant populations in California, and it describes the barriers that respondents confronted as they navigated these programs, and how these barriers were, at times, exacerbated in suburban spaces.

In chapters two and three, I detail how individuals eventually access social services despite the obstacles that they are up against. Chapter two focuses particularly on how co-ethnic, informal networks orient women to different resources for them and their children. While not easy, women generally have stronger family networks coming to the United States and come into contact with “guiding figures” who help women navigate different forms of services. In addition, their status as mothers, or mothers-to-be, institutionally opens up temporary access to public benefits. Informal networks and institutions combined help forge a conditional safety net. I also describe similarities in the resource-seeking process for women across legal status and place.

Chapter three describes how the resource-seeking process distinctly differs for men in the domain of healthcare. I tie this to a larger literature on shaping immigrant bodies for labor, all the while de-valuing their health. In an infrastructure with limited health care opportunities and within a larger federal narrative that positively frames immigrants for their labor, many men embrace their identities as strong, hard workers, and only seek health services in the event of a medical emergency (if that).

My last chapter focuses on the resilience articulated in people’s narratives to counter stigmatizing public discourse on undocumented immigrants. This study took place in a mostly politically progressive region in Northern California, and my last interview took place the day after Trump was elected. I can imagine that in a new federal era, the service-seeking process would only be much worse for immigrants, especially those who are undocumented and it would be much costlier in less politically progressive places. Despite this, I want to zoom in on the strength, resilience, and resistance that shine through in respondent’s stories. When confronted with criminalization and stigma in public discourse, immigrants emphasized their legality, strong work ethic, critically questioned the fairness and legitimacy of federal immigration policies, and they asserted their equality with others regardless of their immigration status. Their strength of conviction illustrates that despite the structural barriers facing vulnerable populations, their dignity is not compromised.

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Figure 1. Map of Study Sites



Table 1: Summary Statistics

	Oakland	Concord	Antioch
Population			
Population, 2016 estimate	420,005	128,786	110,898
Foreign born persons, percent, 2012-2016	27%	27%	22%
Percentage of foreign born population: Latin America	46%	52%	50%
Percentage of foreign born population: Asia	41%	32%	37%
Non-US Citizens	15%	15%	11%
<i>Ethnic/Racial Composition</i>			
Black or African American alone, percent, 2012-2016	24%	4%	19%
Asian alone, percent, 2012-2016	16%	11%	10%
Two or More Races, percent, 2012-2016	5%	4%	5%
Hispanic or Latino, percent, 2012-2016	27%	31%	33%
White alone, not Hispanic or Latino, percent, 2012-2016	27%	49%	31%
Percent of Foreign-born, Hispanic	46%	46%	34%
<i>Poverty & Crime</i>			
Persons below poverty level, percent, 2012-2016	20%	12%	14%
Crime rate (number of crimes per 100,000 people), 2013	1683	348	790
<i>Population Density & Time Commuting</i>			
Persons per square mile, 2010	7,004	3,996	3,611
Percentage of population with at least 60 minute commute	14%	19%	33%

Source: U.S. 2010 Census, 2012-2016 American Community Survey (ACS) Estimates, Guidestar 2015, and FBI 2013

Table 2. Demographic Information for Respondents in Sample**Gender**

Women	64%
Men	36%

	Women	Men
Undocumented	59%	66%
Average Age	42 years	47 Years
Average Time in U.S.	15.5 years	15 years
Education		
Less than High School	55%	48%
High School	25%	28%
Some College/University	20%	24%
Occupation		
Construction Worker/Landscaper	None	14%
Day Laborer	None	64%
Homemaker	52%	None
House Cleaner/Janitor	26%	None
Other	21%	21%
Unemployed	4%	4%
Place of Residence		
Oakland	35%	60%
Concord	24%	35%
East Contra Costa County	41%	5%
Motivation for Coming U.S.		
Join family	57%	10%
Economic opportunity	37%	83%
Political	4%	7%
Family Structure		
Left spouse and/or children to migrate	9%	37%
Only has spouse and /or children in U.S.	91%	20%
No spouse and/or children	N/A	43%
Point of Contact		
Churches	24%	14%
Non-profit Organizations	51%	None
Other	14%	None
Referrals	8%	21%
Worker Centers	4%	66%

CHAPTER 1: NAVIGATING AID AS AN IMMIGRANT IN CALIFORNIA

Magali, a 29-year-old single mother of two, described the birth of her first child as a harrowing experience – her child was over three weeks late and her labor had to be induced. What she imagined to be a natural childbirth turned out to be a C-section; she was so medicated, she doesn't remember holding her newborn son. Magali explained that her situation largely arose from the medical staff's inability to communicate with her in Spanish. The doctor who spoke to her had very limited Spanish, but they did not summon an interpreter at any point in her pregnancy. Magali wasn't informed of what was happening with her labor; she couldn't explain her desire for her intended childbirth, and overall, she felt devalued and disrespected. She explains, "there was a moment when I had four doctors in the room, and they knew that my son and me were in grave danger. And, I didn't understand anything because they wouldn't explain the gravity of the situation [in Spanish] [...] It was like that, and honestly it was a bad experience because I felt that they didn't attend to me like they should have [...] They weren't respecting me."

The language barriers Magali faced as patient illustrate one of the many complicated layers of challenges to accessing healthcare as an undocumented, Spanish-speaking woman. First, Magali had to make the decision, and arguably, risk, of having to reveal her legal status to hospital staff. Then, Magali had to navigate bureaucracy in a foreign language: what programs is she eligible for? How does she sign up for them? What are the steps that she can take to care for her and her child's health? Despite her best efforts, Magali ultimately had a traumatic labor experience and wished that she had done things differently and that the hospital had done more. She states, "To be honest, now that I'm more knowledgeable, I realize that that there are more options, and we can find options where they treat us better, where they can help us, but they don't tell us about those options. When you go to the clinic, they say, 'No, here, we can help you,' but they don't say, 'Oh, there are more resources where they treat you better, where you matter.'" Ultimately, Magali felt like the services provided to her at clinics were not helpful, and she was able to find better care at Kaiser, which was covered by a women's cooperative she joined a couple of years later. In describing her second pregnancy with Kaiser, she says, "[I had] better quality services, so everything was different. I scheduled a C-section and everything." When I asked her if her physicians spoke Spanish, she said, "Yes, and if they didn't, they would get me an interpreter." Even though Magali is grateful for the high-quality healthcare she receives now, she still remains jaded about the health care system as a whole.

Understanding the barriers that Spanish-speaking immigrants face navigating a complex social service system is necessary for medical practitioners who seek to understand the pains their patients make to step into their clinics or offices; it is also useful for service providers and client advocates who aim to streamline and improve the process for accessing services for patients in need. A body of research in public health already lays out the barriers that confront limited English patients (Ponce et al. 2006) and those with irregular legal status (Derosé et. al. 2007; Garcini et al. 2017; Portes, Fernandez-Kelly, and Light 2012). But much of this research focuses on unequal access to and utilization of health care services and focuses less on how patients become informed about and navigate the process of applying to and accessing health care services and other public programs. Exploring the processes that legally and/or linguistically vulnerable populations use to access social services can also be revealing of larger gaps in the

U.S. safety net that affect a broader population. The social service and healthcare system is immensely complex and full of obstacles, big and small, that patients have to navigate through.

In this chapter, I hone in on the legal and language barriers to social services confronted by liminally legal and/or limited English speakers. Having a liminal legal immigration status -- that is, being undocumented or have temporary legal immigration status -- and having limited English speaking abilities present challenges both at the point of access to services and in receiving services; legal and linguistic barriers can also strongly affect feelings of self-worth and overall trust in medical and/or governmental institutions. Before I describe people's on-the-ground experiences with accessing services, I briefly lay out the social policy landscape of what service immigrants have access to at a federal, state, and local level. As emphasized throughout my dissertation, the opportunities offered for women, and in particular, mothers, are much different from those of men. However, both populations face a multitude of legal and language barriers when accessing services.

Laying the Landscape: Social Services for Immigrants in the U.S.

As discussed in the introduction, the federal safety net in the United States is relatively limited compared to other countries, and historically it has been discriminatory towards non-white, low-income populations. For immigrant populations in particular, federal public benefits for immigrants started to become legally restrictive during the 1970s, the decade after the War on Poverty was launched. Undocumented immigrants were excluded from receiving Supplemental Security Income and Social Security numbers in 1972, Medicaid, and Aid to Families with Dependent Children in 1973, and they were barred from receiving food stamps in 1974 and unemployment benefits in 1976 (Fox 2016). In 1994, California voters overwhelmingly cast ballots in favor of Proposition 187 (capturing nearly 60% of the public vote), which would have barred undocumented immigrants from attending K-12 schools or receiving public non-emergency medical care and social services. Moreover, it required social service providers to cooperate with immigration officials to hand over information on individuals' immigration legal status. Within days of its passage, civil rights organizations including the ACLU, MALDEF, and LULAC filed four separate lawsuits contesting the proposition in federal district courts, and a temporary restraining order was issued on the proposition that same month. The civil rights organizations argued that denying undocumented children public education violated the Constitution's equal protection clause, and they asserted that the state had no right to determine such wide-sweeping immigration laws; that was only within the scope of the federal government. Ultimately, Judge Pfaelzer ruled the proposition unconstitutional based mostly on the latter grounds, although she also suggested that taking away health services from undocumented populations would negatively affected the general population. Ironically, she cited the federal overhaul of welfare through the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) as already delimiting non-citizens' access to services (Wroe 2008).

More specifically, with the passage of PRWORA, a five-year waiting period was imposed for recent legal permanent residents to receive services, along with other changes that set work requirements and a time cap for welfare participants.⁹ Since the passage of PRWORA, commonly known as welfare reform, states have opened up public benefit programs for recent

⁹ The PRWORA restrictions only apply to legal permanent residents (LPRs) who arrived in the United States after August 22nd, 1996. LPRs who arrived in the U.S. before that date, are still eligible for public programs.

immigrants. Concerned about meeting the needs of its recent legal permanent residents after the passage of PRWORA, Democratic California assembly members Dion Aroner and Marco Firebaugh introduced a bill in 2000 that would provide assistance to populations that were now cut off from federal public programs.¹⁰ More recently, the Health4All Kids campaign – one spearheaded by non-profit organizations, foundations, and community-based healthcare providers– used the language of human rights to successfully pass the Health for All Kids Act in 2015. This act extended Medi-Cal eligibility to minors under age of 19, without regard to their legal status.¹¹

Why Inclusion in Social Service Access Matters

Why does inclusion to services for immigrant populations matter? As past scholars have noted, one's interactions with service providers can largely shape one's level of trust in governmental institutions (Kumlin and Rothstein 2010) and one's overall feeling of belonging in the United States (Calvo et al. 2017). While more positive interactions can result in more general sentiments of inclusion and further facilitate civic engagement in the United States, more negative interactions can lead to feelings of isolation, anxiety, and/or anger and result in a retreat from public life or willingness to apply for more programs or acquire more resources (Joseph 2011).

At a broader, policy-level, even federal programs that are intended to be inclusive, such as the Affordable Care Act, have the potential to sharpen boundaries between immigrants who are legally eligible for the ACA and immigrants who are not eligible for ACA are subsequently fiscally and socially punished for it because they have to pay an extra tax to the government for being uninsured, and they feel even more left out as they are excluded from this massive federal policy (Joseph and Marrow 2017). Thus, individuals' interactions with social service entities and bureaucrats has significant short and long-term consequences for immigrant populations across generations.

In the sections that follow, I briefly describe the kinds of assistance that exist for recent and undocumented immigrants in California and in the study sites I focus on in my dissertation. Although the federal context is overwhelmingly restrictive for undocumented immigrants, subnational initiatives and programs along with private sector actors significantly shape the scope of services available to immigrant populations in need. California in particular has the most generous safety net for recent and undocumented immigrants, and as of May 2014, California was the only state to have assistance programs for recent immigrants and/or undocumented populations in the realms of 1) food assistance, 2) health coverage, 3) assistance for seniors and persons with disabilities, and 4) assistance for families (Pew Charitable Trusts 2014). The social service programs I will describe are those that were most mentioned by respondents during interviews, and thus are some of the most wide-reaching programs at a national, state, and/or local level. For the following description of the programs, I draw on secondary sources as well as fieldwork observations to contextualize different services and give readers an on-the-ground description of their service locations. The summary of the programs

¹⁰ http://www.leginfo.ca.gov/pub/99-00/bill/asm/ab_2401-2450/ab_2417_cfa_20000403_151123_asm_comm.html

¹¹ The Health4AllKids campaign is only one of several organized by the Health4All Coalition, which aims to expand health care coverage to all undocumented populations. It's website states, "health care is a *human right* and providing health coverage to everyone – regardless of their immigration status – is the *right thing to do*." <http://health4allca.org>

that are available to recent immigrant and undocumented populations in California is shown in Table 3 below.

[Insert Table 3]

Health Care

One of the main social welfare programs discussed by respondents during interviews was public health care. Behind Social Security and Medicare, Medicaid is the third largest public benefit program in the United States (Kaiser Family Foundation 2015).¹² The Medicaid program was established in 1965 for health insurance coverage for low-income adults, and it is jointly funded by state and federal funds. Medi-Cal is California's form of Medicaid, and currently serves 13 million California residents – approximately a third of California's population (California Department of Health Care Services 2017). The high percentage of certified and eligible Medi-Cal recipients in California is due in part to the passage of the Affordable Care Act (ACA) in 2014, which opened Medicaid coverage to low-income adults in Medicaid expansion states (as of July 2016, 31 states and Washington D.C. have decided to opt into the expansion). Currently, ACA expansion clients comprise 29% of all Medi-Cal recipients (California Department of Health Care Services 2017).

Full-scope Medi-Cal provides a wide variety of services including preventative care, primary care, lab tests, and dental benefits, among other services. The full-scope Medi-Cal program is available to eligible, low-income adults with legal immigration status, and for pregnant women and children under the age of 19 without regard to legal status, if they meet the income requirements, which is 138% of the federal poverty line – or around 22k for a two-person household in 2017.¹³¹⁴ There is also Emergency Medi-Cal, which provides funds for state residents to cover verifiable *emergency* medical expenses as long as they make less than 138% of the poverty line. While Medicare is a significant federal health insurance program for seniors and younger people with disabilities, it is only available to U.S. citizens and legal permanent residents who have resided in the U.S. for over five years and have paid into the Medicare system for a minimum of ten years. It is thus unavailable to recent and/or undocumented immigrants.

In terms of primary care, there are federally qualified health care centers, or FQHCs, which are centers that provide primary care for uninsured populations in under-served areas. FQHCs are federally funded by the Health Resources and Services Administration (HRSA) and are only able to provide services for uninsured populations on a sliding scale and require individuals to become members of the center in order to receive services. There are no restrictions on services based on one's legal immigration status, although undocumented individuals typically pay more for health services out of pocket given their limited access to public health insurance coverage. The number and scale of FQHCs can vary largely from one city to another, as well as the size and capacity of clinics operated in different locations by the same FQHC.

¹² <https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/>

¹³ The Children's Medical Insurance Program (CHIP) is subsumed under Medi-Cal, and it served around 1.9 million children in California in 2016.

¹⁴ There was a health insurance program in California called Healthy Families for legal permanent resident and U.S. citizen children who were low-income but made more than the minimum threshold for Medi-Cal, but this was discontinued in 2013.

For example, La Clínica is one of the most well-known FQHCs in the Northern California region. La Clínica was founded in Oakland in 1971 as a small store-front operation, which expanded into over 40 clinics throughout the region in the next four decades. The largest clinic is located in a predominantly Latinx neighborhood in Oakland that is easily accessible by the Bay Area Rapid Transit system (or BART), and it serves over 22,000 patients per year. The bright yellow building is easily identifiable as it is postmarked with bright blue signs pointing towards La Clínica as soon as one steps outside of the BART station. Stepping into the clinic, one immediately sees signs pointing to a variety of clinics one could access. When I came into the clinic for my own fieldwork, I encountered large, full waiting rooms at various clinics, and several receptionists at each front desk, which spoke to its large capacity and multi-faceted operation.

The Oakland clinic contrasts the much smaller Concord clinic, which is located near the center of the city, making it relatively accessible by bus, but slightly less accessible by the high-speed BART system. The clinic itself is housed in a bright, spacious yellow building, and upon coming in, there is one large main lobby on the bottom, with pharmacies and other rooms on the second floor. In contrast to Oakland, the Concord clinic was established much more recently in 2003, and it houses fewer specialty clinics (e.g. dental and optometry clinics) than Oakland (nine compared to three specialty clinics). That said, its stated goal on the website is to serve 15,000 per year.¹⁵

The Pittsburg clinic has been around longer than the Concord clinic (since 1999), but it is a much a smaller clinic location. It is tucked away in a strip mall area, across from a quiet residential neighborhood, and because the clinic is located in a part of a larger building housing other businesses, the clinic lay-out is narrower, with only a small waiting room visible upon coming in. Only four offices are available for consults, which shows its limited capacity. No data are available on the number of patients it serves per year, but the website indicates it collaborates with larger local public hospitals for referrals and services.

According to the FQHC's annual report in 2016, 59.4% of funding comes from patient service revenue and 27.6% comes in the form of private and public grants at the federal, state, or local level.¹⁶ The rest of the funding comes from patients' health insurance providers, also known as capitation fees, (6.7%), in-kind donations (1.6%), and other sources of funding (4.5%). A breakdown of funding sources and revenue at individual clinic locations is not available, but through my visits at each site, we can see how resources vary widely at a local level.

Apart from FQHCs, there are free clinics, which are often operated by NPOs and typically have the lowest barrier towards accessing services. Because they do not have to meet strict federal guidelines for eligibility into programs or services, private organizations can determine their own screening method for low-income clients. The free clinic I volunteered at was run by a religious organization and two staff members – one who worked full time and one who worked part-time to manage its operations. The clinic was housed in a small building, which was close to a freeway exit, but less accessible by public transportation. It served patients one weekday evening every week and one weekend morning every other week, and it typically served around ten to twelve patients in each three-hour session. All the medical and interpreter staff was comprised of volunteers, which sometimes made it difficult to achieve full staff capacity. Clinic funding came from local foundations, corporate sponsorships, and individual

¹⁵ The actual number of patients served per year is not publicly available

¹⁶ The report does not specify whether grants are private or public, or whether they from local, state, or federal sources. https://www.laclinica.org/pub/LC_corporate%20AR%202016.pdf.

donations. Because the clinic was free regardless of one's legal or insurance status, most patients coming into the clinic were uninsured with limited healthcare options. Lastly, there are health services that are available by county programs at a local level, which also vary in their scope and funding. Later in this section, I describe the health services available at county programs in my three research study sites and demonstrate their variation.

Food Assistance

In addition to Medi-Cal, the supplemental nutrition assistance program for women, infants, and children, commonly known as WIC, was often mentioned and used by the women I interviewed. WIC is a federally-funded program officially established in 1975. It helps provide nutrition education, breastfeeding support, groceries, and referrals to other community resources for women who are pregnant and mothers who have infants and children under the age of 5. WIC offers services for women regardless of their legal status, as long as they earn below 185% of the federal poverty line, or about 30k for a two-person household in 2017, and as long as individuals can prove their residency in the state. Because its maximum income threshold is higher than other means-tested public benefits and it pays no regard to legal status in the distribution of services, the program has a wide participant base. In 2013, 60% of all infants were eligible for WIC in their first year, with 76.6% of eligible participants (or nearly 1.2 million individuals) signing up for the program (California WIC Association 2017). According to the U.S. Department of Agriculture website, California had the highest coverage rate in the nation for individuals eligible for WIC in 2014 (71% of eligible individuals were covered in California compared to only 39.1% of eligible individuals in the lowest coverage state of Montana). The high eligibility rate is again due to California's high poverty rates, but the high coverage rate is due, in part, to the state's expansive outreach efforts to families (Long 2002).

Walking through the primarily Latinx neighborhood of Fruitvale, one sees multiple WIC grocery locations, which are easily identifiable through their purple, red, and green logo, which is prominently displayed on the store front windows. Upon entering the small grocery locations, one sees essential staples like produce, milk, and more perishable foods available that WIC participants can purchase with monthly vouchers. The small grocery stores' prices are generally lower than those found at other grocery stores, but their supply is only limited to approved WIC-food staples (Center on Budget and Policy Priorities 2004).

In addition to WIC, the Supplemental Nutrition Assistance Program (SNAP) provides monthly cash assistance for low-income families as long as they earn less than 130% of the federal poverty line. According to the federal SNAP website, "a person must be a U.S. citizen or an eligible, lawfully-present non-citizen to qualify for SNAP benefits."¹⁷ There is a five-year waiting period for all non-citizens, with the exception of those who are under 18, disabled, have a military connection, or are part of qualified groups, including refugees, asylees, and/or victims of trafficking. California's SNAP program, CalFresh, covers all U.S. citizens and legal permanent resident (LPR) children, regardless of where their parents were born, although the benefits only go towards U.S. citizen or LPR children and does not take their undocumented parents and/or siblings into its household count. The California Food Assistance Program (or CFAP) covers legal permanent residents who have lived less than five years in the U.S. as well as other noncitizen populations including those who have been battered or abused, as long as

¹⁷ <https://www.fns.usda.gov/snap/snap-policy-non-citizen-eligibility>

they make less than 130% of the federal poverty line. Even though these food stamps are available to non-citizen populations, few people mentioned being on this program.

Apart from WIC and CalFresh, food assistance programs through private institutions provide in-kind food assistance for low-income individuals, which some people described accessing as well. For example, the Contra Costa and Solano county food bank receives donated food from wholesalers, retailers, local community food drives, fresh fruits and vegetables from the produce industry, and food through the Emergency Food Assistance Program, run by the USDA. The food bank buys food wholesale to complement the donated food, and then distributes the food to other non-profit organizations and partner agencies. One partner agency I worked at, for example, distributed a large box full of groceries to its clients every month that came directly from the county food bank.

Other Services

Other major public benefit programs in the United States include cash assistance through Temporary Assistance for Needy Families (TANF), and Supplemental Security Income (SSI) for low-income seniors and people who are blind or have disabilities. According to the Department of Health and Human Services website, around 2.6 million individuals were enrolled in the TANF program in 2017, and according the Social Security Administration, 8.2 million were enrolled in SSI in 2016. Both federal programs are only available for U.S. citizens and legal permanent residents who have resided in the U.S. for more than five years. The vast majority of those I interviewed were consequently not eligible for these programs. However, to complement the SSI program, California has created the Cash Assistance Program for Immigrants (CAPI), which provides SSI-type benefits to recent immigrants who are 65 or over, blind, or disabled, and whom, apart from their legal status, would qualify for SSI. Because I only interviewed respondents under the age of 65, and all the legal permanent residents I spoke to were able-bodied, I didn't interview anybody who would qualify for these programs.

State Resources as a Band-aid for General Exclusion

From my extensive description of social service programs that are available to recent and/or undocumented immigrants, it may appear that are plenty of resources to go around for liminally legal immigrant populations. However, this is far from the case. A majority of public benefit programs are simply unavailable to undocumented immigrants. For example, in addition to cash-assistance programs, public health insurance, and public food assistance programs being limited to legally permanent residents and U.S. citizens, subsidized housing vouchers, the Earned Income Tax Credit (EITC), and unemployment benefits (among other programs), are only available to U.S. citizens and legal permanent residents who have resided over five years in the United States, and for the latter three programs, there are no similar state options available to recent immigrants in California. Thus, recent immigrants and undocumented immigrants in California are shut out of programs that serve at least 41 million people in the country per year.

1819 20

¹⁸ Internal Revenue Service website, <https://www.irs.gov/eitc-central/about-eitc/about-eitc>

¹⁹ U.S. Department of Labor data, <https://www.dol.gov/ui/data.pdf>

²⁰ Center on Budget and Policy Priorities, <https://www.cbpp.org/research/large-majority-of-housing-voucher-recipients-work-are-elderly-or-have-disabilities>

With regard to health care and health insurance access, an estimated 71 percent of the undocumented population in the United States was uninsured in 2011 (Capps et al. 2013), and in 2015, an estimated 60 to 70 percent of the undocumented population was uninsured in California. This percentage has likely fallen in California with the expansion of Medi-Cal eligibility to undocumented children under the age of 19, and the rates of those who are uninsured have decreased across the U.S. with the passage of the Affordable Care Act (ACA) in 2010. However, because undocumented populations are not eligible to purchase health coverage through the federal ACA Marketplace, this still leaves many adult and elderly undocumented immigrants with limited access to health insurance.²¹ Some individuals may be able to access insurance through their employer or spouse, and undocumented individuals can even purchase private insurance through off-exchange plans. However, with a required deductible of several thousand dollars a year, these off-exchange plans, are, for many, simply out of reach. The resources the state of California has created for recent and undocumented populations are important, but they only serve as band-aids for a much larger wound.

Social Service Infrastructure Across Three Study Sites

Thus, resources for recent and undocumented immigrants are extremely limited at a federal level, and these restrictions have been mitigated, to some extent, by the state of California. In addition to variation in resources at a national and state level, social service programs can vary at a county level as well. For example, in the three study sites for this project, there are significant differences in resources for the two counties my sites were located in. Oakland is part of Alameda County which currently has a program that provides basic health services to undocumented adult immigrant populations. The Health Program of Alameda County (HealthPAC) is a county-wide program offers basic health services for residents of Alameda that are at or below the 200% Federal Poverty Level who are not enrolled in full-scope Medi-Cal and do not have insurance through a private provider. The services offered through this program include wellness check-ups and preventative services, illness and injury care, care for ongoing health issues, mental health care and health education, and prescriptions for medicine. Co-pays for services are based on income, and if participants are below 138% of the federal poverty level, there is no cost for co-pays.²² Although HealthPAC officially started in 2011, this program is an updated version of the County Medical Services program which provided basic health services for low-income, uninsured populations in Alameda county, among others. Program participants can be screened from thirteen medical institutions throughout Oakland that serve low-income patients.²³ This includes screening sites in immigrant-dense neighborhoods such as Fruitvale, with its significant Latinx population and Chinatown, with its Chinese and Southeast Asian populations.

Concord and Antioch are part of Contra Costa County, and which has more limited resources for health care services to undocumented adults. In 2009, at the onset of the recession, primary care services were cut for undocumented adults. Although primary care services were

²¹ A 2017 report from the Kaiser Foundation indicates that 39% of the non-elderly, undocumented population was uninsured in 2016. However, because these estimates exclude those over the age of 65 who are unlikely be employed, it may underestimate the overall rate of those are uninsured. <https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/>

²² <https://www.acgov.org/health/documents/HPACHandbook-en.pdf>

²³ This is according to the Alameda Health Care Organization website: <http://achealthcare.org/health-insurance-info/low-income-coverage-options/screeningenrollment/>

restored in 2015 through the Contra Costa Cares program, the scope and funding for this program is more limited. Only 3,000 participants are allowed, and they are enrolled on a first-come, first-served basis based out of screenings at four medical sites throughout the county. These medical sites are located in a family clinic in Richmond, a primary care clinic in San Pablo, a primary clinic in Concord, and a primary care clinic in Pleasanton, all the locations are located in the west side of the county -- with the exception of the Concord location. For those lucky enough to be registered in the program, participants do have access to preventative and primary care services at the previously mentioned clinics (KQED 2015).

At a city level, Oakland has the most robust non-profit infrastructure, with approximately 309 non-profit organizations with financial resources devoted to providing social services in the realms of health, housing, employment, food assistance, legal aid, and child care, among other services, and there are an estimated 52 Federally Qualified Health Care Centers (FQHCs) in the city as of December 2017.²⁴ Concord has 53 organizations that provide social services in Concord, with three FQHCs as of December 2017. Antioch has the least number of social service non-profit organizations (only nine with financial resources), and as of December 2017 there was only one FQHC in the city. This translates into one non-profit organization per 272 low-income residents in Oakland, 296 low-income residents in Concord, and 1,762 low-income residents in Antioch; it also translates into one FQHC per 1,615 low-income residents in Oakland, 5,237 low-income residents in Concord, and 15,858 low-income residents in Antioch.

While ten respondents in Oakland were part of the HealthPAC program, or had heard of it, only one respondent was involved in the Contra Costa Cares program, while others had not heard of it. The most common healthcare center mentioned in Concord and Antioch was a free clinic operated in the nearby suburb of Pittsburg, and the FQHC, La Clínica, which had four locations throughout Contra Costa County – compared to eighteen locations in Alameda County, including fourteen in Oakland alone. Although some respondents were eventually able to access the services and programs described above, it was not always easy for them and a high quality of care was not always guaranteed. In the sections that follow, I outline some of the legal and language barriers that people faced in accessing services, and the consequences it had on their physical and psychological health.

Legal Barriers: The Risk in Seeking Services

Given the current policy context, liminally legal immigrants—that is, those who are undocumented or have temporary legal immigration status—have limited options for primary care and are excluded from many federal social welfare programs including Medicare, subsidized housing, and aid to the elderly. However even when respondents do have access to programs, they describe feeling fear and wariness at the point of signing up for services, or in some cases, do not sign up for them at all.

Esperanza, for example, remains ever wary of signing up her children for public programs. Born and raised in a big city in Northern Mexico, she described living a happy childhood free of financial worries. She received her degree in business administration right after

²⁴ This is according to the Guidestar Database, which has up to date information on all organizations that file for non-profit status with the IRS, and the National Provider Identifier Database, which tracks the number of Federally Qualified Healthcare Centers nationwide. The number of non-profit organizations is much higher than indicated here, but I only included organizations that had at least one dollar of revenue indicated on their tax filings because they are indicator of the organization's capacity to provide needed services.

graduating from high school, but had trouble finding stable employment despite looking for jobs in multiple cities. Steeped in debt and desperate for employment, she decided to try her luck in the United States. Due to her middle-class status, she was able to obtain a tourist visa, and headed North to stay with her friend who had promised her a job in his company. Unfortunately, the friend was full of empty promises, but they did connect her to another acquaintance who proved to be more helpful in helping her settle in. Throughout the next year, she was able to find employment working as a cashier at a grocery store in a suburb of Oakland. She soon met her future husband there and became pregnant with their first child. Upon learning of Esperanza's pregnancy, her co-workers quickly referred her to Medi-Cal and WIC for services. Since then, Esperanza has used Medi-Cal and WIC for her two other children.

When I asked her if she had any hesitancy seeking services for her children due to her legal status, she responded, "They explained to me that there was no problem – that [I could] obtain medical attention even if I wasn't here legally [...] that my information would supposedly not go to immigration. But, I think it does. To be honest, I haven't researched it well, and I don't know how true it is. But when I asked for the medical service, they said it was private and wouldn't cost anything. [...] But, I don't know." Here, we see that even when she is informed by clinic staff that her information will be confidential, she still maintains her doubts. This isn't surprising given how this information has a precedent of being compromised, and how medical deportations still take place to this day (Park 2011, Molina 2011). The fact that Esperanza was also highly educated may have contributed to her skepticism of case workers. Her information was being put into a system. There was no proof or guarantee this information would not be shared. While other women did eventually apply for public programs like Medi-Cal and WIC, they used the words "fear" and "risk" in describing their decision to do so. As I describe in chapter two, women often described their children as their primary motivators for seeking services.

But even for women who were legal permanent residents, or citizens of the United States, the fear of seeking services stayed with them as they thought about the repercussions that seeking services would have for their citizenship or that of their spouses. Marta, for example, was a 29-year-old U.S. citizen whose husband was undocumented, but had recently received his permanent residency. Marta stood out from other interview respondents because she was a U.S. citizen from birth but grew up in Mexico. Her parents had previously lived as undocumented immigrants in California, but when Marta was just six months old, her family moved back to Mexico due to a parent's illness that prevented them from working and sustaining their family. In her final year of high school, Marta moved to Oakland to live with her aunt. Her hope was to receive her high school degree in the U.S. and find employment after. Unfortunately, the language barrier was hard to overcome, and Marta was not able to receive her degree. She started working as a cashier in multiple grocery stores while continuing to live with her aunt.

About seven years after migrating to the U.S. she met her husband through a mutual friend, and a year later they were engaged with a child on the way. Marta's husband was undocumented during her pregnancy, and she describes this period as extremely stressful and anxiety-producing. She constantly thought to herself, "what if the police stop us and [they see] my husband has no license? I can't [financially] support myself on my own." Marta, thus, drove her husband to work whenever she could before she went to work herself. After their child was born, they made the decision to apply for a marriage visa, and her husband received his green card. They both have a relatively stable immigration status, but they still have trouble making ends meet. Her husband works in construction, while she takes on temporary jobs through an

agency. However, most of their income goes towards paying off their one-bedroom apartment in Oakland – the rent only continues to go up.

When I asked her if she ever uses food assistance programs when her finances are low, she says, “I haven’t applied for food stamps. I’m scared. Maybe I have been qualified for them, but I’m scared to ask for that help.” When I inquired why she was scared, she responded, “I don’t know. I think that maybe with time [...] my husband might have problems with that, and he just fixed his residency, and so we still feel limitations for a little bit.” Other mothers described similar fears about using food stamps that may impact their children’s chances of obtaining residency or citizenship. Ximena, a thirty-nine-year-old mother of three, had her two oldest children in Mexico, and her youngest daughter in the U.S. Because her daughter is a U.S. citizen, it makes her eligible for food stamps, which Ximena can apply for on her behalf.

However, despite the food insecurity they face, Ximena is hesitant to apply for them. She states, “They tell me that there are [food] stamps, but I have the fear that in the future when [my daughter] wants to work, they’ll take away that money [...] if there is amnesty, or there is a way to fix [papers], it would harm us.” When she says, “they,” Ximena is referring to her friends and acquaintances who also told her that if the government catches her lying about anything for benefits, she needs to pay the full extent of benefits back. Even though Ximena would not be lying about her financial situation, she thinks it’s best to avoid any complications by not applying to food stamps at all. Through these narratives, we see that legal status becomes more than just a material barrier to accessing services, it becomes a psychological and social barrier towards service access as well.

Language Barriers

In addition to legal barrier delimiting one’s access to resources, language barriers, particularly at the point of receiving services, profoundly shaped the quality of care that respondents received. When respondents were not able to communicate with service providers in their native language, they confronted harmful and potentially life-threatening situations due to language miscommunications. Beyond having miscommunications, respondents described feeling stigmatized and discriminated against for having limited proficiency in English. These negative interactions not only bear psychological harm, but they can bear physical harm as well, as respondents may be hesitant to use services in the future and/or as they carry the chronic weight of racism and discrimination in their bodies (Nadal et al. 2017).

Complications and Miscommunications

Magali’s story, which opened this chapter, demonstrated the real danger of a language barrier contributing to a traumatic childbirth, and indeed two other women with whom I spoke described facing psychological harm while being in labor as well. Language barriers also led to hazardous situations at the point of surgery. In one particularly poignant example, Rosa, a thirty-nine-year old, mother of four, describes the medically dangerous situation she confronted when she couldn’t understand the pre-surgery instructions given to her in English.

Rosa came to the United States after her husband left her and her two children in Mexico. With no viable job opportunities on the horizon, Rosa painfully left her children behind with her parents to seek a better economic opportunity in the United States. Although Rosa was eventually able to find employment and send some money to her family, she lived on very

limited means. We sat in a small dining area in her threadbare trailer, as I conducted the interview. Her friend had recently dropped off some plastic containers to sell, and as we talked, Rosa slowly and deliberately peeled away the plastic wrap covering the containers and clicked the lids into place. This methodical exercise seemed to represent the only semblance of order in her life in that moment -- she had recently gone through a series of setbacks and was trying to find ways to keep forging ahead.

Due to a workplace injury, Rosa is currently unemployed and is due to have surgery soon for a pinched nerve. This isn't the first surgery she has had. Several years ago, she was a due for surgery for a hernia, which proved to be a humiliating experience for her. The staff who attended her did not speak Spanish and handed her instructions in English instructing to fast before her surgery. Rosa was not able to understand the instructions and ate breakfast -- a meal she distinctly remembered and regretted eating as soon as she was humiliated by the medical staff. Through tears, she told me, "They said, 'Look at that. She comes well fed, she ate her pancakes and everything. When we told her not to eat, she did.' But I did it because I couldn't read the paper. [...] So, one feels bad because people talk, and they think you don't know what they're saying [...] you feel bad because you wish you knew [English]." Thankfully, Rosa was able to alert the staff she had eaten before the surgery, offsetting any potential complications that could have arisen. Unfortunately, Rosa was devalued and shamed in the process, and the whole situation could have been avoided if pre-surgery instructions had been given to her in her native language.

In other instances of language barriers impacting services, a man described receiving food that aggravated his stomach pain because he wasn't able to communicate his dietary needs to staff. Even in environments where Spanish-speakers are available, the service provided wasn't always high-quality. This was the case for Luz, who had experience with medical care in free, smaller clinics and larger private hospitals. Luz grew up in an abusive household in a traditional migrant city in central Mexico where she describes a childhood of limited means, with no opportunity to pursue a high school education. When she was eighteen, she met her now ex-partner in Mexico, and he convinced her to start a new life in Northern California where he had been living with his family. Soon after arriving, she encountered severe domestic violence. Luz fled to safety to her aunt's place in an outer Oakland suburb, where she started a new life.

Luz worked three jobs for many years, but now devotes her time to homemaking and taking care of her three young children. She is now married to a supportive partner, who was the one to bring her to Planned Parenthood when she first became pregnant. At Planned Parenthood, she was then referred to a free clinic in a nearby suburb. The staff at the clinic was nice, and Spanish interpreters were always available. However, she sometimes had to wait up to two hours for a ten-minute appointment. For her second pregnancy, she wanted something different. Her aunt suggested she try going to a private hospital, where her sister had gone and where they accepted Medi-Cal patients. Luz saw a Spanish-speaking doctor at this private hospital, but the doctor was pressed for time to provide adequate care.

Luz described the doctor as being, "very stressed because he was the only one who spoke Spanish. He could be in a good mood or a bad mood. So I get mad too. Why do I come here to get in a bad mood, if I just want to be at ease with my son? So I decided to leave for the clinic when my daughter was born. They [the attendants at the private hospital] were very good but that was the thing.... It's too much pressure for the doctor. The doctor was the only person who speaks Spanish there." After a few months, Luz decided to go back to the free medical clinic for her pre-natal care. Yes, the wait-times were longer, but at least, she would have more amiable

physicians. Several women described how even though they had “bilingual Spanish-speaking staff,” they felt the staff’s Spanish was very limited and still left things to be lost in translation. After interviews, respondents would sometimes praise my Spanish fluency and lament how it compared to their social workers or other service providers they encountered. One respondent described the fluency of three social workers she has had interactions with as the following, “one speaks Spanish, another speaks English but comes with a translator, and then there’s one that [speaks Spanish] but always gets confused!” Even though staff may technically be “bilingual” on paper – this does not ensure high quality translation or communication by any means.

While statistics on the number of medical providers would make it appear like there are plenty of Spanish-speaking physicians to attend to patients’ needs in California, the number of providers who provide care to uninsured or low-income populations is much lower, which leaves many Spanish-speakers and medical providers left to their own devices when it comes to accessing care (Yoon et al. 2004). Scholars have addressed how Limited English Proficient (LEP) populations on a whole, are less likely to have regular access to healthcare than fluent English speakers (Ponce et al. 2006) and report lower quality of care (Seid et al. 2003) and higher levels of dissatisfaction with services (Weech-Maldonado et al. 2003). Missing from this literature is the real shame, embarrassment, and internalized stigma that results from language barriers and miscommunications. It is difficult to overestimate the heavy toll these language barriers can take on people’s health.

Discrimination and Racialization

Beyond language barriers leading to omitted information or miscommunications in medical situations, simply speaking Spanish in medical settings led patients to feel ashamed and discriminated against in public institutions. Ximena, for example, describes feeling direct micro-aggressions in the medical lobby as she waited to receive services. Ximena was born and raised in a small town outside of a traditional migrant city in Central Mexico. Her mother devoted herself to homemaking while the father worked as a fieldworker (*en el campo*) – labor she started to take on at a young age after elementary school. Her oldest brother had come to the United States when he was a teenager and helped support Ximena and her parents, but Ximena didn’t have any plans to head North until she met her husband. After having their second child, he moved to Oakland with Ximena’s brother to financially support the family. Ximena joined him with their two children a year after.

Apart from having her brother and husband in Oakland, Ximena also knew several people from her hometown who, along with her brother, oriented her to the neighborhood and different services in Oakland. She lives with her husband and her three children in a one-bedroom apartment next to her brother in the heart of the Fruitvale neighborhood in Oakland. We conducted the interview at a small dining room table right by her kitchen. There were several dollhouses in the living room, and a small mattress with a princess comforter on it. Ximena explained that her couch had broken, so this was a temporary fix. It was also where her and her husband slept, while her children took the bedroom. It appeared to be a one-bedroom apartment located in a worn down, dilapidated building on a block with other run-down buildings. There was a black and white portrait of her husband and her two daughters, and a frame with a fabric that had an image of Jesus roughly sketched in with a sepia dye. There was also an open bible with several red ribbons marking different passages inside, which spoke to her devout religiosity.

Because two of her children were born in Mexico, Ximena described how she has to pay for her children's care at the federally qualified health center she visited because her children are not U.S. citizens (this was before Medi-Cal was amended to include undocumented minors under the age of 19 in 2015). Beyond being at a financial disadvantage due to her legal status and that of her children, she felt shamed and humiliated as she sought services just because she spoke her native language to her children in the lobby. She recounts, "Sometimes [I sense] discrimination because one doesn't speak English and one's children aren't born here. [...] The doctors are really nice even though they don't speak Spanish, but sometimes the staff, they don't – like sometimes when I go to the registration desk, the children are crying, and they say 'quiet the baby,' or 'they are making too much noise.' [...] And I would see [other mothers] speaking English, and [the staff] would be really kind with them, and not with me. Well, I have to just bow my head because I'm not from this country." Like Rosa, Ximena describes the humiliation and shame that can be felt from feeling racialized and discriminated against while seeking services as a native, Spanish-speaker. These negative experiences can prevent people from wanting to seek important social services in the future.

Informal Work and Housing Barriers

Apart from legal and language barriers impacting people's access and quality of services, there are other situations that can make access to services difficult for low-income, Spanish-speaking populations. Working in an informal labor market can make it difficult to establish proof of income (Marrow 2012). Because individuals may be paid in cash instead of checks in informal work, it makes it more difficult to provide documentation on their labor. Informal work can also lead to unstable, and often long working hours. Unstable working hours are not conducive to setting and making appointments because it makes one's schedule unpredictable. If one's work is unpredictable, how can one make a commitment to a doctor's visit? Beyond making it hard to go to a clinic at a particular time, long and unstable work hours make acquiring information difficult. This is especially the case for men, who are more likely to work odd hours as day laborers or landscapers than women who might have set times for paid childcare or cleaning. For example, Manuel is an older day laborer from Oakland, whom I describe in detail in my third chapter. In talking about his difficulty making a dentist's appointment, he said the following, "... I can't apply [for a dental appointment] because there's no appointments, or because I'm not a member. Well how I do become a member? [...] [The staff members] don't explain that. If I had an idea of how to do it, I would have done it because at least it helps. My teeth are falling out." Struck by Manuel's story, I wondered how it could be that accessing services could be so difficult through a Federally Qualified Healthcare Center, so I visited the Alameda County Healthcare organization website, and they stated: "If you are uninsured, there may be a wait at the health clinics. It may take days, weeks, or longer to complete your registration and establish membership at a clinic. After you establish membership, you may set up an appointment to be seen." If one is working long hours in an unstable job, waiting in line and figuring out all the appropriate steps for this paperwork can prove time consuming, burdensome, and leave one frustrated and confused.

Low-income populations may also be living in crowded and/or informal housing, which makes it difficult to prove one's residency to apply for programs. In places experiencing a housing crisis, like the Bay Area, simply having one's name on a formal housing lease can prove to be difficult. Indeed, in my own experiences working as a bilingual intake volunteer at a food

pantry, I observed the visible worry in people's faces as I asked for proof of income and proof of residency. I would reassure them that if they didn't have a paycheck, they could mark down approximately what their monthly earnings were. If an individual's name weren't on a lease, they could provide a utility statement that indicated their name and residence. After a few weeks, most clients were able to procure this information, but some didn't and subsequently had to be cut from services. This food pantry was privately run and thus had less strict requirements than other places, like Federally Qualified Health Centers. While proof of income and residency requirements may seem easy to meet at first glance, they can be particularly burdensome for undocumented and other marginalized populations.

Does Place Matter? Language, Transportation, and Staff Barriers in Suburban Settings

As I described in my introduction, part of the motivation for my research design was to better understand how the service-seeking process was influenced by suburban versus urban location. Overall, I found that some of the barriers faced towards accessing services (i.e. legal barriers and complex bureaucratic procedures) were common across all study sites. However, I found that language barriers and transportation issues were more pronounced in the suburban site of Antioch compared to Concord. The higher prevalence of language and transportation barriers in the suburb of Antioch versus the suburb of Concord speaks to the potential danger of researchers lumping all suburbs into one category, as opposed to taking a deeper dive into its different histories of place and location. That said, compared to Oakland, suburban sites in both Concord and Antioch faced difficulty in procuring culturally competent, bilingual staff.

Language

Most people I interviewed for my dissertation research were monolingual Spanish speakers, and in our interviews, they described the day-to-day difficulties of not being able to communicate with others in one's native language. While the challenges of not being fluent in English carried across all study sites, respondents living in Antioch reported facing more language barriers in public institutions, like schools and hospitals. Only three (out of thirty-nine) respondents in Oakland described language barriers in those institutions, compared to seven (out of twenty-seven) respondents in Antioch. Given that Antioch's population of first-generation immigrants has only significantly grown in the past ten years, it appears that public institutions, like schools and hospitals, have not increased their bilingual staff capacity to match a changing population. Interestingly enough, only two (out of twenty-three) respondents described language barriers in schools or hospitals in Concord. Concord's longer history with first generation immigration likely contributed to this outcome, as it has built trusted community institutions for immigrants for the past twenty years.

Public Transportation Access & Distance from Employment and Regional Institutions

Given that the focus on public transportation access in the literature on the suburbanization of poverty, I came into this research project hypothesizing that limited public transportation access would significantly impact respondents' access to services. Surprisingly, most respondents either had access to a car, or were able to carpool to different places with others, which reduced transportation barriers to service. However, when respondents weren't

able to access a car, it took respondents long periods of time to get to different places. For example, one woman discussed spending over two hours, taking two separate buses to get to a medical appointment before being told she wasn't scheduled for one that day. Being a limited English speaker, it was hard for her to advocate for herself to an English-speaking staff. The shame and frustration she felt from not being able to investigate why she didn't have an appointment was pronounced by the fact that it took her nearly the whole day to simply have this doctor's visit.

In my own conversations and field work, I noticed how people's distance from their place of employment would come into play for suburban residents. For example, the free clinic I volunteered at was starting up a nutrition education program for those with diabetes. In preparation for the program, staff members and volunteers debated just when the right time would be for the class and what turn-out would look like. Many people spent at least an hour, if not two commuting to their place of work and came home late. Fitting non-work responsibilities and activities into one's schedule was not easy.

Apart from the long commute time in outer ring suburbs, outer ring suburbs were also farther from regional institutions, like county hospitals, and institutions that offered specialty care. This distance led, in part, to Maria's traumatic childbirth as it took her and her husband nearly forty minutes to drive to the county hospital where she was due to have labor. One evening, I drove one of my respondents from Antioch to San Francisco for a surgery at a specialty hospital because her and her husband could not find anybody else to offer them that ride, and it was costly for them to take a taxi. It took me about an hour to get there one way, without traffic. With traffic, I anticipate the trip would have taken at least twice as long. Thus, not having a car in the suburbs can be detrimental in getting to places, but even with access to a car, getting to more specialized medical care often requires going longer distances to get to larger cities with a more extensive range of hospitals and services. The long commutes place significant time constraints on one's day and takes a toll on one's health (Stutzer and Fery 2008) and overall availability to seek and receive services.

Staff Barriers

Lastly, in my conversations with staff members of immigrant organizations, they described the difficulty they faced in procuring bilingual staff members who were willing and able to come out to the suburbs. For example, a non-profit staff member who supervises immigration legal aid programs in Oakland, Richmond, and Concord, talked about how difficult it was to recruit staff in Concord. He states, "it took us a while to find [a bilingual] attorney, even for the temporary position. It's very different; it's not like Oakland... We did not have problems filling those positions, to ask someone to come all the way out here... it is far away from people... we're not attracting the talent coming from wherever they're living." In the same interview, the staff member described how volunteers were easy to recruit in more urban areas like Oakland. Thus, the fact that respondents faced more language barriers, are not necessarily due to an unwillingness of organizations and schools to provide bilingual and/or culturally competent care, although this may also come into play.

Service Seeking as an Added Psychological Trauma

As demonstrated in this chapter, the barriers and challenges in access to services bear important repercussions for people's physical and psychological health and can have important financial consequences as people are excluded from many public programs and forms of federal assistance. Respondents face difficulties in signing up for programs and receiving high quality medical services, and they also feel shamed and discriminated against in the process of seeking and receiving care. These patterns are especially troubling given that undocumented immigrants may have already been exposed to trauma, particularly in their journeys to the United States. This, for example was the case for Sandra and for Fernando.

Sandra's Journey

Sandra, a 53-year-old mother of four, had childhood difficult from the outset. Growing up in a small coastal town of Mexico in the 1960s, Sandra essentially raised her nine younger siblings. Her father suffered from an illness that left him incapacitated for work, and her mother worked long hours as a live-at-home nanny to financially support the twelve-person household that Sandra sustained while her mother was away. Their living situation was worsened when a strong earthquake hit their town, leaving their small house in shambles. Sandra resented her parents for neglecting her and was eager to leave the household with her boyfriend when she was seventeen. They had three children, and when the youngest one was diagnosed with a serious medical condition, she and her husband made the journey to the U.S. with their sick son to seek help.

She stayed with her husband for a few months, but she missed her two other children terribly. She returned to Mexico on her own to attend her daughter's *quinceñera*. Shortly after her daughter's fifteenth birthday, she made a second journey to the United States by herself this time, with a group of strangers. She was one of two women led by a coyote in a group of twenty-five men. One of them sexually assaulted her and attempted to rape her at the border, while the other woman was raped. To make matters worse, she had aggressive hemorrhoids and needed medical help as soon as her husband and brother were able to retrieve her.

When Sandra arrived in the United States the second time, her brother had knowledge of where she could go if she wanted to access medical care. He took her to a Federally Qualified Health Care Center in Oakland, and the staff was able to treat her there and refer her to a therapy group for individuals who had undergone trauma. Having the group helped, but Sandra still felt isolated and out of place. In her first years, the sounds of helicopters would trigger her anxiety and fear. She explains, "one arrives in a different world [when one sets foot in the U.S.] If one hears a helicopter, I would hide because I thought it was *la migra*. [...]" Sandra later suffered in the birth of her premature daughter and still feels guilt from receiving Medi-Cal assistance to cover her daughter's birth. It has been eighteen years since Sandra last saw her oldest daughter, and in that time, her daughter has had a child of her own.

Fernando's Story

Sandra's story is similar to that of Fernando, though it varies in gendered ways. Fernando grew up in Chiapas among 10 brothers and sisters, and he was able to finish middle school before he started working in construction. Over the next few years, he got married and had three

children, who he was able to support for many years while he was working on part of a big project constructing a warehouse in his town. But when that work dried up, he was left with few opportunities for employment. He made the painful decision to leave his wife and three children behind as he made a solo voyage North in the late 1990s.

Like Sandra, Fernando paid a coyote to help guide him to the U.S. along with a group of mostly other men. However, Fernando was held captive by his coyotes, and he didn't know when he was going to be released. After a month, he was released, but he had no home and little money to account for. He waited on street corners to look for work, and he slept on benches in parks until he could find housing with other day laborers he befriended on Los Angeles' street corners. He describes his suffering as minimal because he was young, but one can only infer the trauma that was produced from being held against one's will and having no safety net upon being released from captivity.

Through the years, he has worked as a day laborer, with limited and unstable income. He is now 51-years-old, and it has been decades since he has seen his family. He grew teary-eyed and talked wistfully about returning home, but he didn't have any clear date set on his departure. Listening to Fernando, I wondered just how soon it would happen, if ever. During our conversation, he never described accessing any form of health care provider, or mental health provider to process the trauma he endured while being held hostage. Had he been connected to the right resources, he could have had a case for a U-Visa,²⁵ which may have led him to a pathway to residency and allowed him to reunite with his family. He has been able to save up money to put his children through college in Mexico, but he lives on very limited means. He has no steady income and relies mostly on the wages he garners from his volatile employment in day labor. The uncertainty in his employment situation worried me as Fernando was growing older, and he looked visibly weakened by years of arduous work.

As Sandra and Fernando's stories demonstrate, the act of migrating can induce high levels of stress and expose one to potential trauma as people place their lives and well-being into the hands of paid coyotes who can quickly turn against groups of migrants and subject them to emotional, physical, and sexual abuse. Migrants are also subject to abuse from drug cartels, border patrol agents, and Mexican government officials (Amnesty International 2010). Using the Harvard Trauma Questionnaire, researchers found that at least 82% of undocumented immigrants reported experiencing previous trauma, and 11% of them met criteria for PTSD at a hospital center in New York. Although official statistics on abuse at the border are not available, reports from migrant shelters catalogue thousands of cases of physical and sexual violence at the border (Amnesty International 2010) – trauma which has long-lasting consequences and can worsen without proper medical care (Van der Kolk 1994; Fortuna, Porche, and Alegria 2008).

Even once immigrants cross the U.S. border, their mental health continues to be at risk as they are exposed to other stressors including exploitation in an informal labor market, potential social isolation, discrimination and stigmatization, and the risk of being deported to their country of origin which can separate them from their families and/or expose them to a political violence that they had initially fled. The oppressive conditions that impact people's health are commonly referred to in the public health and anthropology literature as structural violence (Farmer et al. 2006) or structural vulnerability (Quesada et al. 2011) that acutely affects undocumented and/or

²⁵ As stated in the introduction, U-visas are designed for victims of domestic crime, and they initially allow respondents to access some public benefits, work legally in the United States, and after three years, they may apply for legal permanent residency status. In this case, he could have qualified as a victim of domestic crime during his time in forced captivity.

racialized immigrant populations. It should come as no surprise that depressive and anxiety disorders, such as dysphoria (a profound state of unease or dissatisfaction) or anhedonia (the inability to feel pleasure), and other behaviors such as poor appetite or overeating are more common among Latinx parents who entered U.S. without documentation, compared to those who entered with authorization (Ornelas and Perreira 2011). In fact, unauthorized Latinx parents were four times more likely to have depression than those who had authorized entry into the U.S. These statistics are troubling for many reasons, but what makes these patterns even more alarming is that even though undocumented populations are at a higher risk of compromising their mental health, they are one of the least likely populations to be able to access services.

In the year 2000, 65% of undocumented immigrants lacked health insurance (this is compared to 32% of permanent residents) (Goldman, Smith, and Sood 2005), and they overwhelmingly indicated not having a regular source of care, and not having a physician or dental visit in the past year (Pourat et al. 2014). Their likelihood of accessing mental health care was even lower (Nadeem et al. 2007). With the passage of the Affordable Care Act in 2010, the gap in health insurance coverage between documented and undocumented populations has only widened, making some undocumented immigrant populations feel more materially and symbolically excluded from important health services and care (Marrow and Joseph 2015). Apart from limited mental health services for Spanish-speaking and liminally legal populations, there is the added stigma of seeking mental health services, which may be more pronounced in Latinx communities (Nadeem et al. 2007). Given the multiple barriers that respondents are up against as they access care, these statistics are sadly not surprising. However, there are ways to mitigate some of the inequalities in place.

The chapters that follow will explain, in part, what factors help mitigate some of the difficulties in accessing care and services, and they will detail respondents' ways of counteracting stigmatizing rhetoric in a restrictive, racialized immigration system. However, as I go through the factors that help mitigate an exclusive system of social services, I urge readers to be cognizant of the larger structures that shape different avenues of adaptation, coping, and resistance.

Table 3. Social Services for Recent and Undocumented Immigrants in California

Program	Service	Funding	Income Eligibility	Legal Status Eligibility
Medi-Cal	Health Coverage	Joint Federal and State	138% or below of FPL	Available to undocumented minors under age of 19, and available to women who are pregnant, regardless of legal status
Emergency Medi-Cal	Health Coverage	Federally Funded	138% or below of FPL	Available to all, regardless of legal status
Federally Qualified Health Center (FQHC)	Primary Care	Federally Funded	Sliding Scale	Available to uninsured individuals regardless of legal status, but at a sliding scale cost
Free Clinics	Primary Care	Privately Funded	Depends on Provider	Depends on provider (typically no restrictions based on legal status)
Supplemental Nutritional Assistance Program for Women, Infants, and Children (WIC)	Food Assistance, Nutritional Education, and Breastfeeding Support	Federally Funded	185% or below of FPL	Available to all women who are pregnant or have children under the age of 5, without regard to legal status
Supplemental Nutritional Assistance Program (SNAP)	Food Assistance	Federally Funded	130% or below of FPL	LPRs who are disabled, under 18, or have resided in U.S. for five years
California Food Assistance Program (CFAP)	Food Assistance	State Funded	130% or below of FPL	LPRs who have lived in U.S. less than five years, and non-citizen populations who have been battered or abused
Food Pantries	Food Assistance	Privately Funded	Depends on Provider	Depends on Provider (typically no restrictions based on legal status)
Cash Assistance Program for Immigrants (CAPI)	Cash Assistance	State Funded	Same as income threshold for Supplemental Security Income (SSI)	LPRs who have lived in U.S. less than five years and are blind and/or disabled

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CHAPTER 2: WOMEN'S VARIED PIPELINES TO SERVICES

Rosario is a 28-year-old mother of three young children, and she grew up on the outskirts of a big city in Mexico. From the start of the interview, her sharp wit and sociable personality immediately came through. She worked as a vendor in Mexico from a young age, so she was used to cajoling people and making them feel at ease. When Rosario was 18, she met her now husband in Mexico, and after a few years, she became pregnant. They decided get to married, and she would join him in a suburb of the Bay Area where he had been living for the past ten years. Rosario did not know many people upon coming to the suburb; however, she soon started forming friendships with her neighbors and husband's friends. One of those neighbors, Alma, and her became very close. Alma was an undocumented mother like Rosario, and she was critical in helping inform and transport Rosario to different places. They went grocery shopping together, and Alma brought Rosario to all her doctor's appointments and informed her of different places where she could go for support. As Rosario explains:

[...] Not knowing English and [me] being pregnant without knowing where to go, she was the one that moved me. She gave me rides. She said, "Don't worry. You only have to tell me when you have an appointment, and I'll take you." She took me to apply for EVERYTHING. She took me to apply to Medi-Cal; she took me to [a place] to do my pregnancy test; she took me to [a place] to get my vitamins. If it wasn't for her, I don't know how I would have done it.

Without Alma, Rosario would have had more difficulty knowing about and accessing key services.

This short passage addresses one of the main questions driving my dissertation: *given the linguistic and/or legal challenges to accessing services, how do Latinx, and particularly undocumented immigrants, eventually gain a pathway towards services?* As I argue throughout the dissertation, the resource-seeking process is distinctly gendered, with men and women having unique pipelines and obstacles towards services. I will start by focusing on the experiences of women in this chapter before comparing them to the experiences of men in the following chapter.

Women, often faced hesitation and fear upon seeking social services due to their undocumented status, but they described their children and their family's food insecurity as their main motivators towards seeking care. The process of becoming informed about and accessing different services was then facilitated through three main conditions. The presence of "guiding figures", or co-ethnic women who took on the role of orienting women to services through sharing information and transporting them to various organizations and offices. In addition to guiding figures, weaker, co-ethnic ties and serendipitous connections helped orient women to different services. Lastly, pregnancies led people to clinics and non-profit organizations, where women were then connected to more resources, including primary care. Despite having places to go to access different services, I argue that "safety" afforded in non-profit organizations, medical clinics, and state offices is always qualified because the spaces cannot protect them against deportation, and their indifference to immigration status is not guaranteed. This point cannot be overlooked, particularly in the context of a more restrictive federal administration.

Before delving into my findings, I first contextualize how the social networks and immigration literature has answered the question of service access for low-income women. The

literature on social networks and barriers to services access creates a strong foundation from which to analyze undocumented immigrants' experiences navigating social service institutions, but it pays less attention to the empirical mechanisms that *initially* facilitate information and access to services for undocumented women, and ultimately, to advocate for one's self and one's child. I build upon this rich literature in my chapter by offering a unique focus on how undocumented women access services and discuss the role of place and legal status in shaping the service-seeking process.

Social Service Access Literature Among Low-Income and Immigrant Women

In his book, *Unwanted Claims*, Joe Soss examines how African-American women navigate the welfare system in Boston soon after the passage of welfare reform. Among other findings, Soss illustrates how a loose constellation of actors including family members, friends and neighbors, social service professionals, and community-based organizations serve as support systems who help women navigate a complex bureaucracy. Moreover, Soss describes claiming welfare as an inherently political action. Soss' work sets a strong foundation for understanding the mechanisms of accessing public claims and the political nature of this task, but in interviewing only U.S.-born citizens on this welfare claiming process, we gain less traction on how this process plays out for populations who may feel less entitled to such benefits because of what country they were born in and/or their citizenship status.

In the immigration literature, Menjívar (1997) describes how within certain circumstances, kin networks help facilitate access to employment, schools, and even information about particular food pantries or schools. However, some networks are not in a structural position to provide support or information to recently arrived immigrants as they struggle to find employment and make ends meet themselves (Menjívar 2000). Indeed, several scholars have highlighted the possible limitations or constraints of these bonding ties in more recent years. For one, these strong, bonding ties may set-up norms of reciprocity whereby if one person helps another out financially, they are expected to reciprocate in some way, shape or form (Nelson 2000). This can create tension if people are not able to reciprocate support or resources (Nelson 2000, Menjívar 2000). Other scholars argue that homophilous networks can be constraining for upward social mobility, and/or emotionally draining and stressful (de Souza Briggs, Popkin, and Goering 2010). These scholars highlight the strength of "bridging" often "weak" ties that connect people across characteristics, such as class, and provide information and opportunities for upward mobility.

The debate on the importance of "bonding" and "bridging" ties has yet to be resolved, and part of it may be due to the fact that the debate needs to be more nuanced. Under certain conditions, bonding ties may be more important because they require higher degrees of trust among respondents. I found this in my own research, where undocumented women trusted other undocumented women as they described the services that were available to them. Indeed, as I detail below, the process of seeking services differs by legal status because the undocumented and/or liminally legal individuals must contend with the fear of revealing information that could have real damaging consequences. Thus far, the way people interpret and contend with the fear and/or hesitation in seeking services has gained limited attention from immigration scholars and scholars of the welfare state.

The Risk of Seeking Social Services

Seeking social services is no easy task; individuals have to navigate multiple agencies, submit paperwork for applications, and take the initial step of admitting that they need assistance—an act that has been increasingly stigmatized through the portrayal of racialized welfare queens since the 1960s (Soss 2000). For undocumented women, seeking resources involves another important, often scary, step: navigating their lack of legal immigration status.

Legally, Immigration Customs Enforcement, U.S. Customs and Border Protection (CBP), and Immigration Naturalization Services (INS) cannot collude with public health agencies and hospitals to apprehend immigrants, although there have been painful instances of this in the past (Abel 2004). Moreover, ICE and CBP's current and longstanding policy of immigration enforcement is to avoid "sensitive areas," which include medical and educational institutions (Department of Homeland Security 2016).²⁶ Despite the general safeguarding against deportation and confidentiality of individual's information in these spaces, complete "safety" against immigration apprehensions or transfer of immigration to ICE or CBP is not guaranteed, and these policies are subject to change depending on the current federal administration. The National Immigration Law Center, for example, advises clients not to reveal their undocumented status to medical staff if they are asked about being eligible for public benefits, such as health insurance. They recommend stating, "I am not eligible for health insurance and do not want to apply" instead (NILC 2016).²⁷

Their caution is not unwarranted. As recently as September 2015, a women's healthcare clinic in Texas called in sheriff's deputies to arrest an undocumented woman who presented a fake driver's license to them, despite having gone there 18-months for care beforehand (LA Times, 2015). While this is an extreme case of a person's "safety" being violently trespassed in a healthcare clinic, other cases of medical deportations have also been documented at a broader scale (Molina 2011). In 2013, a bill was introduced in Arizona that would require hospital staff to call federal immigration official or local law enforcement if individuals are not able to prove their legal residence in the United States (Los Angeles Times, 2013). The bill was not passed, but that does not prevent similar bills from coming up for vote and possibly being passed in the future. In my interviews with undocumented women, respondents were well aware of the risk they took in seeking social services and described the fear of submitting their information to organizations, and in particular, state programs. However, they described how their children served as primary motivators to eventually seek information and access to different services.

Main Motivations for Seeking Services

Taking Risks for One's Children

From my first interview for this study, the motivation to provide for one's children was vial for a lively and outgoing mother of two named Magdalena. Magdalena came to the United States with a tourist visa to join her husband who had been working construction jobs in Northern California for the past two years. Magdalena was a pre-school teacher in Mexico, but with no work permit or transferable degree in hand, she was left with little to occupy her time

²⁶ <https://www.cbp.gov/border-security/sensitive-locations-faqs>

²⁷ <https://www.nilc.org/wp-content/uploads/2016/12/health-KYR-2016-11-30.pdf>

upon arriving to the U.S. She went into a major depression after having her first child, but with the help of non-profit social worker who visited her home weekly after her birth, she slowly overcame her depression. Magdalena then became involved with several non-profit organizations in the area working first as a volunteer, then serving as a board member, and now she is employed as a program coordinator.

When I asked her if she had any fear initially reaching out to organizations due to her legal status, she responded, “Yes, always. I always...I always had fear, and I always have fear [seeking out resources]. But I say to myself [I do this] because I have to live, I have to do things.” Later in the interview, Magdalena recounted a moment when she felt one of the many negative repercussions of her legal status; she could not volunteer to drive her children’s classmates on a field trip, but she was too ashamed to tell the teacher she did not have a license. She said, “It’s difficult, but I tell myself all the time, all the time I have to take risks, because of the strength that the kids give one, no? Of saying, they have to keep living [...]” Indeed, as I recruited a group of mothers for interviews at a non-profit organization, they stated that the reason they sought the organization’s services was for their children. Moreover, for many women outside of the non-profit organization, their first entry into non-profit organizations and services was facilitated through the needs of their children. Expectant mothers had to go to hospitals for pre-natal care, and through the hospital, they were able to find out about other services for their children. Even though it was a scary step, they decided to take it.

This was the case for Maria, a single mother of two, who was working hard to make ends meet living in a middle-class suburb in California. When I asked her if she had any hesitation or fear disclosing her undocumented legal status at a hospital, she stated, “For a moment, yes. But, I think that, in moments when you know that this is your child’s life [...] I think this is something that pushes you.” Rosa, also a single mother of two, reiterated a similar sentiment. When I asked her if she had any fear or hesitation going to a hospital to seek pre-natal care, she said, “No [...] I knew that I had to go [to the hospital] or find medical attention because this was my son’s life.” In Rosa’s case, her concern for her children eclipsed all other problems or concerns. Several mothers described how they had to overcome their fear of learning to drive and driving without a license to meet the needs of their children. They had to drive to doctor’s appointments in other cities because it was the only place that provided pre-natal health coverage undocumented individuals, in some cases, they had to receive specialized children’s care that was located in hospitals further away from their home.

Pre-emptive Checks when Seeking Services from the State

The fear of seeking services was prevalent throughout my interviews, and women often expressed the most anxiety when signing up for state-based programs, like WIC or Medi-Cal. In these circumstances, women often conducted a pre-emptive check where they would ask their friends and acquaintances if their legal status would prevent them from seeking services. Over time, they became more empowered to ask front desk workers upfront about the paperwork and eligibility requirements for different programs.

Paloma was an extraverted forty-year-old mother of three who busily scurried from one child’s extracurricular activity to another when not cooking, cleaning, or attending to errands at home. She had immigrated to the United States from Mexico with a visa through her husband, but she had trouble renewing the visa and lost her documented status in the United States. Her husband works long hours in construction, but during low employment periods in winter or rainy

days, it can be hard for them to make ends meet. Although she was hesitant at first, she decided to come in for food assistance through a community-based organization about a half-hour drive from her apartment that she had found out about through a friend. I asked her if she felt any fear going into the organization due to her legal status. She replied that at first, she was scared to seek services for her children through the county, but over time, she learned that she must simply be upfront with people about her lack of a social security number to ensure she was eligible for different services. In her words:

Yes, [I was scared] the first time that I asked for [health coverage for my children through the county] because the first question they ask is if are you a legal resident or not. So, then I told her, “I’m not a legal resident” [...] she told me, “It doesn’t matter. This will only cover your children” [...] But, [now] that is always what I ask. “Okay, what do I need to apply? I don’t have a social security number.” That is always the first thing I say.

Paloma has reduced her fear of insinuating her undocumented status through acquiring more experience in seeking support for her children. Later on in our interview, she states that being upfront about her not having a social security number also is a way to ensure that she doesn’t waste a person’s time if she is not ultimately eligible for a service. For the most part, however, she tries to prevent seeking food assistance whenever possible. She sells homemade gelatins or gets paid to pick other children up from school. Like many other people I interviewed, she first used informal means to make extra money, and when that was not enough, she would seek out services.

Marisol, a forty-year-old mother of three, was also hesitant to seek assistance at first, particularly from state institutions. Her father had lived in the suburb of Concord for the past four years, so he directed her to an FQHC when one of her children became ill. Once at the medical clinic, the social workers asked Marisol if she was on WIC, and suggested she apply for it. She decided to apply for the program, but not without checking her sources first. She explains:

“At [the FQHC I didn’t have fear seeking services.] Where I did have it – was at let’s say Medi-Cal because – because I don’t have papers, what’s going to happen? That’s where I did hold myself back a bit because I didn’t know. ‘No,’ my friend told me, ‘there’s no problem. You can go there.’ So, I went.”

Even though both Paloma and Marisol were concerned about revealing their legal status to state institutions, they asked upfront about what documentation was needed to receive services. I consider this pre-emptive check as a protective mechanism because it is a form of protection used by respondents to ensure that their legal status would not be used against them when attempting to access services. Other women who were responsible for procuring health and childcare for their family would describe a similar pre-emptive check to see how their immigration status could impact their access to resources.

Facilitating Conditions

Although twenty of the women that I interviewed were documented at the time of the interview, most of them were undocumented when they first arrived in the United States. Thus,

most of the women in my sample had to confront the reality of revealing their legal status to bureaucracies in the United States. However, for the six women who had papers coming into the U.S., they still had to figure out how to access services. How did Latinx immigrant women access social services upon arriving in the United States? In the sections, I will describe how the presence of “guiding figures,” co-ethnic ties, and medical conditions (often pregnancies) all helped facilitate women’s access to services.

“Guiding Figures”

Over half of the women in my sample described having a guiding figure that served as critical support in accessing important information and services. For most respondents, their guiding figure was somebody who had migrated to the United States several years earlier and also shared an undocumented legal status. In some cases, their guiding figure was a close relative who facilitated their migration to the United States in the first place. I use the term guiding figure because respondents used the term “guiding” or “orienting” to describe the actions that people took to help them navigate different services in the U.S. Instead of having a constellation of networks to inform respondents of one service or another, respondents could reliably count on one or two people to orient them to a variety of services; from local clinics to school registration to food assistance centers, the guiding figures were there to orient them to it all.

For Judy, a sociable mother of three, her sister, Ana, served as this guiding figure. Judy had come to the United States on a whim after her older siblings, including Ana, who lived in the U.S. visited her and recommended that Judy and her husband make the trip north together. Ana told Judy there was a job opening at the grocery store where Ana worked. Judy made the treacherous journey across the desert with her husband and Ana, and Ana offered her a place to stay while Judy and her husband became financially stable enough to make rent. Ana also informed Judy about Medi-Cal and drove Judy to the Medi-Cal office and helped her fill out all the needed forms. When I asked Judy if she was hesitant at first to sign up for Medi-Cal given her legal status, she responded:

Yes, but the big advantage was my sister [...] because my sister was there, and she already had her three children [...] she already knew a little more about how the system was, and she helped me apply; she helped me fill out the forms; bring the forms in; she taught me, and she guided me.

Judy’s sister was also undocumented, so Judy knew that if her sister was able to apply for benefits, she would be able to as well.

Many other respondents told similar narratives; receiving information on services from somebody who was also undocumented gave them more confidence going to organizations. Another guiding figure in Judy’s life was her friend, now *comadre* (or her son’s godparent), who informed her about food assistance through a multi-service center. Judy recounts, “I knew about [the multi-service organization] through my *comadre*...she noticed the needs that I had [...] so she told me, look, come with me, I go ask for food at [the organization] and I also go to two churches.” Together, they went to seek food assistance when needed. Her friend also told her about an NPO that provided early schooling and daycare for her young children, and Marisol was able to take English classes there as well.

Other people similarly had neighbors, sisters-in-law, church or hometown acquaintances orient them towards social services in the United States. Who that person was and the amount of support that person could provide largely depended on their immigration history (e.g. whether they came to the U.S. to reunite with a family member or if they came to the United States by themselves). Rosario, for example, received the greatest amount of support from her neighbor Alma. While her husband provided her emotional support and a place to stay, he had limited knowledge of social services in the area. Rosario had to reach out to neighbors to figure out what was available for her and her U.S. born children, and Alma was happy to step in and fill that knowledge gap. Having a trusted person inform one about services also allowed respondents to ask more sensitive questions, like how their undocumented legal status would affect their access to services. Guiding figures, sometimes undocumented immigrants like themselves, would assure them that no social security number was needed. However, regardless of one's legal status, guiding figures played a crucial role in orienting women to different services.

Fortuitous Circumstances and Co-Ethnic Ties

In addition to, or sometimes in lieu of guiding figures, other conditions facilitated women's access to services: proximity to non-profit organizations and connections to other co-ethnic ties who would inform them of different services. Hilda, for example, had migrated from Mexico to join her husband and adult daughter in a large city in the United States. For the first few months, Hilda felt extremely isolated upon arrival. She had not found work, and she had no connections to other organizations or institutions. One afternoon, Hilda went for a walk to help ease her anxiety. For fear of getting lost, she walked slowly and carefully, making sure to note the streets and signage around her. She happened to stop outside a community-based organization that grabbed her attention because of a sign that read "*consultas gratis*," or "free consultations" in Spanish. Hilda recounts,

I came inside [the organization], and doctor Marshall came out and asked me, "Are you looking for somebody who speaks Spanish?" I started crying. They said, "What's wrong? Sit down. Did something happen?" [I responded], "No, I just came from Mexico." "Don't worry," they said, "why don't you come to the [organization]? [...] we have lots of [resources]. If you want, tomorrow you can come, and we'll help you."

From that point on, Hilda came back to the organization, and throughout the years, she has developed a close rapport with staff members there who have also connected her to different forms of informal employment. This was a very rare case of a respondent being able to serendipitously access an organization, but it is noteworthy. Especially noteworthy is the protective function that speaking her native language played for Hilda. She could communicate easily and felt more at ease explaining her situation to them. Other respondents I spoke to described their encounters with fluent Spanish speakers as a positive experience that allowed them to be fully informed of the services they would receive.

Esperanza, for example, only had one acquaintance, Jose, coming to the United States, and he didn't prove to be very supportive for finding housing and employment. Thankfully, she was able to connect with Jose's friend, Tony, who then connected her to a job in a Mexican grocery store. She met her future husband at the grocery store, and soon became pregnant with her first child. Her co-ethnic co-workers then instructed her to go to the WIC and Medi-Cal

office to sign up for services for her and her child. Similarly, when I asked how Sofia found out about Medi-Cal and WIC after she became pregnant with her first child, she said, “well, I worked with four or five other [Latina] women. I would talk to them, and they would tell me about their experiences and where they had gone for [services].” For about a third of respondents, co-ethnic co-workers, family members or neighbors would notice that respondents were pregnant or were having troubles making ends meet, and they would inform respondents of different organizations where they could receive aid. The neighbors and family members often went to these organizations themselves, so respondents were reassured that this aid was feasible to receive and helpful.

Medical Conditions as a Catalyst for Information

Having trustworthy and informed confidantes was the best-case scenario for respondents in this study. In some cases, respondents had either uninformed or unsupportive networks that either were unable to inform respondents about services available to them or inhibited individuals from seeking much needed services in the first place. For example, Margarita had a much different trajectory than Judy and Rosario; she didn’t feel so much compelled to come the United States as much as forced to by her parents. Her older sister was living in the United States without papers, and having recently left her abusive husband, she needed support taking care of her son. Her sister was uninformed of different services and supports available in the United States, so Margarita was similarly uninformed when she migrated north. Margarita explains:

[...] when my sister was [in the United States], she worked as a single person for a long time taking care of children [...] when she became pregnant, she continued to take care of children, and she never became informed about the type of aid she could receive for her son. She never asked. Nothing. She knew nothing [...] so when I came here, I didn’t know that there was help for her son.

When Margarita became pregnant, she kept it hidden from her employer for as long as she could, and she also didn’t go to the doctor during this time because her employer threatened to replace her if she missed a day of work. Through asking her co-ethnic neighbors in her apartment complex, Margarita found out about a local, free clinic she could go to, and she made the decision to visit it after five months. While she was in the waiting room another patient asked her in Spanish if she was on WIC. Margarita responded that she didn’t know what this was, and the woman instructed her to ask her doctor about it. Margarita did that, and she was able to sign up for the food assistance. Five other women mentioned finding out about WIC, Medi-Cal, and other county-level health insurances (Health PAC) for the first time by going to clinics for pregnancy check-ups and being informed about services there. When I asked another woman how she was able to sign up for Medi-Cal, she stated, “Medi-Cal? Really, [the clinic staff] did everything. They did everything. They told me they would give me insurance that would pay for everything, that I would qualify for it, and they did the entire process completely.” In the absence of a guiding figure, women would become informed of different services through local clinics or hospitals.

However, in one case, a respondent’s family deterred her from accessing the local clinics and hospitals in the first place. Asuncion migrated as a single mother in her forties to join her husband in Oakland. She entered an unsupportive household and social network consisting of her

in-laws and husband. Her in-laws took advantage of Asuncion for free childcare and cooking; her husband gave all his money to her in-laws and left none for her and her son. When I asked Asuncion if she was aware of Medi-Cal or Food Stamps for her son when she first came here, she indicated that her husband never let her go to a clinic or ask for assistance in any form. He said that this would lower their chances of obtaining residency, and he didn't want any problems with *la migra* (or immigration authorities). Other respondents expressed similar concerns about applying for food stamps or other public benefits for their children for fear of ruining their chances of regularizing their immigration status in the future.

It wasn't until she was confronted with a medical emergency that members from her prayer group convinced her to go to a free medical clinic against her husband's advice. Finding that assistance was available there, Asuncion continued to return to the clinic with her son and, through that clinic, applied for state health insurance and food assistance. In contrast to Judy and Rosario, Asuncion did not have guiding figures that led her through different forms of social services; instead, she found the help she needed through connections to a prayer group that gave her a push to seek services after encountering a crisis. Resource-seeking became a reaction rather than pre-emptive action due to an unsupportive kin network. Feeling "safe" at the clinic then pushed Asuncion to seek other necessary resources, such as Medi-Cal and Food Stamps.

Institutional Openings as a Pipeline to Primary Care

However, beyond serving as a motivator and institutional opening, the access to public programs served for women as an opening to healthcare for themselves. Approximately 76% of undocumented women had some venue for primary care, and the percentage grew to 85% for documented women. Women in Oakland described finding primary care more easily than women in the suburbs – in part due to the higher number Federally Qualified Health Centers in Oakland. For women in more suburban areas, a FQHC or free clinic was much harder to come by. Rosario, for example, did have her neighbor Alma orient her to Medi-Cal and WIC. However, it took a few more years for her to discover a primary care clinic for herself. She describes the frustration in not finding a primary care clinic below:

"Sometimes [I had] you know a daily headache, and [I would ask myself], 'where do I make an appointment?' I would call the clinic, and [they would tell me], 'this is only a women's clinic. Is this for pre-natal care? If so, you can get an appointment. If not, then they won't accept you. So, I asked myself, 'Where? Where do I go?' And sometimes my husband would have something, and I would ask myself, 'where? Where do I go?'"

Rosario then explained that through time, she kept asking her acquaintances for places where her and her husband could be seen, and a friend told her about a free clinic she goes to and handed her a bulletin for it. Rosario called the clinic to schedule an appointment, but she wasn't able to get through the line. Her friend assured her that she had to call several times in order to get through, and so she said that the following week, she called for forty minutes straight until she could speak to a receptionist get an appointment. Rosario said the effort was well worth it because she receives really good attention there.

Thus, we see through Rosario's narrative that accessing general primary care is a much less straightforward task than finding pregnancy-related services. Luckily for Rosario, she was able to find a primary clinic that, though hard to reach, was available for needed care. Not all

women, however, were so lucky. For example, Sofia was one of the few women who did not know where to access primary care. When I asked her where she goes if she gets sick, she laughs and says, “I don’t go anywhere! I self-diagnose. I say, okay, ‘I have vomiting; I have an infection. If I go to the hospital, they’ll probably give [...] amoxicillin, so I sometimes order my medicine [from Mexico].” Other women described feeling left out of a system of care simply because of their legal status. For example, Maria, a 51-year-old mother of two, responded the following way when I ask her where she goes for medical services: “Sadly for me, there’s nothing. [...] Obamacare is only for residents. It’s so hard to find medical care [as an undocumented individual]. Before, there used to be more basic exams [...] at county clinics. Now, they have reduced them because there’s supposedly no funds. They’re focused on getting [residents] [...] They know they’ll get money with them, you see?” As other research indicates (Calvo et al. 2017) her lack of access to health services was a signal to her that she was an outsider that did not belong. It was a feeling that even individuals who did access services had to contend with. As my previous chapter illustrated, some of those interactions were discriminatory and humiliated women, and through speaking with women, I found that respondents preferred more specialized clinics for women and/or free health clinics run by community organizations over FQHCs. While men accessed clinics and healthcare at a much lower rate than the women I interviewed, they also described the same preferences, which may signal the presence of more culturally competent care in community and specialty clinic settings.

Moreover, as my interviews with men also confirmed, the options available to uninsured and/or undocumented immigrants were much narrower in suburban settings with less of a history of poverty. These differences were reflected in the presence of county level programs available in Oakland for undocumented immigrants compared to the erasure of many of those programs in Alameda counties after the foreclosure crisis in 2009 that resulted in many budget cuts, including cuts to health services for undocumented immigrant adults. Although a majority of the women in my sample eventually accessed primary care, for all but one undocumented woman who was covered by her employer, health insurance was still out of reach. Health insurance was only available for their children. Even with the support of guiding figures, institutional mediators, and co-ethnic ties, political structures still played a pressing role in their access to high-quality, accessible care.

THE POWER OF BONDING TIES, POLITICAL IMPLICATIONS OF SEEKING RESOURCES, AND DIRECTIONS FOR FUTURE RESEARCH

For the undocumented immigrant women in this study three main conditions and one protective mechanism facilitated respondents’ access to “qualified safe” spaces where they received crucial services for themselves and their families. For half of the women in this study, “guiding figures” almost immediately directed them to needed services upon their arrival. For respondents without guiding figures, an external push in the form of a medical condition or emergency propelled them to go to local hospitals or clinics, and the hospital/clinic staff then informed them of benefits they were eligible to access. In other cases, respondents came upon social service information through more serendipitous circumstances, or through connections with co-ethnic friends, neighbors, or co-workers who received services. Lastly, before seeking these services, respondents established that they would be entering a “qualified safe” space by pre-emptively checking the organization’s legal eligibility requirements.

Social Networks & Resource-Seeking Processes

By underscoring the importance of informal, private ties in accessing information about services and in physically accessing, clinics, hospitals, and other social service institutions, I demonstrate the power of “bonding” ties in resource-finding behavior. This finding complicates past research indicating the importance of “bridging” ties for low-income individuals (de Souza Briggs, Popkin, Goering 2010), and suggests that trust may hold a particular strength for marginalized populations navigating new institutions. Scholars have long addressed the role that social networks may play in propelling people to migrate internationally (Massey 1999), or they describe the overestimation of positive social networks for Central Americans (Menjívar 2000). Other scholars have explored the positive and negative effects of ethnic neighborhoods for shaping access to local resources (Zhou 2009). I add to the literature on immigrant social networks by showing the crucial function private networks have in facilitating information about and access to key resources. Research on NPOs highlights the role that NPOs can play in expanding an individual’s social capital (Small 2009) and acting as a catalyst for collective mobilization (Coll 2010, Bloemraad and Terriquez 2016), but it pays less attention to the *initial* social capital that facilitates access to these institutions in the first place. Understanding how individuals originally access NPOs can help establish better interventions for NPO outreach to low-income and/or immigrant populations.

Moreover, understanding the process involved in making decisions about claiming public benefits complements research that emphasizes the political nature of the claiming process (Soss 2000). Soss (2000: 88) frames claiming welfare as a form of “survival politics” that can complement more collective, confrontational politics to effect broader change. A similar narrative of resource-seeking as political action has been paralleled in the immigration literature. For example, in her work, Coll (2010) outlines how “good information” (or *buena información*) provided through the NPO Mujeres, Unidas, y Activas (MUA) was one of the first initial steps towards the politicization of undocumented women “remaking citizenship” in San Francisco in the mid-1990s. By having information on how to navigate and advocate for one’s children in state institutions, women can become more empowered and savvy as they pursue other resources and pass along their knowledge to others.

Understanding Qualified Safety

I describe the spaces and processes that enable and provide access to services for undocumented immigrants as places of “qualified safety,” because in the absence of federal immigration reform, undocumented individuals face the risk of being deported; of being separated from their children, from their spouses, and from a country they have taken pains to establish themselves in. The risk of deportation *perceived* by respondents varied widely, but they all acknowledged this was a real possibility they had to face. Finding spaces where their legal status would not (at least immediately) be used against them allowed women to take the risk of disclosing their undocumented status to one person or another. Once women found qualified safe spaces, they were able to form bonds with other women, find other forms of resources, and breathe a bit easier knowing their children did not have to go hungry or forgo medical aid.

The concept of “qualified safety” that I have developed in this article is sorely needed in immigration literature, which tends to emphasize “legal violence” and pay less attention to the strategies used to mitigate it. This concept could also be expanded and applied to scholarship that focuses on other marginalized populations, such as homeless populations or individuals with a

criminal record that are negatively impacted by laws that limit where they can live (Beckett and Herbert 2009; Goffman 2009) or what public benefits they can receive (Harding et. al. 2014). Like undocumented immigrants, these marginalized populations may also rely on institutions or strategies to reduce their social suffering. More scholarship is needed that explores other types of qualified safe spaces and the mechanisms that allow vulnerable populations to access them. This scholarship can then be used to inform policies that expand access to “qualified safety” for vulnerable populations and allow these spaces of safety to foster and grow.

In this chapter, I focus on interviews with current or formerly undocumented women because they are most often in contact with public institutions related to health and school through their children (Jones-Correa 1998). While women’s networks helped guide them through different services, this was not the case for the nineteen undocumented men I interviewed. Men did lead other men towards employment and informed them of English classes, but entries into the health system most of the time occurred either through an employer, were prompted by a medical emergency, or most of the time, didn’t occur at all. Even if men did have access to insurance through an employer, they reported never having gone to a clinic despite living years in the United States. I discuss men’s experiences access to social services, or lack thereof, in the following chapter where I show how structural conditions and a culture of masculinity intersect to reinforce men’s limited access to services and care.

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CHAPTER 3: MEN'S FRACTURED PIPELINES TO SERVICES

I met Manuel through a worker center where I went to weekly worker meetings to talk about my project and recruit people who would be interested in an interview. Manuel stood out apart from other workers because of his taller figure, lean frame, and kind eyes that seemed to be constantly smiling. He was enthusiastic about the prospect of an interview to tell his story, and we quickly settled on meeting the following week at the worker center during the morning to talk. When I called Manuel the day before the interview to confirm our meeting, he profusely apologized and asked if we could have the meeting the following day instead. His employer had just offered him work, and he really needed to take it. We both showed up the next morning, and settled into a small room, where the interview took place. Manuel was wearing a long-sleeved white shirt, and jeans, and appeared to look older than his fifty-six years of age. His skin was weathered, and his hands had dried white paint on them, a product of his previous two days of work. He carried a stack of loose-leaf notebook papers, with large, elegant cursive words written on them that were visibly shaking in his hand. I later learned the papers contained his testimony statement to being the victim of a domestic crime – he was in the process of applying to a U-Visa after being badly beaten by a group of men at night. To ease the mood, we talked a bit about the weather, and he told me about the job he had just secured for a few days. It was a real relief to have this multi-day work because stable work was hard to come by. Indeed, Manuel was living on the cusp of real financial precarity – a structural precarity, which he had little control over, which led to real frustration and desperation as he underwent a difficult process to seek resources and aid.

Manuel came to the United States in the early 1990s in order to pay for his children's tuition expenses that were unaffordable for him on his *campesino*, or fieldworker, wages. Even though Manuel expected the trip to be temporary, he has not returned to Mexico since. Manuel has not seen his family in over twenty years, and to make things more difficult, he has not formed a new family here. When I asked him if he had any family when he first came to the United States, he said, "No, even to this day. No wife, no sons. I only came with my friends." His friends were other men that he knew from his hometown, and they all came to the United States to seek whatever employment they could obtain. Together, they decided to meet at corners to wait for work, and they kept each other informed of important resources and services they could access. Manuel recounts, "we told ourselves, 'okay, we'll get together here in [a pharmacy store]. Look, another place, where they pick people up is here in Oakbrook, the one in Northpark."²⁸ And so, we moved [...]" During those years, Manuel recounts, work was abundant, but so were laborers. Everybody had to act quickly to get a job. For the past two decades, Manuel has worked as a day laborer, moving from one corner to another for work, and from one crowded apartment complex to the next for housing. Several months into his stay, Manuel found out about a community-based organization that offered free meals, and where he could find employment opportunities at fair wages. He also took some English classes and computer classes at the center, and he proudly talked about receiving a diploma for completing computer classes; it reminded him of his painstaking efforts to allow his children to receive diplomas for their high school education.

²⁸ The street names are pseudonyms, as are all the names and places described here to protect respondent confidentiality.

However, despite having access to the worker center and its services, Manuel was still hanging by a thin financial thread. The thread became even thinner when he was injured at work several years ago. While working on last-minute side job, he fell through a roof and gravely injured his leg. His employer—an acquaintance of his—did not have insurance and simply handed him some cash as he rushed off to hospital, potentially as a way to make up for his lack of coverage for Manuel. In the end, Manuel was able to have medical expenses covered by the county's emergency medical insurance, and through connections with a labor lawyer he was able to receive money from the city he worked and resided in for his broken leg (as the roof he was working was proven to be structurally unsound). The injury still rests with Manuel, however; and the small sum of money he received from the city does not exempt him from financial instability. Since another workplace injury, Manuel has been unable to afford chiropractic sessions to restore his limbs' mobility. To make matters worse, Manuel has chronic pain in his teeth, but despite his best efforts, he has been unsuccessful in finding dental care. Because he has no other choice, Manuel must work through the pain; it is the only way to ensure his subsistence. After stating his concerns about rising rent, he says, "because today, I don't have work, I don't earn [money]. It's been fifteen days since I've worked, and I've been spending money [on food]. Right now, I only have \$150 for rent, but my own reassurance is that I still have more money coming from two and a half days of work, so that helps me sleep at night." He then went on to describe his careful calculation of living expenses on a day-to-day, week-to-week, and month-to-month basis.

With limited networks, and undocumented status, Manuel was funneled into an extremely precarious informal labor market that involved physically laborious and injury-prone work. His two injuries and aging body make it even more difficult to continue this work and thus to sustain himself. A vicious cycle is replicated in the cruel interaction between labor and health. While not all workers I interviewed experienced such heavy hardship, Manuel's situation serves as a cautionary tale of what happens in an economic regime that prioritizes labor and devalues health.

In this chapter, I argue that while both men and women have limited access to social services and healthcare, the challenges in accessing and receiving services differ. For women, one of the biggest barriers described to accessing services was the fear that their legal status would prevent them from being eligible for programs, and/or would later be used against them or their family members as they sought legal status. Their children, however, gave women a broad institutional opening into social services and healthcare as they become eligible for programs like WIC and Medi-Cal; co-ethnic, gendered networks would then refer them to these programs. Thus, while women did experience fear and hesitation upon signing up for services, the state gave a clear structural opening into services for mothers – an opening which was culturally reinforced by their social networks who facilitated seeking services with less shame.

For men, by contrast, their strategies for seeking different resources and services were more structurally and culturally limited. Structurally, undocumented men did not have access to public programs like WIC or Medi-Cal, so unlike women, they did not have a clear opening to services. Culturally, a larger narrative of masculinity and immigrant work ethic further prevented men from seeking the care that they needed. They described not getting sick or needing to go the doctor, and they ended up using health services only in emergency situations. Thankfully, men's drive to find employment, unexpectedly led some to medical care. As men informed each other about different employment opportunities, men found out about worker centers, which apart from providing access to fair-wage employment, offered information and connections to health-related services, like food assistance, clinics, and county health programs as well. Through this connection, worker centers were able to mitigate some of the barriers to healthcare and services.

By focusing on men's processes for accessing social services, I contribute to the immigration and welfare state literature, which typically focuses on women's access to services. Shifting the focus to an often-ignored population in the literature illuminates how structural and cultural conditions together can further entrench one's exclusion from social services. Moreover, it also shows how processes towards accessing services can also arise in more indirect and organic ways. Although men were not searching for healthcare when they went into a worker center, their connection to health services turned out to be fortuitous in the end. In the sections that follow, I outline some of the literature surrounding the influence of gender, informal work, and health, to show how undocumented men's access to health-related services is a product of both structural and cultural conditions. I then follow with empirical narratives to show how the challenges to accessing healthcare among men unfold, and how they are eventually overcome by some.

Gender and Health

Before I delve into my findings on the access and use of health resources among men and women, I want to first address the fundamental question of how gender may influence resource seeking behavior generally. Since the 1970s and really taking off in the 1980s, researchers found that men were less likely to seek health-related assistance than women (Galdas et al. 2005). Some of the differences in healthcare usage behavior have been attributed to a culture of masculinity that enables men to ignore pain or underestimate the severity of negative symptoms or diagnoses, which often leads to seeking care less and/or seeking it too late (Courtenay 2000). This literature often does not complicate notions of masculinity (Lohan 2007), as it assumes men adhere to a hegemonic masculinity, and doesn't look at male populations that may contest it. Studies that have made comparisons within the male populations have found that in the U.S., men with lower socioeconomic status (SES) have poorer health outcomes than those of higher SES, and Latino and Black men (Cheatham et al. 2008) are less likely to seek health resources than White men, and Latina or Black women (Williams 2008), especially when it comes to accessing mental health care services (Cabassa 2007).

Most of this literature is quantitative and survey-based, which provides less insight into how barriers to healthcare may influence men's access and usage of health care services as well. Researchers have documented how uninsured populations have much less access to healthcare overall (Hadley 2003), and how a majority of the undocumented population is uninsured (Public Policy Institute of California 2015). However, there is less of a systemic understanding of how gender and legal status both interact to shape undocumented men and women's access and pipelines to care.

The Health Implications of Informal Work

What the literature on health, gender, and immigration status has addressed are the dismal conditions that many undocumented migrants are subject to in the informal labor force. Historically, immigrant laborers have been subjected to labor exploitation, employer intimidation, and dangerous working conditions in physically arduous jobs. To this day, agricultural workers are largely relegated to poor housing conditions in areas with limited public amenities and services. In his work, Holmes describes the living conditions of undocumented Latinx workers in the agriculture industry in Washington. There were nineteen people living in a

three-bedroom apartment, and adults worked continuously 12-18 hours a day, six to seven days a week, for at least a month or more. Surveys of agricultural workers indicate a whole slew of chronic health conditions and diseases that workers are prone to from their backbreaking manual labor in the fields. They develop chemical or pesticide-related illness, numerous skin conditions, respiratory conditions, and/or musculoskeletal disorders as they endure chronic pain and headaches on a daily basis (Hansen and Donahoe 2003; Villarejo and McCurdy 2008). Employers dismiss workers concerns about pain or medical conditions and racialize workers' bodies stating indigenous bodies are equipped to endure more pain (Holmes 2013: 170).

Beyond farmworkers, people devoted to day labor and construction work are also prone to irregular wages which make it hard to afford food and housing, and they are also prone to chronic health problems and work injuries. According to a Center for Urban Economic Development Report (CUED) on day laborers (2006), "one in five day laborers has suffered a work-related injury, and more than half of those who were injured in the past year did not receive medical care" (12).²⁹ In examining the reasons for not receiving medical care, the report finds most undocumented workers cannot afford health care, and employers often do not cover the worker under health insurance. Any extra expense must be heavily calculated by workers, who are already living on a very limited budget.

At the same time, the physically heavy toll of their work can serve as a source of pride for undocumented workers, particularly for men. They embrace their identities as hard workers who are able to work long hours at low wages because they are strong enough to handle it. This emphasis on worker identity may shape why some undocumented workers do not report unfair working conditions or wages in the workplace (Gleeson 2010) or reinforce the narrative that different racialized bodies are made to endure varying levels of pain (Holmes 2013). Given that the limited positive discourse on immigrants stems from their roles as laborers and a culture of masculinity that may see acknowledging pain as a sign of weakness, it comes as no surprise that many immigrant men embrace this identity and focus on their physical strength. Options for medical treatment and healthcare are extremely limited for men – a product of longstanding structural violence.³⁰ Even when men were aware of medical options hypothetically available for them, the cost of seeking care was too high. Men rarely used health services, unless a severe medical crisis or work injury arose.

MEN'S LIMITED ACCESS TO HEALTHCARE

In the previous chapter, I detailed how women were eligible for two broad public programs that were available to those who are pregnant or with young children: Medi-Cal and WIC. Despite having some hesitation in finding these programs, women were often able to access them through support of guiding figures, co-ethnic ties, and institutional referrals that connected women to these programs and other services like food assistance, educational classes

²⁹ In describing the relationship between labor and health for men, I do not aim to undermine the heavy toll that labor can take on women. In fact, undocumented immigrant women engaged in informal employment by caretaking and cleaning are subject to low-wages, verbal and sexual abuse, and toxic chemicals which can harm their health. A recent collaborative report by local non-profit organizations in Oakland found that 95% of household workers were uninsured, and 64% did not seek medical care for injuries or illnesses (Behind Closed Doors 2007).

³⁰ According to Holmes (2013) "Structural violence is manifested as social inequalities and hierarchies, often along social categories of class, race, gender, and sexuality" (89). In this case, Mexican men are relegated to informal, exploitative labor markets that worsen their health while simultaneously being excluded from access to comprehensive medical care.

and primary healthcare. As a result, 88% of women, including 77% of undocumented women, reported being connected to and using primary care.

The portrait for men looked quite different. Because men were not able to access broad public programs, like WIC or Medi-Cal, they did not have a clear institutional opening into services. Furthermore, because most of them were in the informal labor market, they also did not have access to health insurance. In fact, out of the twenty-nine men that I interviewed, only eight had access to health insurance, while ten men were not informed of access to health services for preventative care. Unlike the women I interviewed for my dissertation, only 35 percent of undocumented men had access to primary care. Furthermore, medical emergencies were a common intervention that forced men to seek care (a fifth of men (6/29) only sought care after a medical emergency). Without an emergency, men would not go to clinics despite having health insurance and/or knowledge of clinics. They would engage in reactive versus preventative care. The sections that follow below outline how men describe never being sick and only seeking medical services in emergency situations, and by way of example, I illustrate how preventative care can potentially offset emergency health situations.

“I don’t get sick” [but I do get injured]: High Thresholds for Medical Care

Despite the challenges people faced in accessing services, every woman I interviewed had visited a health clinic at least once since they migrated to the United States, and most of them described using regular primary care services. In contrast, out of the twenty-nine men I interviewed in my sample, about a fifth of them (6/29) claimed never to have seen a doctor or gotten sick despite living here for years, or even decades. In this section, I argue that part of the low rate of primary care is due to a combination of information barriers that make knowing about primary care difficult, and cultural narratives that reinforce a non-care seeking behavior among men.

Jorge, a day laborer in his mid-fifties, had come to the United States from El Salvador to give his daughters a better life. When I asked him where he went if he became ill, he said that he had only gone to see a doctor twice in the past sixteen years – both times were serendipitous as he passed by pharmacies that advertised free medical consultations in his Oakland neighborhood. He wanted to be insured, but he didn’t know what options were available for him as he made over the poverty limit for the county-wide health insurance. Information barriers were clearly prevalent as some men didn’t know where to go if they were experiencing pain; they would wait until an emergency arose to get service at a public hospital. When I asked Manuel, the person at the start of the chapter, if he had health insurance, he said, “No, no, no, no. No, no. [Stammering] I don’t have anything. No doctor...no nothing. I mean, I’ve never gotten sick, thank God. The only time [I did], I went directly to a [public hospital], and the other time, that I had tooth pain – it’s horrible to sit with that pain.” Note that before he talks about his two emergency room visits, he says that he has never gotten sick. It is almost as if he wanted to definitively rule out the possibility of ever needing expensive medical services. He did not know where to go to seek affordable care, and the thought of having to pay full cost for medical services made Manuel stressed and anxious.

In another interview, Eddie, a 50-year-old day laborer living in Oakland, said he thinks he has health insurance, but he’s not sure. When I inquired more about it, he said that he went to Highland after a medical emergency, and that through the hospital, he was connected to a “council” person who then helped him register for a MediCal card for low-income people. With

this, he didn't have to pay any medical bills. However, he has not gone to an office or the hospital to try to get a replacement card; this was several years ago. When I asked him if he knew about the doctors at the broader organization the worker center he was a part of, he said that he went with them when he first joined the worker center five years ago, and they did a regular check-up. However, he has not had a check-up since. I tried to inquire why that was the case, and the closest I could get to an answer was that he simply didn't prioritize having health appointments because he was most concerned about having work. For men working in informal sector jobs as day laborers or landscapers, employment was highly irregular, which made it difficult for men to spend time waiting in clinics or seeking out information on how to access different services and resources, including medical care.

Coping Mechanisms in the Face of Limited Care

In the face of limited healthcare access, men had different strategies to cope with limited care. Downplaying the need for medical care was one strategy; emphasizing their agency and ability to maintain their health was another. Ronaldo, a 57-year-old landscaper and father of one, responded in the following way when I asked him where he went if he ever got sick, "I go nowhere [...] I try to avoid a doctor because it's really expensive." He excitedly discussed how he tries to cut red meat from his diet, and how his physical labor keeps him strong. However, soon after his discussion of healthy habits, he admits, "the only thing that bothers me is that I had an accident in Mexico, and I hurt my back. [...] I saw a chiropractor here [in the United States] [...] but it was too expensive; I had to end the treatment because I couldn't pay it. [...] But, other than that, I'm healthy." Ronaldo is currently undocumented, and he works odd jobs to make ends meet; he has no insurance from his employer, and because he lives in Contra Costa County, he also has no access to county-wide health services.³¹ Yet, despite the structural barriers he faces in accessing healthcare, he emphasizes his agency in taking care of his health, which was the general theme throughout the interview. He wanted to maintain a positive attitude; believed in the meritocratic myth of the United States; and he didn't want his legal status to drag him down. Towards the end of the interview, he states, "with papers or without papers, you can prosper in this country." He knew he had value in the United States, but interestingly, he did not critique broader structures that impeded his access to proper healthcare.

In some ways, Ronaldo's views of emphasizing one's agency were paralleled in Jesus's attitude towards not letting one's undocumented status determine his experiences in the United States. He had taken the risk of using a fake Social Security Number to secure employment at different places, which all offered him health insurance. But again, his access to insurance did not mean seeking preventative medical care. He claimed to have never gotten sick or gone to a doctor in his six years in the United States. At the time of our interview, he was visibly sick as he chronically coughed and blew his nose. When I asked him if he would prefer to schedule the interview at another time, he insisted on doing the interview even though he was scheduled to work in a restaurant afterwards. In all likelihood, men did get sick in their time in the United

³¹ As I describe in the introduction of my dissertation, county-level policies on providing healthcare to undocumented populations vary widely. While both counties provide health insurance to children regardless of legal status through California state funding, only Alameda county provides a baseline form of health services through the HealthPAC program for adults. Undocumented adult residents of Contra Costa County must rely on Federally Qualified Health Care Centers, which operate on a sliding fee scale, or free, local clinics, which few men in my interview sample were aware of.

States, but unless the pain was unbearable or was a grave injury, they did not seek medical help. This behavior makes sense given their limited access to medical care and insurance. This rationale of not seeking medical care until an injury arises is exemplified by Mario, a day laborer and forty-six-year-old father of three who has resided in Concord for fourteen years.

When I asked Mario where he went if he had any medical problem, he stated the following, “Well, before I had basic [health] care [...]. But in 2009, they took away the basic care service for immigrants, with the crisis and the [budget] cuts. The state realized that they there were a lot of immigrants with basic [health] care, and they took it away. They only left us with the emergency healthcare. [...] The good thing is that I don’t get sick, so I haven’t had to see a doctor up until now.”³² When I followed up and asked if he didn’t go to a doctor when he became sick, he said, “I don’t get sick. I’ve only gone – for example, one time I hurt myself at work, and I went to Martinez [public hospital]. Because I had emergency health care, they attended me there.” Illustrated through all of these examples are cases where men say they never get sick and do not need medical care, but then qualify these instances with examples of times they became injured and needed to seek care despite the high costs potentially involved. The first reaction in men’s responses to my questions on healthcare was to downplay their need for medical services they did not have easy access to, but as I detail below, the lack of access to primary care has serious, negative implications.

Primary Health Care: The Dangers of Inaccessibility

Not having access to preventative care has all kinds of dangerous implications, from not seeking medical care unless one is convinced it is an emergency situation, to not being able to detect chronic conditions that can be managed, like high cholesterol or diabetes. Ramon, for example, forewent medical care after he was physically assaulted while shopping for work materials. According to Ramon, the robbers held him at gun point and demanded his money before they took off. At the security guard’s insistence, Ramon called 9-1-1. Ramon describes what happened afterwards, “The police came, and so did the ambulance. At this point, I had recently had an operation for my kidney; my main worry wasn’t the assault, or money. No. My main worry was that I would have complications for my kidney. [...] But I didn’t want to go the hospital because I couldn’t count on my medical insurance [to cover the bill].” His employer only covered work-place related accidents, and he didn’t think this would count as one. Thankfully, Ramon did not end up having any complications with his kidney, but he didn’t have this assurance right away because he feared the potentially costly health care. Ramon’s anxiety over seeking out costly services for care is illustrative of how under or uninsured populations may refrain from getting necessary medical help in circumstances when they do need it.

While Ramon forewent seeking medical care because of the risk it might not be covered by his workplace insurance, others were limited by not having insurance at all. Rodrigo, for example, was not able to get a surgery for a hernia for fifteen years because it was not considered an emergency that would be covered by insurance for low-income patients. It was only when a

³² In 2009, at the onset of the recession, primary care services were cut for undocumented adults. Although primary care services were restored in 2015 through the Contra Costa Cares program, the scope and funding for this program is more limited. Only 3,000 participants are allowed, and they are enrolled on a first-come, first-served basis based out of screenings at four medical sites throughout the county. None of the men I interviewed knew about this new program, and only one woman residing in Contra Costa County was part of it after being referred to it by a non-profit.

staff member at the worker center he was a part of subscribed him to a county-wide health services program, that Rodrigo was finally able to obtain the surgery. Through my participant observation as a volunteer in a local clinic for uninsured patients, I also witnessed how important it was to have access to clinic-based preventative care. Even though patients came in with symptoms that on their own would not be cause to seek emergency services— like strong, ongoing headaches, or faint numbness developing in one’s hands— doctors were able to connect these symptoms to potentially harmful conditions, like the onset of a facial strokes or severe diabetes that needed to be managed. If an emergency situation arose, doctors would immediately refer the patient to emergency rooms at hospitals, and if diabetes or high cholesterol was detected, the clinic was able to offer medicine to lower blood sugar or cholesterol and free one-on-one consultations on diabetes education and management to prevent a worsening of the medical condition. When I asked male patients coming into the clinic how they found out about it, they often explained that their family members or friends had told them the resource existed. However, the medical clinic was seldom heard about from interview respondents I spoke to, which indicates that information on free, local clinics remained to be shared more widely, especially among men.

A NARROW PIPELINE TO CARE: EMPLOYMENT SERVICES AS A MEANS TO HEALTH CARE ACCESS

Thus far, this chapter has delineated the barriers and challenges that men face in accessing healthcare, and the dangers this has for their health, and in extreme cases, survival. Given, the obstacles men are up against, how do they eventually access care? Surprisingly enough, the link many men found to care was through their employment, which was reinforced through their gendered networks. In other words, men openly shared information on employment, and in some cases, this led to men finding out about worker centers where men could be connected to day labor employment at fair wages. The worker centers would then inform them about health services and/or help them sign up for different services. While women had a more direct path to service referrals through their pregnancies and referrals to clinics and other resources, men had a much more long-winded, but at times, successful path towards primary care. In the sections that follow, I describe the supportive roles that men shared as they helped each other secure employment and housing upon coming into the United States. I then follow with how this information sharing on employment eventually led to a connection to worker centers and eventually health services. The path towards accessing healthcare is long, but in some cases, it worked out.

“One day I came into the U.S., and the next day I was working”: Co-Ethnic Information Sharing on Employment

One of the main reasons the men in my interview sample came to the United States was to seek higher-paying work opportunities that would grant them and their families a better life than they could afford in their countries of origin. Thus, work was of utmost importance upon coming to the United States, and information on finding work was relatively easy to come by. For some men, their existing social networks in the U.S. helped them secure stable employment through their own employers. Other men forged alliances with people in similar situations and traded information on how to get access to informal sector work. While the stability and nature

of work slightly differed for men, the common thread among their experiences was the role of co-ethnic, often gendered networks who helped them secure employment. The process of how men leveraged their networks and resources to find employment is discussed further below.

Jesus was born in a large city in Mexico, and where he grew up being the oldest son out of six. His mother dedicated herself to the home while his father sold goods at outdoor markets, or *tiangis*. Jesus was able to finish secondary school, and then he worked various odd jobs in the city from the age of fifteen to support his household along with his father. In his early twenties, Jesus then started going out with his future wife, and she became pregnant with their first and only child. Her wife had a lot of family in the states including her older brother who insisted they join them. Jesus didn't want to come, but he left the decision up to his wife. His wife's brother got a coyote, and within a few months, they came to the states.

They initially came in 2005, and his brother-in-law set him up right away with a job at the same construction company he worked at. In describing his quick transition into work, he stated, "My [wife's] brother worked in a [construction] company, and right away, when he found out we were coming, he talked to his supervisor and [said], 'look, my brother-in-law is coming.' 'Yes, bring him in,' [his supervisor said]. [...] One day we came [to the U.S.], and the next day I was working." Ten men had similar stories of having their male family members connect them to a job right away in construction companies, restaurants, or landscaping. If people didn't have the skill sets for a particular job, they would learn it on the job. For example, when I asked Oscar how he was able to obtain work upon coming to the United States, he stated, "[My friends] helped me. They worked as landscapers. I didn't have any experience in it, but they taught me how to landscape." Thus, friends as well as family members all helped orient and support incoming immigrants to help them get by. They shared living spaces, and they shared crucial information.

Gerardo for example, initially resided in the central valley of California. When I asked him how he started to search for jobs, he said, "There are friends who tell you 'go to this place, and there's work.'" He initially had trouble finding work in factories due to his limited English skills, but soon, he was able to locate a temporary agency that would dispatch him to different jobs. Because he had legal permanent residency, he was eligible to work for this agency. For men who were relegated to the informal labor sector, they described how they would hear about different street corners to search for work and head there together. For example, Jorge started looking for work on street corners in Berkeley even though he lived in Oakland. When I asked him why, he said, "Through my friends, they told me it was good. Really good because there if we didn't get work, organizations would come by and give us lunch." Indeed, when I asked Manuel how he found out about a day labor organization, he said, "[my friends] and I would wait in street corners, and [organization staff] would let us know that an organization existed there [...] and they had food. So, we walked [from where we were to the organization]." As I describe later in section that follows, once the workers were in the day labor center, they would find out about much more services and resources that were available to them outside the scope of employment.

Workplace Interventions in Accessing Care

About a quarter of the men (7/29) I spoke to were connected to health services for the first time when they joined the worker center despite having lived and worked in the United States for many years. Because Oakland is located in Alameda County, undocumented day

laborers at the worker center in Oakland were able to get access to the HealthPAC program that gave them access to basic health services and care. At the Concord location, however, the free county health service program was less robust. The Contra Costa Cares program provides free health services for up to 3,000 low-income residents based on those who apply first out of four medical sites. But because the county cut funding for primary care services from undocumented adults in 2009, most men were under the impression that no primary care options were available for them in the county. Instead, men typically found out about an FQHC that one had to become a member of to receive services. Once people were a member, they could also potentially be referred to the Contra Costa Cares program. Still this low-cost clinic information can still provide an outlet for needed care.

The process of referrals to clinics is illustrated through my exchange with Carlos, a day laborer who had immigrated to Concord from El Salvador a month before the interview took place. After asking him if he had found out about any services to help with food or medical services, he said that just yesterday, the staff members were talking about it at the center. He said, “[the staff told us we had centers where we could go for a [low-cost] medical consultation. For me, that’s good. It’s a good help because getting sick is really expensive. The best thing is not to get sick, but one isn’t in charge of that, illnesses come of their own accord.” Interestingly enough, Carlos didn’t recall the name of the clinic that was recommended to him. But perhaps if a situation arose where he would want or need a medical situation, he could reach out the center or other members of the center to know where to go for care. As the previous part of this chapter demonstrates, seeking care among men is not assumed, but at least if they are informed, the process of seeking care is made possible.

Work Centers as Resource Hubs

While workers were initially attracted to coming to the center for food and for work opportunities, they soon learned about other services they could access either through the center or other organizations. They found out about other food pantries, English classes, computer classes, medical clinics, and in some cases, were connected to health service programs like HealthPAC in Alameda county.

Workers who knew about the organization would then refer their friends about what was available. While not everyone came to like the organization, some workers did decide to stay. In one rare case, Rodrigo brought his friend into the organization not merely to seek work, but also to seek treatment for his diabetes at an on-site clinic. He explained, “Just yesterday, I brought my friend. I wanted to show him the place. Even though they had told him that he can look for work here and they told him that here’s a clinic here to help treat his diabetes, I brought him here, so I can directly show him the place.” One other worker described how he himself was oriented to different resources and services available in the town through his family. He explained, “When I first came [to the U.S.], the first thing my friends told me is where the adult school was to learn English, where the work center [day labor organization] was, where stores were, and that the police wasn’t immigration, so there was no need to hide from the police.” Through the day labor center, he then found out about a federally qualified health center, he is now a member of, and a food pantry where he seeks food assistance when needed. In this way, organizations were able to serve as referral hubs and sources of key resources, and it was through the guidance of co-ethnic networks that people were able to secure them. Thus, in the case of many of the men in my sample, seeking work fortuitously turned into an opportunity to learn about healthcare and other

resources. However, in the absence of labor centers, or medical emergencies, referrals to healthcare services were much harder to come by.

Gendered Institutional Pipelines and Changing Immigrant Narratives

In the previous chapter, I described how women, often in their role as mothers and mothers-to-be, were able to access key health services, particularly through the role of their co-ethnic networks and in some cases, “guiding figures” – other women who would take on a large responsibility and role in informing fellow, Latinx immigrant women of services and literally transporting them to different offices and clinics. Once women entered clinics, they were able to be referred to other resources for themselves and their children, and in some cases, places to seek primary, non-pregnancy-related care. Men’s co-ethnic networks also supported each other and shared information on resources,³³ but the types of resources they shared were more focused on employment. Compared to their women counterparts, information on healthcare was much harder to come by. Women also had referrals to employment, but the difference between most of the men and women in my sample is that women were referred to *both* employment opportunities and places for receiving medical care. Information on medical care was typically accessed only after a medical emergency, or via a worker center that was able to intervene by providing information on clinics, health service or insurance programs, and in some cases, on-site medical care.

Yet, work centers are only a small bandage for a much larger system that reproduces structural violence. As Manuel’s story shows at the beginning of this chapter, even having access to the worker center, he still suffered from chronic back and tooth pain, and as an undocumented adult, he had no access to low-cost specialized services, like chiropractic or dental appointments. Even though belonging to the worker center helped, Manuel was still stuck between a rock and a hard place. In order for broader systemic change to occur, the narrative on immigrants’ health needs to change. Immigrants’ health should not only matter because it translates into labor and economic benefit, it should matter in its own right. As the concluding chapter in my dissertation demonstrates, undocumented immigrants are already challenging the stigmatizing public discourse that casts Latinx immigrants as unwanted individuals subject to deportation; they recognize their value not only as laborers, but as a population deserving of dignity, regardless of their immigration status.

³³ Of course, sometimes for both men and women, co-ethnic networks were exploitative, but in these chapters, I highlight their supportive role for services since that is a key focus of my dissertation.

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CHAPTER 4: RESISTING OPPRESSIVE STRUCTURES

Magdalena was at her wits end. After years of working towards her teaching degree in Mexico, it was of no use in the United States. She wanted to pursue her passion while earning an income to help support her family, but because she was undocumented, she couldn't pursue this opportunity. Instead, she invested in her children and their schooling by enrolling them in supplementary education programs, and she also took on some English classes herself. Slowly but surely, she started becoming more involved in community-based organizations and finding out about more resources and opportunities for herself and her family. One evening, she found out a non-profit was offering to subsidize courses at a community college for low-income adults. Maybe this was finally her chance to earn the credentials she needed to teach.

She went to an information session at the non-profit to find out more about the program, and Magdalena learned that she needed to have a social security number to be eligible for the subsidized courses. Recounting this in our interview she exclaimed, "It's not fair! [...] I have my rights too, and I don't always want to be low-income." Furious, she told her friends about her situation, and the friends advised her that it may not be an issue to not have a social security number if one goes to the college to enroll in-person. "I went with my stroller and my children, and they never asked me for my social [security]. I don't know if they overlooked it, if they forgot, but they gave me my student number." Magdalena, like other respondents that I spoke in my project, spoke out about the injustice of a system that restricted the upward mobility of people simply because they didn't have papers. In the end, Magdalena acted out against this injustice, and through it, she was able to further her education.

Over the past few chapters, I have detailed the barriers people face in accessing services, and the gendered obstacles and pipelines to services. The structures they have to navigate within and the process for accessing services is crucial to my research project, but I would remiss not to discuss the continual resilience and forms of resistance that people demonstrate as they navigate an exclusive system where anti-immigrant rhetoric still makes waves at a national level. In this chapter, I illustrate how individuals combat some of the negative public discourse around Latinx immigrants, and the gendered component of their narratives.

I did not ask respondents to solicit resistant narratives or talk about the negative public discourse they felt was directed against them. Nevertheless, a fifth of respondents used one or a combination of frames to resist their stigmatization as I posed questions about respondents' experiences accessing services, their interpretations of their legal status and how their status impacted them, and their general plans and hopes for the future. The fact that these resistant narratives were evoked without explicit solicitation demonstrates that even though immigrants may face multiple forms of exclusion and exploitation, they do not always internalize the negative status that the public attributes to them.

By analyzing the discourse of the subset of respondents who directly resisted anti-Latinx immigrant discourse, I found that respondents used at least one of four frames to "flip the script" and denounce the stigma attached to their illegality. Through the frames of legality, work, injustice, and equality, immigrants demonstrated how they are far from illegal in their law-abiding lifestyles (legality frame); they emphasized their strong work ethic and contrasted it to that of the native-born (work frame); they cast the immigration system that separated families and limited their job opportunities as unjust (injustice frame), and they de-legitimized the importance of papers by discussing their equal self and moral worth to others regardless of their immigration status (equality frame). I also found that men's and women's positioning as laborers

and mothers influences the frames they use and the actions they take to resist their stigma and exploitation.

These findings complement the literature on the management of stigma by adding the perspectives of undocumented immigrants, which has been less explored in the literature thus far. It also brings a different lens to the literature that has traditionally focused on use of intentional framing and re-articulation in broader immigrant rights movements by illustrating what frames most strongly resonate with non-activist individuals. Furthermore, it nuances Abrego's (2011) work on legal consciousness by illustrating that while fear is real and prevalent among first generation immigrants, the sentiment of fear does not cancel out their feeling of self-worth and broader contribution to the United States. Moreover, legal consciousness can also be influenced by gender and relation to the labor market. Through understanding the frames that non-activist, undocumented immigrants use to confront their stigma, activists can create a stronger platform that can resonate with a broad base in immigrant rights political mobilization.

How is the script re-articulated in social movements?

How do undocumented respond to the stigmatization and criminalization of their legal status, and the laws that delimit their legal rights? As Abrego (2011) argues, deep-rooted fear can develop, which can result in people limiting where they go and make them hesitant to seek social services (Capps et al. 2007). Workers may also hesitate to demand their labor rights to avoid risking deportation (Gleeson 2010). However, mobilization in the immigrant community is still present. Immigrant rights movements have used different frames to challenge and counteract stigmatizing and criminalizing frames to emphasize the social citizenship of immigrants and demand the right to legal citizenship as well.

From the introduction of the Development, Relief, and Education for Alien Minors (DREAM) Act in 2001, self-identified DREAMers and allies have had marches, staged sit-ins at the White House, and have been outspoken critics of a system that limits them from achieving their full potential (Nicholls 2013).³⁴ In the beginning of their movement, DREAMer activists emphasized their assimilation in the United States to demonstrate their "American-ness" and positive contribution to the nation (Nicholls and Fiorito 2015; Lauby 2016). These themes are similar to the frames and imagery used in the widespread immigration marches of 2006. These marches were the result of concerted efforts and mobilization by churches, media, schools, and other institutions who rallied hundreds of thousands of immigrants and allies to march on the streets of over 140 cities in 39 states to protest H.R. 4437 (aka as the Sensenbrenner bill). The bill would have made it a felony to be in the United States illegally, and would have also made it a felony for anybody to aid undocumented immigrants. (Pantoja, Menjivar, and Magaña 2008; Bloemraad and Voss 2011). In these marches, organizers emphasized immigrants' positive contributions through their labor in the United States, and the right for all families to remain together to rally people to march on the streets (Zepeda-Millán 2014). The American flag was

³⁴ The DREAM Act would provide a pathway towards permanent legal residency for undocumented immigrants who arrived in the United State as children and met a number of other criteria involving attending or graduating from an institution of higher learning. While Deferred Action for Childhood Arrivals (DACA) was passed in 2012, it is temporary, does not offer a pathway towards citizenship, and may not offer a safeguard against deportation (New York Times 2017).

also proudly waved throughout many of the marches to demonstrate immigrants claims to citizenship and belonging in the United States (Santa Ana 2002).³⁵

In their work, Bloemraad, Voss, and Silva (2014) conducted a survey of nearly two thousand randomly sampled Californian residents to compare how using the frames of economic contribution, family unity, and human rights affected people's views towards undocumented immigrants having a pathway to citizenship and undocumented immigrants using public services. In their survey data, they find that while the human rights frame has the most potential for expanding notions of American citizenship and being inclusive, it resonates the least with the larger public. In addition, while the frame of economic contribution is largely used in the immigrant rights movement, it does little to sway public opinion on legalization or provision of public services to undocumented immigrants; instead, the frame of family unity is the strongest, especially among self-reported conservatives. Enriquez and Saguy (2016) discuss how a "coming out" frame was a self-empowering metaphor to advance the immigrant rights' youth movement because it framed being open about one's legal status as a courageous act that would allow youth to "destroy" the "myths and lies" surrounding their population and allow them to openly engage in a political movement.

Indeed, Nicholls and Fioritio (2015) describe how the DREAMer activism took a sharp turn around 2010 as some DREAMers in the movement started to embrace more confrontational tactics to push back on the Obama administration's deportation strategies. At the time of their writing, they found that DREAMer activists largely employed more confrontational frames against anti-immigrant rhetoric and policies, with appeals to their exceptional character being less common.

How do non-activist individuals challenge the script and deflect stigma?

While the social movement literature identifies what frames and strategies are used in broader immigrant rights campaigns, less explored are the strategies and frames that non-activists use to maintain their sense of self-worth in an environment that questions it. Scott's work demonstrates how everyday individuals exercise individual forms of resistance, which Scott describes as a form of "infra-politics." The use of subaltern narratives and actions that counter hegemonic ideals dates back centuries to when slaves used tactics such as foot-dragging, feigned ignorance, sabotaging crops, or even running away to contest their subordinate position (Scott 1990:188). Through the use of *hidden transcripts*, slaves also created narratives that explicitly denounced their structural oppression. Hidden transcripts here refer to, "discourse that takes place 'offstage,' beyond direct observation by powerholders" (Scott 1990:4). These hidden transcripts have the power to challenge and contest hegemonic narratives, which can at a minimum provide a space to vent about structural injustices, and at a maximum can sow the seeds for broader, collective action.

In his study of peasants and land-owners in Malaysia, Scott (1985) describes how peasants invoked a worldview that prioritized one's morality and work ethic over profit and capital gain – goals of the wealthy, landowning class. In disavowing the moral authority of the dominant class, they rejected the symbolic authority that the wealthy land-owning class had over them. He writes, "Much of what [the peasants] have to say among themselves is a decisive

³⁵ There were more Mexican flags visible in LA protests compared to protests in other cities; however, protesters were met with heavy backlash for the use of this imagery from both proponents and opponents of the marches.

rejection of the attempt to relegate them to a permanently inferior economic and ritual status and a decisive assertion of their citizenship rights in this small community” (236).

Decades later, in much the same way, Lamont (2000) found that working-class, non-college educated men in the United States and France used similar moral boundaries to distance themselves from both poor populations (particularly in the United States) and rich populations (in both countries). Through emphasizing their strong work ethic and strong moral character, working-class men maintained dignity in the face of a changing economy that increasingly marginalized their economic and social position. Fleming, Lamont, and Welburn’s (2012) interview-based study in the United States finds that when confronted with stigmatizing discourse in inter-personal interactions, most African-Americans directly challenge the discourse by asking respondents to “teach themselves” about racism, while a smaller number reluctantly engage in intentional emotional management of self-contain their anger and emphasize their professional identity at work, so as not to perpetuate negative stereotypes about African-Americans being “loud” or “angry.”

In the immigration literature, Coll (2010) found how in an immigrant non-profit setting, women became emboldened to claim their motherhood and redefine citizenship in San Francisco. Other research describes how immigrant men value the work and contribution they make to the country and see that as a strength of their status (Gleeson 2010) and undocumented activists even use humor to humanize the experiences of undocumented youth (Seif 2014). In this chapter, I further explore how everyday individuals maintain their sense of self-worth and show the frames they use to not only maintain their self-dignity, but also question larger unjust immigration structures.

“I’m more legal than the legal ones, no?” – Legality as Counter-Frame to Criminalization

Juan was by far one of the most brazen respondents that I spoke to during my research, although I didn’t expect him to have such sharp charm and wit coming into the day labor center where I interviewed him. He sat by himself hunched in a chair in front of the computer area donning an orange camouflage hoodie, paint-crusted jeans, and as we started the interview, I found him quickly switching from topic to topic. However, what was unshakeable and unmistakable about Juan’s interview was his strong commitment to hard work and respectability.

He was accustomed to working from a young age as he helped in the fields of his small town along with his family. When work was hard to come by, and his mother became ill, he made the trip across the border to join his nephews who had already been working in the construction industry in the suburbs of Oakland. Although he was apprehended at the border several times, he kept coming back, and now had been living over ten years continuously in the United States with his sister, and after battling alcoholism for the better part of the past fifteen years, Juan was now five years sober. He prided himself in his work, and he describes how he feels that sets him apart from others. After describing the growing pains in starting out in construction work, he describes how over time he has produced better and better work. He says, “all of the jobs that I do, I don’t do them badly – my employers say it’s the best.”

Even though Juan has earned the respect of his employers, he has still encountered racial slurs from some of his co-workers, some of which imply his illegality. When I asked him if it bothers him when people call him racial slurs states, “No. I’m human just like anyone else. There are some people that get depressed. [...] I don’t get depressed. *I’m not from here*, I say. [emphasis mine].” Juan has been living here for over a decade, but he still invokes on his own

foreignness as he speaks nonchalantly about people belittling him. His own othering made the following statement that he made all the more surprising.

If I'm legal, illegal, life is the same. They give me work; they give me an opportunity to make money. As long as I have the chance to do that, why would I want to be legal? [Employers] see that I do a good job, and that I respect their things and don't take anything. [...] I'm more legal than the legal ones, no?

Juan is simultaneously revoking the importance of papers, while also challenging the claims that the papers broadly make. Papers are supposed to render him illegal, but what really shapes his legality are his actions. Juan then expanded on how he noticed that people who had papers were more likely to take things from employers or work less hard; he drew a moral boundary between himself and people who had papers to show that despite being called "illegal" – his actions spoke louder than this label. Juan was only one of several respondents who used the frame of legality to combat some of the stigma that was directed against immigrants who were cast as law-breaking individuals. Essentially using the legality frame, people rightly cast the "illegal" term as a misnomer and asserted: I am a fully law-abiding resident.

Take the following example of Jesus. Jesus was a 46-year-old construction worker and father of three who came to the United States for better economic opportunity. When I asked Jesus how being undocumented affected him socially, he stated the following:

There are people who are racist and view you as Hispanic and say you don't have papers. That you live off what they pay in taxes. If they knew that I pay more in taxes [because I don't have papers] – I have an ITIN [Individual Taxpayer Identification Number], and they don't give me deductions because when I file my taxes, I have to deduct for everything I've earned."

The ITIN essentially allows undocumented individuals to pay taxes without having a social security number, but this means that they do not receive Social Security Benefits, or the Earned Income Tax Credit, which is likely the deduction Jesus was referring to. Through this passage, Jesus highlights his economic contribution and legally abiding behavior of paying taxes.

Although men were generally more likely to evoke frames of resistance in their interviews than women, women used law-abiding frames in their resistance as well. For example, Marisol, a talkative working mother of two, said the following when I asked her whether she experiences any fear of deportation. She states:

I have been driving for six years, and I haven't been stopped by police. [...] I don't have debts anywhere; I don't owe money anywhere. Since I've started working [...] I've been paying my taxes. I don't see how they would harm me because I don't have any bad record, no crimes, no robberies, no nothing.

Other respondents similarly described how they are not suitable to being deported because they work and pay their taxes, and they abide by all the laws. While not all respondents challenged the laws that rendered them subject to deportation in the first place, they did invoke their legality as they explained how they deserved to be in the United States. In some ways, this frame most challenges the script of immigrants as "rapists," "drug dealers," and "bad hombres" by

illustrating how they are fully law-abiding individuals.³⁶ The economic contribution they make through their taxes is important, but most importantly, they highlight their commitment to the rule of law, despite media outlets and others rendering them as “illegal.”

“They’re not going to kick us out because they need us,” Labor, Boundary-making, and Critiquing the System

In the previous section, Juan displayed this attention to work ethic and boundary-making as he described what sets him apart from others, and in the narrative that follows, I describe how Isabel emphasized her work ethic and exercised boundary-making in her narrative as well. Isabel was a 43-year-old mother of three adult children, and a grandmother of one. She moved from one place to another in Mexico as her widowed mother took care of her and her five sisters. Isabel was able to complete middle school, and in high school, she met her soon-to-be husband and father of three children. After several years of taking care of her children in Mexico, she made the trip to a suburb of the Bay Area, and she spent three years saving up money for her daughter’s quinceñera in Mexico.

She was able to return for her daughter’s quinceñera, but several months after coming back to Mexico, her and her husband decided that it would be best for Isabel to come to the United States with her children. Isabel worked multiple jobs cleaning houses, while her husband worked in landscaping, and when her and her husband divorced two years ago, her financial situation worsened as she now had to find and pay for a place to live on her own. She was able to find a small shack next to a big house in the suburbs, and she now works multiple jobs to make ends meet. Apart from cleaning houses for different clients throughout the week, she takes care of an elderly woman in the evenings in another suburb. She was frustrated with the limited options she had for jobs as an undocumented individual. She said:

There are some people who are bothered because they say that we come here and take away jobs. But if you notice, how many people are out there in the street, under the bridge, asking for money, and they have papers. And a Mexican, for as old as they may be, they’re still there [working]. Even if it’s picking up the recycling, they’re still making money.

Like Juan, Isabel employed a boundary-making strategy to highlight the work ethic of Mexican immigrants. Isabel was clearly ready and willing to work, and she grew frustrated not being able to pursue it. This became more evident for me at the end of our interview when Isabel asked me if I could help her fill out a job application in English. She had just started a job as a caregiver, but she needed to complete the paperwork to get her pay. I started going through the paperwork in English, translating a few sentences, and filling it out.

It felt simple enough to do this until I reached the employer verification section. In it, there was an employer e-verify form that said they would check her information with the Department of Justice (DOJ). We left the e-verify paper blank, and only filled out some information for the finger-printing one. I was surprised by how many questions there were about

³⁶ This is in reference to Donald Trump’s presidential announcement speech in 2015, where he referred to Mexican immigrants as bring drugs, crime, and being rapists – a frame he similarly invoked in his third and final presidential debate as he vowed to secure the borders and get rid of “bad hombres.” https://www.washingtonpost.com/news/the-fix/wp/2016/10/20/from-mexican-rapists-to-bad-hombres-the-trump-campaign-in-two-moments/?noredirect=on&utm_term=.481edbb65cd1

being a U.S. citizen, or lawful resident, and I wondered if Isabel would get the job. I was hesitant to ask her if her other contacts who worked there had papers, but I noticed she was hesitant to mark them down as contacts. I grew concerned and felt uncomfortable. This was me facing her situation head to head and realizing the limits of her legal status.

While Isabel evoked boundary-making in her framing of immigrants as hard workers, Mario also evoked the work frame to explicitly call out the way the immigration system is set up to exploit labor in the United States. Mario is a 45-year-old construction worker and father of two grown adult children in Mexico who has been living in the Bay Area suburbs for the past fifteen years. He came from a nine-person household, and he made his first trip to the U.S. to help support them. When he came back to Mexico, he started his own family including his two children. His subsequent trip to the United States was to help support his wife who had fallen ill and his children's educational expenses. He started working as a day laborer searching for work on street corners, and living in crowded housing with other men. But through time, he was able to find stable employment with a small contractor, and he is now able to live on his own. He describes himself as a solitary man, and it has been ten years since he has seen his family. When I asked him how his legal situation affected his life, he offered the following commentary about immigration laws and systems of exploitation in the U.S. He states:

Those of us who come as immigrants are an unfortunate necessity here. Because we do – a lot of people say that they don't want us [...] but in reality, we're the ones that do the work. [...] And even though they may say that they're going to kick us out, they're not going to kick us out because they need us [...] and, they'll always need us.

Through this framing, Mario pinpoints the paradox and hypocrisy of a broken immigration system. Even though “illegal immigration” is cast as a problem in the United States, the national economy is dependent on the exploitation of undocumented workers. He rearticulates the script of undocumented immigrants taking away others' jobs, but he flips it by saying that the jobs are those nobody wants, and their labor is necessary. Like Isabel, Mario uses the collective “we” to refer to undocumented immigrants and demonstrates how his struggle and fate is bound up with that of others within a broader, structurally broken system. This framing and narrative was used by both men and women in my sample, but slightly used more often by men. For women, a framing of the immigration system as an injustice to them and their families was far more common.

“We give the best to the country, but the country is not ready to give the best to us.” – Injustice Framing of the Immigration System

In my opening vignette, I described how Magdalena viewed her not being able to take community college courses to further her college education as an injustice. The theme of injustice ran more broadly among women, especially as they described how a broken immigration system harmed them and their families. Many mothers described how they worry that their children will be made fun of for being born in a different country and hence accused of being “illegal,” or lamented how they cannot grant their children the opportunity to go to different states for fear of being caught. When I asked Magdalena about how her legal status affects her, she said:

It's different. You can't go out for fun, you can't go on vacation. [...] No, here there is always fear, so we have to stay in the city, and what can we do? The children aren't at fault [...] They need to live and feel normal. I mean, they don't have to feel less than other people because – [we] made the decision to come here; it was me, not them.

Pati, a home-maker, mother of three, and devoutly religious woman similarly felt that the current immigration system was set up against undocumented immigrants, and worried endlessly about how it would affect her oldest daughter who was born in Mexico and also undocumented upon coming to the United States. As her daughter grew up, Pati advised her daughter to not mention where she was from, and if anybody asked her, she told her to state that she was born in Oakland. She had heard of how children would make fun of others for being “illegal,” and she didn't want her daughter to be bullied because of her status. At the time of the interview, Pati was feeling hopeful as her daughter was able to receive DACA and go to college.³⁷

However, overall, Pati felt stressed from having difficulty paying rent and not being able to access rental assistance programs due to her legal status. She stated:

In the years that my husband barely had work, it was really difficult to [have food to] eat, to pay the rent, it was almost impossible. It didn't help that we didn't have access to rental aid. [...] [My legal status] is a big barrier. We give the best to the country, but the country is not ready to give the best to us. Maybe one day. We have to keep trying and try to be the best we can be.

She explicitly points out how the immigration system negatively affects her and her family, and how they, as undocumented immigrants, contribute to the country, but the country is treating them unjustly by saying that “it's not ready” to give the best to the undocumented community, even though they are deserving of it. She later goes on to say:

Even though I was born in Mexico, I appreciate and respect what I have received here, and I respect everyone here. The family separation that the immigration raids creates greatly affect the country's progress. The best values come from the family, and that is the best for the country.

In this statement, Pati demonstrates how nonsensical the immigration raids are: she is somebody who respects everybody and instills those values in her children. It doesn't make sense for her family to be separated because of immigration laws when she is raising her children to be respectful, kind citizens

While women were more apt to describe the immigration system as unjust, men also saw the injustice of the immigration system, and questioned what was gained from immigration raids. In the following passage, for example, Ronaldo, a landscaper and father of one described how people he heard about being deported were not criminals, and they did not deserve to be separated from their families. He said:

[I've heard of immigration raids] that are completely unjust. [...] They came to find one person [...] and they took away the whole family [...] They're not delinquents. They're

³⁷ Since the time of the interview, DACA has been rescinded, and the status of DACA recipients has yet to be determined.

citizens that work. They're earning an honest living. They have their own apartment; they pay rent; they're not parasites. [...] They're people that, that fight.

Other men similarly lamented the raids that broke apart families and described the worry they felt sometimes about being separated from their families in the United States.

'I only have toilet paper!' Humor and Equality Frames to Challenge and Combat Stigma

While people questioned the intentions and consequences of the law, others took another step to devalue and mock the terminology and logic of "having papers." Although there were many somber moments during my interviews, there are also some moments interrupted by humor and lightness. One of the most memorable ones came from Estanislao, a 38-year-old father of three who came to the United States to better support his three children which he left behind in Guatemala. Despite having an initially rocky start to this stay in the United States as he stayed with an unsupportive family member in Los Angeles, he had now forged his own path in Oakland with the help of another family member, and he worked odd jobs in construction to support himself and send money home to his children. Estanislao is currently undocumented, and he has no steady income from his job as a day laborer, but he maintained a chipper and almost jovial attitude throughout the interview. This was reflected when I asked Estanislao about if the topic of legal status ever came up in conversations with his friends, he responded, "sometimes my *compas* (friends) will ask me, 'do you have papers?' 'No, I say, 'I only have toilet paper!' and he gave out a hearty laugh.

Juan, another day laborer recounted how if others would use derogatory terms like wetback, they would respond that they had just showered that morning. Through their use of humor, they delegitimized the importance attached to whether one had papers or not, and also directly confronted and challenged derogatory terms.

Similar to an injustice framework, respondents explicitly described an equality framework to describe how they do not see themselves as any different from people who do have papers. Some workers described how they have a right to fair wages, just like anybody else. And they emphasized how everybody is equal, or by saying that as long as they had work, they didn't feel their legal status made them any different from others. They said things such as, "with documents or without documents, I have value" or "well, for me, not having papers or having papers is the same, it doesn't make me any better or worse [than others]." The equality frame differentiates itself from the injustice framework because it does not necessarily challenge the law, but rather challenges the stigma attached to their legal status by evoking notions of equal individual self-worth.

Resistant Frames and Resistant Actions

However, people's resistance was more than about their framing, it was also about their actions. As was exemplified through Magdalena, her way of resisting exclusionary laws was by finding work-arounds to allow her to pursue a higher education. But, for Rosario, whom I mentioned earlier, simply telling others about resources available to low-income individuals and the undocumented community was also its own form of resistance. She had recently discovered a Facebook group where people from different neighborhoods, blocks, and towns could showcase their business or announce upcoming community events or other announcements. The group was

run by Spanish-speakers, and she saw that several people were asking what affordable clinic they could go. Rosario quickly posted about the free clinic she went to, and she also said that anybody who had a question about services could dial the number 211 – a bit of information she had learned from a non-profit organization she was involved in. She says, “I felt it was necessary to [share the information] because I didn’t know where to go.” Beyond posting information about free clinics and other resources for people to get access to services, she also helped her neighbor secure section 8 housing even though Rosario wasn’t eligible for it. Rosario in many ways was paying it forward by serving as other people’s guiding figure and pushing back against laws that were exclusionary towards immigrants in doing so.

Work and Resistance

While Rosario, Magdalena, and many others display resistance through seeking out services and accruing resources, others talked about resisting oppressive structures in the workplace. Such forms of resistance were often met with pushback, but despite the pushback, respondents insisted on fair treatment and wages.

We can see this in the case of Mayra, a 54-year-old mother of three grown children who had spent the past eighteen years in the United States. When I asked her how her legal status impacts her, she says, “A lot of people say, ‘you have to adapt to whatever is given to you’ for example a job that pays you because one doesn’t have a [social security number]. They say, ‘you have to put up with it. I had a job ironing at a dry-cleaner, and I had to get out of there.’” She then went on to describe how apart from being paid low wages without overtime, the owners berated her because she looked at the clock during work. Mayra told them that she simply looked at the clock, so she could know the time, but the owners wouldn’t have it. They called her stupid and told her to leave the building. As she described this, Mayra was defiant as she asserted the ridiculousness of the accusation. She didn’t return to work at the dry cleaner after that incident.

Instead, she moved on to taking care of children, which she has done for the last several years. But in this work as well, she challenged her exploitation. Her employers would pay her only \$20 to \$25 for taking care of their children for approximately ten hours. Taking care of multiple children was not easy; she had to change their diapers, feed them, and engage them in playtime while keeping them safe from harm. One of her friends who also took care of children told her, “You are giving away your work. They pay me \$110 a day; I go to my employer’s home, but the only thing I do is take care of one baby...” With this into account, Mayra raised her price to \$30 to \$35 dollars a day. When her employers resisted, she stopped taking care of their children. Her three grown children had enough money to support her, so after devoting a majority of her life to taking care of others, she decided to focus on herself instead.

Another instance of resistant action comes from Ramon – a 40-year-old restaurant and retail worker with a young daughter in the United States. At the end of the interview, I asked Ramon if there was anything else he wanted to say about being an immigrant living in the United States. He said, “I feel like, even myself, [we] illegal immigrants sometimes close opportunities for ourselves. [...] We restrict ourselves by saying, ‘Oh well, I’m illegal, so I can only work in gardening or construction, or restaurants.’” Yeah, but we don’t ask to see if we can get work in a business that’s – bigger, that would be able to us benefits.” Ramon was one of the few undocumented respondents I spoke to who had a job in the formal labor market, and subsequently, he was also one of the few men who had full health insurance from his employer. His decision to pursue a job in the formal labor market was his way of showing that the

immigration system was not going to dictate what the terms of his life would be like in the United States. Although Ramon's action was not widespread in my interviews, it does show the small and big ways that immigrants' contest and purposively go against laws that are meant to exclude them and exploit their labor simply because of their immigration status.

Gendered Frames of Resistance

This chapter showed that through adopting the frame of legality, work, injustice, and equality, individuals demonstrate how the criminalization of undocumented immigrants does not ring true with their law-abiding behavior; how they are hard workers whose labor is integral to the United States; how immigration laws are unjust and not in the country's best interest; and how regardless of what others say, they see themselves as equals with people who have papers.

In their frames, respondents also expose the contradictions and paradoxes of the immigration system, sometimes reflected in their own answers. Even though the federal government may claim they are "kicking undocumented immigrants out," the United States depends on their labor. Despite the claims to equality respondents make, they still cast themselves as outsiders who are given the opportunity to work in an exploitative labor market. The "flipping of the script" may not be complete, but in respondents' voices there are strong tones of defiance and triumph in spite of living in a country that continues to oppress them. They demonstrate that they see the stigma and the criminalization of their status, but they do not let that script define how they see themselves and shape their conception of their self-worth.

I found women more often used the injustice frame and most often discussed how these policies affected their children and their livelihood. Men, in contrast, were the only ones to use the equality frame and delegitimize the importance of papers. In their words, their legal status didn't diminish their economic and labor contribution and how hard they are willing to work. This could perhaps be a reflection of their family structure, or their work atmosphere. The men I recruited were from day labor centers, where the organizations emphasized a dignified working atmosphere where employers had to pay at least the minimum wage. These labor centers were also part of non-profit organizations that engaged in advocacy that members could become involved in, such as participating in the Labor Day march for workers' rights in Oakland. However, no respondents I interviewed were involved in direct advocacy for workers and/or immigrants. In fact, the most powerful quotations contesting the legitimacy of having papers came from people who had the least at stake in the United States. They did not have families here, and some of them described not having a fear of deportation. In some ways, they are able to be more unabashed in their accusations of an unjust system and in adopting new frames in demonstrating their moral worth.

This chapter demonstrates that there are varying frames and ways that immigrants interpret their experiences, and how these frames may be shaped by one's gender, relation to the labor market, and how this can translate into resistant actions. Despite being excluded from the formal labor market, respondents still apply (and sometimes get) contracts with employers, they demand higher pay, and they sign up for higher education classes. While not all respondents I spoke to fearlessly sought out social services or filed labor claims in the event of an accident, it does not mean that they morally accept immigration laws and policies. The hidden transcripts described in this chapter may not always result in actionable behaviors, but the frames developed by immigrants themselves can resonate with other immigrant populations, especially in appeals

to collective action. Regardless of restrictive public discourse and laws surrounding immigration, people will continue resist, in part through flipping the script.

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CONCLUSION: THE CHANGING FEDERAL LANDSCAPE

My last interview took place the morning after Donald Trump was elected into presidential office. As I walked into the day labor center to meet Gerardo, I greeted a staff member, and she asked me how I was doing. “Bien,” I said cheerily, and then I stopped myself and added, “well, okay, given what happened yesterday.” The staff member smiled, and said, “But, we’re still here, right?” “Yes – we’re still here.” Coming back from the interview, the importance of that interaction began to dawn on me. I was reminded that individuals and community organizations have been in a long battle to restore human dignity and grant basic rights to disenfranchised populations for decades – and through those decades the political context has ebbed and flowed with victories and setbacks. The presidential election may usher in restrictive and discriminatory policies that negatively affect immigrant and low-income populations, but for every restrictive policy that is passed, organizations and individuals will push back.

Although most of the immigrants I interviewed were not community activists, the act of navigating a limited and restrictive assistance system was a form of resistance against racially-tinged exclusive policies, and respondents showed their resilience and strength in forging ahead despite the obstacles set against them. The road to obtaining crucial resources and services was not easy. In navigating institutions with a limited number of Spanish speakers, and with limited culturally competent care, individuals faced recurring psychological harm as they encountered miscommunications, stigmatization, and embarrassment. It took the work of trusted *confidantes* to reassure individuals that signing up for public benefits would not be used against them (even though under this new administration this principle may be under threat). Once individuals were informed of how to navigate services, they would then pass this knowledge forward. While women had a clear institutional opening to pre-natal services as mothers, their pipelines to care become narrower after their pregnancy and after their children were no longer eligible for public programs. Still, through their networks, they eventually found and used primary care.

For men, the landscape looked a bit different. With no clear institutional opening to public services, men had less social services available to them as a whole. Men are generally less likely to seek social services—particularly medical care than women—but the fact that services were so hard to access gave men even less of an opening to receive the medical care they needed. In the case of the men I interviewed, institutions like worker centers were able to provide on-site medical services, fresh meals, and assist in enlisting men into county health programs. However, in the absence of such an intervention, many men were left with little recourse to access medical care. These findings do not mean to imply that women had an easy path to care, and men did not. It simply showed that gender mattered in the institutional openings that were available for public benefits, and networks reinforced this institutional opening as well.

Regardless of gender, both men and women described the frames that they used to counter the negative stereotypes against undocumented and Latinx immigrants – negative discourses that continue to justify the restriction of resources to racialized populations. It is through these forms of resistance in both mind and action that people are able to resist oppressive structures that shape their everyday lives. These research findings have several implications for both scholars and practitioners aiming to forge more equitable access to resources.

Empirical and Theoretical Contributions of Work

Empirically, my research contributes to the literatures on immigration, the welfare state, and the suburbanization of poverty in three main ways. First, by focusing on immigrants' access to social services and public programs in my research, I extend previous immigrant scholars' focus on integration to include analyses of immigrants' inclusion in safety net programs and services in the U.S. Secondly, I re-shift the focus on inclusion to undocumented, first-generation immigrants, as opposed to those in the 1.5 or 2nd generation. This first generation is arguably the most vulnerable to a new draconian immigration regime.

Welfare state scholars commonly focus on the ways that native-born respondents access and navigate public programs (Soss 2002), and when they do so, they almost exclusively focus on the experiences of mothers using cash assistance (Edin and Lein 1997). Fewer studies examine non-citizens, and in particular, undocumented immigrants' access to the welfare state (Coll 2010; Yoshikawa 2011). Moreover, my dissertation studies the gendered terrain of social service access for men and women across multiple immigration statuses. My research thus demonstrates how gender and legal status *intersect* to facilitate or impede one's pipeline to public and private aid.

Finally, I contribute to the suburbanization of poverty literature in two main ways. First, by focusing on suburban residents' narratives on accessing social services, I complement the predominant quantitative literature on the suburbanization of poverty that shows spatial mismatches between service providers and populations in need (De Graauw, Gleeson, and Bloemraad 2013; Joassart-Marcelli 2013; Panchok-Berry, Rivas, and Murphy 2013, Allard 2017). In doing so, I illustrate how informed, personal networks can mitigate some of the harmful effects of less resources in a suburban location. For those who are socially isolated, however, a suburban place can perhaps worsen the effects of that isolation and reduce one's chances of accessing services. By focusing on immigrant populations in particular, I also show how individuals and families cope with legal and linguistic barriers towards service access that may be more pronounced in a suburban place.

Qualified Safety – Reconsidering “Safety”

Theoretically, I advance knowledge on the U.S. immigration state by showing how federal laws permeate ostensibly “safe” spaces. Currently, federal policy generally advises against enforcing immigration related matters in “sensitive areas,” such as health centers, courts, schools, and churches, among others. However, respondents remain rightfully wary of sharing information with institutions which fall into these “sensitive areas.” Cooperation between such institutions and ICE has occurred in the past, and breaches of this policy have only increased since January 2017 with a decidedly anti—particularly Latinx—immigrant administration. The sanctity of such spaces can simply not be taken for granted. Furthermore, policies regarding public benefits for non-citizen populations are always prone to change, and at a federal level, non-citizen's access to public programs has only become more stringent in the past fifty decades. Despite the protections that can try to be created by the state and sub-state actors for their residents, these protections are always limited. Any form of “safety” for undocumented and non-citizen populations from surveillance and ultimately, deportation is, unfortunately, always qualified. Even when advances in immigrant protections are made by one administration, they can be vetoed or worsened in the next.

Gendered Pipelines

My research also shows how structure and culture work together to facilitate or impede relations with the state. Structurally, the existence of public programs for soon-to-be and/or recent mothers, creates an institutional pipeline into what some scholars fittingly describe as the left, “maternal” side of the state. This structural condition is then reinforced by a culture of information sharing among women’s networks to gain access to these programs. The lack of these programs for men, accompanied by a culture of hegemonic masculinity, in turn, makes access to services much more limited. I use the term pipeline because it highlights the restrictive nature of federal immigration policies in the United States. A pipe is continually bounded, but much like immigration policies in the past century, it can expand and contract with changes in political climate (and labor needs). Pipes can also come in many shapes and sizes. The pipeline is narrow for non-citizens, even narrower for undocumented populations, and the narrowest for undocumented, single men. The term pipeline also reinforces the notion of qualified safety because like “safety” for immigrant populations, access to services is continually bounded as well.

Looking Towards the Future: A New Era of Exclusion

The post-1996 welfare reform was one that not only vastly overhauled the way welfare benefits were determined, it dramatically changed legal immigrants’ relation to the state. In making otherwise eligible, legal permanent residents (LPRs) wait five years in order to receive public assistance for basic needs, the current welfare state exacerbated financial, food, and housing insecurity for them in their first years permanently settling into a new country. The changing policies also had the effect of reducing enrollment in public programs, even among individuals eligible for public aid.

Currently, a new era of welfare reform could be upon us. In February 2018, political news outlets published a leaked draft of an executive order that would bear grave consequences for legal immigrants. The leaked draft indicated that the federal administration would redefine the threshold and consequences for being a “public charge,” which would result in non-citizens being penalized for using *any* form of federal public assistance that is means-tested (i.e. requires proof of income). According to a recent report by the Migration Policy Institute (2018), this new definition would include food assistance programs like SNAP and WIC, medical insurance for children and adults, like CHIP and Medicaid, cash assistance, housing and energy assistance, and the Earned Income Tax Credit. While current and aspiring visa holders are the main target for the new “public charge” proposal, legal permanent residents may be impacted by this new rule as well if their use of public benefits becomes grounds for deportation (MPI 2018: 1). Currently, the legislation only deems LPRs deportable under extreme circumstances where individuals are highly dependent on the state. By criminalizing and punishing individuals for using services that help them meet their basic needs, the government is putting the health and potentially lives, of many individuals and families in danger.

The repercussions of a Trump presidency, however, have already begun. Since the beginning of his presidency, immigrant advocates have come forth with testimonies of immigrants being less willing to report crimes, including domestic violence, and applications for financial aid have also gone down. In September 2016, democratic senators in California applied for a State Innovation Waiver, which would allow undocumented adults to enter an alternative

health insurance marketplace in California. This same application was later rescinded in January 2017 by its spear header, Senator Lara, who was concerned about the Trump administration using the names of individuals in the alternative marketplace for deportation purposes.³⁸ Other previously proposed bills to expand health care for undocumented adults in California have now been amended to only include those under the age of 26 or over the age of 65. This leaves out much of the working-age adult population from needed care.

The decisions to rescind and/or amend previously proposed bills designed to support undocumented immigrants are examples of how limiting power of supposed state “protections” are. They can be overridden and torn apart by federal laws. And even among more progressive states like California, local jurisdictions can aim to have more zero-tolerance against undocumented communities and their ability to meet their basic needs.

Supporting Pro-Immigrant Policies, Institutions, and Dignifying Language

The current federal administration may give us little hope for immigration justice. However, that does not imply we, as scholars and residents, should throw in the towel and render pro-immigrant mobilization futile. Some states, counties, and local governments have already created some amends to mitigate the fallout from exclusive welfare reform policies. More recently, programs like Healthy SF, Healthy Families in LA, and even the HealthPAC program in Alameda county have pushed for primary care services to be more inclusive and readily available to those in need. Also, though less expansive in scope, the Contra Costa Cares program can serve as a starting point to expand upon, with the strong and consistent local mobilization. One of the greatest successes of health care advocates occurred in 2015, when California expanded Medi-Cal access to all minors, regardless of their legal status. My research largely showed that state interventions and policies proved to create the widest form of access for women in particular. Residents need to keep pushing their representatives for these public programs, so that private organizations can focus less on providing medical resources themselves and focus more on connecting the right populations to needed public services. Yes, there is an opportunity this can be information can be negatively used by the federal administration, but by having these programs be an option, individuals and families can choose whether they will take the risk of applying for programs that meet their basic needs.

Apart from expanding access to social services, there are numerous policies that can mitigate the harmful effects of legal violence for legally liminal populations. They include the creation of municipal IDs for city residents, so that everyone has a valid form of identification that can be for opening up bank accounts, for use at schools, hospitals, workplaces, and other institutions that may ask for formal identification (De Graauw 2016). Opening up driver’s licenses to local residents, regardless of their immigration status, allows undocumented populations to have more peace of mind when they drive. It would also prevent costly citations (and possible car impoundments) for driving without a license. Such policies have been passed in California, and respondents I spoke to described how the new policy reduced the chronic stress they felt from driving without a license before. The passage of DACA also benefitted parents of DACA beneficiaries as they and their children could envision more upward financial and social mobility in their future. Worker centers provided a place for individuals to seek employment for fair wages and to report any abusive behavior or exploitation by employers. Many of these

³⁸ <https://khn.org/news/california-withdraws-bid-to-allow-undocumented-immigrants-to-buy-unsubsidized-obamacare-plans/>

centers are funded by grants from local foundations and business sponsors; creating sustainable, public sources of funding for these centers can go a long way.

In efforts to pass these policies, framing deeply matters (Haynes et. al. 2016) In a recent public meeting in Concord, a house representative stood in front a crowded room and stated her support of expansion to health services for immigrant populations. In her call to mobilize for such reform, she suggested that people convince their friends and neighbors that expanding health care access was a public health issue; not providing medical care could lead to the spread of communicable disease. She acknowledged this was a “selfish” perspective, but it was a way to reach across the aisle. While her intentions were well-meaning, her suggested justification to increase support to healthcare did little to humanize immigrant populations and harkened back to the portrayal of immigrants as “dirty” instead (Molina 2011). Policy makers, politicians and everyday residents must be mindful of the language they use to frame and describe marginalized populations as it can contribute to racializing discourses and negative stereotypes that dehumanize, otherize, and justify the exclusion of millions of people from basic services and needs, among other consequences.

Suggestions for Practice

Regarding the practical implications of my research, my dissertation reinforces the importance of communicating in one’s own language and in the importance of feeling respected in public institutions whether they be hospitals, schools, medical clinics, or other places where people seek public services. One way to help remedy language barriers that people face at community institutions is to introduce a language diversity assessment to assess what languages the staff can fluently communicate in at schools, hospitals, and social service offices, and how that compares to the clientele they serve. Different language interpreters can be brought in to fill in the gaps, depending on where the greatest need lies. I recognize this would only be the first step in facilitating easier communication among ESL populations; the next step is to make sure staff are trained in practicing cultural humility when they interact with clients. Researchers can step into the fold as well as they identify where the greatest need is for language interpreters in different local jurisdictions.

Recent research has indicated how undocumented populations feel the need to “deserve” the services non-profits provide by volunteering their time and hours to the organization (Gast and Okamoto 2016). While this is an effective organizing strategy, it can reinforce the concept that immigrants must “prove” their worthiness to access basic services and needs. Service providers must be cognizant of the messages they send to clients that they must “earn” or “deserve” access to basic needs. In addition to this, they can learn from clients on what their greatest needs, hopes, and aspirations are, and lead discussions on what can be done to facilitate access to services for them. This will also give them an opportunity to learn more about the structural conditions that shape their everyday lives and build a foundation to mobilize for change against these very conditions. This can also help build more targeted outreach efforts to reach hard-to-reach populations, like single, undocumented men. To be more specific, some of the non-profit organizations I interacted with had *promotores* programs where participants would be tasked with outreach efforts to their networks and other community members. Most of the *promotores* were women, but perhaps specifically recruiting men to serve as *promotores* could help boost participation for that particular population. Compensating *promotores* for their efforts could also help with building a strong base for outreach in services and programs.

While access to services and the safety net is important, I would be remiss not to talk about the larger structural conditions that push immigrant populations into positions of vulnerability in the first place. This vulnerability is maintained through unjust immigration laws, exploitative labor markets, and a global capitalist state, which values profit over individual health and human rights. In my interviews with many respondents, one of the biggest sources of anxiety they experienced came from financial instability as a result of unpredictable, low-wage labor. This was worsened by rising costs of living through soaring rent prices and neighborhood gentrification. These are problems that are affecting many California residents—widening inequality affects us all. Finding ways to work with and across populations experiencing intersecting forms of marginalization is perhaps the most powerful form of solidarity in itself. Across gender, immigration status, and place, every respondent I spoke to recognized the harms of the current immigration system. This broken immigration system combined with a weakening welfare state creates a narrow pipeline to services. Further understanding the contours, contradictions, openings, and closings of service access is only the first step in re-envisioning and actively working towards a rightful safety net for all.

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Methodological Appendix

I have heard from many scholars that the greatest challenge and reward in research is fieldwork, and I couldn't agree more. Undertaking a multi-sited project that sought to speak to the experiences of Spanish-speaking immigrants across at least three dimensions of difference (place, gender, and legal status) proved to be more challenging and rewarding than I anticipated it to be. In this appendix, I aim to provide a more detailed, humanized portrait of undertaking a larger research project. Often missed in the methods of social science research is day-to-day emotional labor and meaning making that goes into the research process. I aim to fill in some of the more intimate gaps of this research process by giving a candid portrait of being "in the field," reflecting on how my positionality may have affected the research process, and by being open about the strategies I used to handle emotionally tough moments and interviews. I also end with some thoughts on how I can approach my research projects differently in the future.

The Ask: Recruiting Respondents for In-depth Interviews

Because the initial question that led to this research project was: "how do social service providers respond to the increased demand for social services in the suburbs?" I first started my project by contacting non-profit organizations that worked with immigrant populations in Oakland's eastern suburbs. I used resources like Guidestar to identify key immigrant organizations, and through my interviews with staff members, I learned more about other key organizations that worked with the Latinx immigrant community. Every person I spoke to was kind and enthusiastic about my project, which made me all the more willing to give back in whatever way I could. I started volunteering as a bilingual intake interpreter for an NPO that provided food assistance by day, and I co-taught English and citizenship classes by evening. On weekends, I went to citizenship workshops, and I attended Spanish mass at different churches, from which I recruited people later on. I enjoyed the ethnographic experience of these spaces, but I knew that eventually I would need to step forward and recruit people for interviews. They weren't going to conduct themselves.

After several weeks of observing and/or volunteering at an organization, I slowly, but surely began asking NPO staff if I could start recruiting people for interviews for my project. Even though I was nervous at each "ask", non-profit staff were often open to having me talk about my project, and they provided opportunities and spaces for me to recruit people and even provided space for conducting interviews. For example, I was able to recruit many mothers with young children for interviews by coming into the center after parent meetings to talk about my project. Some centers supplied me with a small room to conduct interviews inside the organization's building, which made it easier for respondents to meet with me. Mothers talked to me while their children were tutored at a center. Day laborers talked to me while they waited for employers to come by worker centers. When I wasn't able to obtain a space at a center, I would offer to go to respondents' homes, and/or meet in public spaces like cafés or parks near where they worked or lived. The interviews in respondents' homes always proved to be the most fruitful because we were in a safe, private space, and I gained a better sense of their living situation and their family dynamics (although admittedly, most of my home interviews were with women).

While I was pleased that respondents were willing to give their time, trust, and energy to conduct an interview with me, I worried that my recruitment methods led to a biased and

selective sample. In an attempt to recruit a more extensive and potentially more varied sample for my research, I was able to secure the permission of a prominent Federally Qualified Health Center to distribute flyers in Spanish to recruit people for interviews. But months after I had posted the flyers, not a single person had called expressing interest in participating in the study. I tried to ask clinic staff if I could briefly introduce myself in waiting rooms in clinics to present my study, but reasonably explaining this would serve as a disruption, I was unable to do so. Given that I couldn't recruit people from posting flyers, I purposefully changed my recruiting methods to recruit respondents in person at different spaces. I spoke to street food vendors in Oakland, and I frequented different flea markets to recruit vendors for interviews. I also scheduled meetings with priests, so that I could talk to them about my project and ask if I could make an announcement during services about my project. All of the priests I spoke to were very helpful and interested in my project, and I was able to successfully recruit respondents for interviews at three separate churches.

Then, there was the issue of legal status—one of the contributions of my research design is that I include people from varying legal statuses to see how one's immigration status may influence their options and strategies for accessing services. I wanted an equal number of respondents from both sides, but I did not know how this would unfold. I certainly did not feel comfortable asking people for their immigration status forthright, so I decided to take a risk and not include questions on legal status as part of my screening process for conducting interviews. Fortunately for me, people of all legal statuses felt comfortable conducting interviews with me, and surprisingly, I was also able to speak to a disproportionate number of people who had acquired, or were in the process of acquiring, a U-Visa. Because they had already talked to a lawyer and sent in their application to U.S. Citizenship and Immigration Services in request of the visa, they felt assured that there was no harm done in talking to me because they had already disclosed their status to a U.S. legal entity. Interestingly enough, people with LPR status worried their stories wouldn't be "helpful" to me, and they asked me if I was sure I wanted to capture their story. While sixteen respondents preferred I not record the interview, most of them felt comfortable sharing their story with me. I took every precaution I could to make sure that their story and personal information could be traced back to the individual. I received verbal versus written consent for interviews; I asked for respondent's first names throughout the recruitment and interview process, I created and used pseudonyms for every individual in my field notes; I deleted respondents' phone number from my phone after conducting the interview; and I stored all information in separate and password protected files on an encrypted hard drive. That said, the fear of unintentionally risking respondents' confidentiality stayed with me throughout the project – and still does to this day.

Positionality

My position as a 1.5 generation, Mexican immigrant and fluent native Spanish-speaker, made it easier for me to connect with respondents, which made both of us feel more comfortable and familiar with each other (and potentially made it possible for me to conduct an interview in the first place). Many women would use the endearing *mija* with me, and some were enthusiastic about having me meet their daughters, so that I could talk to them about college. I didn't end up meeting too many respondent's children, but when I did, I would ask them about what year in school they were in, or comment on an extracurricular activity their parents mentioned, and I would ask them what college choices they were interested in (if the parents had mentioned they

were planning to go to college). I still left my e-mail address and said I'm happy to discuss any questions about college or school, but unfortunately and in some way, unsurprisingly, no mentoring relationships developed from such a brief interaction.

While women were the most likely to take me into their home for interviews, they talked less about their legal situation or their financial or emotional hardships than the men I interviewed. My guess is that men perhaps talked less at length about themselves with others on a regular basis, so this interview provided a space to process and reflect on their lives with an interested listener. Both men and women, sometimes turned to me with legal questions, and I felt powerless being unable and unqualified to equip them with an answer. Nonetheless, I compiled a list of nearby non-profit organizations that offered low-cost services such as legal aid, medical care, child care, education classes, and food assistance, so at the very minimum, I could refer them to relevant NPOs. I also supplied them with a phone number to call to be referred to different social services. That said, the information supplied can only go so far because as my research showed, personal connections and referrals are the most effective form of outreach for services. I hadn't used the services myself, so I couldn't provide them with information on how my experiences seeking services played out at different organizations.

Many of the respondents I interviewed were deeply religious, and as self-identifying agnostic and culturally Catholic person, I felt a bit nervous at the thought of having my religiosity put to the test. With one minor exception, most respondents did not inquire into my own religious beliefs or faith, but rather they described the role faith played in their lives. Some respondents would invite me into their congregation, and I would thank them for the invitation. That said, I did find myself praying more and becoming slightly more religious as I interacted with devout people of faith, which speaks to the power of the social in shaping one's behavior.

An unexpected finding from my fieldwork was having people view me as a financial resource for their businesses. Women in particular would give me their business cards or showed me jewelry that they sold to see if I would like to buy it. Normally this would come after the interview, and I would politely look through their collection and ask them more about how their business started and how it ran, which gave me more of an opportunity to get to know them. I did not purchase any items from respondents, but I did provide financial compensation at the end of each interview.

Although I expected my white passing appearance to play a bigger role in how respondents opened up or interacted with me, I found that generally, most people did not question my Latinx identity once I spoke Spanish to them. There was only one respondent who thought I was ethnically white at the start of the interview, and she skeptically asked me what motivated me to do this project. When I told her that my background as a Mexican immigrant personally motivated me to do this research, she opened up and said this made much more sense to her. This said, my light-skinned privilege along with my class privilege and educational background likely influenced my interaction with respondents in ways that were not perceptible to me. I am also less informed and knowledgeable about indigenous history in Mexico and Central America, so when I spoke to two respondents who were part of indigenous groups and spoke an indigenous language, like Ma'am or Mayan, I likely missed much of the nuance and structures that put them in a vulnerable position in their countries of origin. This made me all the more aware of the need of more indigenous scholars' and a focus on indigeneity in immigration research.

Recommendations and Take-Aways for Future Research

Conducting my first larger scale research project was a continual learning experience, and there were several take-aways that came through the research process. First, I learned that I had to push myself outside of my comfort zone to recruit a diverse sample for my interviews. While speaking to respondents who were involved in non-profit organizations was useful, expanding my recruitment methods to talk to street food and flea market vendors and priests at different churches would give me a wider range of experiences, even if I felt more nervous with this style of recruitment. When it came to conducting interviews, I learned to be patient and accommodating with every person who was willing to devote time talking to me. I understood not to take it personally if respondents missed or cancelled an interview, and if this happened multiple times, it might be a sign that the respondent may not actually be comfortable with being interviewed for this project. I would no longer contact them if that was the case. Another best practice I found out about after the interview process was to provide compensation for respondents' time in the beginning of an interview, so respondents did not feel pressured to finish completing an interview with me if they did not feel comfortable doing so.

Lastly, I had to recognize my limits as a researcher and prioritize strategies for self-care while doing emotionally heavy and powerful fieldwork. After some interviews, I needed to come home, sometimes cry, sometimes think, and sometimes just take a nap to allow myself to process everything. It was only after this period of processing and decompression that I could give myself the clarity to go into detail and capture the essential components of different interviews if they were recorded or capture the whole of the interview if it was not recorded at all. I needed to give myself this space to fully take in and respect respondents' life experiences and narratives, so, with a few exceptions, I only conducted one or two interviews in any given day.

Towards the end of my research project, I had the opportunity to collaborate with a non-profit organization by writing an internal report for them on how participants accessed different services, and what organizational strategies worked well to facilitate access and what strategies could use improvement. The findings from this internal report then helped inform future grant proposals to expand the organizations' programs and funding. This more applied research proved to be one of the most rewarding parts of my experience, and going forward in my career, I know how to approach and ask about potential for collaborations with organizations earlier in the research process. I also would like to build in ways to incorporate sharing my findings with respondents, so that I can garner constructive feedback from them on what seemed to resonate, what didn't, and gather any critiques or suggestions they have for future research. I tried my best to honestly and fully capture the range of respondents' experiences, but as with any research project, my perspective cannot capture the full scope of the topic we examine. There is always room for more critique, interrogation, and growth.