UNIVERSITY OF CALIFORNIA

Santa Barbara

La Gente Unida: Latinx Immigrant and Indigenous Health and Advocacy on California's Central Coast

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Sociology

by

Mario Alberto Viveros Espinoza-Kulick

Committee in charge:

Professor Victor Rios, Chair

Professor Verta Taylor

Professor Edward Telles

June 2021

The dissertation of Mario Alberto Viveros Espinoza-Kulick is approved.

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Edward Telles

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Verta Taylor

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Victor Rios, Committee Chair

May 2021

La Gente Unida: Latinx Immigrant and Indigenous Health and Advocacy on California's Central Coast

Mario Alberto Viveros Espinoza-Kulick

ACKNOWLEDGEMENTS

I dedicate this dissertation to my father, Juan Espinoza. His last words to me were, “Hechale muchas ganas en la escuela mijo, supérate,” which means, “Give it your best in school son, and better yourself.” These words have motivated me to continue to persevere and succeed as a scholar and community leader. This project on Latinx immigrant and Indigenous health honors his memory and my family. I would like to thank my mother, Josefina Espinoza, as well as Maria (Nena) Viveros, Luis Hernandez, Juan Espinoza Jr., Maria Flores, and Luis (Danny) Espinoza for their support and solidarity, along with my entire extended family. I would also like to thank Monique Kulick, Jonathan Kulick, Mike Kulick, Chelsea Kulick, and Finn Kulick for their encouragement and care. I could not have done this without my family. I am deeply grateful to my husband and partner, Dr. Alex Espinoza-Kulick, and our fur babies, Tigro, Nina, Moana, Taco, and Tank, who were there with me every step of the way.

My thanks to the community members, leaders, and advocates who participated in the study through interviews, focus groups, and the survey, as well as indirectly through conversations and collaboration during participant observation. The fierce advocacy and resilience in our community is a constant source of inspiration. Thank you to my dissertation committee, especially my chair Dr. Victor Rios for his unwavering support, and committee members Dr. Verta Taylor and Dr. Edward Telles for the consult and advice. I would like to express my gratitude to Dr. Melissa Smith, who emphasized the importance of working directly and authentically with community partners. I also benefited greatly from the hard work of undergraduate research assistants, especially Elisa González and Jodene Takahashi. I want to express my appreciation for the support from the Health Policy Research Scholars team, especially Director Dr. Keshia Pollack Porter, Director of Scholar Leadership

Development Jessica Harrington, Career Coaches Dr. Marguerita Lightfoot and Dr. Ernesto Castañeda, and my coach, Shemekka Ebony, as well as the program staff and my cohort.

I appreciate my colleagues who gave feedback on the formation, development, and execution of this project at the following conferences: National Association for Chicana and Chicano Studies (2021), Pacific Sociological Association (2021), AcademyHealth Virtual Datapalooza and National Health Policy Conference (2021), American Anthropological Association (2020), California Sociological Association (2020), University of California Santa Barbara Graduate LGBTQIA+ Research Festival (2020), American Sociological Association (2020), and Pacific Sociological Association (2020). Many thanks to the innumerable others who contributed their time in any way and supported me through this journey.

Financial support for this project was provided by the Robert Wood Johnson Foundation through the Health Policy Research Scholars Program Fellowship, Dissertation Award, and Dissemination Award. Additional funding for this project was received from the Community Change Leadership Network, Scholars Strategy Network, University of California, Santa Barbara Migration Initiative, and California Polytechnic State University, San Luis Obispo Believe, Educate & Empower, Advocate, Collaborate, and Nurture (BEACoN) grant.

VITA OF MARIO ALBERTO VIVEROS ESPINOZA-KULICK
May 2021

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EDUCATION

PhD in Sociology, University of California, Santa Barbara — Expected 2021
Dissertation: "La Gente Unida: Latinx Immigrant and Indigenous Health and Advocacy on California's Central Coast"

MA in Sociology, University of California, Santa Barbara — 2018
Thesis: "The Care-Advocacy Paradox: How Social Movement Organizers Strategize in Support of People Living with HIV/AIDS" (Martin Levine Student Paper Award, ASA)

BA in Comparative Ethnic Studies, California Polytechnic State University, San Luis Obispo — 2016
Minor: Indigenous Studies in Natural Resources and the Environment

AA in Arts & Humanities, Cuesta College, San Luis Obispo, CA — 2014

AA in Social Sciences & Behavioral Studies, Cuesta College, San Luis Obispo, CA — 2014

Research and Teaching Interests:
Medical Sociology; Community Health; Health Policy; Health Services; Equity; HIV/AIDS; Immigration; Theory; Queer of Color Analysis; Race, Class, and Gender; Latina/o/x Studies; Social Movements

SKILLS

Program Evaluation	Mixed Methods	Decolonial Ethnography
Software (Dedoose, SPSS, Stata)	Data Visualization	Policy Analysis
Mentorship	Team Management	Public Speaking
Bilingual (Spanish: Fluent)	Online Teaching	Inclusive Leadership

PUBLICATIONS

Espinoza-Kulick, Mario Alberto V. Forthcoming. "Decolonial-Inspired Ethnography: Centering Indigeneity in Culturally Responsive Evaluation with Latinx Immigrant Communities." *New Directions for Evaluation*. — Expected 2021

Espinoza-Kulick, Mario Alberto V., Maura Fennelly, Kevin Beck, and Ernesto Castañeda. 2021. "Ethnic Enclaves" in *Oxford Bibliographies in Sociology*, edited by Lynette Spillman. New York, NY: Oxford University Press. (Available Online) — 5/1/2021

Espinoza-Kulick, Mario Alberto V., and Alex Espinoza-Kulick. Forthcoming. "Marijuana and the Hippies" in *Marijuana in America: Cultural, Political, and Medical Controversies,* edited by James Hawdon, Bryan Miller, and Matthew Costello. Santa Barbara, CA: ABC-CLIO, LLC.	10/1/2021
Espinoza-Kulick, Mario Alberto V., and Alex Espinoza-Kulick. Forthcoming. "Marijuana Policy Project" in *Marijuana in America: Cultural, Political, and Medical Controversies,* edited by James Hawdon, Bryan Miller, and Matthew Costello. Santa Barbara, CA: ABC-CLIO, LLC.	10/1/2021
Espinoza-Kulick, Alex, and **Mario Alberto V. Espinoza-Kulick**. Forthcoming. "Drug Policy Alliance" in *Marijuana in America: Cultural, Political, and Medical Controversies,* edited by James Hawdon, Bryan Miller, and Matthew Costello. Santa Barbara, CA: ABC-CLIO, LLC.	10/1/2021
Espinoza-Kulick, Mario. 2021. "Big Promises for Immigrants." *Santa Barbara Independent*. (Available Online)	2/9/2021
Cruz-Orduña, Karen., and **Mario Espinoza-Kulick (Featured researcher)**. 2021. "Community Health Movement Launches for Santa Maria, Guadalupe Residents." KEYT News Channel 3-12. (Available Online)	2/9/2021
Place, Laura, and **Mario Espinoza-Kulick (Featured Researcher)**. 2020. "Cal Poly Center for Health Research Launches People's Health Movement in Santa Maria." *Santa Maria Times*. (Available Online)	12/7/2020
Place, Laura, and **Mario Espinoza-Kulick (Featured Researcher)**. 2020. "Cal Poly Center for Health Research Launches People's Health Movement in Santa Maria." *Santa Ynez Valley News*. (Available Online)	12/7/2020
Place, Laura, and **Mario Espinoza-Kulick (Featured Researcher)**. 2020. "Cal Poly Center for Health Research Launches People's Health Movement in Santa Maria." *Lompoc Record*. (Available Online)	12/7/2020
Espinoza-Kulick, Mario. 2020. "Latinx Immigrant Health in San Luis Obispo County: A Report from the La Gente Unida Project." *SSN Key Findings*. Scholar Strategy Network (Available Online).	11/4/2020
Espinoza-Kulick, Mario. 2020. "El Idioma Crea Barreras." (Language Creates Barriers) *El Latino* (Available Online).	11/4/2020
Espinoza-Kulick, Mario (Featured Community Leader). "Protect. Respect. Wear Your Mask Campaign." (Protéjase. Respete. Use Su Mascarilla.)" Posted on County of Santa Barbara Facebook (Available Online), Instagram (Available Online), and Twitter (Available Online). Featured on regional and city transit bus advertisements.	7/21/2020 to 8/14/2020
Espinoza-Kulick, Mario, Fanice Thomas, Raven Hardy, Laurie Unruh, and Keshia Pollack Porter. 2020. *HPRS 2020 Graduation Land Acknowledgment*. Baltimore, MD: Health Policy Research Scholars Program, Johns Hopkins Bloomberg School of Public Health.	7/18/2020

Mart, Greta, **Mario Espinoza-Kulick (Featured Researcher)**, Ian Delinger, Brian Reynolds, Scott Rodd/CAP Radio, Erika Mahoney/Kazu, and Consuelo Meux. 2020. "Issues & Ideas: NAACP, Latinx Healthcare, and Miss Odette." *KCBX News: Central Coast Public Radio*. (Available Online)	7/17/2020
Espinoza-Kulick, Mario. 2020. *Resources for Safely Returning to Work for Access Support Network*. San Luis Obispo, CA: Access Support Network.	7/1/2020
Barros, Michael, Greta Mart, and **Mario Espinoza-Kulick (Featured Faculty)**. 2020. "For Safekeeping or the Ousting of a Noxious Symbol, Serra Statues Come Down." *KCBX News: Central Coast Public Radio*. (Available Online)	7/1/2020
Espinoza-Kulick, Mario, and Alex Espinoza-Kulick. 2020. "Building Teaching Capacity for LGBTQ+ Inclusion with Queer Ethnic Studies." *Carnegie Education Blog*. Leeds Beckett University. (Available Online)	6/26/2020
Espinoza-Kulick, Mario. 2020. *Community Report: Preliminary Findings*. Santa Maria, CA: La Gente Unida. (Available Online)	6/24/2020
Vargas, Marco, Arturo Raygoza, Florence Bednersh, Sherrill Nickerson, **Mario Espinoza-Kulick**, Rep. Salud Carbajal, Adelante Guadalupe, Anthony Loverde, Aracely Garcia-Gonzalez, Anjelica Haro, Joan Hartmann, Gail McNeely, Ken Hough, Doug Walker, Gabriela Chavez, and Julia Hamilton. 2020. "FUND for Santa Barbara – Spring 2020 Grantee Awards Video." You-Tube Web site. Retrieved June 9, 2020 (Available Online)	6/9/2020
Espinoza-Kulick, Mario and student contributors. 2020. *LGBTQIA+ Inclusive Curriculum Report.* San Luis Obispo, CA: California Polytechnic State University, San Luis Obispo.	2/1/2020
Espinoza-Kulick, Mario and Health Policy Research Scholars**.** 2019. "A Conversation with Mario Espinoza-Kulick – Health Policy Research Scholars." You-Tube Web site. Retrieved August 15, 2019 (Available Online)	8/15/2019
Kulick, Alex. Laura Wernick, **Mario Alberto V. Espinoza**, Tarkington Newman, and Adrienne Dessel. 2018. "Three Strikes and You're Out: Culture, Facilities, and Participation among LGBTQ Youth in Sports." *Sport, Education and Society*. (Available Online)	7/26/2018
Espinoza, Mario Alberto Viveros. "The Care-Advocacy Paradox: How Social Movement Organizers Strategize in Support of People Living with HIV/AIDS." Thesis, Sociology, University of California Santa Barbara. University of California eScholarship. (Available Online)	6/30/2018
University of California Santa Barbara Graduate Division, and **Mario Espinoza (Featured Graduate Student Researcher)**. 2018. "Pushing the Boundaries: Graduate Student Research at UC Santa Barbara." Santa Barbara, CA: University of California Santa Barbara Graduate Division. (Available Online)	6/30/2018

Polletto, Nicole, and **Mario Espinoza (Featured Graduate Student Researcher)**. 2017. "Gaucho Grad Selected for National Leadership Program to Build Health Equity." *Grad Post: The Voice of the Graduate Student Research Center Blog, University of California Santa Barbara*. (Available Online)	10/6/2017
De Los Santos, Brian, Tre'vell Anderson, Priya Krishnakumar, and **Mario Espinoza (Featured Community Member)**. 2017. "'We've Woken Up': What It's Like to Be LGBT under Trump." *Los Angeles Times*. (Available Online).	2/3/2017
Entravision and **Mario Espinoza (Featured Activist)**. 2016. "Video: Hispanos Son Más Propensos a Infectarse del VIH." *Univision Costa Central*. (Available Online)	5/22/2016
Entravision and **Mario Espinoza (Featured Activist)**. 2016. "Posible Incremento en Matrículas Universitarias." *Univision Costa Central*. (Available Online)	5/5/2016
Mustang News Staff Report and **Mario Espinoza (Featured Activist)**. 2015. "SLO Solidarity Responds to Postponement of Action Plan." *Mustang News*. (Available Online).	12/17/2015
Mustang News Staff Report and **Mario Espinoza (Featured Activist)**. 2015. "Admin Responds to SLO Solidarity Demands." *Mustang News*. (Available Online)	12/1/2015
Espinoza, Mario Alberto Viveros. "Know Your Status: Alleviating Stigma from the HIV Community of, San Luis Obispo". Thesis, Ethnic Studies, California Polytechnic State University, San Luis Obispo. Kennedy Library Digital Commons. (Available Online)	9/1/2015
Espinoza, Mario Alberto. 2015. "Discovering Silence through Indigenous Methodologies." *UC Santa Barbara Undergraduate Research Blog*. (Available Online)	8/6/2015

MANUSCRIPTS IN PROGRESS

Espinoza-Kulick, Mario Alberto V., and Jessica P. Cerdeña. In Review. ""We Need Health for All": Mental Health and Barriers to Care among Latinxs in California and Connecticut." *Psychological Services*.

Espinoza-Kulick, Mario Alberto V. In Review. "Immigration Policy is Health Policy: News Media Effects on Health Disparities for Latinx Immigrant and Indigenous Groups." *Health Promotion Practice*.

Espinoza-Kulick, Mario Alberto V. In Review. "Movement Pandemic Adaptability: Mobilizing for Latinx Immigrant Health during COVID-19." *Voices from Within: A Public Health Perspective on the Response to COVID-19*, edited by Caroline Kingori and Shannon Nicks.

FUNDING, FELLOWSHIPS, AND AWARDS

Dissemination Award, Health Policy Research Scholars Program, Johns Hopkins University ($1,500)	Spring 2021
Policy Support for Newly Electeds program, Scholar Strategy Network ($750)	Fall 2020
Equity Fund, Community Change Leadership Network ($2,000)	Fall 2020
Future of Ethnic Studies Alumni Award, Ethnic Studies Department, California Polytechnic State University, San Luis Obispo	Winter 2020
Certificate of Leadership for Contributions to the Cal Poly LGBTQ+ Community, Pride Center, California Polytechnic State University, San Luis Obispo	Winter 2020
Believe, Educate & Empower, Advocate, Collaborate, Nurture (BEACoN) Mentor Award, California Polytechnic State University, San Luis Obispo ($5,000)	Winter 2020
Most Comprehensive Policy Recommendation, Health Policy Research Scholars	Summer 2018
Health Policy Research Scholars Dissertation Award, The George Washington University ($7,840.10)	Spring 2019
Martin Levine Student Paper Award, Sociology AIDS Network, American Sociological Association ($100)	Summer 2018
Health Policy Research Fellowship, Robert Wood Johnson Foundation ($120,000 with $63,861.12 matched by University of California, Santa Barbara, over 4 years)	Fall 2017
Sociology Departmental Fellowship, University of California, Santa Barbara ($37,847.28)	Fall 2016
Lavender Leadership Award, California Polytechnic State University	Spring 2016
Vantage Point Grant, Student Affairs, California Polytechnic State University ($500)	Spring 2016
National Association for Chicana and Chicano Studies Conference Fellowship ($500)	Spring 2016
Growing Together Initiative Grant, The Community Foundation, San Luis Obispo ($2,000 over 2 awards)	Spring 2016, Spring 2015
California Legislature Assembly Certificate of Recognition	Winter 2016
California State University Trustees' Award for Outstanding Achievement ($6,000)	Fall 2015
Academic Research Consortium Scholar, University of California, Santa Barbara ($2,500)	Summer 2015
President's Diversity Award, California Polytechnic State University ($1,000)	Spring 2015
Garry Grossman Scholarship, The Community Foundation, San Luis Obispo ($2,500)	Spring 2015
Permanent Membership, Alpha Gamma Sigma Academic Honor Society	Fall 2013

RESEARCH EXPERIENCE

Health Equity Policy Manager 3/8/2020 to Present
Future Leaders of America
Santa Maria, CA
Design and implement issue-based campaigns for health equity, focusing on the Santa Maria region. Support data analysis and policy research for youth organizers throughout the Central Coast. Oversee organization-wide equity efforts and integrate evidence-based research practices into leadership initiatives. Develop strategic relationships with city, county, and community leaders to inform policymakers and systemic change efforts.

Co-Principal Investigator 1/24/2020 to Present
Mi Gente, Nuestra Salud / A People's Movement for Health, Center for Health Research, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Awarded a Strategic Initiatives grant for $150,000 to close health equity gaps by creating a movement for community health ownership. Coordinate community-academic partnerships with Latinx Immigrant and Indigenous peoples, elected officials, and healthcare workers in Santa Maria. Mentor students and co-investigators to conduct ethical, culturally responsive research methods. (Co-Principal Investigators: Drs. Suzanne Phelan & Marilyn Tseng).

Survey Research Consultant 7/1/2020 to Present
Lived Experience Advocacy Development (LEAD) program, Transitions-Mental Health Association
San Luis Obispo and Santa Maria, CA
Conduct a comprehensive health services evaluation for mental health resources in northern Santa Barbara county, focusing on Monolingual Spanish-speaking adults and transition-age youth (16-24 years old). Collaborate with community leaders and agency staff to create, disseminate, and analyze survey data. Train community advocates to directly apply results to local policy advocacy. (Co-Investigator: Dr. Alex Espinoza-Kulick)

Graduate Student Research Assistant Level 2 7/22/2016 to Present
Sociology, University of California, Santa Barbara
Santa Barbara, CA
Develop bibliographies, write, review, and edit research articles for publication. Collaborate with faculty leaders to design new projects and supervise students. Submit, revise, and publish manuscripts in academic journals (Principal Investigator: Dr. Victor Rios).

BEACoN Faculty Research Mentor 12/5/2019 to 6/14/2020
Office of University Diversity & Inclusivity, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Selected to serve as a mentor and advocate for underrepresented students. Lead team meetings and workshops on ethnographic research and data analysis. Coached students to fully execute a research project and provide professional development advice to promote student success. Extended opportunities for underrepresented students by creating additional volunteer positions.

Research Assistant 1/12/2017 to 3/30/2017
Mobilizing Millions: Engendering Process Across the Globe, University of California, Santa Barbara
Santa Barbara, CA
Attended Women's March on January 22, 2017 in Philadelphia, PA. Distributed surveys to participants in marches and documented observation of march for research team analysis (Direct site lead: Alex Kulick, MA; Principal Investigator: Dr. Zakiya Luna).

Graduate Student Mentor 5/1/2017 to 8/10/2017
Graduate Division, University of California, Santa Barbara
Santa Barbara, CA
Mentored students in research endeavors through group workshops and one-on-one meetings.

Community Advisor 8/7/2016 to 9/22/2017
"Stick To It!" Community Advisory Board, AIDS Healthcare Foundation, University of California Berkeley and University of California Los Angeles
Berkeley and Los Angeles, CA
Provided feedback on program evaluation methodology to improve the relationship between gay, bi, and queer men and existing sexual health programs in California.

Academic Research Consortium Scholar 6/1/2015 to 8/1/2015
Department of Chicana/o Studies
University of California, Santa Barbara
Conducted independent research under the supervision of Dr. Gerardo Aldana.

PROFESSIONAL EXPERIENCE

Participant, Justice Leadership Institute 3/20/2021 to Present
Central Coast Alliance United for a Sustainable Economy (CAUSE)
Santa Maria, CA
Actively contribute to discussions and activities during trainings on organizing, policy advocacy, and elections. Built networks of stakeholders committed to equity and justice.

Certified Trainee, Youth Mental Health First Aid 5/20/2021
National Council for Behavioral Health
Santa Barbara, CA
Trained to help a young person experiencing a mental health or substance use challenge.

Participant, Creating Accessible Course Materials 9/28/2020 to 10/24/2020
Center for Teaching, Learning & Technology, California Polytechnic State University, San Luis Obispo and California State University Chancellor's Office Quality Assurance Project
San Luis Obispo, CA
Certified in applying best practices for course design using accessible online materials, as well as relevant accessibility standards and policies.

Participant, Introduction to Online Teaching and Learning 7/20/2020 to 8/8/2020
Center for Teaching, Learning & Technology, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Applied research-based best practices in online teaching and learning to refine courses for online delivery. Practiced alignment with policies for accessibility and meaningful engagement.

Professional Development Consultant 4/1/2020 to 6/30/2020
"Applying Queer Ethnic and/or Trans* Studies in the Classroom," Santa Maria Joint Unified High School District (Independent Contract)
Santa Maria, CA
Developed and facilitated a professional development workshop for Ethnic and Gender Studies Faculty at a local high school district.

Telework Supervisor 5/14/2020 to 6/30/2020
California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Met weekly with two student assistants to provide instruction and feedback on regular tasks. I trained one student in workflows for data entry and transcription. I collaborated with the second student to conduct graphic design work for future research dissemination efforts. Completed necessary administrative tasks.

Senior Graduate Student Assistant 9/06/2016 to 7/1/2018
ONDAS Center, University of California, Santa Barbara
Santa Barbara, CA
Developed and facilitated programming geared towards the first-year experience, first-generation and low-income college students. Combine institutional data on equity gaps and student perspectives to create focused and responsive programmatic interventions. Served as a mentor to academically disadvantaged students and compiled resources to assist with undergraduate student success.

Student Administrative Assistant 9/21/2015 to 7/22/2016
Office of University Diversity & Inclusivity, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Assisted Office of University Diversity & Inclusivity with research and evaluation. Facilitated events and promoted diversity and inclusivity initiatives. Organized a $2500 campus event with renowned speaker, Dr. Victor Rios.

Student Administrative Assistant 1/28/2015 to 6/12/2016
Institute for Advanced Technology and Public Policy, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Evaluated accessibility for use by diverse public audiences for a platform of digitally archived state legislative hearings on relevant policy debates. Facilitated and analyzed focus groups on bilingual literacy resources.

PRISM Peer Counselor/ Volunteer 6/1/2014 to 6/12/2016
CrossCultural Centers, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Counseled peers and made resources accessible for mentees. Facilitated safe-space dialogues with the LGBQTIA+ community to increase actions toward equity and justice. Mandated reporter of sexual abuse and suicide.

Outreach and Testing Coordinator/ HIV Test Counselor / Positive Speaker 1/21/2014 to 7/15/2016
Access Support Network
San Luis Obispo, CA
Coordinated outreach events for sexual health awareness and curricula for HIV stigma. Designed and managed a full-day symposium, "Know Your Status" ($15,000 budget), as well as a regional multi-day training conference that required overseeing and managing a $50,000 budget. Collaborated with co-workers to ensure effective and culturally responsive programming to reach clients affected by HIV and HCV. Oversaw HIV testing efforts for students and community members.

TEACHING EXPERIENCE

Lecturer, Ethnic Studies and Women's and Gender Studies, California Polytechnic State University, San Luis Obispo 8/1/2018 to 3/23/2021
San Luis Obispo, CA
ES 243: Survey of Latinx Studies
ES 340: Latinx Cultural Productions
ES/WGS 345: Queer Ethnic Studies
ES/WGS 350: Gender, Race, Culture, Science and Technology
ES 390: Research Methods in Ethnic Studies
ES 450: Fieldwork in Comparative Ethnic Studies

Teaching Associate (Instructor of Record), Sociology, University of California, Santa Barbara 6/2019 to 8/2019
Santa Barbara, CA
SOC 108C: Methods of Cultural Analysis

Teaching Assistant, Sociology, University of California, Santa Barbara 6/2017 to 12/2019
Santa Barbara, CA
SOC 170J: Juvenile Justice (Dr. Victor Rios)
SOC 108C: Methods of Cultural Analysis (Dr. Annie Hikido)
SOC 118C: Culture (Dr. Jon Cruz)
SOC 108: Methods of Sociological Research (Dr. Alicia Cast)

Teaching Assistant, Ethnic Studies, California Polytechnic State University, San Luis Obispo 1/2016 to 6/2016
San Luis Obispo, CA
ES 310: Hip-Hop, Poetics, & Politics (Dr. Jenell Navarro)
ES 114: Introduction to Comparative Ethnic Studies (Dr. Jenell Navarro)
ES 112: Race, Culture and Politics in the U.S. (Dr. Jenell Navarro)

SERVICE

Board Member 5/1/2020 to Present
Access Support Network
San Luis Obispo, CA
Co-construct our vision to save and enhance lives of people impacted by HIV and Hep C in San Luis Obispo and Monterey counties. Ensure organizational sustainability over the next 20 years and beyond. Evaluate programs and increase equitable service provision and outreach for farm working communities at risk of HIV and HCV, focusing on LGBTQ+ and MSM constituencies.

Executive Board Member, Secretary 1/1/2020 to Present
Corazon del Pueblo: Cultural & Creative Arts Center of Santa Maria Valley
Santa Maria, CA
Ensure accountability to develop and evaluate artistic and activist campaigns in Santa Maria. Chair of Arts for the People Committee, including maintaining public relations with organizational partners and grantors. Supervise Creative Arts Manager with regard to organizational communications, newsletter, website, and outreach.

Member 2/1/2019 to Present
Coalition Engaged in a Smoke-Free Effort (CEASE)
Santa Barbara County, CA
Provide feedback and technical expertise for community practitioners advocating for positive health behaviors around smoking cessation, emphasizing underserved populations. Supported efforts to restrict the sale of flavored tobacco products targeted to youth in low-income areas.

Diversity, Equity, and Inclusion Policy Creation 3/3/2021 to 3/26/2021
Gala Pride and Diversity Center
San Luis Obispo, CA
Contributed to group discussions about best practices in non-profit organizations for diversity, equity, and inclusion efforts. Provided expert guidance on local issues facing LGBTQ communities of color and effective intervention strategies for disrupting racism and white supremacy.

AB 1460 Implementation Working Group Faculty Member 9/9/2020 to 3/23/2021
California State University Council on Ethnic Studies
California
Develop a comprehensive plan for the implementation of the new Ethnic Studies graduation requirement throughout the California State University system, focusing on implementing campus-level policies in San Luis Obispo and coordinating with state-wide efforts. Advocate for rigorous teaching standards in Ethnic Studies to be upheld.

Participant, LGBTQ+ Healthcare and COVID-19 Campaign 6/9/2020 to 10/1/2020
University of California Cooperative Extension
California
Provide expertise on the role health disparities facing LGBTQ+ communities play in disparate rates of impact during the COVID-19 pandemic. Contribute to ongoing efforts to coordinate increased equity in access to quality healthcare.

Faculty Advisor 9/19/2019 to 12/11/2020
Queer and/or Trans* People of Color Collective (QTPoCC), Associated Students INC. California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Advised students and approved institutional proposals for social gatherings and events. Advised on capacity-building, fundraising, and public campaigns for diversity and equity.

Teach-In Track Organizer, "Public Health Inequities and Movements" 11/30/2020 to 2/11/2021
College of Liberal Arts, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Coordinated the "Public Health Inequities and Movements" track for the annual Teach-In event that links the campus community to tangible knowledge being created by their professors.

Teach-In Faculty 2/11/2021
"Introducing "Mi Gente, Nuestra Salud:" A People's Movement for Health in Santa Maria, CA" (with Marilyn Tseng and Suzanne Phelan), College of Liberal Arts, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Educate faculty, staff, students, and community members on how the "Mi Gente, Nuestra Salud" uses a community health ownership approach to empower people in Santa Maria, CA.

Teach-In Faculty 2/11/2021
"Somos Esenciales: Farmworker and Indigenous Health Video, Gallery and Discussion by Corazón del Pueblo Cultural and Creative Arts Center of the Santa Maria Valley" (with Corazón del Pueblo, Leo Ortega, Viviana Hall, and Alex Espinoza-Kulick), College of Liberal Arts, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Amplify the voice of community artists and local activists by collaborating with them to directly share their work documenting the experiences of farmworkers and Indigenous peoples.

Teach-In Faculty 2/11/2021
"Latinx Immigrant Health Inequities in San Luis Obispo: Findings and Recommendations for Health Equity and Policy" (with Jodene Takahashi and Elisa González), College of Liberal Arts, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Shared findings from a report on the health inequalities facing Latinx Immigrant and Indigenous communities in San Luis Obispo county. Mentored students in effective communication and presentation strategies for discussing health research and policy.

Teach-In Faculty 2/11/2021
"Downstream Determinants of COVID-19 in the Central Coast: Findings from a Regional Health Needs and Assets Survey and the Womxn and Infants Mobile Health Unit" (with Marilyn Tseng)
San Luis Obispo, CA
Informed campus community on how the mobile health unit has impacted already vulnerable minoritized groups like Latinx Immigrants, Spanish-Speakers, and Womxn.

Teach-In Faculty 2/11/2021
Workshop: "Creating and Disseminating Multilingual Information for Positive Health," College of Liberal Arts, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Reviewed general conceptions and pitfalls of dissemination and implementation to prepare attendees for creating health information materials that are culturally relevant and multilingual.

Invited Community Leader, Community Vision Workshop 12/3/2020
Community Development and Planning Division, City of Santa Maria
Santa Maria, CA
Provided feedback on the development of Santa Maria's General Plan for the next three decades. Shared evidence-based approaches for expanding opportunity, education, and healthcare.

Contributor, Program Values for Health Policy Research Scholars 8/13/2020 to
Johns Hopkins University Bloomberg School of Public Health 10/9/2020
Baltimore, MD
Co-develop the values guiding the Health Policy Research Scholars Program to inform the selection of funded PhD scholars, direction of program activities, and funding of research grants.

Invited Representative, Racial Justice Action Committee 7/1/2020 to
Department of Sociology, University of California Santa Barbara 10/15/2020
Santa Barbara, CA
Crafted a recommendation for implicit bias training among department leadership, faculty, and staff. Collaborated with faculty and graduate students to introduce a comprehensive plan for a more equitable and inclusive climate in the sociology department. Advocated for student representatives to have equal standing with faculty.

Volunteer Racial Equity Consultant 3/7/2020
Faculty Equity Summit, Cuesta College
San Luis Obispo, CA
Invited by Cuesta College's Director for Student Success and Equity to observe and provide feedback to faculty during diversity training in partnership with Skyline Community College.

Event Support Volunteer for ES at 50 Gala 2/15/2020
Ethnic Studies Department, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Designed program materials for networking and community engagement. Supported department leadership with set-up tasks prior to the Gala. Welcomed students and guests.

Faculty Attendee for ES at 50 Luncheon 2/13/2020
Ethnic Studies Department, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Invited to represent the Ethnic Studies faculty to welcome and inspire students from underrepresented groups. Shared personal experiences and answered student questions.

Teach-In Faculty 2/13/2020
Inclusion Starts with Me Teach-In Workshop: "Mobilizing Under Threat: Latinx Immigrant Health Advocacy on California's Central Coast," College of Liberal Arts, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Educated faculty, staff, students, and community members on pressing health disparities for Latinx immigrant groups in San Luis Obispo and along California's Central Coast and the advocacy strategies being used to close equity gaps through policy.

Faculty Panelist 1/28/2020
Paulding Middle School, Lucia Mar Unified School District, Ms. Sara Roudebush
California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Invited as Ethnic Studies faculty to welcome and inspire youth attending a local middle school, serving as a role model for students of color to see themselves in academia.

Faculty Panelist 10/11/2019
National Coming Out Day Panel, Pride Center, Cross Cultural Centers, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Invited by the Pride Center to discuss the impacts of coming out as a queer person of color and share with panelists about navigating being out in the workplace.

Faculty Presenter 9/14/2019
Creating Opportunities for Representative Engagement Program, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Invited by Assistant Vice President for Student Affairs, Dr. Jamie S. Patton, to share my personal story of overcoming barriers in academia for a group of 200 incoming multicultural students.

Know Your Status Consultant 4/2/2019 to
Pride Center, California Polytechnic State University, San Luis Obispo 6/7/2019
San Luis Obispo, CA
Provided feedback to organizational leadership within the Pride Center to utilize written evaluations of the annual "Know Your Status" event. Advanced efforts to address HIV stigma.

Roundtable Facilitator 1/22/2019
Community-Based Participatory Research Seminar, University of California, Santa Barbara
Santa Barbara, CA
Facilitated a roundtable on using the community-based participatory research model for planning and visioning a research project.

Survey Reviewer 1/17/2019
Ethnic Studies, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Reviewed the internal Alumni survey for the Ethnic Studies Department. Helped with editing, suggestions, and specific design for demographic questions to be inclusive for diverse students.

Faculty Partner 9/1/2018 to
ONDAS Center, University of California, Santa Barbara 6/30/2019
Santa Barbara, CA
Contributed to programmatic efforts to support the 2,507 students accessing this center for first-generation students' academic success. Held all office hours at the center to increase access and awareness of on-campus support resources. Participated in regular events as a faculty representative to set a welcoming and inclusive tone for underrepresented students.

Student Representative 8/1/2018 to
Latina/o Section 8/1/2019
American Sociological Association
Coordinated section activities for 350+ members, including voting, creation and dissemination of quarterly newsletter, attending council and business meetings.

Committee Member 8/1/2018 to
Colloquium and Professional Development Committee, Department of Sociology, University of California, Santa Barbara 6/30/2019
Santa Barbara, CA
Coordinated regular professional development and research dissemination presentations that address students' interests.

Assistant to the Chair (Dr. Victor Rios) 8/1/2017 to
Latina/o Section 8/1/2018
American Sociological Association
Coordinated scheduling and logistical planning for section activities, including conference presentation tracks, Chairing the Norma Williams Workshop Steering Committee, and hosting the section's award ceremony.

Graduate Student Representative 9/1/2017 to 7/21/2019
Healthy Campus Network Steering Committee, University of California, Santa Barbara
Santa Barbara, CA
Reviewed aspects of the environmental, financial, physical, professional, social, emotional, psychological, and cultural wellness of the campus community.

"**Hype" Committee Head** 6/1/2015 to 10/1/2016
Poly Cultural Weekend (PCW), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Responsible for writing the "rules video" script, recruiting actors, and establishing dates and times for filming. Directed the PCW orientation show to maintain excitement.

Student Diversity Advisory Council Member 8/1/2015 to 6/21/2016
Office of University Diversity & Inclusivity, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Enhanced the campus community by involving students in diversity and inclusivity initiatives. Brought students' voices to the forefront of discussions regarding diversity and inclusion.

Student Council Member 9/1/2015 to 12/1/2015
University Union Project Student Advisory Board, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Represented the CrossCultural Centers in the development of a campus wide student referendum for a $180 million expansion and renovation for Cal Poly's University Union.

Student Representative 1/13/2015 to 6/21/2016
Inclusive Excellence Council, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Participated as a student voice for a campus wide initiative on enhancing diversity and inclusivity. Worked with Dr. Carrigan to advance cultural change on campus.

Coordinator (Community/Campus Outreach and Public Relations) 6/18/2015 to 12/10/2015
Culture Fest Board, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Collaborated with the CrossCultural Centers to help plan, organize, and facilitate Culture Fest. Supervised three committees to ensure effective teamwork.

Co-Chair/ Secretary 9/25/2014 to 6/1/2016
Movimiento Estudantil Xicano Aztlan, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA
Oversaw proposed activism-oriented events, philanthropic initiatives, campus tours and fundraising for social programs.

CONFERENCES

Espinoza-Kulick, Mario. "Together We Can: Decolonial Ethnography as a Method for Advancing Health Equity." Accepted for presentation at the American Sociological Association annual meeting to be Online. 8/7/2021

Espinoza-Kulick, Mario. "Decolonizing during a Pandemic: Peril and Promise for Latinx Immigrant Health." Presented at the National Association for Chicana and Chicano Studies annual conference to be Online. 4/15/2021

Espinoza-Kulick, Mario. "La Gente Unida: Latinx Immigrant Health Advocacy in Perilous Times." Presented at the Pacific Sociological Association annual meeting to be Online. 3/26/2021

Espinoza-Kulick, Mario. "La Gente Unida: Latinx Immigrant Health Advocacy and the Downstream Effects of Racism." Poster presented at the AcademyHealth Virtual Datapalooza and National Health Policy Conference Online. 2/16/2021

Cerdeña, Jessica P., Luisa Rivera, Mario Espinoza-Kulick, Samantha Herrera, Sandra Amezcua Rocha, and Sierra L. Talavera-Brown. "Reforming Mental Health Services for Indigenous Communities." Presented at the American Anthropological Association meeting Online. 12/2/2020

Espinoza-Kulick, Alex and Mario Espinoza-Kulick. "Applying Sociology: Report on the Development of a Model Ethnic Studies Curriculum." Presented at the California Sociological Association annual meeting Online. 11/7/2020

Espinoza-Kulick, Mario. "La Gente Unida: Immigrant Health and Advocacy in California's Central Coast." Poster presented at the California Sociological Association annual meeting Online. 11/6/2020

Espinoza-Kulick, Mario. "La Gente Unida: Resiliency in the Face of Racism and the COVID-19 Pandemic." Presented at the California Sociological Association annual meeting Online. 11/6/2020

Espinoza-Kulick, Mario. "La Gente Unida: Immigrant Health and Advocacy in California's Central Coast." Presented at the University of California Santa Barbara Graduate LGBTQIA+ Research Festival Online. 8/7/2020

Espinoza-Kulick, Mario. "Theorizing Immigrant Health Movements: Mobilization & Resistance in Precarious Times." Presented at the American Sociological Association annual meeting Online. 8/10/2020

Espinoza-Kulick, Mario, and Alex Espinoza-Kulick. "Expanding the Sociological Imagination: Translating Queer Ethnic Studies for Teaching Sociology." Accepted for presentation at the Society for the Study of Social Problems Annual Meeting in San Francisco, CA. 8/7/2020

Espinoza-Kulick, Mario. "Together We Can: Decolonial Ethnography as a Method for Advancing Health Equity." Accepted for presentation at the Pacific Sociological Association in Eugene, OR. 3/26/2020

Espinoza-Kulick, Mario, and Alex Espinoza-Kulick. "Teaching Queer Ethnic Studies". Workshop presented at Change The Status Quo, Center for Service in Action, California Polytechnic State University, San Luis Obispo, CA. 2/29/2020

Espinoza-Kulick, Alex, Laura Wernick, Mario Espinoza-Kulick, Tarkington Newman, and Adrienne Dessel. "Three Strikes and You're Out: Culture, Facilities, and Participation among LGBTQ Youth in Sports." Presented at Annual Conference of the Society for Social Work Research in Washington, DC.	1/15/2020
Espinoza-Kulick, Mario, and Alex Espinoza-Kulick. "Addressing the Care-Advocacy Paradox: Analyzing AIDS Coalition to Unleash Power (ACT UP) to Understand Contention around HIV/AIDS." Presented at the California Sociological Association in Sacramento, CA.	11/16/2019
Espinoza, Mario and Alex Kulick. "Advancing Youth-Centered Approaches to Social Justice and Equity." Workshop presented at the Social Justice Education Conference in Santa Maria, CA.	5/4/2019
Kulick, Alex and Mario Espinoza. "Cruel and Unusual Punishment: The Shackling of Inmates and Immigrants during Pregnancy and Childbirth." Presented at the Pacific Sociological Association in Oakland, CA.	3/29/2019
Espinoza, Mario Alberto V. "Resiliency" Facilitated and led a roundtable discussion at the Annual Leadership Institute for the Robert Wood Johnson Foundation in Indianapolis, IA.	1/14/2019
Espinoza, Mario Alberto V. "Change Leadership" Facilitated and led a roundtable discussion at the Annual Leadership Institute for the Robert Wood Johnson Foundation in Indianapolis, IA.	1/14/2019
Espinoza, Mario Alberto V. "Addressing the Care-Advocacy Paradox: Analyzing ACT UP to Inform Advocacy Practices." Presented at the American Sociological Association annual meeting in Philadelphia, PA.	8/14/2018
Espinoza, Mario Alberto V. "Addressing the Care-Advocacy Paradox: Analyzing ACT UP to Inform Advocacy Practices." Presented at the ASA Sexualities Section Preconference in Philadelphia, PA.	8/10/2018
Espinoza, Mario Alberto V. "Addressing the Care-Advocacy Paradox: Analyzing ACT UP to Inform Advocacy Practices." Accepted for presentation at the "Mobilization" conference at San Diego State University in San Diego, CA.	5/5/2018
Espinoza, Mario Alberto V. "Reading Between the Lines: Relationships between HIV Crime Laws' Sentencing Length, Race and Region." Presented at the National Association for Chicana and Chicano Studies (NACCS) in Irvine, CA.	3/22/2017
Espinoza, Mario Alberto V. "Combatting Sexual Health Stigma Under Immigration and Customs Enforcement (ICE)." Presented at NACCS in Denver, CO.	4/6/2016
Espinoza, Mario Alberto V. "Discovering Silence Through Indigenous Methodologies." Presented at the Academic Research Consortium Symposium at UCSB.	8/7/2015

INVITED TALKS

Panel Speaker 7/8/2021
"Investing in Youth of Color," Summer of Change series, Central Coast Alliance United for a Sustainable Economy (CAUSE)
Santa Maria, CA

Invited Speaker 5/11/2021
"La Gente Unida: Results and Recommendations for Health Equity," City of Guadalupe
Guadalupe, CA

Panel Speaker 4/24/2021
"Symposium for Equity Driven Leadership," Educational Leadership and Administration Program, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Community Talk 4/17/2021
"Results and Recommendations for Health Equity on the Central Coast," Corazón del Pueblo: The Cultural and Creative Arts Center of the Santa Maria Valley
Santa Maria, CA

Keynote Speaker 12/18/2020
Multicultural Graduation, Cuesta College
San Luis Obispo, CA

Event MC 12/10/2020-12/12/2020
Santa Maria People's Movement for Health Kick-Off Events, Mi Gente, Nuestra Salud, Center for Health Research, California Polytechnic State University, San Luis Obispo
Santa Maria, CA

Invited Panelist 11/21/2020
"LGBT y Más," Authenticity Series, The Gala Pride and Diversity Center
San Luis Obispo, CA

Invited Lecturer 11/16/2020
"Dissemination and Implementation," Health Behavior Health Education 600: Psychosocial Factors in Health-Related Behavior, School of Public Health, University of Michigan
Ann Arbor, MI

Moderator 10/8/2020
"A LatinX Narrative: A World Where Our Voices Count," Latina Leadership Network, Cuesta College
San Luis Obispo, CA

Guest Speaker 10/8/2020
"Communicating with Professors," CLA 100: Multicultural Scholars Program Orientation, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Community Leader 10/5/2020
"Latinx Community Learning Session," City of San Luis Obispo Diversity, Equity, and Inclusion Taskforce
San Luis Obispo, CA

Faculty Panelist 10/1/2020
"State of Latinx," California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Faculty 10/1/2020
Coffee Talk Conversation, Social Justice and Racial Equity in the Classroom, Cuesta College
San Luis Obispo, CA

Panel Facilitator 9/26/2020
"Social and Economic Justice," 100 Thousand Poets for Change, Corazón del Pueblo: The Cultural and Creative Arts Center of the Santa Maria Valley
Santa Maria, CA

Break-Out Room Facilitator 9/25/2020
"Incorporating Ethnic and Gender Studies in the Classroom," Social Justice and Racial Equity in the Classroom Conference, Cuesta College
San Luis Obispo, CA

Faculty Advisor and Panelist 6/10/2020
"La Gente Unida: A Resource Guide for Latina/o/x Immigrant Health in San Luis Obispo" (Student Assistant: Elisa González), BEACoN Research Symposium, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Faculty Advisor and Co-Presenter 5/28/2020
"La Gente Unida: A Resource Guide for Latina/o/x Immigrant Health in San Luis Obispo" Teach ON!, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Workshop Facilitator 5/26/2020
"Strengths and Values Workshop," BEACoN Professional Development Workshop, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Presenter 5/15/2020
"Using SORT (Specific Obstacles Relevant Timely) Goals for Success," Health Policy Research Scholars Seminar
Johns Hopkins University and Robert Wood Johnson Foundation

Invited Lecturer 10/30/2019
"Academic Profiling: Labels and Juvenile Justice," SOC 170J: Juvenile Justice (Dr. Victor Rios), Sociology, University of California Santa Barbara
Santa Barbara, CA

Keynote Speaker 6/7/2019
American Indian and Indigenous Commencement, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Faculty Panelist, 5/23/2019
Grad School Panel, Ethnic Studies, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Speaker 5/7/2019
"La Gente Unida (The People United): A Community-Engaged Approach to Defining Immigrant Health Movements and Advocacy in California's Central Coast," Sociology Colloquium Committee, University of California, Santa Barbara
Santa Barbara, CA

Invited Lecturer 3/7/2019
"Is Immigrant Policy Anti-Health?: Consequential Outcomes of Anti-Immigrant Policy," Cal Poly Center for Health Research, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Lecturer 2/1/2019
"Ethnographic Methods Workshop: Dedoose 101," Ethnography Workshop, Sociology Department, University of California, Santa Barbara
Santa Barbara, CA

Invited Speaker 1/24/2019
"Divest from War, Invest in People," Food Not Bombs and, San Luis Obispo Peace Coalition, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Panelist 8/7/2018
"Thriving, Not Surviving: Navigating Higher Education as a First-Generation Student," Summer Sessions, TSC, OSC, and MCC, University of California, Santa Barbara
Santa Barbara, CA

Invited Lecturer 5/16/2018
"Love as Discursive FORMATION: Examining Race, Gender, and Sexuality in Lemonade," ES 470: Beyoncé: Feminism, Race, & Politics (Dr. Jenell Navarro), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Keynote Speaker 5/4/2018
Know Your Status, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Speaker 4/26/2018
"Addressing the Care-Advocacy Paradox: Analyzing ACT UP to Inform Advocacy Practices," Social Movements Workshop, University of California, Santa Barbara
Santa Barbara, CA

Invited Speaker 4/24/2018
"Addressing the Care-Advocacy Paradox: Analyzing ACT UP to Inform Advocacy Practices," OSC Research Series, University of California, Santa Barbara
Santa Barbara, CA

Invited Lecturer 4/14/2018
"HIV/AIDS and Social Movements", Office of Admissions Research Exposition, University of California, Santa Barbara
Santa Barbara, CA

Opening Speaker 1/12/2018
Opening Day, Cuesta College
San Luis Obispo, CA

Master of Ceremonies 11/29/2017
University of California Workers Union – United Auto Workers (UAW) 2865
Santa Barbara, CA

Keynote Speaker 6/10/2017
Lavender Commencement, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Speaker 6/2/2017
"Sorry, Not Sorry", Bey Day, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Lecturer 5/15/2017
"Love as Discursive FORMATION," ES 470: Beyoncé: Feminism, Race, & Politics (Dr. Jenell Navarro), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Lecturer 4/20/2017
"Using Conversation Analysis to Research Social Movements," Social Movements Workshop, University of California, Santa Barbara
Santa Barbara, CA

Invited Lecturer 7/21/2016
"Hip-Hop, Gender, & Sexuality," ES 310: Hip-Hop, Poetics, & Politics (Dr. Jenell Navarro), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Lecturer 5/23/2016
"American Indian Women's Activism," ES 114: Introduction to Ethnic Studies (Dr. Jenell Navarro), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Lecturer 2/17/2016
"Constructed Gender Roles and The Birth of Homophobia," ES 112: Race, Culture, and Politics in the U.S. (Dr. Jenell Navarro), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Lecturer 2/10/2016
"Academic Profiling: Youth of Color and the Justice System," ES 112: Race, Culture, and Politics in the U.S. (Dr. Jenell Navarro), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Lecturer 10/28/2015
"Applied Research Methodology: An Ethical Approach," ANTH 201: Cultural Anthropology (Dr. Colleen Carrigan), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Lecturer 10/20/2015
"An Ethnic Studies Experience"
ES 241: Survey of Indigenous Studies Section 1 & 2 (Dr. Kate Martin), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Speaker 10/20/2015
"Sexually Transmitted Infections in San Luis Obispo: Resource Guide," PRISM Peer Counselor Retreat, California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

Invited Speaker 8/7/2015
"Discovering Silence Through Indigenous Methodologies," Academic Research Symposium (Dr. Gerardo Aldana), University of California, Santa Barbara
Santa Barbara, CA

Invited Lecturer 5/28/2015
"Know Your Status: Research Methods," ANTH 201: Cultural Anthropology (Dr. Colleen Carrigan), California Polytechnic State University, San Luis Obispo
San Luis Obispo, CA

PROFESSIONAL ASSOCIATIONS AND MEMBERSHIPS

Graduate Associate, *Migration Initiative, University of California, Santa Barbara*	November 2020 to Present
Member, *Edge for Scholars Network*	August 2020 to Present
Graduate Student Member, *Academy Health*	March 2019 to Present
Graduate Student Member, *California Sociological Association*	October 2018 to Present
Graduate Student Member, *Society for the Study of Social Problems*	August 2017 to Present
Graduate Student Member, *Pacific Sociological Association*	January 2017 to Present
Graduate Student Member, *American Sociological Association*	July 2016 to Present
Graduate Student Member, *National Association for Chicana and Chicano Studies*	January 2016 to Present
Permanent Membership, *Alpha Gamma Sigma Honor Society, Cuesta College*	January 2014 to Present

ABSTRACT

La Gente Unida: Latinx Immigrant and Indigenous Health and Advocacy on California's Central Coast

by

Mario Alberto Viveros Espinoza-Kulick

Anti-immigrant policies undermine the health and wellbeing of Latinx communities, who also face white supremacy and xenophobic violence. For many Latinx immigrants who are also Indigenous, these risk factors overlap with exposure to colonial trauma. Further, the COVID-19 pandemic has exacerbated existing health disparities and structural vulnerabilities. This study documents health disparities facing heterogenous Latinx Immigrant and Indigenous groups and analyzes immigrant health advocacy strategies. For this project, I developed a decolonial-inspired framework that prioritizes questions directly useful to community members, deconstructs settler-colonial norms in research, and centers Indigenous ways of knowing. Multiple methods provide a holistic understanding of the health needs/assets and advocacy resources for Latinx immigrants in California's Central Coast: two years of participant-observation (2018-2020), collection of news data (n = 148), interviews with community members and advocates (n = 31), regional focus groups (n = 12), and a survey of health needs and assets (n = 260). The patterns in this data demonstrate a crisis in the social determinants of health for Latinx Immigrant and Indigenous groups, in which both resources and access are severely lacking.

The systematic effects of unequal access, lack of insurance, and discrimination on the wellbeing of Latinx immigrants include heightened anxiety, lowered overall health, and a disproportionate burden of COVID-19 impacts. Despite negative conditions, Latinx immigrants and Indigenous groups demonstrate a high level of resiliency. Advocates have mobilized California's political elites to expand public health insurance programs to include undocumented minors and young adults up to age 26. Demonstrating what I call "movement pandemic adaptability," community organizations share resources and translate public health directives into Mixteco and other Indigenous languages to address exclusions from care. By centering those directly affected by health disparities, this study shows critical gaps in healthcare systems and spotlights the capacity for communities to demand equity and health opportunities for all.

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LIST OF FIGURES AND TABLES

I. Health Social Movements and Immigration

For decades, scholars of social movements have studied the impacts of activism on American health care and, more importantly, the systematic effects of unequal access and discrimination on the health and wellbeing of disenfranchised communities most at risk for disease in this country. Knowledge of mobilization for health justice and reform is needed to undo the harm done to marginalized communities, including through reckless policy ventures sponsored by the far right of the republican party, and championed by the 45th United States president's administration. Busy with fabricated emergencies at the southern border, healthcare and humanitarian efforts have been diminished and attacked in an environment of xenophobia. Anti-immigrant policies—like those that make it harder for immigrants to gain citizenship in the United States—undermine the health of immigrant communities by contributing to a fear of deportation and family separation. This dissertation responds to these realities with a decolonial-inspired study of Latinx Immigrant and Indigenous communities' health on the Central Coast, the ways policy influences health disparities, and how advocacy strategies reflected "movement pandemic adaptability" to close equity gaps. This chapter analyzes the theoretical and typological components of health social movements. To demonstrate this theoretical framing, I analyze research articles that describe anti-immigrant health policy, their impact on immigrant communities, and relevant mobilization efforts.

Health Social Movements

Health Social Movements (HSMs) are defined as "informal networks comprised of an array of formal and informal organizations, supporters, networks of cooperation, and media that mobilize specifically in response to issues of healthcare policy and politics, medical

research and practice, and medical and scientific belief systems" (Brown et al. 2010:102). HSMs consist of *disease constituencies*, which Steven Epstein (2016) defines as "groups that mobilize around specific illness states or health vulnerabilities to demand various forms of biomedical and political action or redress" (5). Within these broad categories, HSMs focus on health access, inequality, inequity, experiences, and contested illnesses (Brown et al. 2004; Brown and Zavestoski 2004; Epstein 2016). Epstein (2016) argues that "activism sparked by an imminent disease threat… forges connections across difference" (1) and mobilizes actors that are not directly affected by the disease. For example, family members of those with an illness may advocate for their family member, including to healthcare professionals and by raising money. This type of advocacy, on a collective level, contributes to the broad-scale mobilization that makes up HSMs. These types of movements are changing health policy, even when they do not directly target the state.

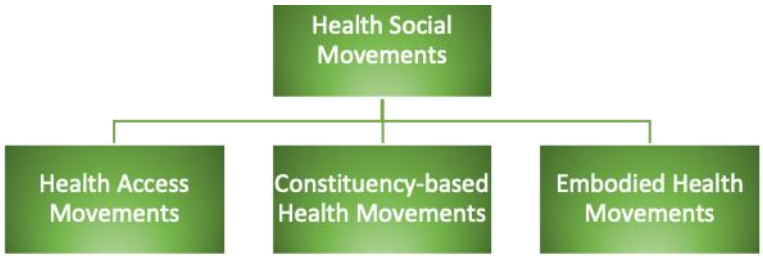
Health movements have launched "campaigns to promote occupational health, oppose racially segregated hospitals, [and] challenge gender bias in medicine" (Epstein 2016:3). When illness becomes tied up with power relations, health movements become necessary in order to challenge the status quo and promote a culture of health. Such efforts involve targeting "professions, political parties, labor unions, insurance industry lobbyists, the pharmaceutical industry, managed care organizations, and a variety of other groups to establish or forestall national- and state-level plans to authorize large new [health] programs" (Taylor and Zald 2010:301). Insiders also work with health social movements, changing the rules and protocols from the position of healthcare providers and experts, including reform efforts that balance oppositional political approaches (Epstein 2016; Rabeharisoa, Moreira, and Akrich 2014). In this section, I describe the typology of the

health social movements, major factors related to health movement mobilization, and how to theoretically frame health social movements.

Health Social Movement Typology

One way of classifying HSMs is into three types: health access movements (HAMs), constituency-based health movements (CBHMs), and embodied health movements (EHMs) (Best 2013; Brown et al. 2004, Brown and Zavestoski 2005). Figure 1, below, visualizes by Brown and colleagues' typology of health social movements. HAMs aim to improve health access in terms of services, insurance coverage and/or universal health-care, and

Figure 1. Health Social Movement Typology



accessibility. CBHMs tackle inequalities and inequities based on structural power differences (e.g. ethnicity, race, class, gender) and advocate for contested illnesses (e.g., HIV/AIDS). EHMs "address disease, disability or illness experience by challenging science on etiology, diagnosis, treatment, and prevention" (Brown et al. 2004:50). For example, cultural beliefs about women's bodies and motherhoods, including across race and class lines are relevant to understanding, screening, treating, and advocating for conditions like breast and cervical cancer (Chavez et al. 1995; Chavez et al. 2001; Sweeney 2012). Some researchers have developed new typologies and different iterations of these original three. For instance, "evidence-based activism" in healthcare seeks to transform medical

organizations from the inside, and these activists see themselves as reformers within their professional positions (Rabeharisoa, Moreira, and Akrich 2014).

Health Access Movements

Health access movements are invested in the availability of medical and clinical establishments and health care reform. These include movements that have fought against hospital closures, lobbied for expanding health care coverage through political legislation and sponsor preventative care and health education efforts (House 2015; Jarman and Greer 2010; Waitzkin 2001). Although some version of universal healthcare has been implemented in most wealthy democracies, especially in North America and western Europe, the United States has struggled for the system anchored by Obama's banner legislation, the Patient Protection and Affordable Care Act (Obamacare). Although the Affordable Care Act (ACA) did not achieve universal health care for U.S. residents, it has greatly increased the number of insured people living in the United States (House 2015). The ACA maintains the for-profit insurance industry while expanding access to individual buyers and incentivizing expanded coverage through Medicare programs (House 2015).

Health access movements are interested in expanding equitable access to health care coverage and improvements to health care delivery. Thusly, groups might advocate for enrolling individuals into insurance programs, as well as advocating for proposals like Medicare-for-All. HAMs may also work in a more local context to increase health access or focus on access to services and care relevant to a specific illness or disease. For instance, the AIDS movement expanded access to treatment for folks living with HIV/AIDS (Gamson 1989; Gould 2009), such as the AIDS Drug Assistance Program and Housing Opportunities for People with AIDS. The AIDS movement, like other HSMs included aspects of health

access in addition to sharing characteristics with CBHMs and EHMs by representing a specific constituency and addressing the embodied experiences of people living with HIV/AIDS.

Constituency-Based Health Movements

Health movements that are constituency-based often tackle issues based on an identity category (e.g., race, ethnicity, class, gender, sexuality). This includes efforts such as the women's health movement, gay and lesbian health movement, and movements that are based on Native land rights and environmental justice (e.g., #NODAPL; Carter and Kruzic 2017). The environmental justice movement is an interesting example because we are all constituents of the land (LaDuke 2005). However, not everyone respects the land with reciprocity. Colonial institutions, like the Dakota Access in Iowa and the Iowa Utilities Board, jeopardize the health and wellbeing of the land and of Indigenous peoples due to the risk of toxic spillage (Karter and Kruzic 2017). Issues of environmental degradation thus invoke constituencies that upend political boundaries and borders. For Native communities, colonial assaults on land rights and use are inextricably linked to the history of genocide and settler-colonialism. For example, displacement from tribal homelands contributed to the disruption of healing systems based on traditional knowledge and kinship networks (Jolivétte 2016). In this way, Indigenous health movements also traverse the domain of embodied-health movements, which focus on the lived experience of disease constituencies, as well as the role of various healthcare providers in defining those experiences (Brown et al. 2004; Jacob 2013).

Embodied Health Movements

Embodied health movements necessarily invoke some characteristics of health access and constituency-based HSMs (Raz et al. 2014). For example, while the women's heath, gay and lesbian, and AIDS movements all focus on issues of access in terms of gender and sexual identities (among others), embodied health movements focus on health issues that are closely related to the embodiment or experience of living at a specific intersection of disease, illness, and identity, such as women with or at risk of postpartum illness or breast cancer (Sweeney 2012; Taylor 1996; Whittier 2018). Similarly, embodiment can also become relevant for specific constituencies who share belief systems for understanding health, values and culture, such as those based on an identity like race, ethnicity, or national citizenship. Dorothy Roberts (2011) explains that "embodiment scientists believe that experiencing racial discrimination on a daily basis throughout life is a form of chronic stress that pushes allostatic load to dangerous levels…" (132). Social movements, like #BlackLivesMatter, are invested in access to health services and racial identity to impact the embodied experience of being Black and a woman, trans*, queer, or any other combination of identities while being Black in the United States (Garza 2016).

Health Movement Mobilization

Scholars across disciplines such as public health, sociology, and law have pointed to how health outcomes vary when analyzed through a lens of intersectionality that considers the compounding effects of race, gender, class, and sexuality on top of health issues (Cho, Crenshaw, and McCall 2013; Crenshaw 1991; Viruell-Fuentes, Miranda, and Abdulrahim 2012; Watkins-Hayes 2014). Health movement activists are willing to question the status-quo, challenge and explore the anatomy of disease and illness—including social factors such

as racism, sexism, and homophobia—and approach mobilization intersectionally (Brown et al. 2010; Roberts 2011; Watkins-Hayes 2014). In Tamar Carroll's (2017) study on intersectionality and identity politics, she draws on ACT UP's (2002-2015) Oral History Project Archive to analyze how ACT UP also worked towards reproductive liberty for women (604). ACT UP paired with the Women's Health Action Mobilization (WHAM) to "form a coalition around sexual freedom and access to health care" to dissuade the control of hospitals from Catholic (religious) influence that actively repressed LGBTQ communities (e.g. withholding prevention knowledge like abortion and condoms) (Carroll 2017:604). In social movements, scholars have only just begun to analyze health movements intersectionally. Claire Decoteau (2017) argues that in addition to illness, EHMs must also take into account race, ethnicity, and citizenship when analyzing health social movements relationship to capacity building, medical care, and the etiology and of diseases.

This is also referred to by Meyer and Whittier (1994) as *spillover*. Movements create knowledge within their circles, and these tactics for knowledge production migrate between and beyond individual social movement organizationss. Further, spillover between HSMs and practitioners operates when medical experts coopt the knowledge produced in movement circles (Brown et al. 2004; Epstein 2016; Meyer and Whittier 1994). In Verta Taylor's (1995) study of self-help movement groups for postpartum depression she reports, "a family practitioner admits getting most of her information about postpartum depression not from medical journals, but from women's own accounts" (36). Activists often compile important medical information that is relevant to patients' experiences and accessible for constituencies of these health movements (Taylor 1995). Health movements are sites of knowledge construction (Brown et al. 2010; Epstein 2016; Taylor 1995). These are also referred to as "hybrid movements" (Brown et al. 2004, Epstein 2016) due to their nature of

traversing between professional and informal boundaries. Activists became "lay experts" by learning about medical languages (e.g., immunology, virology, biostatistics) and passed as "credible players" that pushed the scientific method and pharmaceutical drug development (Epstein 2016:11).

Disease-constituency activism has been "the most potent" model of mobilization in that it "has affected the management of illness, attitudes and practices of health professionals, research practices, innovation processes, state policies, and corporate behavior" (Epstein 2016:5). This type of activism depends on a *politicized collective illness identity*, which is formed when constituents link their identity with inequalities that are interrelated with disease (Brown et al. 2004; Epstein 2008). As new and longstanding illnesses and health conditions exist in society, "social movements in health have been persistent" and "regularly renew" motivation for "health advances in Europe and the United States" (Brown and Fee 2014:386). Within health movements, patients become policy actors because of their networks and potential to change policy in order to improve health conditions (Brown et al. 2004; Epstein 2016; Hoffman et al. 2011). Patient-group mobilization consists of activists that not only work with each other, but also work with professionals in different sectors to improve living conditions within disease-constituencies' communities (Epstein 2016). Health social movements also work at both state and national levels to advance broad policy goals, as ACT UP did to advance universal healthcare in 1992 and 1993 (Hoffman 2003:15).

Phil Brown and colleagues (2010) describe this as "citizen-science alliances in which citizens and scientists collaborate on issues that usually have been identified by laypeople" (380). Epstein (2016) further explains these partnerships by stating that "social movements such as the AIDS activist movement and feminist women's health movement have served as

direct models or templates" for health movement mobilization that emphasizes community-engaged work (13).

Table 1. **Framework for Defining Health Social Movements**

HSM Category	HSM Constituencies	Related Health Issues	Unique Characteristic
Health Access Movements	• Researchers • Policy makers • Physicians • Nurses • Organizers • Low socioeconomic class status • Immigrants • Public Health	• Health insurance • Transportation for health services • Health care reform • Syringe exchange • Freedom to choose specialists • Food access	aim to improve health access
Constituency-based Movements	• Elderly • Low socioeconomic class status • Immigrants • Fathers, Mothers, Children • Indigenous peoples • Women • LGBTQ+ peoples • People of color	• Neighborhood segregation • Environmental justice • Racism and other forms of discrimination (e.g., sexism, homophobia, transphobia) • Women's health • Immigrant health	tackle inequalities and inequities based on identity
Embodied Health Movements	• Postpartum patients • Mental health patients • Transgender persons • Breast cancer patients • Communities living with HIV/AIDS • Individuals or communities at risk for disease or illness • Cannabis users	• Awareness of illness or disease • Reproductive Justice • Racism and other forms of discrimination (e.g, sexism, homophobia, transphobia, etc.) • Unequal access to care or treatment	Constituency identity with health inequalities are interrelated with disease/illness

Note. The above examples are not an exhaustive list and are examples based off of the literature reviewed around different types of health social movements (see Brown et al. 2004, 2010; Best 2017; Decoteau 2017; Epstein 2016; Jarman and Greer 2010; Karter and Kruzic 2017; Roberts 2011; Penn 2014; Taylor 1996; Waitzkin 2001; Zavella 2016)

Although many health movements have been active for decades, there has been a decline in treatment advocacy (Best 2017). In her study of thousands of advocacy organizations, Rachel Khan Best (2017) finds that organizations with significant memberships and donors are more likely to advocate for treatment in their policy agendas, but those with researchers were less likely to include treatment in their agendas (437).

Further, due to changes in the political climate, advocacy organizations redefined their missions and encyclopedias to exclude treatment access because "government services became increasingly controversial." Best (2017) explains that advocacy organizations "focus on asking for what they think Congress wants to give them," resulting in delineation from organizational priorities (451). The policy arena has the potential to shape mobilization efforts among health movements, especially in a political climate that poses uncertain futures for communities living with HIV/AIDS, women, and other marginalized groups, such as immigrants and racial minorities.

Framework for Defining Health Movements

The typology of HSMs helps to specifically categorize and comparatively analyze different organizations invested in advancing health equity and responding to issues of health injustice at all levels. It paints a picture not only of the diverse health social movements, but also of the diversity of health movement activists and constituents. Drawing on both frameworks of typifying and mobilizing health social movements, the above table illustrates a framework for defining health social movements based on examples from the literature reviewed (Brown et al. 2004). How is this framework useful? What can we do with a working system to define and categorize health social movements? Defining health social movements can give us a frame of reference to identify health issues specific to diverse

populations, whether they are issues of access, constituency, or embodiment. For the next part of this chapter, I will utilize this framework for defining an *immigrant health social movement*. To do so, I will outline barriers that are facing the Latina/o/x immigrant population based on scholarly contributions to the burgeoning field of Immigrant health social movements and the sociopolitical context of immigrants in the United States.

Immigration

It is important to note, here, that the term "immigrants" often also refers to Latin American Indigenous peoples. For example, immigrants from Oaxaca, Mexico may also Identify as *Indigena* (Indigenous) and speak their native language of *Mixteco* (McGuire 2006, 2014; Fox and Rivera-Salgado 2004). Although not all undocumented immigrants are from Mexico or Latin America, the discourse of illegality coincides with racial profiling directed toward Latina/o/x individuals and communities. Immigration policy and an anti-immigrant climate create a need within and beyond the immigrant' rights movement for an *immigrant health movement.* The very real fear of deportation and accepting the "master status" of being "illegal" has consequences on undocumented immigrant health (Gonzales 2016). Gonzales (2016) explains this in terms that are relevant to an *embodied health movement*: "for undocumented members of the 1.5 generation, illegality extends far beyond legal boundaries. It reaches into their bodies, minds, and hearts. It saps their energy, consumes their dreams, and crushes their spirits" (206). Dealing with the multigenerational effects of stigma and legal exclusion affects their mental and emotional wellbeing, and economic sacrifices for survival mark immigrants as vulnerable to exploitation in precarious work environments.

Characteristic of a *constituency-based movement*, immigrants' relatively unregulated work environments contribute to chronic negative health conditions "… such as back pain, arthritis, carpal tunnel syndrome, asthma and other lung problems, joint strains, and skin exposure to toxic chemicals" (Gonzales 2016:126). Further, issues in immigrant health also reflect important tenets of *health access movements*, such as access to health insurance. In Gonzales' study, a portion of their participants (n =73) did not have health insurance or a health fund to rely on in case of an emergency or to seek preventative care (Gonzales 2016). In the following section, I highlight how fear of deportation is central to anti-immigrant health policy, which extends to cultural, political, and legal barriers to health and healthcare.

Fear of Deportation

Undocumented people and their families are excluded from public spaces by instilling a stigma and fear associated with being "illegal". Restricting the use of health services has proven to be a "powerful deterrent" in accessing care among immigrant communities (Berk and Schur 2001:155). For instance, the 1994 Proposition 187 in California made immigrant health care access an intense topic of debate. Unenforceable parts of this law were repealed in 2014, which would have required physicians to report undocumented individuals to immigration authorities. Even when official policies change, the routine discourse on these topics instills fear in the hearts and minds of Latina/o/x communities, especially those who are undocumented and live in mixed-status families, creating barriers for health and wellbeing. Karen Hacker and colleagues (2011) used community-based participatory research to investigate the impact Immigrant Customs Enforcement (ICE) has on immigrant health. In analyzing six focus groups among immigrant participants (n = 52), they found that fear of deportation, fear of partnership between the police and ICE, and not having the paperwork to apply for health care coverage were among the key themes that impacted

participants' emotional health as well as their access to health care services (Hacker et al. 2011). The authors affirm, "when immigrant communities do not trust their community institutions, they are less likely to fully engage as members of the community" (Hacker et al. 2011:592).

Chronic deportation fear exacerbates current health conditions and increases vulnerability to others (Hacker et al. 2011). As a consequence of various policies, widespread fear of deportation affects both individual immigrants and the communities they associate with, regardless of country of origin (Hacker et al. 2011; LeBrón, Lopez, et al. 2018; Lopez et al.2018). According to one study of 756 participants, 39% of undocumented immigrants indicated that they were afraid of receiving medical care due to their citizenship status (Berk and Schur 2001:153). Khiya Marshall and colleagues (2005) compared immigrant documented and undocumented Latina women in North Texas in terms of sociodemographic factors, migration context, health status, and access to health care. Among their subjects (n = 197), undocumented women were less likely to report having health insurance (8.9%) than documented Latina women (41.7%) due to fear of arrest and deportation (Marshall et al. 2005:928). This somewhat direct link between deportation regimes and fear-driven health issues reflects a broader pattern in which restrictive, anti-immigrant policies lead to negative health outcomes for migrants, as well as the citizens and residents with whom they live, work, and form families.

Anti-Immigrant Health Policy

Immigration and immigrant policies have significant health effects on targeted communities (LeBrón, Lopez, et al. 2018; Lopez et al. 2018; Toomey et al. 2013; Vargas and Ybarra 2017). For instance, Arizona's SB 2070 allowed law enforcement officers to

racially profile Latina/o/x drivers if they appeared to be without citizenship documents and allowed for their arrest and deportation if they were not carrying proof of U.S. citizenship such as a birth certificate, passport, or naturalization documents (Toomey et al 2013). As citizens and residents alike are not typically expected to carry proof of citizenship for routine actions, the system of unequal enforcement over proving one's citizenship reveals the racial anxieties that motivate these policies (LeBrón, Lopez, et al. 2018; Toomey et al. 2013). Undocumented and mixed-status immigrant families report fear of accessing public health services due to restrictive immigrant policies and a culture of fear that is manifested by anti-immigrant groups (Berk and Schur 2001; Chavez 2007). Anti-immigrant sentiments are not only sponsored by state-sanctioned citizenship procedures, but also through community groups, religious organizations, and healthcare providers. For instance, doctors in LA county hospitals engaged in routinely targeting the fertility and reproduction of Mexican origin women, even when accessing other types of health services (Gutierrez 2008).

Policy does not need to be implemented for it to have an effect on immigrant health. For example, there was a reported 60% drop in care by the Community Health Foundation in East Los Angeles the week Proposition 187 passed in 1994 (Berk and Schur 2001:151). In the fall of 2018, the Trump administration proposed to expand the Public Charge Rule. According to the United States Citizenship and Immigration Services (USCIS), an individual seeking admission to the United States or seeking lawful permanent residence (green card) is inadmissible if the individual, "at the time of application for admission or adjustment of status, is likely at any time to become a public charge." This means that immigrants seeking pathways to citizenship will become ineligible if they are "dependent" on the government or suspected to become eligible for public assistance. The proposed

policy change by the Department of Homeland Security (DHS) has increased fear of utilizing government-sponsored programs among immigrant groups, particularly in California (Amaro 2018; Ponce, Lucia, and Shimada 2018; Montoya-Galvez 2018). Conservative health policy, such as the above, sends a message to communities of color that have consistently been antagonized by the Trump administration and U.S. conservatives, especially Latinx people of Mexican origin, that they are not deserving of health and human services. Such antagonisms are unsurprising given the cultural, political, and legal structures that restrict access to equal citizenship for migrants to the United States.

Cultural Barriers

Cultural barriers can impede health care access across a range of factors (Arenas et al. 2015; Campero et al. 2010; González-López 2005; Marshall et al. 2005). Language barriers between non-English speaking immigrants and non-Spanish speaking healthcare providers can prevent access to healthcare (Marshall et al. 2005:917). Even when Spanish-language healthcare services are available, some individuals speak only an Indigenous language and not English or Spanish. In addition, cultural norms can diminish individuals' motivation to seek healthcare in the first place. Lourdes Campero and colleagues (2010) analyzed how communication about sex in Mexican households is easier when parents are sensitized to the risks adolescents face in contracting sexually transmitted infections (STIs). Although this study was about Mexican nationals, the cultural contexts still stand for many Latina/o/x households in the United States. Parent-child communication is not always comfortable in these cultures, especially with respect to issues related to physical and sexual health (Campero et al. 2010). Few educational programs on sex exist in Mexico, let alone programs on communicating about sex with adolescents. Mexican families often rely on Catholicism for sexual risk prevention through abstinence or *disciplina del cuerpo* (Campero et al. 2010;

González-López 2005). In this context, sharing knowledge about STI prevention and contraceptives would imply a tacit endorsement of adolescents engaging in sexual activity. Thus, dialogues around sex are hindered because of fear and embarrassment (Campero et al. 2010). González-López (2005) found that women tended to report fear related to the consequences of infection on their marriage and children, while men reported fear due to casual, extramarital, and/or commercial sex (146). These beliefs and norms prevent many Latina/o/x young people from gaining the knowledge and skills they need to manage their own healthcare, including safer sex practices, testing, and treatment for STIs. The challenges that Latina/o/x immigrant communities in the United States face are exacerbated by immigration and immigrant policy that sets multiple institutions in contention with the immigrant community and motivates the work of immigrant health social movements.

Immigration and Immigrant Policy

Although immigrant and immigration policy sound alike, they each play different roles in shaping the ways immigrants experience life in the United States. Bean and colleagues (2015) highlight these differences: "immigration policy refers to laws and practices about which and how many persons can come, whereas immigrant policy refers to laws and practices affecting those already here" (196). For example, immigration policy reflects systems such as visa lotteries and temporary worker programs, whereas immigrant policy is enforced by federal institutions such as Immigration Customs and Enforcement (ICE). Although both immigrant and immigration policies have aimed to limit the inflow of Latin-origin migration, they have ultimately failed and merely perpetuated unauthorized migration to the United States (Massey and Pren 2012). Although unauthorized immigration has recently been low, conservative policymakers are advocating harsh border control, including the militarized treatment of asylum seekers, refugees, and migrants (James 2018; Krogstad,

Passel, and Cohn 2018). These punitive logics are unsurprising, given the growth of militarized deportation and detention facilities. The differences, and effects of, immigration and immigrant policies are expanded on below.

Immigration Policy

The U.S. has a long history of racialized immigration policy (Drevdahl and Dorcy 2007). For example, early immigration acts (e.g., Immigration Act of 1875, 1882 Chinese Exclusion Act, and 1952 Immigration and Nationality Act) enforced racial and ethnic (national) quotas on immigrants coming to the United States and, ironically, called for the removal of Native Americans (Jacob 2013; LaDuke 2005). The use of quotas creates a baseline expectation that migration to the United States will be carefully limited and the rights and responsibilities of citizenship will be restricted. Ximena Clark and colleagues (2007) explain the changes in immigration policy since the late 1970s. The number of legally admitted immigrants grew over the second half of the 20th century, from a quarter of a million in the 1950s to half a million in the 1970s and around one million in the 1990s. Over this time, western European immigrants only made up 5% of immigrant entrants (Clark et al. 2007:359).

The largest shift during this period was between the 1950s and the 1970s, due to a major policy shift in 1965 (Clark et al. 2007:359), when amendments were made to the Immigration and Nationality Act to effectively eradicate all country-of-origin quotas "so that immigrants from all countries could compete more equally for the available visas (Clark et al. 2007:359). This system actually led to a surprising increase in Latin migration, from 459,000 in the 1950s to 4.2 million during the 1990s (Massey and Pren 2012). In addition, the Bracero Program (1942-1964) created a large influx of cyclical migration between the

U.S. and Mexico (Davies 2009). However, due to its sudden and necessary termination in 1964, there was an increase in illegal immigration (Massey and Pren 2012). The 1965 Hart-Celler Act allowed for *Braceros* to become legalized if sponsored by their employers and removed numerical quotas from family reunification provisions. Since the end of national quotas, labor-force factors and family connections have been the two limited pathways for individuals to gain access to citizenship. Additionally, two pieces of legislation contributed to yet another boom in the Mexican presence within the United States: The Immigration Reform and Control Act (IRCA) of 1986 and Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA) of 1996. Although IRCA offered amnesty and made it easier to legalize 2.7 million undocumented Mexican migrants (Gonzales 2016; Smith 2006), it also appeased conservatives through its "punitive measures and controls on future arrivals" (Davies 2009). However, like IRCA, it resulted in a majority of undocumented Latin origin immigrants petitioning for naturalization (Davies 2009).

Immigrant Policy

Immigrant policies refer to laws and policies that affect immigrants living in the United States. After September 11, 2001, immigrant policies—and the enforcement of said policies—were developed with a lens of a militarized campaign against the abstract threat of terror (Frederking 2012; Jiménez 2010). The introduction of federal immigrant policies, such as the 2001 USA Patriot Act and both the Deficit Reduction and REAL ID acts of 2005, create a divide between citizen and noncitizen in the U.S. (Frederking 2012; LeBrón, Cowan, et al. 2018). The Patriot Act's Customer Identification program requires financial institutions, such as banks and creditors, to use exclusionary discretion when verifying consumers' identities (e.g., government issued identification cards, ID) when accessing services (LeBrón, Cowan, et al. 2018). Ultimately, since not every immigrant can acquire a

government-issued ID, this provides institutions with the ability to discriminate against undocumented immigrants and creates barriers to accessing health services (Hacker et al. 2011; Hacker 2013; LeBrón, Cowan, et al 2018). The REAL ID Act "established a national standard for identification credentials, mandating proof of authorized US presences in order for state-issued IDs to be used for federal identification purposes" (LeBrón, Lopez, et al 2018:256). Therefore, federal immigrant policies provide states the authority to deny state-issued IDs to undocumented immigrants and act as gatekeepers to accessing health care.

State agencies enforce federal policies of social control and exercise power over undocumented immigrants. After 9/11 in 2001, the Integrated National Security (INS) divided itself into three branches, U.S. Citizenship and Immigration Service (USCIS), Immigration and Customs Enforcement (ICE), and U.S. Customs and Border Protection (USCBP). Two branches in particular, ICE and USCBP, enforce policies by detaining and deporting undocumented immigrants to their "origin" country. This includes undocumented immigrants who were brought as children, by their parents, that are forced to live in a country they have no familiarity with. Such cases are the targets of the Deferred Action for Childhood Arrivals (DACA) and DREAM Act initiatives. Scholars in the field of Latina/o Sociology, Amada Armenta and Greg Prieto, have published detailed accounts of state law enforcement collaborating with federal ICE agents by supplying them with identification details and local intel (Armenta 2017; Prieto 2018). Moreover, state policies like Senate Bill 1070 in Arizona, gave the police, not ICE, the ability to detain folks indiscriminately if they could not verify authorized U.S. residency (Toomey et al. 2013). Consequentially, these policies not only separate families, but they perpetuate a "Latino Threat" narrative and illegalization of human beings (Chavez 2007, 2013).

Illegality

Pervasive immigration and anti-immigrant policies at both state and federal levels, perpetuate nativist discourses of "us" versus "them," where Latina/o/x immigrants are overwhelmingly portrayed by the media as criminals, invaders, and terrorists (Massey and Sanchez 2010). This leads to an illegalized identity that can have serious ramifications for undocumented groups' health, particularly Mexican-origin immigrant communities. Hegemonic institutions, like ICE, instill fear among migrants by threatening their livelihood and family life. For example, José Luis asks why does INS strip search migrant workers during factory raids? (De Genova 2005:14) The use of sexual violence in the enforcement of immigrant policy extends beyond the authority of the law. In addition, racial bias has been apparent in the enforcement of immigrant policy for decades. For instance, in 1971 in Chicago, 8,728 individuals were apprehended, of which 85 percent were Mexican nationals, fueling a narrative of an immigration "problem" in *The Illegal Mexican Alien Problem*. More recent workplace raids between 1996 and 1997 both show evidence of bias, where 96 percent of undocumented workers arrested were Mexican (De Genova 2005:126–127).

The English language, as well, served as a subordination tool by enforcing rules like "No English, No Service" (De Genova 2005:45) Relatedly, a Mexican woman explained that an encounter with a police officer for a traffic violation quickly became a humiliating incident. She explained that the officer, "just shouted that I had to speak English [...] 'You have to speak English because you are living here now'" (Massey and Sanchez 2010:131). Although there is no legal requirement for U.S. residents to speak English, law enforcement officers felt emboldened to verbally harass this woman for speaking a common language, Spanish. Without a doubt, experiencing severe discrimination at a quotidian level increases risks for

embodiment of chronic race-related stress, which can cumulatively lead to cardiac arrest and high blood pressure (Roberts 2011).

Edna Viruell-Fuentes and colleagues (2012) contend that cultural explanations have masked the effects of social inequality on immigrant health outcomes. They argue for a shift from an individual-centered, culturally-based framework to an intersectional approach that takes into account structural factors that reproduce health inequality within immigrant communities (Viruell-Fuentes, Miranda, and Abdulrahim 2012). The authors argue that focusing on cultural influences tends to focus on behaviors (e.g., smoking, drinking, and diet) that can increase negative health outcomes, while failing to account for the unequal opportunities available for Latinx and immigrant communities. They propose intersectionality theory as a guiding framework to examine how structures that operate at the intersections of race, class, gender, and immigrant status to create hierarchies in access to health as well as health outcomes. They explain that intersections between perceived discrimination, immigration, and health have only recently began to gain attention:

> Amidst increasing anti-immigrant environments, a focus on the structural factors that influence the lives of immigrants and those of subsequent generations is necessary to better develop multi-level interventions that promote the successful, healthy integration of immigrants and their children into the country. (Viruell-Fuentes et al. 2012:2104)

The intersections of citizenship status, race, gender, and culture, then, inform how to best approach these communities.

Immigrant and immigration policies are health policies. Anti-immigrant policies have impacts on immigrant health—like chronic fear of deportation—and bureaucratic policies impose barriers to health care access. This justifies the definition of an immigrant health social movement, due to its bridging the relatively established areas of health advocacy and immigrant advocacy together. Broadly, political, cultural and health issues in immigration

call for closer attention to *health access*, *constituency-based*, and *embodied immigrant health movements*. Because this area of research is relatively new, ethnography is an appropriate method for exploring this topic in an open-ended way that is informed by community members and leaders. How can we ethically query the culture of mobilization in an immigrant health movement? Since the constituents of an immigrant health movement in California include Indigenous people from throughout North America, in the next chapter, I outline a decolonial-inspired approach using ethnography as a methodological tool for researching health social movements.

Conclusion

Inequality plays a central role in determining the health, wellbeing, and opportunity of communities in the United States. Immigration status, especially as it intersects with race, class, Indigeneity, gender, and sexuality, can restrict one's access to basic human rights, including health. HSMs are positioned to contend with these dynamics of power in order to advance health equity and promote a culture of health. A basic typology of HSMs divides them into health access movements, constituency-based health movements, and embodied health movements. However, this can be expanded and refined, specifically, in the context of Latina/o/x and immigrant communities' health. By using the framework of health advocacy, we can define an immigrant health movement in terms of these same characteristics that adhere to the tenets of HSM typologies. This was illustrated through how fear of deportation can have widespread and enduring health impacts, alongside other policies and procedures that restrict citizenship, such as ID requirements.

Decolonial methods help to avoid blind-spots that are inherent in un-reflexive logics of inquiry that reproduce racist tropes (Rios et al. 2017). Approaching ethnography with a

decolonial-inspired lens centers community-engaged research and aims to establish long-lasting relationships with research participants and collaborators (Manzo et al. 2020). The second chapter elaborates on the principles of Indigenous knowledge production and how these principles can inform ethical research practices with diverse communities that include Indigenous populations. Latinx immigrant communities on the Central Coast are a clear example of the need for this approach. The principles of decolonial-inspired methods were developed through the direct experience of collaborating with community stakeholders to conduct this study, along with expertise of Indigenous scholars (Driskill 2010; Jacob 2013; Jolivétte 2016; Kukutai and Taylor 2016; Rodriguez-Lonebear 2016; Smith 2012). The remaining chapters further demonstrate the utility of this approach in practice, by focusing on diverse aspects of Latinx immigrant and Indigenous health and advocacy.

In the third chapter, I utilize data from a survey of health needs and assets to identify the heterogeneity of the Latinx immigrant and Indigenous community as it pertains to mental health needs and risk. Researchers have established in broad terms that major inequities exist in health access and health outcomes for immigrant communities (Barcellos, Goldman, and Smith 2012; Becerra et al. 2020; Cabrera-Nguyen 2015; Garcini et al. 2018). This study adds to this knowledge by showing that factors like knowledge of mental health, having insurance, and experiencing discrimination were significant predictors of anxiety symptoms. Along with qualitative findings from interviews with affected individuals, these findings show the need for a comprehensive approach to mental health services that are culturally responsive and considers structural factors (WHO 2009).

Beyond services themselves, one major barrier to healthcare, including mental health, is the restriction of immigrants from health insurance coverage. In chapter 4, I examine news media to demonstrate the connections between policy discourse and health behaviors (Díaz

McConnell 2019; López-Sanders and Brown 2019). Data from community member and advocate interviews further show how the language used in public directly affects immigrants and has ripple effects throughout mixed-status families and entire communities.

The existence of these issues has inspired collective action by immigrant communities who mobilize for rights, recognition, and dignity (Burciaga and Martinez 2017; Mora et al. 2018), as well as health advocates who have identified anti-immigrant policies and racism as a threat to public health (Ford et al. 2019; Ford and Airhihenbuwa 2010; Viruell-Fuentes, Miranda, and Abdulrahim 2012). The fifth chapter bridges these two areas of scholarship to analyze how immigrant health advocacy responded to the shifting political, social, and environmental context brought about by the COVID-19 pandemic. Advocates demonstrated what I call "movement pandemic adaptability" by developing culturally responsive, multilingual community programs, shifting quickly to respond to available opportunities, working at multiple levels to advocate for change, and consistently centering experts at the local level.

The final chapter reflects on the contribution of the project as a whole and identifies how this study can be useful to inform future research, policy change, and programmatic interventions. The decolonial-inspired approach allows for localized changes that make an immediate impact on the experiences of underserved groups, as well as inspiring large-scale systems change and contributing to collective advocacy.

II. Decolonial-Inspired Methodology

Research should reflect the communities it comes from, build from existing traditions of knowledge, and be useful for the communities being studied. Within the field of sociology, there are a range of unnecessary barriers facing Indigenous scholarship. Victor Rios (2015a) explains the organization of these barriers in terms of "white space," which is a "social-psychological state of being in that our attitudes, perceptions, and [work] perpetuates whiteness, white privilege, and white spaces. And we don't even know it" (Rios 2015:259). In conjunction with white supremacy, settler-colonialism is deeply embedded within academic institutions, including the knowledge it produces. This chapter elaborates on the struggle to decolonize knowledge and introduces a "decolonial-inspired" framework for conducting research. This is then demonstrated through the example of my dissertation project examining Latinx Immigrant and Indigenous Health on California's Central Coast.

Indigenous Methodologies and Decolonization

Indigenous scholar-activists have called to decolonize knowledge production by critically interrogating settler-colonialism in the norms about ways that information is collected, interpreted, and shared (Hennessy 2004; Smith 2002, 2012). As stated by Qwo-Li Driskill (2010), decolonization is a process of "radical resistance against colonialism that includes struggles for land redress, self-determination, healing historical trauma, cultural continuance, and reconciliation" (69). Elite knowledge, such as the U.S. legal framework and western medical science, has historically undermined the integrity of Native peoples' health and healing systems (Jacob 2013; Jolivétte 2016; Smith 2012). Thus, decolonial research centers the lived knowledge of Indigenous communities, even when it cannot be rendered for literary audiences. With attention to the historical realities of settler-

colonialism, decolonial research looks to the margins to examine what is not being heard and knowledges that have been marginalized (Smith 2012).

Decolonial methodologies dismantle the oppressive assumptions and outcomes of dominant knowledge production. These critiques actively interrogate struggles over sovereignty (Barker 2008; Gokiert et al. 2017), going beyond the aspects of misrepresentation that are associated with other forms of identity and inequality, like race, gender, and sexuality. In considering sovereignty, decolonial research centers the authority of traditional knowledge production by and for Indigenous peoples (Doxtater 2004; Smith 2012). Tahu Kukutai and John Taylor (2016) define this as *data sovereignty*, "Indigenous peoples have a right to self-determination that emanates from their inalienable relationship to lands, water and the natural world, and that to give practical effect to this right requires a relocation of authority over relevant information from nation-states back to Indigenous peoples" (14). This shift includes a recognition that Indigenous peoples have always collected their own meaningful bodies of data (Kukutai and Taylor 2016; Rodriguez-Lonebear 2016).

Indigenous methods are specific to the lived realities of diverse peoples, tribes, and nations, and attempting to generalize runs the risk of erasing important differences between groups. Some common themes in Indigenous struggles for decolonization is sharing knowledge in the community and the practice of accountability to community leaders and members (Smith 2006). University-based researchers typically follow ethical guidelines and regulations based in settler institutions and enforced through internal peer review processes (Stiegman and Castleden 2015). This process excludes Indigenous expertise about their own communities. By contrast, decolonial methods are accountable to relevant Indigenous experts, community members who are affected by the topic of a research study, and to

public audiences (Kukutai and Taylor 2016). Indigenous methods both generate knowledge within existing communities and share it through storytelling practices and intergenerational traditions (Cunsolo Willox et al. 2013; Iseke 2013; Skinner et al. 2020).

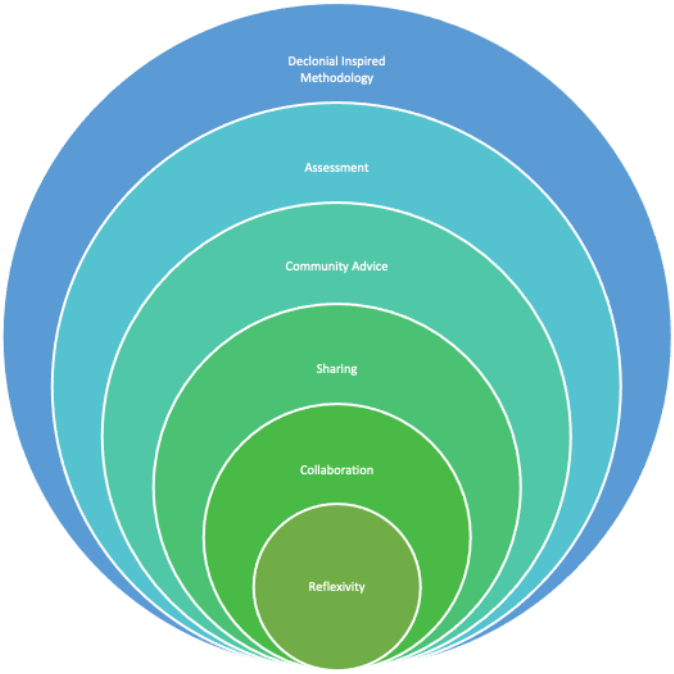
Decolonial-Inspired Methods

What I call the "decolonial-inspired" methodological framework names decolonization as the primary aim of research, while translating decolonial methods to the context of heterogenous groups who hold contested relationships to Indigeneity. This is illustrated in the following sections through a case study with immigrant communities from Latin American descent living on unceded Native lands on California's Central Coast. When migrants cross national borders, they contend with state-sponsored immigration agencies, but they also carry a range of Indigenous affiliations, including *mestiza/o/x* identities (Blackwell, Boj Lopez, and Urrieta 2017). The Critical Latinx Indigeneities (CLI) perspective helps us "to consider both the overlap and difference that Mayas, Zapotecs, Mixtecs, Garífuna, and P'urhépecha, among others, have in relation to Northern Native communities and does not naturalize displacement and migration by simply claiming that the entire hemisphere is Indigenous land or by pointing to precolonial routes and relations that predate nation-state borders" (Blackwell et al. 2017:128). In line with this approach, a recognition of Indigeneity among Latinx groups does not negate the realities of settler-colonialism and the varying degree of immigrant communities' complicity in maintaining state-sanctioned hierarchies and exploitation.

The naming of this framework as decolonial-inspired signals that the specific definition of decolonization must not be diminished or distorted. Decolonization is a practice built from Indigenous knowledge production and should not be misrepresented as a general

framework for social justice and equity (Baldy 2015; Tuck and Yang 2012). Ultimately, decolonization is defined and operationalized by Native nations and tribes. Decolonial-inspired methods are a blueprint for being in active solidarity with the larger struggle of decolonization, while working with diverse communities that include Indigenous peoples who are uninvited guests on others' homelands.

Figure 2. Practices of Decolonial-Inspired Research



The decolonial-inspired framework, summarized in Figure 2, is made up of a set of complementary practices: reflexivity to the conditions of settler-colonialism, collaboration with Indigenous experts, sharing knowledge in public, listening to and acting on community advice, and assessment of ongoing research norms. Each of these five practices is rooted in the dimensions of struggle outlined by Linda Tuhiwai Smith (2012) for Maori decolonization: awakening, reimagining, difference, disturbance, and structure. Awakening is the effort required to critique the status quo and identify that action is needed to make change. This is put into practice for decolonial-inspired methods through reflexivity.

Understanding and consistently reflecting on one's social position allows researchers to gain effective knowledge of the people and topics they study (Rios 2011, 2015b, 2017a). For decolonial-inspired methods, reflexivity takes on the added component of continually awakening to see the prevailing conditions of settler-colonialism and undo repression of ancestral knowledges.

The second condition of decolonial struggle, reimagining, means fueling an alternate epistemology the repositions the role of Indigenous peoples in this world. In research, collaboration with Indigenous experts can take on different forms (Baquedano-López 2021; Cahuas and Matute 2020; Dhillon 2020; Miville and Hill 2020; Rose-Redwood et al. 2020). Tribes, nations, and communities cultivate intellectual leadership and recognize their own experts, who may not be validated by academic institutions. Collaborative relationships cannot be reduced to consultation, communication, or advice. Rather, they require sustained engagement over time, clarity, accountability, trust, shared decision-making, and mutual benefit (Chisita and Fombad 2021; McKivett et al. 2020; Reed et al. 2020). The investment in specific relationships is complemented by the third practice, sharing knowledge in open and public venues. Sharing should be open and transparent, as well as targeting a broad set of key stakeholders (Maisiri 2020; McGinnis, Harvey, and Young 2020). This creates space for the "the coming together of disparate ideas, the events, the historical moment. This condition creates opportunities; it provides the moments when tactics can be deployed" (Smith 2012:201). The strength of difference in knowledge production comes from the ability to inspire coordinated action across institutions and sectors.

Community stakeholders are not just recipients of knowledge. They are also necessary sources of accountability through soliciting advice from recognized community experts and directly affected individuals (Smith 2006, 2012). For this advice to be meaningful, it must be

given real weight in decision-making about research design, analysis, and dissemination. Relative to the fourth dimension of decolonial struggle, disturbance (Smith 2012), this creates opportunities to understand unstable movement in social norms. The broadest practice of decolonial-inspired methods is to critically examine how Indigenous peoples and Indigeneity are being neglected in our fields of study, disciplinary norms, and ongoing research projects (Jacob et al. 2020; Meghji 2020; Watts, Hooks, and McLaughlin 2020). This responds to the prevailing struggle against existing structure, which reproduces inequalities and marginality. Taken together, these practices are not sequential or hierarchal. All hold equal importance and may be repeated with varying salience throughout the practice of creating and sharing knowledge through research studies.

This framework is relevant to solving pressing social problems and applicable to knowledge production within the fields of Sociology, Public Health, and Ethnic Studies (e.g., see Baker-Cristales 2009; Bean et al. 2015; Costanza-Chock 2014; Enriquez and Saguy 2016; Gleeson 2015; Milkman and Terriquez 2012; Nicholls 2013; Terriquez 2015; Zimmerman 2012). Decolonial-inspired methods are useful for recovering from the distortions produced by western knowledge systems. For example, researchers attempting to understand the heterogeneity of health conditions among Latinxs sometimes divide groups by country of origin (Acevedo-Garcia and Bates 2008; Carrasquillo, Carrasquillo, and Shea 2000; Van Wieren et al. 2011). This can explain some aspects of difference but erases and marginalizes the experiences of Indigenous peoples. Applying the decolonial-inspired framework is an opportunity for more effective and useful scholarship with Indigenous migrants (Fox and Rivera-Salgado 2004), as well as in communities with diverse Native, Indigenous, and mestiza/o/x traditions (Jolivétte 2016).

This approach shares values and practices with some recognized frameworks, including community-based participatory research (Collins et al. 2018; Hacker 2013; Hacker et al. 2011; Horowitz, Robinson, and Seifer 2009; LeBrón et al. 2018; Wallerstein et al. 2017) and research justice (Jolivétte 2015). Community-based research approaches value community input as a primary source of knowledge production for identifying needs and assets within communities (Newman and Rubincam 2014; Wallerstein et al. 2017). These frameworks emphasize reflexivity and utility of research to producing tangible outcomes for affected communities (Hacker 2013; Jolivétte 2015; Rusch, Walden, and DeCarlo Santiago 2020). The differentiating aspect of decolonial-inspired methods is its relationship to struggle and change. This is specifically about decolonial efforts, meaning that it is addressing the sovereignty of Indigenous peoples and disrupting the assumptions of settler-colonialism that go unchecked in more generalist approaches. As stated by Linda Tuhiwai Smith (2012), "People, families, and organizations in marginalized communities struggle every day; it is a way of life that is necessary for survival and, when theorized and mobilized, can become a powerful strategy for transformation" (154). Employing a decolonial-inspired methodological framework provides an ethical way of gaining appropriate and effective insight into the needs, assets, and systemic barriers that define the contexts for advocacy and change.

Latinx Immigrant Health and Advocacy on California's Central Coast

This dissertation project demonstrates the decolonial-inspired methodological framework through an ethnographic study of immigrant health and advocacy on California's Central Coast. In this region, there is a large concentration of Latinx immigrants who reflect the diversity of migrant experiences. Families draw their lineages from various regions in Mexico and Latin America, including members of Indigenous groups and peoples of mixed

European, Indigenous, and African descent. Settler-colonialism and racism continue to drive stark inequities in healthcare access and health outcomes for Latinx Immigrant and Indigenous groups (Garcia et al. 2020; Jolivétte 2016; Lines, Yellowknives Dene First Nation Wellness Division, and Jardine 2019; Page and Flores-Miller 2020). A decolonial-inspired framework is needed to fully reflect the heterogeneity of identities and community formations among Latinx groups, as well as grounding research in a commitment to directly impacting health equity and policy.

Indigenous peoples have always known that "health is a holistic concept that extends beyond Individual behaviors and genetics" (Lines et al. 2019:176). While western researchers have started to adopt this perspective through examining structural and social determinants of health, First nation groups include "unique structural (or foundational) determinants such as history, political climate, economics and social contexts" (Lines et al. 2019:176). Settler-colonial traumas, including the disruption of kinship networks and traditional healing practices, create structural vulnerabilities for Indigenous peoples (Jolivétte 2016). Further, racism is reproduced in healthcare through the negotiation of linguistic and behavioral codes in both clinical and community contexts (Villalobos et al. 2016).

Linguistic and cultural factors are especially important to consider in terms of both race and Indigeneity. For instance, in places with large Latinx populations, translation disproportionately prioritizes Spanish speakers, leaving gaps in resources for Indigenous language interpretation and multilingual services. Even when language access is in place, multiple layers of barriers persist, including exclusion from public health insurance programs for immigrants, restriction to emergency services, and a culture of fear emerging from militarized immigrant enforcement strategies (Armenta 2017; LeBrón et al. 2018;

Lopez et al. 2017a; Perreira et al. 2019; Prieto 2018). While some researchers have examined these overlapping dynamics of race and Indigeneity in urban centers (Jolivétte 2016) and in Native communities (Jacob 2013; Rodriguez-Lonebear 2016; Smith 2012), this study was motivated by the specific local need to address these dynamics in a rural environment on California's Central Coast (Jiménez 2010).

Defining the Central Coast

The state of California operates on unceded Indigenous lands, and the region known as the Central Coast includes the homelands of Chumash and Salinan peoples. To make legible boundaries for inclusion in the study, the Central Coast was defined as Ventura, Santa Barbara, San Luis Obispo, and Monterey counties. In general, Latinx communities in this region have been understudied compared to large urban centers, despite the crucial role of the immigrant population and agricultural economies present in the area (Jiménez 2010; Prieto 2018). Alongside the high concentration of migrant field workers, Latinx families play an important role in the community, culture, and economy of the region (Jiménez 2010). There is substantial ethnic diversity among Latinx communities in the Central Coast, including Central and South American migrants, as well as Indigenous peoples, such as Oaxacan, Zapotec, and Purépecha. Despite the presence of a highly diverse and resilient Latinx community, organizing for racial justice, immigrant rights, and political representation for Latinx peoples has not taken on the same form and scope as what is seen in large urban centers.

Advocates and community leaders play a key role in mobilizing communities on the Central Coast to address equity in their local context. In this study, some of those key groups include Central Coast Coalition for Undocumented Student Success (CCCUSS), Central

Coast United for a Sustainable Economy (CAUSE), Mixteco Indigena Community Organizing Project (MICOP), Immigrant Support Network (list-serve), Access Support Network, RISE, Community Action Partnership – San Luis Obispo, Gala Pride and Diversity Center, House of Pride and Equality (HOPE), Transitions-Mental Health Association, IMPORTA, the FUND for Santa Barbara, California Immigrant Policy Center, Dream Centers and student groups at colleges and universities, religious groups, and healthcare providers. Advocacy around health, in particular, takes on a distinct character in this rural environment, as healthcare and services themselves are generally under-resourced compared to the size of the population. High-quality services do exist, especially in nearby regions, and some immigrants travel for healthcare when needed. However, issues of cost, missing work, and documentation status make these inaccessible for too many in the community. Following the logic of a decolonial-inspired framework, the research centers the Central Coast because of its marginal status and the opportunity to be useful for ongoing movements impacting equity and justice.

Decolonial-Inspired Ethnography

A mixed-methods ethnographic approach was used to organize multiple types of data collection. Specifically, ethnographic methods are used to guide the process of cultural inquiry, entering and exiting community field sites, logging relevant public discourse, recruiting participants and key informants, and guiding interview and focus group design (Rios 2011, 2015b, 2017a, 2017b). In addition to typical ethnographic tools, this project centers community input and accountability as a source of knowledge production (Smith 2012). Community input was especially prioritized through participant-observation, a survey of community health needs and assets, and focus groups. Members of the community hold

diverse and sometimes competing views, and thus I practiced reflexivity to organize and evaluate the perspectives presented through various data collection procedures.

Multiple sources of knowledge production are useful for addressing complex research questions and communicating information to diverse stakeholders. For this study, I intentionally employed multiple forms of data collection: participant-observation of in-person and virtual events (2018-2020), reflexivity through field notes and memos, content analysis of ethnographic news data (n = 148) and Central Coast news (n = 4,768), interviews with community members and advocates (n = 31), six focus groups with community members and advocates (n = 12), a survey of health needs and assets (n = 260), and public engagement through a project website and social media. Institutional Review Board approval was received for this project from the University of California, Santa Barbara. Using a decolonial-inspired method means disseminating these findings to the community directly, to local and Indigenous stakeholders, and through academic venues to influence broader processes of knowledge production.

The iterative sequencing of research activities built and refined knowledge over time. For instance, preliminary themes generated in participant observation, interviews, and focus groups guided the topics covered in the survey. Open coding of transcribed field notes was used to create a deductive codebook which was then expanded through coding of interviews, focus groups, and additional field memos (Charmaz 2006, 2011). Focus groups were especially key for synthesizing findings from multiple data sources and sharing them with directly affected communities. Participants in focus groups identified key areas of focus for analysis, including mental health services, and they highlighted the importance of disseminating findings to policymakers and public audiences. The use of mixed-methods

data sources provides multiple perspectives on the key issues of health disparities and advocacy, enabling knowledge production that is useful for multiple audiences.

Participant Observation

I used participant observation to organize the research process, gather information about collective action and public advocacy, and develop relationships with key informants (Jiménez 2010). Observation was an opportunity to center the expertise among Indigenous groups, immigrant families, and social movements. I also observed multiple sectors that influence Latinx Immigrant and Indigenous health, including county and local governments, healthcare provider networks, and advocacy coalitions. This process guided the collection of news data, interviews, focus groups, and the health needs and assets survey. I also observed public responses to events and related social media conversations (Bonilla and Rosa 2015; Brown et al. 2017). For example, during debates over changing the public charge rule, I noted how government agencies and non-profit groups put forth statements online and shared information through in-person events.

The COVID-19 pandemic emerged during my time in the field, highlighting longstanding inequities in health and changing the ways that people advocate. Because this project was designed to be responsive to community needs, I continued participant observation in a primarily digital environment. When advocates moved direct actions to Zoom and live streaming, I attended these events and downloaded public recordings to analyze asynchronously. Concerns about COVID-19 were also added to the interviews, focus groups, and health needs and assets survey. Beyond the virus itself, the failure of an effective government response to the pandemic exacerbated fear and instability. At a policy level, the budget strain from the pandemic in the state of California pushed Governor

Newsom to walk back past commitments to cover undocumented elders in Medi-Cal, emphasizing uncertainty for immigrant communities. Although mental healthcare was already a priority within the study, the pandemic further elevated the importance of these issues within Latinx Immigrant and Indigenous communities.

Before, during, and after my formal time in the field, my family and myself have lived on the Central Coast for decades. I utilized aspects of my insider knowledge to gain greater insight into the formal observations (Rios 2017a). In addition, during my time in the field, I also informally observed a range of everyday activities, behaviors, and community formations. This provided important relationships and connections to individuals who do not occupy formal organizational leadership positions but play a key role in maintaining community relations and mobilizing grassroots actions. I shopped in locally owned stores and grocery markets, attended family celebrations, frequented public parks, participated in cultural events and holidays, accessed healthcare, and interfaced with local government agencies as a resident, constituent, and advocate. My daily investment in these communities has helped me to continuously privilege the need for effective and equitable solutions to healthcare disparities.

News Data and Content Analysis

News articles play an important role in shaping how people view Latinx Immigrant and Indigenous groups (Díaz McConnell 2019; López-Sanders and Brown 2019). The choices journalists make shape public awareness of Immigrant and Indigenous experiences, changes in immigration policy, and advocacy for Latinx groups. For this study, I collected a sample of news data through the course of my ethnographic fieldwork (n = 148). Articles were identified through conversations with key informants, regularly reading the news, and

downloading articles shared by advocacy organizations on social media. For analysis, news items were included if they covered health disparities affecting Latinx and immigrant communities, immigration policy issues, or immigration enforcement strategies (e.g., family separation, deportation, detention). The range of news sources collected through this approach is useful because it includes national and local sources, mirroring the ways that community members access information about these policies and issues.

To evaluate the themes and trends present in the ethnographic news, a systematic sample of Central Coast news articles was collected (n = 4,768). Ten local newspapers from Salinas, Monterey, Morro Bay, San Luis Obispo, Santa Barbara, and Ventura were searched for relevant articles between January 1, 2006 to April 30, 2020. These local sources provide a distinct perspective beyond national news. For each news outlet, two distinct searches were collected. The first search included articles that mentions "immigrant," "immigrants," or "immigration," along with one of the terms, "health," "public health," "illness," "sick," or "sickness." The second search included articles that mention "Border Patrol," "Customs and Border Patrol," "Immigration and Customs Enforcement," or "Deportation." Comparing the content from these two searches over time shows how structural factors of immigration policy influence health behaviors.

Interviews with Community Members and Advocates

Individuals were recruited for interviews from two groups: immigrant community members (i.e., "Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen"), or as advocates (i.e., "individuals that actively participate in social change efforts toward advancing immigrant health equity"). Both groups were asked about themselves, their perception of health needs in the community, experiences with language

diversity, and how they see the political climate and its effect on community health. The conversations for the community member interviews emphasized their understanding of health needs and assets, as well as the social context. This provided an opportunity to center community expertise on these topics. Many respondents indicated that they were grateful to speak at length about these issues and have their perspective valued.

Advocates were additionally asked more detailed question about institutional cultures and advocacy strategies. Using a semi-structured approach, all interviews followed the same general protocol, but I adapted in the moment to pursue lines of conversation, ask follow-up questions, and skip items that became repetitive or unnecessary. For instance, when community members revealed that they played a role in advocacy in the community, they were also asked those relevant questions for advocates. Similarly, in advocate interviews, the questions were made more specific based on whether advocates worked primarily in healthcare settings, community organizing, or political advocacy. For full details on recruitment procedures and interview protocols, see the Appendix.

Recruitment strategies emphasized difference within a heterogenous community and creating opportunities for mutual benefit for the community members within the research. Primary recruitment included contacting organizations identified through participant observation, sharing flyers online and in-person, and promoting the opportunity to be interviewed through social media. Relevant groups were contacted by phone and email, including those that provide healthcare and legal aid to immigrant communities and community-based advocacy organizations. Flyers were also shared on college campuses and laundromats throughout the Central Coast, and at cultural events. Snowball sampling was used to connect with interviewees who were known to the participants, which helped to create trust and accountability (Naderifar, Goli, and Ghaljaie 2017; TenHouten 2017).

Snowball sampling is a way of linking to new participants through relationships with existing participants, and it is especially useful in recruiting participants among underserved groups with low trust in government and university institutions.

Mutual benefit took on many forms for the community (Smith 2006). At a basic level, research funds were used to provide a $25 honorarium for all those who participated. Compensation is a necessary way of valuing the time and expertise of community members as knowledge producers. However, other forms of engagement were also useful for building trust and connecting with community members over the larger mission of the project (Horowitz et al. 2009). For example, when I made myself available to community members, they asked for help to find work, get resources about health concerns, register for college classes, solve technical problems, and learn about health issues facing their family members. I also partnered with a small tire shop in a predominantly immigrant community so that people could be interviewed while their car was being worked on. This created a benefit for the tire shop owner, who advertised the honorarium to promote his business, as well as the participants themselves.

Many advocates were quick to see the opportunity for mutual benefit by participating in this study. Recruitment materials and the informed consent form all emphasized how society and advocacy organizations would benefit from these research findings. One interviewee remarked that her organization regularly reads research reports and would be including the findings of the study in their strategic planning efforts. However, some local community-based organizations saw the benefits of the study but did not have the capacity or desire to participate in research with a university partner. Individuals who were somewhat interested in the study were provided with other ways to contribute, like connecting at an event or sharing the health needs and assets survey with their networks.

I provided and reviewed informed consent forms in English or Spanish, and all individuals consented to have their interviews audio recorded. Anonymity and confidentiality were a particular concern for immigrant community members who were undocumented themselves or shared the experiences of their undocumented family members. In-person interviews were recorded using a small tape recorder and phone and video chat interviews were recorded using the record function in Zoom. Following each interview, individuals were given an optional demographic survey to record their gender, race, ethnicity of Latinx individuals, Indigenous identity and affiliation, whether or not Indigenous individuals are Two-Spirit, sexual orientation, age, and year of arrival to the U.S. (for immigrants only). Demographic information is used to describe the sample as a whole and to provide context for commentary without identifying individual people.

Audio recordings were transcribed by a professional service and edited for accuracy. All names and identifying information were removed from the interview, including mention of others' names or overly specific contextual details. Recording files were stored in a secure drive and removed from tape recorders and digital cloud storage. This project uses multiple methods to meet diverse community members at the margins. Even before the pandemic, consent forms were created electronically using Qualtrics and protocols included options for remote tools (i.e., phone and Zoom). Therefore, the shift away from in-person data collection was a matter of re-direction within the existing research framework.

Regional Focus Groups

Focus groups were conducted to share preliminary findings with Latinx immigrant community members and advocates from throughout the Central Coast region. The discussions allowed their voices to inform the interpretation of findings and set the priorities

for analysis and dissemination of findings (Gonzalez et al. 2020). To facilitate opportunities for free-flowing discussions in an entirely online environment (via Zoom), focus groups were limited to four participants each. Participants were recruited from all counties represented in the study. A total of six focus groups were held with one to four participants each, with an average of two participants per focus group. Three of the six focus groups were conducted in English and the other half were conducted in Spanish ("cafecitos"). Similar to the interviews, each participant was given an honorarium of $25.

In each focus group session, participants were provided with information about the study and the methodologies used in ethnographic data collection. Results were shared from participant-observation, content analysis, interviews, and the health needs and assets survey. The conversations were structured around major themes in the study: political climate, health needs/assets, and language. Within each section, relevant findings were shared, and then participants had the opportunity to respond, ask questions, and discuss. The full slides used in the focus group are included in the Appendix. In the final section, I added some personal reflections and made space for any additional questions or comments. These open-ended conversations set a tone for sharing knowledge and held the research accountable to the lived experiences of diverse community members (Aronson et al. 2007; Pilar et al. 2014). Some of the key recommendations that were repeated across focus groups was a focus on mental health concerns, making data relevant for local stakeholders, and informing policymakers directly.

Survey of Health Needs and Assets

A survey of Latinx immigrant health, healthcare, and advocacy was developed in collaboration with community leaders. Latinx immigrant community members and

advocates were recruited to provide their input between September 2019 – September 2020. For eligibility criteria, immigrant community members were defined as, "Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen." Advocates were those who identified as "individuals that actively participate in social change efforts toward advancing immigrant health equity." In total, 177 eligible respondents took the survey out of 260 individuals who accessed the survey in English or Spanish. This data provides important quantifiable information that can inform community members and political decision-makers about the breadth and scope of the impacts of health inequity.

The survey was shared with help from community organizations throughout the central coast. Recruitment materials were shared with existing contacts as well as a range of organizations focused on health, immigration, and advocacy, including: Central Coast Coalition for Undocumented Student Success, Central Coast United for a Sustainable Economy, Mixteco Indigena Community Organizing Project, Just Communities, Lideres Campesinas, Latino Outreach Council, Planned Parenthood, Advantage Healthcare Services, Essential Access Health, promotora/x (community health promoter) networks, California Legal Rural Assistance, Immigrant Support Network (list-serve), IMPORTA, Gala Pride and Diversity Center, Transitions-Mental Health Association, House of Pride and Equality (HOPE), Corazón del Pueblo: The Cultural and Creative Arts Center of the Santa Maria Valley, the FUND for Santa Barbara, United Way, California Immigrant Policy Center, as well as colleges, universities, county public health offices, and local elected officials. Additional momentum for recruitment was generated through paid social media advertisements on Facebook and Instagram, and by supportive individuals who shared the survey. An incentive was provided in the form of a raffle, where two individuals were selected to win a $100 gift card.

Survey questions asked respondents about their demographics, personal experiences of health and healthcare, and perceptions of community health needs and assets. Items were developed for the survey by centering priorities identified in participant observation and interviews, including access to health insurance, language use, Indigeneity, trust in service providers, healthcare barriers, and discrimination. Draft protocols were created by adapting items from existing community and academic surveys on health, especially for Latinx and immigrant groups. These drafts were then reviewed and edited by experts from various standpoints. Community advocates were consulted to provide feedback on the content of the survey, missing aspects, accessibility, and confusing wording. I also consulted research experts on Latinx immigrant health and survey methodology to provide technical guidance and ensure face validity for all items.

Project Website and Social Media

The project website (https://lagenteunidacc.wixsite.com/recursosdesalud) was designed to create a mechanism of transparency so that the communities that are directly affected can access and evaluate the findings of the study. All content on the website is in both English and Spanish. As accessing service providers was a primary concern identified early on in the fieldwork and interviews, the foundation of the website was a guide of resources. It was also useful as a hub for recruitment, with pages dedicated to the survey, interviews and focus groups. Participants were able to learn more about the study, sign up to participate, and access consent forms all in the same place. During the survey data collection period, community members used the Contact form to ask questions about the incentives to participate and share their perspectives. In total, 179 individuals left a comment or question through the website.

As findings have been published and shared through conferences, those have also been added to the Reports ("Informes") page. In addition to website visitors, this information is also actively shared on social media through a Facebook page for the project: https://www.facebook.com/lagenteunidacc/ At the end of 2020, the page had 138 Likes and 150 Followers. Having a social media presence allowed for interactive engagement with community members and means to formally connect with community partners. Social media advertisements on Facebook and Instagram were used to promote the survey and targeted to the geographic region of the study. The social media both shares content directly and drives traffic to the website to help build further awareness about these topics.

Reflexivity

The practice of reflexivity was often done through dialogue, conversation, and public engagement, in addition to self-awareness and private analysis. Participant observation provided continuous opportunities to take field notes and intentionally practice unsettling the norms and expectations of settler-colonialism. For instance, preliminary community engagement events with health advocates, like a local field nurse for the health department, shed light on the role of gendered dynamics for Oaxacan women receiving care. My identity as a queer Indigenous Latinx cisgender male means, from the outset, that I occupy a marginalized identity. This positionality provided me with a sharp insight into the workings of power dynamics and the consequences of health inequities. At the same time, my status as a doctoral candidate, researcher, lecturer, and income-earning able-bodied person suggests that I also have certain entitlements and privileges. My associations with state universities added a layer of caution and mistrust to many of my interactions for undocumented individuals and their families. As both a U.S. citizen and a man, I have not lived through the experiences that affect many of the participants in this study. For these reasons, I

consistently initiated opportunities for feedback and open dialogue with individuals who held different identities from my own.

In conversations with key informants and through the focus groups, participants emphasized the importance of relating findings to those who can affect broad changes in the lives of immigrants. Responding to these calls, I have built avenues for sharing the results of this study and the voices of the Latinx Immigrant and Indigenous participants with policymakers and researchers. The overall project and individual chapters have been presented for the American Sociological Association, Pacific Sociological Association, California Sociological Association, Academy Health, National Association for Chicana and Chicano Studies, American Anthropological Association, University of California, Santa Barbara LGBTQIA+ Research Festival, and the California Polytechnic State University, San Luis Obispo Change the Status Quo Conference. Two manuscripts from the dissertation are currently under review at *Psychological Services* and *New Directions for Evaluation*. Feedback from researchers and students in these settings led to a deeper insight of how these findings are useful to improving health equity and policy across multiple contexts.

Conclusion: Practicing a Decolonial-Inspired Approach

The decolonial-inspired approach of this study generated unique opportunities to amplify and bridge the work of advocates and community leaders who mobilize around Immigrant and Indigenous health. It is also a call to action to advance health equity and resist settler-colonial and racist policies. The findings of this study are being shared with policymakers and advocates, beginning with those who are invested in the health and wellbeing of Latinx immigrant groups in California (Ibarra and Rowan 2019; Pickoff-White and Small 2019; Valle and California Pan-Ethnic Health Network 2019). At the local level, this includes the

City of San Luis Obispo Diversity, Equity, and Inclusion Taskforce, Santa Maria City Councilmember Gloria Soto, and Santa Barbara County Supervisor Joan Hartmann, in addition to advocacy groups and service providers operating across Monterey, San Luis Obispo, Santa Barbara, and Ventura counties. Through a program with the Scholar Strategy Network, these results are also being shared through relevant policy materials for California senator Monique Limón. At the national level, through partnerships with the Mi Gente Nuestra Salud project, the findings of this study have also reached U.S. Congressman Salud Carbajal and Deputy Surgeon General, Rear Admiral Erica Schwartz.

Creating systemic change and dismantling settler-colonialism also means building grassroots capacity and healing historical traumas for Indigenous peoples. I utilized my insider status and relationships built during fieldwork to continually share findings with affected individuals and community leaders. In addition to sharing findings through the website, I also published in *El Latino*, a Spanish-language newspaper for the Central Coast, and was covered on *KCBX* (Central Coast Public Radio) and the *Santa Maria Times*, reprinted in the *Santa Ynez Valley News* and *Lompoc Record*. To reach policymakers directly, I partnered with the Scholar Strategy Network to design and distribute a fact sheet on state-level policy to California Assemblymembers, Senators, and the Governor and Lieutenant Governor. The fact sheet was shared to 23 elected officials in key committees such as Health, Appropriations, and Budget. Seven offices, including the Lieutenant Governor, requested briefings to learn more about the findings of the study. In addition, these findings have been useful for advocacy. I submitted positions papers for seven state bills on topics of health, immigration, and racial justice utilizing specific findings from this study.

Centering the experiences and perspectives of Immigrant and Indigenous community members has demonstrated how immigration policies affect health opportunities of immigrants as well as broader networks of mixed-status families. More broadly, utilizing decolonial-inspired approaches within Sociology, Public Health, and related fields can demonstrate how to include Indigenous scholarship in the development of the field, opening new opportunities for collaboration and critical inquiry. The remaining chapters demonstrate the breadth of topics that can be addressed through decolonial-inspired methods. In the next chapter, I show how decolonial-inspired methods can align survey analysis with a critical mixed-methods investigation of the mental health needs of Latinx Immigrant and Indigenous groups.

III. "We Need Health for All": Mental Health and Barriers to Care among Latinxs in California

Latinx immigrant groups remain underserved by existing mental health resources. Past research has illuminated the complex factors contributing to this problem, including migration-related trauma, discrimination, anti-immigrant policies, and structural vulnerability. This chapter uses decolonial-inspired methods to present and analyze results from Latinx immigrant communities on California's Central Coast in the United States. Using mixed quantitative and qualitative analysis, I demonstrate the intersectional complexities to be addressed in formulating effective mental health services. Relevant social and structural factors like knowledge of mental health, having insurance, and experiencing discrimination were significantly associated with anxiety symptoms, based on linear regression analysis. Interpreted within the context of past research, these findings show how overlapping aspects of gender, language barriers, fear of authorities, and immigration status contoured the lived experiences of Latinx immigrants. Thematic analyses of open-ended survey responses also provide recommendations for solutions based in these experiences of those directly affected by these health disparities, particularly relating to healthcare access, affordability, and capacity. Building from these findings and past research, I recommend the adoption of a comprehensive model of mental health service provision for Latinx immigrants that takes into account Indigenous language access, structural competency, expanded health insurance, and resources for community health workers.

Introduction

Latinxs are the largest racial or ethnic group in the United States, numbering 60.6 million and constituting 18.5% of the population as of 2019 (U.S. Census Bureau 2020). By

2030, Latinxs are expected to comprise nearly 30% of Americans (Vespa et al. 2020). Latinxs are also the youngest racial or ethnic group in the U.S.: one-third of the nation's Latinxs is younger than 18 years old (Noe-Bustamente and Flores 2019). However, a gap persists in mental health care services that are culturally responsive and effectively implemented among this diverse population. This chapter builds on existing research that documents influences on mental health among Latinx groups to inform a model for services that addresses language, cultural relevancy, access, and structural vulnerability. Latinxs—which is a gender-neutral term for "Latino/as," abbreviated from Latinoamericanos—are a remarkably heterogeneous group. Latinx/o/a is an endonym referring to origin in or heritage from Latin America, including individuals who trace their roots to Central and South America and the Caribbean. Thus, a Quechua-speaking rural Indigenous Ecuadorian, a Spanish-speaking mestizo Costa Rican, a Totonaco-speaking coastal Mexican, a Creyol-speaking Black Haitian, and an Italian-speaking White Argentine may all identify as Latinx in the U.S. In addition, many descendants of Spanish settlers in the southwestern U.S.—the *hispanos*, *tejanos*, and *californios*—who became U.S. residents after the Treaty of Guadalupe-Hidalgo in 1848 may also identify as Latinx/o/a (Haverluk 1997; Nostrand 2010). Responses to the needs of the Latinx community must therefore attend to pluralities in racial identity, language, origin, and migration history (Silva et al. 2017).

Likely due to this heterogeneity, Latinxs demonstrate variability in prevalence of mental health disorders. In 2018, 8.6 million Latinx adults had a mental health or substance use disorder (Substance Abuse and Mental Health Services Administration 2020). Overall, evidence suggests that Latinx individuals experience lower risk of most mental health disorders compared with non-Latinx White individuals (Lisotto 2017). However, U.S.-born Latinxs report higher rates for most psychiatric disorders compared with Latinx immigrants

and these rates vary when stratified by nativity and disorder and adjusted by demographic and socioeconomic differences (Alegria et al. 2008). Several mutually constitutive and overlapping factors contribute to the development of mental health disorders in Latinxs. First, Latinxs, particularly those who have migrated to the U.S., report high rates of trauma. Migration entails multiple vulnerabilities, including violence and economic precarity in one's country of origin; threats or risks of physical and sexual violence, dehydration, kidnapping, and exploitation during border crossings; family separation; and detention and deportation (Perreira & Ornelas 2013; Vogt 2018). Experiences are particularly harrowing for women, who may confront rape, forced prostitution, trafficking, and physical violence (Miller et al. 2007). Reports of trauma exposure are extremely high among Latina migrant women, with prevalence rates around 75% (Cleaveland & Frankenfeld 2020; Fortuna et al. 2019). In addition, many Latinxs share histories of historical trauma relating to the European colonization, enslavement, sexual violence, and genocide of Indigenous peoples of the Americas. Such reproductive and genocidal violence continues with reports of recent coerced hysterectomies on immigrant women detained in Georgia (Treisman 2020).

Latinx migrants and their descendants experience discrimination. Both acculturative stress and discrimination have been shown to impact physical health through the mediating effects of anxiety (Cariello et al. 2020). In addition, greater experiences of discrimination also moderated the effect of harsh working conditions, increasing symptoms of anxiety and depression among migrant farmworkers in the rural Midwest (Andrews et al. 2020). Perceived discrimination is also significantly related to substance use behaviors among Latinxs (Tran et al. 2010). A recent systematic review found that discrimination, family separation, and fear of deportation exacerbate acculturative stress (Bekteshi & Kang 2020). Further, restrictive immigration policies and enforcement contribute to psychosocial stress

among Latinxs. Increased immigration enforcement has been found to associate with increased mental distress and decreased self-reported health (Becerra et al. 2020; Martinez et al. 2015; Wang & Kaushal 2019). Citizen children who worry about losing a caregiver suffer from higher rates of depression, anxiety, emotional distress, and hypervigilance (Vargas & Ybarra 2017). Among pregnant women, fear of deportation and fear of a family member being deported associated with higher prenatal and postpartum anxiety (Lara-Cinisomo et al. 2019). Furthermore, following the implementation of 287(g) agreements, which permit cooperation of federal immigration authorities with local police, pregnant Latina women sought prenatal care later and had inadequate care when compared with non-Latina women (Rhodes et al. 2014). One study found that a 1-percentage-point increase in a state's immigration arrest rate was significantly associated with multiple mental health morbidity outcomes (Bruzelius & Baum 2019). In the wake of immigration raids and mass deportations, immigrants and Latinxs in particular report greater stress and fear and worse health (Hacker et al. 2011; Lopez et al. 2017).

These patterns are particularly relevant amid intensifying anti-immigrant sentiments and increased deportations in recent years. From 2009 to 2016, five million undocumented immigrants were deported (Chishti et al. 2017). Under the current presidential administration, a series of restrictive actions have been implemented with serious implications for Latinxs. Within days of his inauguration, President Trump signed Executive Order 13768 entitled "Enhancing Public Safety in the Interior of the United States," which expanded deportation priorities to effectively include every undocumented immigrant, promoted increased use of state and local police to enforce federal immigration law through section 287(g) of the Immigration and Nationality Act (i.e., 287(g) agreements), and directed the hiring of 10,000 Immigration and Customs Enforcement (ICE) officers

(American Immigration Council 2017; Ramos-Sánchez et al. 2020; Trump 2017). Following this order, an additional 52 jurisdictions have signed 287(g) agreements (Immigrant Legal Resource Center 2018). In addition, the Trump administration attempted to revoke temporary protected status from individuals who emigrated from Nicaragua, Haiti, and El Salvador; however, this effort was stymied by the *Ramos et al. v. Nielsen et al.* decision by the U.S. District Court for the Northern District of California (U.S. Citizenship and Immigration Services 2019). The administration also enacted a "Zero Tolerance Policy" with respect to unauthorized immigration, prosecuting immigrants as criminals, detaining them in hieleras or ice-cold cells, and separating children from their parents at the border (M. E. Miller 2018; Ramos-Sánchez et al. 2020).

Structural vulnerability—or an individual's "location in their society's multiple overlapping and mutually reinforcing power hierarchies (e.g., socioeconomic, racial, cultural) and institutional and policy-level statuses (e.g., immigration status, labor force participation)" (Bourgois et al. 2016)—conditions mental distress and inadequate access to care. Only 1 in 10 Latinxs with a mental disorder receives mental health services from a general health care provider, and just 1 in 20 receives treatment from a mental health specialist (Office of the Surgeon General (US) et al. 2001). Among migrant farmworkers, harsh working conditions significantly predict symptoms of anxiety and depression (Andrews et al. 2020). Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), permanent residents are ineligible for public assistance during their first five years in the U.S. Recently, "the public charge rule," a broader interpretation of Immigration and Nationality Act (INA) § 212(a)(4), which states that individuals are inadmissible to the U.S. if they are "likely at any time to become a public charge," has discouraged noncitizens from pursuing needed benefits prior to

regulating their status (Quinn & Kinoshita 2020). Due to their explicit exclusion from the Affordable Care Act, undocumented immigrants have almost no access to public health insurance as well as limited options for employer-based or private insurance (Artiga & Diaz 2019; Bucay-Harari et al. 2020). Furthermore, by June 2020, due to the outbreak of COVID-19 in the U.S., an estimated 41% of Americans had delayed or avoided medical care and this prevalence was 1.5 times higher among Latinxs (Czeisler et al. 2020).

This chapter aims to answer the following questions: (1) What factors influence mental health among Latinx immigrant community members? (2) What barriers to healthcare among this group are relevant to mental health care services? (3) How can services be effectively improved to address these factors and reduce these barriers? To answer these questions, I draw from a sample of Latinx populations individuals from California's Central Coast. This sample reflects the multigenerational, majority Mexican, Mexican American, and Chicana/o/x community present in California, as well as diversity in Indigenous affiliations and citizenship.

Methods

This chapter uses a mixed-methods analytic approach, inspired by a decolonial framework (Jacob 2013; Jolivétte 2016; Rodriguez-Lonebear 2016; Smith 2012). Decolonization centers the perspectives of Indigenous peoples throughout research design, interpretation, and dissemination, focusing on the ways in which knowledge production can be directly useful. In the context of Latinx immigrant health, this is particularly relevant given the many Indigenous identities, cultures, and languages of Latin American origin (Blackwell et al. 2017). For this chapter, the decolonial-inspired methods focus on research questions that are centered in participants' perspectives, specifically those that are directly

useful to improving the conditions under which people live their lives. This study received Institutional Review Board approval from the University of California, Santa Barbara.

Survey Data on Latinx Immigrant Health Needs and Assets

The study was based on a larger ethnographic project examining Latinx immigrant health and advocacy, which included participant observation in-person and online, a survey of health needs/assets, as well as interviews and focus groups with Latinx immigrant community members and immigrant health advocates. This larger project allowed for a survey to be developed in collaboration with community representatives and leaders, and findings are directly communicated to those stakeholders. Survey data was collected among self-identified Latinx immigrant community members and advocates for immigrant health. The demographics for the participants are presented in Table 2.

***Table 2*. Demographic Summary for Study Sample**

		Central California Sample	
Variables	Response categories	*n*	%
Gender	Women	123	82.0
	Men	14	9.3
	Not Listed	13	8.7
Indigeneity	Not Indigenous	125	83.3
	Indigenous	25	16.7
Country of Origin	Belizean	2	1.5
	Brazilian	2	1.6
	Chicana/o/x	5	3.9
	Chilean	2	1.6
	Cuban	1	0.7
	Dominican	1	0.8
	Guatemalan	9	6.6
	Honduran	1	0.7
	Mexican	91	66.9
	Mexican American	23	16.9
	Peruvian	2	1.5
	Salvadoran	7	5.1

Respondents were recruited through organizational networks of immigrant and health advocates, community-serving organizations, and key informants identified in the larger ethnographic project. The survey was available in English and Spanish, and respondents were encouraged to receive assistance from family members and interpreters as needed to take the survey. These strategies help to ensure the inclusion of hard-to-reach groups who may have limited trust in processes associated with the government, including university-based research. In addition, a random sample of respondents was recruited using paid Facebook and Instagram advertisements in both English and Spanish. The survey addressed health holistically and asked about respondents' demographics, experiences of health and healthcare, community-level perceptions, and barriers to health access. In addition to defined-response quantitative measures, open-ended questions were included and analyzed using deductive thematic coding. All measures used for regression analysis are summarized in Table 3.

***Table 3*. Summary Statistics for Variables used for Regression Analysis**

Categorical variables	Response categories	*n*	%
Eligibility criteria	Outside advocate	38	21.5
	Immigrant community members	139	78.5
Language	English	95	53.7
	Spanish	82	46.3
Race	Other Race	22	14.3
	Latina/o/x or Hispanic	132	85.7
Indigeneity	Not Indigenous	125	83.3
	Indigenous	25	16.7
Insurance Coverage	No / Decline to State	34	30.1
	Yes	79	69.9
Continuous Variables		*M*	*SD*
General anxiety disorder symptoms [a]		1.91	0.77
Trust in biomedical healthcare [b]		2.89	0.62
Trust in therapists [b]		2.79	0.76
Mental health knowledge [c]		3.35	1.32
Concern for mental health issues [c]		3.57	1.44
Experiences of discrimination [a]		0.47	0.90

Notes. [a] Range: 0-3, [b] Range: 1-4, [c] Range: 1-5.

Sampling and Eligibility Criteria

To be eligible for the survey, individuals had to be adults and identify as an advocate for immigrant health and/or as an immigrant community member, "i.e., Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen." Advocates for immigrant health were defined on the survey as, "individuals that actively participate in social change efforts toward advancing immigrant health equity." Both groups were included for analytic purposes (n = 177). For regression analysis, I controlled for differences between advocates who were not community members (coded "0") with all community members, including those who also identified as advocates (coded "1"). Alternative operationalizations were tested, including the interaction between being a community member and an advocate, but the community member or not variable was the only version significantly associated with anxiety scores in bivariate tests.

Anxiety

Anxiety is one indicator of mental health. General anxiety represents a pattern of experiencing excessive worry and can be caused by many factors. Some external factors that are associated with anxiety include surveillance and isolation, both of which are common to Latinx immigrant groups (Hurtado-de-Mendoza et al. 2014). To measure general anxiety, I used the GAD-7 Scale (Spitzer et al. 2006). The GAD-7 asks respondents to indicate the frequency of experiencing seven anxiety symptoms over the past two weeks on a 4-point scale (0 = "Not at all," 1 = "Several days," 2 = "Over half the days," 3 = "Nearly every day"; sample item: "Worrying too much about different things"). Among this sample, the measure showed excellent internal reliability, Cronbach's $\alpha = .925$.

Socio-Demographic Factors

To understand aspects of respondents' social position and control for potential group patterns in anxiety symptoms, the survey assessed respondents' primary language spoken, their racial identity, and whether or not they identify as Indigenous. Language was measured by whether they accessed the survey in English (coded "0") or Spanish (coded "1"). These categories were consistent with responses to the question, "What language do you primarily use?" and contained no missing data. Respondents self-identified their race in response to the question, "What race(s) do you primarily identify with?" and were allowed to select all that apply from a list. For this analysis, individuals were divided between those who self-identified as "Latina/o/x or Hispanic" (coded "1") and all other respondents (coded "0"). Finally, respondents were asked the question, "Do you identify as Indigenous?" and categorized based on their response (0 = No, 1 = Yes). This question was asked separately from race, as the categories "American Indian or Alaskan Native" and "Native Hawaiian or Other Pacific Islander" used for racial classification do not include many Native Americans and Indigenous people who fall outside of these categories (Villegas et al. 2016). Further, a separate question inquired about tribal affiliation. Sample sizes were too small to perform further disaggregated analyses, as a wide range of affiliations was present among respondents, including tribes with homelands across the Americas.

Mental Health Services Access

Respondents were asked about both general factors of healthcare access, as well as domain-specific access points for mental health. First, a four-item scale was constructed to assess trust in biomedical healthcare services. Beginning with the stem, "How much trust do you have in the following types of healthcare providers?", respondents reported on a four-

point scale (1 = “Do not trust at all,” 2 = “Trust somewhat,” 3 = Trust moderately,” 4 = “Trust completely”) for “general medical doctors (MD, DO),” “Specialty medical doctors (OBGYN, Oncologists, etc.),” “Nurses (RN, LVN, CNA, NP),” and “Physicians assistants (PA).” This scale showed strong internal reliability, Cronbach’s α = .84. A separate measure was used to indicate respondents’ trust in “Therapists (psychologists and social workers),” using the same stem and response scale. Health insurance coverage was assessed using the single question, “Do you have health insurance?” and respondents were grouped by those who responded affirmatively (coded “1”) and those who responded negatively (coded “0”). Having access to insurance coverage increases the likelihood of interactions with biomedical healthcare services. Lastly, the survey inquired about both knowledge and concern for mental health. Knowledge was measured using the question “On a scale from 1-5, how knowledgeable are you of the following health concerns?” with the item “Mental health” (1 = “No Knowledge,” 5 = “Very Knowledgeable”). Similarly, concern was measured using the question, “On a scale from 1-5, how knowledgeable are you of the following health concerns?” with the item “Mental health” and responses on a 5-point scale (1 = “Not Concerned,” 5 = “Very Concerned”).

Experiences of Discrimination

The survey provided an opportunity for respondents to share about discrimination within a larger question that asked about personal experiences, as well as witnessing and knowing of others’ experiences. A three-item scale was constructed by taking the average of dichotomous items (coded “0”/”1”), based on respondents affirming that they had “Experienced this myself,” with respect to: “Discrimination based on immigration status,” “Discrimination based on race or ethnic identity,” and “Discrimination based on gender and sexuality.” Respondents were allowed to select all that apply, so this does not discount

intersectional experiences of discrimination that are on the basis of multiple factors. This scale showed acceptable internal reliability among this sample, Cronbach's $\alpha = .78$. Experiences of discrimination are associated with increased mental health burden, including higher rates of anxiety symptoms (Potochnick & Perreira 2010).

Reported and Perceived Barriers to Mental Health Services

To understand the barriers facing Latinx immigrant groups, this survey asked respondents to self-report experienced barriers to healthcare in response to the question "In the past three months, have you delayed or gone without healthcare for any of the following reasons?" Twenty response options were provided, including cost (for example, "Services are too expensive"), access (for example, "Healthcare providers do not speak my language"), and capacity (for example, "Appointments not available"). Questions about COVID-19 were added during Spring 2020 and are presented with a reduced sample. General barriers to healthcare create a larger context in which mental health services can happen. A similar question was asked later on in the survey with the stem, "On a scale from 1-5, rank how much you perceive the following barriers to prevent this community from accessing healthcare" with the same response categories provided. Both indicators are included to describe the relative prevalence of directly observed as well as perceived barriers to healthcare.

More specifically, the survey instrument directly inquired about respondents' perceptions of the community's relationship to mental health through a series of single items. First, respondents were asked "On a scale from 1-4, please rank how easy or hard it is accessing the following types of resources for this community?" including the item, "Mental health services." (1 = "Very difficult," 4 = "Very easy"). Relatedly, the survey inquired

about the perceived knowledge and concern at the community level about mental health ("In your opinion, on a scale from 1-5, how [knowledgeable/concerned] are immigrant communities on the Central Coast of the following health concerns?": "Mental health"). These items are supplemented by two open-ended questions that allow for additional interpretation of these findings and how barriers can be overcome: "What are the most pressing health needs for this community?" and "How can society better support immigrant health needs?"

Analysis

The analytic strategy followed a primarily deductive approach, guided by the research questions motivated in the literature and prompted by the experiences of participants. While existing research has illuminated some of the specific dynamics affecting mental health conditions and strategies for service provision, this chapter utilizes multiple data sources to address these questions from the perspective of the individuals directly affected. Importantly, expanding culturally competent mental health services was identified as a community need by focus group participants within the larger project. To address factors that are associated with anxiety among Latinx immigrant community members, I used a linear regression model with ordinary least squares (OLS) estimators, including the predictors described above: socio-demographic factors, mental health services access, and experiences of discrimination. All variables were examined for multicollinearity and no issues were detected. To understand community-level perceptions of the barriers between immigrant groups and mental health services, I utilized summary statistics of survey items. Finally, thematic coding of open-ended survey responses was used to group responses into three categories based on the relevant emergent patterns: barriers in access, barriers based on cost, and barriers due to low healthcare capacity.

Results

Research Question 1: What factors influence mental health among Latinx immigrant community members?

In terms of anxiety, survey respondents indicated on average that they experienced anxiety symptoms "nearly half the days" in the past 2 weeks (M = 1.91, SD = 0.77). The summary statistics for all predictor variables are reported earlier in Table 3. When entered together in a linear regression model (n = 99), socio-demographic factors, mental health services access, and experiences of discrimination estimated 32.6% of the variance in anxiety scores among respondents (R^2 = .326) and the model was statistically significant, F (10, 80) = 3.87, p < .001. The full model is reported in Table 4.

Socio-demographic factors (language, race, and Indigeneity) were not significantly associated with anxiety. The identities individuals hold are not associated with anxiety, but relevant questions of access and discrimination were. Self-reported knowledge of mental health was significantly associated with lower general anxiety scores, β = -.37, p = .003. Those respondents who indicated that they had knowledge about mental health issues, gained through any source, were less likely to report anxiety symptoms over the past two weeks. In contrast, people with insurance reported significantly higher rates of anxiety β = .29, p = .008. Experiencing discrimination on the basis of immigration status, race, ethnicity, gender, and/or sexuality was significantly and positively associated with anxiety scores among this sample, β = .29, p = .008. Further, reporting higher concern of mental health was also associated with a significant increase in symptoms of general anxiety disorder, β = .22,

p = .048. Trust in healthcare providers, both biomedical services and therapists specifically were not significantly associated with anxiety scores.

***Table 4*. Factors Associated with General Anxiety Disorder Symptoms among Latinx Immigrant Communities**

Independent Variables	*B*	*SE*	β
Immigrant community member	-0.03	0.19	-.02
Spanish-speaking	-0.18	0.18	-.12
Latina/o/x or Hispanic	-0.43	0.24	-.19
Indigenous	0.29	0.20	.14
Insured	0.47**	0.17	.29
Trust in biomedical healthcare	0.11	0.16	.09
Trust in therapists	0.10	0.14	.10
Mental health knowledge	-0.21**	0.07	-.37
Concern for mental health issues	0.11*	0.06	.22
Experiences of discrimination	0.19*	0.08	.26
Constant	1.55***	0.47	
Model Summary			
F (10, 80)		3.87***	
R^2		.326	

Note. * $p < .05$, ** $p < .01$, *** $p \leq .001$

Research Question 2: What Barriers to Healthcare among this Group are Relevant to Mental Healthcare Services?

Respondents were asked directly to report their own experiences of barriers to healthcare. A high proportion of the sample had reported avoiding healthcare within the past three months for one or more reasons. The most commonly reported barriers to healthcare at the individual level were reported by over a quarter of respondents. Two of these were related directly to cost and healthcare capacity, “Appointments are not available” (46%) and “Services are too expensive” (38%). The remainder were related to the early days of the COVID-19 pandemic: “Fearful of getting COVID-19 / coronavirus” (46%, *n* = 50) and “Health services closed due to COVID-19 / coronavirus” (26%, *n* = 47). Each of these general barriers to healthcare also apply to mental health services. In addition to their own

experiences, respondents were asked to rank barriers present within the community overall, on a scale of one to five. The highest ranked items similarly had to do with COVID-19: "Fearful of getting COVID-19 / coronavirus" (M = 4.18, SD = 1.24, n = 50), as well as barriers related to cost and insurance: "Services are too expensive" (M = 4.06, SD = 1.17), "Don't have insurance" (M = 3.97, SD = 1.39), and "My insurance policy didn't cover what I need" (M = 3.97, SD = 1.26). These mirror the findings at the individual level, but further emphasize the lack of insurance coverage in the community, especially adequate insurance that covers preventative care and mental health services.

The majority of the sample said it was difficult or very difficult to access mental health services among Latinx immigrant groups (71%). When asked about collective awareness about mental health, the respondents rated the Latinx immigrant community as moderately knowledgeable (M = 2.34, SD = 1.08) and moderately concerned (M = 2.89, SD = 1.20). The substantial variation in these measures highlights the existence of strengths and resources among the community to address mental health, despite persistent gaps in healthcare access.

Research Question 3: How Can Services be Effectively Improved to Meet these Factors and Barriers?

At the conclusion of the survey, respondents were provided the opportunity to write-in answers to a number of open-ended questions. Thematic coding revealed three categories of barriers that respondents identified and linked to specific health needs and solutions. These groups, "Access," "Cost," and "Capacity" are summarized in Table 5. Each of these categories are interrelated, meaning that addressing one of these barriers effectively necessitates addressing all of the factors.

Table 5. **Thematic Analysis of Open-Ended Responses on Barriers to Mental Health Services**

Barriers	Health Needs	Relevant Quotes
Access	• Preventative health services • Accessibility • Transportation • Language support • Remove fear and stigma • Nutrition	"We need health4all. I am undocumented (DACA), and was accessing [student health insurance] but now that I've graduated I will lose coverage." "Outreach is essential." "Tener mas [*sic*] recurso y confiar en el sistema." [a]
Cost	• Free or low-cost services • Affordable sliding scales • Insurance coverage • Child-care • Affordable housing	"Mas recursos economicos [*sic*] para todos" [b] "Recognizing that emergency Medi-Cal and sliding scales are not equitable care." "Ser mas [*sic*] considerados y flexibles ala hora de ayudarlos en cualquier problema ya sea de salud o de algun otro recurso que ocupen para mejorar su estilo de vida" [c]
Capacity	• High-quality and consistent health services • Mental health services • Specialty doctors • Health promotion and outreach	"More education, more promotion and easier access to services" "Ahora la salud mental no hay ayuda si no tienes papeles ahora la estan ofreciendo solo x lo del covid19, si no ni ofrecen ayuda psicológica" [d] "Proveyendo mas [*sic*] servicios y haciendo mas [*sic*] outreach para que la comunidad sepa de ellos, muchas veces si hay servicios pero la gente no esta [*sic*] informada y/o no saben que existen esos servicios" [e]

Note. Quotes are preserved in the language and form written by respondents. All open-ended responses were coded using a deductive thematic strategy. Quotes were selected because they are clearly written and summarized patterns repeated in other responses.

[a] "We need more resources and trust the system."

[b] "More financial resources for all."

[c] "Be more considerate and flexible when it comes to helping them with any health problem or any other resource they use to improve their lifestyle."

[d] "Now for mental health, there is no help if you do not have papers. Now they are offering it only because of covid19, if not they do not offer psychological help."

[e] "Providing more services and doing more outreach so that the community knows about them, many times if there are services but people are not informed and / or do not know that these services exist."

At the same time, addressing each factor can also have a positive impact in working against the underlying mistrust between Latinx immigrant groups and mental healthcare providers. Access included a range of factors that prevented individuals who were seeking care from receiving it, or from receiving care that was timely, effective, and useful. The issues that immigrants face when accessing healthcare, including fear of driving and public transportation and lack of interpretation/translation services, become known within communities undermining trust with medical services, especially those attached to government institutions. As advocated by one respondent, "Tener mas [sic] recurso y confiar en el sistema" [We need more resources and trust in the system]. Existing service providers and advocates are responsible for building trusting relationships with underserved communities to expand access to resources that may be under-utilized.

The issue of cost was raised both with respect to services themselves, as well as the larger conditions that are affecting communities. Cost was emphasized in terms of the inadequacy of current efforts to provide for low-income individuals, including sliding scale policies and emergency Medi-Cal (California's Medicaid program). Free and low-cost services were identified as a major health need, in part due to the high cost of housing and child-care. Economic marginalization throughout the community has led to the need for "Mas [sic] recursos economicos [sic] para todos" [More economic resources for all]. Beyond the simple financial cost, participants also emphasized value of services, indicating that many service providers were not considerate and flexible enough to actually solve health problems effectively. Finally, the survey respondents indicated that health needs grew out of a lack of capacity present within their communities. Mental health service providers, as well as other specialty doctors, were identified as health needs within this community. For undocumented individuals, healthcare resources are especially limited, and this can affect

service usage among family members. In addition, COVID-19 was identified as a strain on healthcare capacity itself, and its larger effect on the economy exacerbated ongoing issues of access and cost. Education was offered as one solution to train effective and culturally relevant service providers.

Discussion

The decolonial-inspired analysis conducted in this chapter was motivated by the respondents in the California study who identified the lack of mental health services as a needed resource to address problems in their communities (Jolivétte 2015). Accordingly, there are multiple key findings from this study. First, structural factors influence mental health among Latinx immigrant groups. Although socio-demographic factors such as language, race, and Indigeneity were not associated with anxiety, experiences of discrimination were positively associated with anxiety. Further, increased knowledge of mental health was negatively associated with anxiety. And surprisingly, insurance was positively associated with anxiety. California study participants identified multiple barriers to mental health services, particularly around cost, healthcare capacity, underinsurance, and fears relating to contracting COVID-19. In addition, particular gender-related concerns may apply to women who depend on their partners financially and thereby for healthcare. Third, participants named multiple solutions to overcome these barriers to mental health services, which I thematically categorized around cost, access, and capacity. These include support relating to nutrition, transportation, interpreter services, free or sliding-scale care, and health promotion and outreach.

Within the quantitative findings, the regression results showed a strong significant negative relationship between mental health knowledge and anxiety symptoms. On average,

individuals with higher levels of mental health knowledge showed lower rates of anxiety symptoms. Relatedly, concern over mental health issues was associated with higher rates of anxiety symptoms. The results of regression analysis cannot prove causation; however, these findings emphasize opportunities for positive interventions. Existing knowledge of mental health, gained through sources such as health education campaigns, mental health treatment, or traditional knowledge, can be a resource within families and community health programs that develop positive coping skills. Although mental health education is not a substitute for treatment, it can be a building block for prevention strategies.

Experiences of discrimination were significantly and positively associated with anxiety symptoms in the California sample. Anxiety was higher amongst those individuals who experience multiple forms of discrimination or compounded experiences. While some components of migration may be traumatic in and of themselves, the experience of discrimination leads to undue mental health burden (E. Miller et al. 2007; Perreira & Ornelas 2013; Vogt 2018) and may decrease access to existing services. Other relevant forms of discrimination perpetrated against Latinxs can contribute to depression and exacerbate stress (Bekteshi & Kang 2020; Tran et al. 2010) as well as contributing to physical health symptoms (Cariello et al. 2020). Relative to healthcare, discrimination experienced by community members has a ripple effect in families and communities, compounded by anti-immigrant policy (Lara-Cinisomo et al. 2019; Rhodes et al. 2014; Vargas & Ybarra 2017).

These results further demonstrate a need to attend to structural vulnerability, particularly insurance and documentation status. While insurance may increase opportunities for access to biomedical healthcare, by itself, it is not associated with more favorable outcomes in this case. Having insurance was significantly associated with anxiety symptoms among

California participants, contrary to what might be expected. One explanation is that the cost of insurance and related care may cause anxiety (Iturralde et al. 2019). California recently expanded its state Medicaid program, Medi-Cal, to young adults through age 25 (Young Adult Full Scope Medi-Cal Expansion 2019); however, this sample included a majority of individuals over 26 who would not receive any benefits under this policy change. As such, lack of documentation is a significant contributor to being uninsured and this insurability should be considered when recommending services.

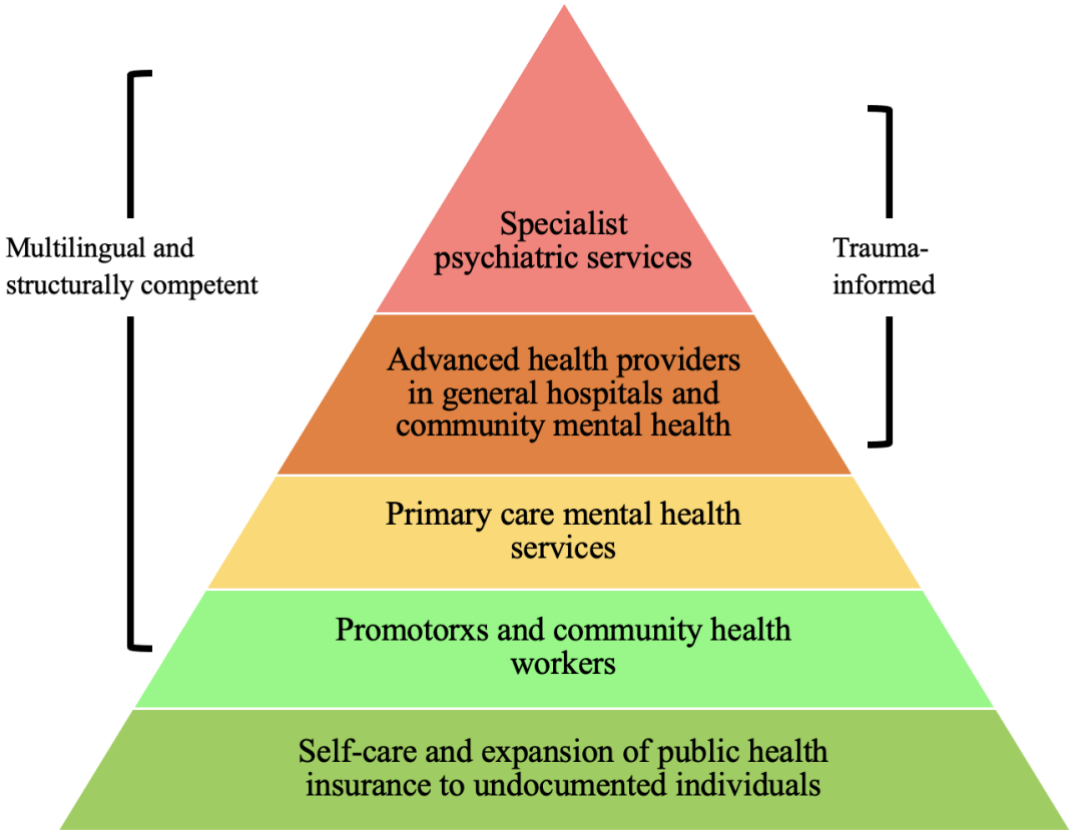
This chapter carries limitations. First, the data do not fully represent the rich complexity and heterogeneity of the Latinx community. This sample was largely composed of women, which limited the ability to examine gendered experiences of men. Although there was a high degree of participation by Indigenous-identifying individuals, I did not have a large enough sample to compare by any meaningful differences related to tribal/national affiliations. This chapter also did not speak to specific concerns of sexual and gender minorities, who face particular challenges with respect to mental health and care (Burgess et al. 2007). Further, the online format of the survey restricted sampling to those with Internet access and availability to respond to an online questionnaire in English or Spanish. Although individuals were allowed to have outside assistance, there was no guarantee of reliable interpretation. Despite these limitations, however, this chapter conveys important findings regarding the variety of contributors to mental distress and impediments to care in a diverse population of Latinxs.

Recommendations

Based on these findings, a number of overlapping factors are relevant to improving mental health care services for Latinx immigrants. Based on existing research and the

findings of this research, discrimination, structural vulnerability, language barriers, identity, culture, access, and cost were all influences on the mental health needs and service usage of this group (Mio & Iwamasa 2013).

Figure 3. Mental Health Services Pyramid for Latinx Immigrant Communities



Note. Adapted from the World Health Organization Optimal Mix of Services Pyramid (WHO 2009)

Utilizing the World Health Organization Optimal Mix of Services Pyramid (World Health Organization 2009), I adapted a comprehensive model for mental health services for Latinx immigrant communities, summarized in Figure 3 above. Fundamental to addressing the mental health needs of the widest group of individuals is to expand public health insurance programs, including to undocumented individuals of all ages. Further, additional funding and resources are needed for community health workers, including to ensure

accessibility and interpretation services are available for individuals seeking care. Addressing these preventative measures can reduce the strain on general and specialty care providers. However, for those who do need more intensive forms of mental health care, it is necessary that providers be structurally competent, meaning that they can assess how environmental and social factors may be influencing the individual health of their patients. Paid interpreters can ensure multilingual services for individuals who may speak any number of Indigenous languages. Lastly, effective advanced health providers and specialty psychiatric services will be multilingual and trauma-informed, in order to identify and address the potentially traumatic events influencing individuals' high mental health burden.

Future Directions

The findings of these studies illuminate multiple directions for future research and implementation. Localized interventions can provide a model for developing effective translation and interpretation services. Researchers should partner with Indigenous language speakers and community leaders to design and implement such interventions. Further, programs for physicians and other healthcare providers to gain structural and cultural competency must be rigorously evaluated and refined. In addition to improved services, policy changes and necessary funding can contribute to greater equity in mental health for Latinx immigrant communities. The next chapter focuses on newspaper data to identify how policy factors drive disparities in health behaviors and health outcomes.

IV. Immigration Policy is Health Policy: News Media Effects on Health Disparities for Latinx Immigrant and Indigenous Groups

Latinx immigrant and Indigenous communities face a number of health disparities, including major barriers to accessing care. These disparities are driven by legal exclusions, as well as cultural factors that reproduce barriers between citizens and immigrants. This study utilized a mixed-methods examination of news media to demonstrate the linkages between policy discourse and health behaviors. Both newspaper articles themselves and interviews with affected stakeholders show how immigrants and their families are negatively impacted by policies themselves, and the threat of future changes to inclusion. The findings of this study emphasize that structural factors maintain exclusions for immigrant groups, regardless of political regime. Enforcement strategies may take on distinct forms, but the net effects on health are sustained by media discourses that promote fear and threat. Immigration policy is health policy, and these laws should be evaluated in terms of their impact on public health, in addition to other factors. Further, the news media must adopt a systematic effort to remove biased language and perspectives from content on immigrant and Indigenous communities.

Introduction

News articles play an important role in shaping how people view Latinx immigrant and Indigenous groups (Díaz McConnell 2019; López-Sanders and Brown 2019). The choices journalists make shapes public awareness of health experiences, as well as changes in immigration and health policies. This chapter reports on an in-depth analysis of the research question: How do messages of fear and threat in news on immigration policy impact the health behaviors of Latinx immigrant and Indigenous communities?

Health Disparities for Latinx Immigrant and Indigenous Groups

The immigrant population, particularly undocumented immigrants, has consistently been affected negatively by social determinants of health such as poverty, food and housing insecurity, lack of educational attainment, and barriers to health care access. Many immigrants from Latin American carry with them Indigenous traditions and affiliations on top of national and ethnic identities (Blackwell et al. 2017). In addition, they face stigma and marginalization, difficulties with acculturation, and constant fear of deportation. Given these challenges that immigrants and their children face, physicians and public health professionals have a responsibility of analyzing these social determinants of health and providing comprehensive care for this population (Chang 2019). Mental and physical health can be impacted by factors such as discrimination and fear. For example, mental health outcomes among Latinx students with immigrant parents have been found to be poorer among those who experience discrimination based on their ethnic identity at school (Lopez et al. 2016). Undocumented immigrants experiencing physical illness may delay seeking medical attention due to fear of being reported to immigration authorities by medical providers (Asch, Leake, and Gelberg 1994).

Financial and linguistic barriers to accessing care are two stark examples of barriers facing immigrants when seeking medical care. Undocumented immigrants make up a large sector of uninsured people living in the United States. Not having access to affordable insurance options makes medical care frequently financially infeasible for these populations. When individual immigrants are unable to receive treatment, public health is negatively impacted, and emergency department and community clinic resources are overburdened (McConville et al. 2015). Immigrants also struggle to find providers who practice in an Indigenous language, forcing many immigrants to receive their medical information filtered

through English (Gurrola and Ayón 2018). Behavioral factors also play a role in immigrants' ability to receive healthcare, including factors like seeking preventative care, ability to follow-through on medical advice given at appointments, and feeling unwelcome in medical settings. Undocumented immigrants experience fears of being reported to government agencies, being exposed to a hostile environment while seeking care, and lack of financial support makes preventative visits and follow-ups less likely (Hatzenbuehler et al. 2017). The combination of these barriers produce health disparities and have a marked impact on mental and physical health among Latinx immigrants.

News Media and its Impact on Latinx Communities

Latinx communities are more likely to be portrayed through negative stereotypes in the news media as lazy, or a threat and a burden to society (Chuang and Roemer 2015). Media coverage has an influence on how Latinx individuals see themselves, and the media's specific choice of words can shape how people view and evaluate policies (Farris and Mohamed 2018). For instance, more than 54% of images accompanying news stories studied that depicted immigrants portrayed them as unauthorized to be in the United States, but in reality less than 25% of the nation's foreign-born population is unauthorized (Farris and Mohamed 2018). The text and images used in the media often characterize immigrants in a negative tone that is not representative of actual immigrant demographics. Given how important these stories are in shaping the public attitudes toward immigration policies and immigrants themselves, these representations can lead to negative outcomes.

Media has an impact on the public's perception of social life, and constant bombardment with stories related to violence or threat in the media can lead people to perceive social life as more dangerous. Media frequently overestimates the severity and frequency of violence

and threat, leading people to believe that the risk of personally coming face to face with these threats is more common than it actually is. Framing is a concept that can be applied to media, where media curates the parameters of discussion, deciding what to discuss, how it will be discussed, and how it will not be discussed (Altheide 1997). The concept of Latino Threat relates to a post 9/11-era of fear surrounding immigrants, specifically rhetoric describing Latinx immigrants as being unwilling or incapable of assimilation into mainstream Anglo-Protestant U.S. culture, and that Latinx immigrants aim to "re-conquer" the southwest of the United States, thereby creating the narrative that Latinx immigrants are a threat to national security (Chavez 2013). The creation of a new citizenship category in the 1920s—"illegal alien"—reframed immigration from Mexico as undesirable and threatening to strong American values of law and order. These frames have not only persisted but have been applied, at least in popular discourse, to all Latinx immigrants as well as their U.S.-born children (Reny and Manzano 2016).

Media are produced in an institutional context and layered with meanings, including through the process of editing, presentation in news media, and anticipation of the audience. When immigration is discussed in the media, it is important to note that immigration or immigrants themselves are not being displayed, but rather messages are filtered through the lens of the media outlet, as well as the audience (Hall 2006). A given piece of media's portrayal of immigrants sets limits on the takeaways that audiences will walk away with regarding immigrants. A prominent example would be the transition from using the term "illegal immigrant" to "undocumented," which resulted from advocacy and was also endorsed by many newspapers and eventually the *Associated Press*, thus becoming the institutional standard for newspapers.

Materials and Methods

Data Sources

For this study, the I collected a sample of news data (n = 148) through the course of ethnographic fieldwork on California's Central Coast between 2018 and 2020. Articles were identified through conversations with key informants, regularly reading the news, and downloading articles shared by advocacy organizations on social media. For analysis, news items were included if they covered health disparities affecting Latinx and immigrant communities, immigration policy issues, or immigration enforcement strategies (e.g., family separation, deportation, detention). The range of news sources collected through this approach is useful because it includes national and local sources, mirroring the ways that community members access information about these policies and issues.

To evaluate the themes and trends present in the ethnographic news data, a systematic sample of California Central Coast news articles was collected (n = 4,768). Ten local newspapers from Salinas, Monterey, Morro Bay, San Luis Obispo, Santa Barbara, and Ventura were searched for relevant articles between January 1, 2006 to April 30, 2020. These local sources provide a distinct perspective beyond national news. For each news outlet, two distinct searches were collected. The first search included articles that mentions "immigrant," "immigrants," or "immigration," along with one of the terms, "health," "public health," "illness," "sick," or "sickness." The second search included articles that mention "Border Patrol," "Customs and Border Protection," "Immigration and Customs Enforcement," or "Deportation." Comparing the content from these two searches over time shows how structural factors of immigration policy influence health behaviors.

As part of the larger ethnographic project of this study, individuals were recruited for interviews from two groups: immigrant community members (i.e., “Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen”), or as advocates (i.e., “individuals that actively participate in social change efforts toward advancing immigrant health equity”). Both groups were asked about themselves, their perception of health needs in the community, experiences with language diversity, and how they see the political climate and its effect on community health. The conversations for the community member interviews emphasized their understanding of health needs and assets, as well as the social context.

Analysis

The ethnographic sample of news data was coded using a combination of deductive and grounded theory coding in Dedoose. A coding framework was developed based on the stated research questions, focused on thematic topics of advocacy, health, and policy. A team of six research assistants were involved in coding the data. Everyone was provided an in-depth introduction to the codebook, as well as coding procedures. Line-by-line coding was conducted by multiple team members, with grounded theory coding used to add codes and themes that were not present in the original codebook. Any conflicting codes between team members were discussed as a group until consensus was reached. These efforts help to ensure the validity and reliability of the final codebook. Beyond thematic analysis, co-occurrences of codes within excerpts and within documents was used to identify meaningful patterns and trends.

Analyses of the systematic sample were conducted using RStudio (version 1.3.1093) for R (version 4.0.3). Topic modeling was conducted using the packages, “seededlda” and

"quanteda," for R. News articles were first converted to plain text and meta-data were extracted for each document: title, author, publication date, publication venue, and search source. Topic modeling is a machine-learning procedure that groups words across a set of documents into "topics." These topics are ranked lists of keywords that estimate an underlying concept within a process of meaning-making. In addition to estimating the topics themselves, the results of LDA (Latent Dirichlet Allocation) topic modeling provides quantitative estimates for the distribution of these topics across documents (Blei 2012). Seeded topic models were used to incorporate prior knowledge into the estimation of topics in this dataset of news articles (Ferner et al. 2020; Li et al. 2018). Codes generated from the ethnographic sample were used to start an initial dictionary of topics. Titles were based on the codes themselves, and keywords were identified from relevant excerpts. In addition, a topic for "threat" included the terms identified by previous research on Latino Threat Narrative in the news (Díaz McConnell 2019).

The use of seeded topic models allows for the introduction of these subtleties of language into the estimated results, as compared to simply relying on how close the words are to each other. Titles and initial keywords are assigned to each topic before the procedure estimates the presence of topics based on the text in the documents. To ensure alignment between the seed dictionary and the language used within the corpus of documents, unsupervised topic models were run and examined for 10, 20, 25, and 30 topics. The top-ranked terms in these topics were used to inform and refine the dictionary utilized for the structured topic model.

The top-15 keywords for each topic in the final model are included in Table 6. A total of 16 topics were utilized, with three topics included to control for extraneous content: places, television schedules, and "other." Bold terms were part of the seed list for each topic. When

seed words were not present in the top-15 keywords, they are included in the next column. Topics were analyzed relationally by using network models. Connections between concepts are estimated by examining the presence of topics occurring above the median score in each document. For these models, the control topics (places, television schedules, and other) were removed. The co-occurrence of topics is examined for those occurring above the median for the full network (Espinoza-Kulick 2020). The relationships between these topics are interpreted by using centrality scores and in the context of the overall qualitative analysis strategy.

Interview data were coded separately from this analysis for general themes and content. A focused coding strategy was used to identify relevant responses about how community members discussed the news and its relationship to health. Interviews and codes were both reviewed to identify any places in which participants talked about the news, whether it was in response to questions about policy and advocacy or came up in other domains. This focused set of codes was extracted to address the research question of this chapter.

Results

Health Environments and Health Behaviors

Thematic analyses of the ethnographic news data show how immigration policy influences health through the creation of negative health environments and by producing the social context that supports a pattern of negative health behaviors. Immigration policy functions as a social determinant of health by creating boundaries to accessing community resources and directly producing bodily harm.

The practice of separating children from their parents and detaining them in inhumane conditions shows the myriad ways that immigration policy directly produces a negative

health environment. This is just one policy that reflected a larger logic of constructing illegality through ICE procedures, planned raids, naturalization policies, and the public charge rule. Child detention directly enacts trauma through the deprivation of social contact, physical safety, food, and adequate shelter. The health impacts of this are immediate and result in fatalities, illness, and negative conditions, as well as enduring effects. The effects of childhood trauma can carry well into adulthood and even influence future generations' quality of life. While children are subjected to these conditions, they are systematically excluded from any opportunity at fair representation in systems of justice. Children who are placed into these negative health environments are treated as if they were making the choice for themselves, despite their dependence on adult caretakers. Similarly, while immigration policy treats individuals as if they were acting out of personal desire, they are responding to social, economic, and political forces that encourage migration.

The negative aspects of child detention are not aberrations of a functioning system. They grow out of a long-standing structure of state-sanctioned xenophobic violence. For instance, one article reported that, "An unprecedented 69,550 migrant children [were] held in U.S. government custody over the past year [2019]… And it's happening even though the U.S. government has acknowledged that being held in detention can be traumatic for children, putting them at risk of long-term physical and emotional damage." The apparent cruelty of these policies communicates a clear message to immigrant communities, one that produces a culture of fear. Those communities that are targeted for xenophobic violence adapt to this reality by revoking their trust in government services and anticipating violence from authorities. This burden of cognitive dissonance - being put in a position and then being punished for being there - deteriorates both mental and physical health.

The aggressive and violent position of anti-immigrant policies contradicts the organizational and professional commitments of local health workers and social service providers. The expansion of immigration raids to include all kinds of settings, including homes, workplaces, and hospitals, demonstrates a way that a sense of fear produces negative health environments. One sampled article reported on Lis-Marie Alvarado, who shared that, "the threat of ICE raids in hospitals is real, but we are urging the community to take measures to prevent the coronavirus and to go seek medical attention at our community clinics and public hospitals if they have any symptoms." While public health leaders are attempting to protect the global population from a deadly pandemic, these efforts are directly undermined by inhumane policies that create a threat when attempting to access healthcare.

Vignette. News and Policy Impact on Health Care Access

"What we've noticed actually is a drop in the amount of clients that come to our office [when ICE is in the news]. Normally, our waiting room is pretty packed and there aren't any seats available and lately, people haven't been coming into our office. Also, like I mentioned earlier, we have those community women's classes, and normally there's a high turnout, it's like 50 people, but now only like maybe 10 or 20 will come. That has been because of ICE and all these talks of raids, but it's also been because of the public charge discussion that's been going on. I think people are just really scared."
—Advocate Interview

The effects of immigration policy on health during this time period are severe. Like a range of policies that affect the social determinants of health, immigration policy has an impact on the quality and length of people's lives. Beyond this, immigration policies influence a broad set of health behaviors. The complex linkages between policy and behavior become clear when viewing the Trump-era policy deliberation over the public charge rule. In addition to the rule itself, which limits access to certain public services for new immigrants, the talk about changes in the policy worked to increase the spread of fear and misinformation among immigrant communities.

Table 6. Topic Summary

Topic	Top-15 Keywords	Other seed words	Centrality
enforcement	**deported, detention, deportations, deport, deporting, unaccompanied minors,** fullscreen, asylum, central, process, human, cases, el, facility, migrants	raid, family separation	0.245
illegality	**criminal, jail, policies, crime, crimes, prison, arrest, criminals, sheriff, convicted, guilty, convictions, arrested,** authorities, officers	illegal	0.534
agencies	**ice, border patrol,** agents, mexican, guard, wall, homeland, coast, boat, north, arizona, miles, noozhawk, smuggling, agent	customs and border patrol, immigration and customs enforcement, ins	0.224
health	**insurance, hospital, sick, doctor, clinic,** medical, information, census, access, coverage, covered, population, provide, patients, report	illness, nurse	0.234
politics	**democrats, vote, campaign,** election, **voters, democratic, candidates, gop, candidate, elected, conservative, voted, democrat, votes, voting**	republican, liberal, progressive, moderate	0.648
policy	**rights, legislation, daca, amnesty, visa, dreamers, executive order,** senate, reform, plan, citizenship, brown, action, passed, lawmakers	pathway to citizenship, public charge	0.571
family	**parents, child, kids, wife, husband, childhood, parent,** students, college, mother, young, father, born, son, university	spouse	0.425
environment	**water, housing, park, beach, shelter, oil, development, environmental, environment, shelters,** district, board, residents, coast, project		0.293
movements	**sanctuary, protest, activists, advocacy, protesters, activist,** council, church, meeting, letter, decision, cities, mayor, attorney, video		0.247
economy	**tax, budget, economy, economic, cost, spending, costs, taxes, spend, taxpayers, irs,** billion, cuts, education, says		0.263

***Table 6*, continued**

labor	**workers, jobs, labor, worked, employees, employers, works, worker, wage, wages, employment, employee, employer,** business, farmworkers		0.269
Military	**war, military, defense, veterans, veteran,** women, de, violence, la, men, gun, press, minutes, former, man	war, air force	0.167
LTN	**foreign, emergency, crisis, threat, shot, surge, caravan,** americans, problem, nation, re, something, article, fact, nothing	flow, swell, tide, wave, flood, iceberg, influx, inundate, pour, stream, tide, burst, explode, skyrocket, rocket, exodus	1.000
television	**tcm, cinemax, pg, encore, showtime, starz, amc, hbo, lifefilm,** cc, sun, sat, fri, thu, mon		--
places	**camarillo, santa barbara, san luis obispo, thousand oaks, simi valley, san diego, ojai, port hueneme, santa maria, paso robles, sb, cal poly,** restaurant, food, dishes		--
other	call, information, event, club, march, visit, free, music, santa, book, road, april, st, art, saturday	--	--

Discussion about changes to the public charge rule serve as a reminder that as immigrants, any aspect of engagement with public life can be used as a weapon against one's security and family. One report indicated how this directly leads to behaviors that are detrimental to health: "The chronically and even fatally ill are avoiding hospitals and rejecting medical care," and these impact a wide range of services and resources, causing eligible families to stop "accepting WIC and … were also turning down reduced-price lunches. Both of those programs are exempted from the public charge rule — using them

will not count against a person's visa or green card application — but those families were too afraid to chance it."

Topics in Immigration Policy News

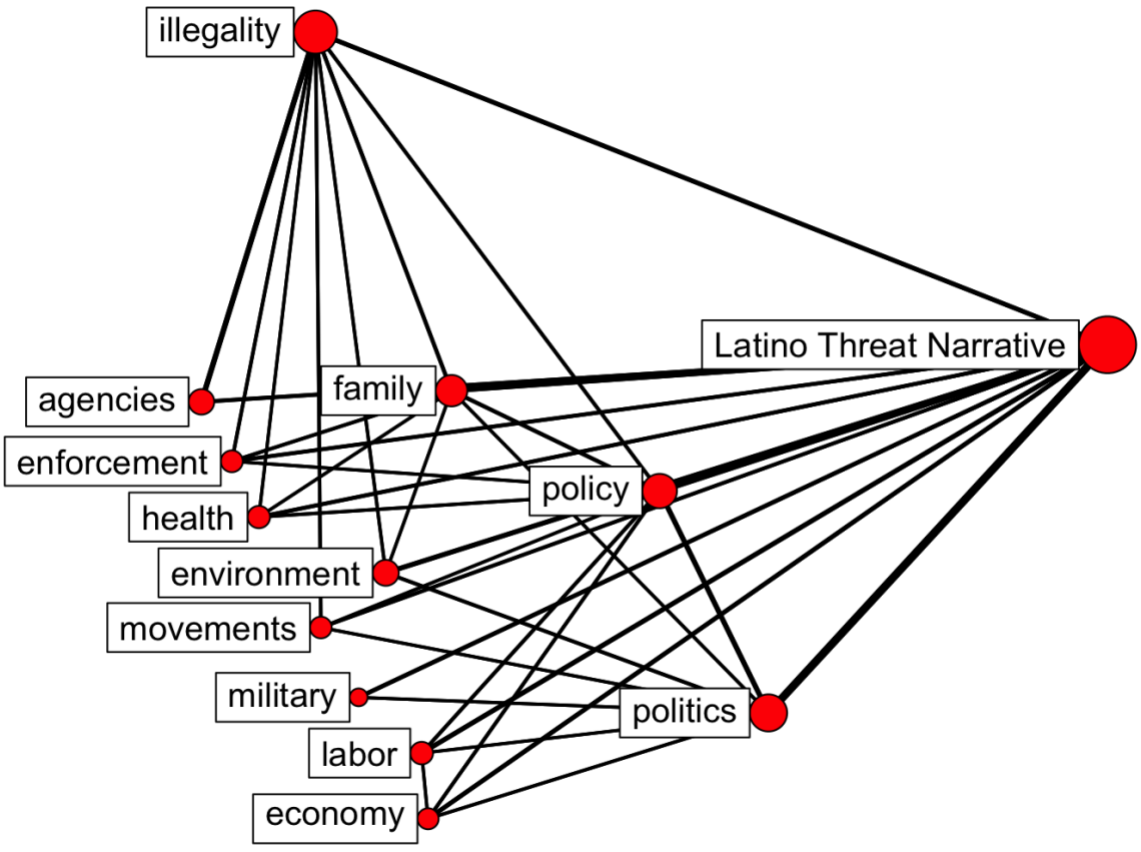
The topics detected in the systematic sample of articles from 2006-2020 are summarized in Table 6. First, these topical findings validate the themes described above. Seeded models using the vocabulary of manually coded documents produced a legible set of topics. The continuity of these findings emphasizes that discourse around immigration policy has proceeded using enduring structures of discourse through both Republican and Democratic administrations. This emphasizes that the humanitarian abuses made visible during the Trump administration are not an anomaly, but a politicized outcome of an exploitative system.

In addition to the presence of topics themselves, network analysis was used to test and visualize the degree to which topics were used in conjunction with one another, beyond average levels of co-occurrence. Non-substantive topics (television agendas, places, and "other") were excluded from network analysis. As seen in Table 6, the topic with the highest centrality score was "Latino Threat Narrative." Discourse that related negative stereotypes about Latinx communities permeated news conversations, in both implicit and explicit ways. Centrality scores are useful because they take into account both the number of connections a topic has with other topics, as well as the degree to which they connect topics that would otherwise be far apart (Espinoza-Kulick 2020).

Latino Threat Narrative bridges the conversation around the topic of "politics" with the topic of "illegality." Politics refers to the legislators and policymakers who make decisions about immigration rules and regulations, while illegality referred to the practices of policing

and criminal charges. This linkage shows that a biased ideology maintains the connection between harsh enforcement strategies that cause negative health behaviors and the political discourse that reproduces this fear. Whereas political discourse was associated with macro-level topics like the military, economy, and labor, the health impacts of immigrant policy were disproportionately discussed relative to localized aspects of enforcement, as well as the context of families and the policy environment.

Figure 4. Network of Topics in Immigration News on the Central Coast from 2006 to 2020



The construction of "illegality," is supported by Latino Threat Narrative, connecting the news coverage of specific agencies and the mentions of health outcomes and health

disparities. The portrayal of individuals as "illegal" enables federal agencies to undermine the health and wellbeing of communities, while policies sustain a culture of fear.

Health Impacts, Resiliency, and Resistance

Conversations with Latinx immigrant and Indigenous community members revealed the ways in which people interpret and make sense of public policy discourse (Hall 2006). Their experiences shed light on to the real impacts of fear in avoiding and delaying healthcare. For instance, one advocate that works directly with this community stated:

> "My clients see it on the news and hear it on the radio, and have had experiences where people are always telling them, 'No, you're wrong. No, you don't know. No, you don't speak the language.' It's like, 'I've been told this in a million different ways in a million different spaces, so it must be true.' … They don't fight back, and they don't utilize the rights that they have."

Newspapers make up just one part of a larger media eco-system, which repeatedly communicates the aspects of exclusion and fear for immigrants when discussing policy. Another advocate and community member echoed how this plays out in her work:

> "We get calls from people that they want to become US citizens but they hear the news, 'Oh, you are a legal permanent resident. You're using public benefits, public charge is going to affect you.' … Public charge is not going to affect you unless you leave the country for 180 days then you come back, that's the thing. That's the fear. They hear something in the news. The way they show the news, they like to scare the people."

While fear and doubt spread, these barriers are countered by resilience in action. Local leaders in the community work to combat misinformation and share their expertise with affected individuals. For instance, another advocate described how her group tries to respond when messages of fear spread after immigration raids. She said,

> "I think everyone is on the lookout for that sort of thing in the news on social media, any update like that, or they come across it and the word gets spread pretty quickly, I would say. … we just get the word out so that people aren't as anxious and afraid as they would be with no knowledge."

These quotations demonstrate how communities decode the messages presented in the news media and create opportunities to work against prevailing health disparities.

Discussion

The findings of this study clearly demonstrate that immigration policy, and especially the way it is covered and described in the news media, has multilayered effects on health outcomes and health behaviors. Immigration policy is health policy, and interventions to address disparities in care for immigrant and Indigenous communities are affected by cultures of fear and mistrust (Farris and Mohamed 2018; Gurrola and Ayón 2018; Hatzenbuehler et al. 2017; McConville et al. 2015). While immigration policy has been politicized with extremely xenophobic rhetoric and action, structural patterns drive exclusion and threaten collective health. For instance, the public charge rule infamously debated and changed under the 45th Presidential administration of the United States, has been in effect in one form or another since 1882 (Alpert 1939). These problems persist through the 21st century, with the Biden administration continuing practices of child detention and deportation, like the Obama administration before him. While rhetoric and strategy may differ, the net effect of immigration policy has been to deter positive health (Chavez 2013; Díaz McConnell 2019).

Recommendations

Persistent health inequities for Latinx immigrant and Indigenous communities require systemic solutions. Immigration and immigrant policies must be considered in terms of their health impacts, especially detention, deportation, raids, and all violent enforcement strategies. Decriminalizing border crossings could also free up capacity in federal courts to focus on serious matters, such as hearing lawful claims for asylum. Public health and

medical experts have demonstrated the collective cost and loss of social capital that arises from unnecessarily punitive immigration enforcement strategies (Chang 2019; Hatzenbuehler et al. 2017; Lopez et al. 2017; McConville et al. 2015). These experts should be involved in shaping immigration policy as a matter of public health. In addition, citizenship status should not be used as a category of exclusion for healthcare services and access. Utilizing resources to provide culturally relevant, multilingual primary care can contribute to lowering overall healthcare costs, especially overburdened emergency care providers.

Beyond policies themselves, this study's findings also show how news discourse plays a role in shaping the links between immigrant and Indigenous communities and health outcomes. The use of biased language about Latinx communities distorts the public's perception of risk and threat when it comes to immigration concerns (Díaz McConnell 2019; López-Sanders and Brown 2019). Organizational policies and practices in the news media can contribute to positive health outcomes by ending the use of Latino Threat Narrative in all coverage of immigrant experiences and immigration policies. Social movement groups have advocated for both policy reform and cultural change to disrupt systemic racism and its impacts on health. In the next chapter, I analyze how Latinx Immigrant and Indigenous health advocates utilized their experience resisting negative stereotypes in their resilience to challenges brought on by the COVID-19 pandemic.

V. Mobilizing Resilience and Solidarity: Immigrant Health Advocates and Movement Pandemic Adaptability

The COVID-19 pandemic has exacerbated longstanding inequities in resources and healthcare. Stacked on top of historical systems of exploitation facing immigrants and communities of color, this puts a particular strain on the social movement organizations that have already been concerned with identifying and mobilizing limited resources. This chapter conceptualizes what I call, "movement pandemic adaptability," drawing from participant-observation (September 2018 – September 2020), interviews (n = 31), and focus groups (n = 12) with community members and health advocates. Data collection began before the COVID-19 pandemic (September 2018 – February 2019) and continued during its emergence and the initial shelter-in-place orders (March 2019 – September 2020). Advocates demonstrated movement pandemic adaptability by drawing from pre-existing networks and solidarities and cultural resources for resilience in the face of a global pandemic. While the state of California is a comparatively receptive political environment for immigrant and health advocacy, the pandemic stressed existing structural issues, while also providing new opportunities for mobilization.

Locally oriented mutual aid and assistance resources have been infused with cultural sensitivity and language access, especially for Indigenous language speakers. Increasing the use of digital communication tools, on top of in-person organizing strategies, expanded the reach for information sharing and outreach initiatives to promote health equity. However, information alone has not dispelled structural inequities. Federal policies exclude and exploit immigrants, while the state of California staggered on Medi-Cal expansion to undocumented elders based on budgetary issues. Localized victories that demand

accountability for our essential workers and underserved communities can provide a blueprint for broader policy interventions and structural change.

Introduction

Social movements advocate for groups that have been excluded from mainstream political processes, which is often the case for immigrant communities. While some naturalized citizens in the U.S. vote and hold political office, all legal residents and undocumented immigrants are excluded from opportunities for representation. Groups that advocate for immigrants, especially immigrant rights, rely on creative direct action strategies to organize for change (Burciaga and Martinez 2017; Mora et al. 2018). Similarly, collective efforts related to health often utilize social movement strategies to target healthcare providers, insurance companies, and other aspects of the medical industry directly (Archibald and Crabtree 2010; Banaszak-Holl, Levitsky, and Zald 2010; Brown et al. 2004; Brown and Fee 2014; Taylor and Leitz 2010; Taylor and Zald 2013). However, there has been little research examining the connections between immigrant health advocacy movements, despite the presence of major inequities in health access and health outcomes within immigrant communities (Barcellos, Goldman, and Smith 2012; Becerra et al. 2020; Cabrera-Nguyen 2015; Garcini et al. 2018). This chapter bridges these two areas of research to analyze how immigrant health advocacy responded to the shifting political, social, and environmental context brought about by the COVID-19 pandemic.

Like other large-scale social and environmental events, the onset of a global pandemic creates a cascade of changes and instability to society (Bloss 2007; Earl 2009; Falicov, Niño, and D'Urso 2020; Golash-Boza 2012; Maira 2016; Rechitsky and Hoekstra 2020). Some of these changes are in direct response to the pandemic. For example, the transmission

of the virus leads to illness and death among large numbers of people, new safety measures, and challenges for the healthcare workforce. In addition, the environment of the emergency response also creates some openings within the broader political environment for groups to amplify efforts for change (Griffin 1992; Hoekstra 2019). For instance, the uptake of video-communication technology has increased calls by disability activists to have accessible multimedia content in our schools, workplaces, and government offices. For industries that cannot be digitized, the pandemic has put a spotlight on "essential" work. Social movements have deployed this framing to develop solidarities and support for the dignity and worth of historically underpaid labor.

As the pandemic increased social strain, it also created new opportunities for movements. Advocates draw on existing networks and communities of support to mobilize effectively during times of renewed opportunity (Taylor 1989). Immigrant health movements are accustomed to operating in limited-resource environment with political hostilities, leading to a range of creative and efficacious strategies (Falicov et al. 2020). The concept of "movement pandemic adaptability" highlights how groups and organizations can lead through and beyond the COVID-19 pandemic with a central focus on equity. This theory emerged from a decolonial-inspired study of Latinx immigrant health advocacy on California's Central Coast (see Chapter 2). In general, movement pandemic adaptability includes building culturally responsive and language accessible resources for community support, understanding opportunities in a changing world, identifying policies that impact communities at multiple levels, and drawing from localized expertise.

Immigrant Health Movements in Perilous Times

Unequal access and discrimination have systematic effects on the wellbeing of communities most at risk for disease. In the U.S. context, there is a long history of excluding immigrant communities from opportunities to sustain good health (Molina 2006). Vocal xenophobic political ideologies and anti-immigrant policies—such as family separation, the widespread use of militarized enforcement raids, deportation, and detention—contribute to a culture of fear and reproduce health disparities (Golash-Boza 2012; Lopez 2019; Prieto 2018). These inequities have widespread effects in immigrant and Latinx communities, including on mental health, families, and chronic disease. While academic researchers have spent considerable resources to document these inequities, scholars must move beyond simply observing racial disparities. Rather, researchers must work toward ending systemic racism and its influence on healthcare systems and practices in concert with community stakeholders (Ford et al. 2019; Ford and Airhihenbuwa 2010; Viruell-Fuentes, Miranda, and Abdulrahim 2012). This chapter contributes to those efforts by demonstrating the interlinkages between immigrant advocacy and health advocacy (Banaszak-Holl et al. 2010; Best 2017; Brown et al. 2004; Burciaga and Martinez 2017; Costanza-Chock 2011, 2014; Enriquez and Saguy 2016; Hoekstra 2019; Mensink 2020; Mora et al. 2018; Prieto 2018; Rusch et al. 2020; Taylor 1995; Taylor and Leitz 2010; Taylor and Van Willigen 1996; Taylor and Zald 2013).

Advocates focused on immigration have used creative strategies to advance policy goals for groups who are formally excluded from political representation and legal rights in the United States. However, federal policy change has been characterized by hostility toward immigrants and inaction on relief efforts and a pathway to citizenship (Baker-Cristales 2009; Costanza-Chock 2011; FitzGerald and Cook-Martín 2014; FitzGerald and Skrentny 2021;

Mora et al. 2018; Wray-Lake et al. 2018). Immigrant justice movements mobilize around a range of issues that include, but are not limited to, legal reforms around immigrant rights (Enriquez and Saguy 2016; Fortuna et al. 2019; Fujiwara 2005; Hing and Johnson 2006; Hoekstra 2019; Hondagneu-Sotelo et al. 2016; Mora et al. 2018; Nicholls 2013; Terriquez 2015; Yukich 2013). This considers the heterogeneity of immigrant communities whose concerns also include dignity, health, economic justice, and connections with mixed-status family members. While activism focused on legal rights reifies the state's control over citizenship, immigrant communities also include Indigenous peoples from Latin America and advocates focused on sovereignty and cultural preservation (Blackwell et al. 2017; Fox and Rivera-Salgado 2004; Jacob 2013; Jolivétte 2016; Manzo et al. 2020; McGuire 2006, 2014; Rodriguez-Lonebear 2016; Smith 2012). The range of concerns present among Latinx immigrant and Indigenous communities leads to movements that combine direct action with community support and policy change at every level (local, state, and federal).

Health social movements are similar in that they can be defined as "informal networks comprised of an array of formal and informal organizations, supporters, networks of cooperation, and media that mobilize specifically in response to issues of healthcare policy and politics, medical research and practice, and medical and scientific belief systems" (Brown et al. 2010:101). While health is sometimes a question of legal policy, it is deeply influenced by other factors like social standing, family relationships, behaviors, and environmental context (Archibald and Crabtree 2010; Best 2013; Brown et al. 2004; Brown and Fee 2014; Hoffman 2003; Keefe, Lane, and Swarts 2006). Accordingly, health movements have launched campaigns around an array of topics like occupational health, racial segregation in healthcare facilities, and gender bias within medicine (Epstein 2016; Taylor 1995; Taylor and Leitz 2010; Taylor and Zald 2013). A key factor that drives the

success of health movement advocacy is when members of underserved groups influence decision-makers in the medical system (Banaszak-Holl et al. 2010; Taylor and Zald 2013). This mobilization can include influencing, recruiting, and even becoming medical experts (Epstein 1996, 2016; Rabeharisoa, Moreira, and Akrich 2014).

When movements target expertise, this is a clear example of multi-institutional politics (Armstrong and Bernstein 2008). This perspective on social movements decenters the state and recognizes multiple sources of social influence, like businesses, health institutions, non-profit agencies, and educational settings. Decolonial movements similarly emphasize that sovereignty itself is a point of contestation (Jacob 2013; Jolivétte 2016; Kukutai and Taylor 2016; Smith 2012). Analyzing resistance outside of the state allows for researchers to identify creative and emergent strategies for creating change. In the case of health, movements form around *politicized collective illness identities* (Brown et al. 2004) that bring together the experience of health itself with the social conditions that produce experiences of illness and wellbeingwellbeing. This can include government policies, as well as insurance, health barriers, social and ecological factors that contribute to poor health outcomes. When illness becomes politicized, these collective identities intersect with and are constructed by categories like race, ethnicity, Indigeneity, immigration status, gender, sexuality, class, and disability (Taylor and Van Willigen 1996; Viruell-Fuentes et al. 2012).

Immigrant health advocacy encompasses multiple forms of health movements, including constituency-based, health access, and embodied health movements (Brown et al. 2004). The *constituencies* affected by immigration policy include mixed-status families (Mendoza 2009; Vargas and Ybarra 2017), as well as Latinx communities that are affected by racialized discourses around immigration (Blackwell et al. 2017; Hoekstra 2019; Telles 2012). Exclusions and discrimination based on immigration status and language contribute

to a broad culture of mistrust toward healthcare providers. These factors drive equity gaps in *health access* and health outcomes (Becot et al. 2020; Berk and Schur 2001; Edward 2014; Joseph 2017; Ku and Matani 2001; Vargas, Sanchez, and Juárez 2017). Immigration becomes an *embodied health* issue through the direct experiences of mental and physical harm as a result of immigration policy. This is especially true in the case of child detention and family separation policies (Linton et al. 2017; Lopez 2019; Rojas-Flores et al. 2017; Wood 2018) and all forms of detention during the COVID-19 pandemic (Lopez et al. 2020). McGuire (2006) describes this in terms of "undocumentedness" as a category of risk for negative health (De Genova 2004). For example, Roberto Gonzales (2015) describes how "for undocumented members of the 1.5 generation, illegality extends far beyond legal boundaries. It reaches into their bodies, minds, and hearts. It saps their energy, consumes their dreams, and crushes their spirits" (206).

Immigrant advocates have long contended with risk in their lives and activism (Lopez 2019; Prieto 2018). Deportation, detention, and other punitive policies makes direct action inherently risky for undocumented individuals and mixed-status families. However, "undocumented and unafraid" young people have also leveraged that risk to effectively gain visibility for policy change (Costanza-Chock 2014; Enriquez and Saguy 2016; Muñoz 2015; Terriquez 2015). These creative responses to high-risk environments have prepared immigrant health advocates to lead equitably during the pandemic by prioritizing those most affected and at risk. This chapter adds to the literature on social movements by showing how the continuity in risk and threat for immigrant communities enabled advocates to effectively adapt to the structural shifts brought on by the pandemic.

Methods and Data

This chapter uses a decolonial-inspired ethnographic framework, based on deconstructing western research methods, privileging Indigenous and place-based knowledge production, and holding research accountable to its utility for underserved groups (Jacob 2013; Jolivétte 2016; Kukutai and Taylor 2016; Rios 2017a; Rodriguez-Lonebear 2016; Smith 2012). To better understand movement processes, data collection focused on participant-observation between September 2018 to September 2020, and interviews with community members and advocates (n = 31) and focus groups with respondents from throughout the Central Coast (n =12). Community advocates played a crucial role in shaping the research questions and informing the study's priorities and commitments. In combination with the broader project, this provides a unique insight into the contexts of Latinx immigrant and Indigenous health advocacy. For more details on the procedures in the larger study, see Chapter 2.

Data Collection

Participant observation included attending collective action and public advocacy along with developing relationships with key informants (Jiménez 2010). Because this project was designed to be responsive to community needs, I continued participant observation in a primarily digital environment (Bonilla and Rosa 2015; Brown et al. 2017). Even prior to the pandemic, I was regularly collecting new media, organizational communications, and online archives of group events or meetings. I utilized aspects of my insider knowledge to gain greater insight into these observations (Rios 2017a). During my time in the field, I informally observed a range of everyday activities, behaviors, and community formations in my family and community. This provided important connections to individuals who do not

occupy formal organizational leadership positions but play a key role in maintaining community relations and mobilizing grassroots actions. My daily investment in these communities has helped me to continuously privilege the need for effective and equitable solutions to healthcare disparities.

Individuals were recruited for interviews if they identified as one or both categories: immigrant community members (i.e., "Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen"), or as advocates (i.e., "individuals that actively participate in social change efforts toward advancing immigrant health equity"). Both groups were asked questions about health needs in the community, language and cultural diversity, and perceptions of the policy environment. Participants were recruited by phone, email, flyers, and social media ads. These efforts focused on groups that provide healthcare and legal aid for immigrant communities, community-based advocacy groups, schools, and community gathering places. Snowball sampling was used to recruit participants from the networks of previous interviewees (Naderifar et al. 2017). This procedure is especially useful for recruiting participants and building trust among groups that have been historically exploited by government agencies.

Focus groups were structured to include knowledge sharing from earlier interviews and the survey of health needs and assets (see Chapter 3). The conversations were structured around major themes in the study: political climate, health needs/assets, and language. Within each section, relevant findings were shared, and then participants had the opportunity to respond, ask questions, and discuss. Open-ended conversations set a tone for sharing knowledge and held the research accountable to the lived experiences of diverse community members (Aronson et al. 2007; Pilar et al. 2014). The discussions allowed their voices to

inform the interpretation of findings and set the priorities for analysis and dissemination of findings (Gonzalez et al. 2020).

To facilitate opportunities for free-flowing discussions in an entirely online environment via video call on Zoom, focus groups were limited to four participants each. Participants were recruited from all counties represented in the study (Monterey, San Luis Obispo, Santa Barbara, Ventura). Half of focus groups were conducted in English and the other half were conducted in Spanish ("cafecitos"). Incentives were provided for each interview and focus group participant ($25) and key informants ($30) in the form of cash or gift card.

Analysis

Data were coded using a grounded theory approach (Charmaz 2006, 2011) with the software, Dedoose (Dedoose Version 8.3.43). From participant observation, data included field notes, audio memos, recorded events, public materials, organizational documents, emails, newsletters, and news media. Codes were developed by closely reading materials and capturing relevant themes in participants' own words. The codebook developed from this stage was used for analysis of interviews and focus groups. In continuing with the grounded theory approach, new codes were added upon comparing the interviews with field work documents (Charmaz 2014). A team of six research assistants were trained in coding techniques and completed line-by-line coding of each transcript. I established inter-rater reliability by meeting to discuss themes and resolve any discrepancies in the assignment of codes or creation of new codes. Themes from this coding processes were then used for focused coding to interrogate social movement dynamics that bring together aspects of immigrant and health advocacy and how they changed during the pandemic.

Results

The COVID-19 pandemic has had a disparate impact on Latinx immigrant and Indigenous communities, a trend that is reflected nationally (Gil et al. 2020; Page and Flores-Miller 2020) and on the Central Coast (Hodgson 2020). Interviewees shared a range of reactions to the pandemic itself, including personal experiences and family loss. They also reflected on acts of collective resilience, which was evident in advocates' quick response to spread information and resources to protect vulnerable community members. During the same time, the threats to Latinx immigrant and Indigenous communities also included the proposed changes to the public charge rule and a systematic exclusion from government relief and aid programs.

To combat this, groups used language accessible and culturally responsive communication to promote heath literacy and share relevant COVID-19 information. Direct support efforts worked to address the legal exclusion of immigrant from federal safety net programs. The practice of mutual aid and collective responsibility enacted during the pandemic builds from traditions of solidarity and kinship within Latinx immigrant and Indigenous communities. Further, advocates went beyond repairing immediate harm to preventing future risk and exploitation. Working at a policy level influences future opportunities for mobilization and can change systems. Throughout these actions, local experts are successful in implementing change when they bridge new information with meaningful cultural frameworks shared by multiple stakeholders.

Multilingual Interpretation for Health Access

Access to multilingual translation and interpretation facilitates inclusion for Spanish speakers and Indigenous language speakers within Latinx communities. On the Central

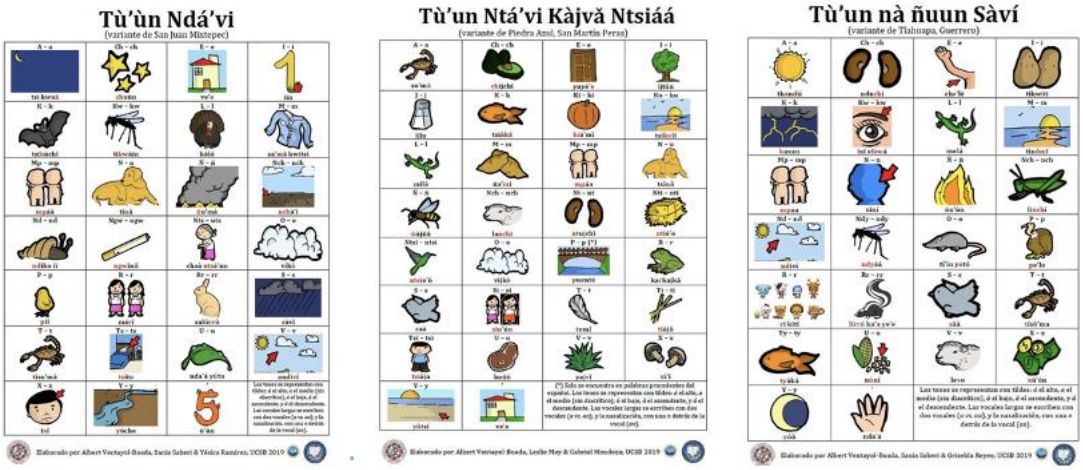
Coast, the Mixteco/Indígena Community Organizing Project (MICOP) centralizes language interpretation in their work and lifts up Indigenous language access within networks of immigrant and health advocates. The group launched *Radio Indígena* in 2014, a local FM station with over 40 hours of weekly live programming, featuring at least seven Mixteco languages, Zapoteco, and Purépecha. This service provides information and entertainment that is relevant to Indigenous farm working communities, such as support for low-income individuals to receive rental assistance, energy payment programs, and family paid leave.

This platform served a crucial role in spreading vital public health information during the COVID-19 pandemic. They quickly expanded to include Facebook Live broadcasts to supplement radio programming and demonstrate visually how testing works and show images of how others have participated in testing. These events are interpreted in at least one Indigenous language, often through consecutive interpretation. In engaging the audience, the speakers use a conversational style. The interpreter does not just repeat the words translated from Spanish, but rather, they have coordinated in advance to share the message in a relevant way for a heterogenous audiences. For further accessibility, the videos include visual aids and photographs to guide individuals through practical steps for how to access transportation and where to arrive for testing. This visual demonstration helps to work against stigma and decrease fear of health services. The group emphasized overall health and wellbeingwellbeing to encourage maximum prevention and safety when information about transmission was limited.

Interpretation services must be culturally responsive to regional diversity. One advocate interviewee elaborated on this, saying “Mixteco, there's not only one variant, there's, 20 to 23 if not more. It is a big barrier, but that's why there’s organizations like 805 UndocuFund or MICOP [Mixteco/Indígena Community Organizing Project], and IMPORTA” (Advocate

Interview). As seen in Figure 5, MICOP created materials for World Languages Day to demonstrate regional differences between dialects from San Juan, Mixtepec, Piedra Azul, San Martín Peras, and Tlahuapa, Guerrero. Herencia Indígena is an organization that specializes in medical interpretation and partners with service providers to increase access to healthcare directly. Sharing complex medical information had increased salience during the pandemic. A *Radio Indígena* broadcast from June 2020 notified the community about a COVID-19 outbreak in H2A housing for farmworkers in Ventura County. The advocates shared information about how to best protect yourself, acknowledging the reality that social distancing is practically impossible in crowded common areas. This broadcast was interpreted in three languages, with speakers in Spanish, Mixteco, and Purépecha.

Figure 5. Regional Variations in Mixteco Dialects Spoken



Creating Direct Support Mechanisms: Immigrants and Mutual Aid

While the virus was a central concern during the pandemic, it joined several longstanding issues affecting the community. In particular, the 45th U.S. Presidential administration sponsored a number hostile, xenophobic policies. This included continuing to deport and detain migrants during a pandemic, increasing construction of a Border Wall,

excluding immigrants from emergency and pandemic aid programs, and seeking to change the public charge rule. These political hostilities advance a culture of threat and fear, but advocates support an alternate vision. As MICOP put it in an informational session on the public charge rule, "¡El conocimiento es la mejor defensa contral el miedo!" ("Knowledge is the best defense against fear.") Their program provided a direct service to immigrants by working to help them understand how certain policies do and don't affect them. Although information sharing is vital, it cannot reverse the exclusions that do exist.

To provide a direct and clear response to these exclusions, advocates organized in networks of solidarity. These were typically organized around region or county, allowing service providers and business to coordinate and share resources with community members. These efforts mirror how state agencies seek to create wrap-around services with multiple points of access to resources. Although, these groups are usually organized on a voluntary basis, or subsidized by personnel from non-profit and community-based organizations. Advocates demonstrated their tenacity and resourcefulness in mobilizing under hostile conditions. One community member shared her perspective when she said, "Nuestra estrategia es más que nada seguir insistiendo, seguir tocando puertas por puertas, seguir insistiendo dándoles la información correcta. Hay muchos recursos de los que ellos se pueden beneficiar… Eso nos hace más fuertes." (Translated: "Our strategy is more than anything to keep insisting, keep knocking door by door, keep insisting, by giving them the correct information. There are many resources for their benefit… This makes us all stronger.")

The 805 UndocuFund is a resource for immigrant communities that has provided substantial benefits in the face of legal exclusions from federal programs. The program was first started in response to the 2017 Thomas Fire as a collaboration between CAUSE

(Central Coast Alliance United for a Sustainable Economy), MICOP, Future Leaders of America (FLA), and Ventura County Community Foundation. The fund raised over $5 million for struggling workers and their families during the COVID-19 pandemic. These were distributed to workers in small grants of $1,000 each, but they were not able to meet the full level of demand within the community. Similar groups distributed community-generated funding to undocumented communities throughout the Central Coast, like the San Luis Obispo County UndocuSupport group. These funds are distributed by community groups with trusting relationships in the communities, who ward against fraud and scams.

Figure 6. Community Fundraising for Undocumented Immigrants

Mobilizing for Farmworker Dignity

Latinx Immigrant and Indigenous advocates are heavily involved in improving working conditions for farm working communities. For example, youth leaders from CAUSE, provided powerful testimony at the Santa Barbara and Ventura County Board of Supervisors in July of 2021. One young person spoke to the experience of her parents who were fired from the farm on the claim that there was no fruit to be harvested. She said:

> We all know that's a lie. It's the right season to grow fruit. It's also the right season to give the farmworkers the help they need. They are expected to work in the sun and feed this nation, how can we turn our back on them when they have been doing so much for us? How many more lives needs to be at risk before you bat an eye at them? How many more mothers are you going to take from us? I urge you to do the right thing and help them by providing masks, gloves, clean water, anything they need. They help feed our families and we should help keep their families safe. What are you going to do? Give them a helping hand, or wait until my mother or her coworkers also get COVID?

Advocates embraced and deployed the framing of farmworkers as "essential workers" to hold policymakers and farm owners accountable. The pandemic brought into sharp relief those aspects of the global economy that society cannot do without, including agriculture. Moreover, it also showed that the government can mobilize resources, funds, and services to communities in need, especially when "crises" are declared.

Policy change for farm workers includes organizational policies by individual farms, especially those that set industry standards for practices, pay rates, and conditions. For example, targets for social movement organizing included County Boards of Supervisors, as well as worker housing sites, employers, and labor contractors. During the pandemic, housing became an important site of direct advocacy to increase health regulations for testing and screening of COVID-19, as well as making opportunities available for quarantine when farm workers tested positive. Through an initiative called Housing for the Harvest, hotel rooms were made available along with services in English, Spanish, and Mixteco (Place 2020). Because immigrants are excluded from most formal relationships with the state, employers also take on a more pronounced role in influencing community members' daily experiences.

During 2020, advocates in Santa Maria organized farm workers to win a raise and improved working conditions. The central victory at Rancho Laguna Farms was a raise to $2.10 per box of strawberries (Padilla 2020a), in addition to increased access to shade for safe, socially distanced breaks, and training for more effective communication by

supervisors. After over a decade with no wage increase, this change was a historic win for organizers. Successful mobilization was a result of multiple strategies, including petitions, a work stoppage, and public demonstrations (Padilla 2020b). This action inspired resistance among the farm owners, who attempted to suppress organizing by contacting law enforcement officers.

CAUSE was able to successfully win a settlement through the California Agricultural Labor Relations Board of $30,000 to 212 farmworkers in Santa Maria as compensation for damages caused by unlawful retaliation. The farm owners were additionally required to provide training on farmworkers' rights to supervisors under the Agricultural Labor Relations Act, including the right to organize. By exercising their collective power, farm workers inspire others to honor the dignity and value created by essential workforces, during and beyond the pandemic.

Figure 7. Successful Farm Worker Organizing

By Genelle Padilla
Published June 23, 2020 12:41 pm

NEWS CHANNEL 3 FOX 11 12

Hundreds of Santa Maria farmworkers receive raise after over a month of organizing

CAUSE

SANTA MARIA, Calif. - After a month of organizing for better pay and work conditions, over 600 farmworkers will receive a raise from Driscoll's Berries' supplier, Rancho Laguna Farms.

The push for higher pay and improved work conditions began in early May, when over 100 Rancho Laguna farmworkers coordinated a work stoppage.

Discussion

Latinx Immigrant and Indigenous Health movements demonstrated adaptability in the pandemic environment by building from existing resources and networks of solidarity. These strategies were culturally responsive and language accessible to provide resources to the community for support. This is characteristic of both health access movements and constituency-based movements (Best 2013; Brown et al. 2004, 2010; Brown and Fee 2014). However, the efficacy of information is limited by structural constraints like housing conditions, racism, and xenophobic policies (FitzGerald and Cook-Martín 2014; FitzGerald and Skrentny 2021; Vargas et al. 2017). Advocacy and direct action disrupted patterns of exploitation and mobilized supportive decision-makers at the local and state levels (Costanza-Chock 2014; Enriquez and Saguy 2016; Keefe et al. 2006; Mensink 2020; Nicholls 2013; Terriquez 2015). The state of California polarized against the federal government's outright hostilities toward immigrants, creating political openings for policy change. For instance, advocates won Medi-Cal expansion to include income-eligible minors and young adults, up to age 26.

Immigrant health movements depended on grassroots mobilization to build trusting relationships between community leaders and those most in need. Due to historic systems of exploitation, Latinx communities mistrust government agencies and mainstream healthcare providers. The shared experience of structural exclusion shapes an embodied experience of health risk (De Genova 2004), so that being an "essential worker" becomes politicized as a condition of health risk. This demonstrates how health social movements mobilize collective identities beyond illness itself (Brown et al. 2004; Viruell-Fuentes et al. 2012). This mobilization was effective because of the expertise of community leaders who advocate for systems change at every level.

Recommendations

Legislative change, organizational policy, and local actions can further close health equity gaps present among Latinx Immigrant and Indigenous communities. These recommendations build from the movement pandemic adaptability of local organizers and state-level advocates. In California, state legislation can lead the way for national change that is more inclusive and equitable for Latinx Immigrant and Indigenous communities. Senate Bill (SB) 56, introduced by Senator Durazo, would heed the calls of the #Health4All movement by expanding Medi-Cal to include income-eligible undocumented elders (age 65 and up). In addition, state legislators can further expand Medi-Cal to include undocumented adults of all ages, as proposed by Assemblymember Arambula in Assembly Bill (AB) 4. The currently proposed AB-1400, introduced by Assemblymembers Kalra, Lee, and Santiago, would go even further by expanding health coverage to all Californians through a single-payer system. However, health insurance only addresses part of the issue.

The Central Coast needs increased healthcare capacity and resources, especially culturally relevant care for underserved communities. At the state level, SB-40, introduced by Senator Hurtado, would establish a California Medicine Scholars program to increase pipelines between local community colleges and medical training. This would encourage physicians to return to their communities and increase healthcare opportunities. Similarly, Assemblymember Rodriguez introduced AB-240 to evaluate and address gaps in the local health department workforce. This assessment should be guided by an equity framework, and in many cases, enough information already exists to inform necessary interventions. For example, the exploitation and vulnerability of farmworkers is clear, especially from the results of this study. Assemblymember Bennett has introduced AB-941 to fund Farmworker Resource Centers that would partner with community-based organizations to provide

multilingual support ranging from education and healthcare to housing and farm worker's rights. AB-1007, introduced by Assemblymember Carrillo, would provide reparations to the survivors of eugenicist forced sterilization campaigns carried out in California, including against prisoners and immigrant detainees. These legislative proposals would provide a measure of justice for a foundation of trust and equity in public health systems.

City, County, State, and Federal governments can declare racism a public health crisis, and take action accordingly. Taking aggressive action against racism means immediately ending practices that reproduce health disparities. For instance, policymakers can disallow County Sheriffs and City Police from coordination with federal immigration agencies like Immigration and Customs Enforcement. Appropriate action also includes providing funding, resources, and capacity support for anti-racist organizations. Local groups can contribute to equity and access by regularly hiring multilingual interpreters. In a medical context, this is necessary to ensure access for individuals to receive care. In all contexts, translation and interpretation needs to be responsive to local audiences, including Indigenous language speakers.

VI. Conclusion

This study has uncovered key insights into the health of Latinx immigrant and Indigenous communities on the Central Coast and documents the strategies of effective advocates. As a decolonial-inspired study, it is grounded in the impacts of persistent health equity gaps and made concrete contributions to communities throughout the process of research (Doxtater 2004; Jacob 2013; Jolivétte 2016; Manzo et al. 2020; Rodriguez-Lonebear 2016; Smith 2012). Community members and advocates also shaped the priorities of data analysis, including a focus on mental health, language barriers and access, and the changing socio-political environment. During this study on health, the emergence of a global pandemic raised the stakes of these disparities and mobilized community members, leaders, and researchers to prioritize health access among the most vulnerable communities (Becot et al. 2020; Czeisler et al. 2020; Falicov et al. 2020; Garcia et al. 2020; Gil et al. 2020; Hodgson 2020; Lopez et al. 2020; Page et al. 2020).

Researchers have identified healthcare disparities for Latinx, immigrant, and Indigenous communities in general environments, but the local context complicates these trends and can lead to heterogenous health outcomes (Bourgois et al. 2017; Chang 2019; Lisotto 2017; Mendoza 2009). This study demonstrated the complex health needs and assets that exist within the Central Coast (Jiménez 2010). For instance, survey findings highlighted that the high levels of mental health burden co-existed with high degrees of resilience. Further, barriers to healthcare access affected the entire region, but the layering of barriers led to healthcare avoidance disparities. Structural factors like immigration policy and language barriers produce unique vulnerabilities (Garcia et al. 2020; Martinez et al. 2015; Vargas and Ybarra 2017; Villalobos et al. 2016). Specific legal barriers have cumulative effects that result in a culture of fear, which affects mixed-status families and entire communities

(Andrews et al. 2020; Asch et al. 1994; Berk and Schur 2001; Vargas et al. 2017). The news media helps to maintain these links, including through implicit deployments of Latino Threat Narrative (Chavez 2013; Prieto 2018). However, advocates resist racism and settler-colonialism in health by mobilizing community members, healthcare providers, and local agencies (Ford et al. 2010; Jacob 2013; Viruell-Fuentes et al. 2012). These strategies can build toward long-term change by informing new laws, organizational policy change, and direct interventions.

Contributions

While decolonial-inspired methods prioritize the impacts that research can have for the community, this study also makes multiple contributions to academic scholarship. The articulation of this framework provides a blueprint for ethical research conduct with diverse communities that include Indigenous populations. Alongside decolonial and Indigenous methods, the practices of reflexivity, collaboration, sharing, community advice, and assessment can transform research to be more inclusive, equitable, and accurate. The framework can utilize multiple methods and mixed-methods tools, so it is relevant for researchers in sociology and public health, nursing, medicine, ethnic studies, education, and other related disciplines.

The substantive findings of this work also make contributions to medical sociology, immigration studies, and social movement scholarship. Researchers have identified health disparities using clinical data, census data, and large-scale surveys. However, these methods all tend to exclude the most vulnerable individuals, like those in rural communities, people without reliable access to the Internet, and those excluded due to language barriers. The findings of this study provide a unique view into the experiences of historically underserved populations, including both health needs and assets.

Further, scholars of immigration have often identified the limitations of state-centered and legal approaches to understanding community formations. These systems contain inherent biases and construct migrants in subordinate positions. However, my analysis of news data supports the link between immigration policy and health behaviors. This shifts the framing of immigration from questions of worthiness to questions of dignity.

Finally, immigrant health movements demonstrated the efficacy of working at this intersection through their successful advocacy and what I call "movement pandemic adaptability." These groups identified the contradictions between workers treated as essential while also being consistently undervalued and mistreated. Exposing these contradictions leads to successful advocacy when targeted toward a receptive audience. In the context of a hostile policy climate, advocates made their opportunities by raising awareness, winning public support, and securing representation in elected office and organizational leadership positions.

Limitations

This study carries with it some limitations that can help to identify areas of future research and action. The survey sample over-represented women, which is helpful to represent experiences that researchers have historically neglected. However, some health issues relevant to men's experiences should be the focus of future health needs assessments. Similarly, lesbian, gay, bisexual, and queer respondents were underrepresented in the survey sample. The survey data was supplemented by other strategies, like participant observation, interviews, and content analysis, which used strategies to ensure equitable representations.

Another limitation was the inclusion of Indigenous language speakers in some aspects of data collection. Specifically, the surveys, interviews, and focus groups were conducted in English and Spanish. Survey respondents were given the option of providing their own

interpretation services, but these steps alone are not enough to ensure equitable representation. Participant observation was more effective for including Indigenous language speakers because of the public events hosted by advocacy groups. However, in future research on the Central Coast and similar communities characterized by language diversity, funding for interpreter services should be prioritized alongside incentives. Within this study, community partnerships that developed over time were also a key asset for ensuring dissemination of findings to affected communities, including Indigenous language speakers.

Finally, the study prioritized adult experiences, as minors could not participate in the survey, interviews, or focus groups. While recruitment strategies included young adults and college-age students, children and youth were only included through secondary sources like news articles. During the time of this study, age was an important issue at a policy level. At the federal level, family separation and child detention policies targeted children and stirred considerable public criticism. At the state level, in California, Medi-Cal expansion was stratified by age, with children and young adults gaining access but not elders or adults over age 26. The perspectives of young people are essential for understanding how these changes are affecting community relationships with healthcare systems and persistent barriers to Medi-Cal uptake among undocumented and immigrant youth.

Future Directions

Following the logic of a decolonial-inspired method, community partnerships, knowledge sharing, and interventions based on findings have already begun. The future directions of this study will be to continue these efforts and establish new initiatives to more deeply explore the inequities and advocacy strategies documented in this dissertation. Community members are already using this information to have conversations with family

and friends about health in their lives. These findings have been shared through reports, workshops, presentations, and a community talk.

A second audience for this research is the community leaders and agencies who advocate and share resources in addition to these affected individuals. Maintaining meaningful relationships with these groups extends beyond sharing knowledge to include taking action. To accomplish this goal, I have taken on a leadership role organizing for Mi Gente, Nuestra Salud, a movement for people's health ownership in Santa Maria, and a regional coalition of health Equity assessment projects throughout the central coast. I have also used these skills for collecting data with underserved populations to launch additional survey projects on mental health needs among Spanish-speaking adults, mental health needs among transitional-age youth, alcohol and other drug perceptions among youth, and needs and assets of BIPOC youth throughout the central coast.

Finally, this work clearly shows patterns that require policy interventions to address racism as a public health crisis at every level. At a local level, governments can invest in language accessibility in health and other services. For immigration policy, cities and counties can discontinue coordination between sheriffs and police with immigration authorities. Schools can also make clear policies that prevent immigration authorities from entering school grounds for enforcement actions or recruitment efforts. At the state level, California can lead on both healthcare policies and immigrant inclusion. Some of the most relevant efforts currently include expanding Medical to undocumented communities, establishing universal healthcare in California, funding public health infrastructure, and expanding opportunities for healthcare workforce development, especially among Latinx immigrant and Indigenous communities. Finally, at the federal level, advocates are presently focused on recovering from the damage done by the Trump administration, along with

centuries of xenophobia, racism, and settler colonialism. This healing will take the effort of many generations. Justice for immigrant communities is a necessary condition for public health and continually expanding opportunities for communities to thrive.

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Appendix


SEEKING PARTICIPANTS FOR AN IMMIGRANT HEALTH NEEDS & ASSETS SURVEY
THE SURVEY SHOULD TAKE ABOUT 15 TO 30 MINUTES TO COMPLETE AND THE RESULTS OF THIS STUDY MAY POTENTIALLY BE USEFUL TO YOUR COMMUNITY AND INFORM BROADER EFFORTS FOR IMMIGRANT HEALTH ADVOCACY.
MUST BE 18YRS+ TO PARTICIPATE
AND
IDENTIFY AS AN IMMIGRANT COMMUNITY MEMBER
OR
IDENTIFY AS AN ADVOCATE FOR IMMIGRANT HEALTH
ALL PARTICIPANTS WILL BE ENTERED TO WIN 1 OF 2 $100 GIFT CARDS OR CASH PRIZES
SCAN THE QR CODE BELOW TO START! OR VISIT:
TINYURL.COM/IMMIGRANT-HEALTH-SURVEY
CONTACT MARIO ESPINOZA-KULICK AT MVESPINOZA@UCSB.EDU OR 805-904-9225
APPROVED BY THE UCSB HUMAN SUBJECTS COMMITTEE FOR USE THRU 9/3/2020
PROTOCOL NUMBER: 22-19-0595


SE BUSCA PARTICIPANTES PARA UNA ENCUESTA SOBRE LAS NECESIDADES DE SALUD PARA LOS INMIGRANTES
LA ENCUESTA ANÓNIMA DURA ENTRE 15 Y 30 MINUTOS Y LOS RESULTADOS DE ESTE ESTUDIO PUEDEN SER POTENCIALMENTE ÚTILES PARA SU COMUNIDAD Y PARA INFORMAR ESFUERZOS PARA LA DEFENSA DE LA SALUD DE LOS INMIGRANTES.
DEBE TENER 18 AÑOS+ PARA PARTICIPAR Y
IDENTIFICARSE COMO MIEMBRO DE LA COMUNIDAD INMIGRANTE
O
COMO DEFENSOR DE LA SALUD DE LOS INMIGRANTES
TODOS LOS PARTICIPANTES INGRESARÁN PARA GANAR 1 DE 2 PREMIOS DE $ 100 EN EFECTIVO O TARJETA DE REGALO.
¡ESCANEA EL CÓDIGO QR A CONTINUACIÓN PARA COMENZAR! O VISITAR:
TINYURL.COM/IMMIGRANT-HEALTH-SURVEY
CONTÁCTAME, MARIO ESPINOZA-KULICK
MVESPINOZA@UCSB.EDU O 805-904-9225
APPROVED BY THE UCSB HUMAN SUBJECTS COMMITTEE FOR USE THRU 9/3/2020
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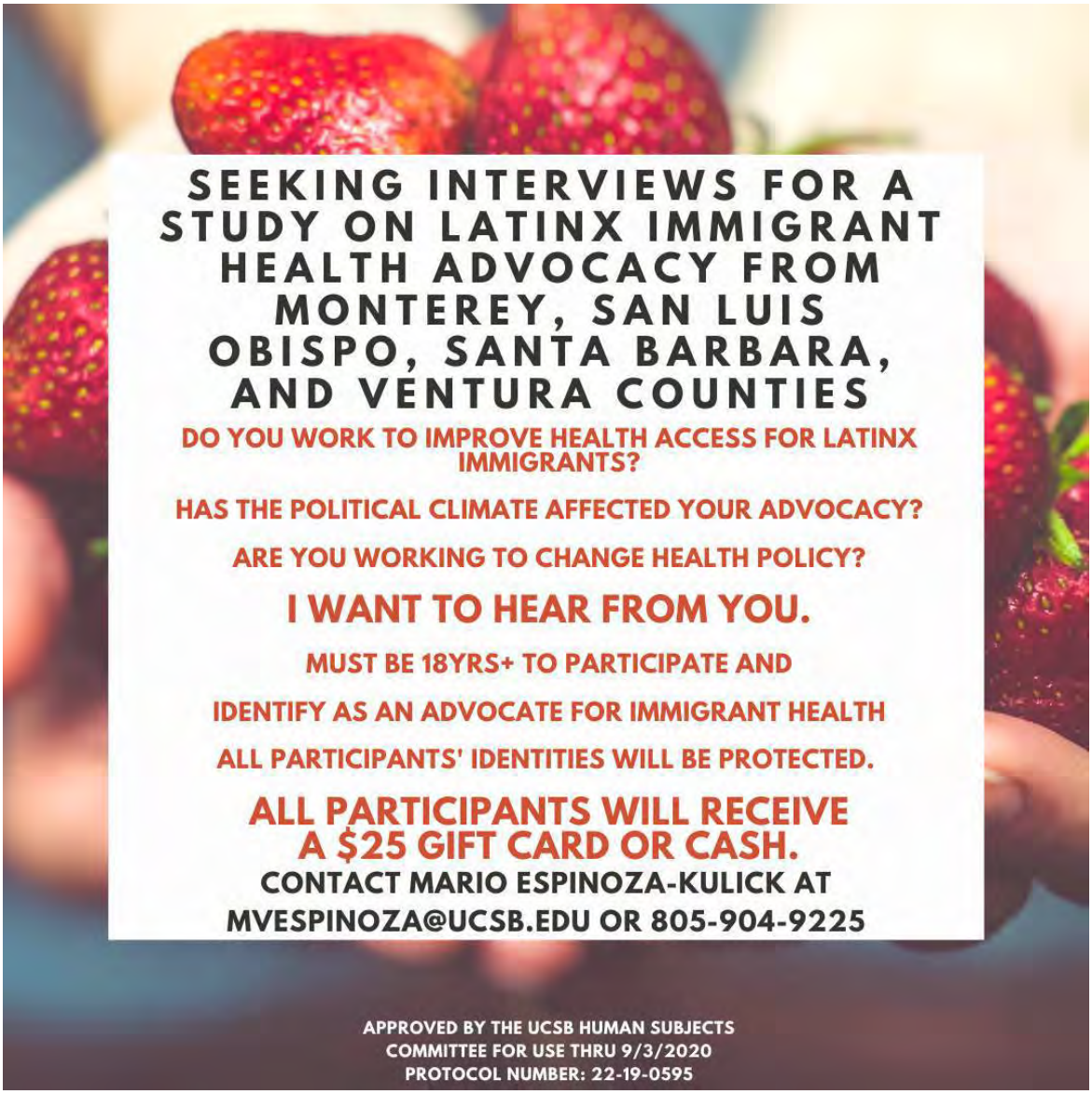

SEEKING INTERVIEWS FOR A STUDY ON LATINX IMMIGRANT HEALTH ADVOCACY FROM MONTEREY, SAN LUIS OBISPO, SANTA BARBARA, AND VENTURA COUNTIES
DO YOU WORK TO IMPROVE HEALTH ACCESS FOR LATINX IMMIGRANTS?
HAS THE POLITICAL CLIMATE AFFECTED YOUR ADVOCACY?
ARE YOU WORKING TO CHANGE HEALTH POLICY?
I WANT TO HEAR FROM YOU.
MUST BE 18YRS+ TO PARTICIPATE AND
IDENTIFY AS AN ADVOCATE FOR IMMIGRANT HEALTH
ALL PARTICIPANTS' IDENTITIES WILL BE PROTECTED.
ALL PARTICIPANTS WILL RECEIVE A $25 GIFT CARD OR CASH.
CONTACT MARIO ESPINOZA-KULICK AT MVESPINOZA@UCSB.EDU OR 805-904-9225
APPROVED BY THE UCSB HUMAN SUBJECTS COMMITTEE FOR USE THRU 9/3/2020
PROTOCOL NUMBER: 22-19-0595


SE BUSCA ENTREVISTAS PARA UN ESTUDIO SOBRE LA DEFENSA DE LA SALUD PARA LOS INMIGRANTES LATINX DE MONTEREY, SAN LUIS OBISPO, SANTA BARBARA Y VENTURA
¿TRABAJAS PARA MEJORAR EL ACCESO A LA SALUD DE LOS INMIGRANTES LATINX?
¿EL CLIMA POLÍTICO HA AFECTADO SUS ESFUERZOS DE DEFENSA?
¿ESTÁS TRABAJANDO PARA CAMBIAR LA POLÍTICA DE SALUD?
QUIERO ESCUCHAR TU HISTORIA
DEBE TENER 18 AÑOS+ PARA PARTICIPAR Y
IDENTIFICARSE COMO DEFENSOR DE LA SALUD DE LOS INMIGRANTES
LAS IDENTIDADES DE LOS PARTICIPANTES ESTARÁN PROTEGIDAS
LOS PARTICIPANTES RECIBIRÁN $25 EN EFECTIVO O EN UNA TARJETA DE REGALO.
CONTÁCTAME, MARIO ESPINOZA-KULICK
MVESPINOZA@UCSB.EDU O 805-904-9225
APPROVED BY THE UCSB HUMAN SUBJECTS COMMITTEE FOR USE THRU 9/3/2020
PROTOCOL NUMBER: 22-19-0595


SEEKING INTERVIEWS FOR A STUDY ON LATINX IMMIGRANT HEALTH FROM MONTEREY, SAN LUIS OBISPO, SANTA BARBARA, AND VENTURA COUNTIES
DO YOU SPEAK AN INDIGENOUS LANGUAGE?
ARE THERE BARRIERS TO HEALTHCARE IN YOUR COMMUNITY?
HAS THE POLITICAL CLIMATE AFFECTED YOUR HEALTH?
I WANT TO HEAR FROM YOU.
MUST BE 18YRS+ TO PARTICIPATE AND
IDENTIFY AS AN IMMIGRANT COMMUNITY MEMBER
ALL PARTICIPANTS' IDENTITIES WILL BE PROTECTED.
ALL PARTICIPANTS WILL RECEIVE A $25 GIFT CARD OR CASH.
CONTACT MARIO ESPINOZA-KULICK AT MVESPINOZA@UCSB.EDU OR 805-904-9225
APPROVED BY THE UCSB HUMAN SUBJECTS COMMITTEE FOR USE THRU 9/3/2020
PROTOCOL NUMBER: 22-19-0595


SE BUSCA ENTREVISTAS PARA UN ESTUDIO SOBRE LA SALUD DE LOS INMIGRANTES LATINX DE LOS CONDADOS DE MONTEREY, SAN LUIS OBISPO, SANTA BARBARA Y VENTURA
¿HABLAS UNA LENGUA INDÍGENA?
¿EXISTEN BARRERAS PARA LA ATENCIÓN MÉDICA EN SU COMUNIDAD?
¿EL CLIMA POLÍTICO HA AFECTADO SU SALUD?
QUIERO ESCUCHAR TU HISTORIA
DEBE TENER 18 AÑOS+ PARA PARTICIPAR Y IDENTIFICARSE COMO MIEMBRO DE LA COMUNIDAD INMIGRANTE
LAS IDENTIDADES DE LOS PARTICIPANTES ESTARÁN PROTEGIDAS
LOS PARTICIPANTES RECIBIRÁN $25 EN EFECTIVO O EN TARJETA DE REGALO.
CONTÁCTAME, MARIO ESPINOZA-KULICK
MVESPINOZA@UCSB.EDU O 805-904-9225
APPROVED BY THE UCSB HUMAN SUBJECTS COMMITTEE FOR USE THRU 9/3/2020
PROTOCOL NUMBER: 22-19-0595


SEEKING VOLUNTEERS TO TAKE PICTURES FOR 3 - 6 WEEKS USING A PERSONAL CAMERA TO ANSWER THE FOLLOWING QUESTIONS:
HOW DO YOU ACCESS HEALTH CARE SERVICES AND PRACTICE HEALING?
HOW DO YOU PERCEIVE THE CURRENT POLITICAL CLIMATE?
I WANT TO HEAR FROM YOU.
MUST BE 18YRS+ TO PARTICIPATE AND
IDENTIFY AS AN IMMIGRANT COMMUNITY MEMBER
ALL PARTICIPANTS WILL MEET MARIO ESPINOZA-KULICK FOR GUIDANCE BEFORE TAKING PICTURES AND FOR AN EXIT INTERVIEW UPON COMPLETION.
ALL PARTICIPANTS WILL RECEIVE A $30 GIFT CARD OR CASH.
CONTACT MARIO ESPINOZA-KULICK AT MVESPINOZA@UCSB.EDU OR 805-904-9225
APPROVED BY THE UCSB HUMAN SUBJECTS COMMITTEE FOR USE THRU 9/3/2020
PROTOCOL NUMBER: 22-19-0595


SE BUSCA VOLUNTARIOS PARA TOMAR FOTOS DURANTE 3 A 6 SEMANAS USANDO UNA CÁMARA PERSONAL PARA RESPONDER A LAS SIGUIENTES PREGUNTAS:
¿CÓMO ACCEDE A LOS SERVICIOS DE ATENCIÓN MÉDICA Y PRACTICA LA CURACIÓN?
¿CÓMO PERCIBE EL CLIMA POLÍTICO ACTUAL?
QUIERO ESCUCHAR TU HISTORIA
DEBE TENER 18 AÑOS+ PARA PARTICIPAR Y IDENTIFICARSE COMO MIEMBRO DE LA COMUNIDAD INMIGRANTE
TODOS LOS PARTICIPANTES SE ENCONTRARÁN CON MARIO PARA ORIENTACIÓN ANTES DE TOMAR LAS FOTOS Y PARA UNA ENTREVISTA DESPUÉS.
LOS PARTICIPANTES RECIBIRÁN $30 EN EFECTIVO O EN TARJETA DE REGALO.
CONTÁCTAME, MARIO ESPINOZA-KULICK
MVESPINOZA@UCSB.EDU O 805-904-9225
APPROVED BY THE UCSB HUMAN SUBJECTS COMMITTEE FOR USE THRU 9/3/2020
PROTOCOL NUMBER: 22-19-0595

Questions for Immigrant Health Advocates

Warm-up Questions

1. How long have you worked on issues related to immigrant health advocacy?
2. What is your primary role in working on immigrant health advocacy?
3. What motivates you to advocate for immigrant health?

Health Needs/Assets

4. In your experience, what barriers are faced by Latinx immigrant community members (e.g. Infants, children, young adults, adults, senior citizens/elders) when accessing formal healthcare services (e.g. clinics, dentists, pharmacies, etc.)?
5. Are there specific barriers experienced by cisgender and heterosexual women?
    a. Non-heterosexual men and women?
    b. Trans* or gender-nonconforming individuals?
6. How do you address these differences?
    a. Are there specific barriers experienced by Lesbian, Gay, Bisexual, Trans*, Queer, and/or Gender-Nonconforming groups?
7. What barriers do undocumented individuals who seek medical care face?
    a. What solutions do you think might help address those barriers?

Language and Culture

8. Do you speak a language other than English?
    a. If so, what language?
9. How does your program address language barriers that exist?
10. What languages are translated for your patients/clients?
    a. What translation services are available for this community?
    b. Do family members help translate for patients/clients?
    c. What written health resources exist in other languages besides English? What specific languages?
11. What solutions do you think can help address language barriers?
12. Are there any cultural norms unique to the communities you work with?
13. To your knowledge, are there any health services that present fewer barriers to Latinx immigrant community members experience?
14. What cultural health assets, that you know of, exist within Latinx immigrant communities?
15. Has the contemporary U.S. political culture affected the way organizers strategize and advocate for immigrant health rights?
    a. If so, How?

Political Climate

16. What is your perception of the current political climate towards immigrants?
17. What are your perceptions of Immigration, Customs, and Enforcement (ICE)?

18. How do advocates mobilize when news about ICE raids break in?
19. How have advocates discussed family separation at the border, and as a result of ICE raids, in relation to immigrant health?
20. How do immigrant health advocates mobilize in response to ICE threats?

Advocacy Strategies

21. What advocacy strategies currently exist to address immigrant health concerns?
22. What strategies would you consider the most impactful in changing/impacting health policy?
23. What do you believe is the best approach to partnering with Latinx immigrant community members for advocacy?
24. How do you better understand and address inequitable health issues (e.g. environmental health, mental health, insurance, etc.)?
25. Have Latinx immigrant community members directly communicated any health concerns and/or barriers they face to you?
26. As an immigrant health advocate, what challenges do you face in serving Latinx immigrant communities?
27. What solutions do you think could address these challenges?
28. How would you describe the level of trust between you and the community?
29. What can advocates be doing in order to advance health equity and access for Latinx immigrants?

Snowball and Conclusion

30. Is there a specific person or organization who you believe may be interested in participating in this study?
31. Do you have any other comments, suggestions, or questions for me?

Demographic Survey for all participants

1. What gender do you identify as?
    a. Cisgender Man
    b. Cisgender Woman
    c. Transgender Man
    d. Transgender Woman
    e. Genderqueer
    f. Not Listed, Write-in response:
2. What is your race?
    a. White
    b. Black or African American
    c. Latina/o/x or Hispanic
    d. American Indian or Alaska Native
    e. Asian or Asian American
    f. Native Hawaiian or Other Pacific Islander
    g. Biracial or Multiracial
    h. Not Listed, Write-in response:
3. *If you identify as Latinx*, what is your ethnicity?
    a. Argentinian
    b. Belizean
    c. Bolivian
    d. Brazilian
    e. Chicana/o/x
    f. Chilean
    g. Colombian
    h. Costa Rican
    i. Cuban
    j. Dominican
    k. Ecuadorian
    l. Guatemalan
    m. Haitian
    n. Honduran
    o. Jamaican
    p. Mexican
    q. Mexican American
    r. Nicaraguan
    s. Panamanian
    t. Paraguayan
    u. Peruvian
    v. Puerto Rican
    w. Salvadorian
    x. Uruguayan
    y. Venezuelan
    z. Other Caribbean, Write-in:
    aa. Multicultural, Write-in:
    bb. Not Listed, Write-in:

4. Do you identify as Indigenous?
    a. Yes
    b. No
5. *If you identify as Indigenous*, what tribal or national affiliation(s) do you associate with?
    a. Write-in response:
6. *If you identify as Indigenous*, do you identify as Two-Spirit or other similar identity?
    a. Yes
    b. No
7. What is your sexual orientation?
    a. Gay
    b. Lesbian
    c. Straight or Heterosexual
    d. Bisexual
    e. Pansexual
    f. Queer
    g. Decline to state
    h. Write-in response:
8. What is your age?
    a. Write-in response:
9. *For Latinx immigrant participants:* In what year did you first arrive to the United States?
    a. Write-in response:

Preguntas Para Defensores De La Salud De Los Inmigrantes

Preguntas De Calentamiento

1. ¿Cuánto tiempo ha trabajado en temas relacionados con la defensa de la salud de los inmigrantes?
2. ¿Cuál es su papel principal en el trabajo de defensa de la salud de los inmigrantes?
3. ¿Qué te motiva a abogar por la salud de los inmigrantes?

Necesidades De Salud / Activos

4. En su experiencia, ¿qué barreras enfrentan los miembros de la comunidad de inmigrantes latinx (por ejemplo, bebés, niños, adultos jóvenes, adultos, ancianos / ancianos) al acceder a los servicios formales de atención médica (por ejemplo, clínicas, dentistas, farmacias, etc.)?
5. ¿Existen barreras específicas experimentadas por mujeres cisgénero y heterosexuales?
    a. ¿Hombres y mujeres no heterosexuales?
    b. ¿Personas trans * o no conformes con el género?
6. ¿Cómo abordas estas diferencias?
    a. ¿Existen barreras específicas experimentadas por grupos de lesbianas, gays, bisexuales, trans*, queer y / o de género no conforme?
7. ¿Qué barreras enfrentan las personas indocumentadas que buscan atención médica?
    a. ¿Qué soluciones cree que podrían ayudar a abordar esas barreras?

Lenguaje Y Cultura

8. ¿Hablas otro idioma que no sea inglés?
    a. Si es así, ¿qué idioma?
9. ¿Cómo aborda su programa las barreras del idioma que existen?
10. ¿Qué idiomas se traducen para sus pacientes / clientes?
    a. ¿Qué servicios de traducción están disponibles para esta comunidad?
    b. ¿Los miembros de la familia ayudan a traducir para pacientes / clientes?
    c. ¿Qué recursos de salud escritos existen en otros idiomas además del inglés? ¿Qué idiomas específicos?
11. ¿Qué soluciones crees que pueden ayudar a abordar las barreras del idioma?
12. ¿Existen normas culturales exclusivas de las comunidades con las que trabaja?
13. Que usted sepa, ¿existen servicios de salud que presenten menos barreras a la experiencia de los miembros de la comunidad de inmigrantes latinx?
14. 14. ¿Qué activos culturales de salud, que usted sepa, existen en las comunidades de inmigrantes latinx?
15. ¿Ha afectado la cultura política estadounidense contemporánea la forma en que los organizadores elaboran estrategias y abogan por los derechos de salud de los inmigrantes?
    a. ¿Si es así, cómo?

Clima Político

16. ¿Cuál es su percepción del clima político actual hacia los inmigrantes?
17. ¿Cuáles son sus percepciones de inmigración, aduanas y cumplimiento (ICE)?

18. ¿Cómo se movilizan los defensores cuando entran las noticias sobre las redadas de ICE?
19. ¿Cómo han discutido los defensores la separación familiar en la frontera, y como resultado de las redadas de ICE, en relación con la salud de los inmigrantes?
20. ¿Cómo se movilizan los defensores de la salud de los inmigrantes en respuesta a las amenazas de ICE?

Estrategias De Defensa

21. ¿Qué estrategias de defensa existen actualmente para abordar las preocupaciones de salud de los inmigrantes?
22. ¿Qué estrategias consideraría más impactantes para cambiar / impactar las políticas de salud?
23. ¿Cuál cree que es el mejor enfoque para asociarse con miembros de la comunidad de inmigrantes latinos para la defensa?
24. ¿Cómo comprende y aborda mejor los problemas de salud no equitativos (por ejemplo, salud ambiental, salud mental, seguros, etc.)?
25. ¿Los miembros de la comunidad de inmigrantes latinx le han comunicado directamente cualquier problema de salud y / o barreras que enfrentan?
26. Como defensor de la salud de los inmigrantes, ¿qué desafíos enfrenta al servir a las comunidades de inmigrantes latinx?
27. ¿Qué soluciones crees que podrían abordar estos desafíos?
28. ¿Cómo describiría el nivel de confianza entre usted y la comunidad?
29. ¿Qué pueden hacer los defensores para promover la equidad en salud y el acceso para los inmigrantes latinx?

Bola de nieve y conclusión

30. ¿Existe una persona u organización específica que usted cree que puede estar interesada en participar en este estudio?
31. ¿Tiene algún otro comentario, sugerencia o pregunta para mí?

Encuesta Demográfica Para Todos Los Participantes.

1. ¿Con qué género te identificas?
    a. Hombre Cisgenero
    b. Mujer Cisgenero
    c. Hombre transgénero
    d. Mujer transgénero
    e. Genderqueer
    f. No listado, respuesta de escritura:
2. ¿Cuál es tu raza?
    a. Blanco
    b. Negro O Afroamericano
    c. Latina / O / X O Hispana
    d. Indio Americano O Nativo De Alaska
    e. Asiático O Asiático Americano
    f. Nativo De Hawai U Otra Isla Del Pacífico
    g. Birracial O Multirracial
    h. No Listado, Respuesta De Escritura:
3. Si te identificas como Latinx, ¿cuál es tu etnicidad?
    a. Argentino
    b. Beliceño
    c. Boliviano
    d. Brasileño
    e. Chicana/o/x
    f. Chileno
    g. Colombiano
    h. Costarriqueño
    i. Cubano
    j. Dominicano
    k. Ecuatoriano
    l. Guatemalteco
    m. Haitiano
    n. Hondureño
    o. Jamaiqueño
    p. Mexicano
    q. Mexicano-Americano
    r. Nicaragüense
    s. Panameño
    t. Paraguayo
    u. Peruano
    v. Puertorriqueño
    w. Salvadoreño
    x. Uruguayo
    y. Venezolano
    z. Otro Caribe (por escrito):
    aa. Multicultural (por escrito):
    bb. No Listado (por escrito):

4. ¿Te identificas como indígena?
    a. Sí
    b. No
5. Si se identifica como indígena, ¿con qué afiliaciones tribales o nacionales se asocia?
    a. Respuesta por escrito:
6. Si te identificas como indígena, ¿te identificas como Doble-Espíritu otra identidad similar?
    a. Sí
    b. No
7. ¿Cuál es tu orientación sexual?
    a. Gay
    b. Lesbiana
    c. Heterosexual
    d. Bisexual
    e. Pansexual
    f. Queer
    g. Rechazo de declarar
    h. Respuesta por escrito:
8. ¿Cuál es tu edad?
    a. Respuesta por escrito:
9. Para los inmigrantes Latinx: ¿en qué año llegó por primera vez a los Estados Unidos?
    a. Respuesta por escrito:
    b. Rechazo de declarar

Questions for Latinx Immigrants Community Members

Warm-up Questions

1. What do you do for work?
2. Do you live with your family?
3. Do you have any children?

Health Needs/Assets

4. Leading question: What are the barriers people experience in accessing formal or informal health services?
5. What is the closest clinic to you and have you personally faced obstacles in accessing your clinic or the services it provides?
6. Do you or anyone in your household have medical insurance or medi-cal?
7. Do you have access to transportation?
    a. How has transportation affected your access to heath services?
8. In your experience, what are the common situations where people in your community seek out health services?
9. What are the formal health care services you routinely visit?
    a. Informal services?
10. How has the documented status of individuals within the community hinder their ability to seek our formal or informal health services?
11. Can you please describe a good experience you have had with accessing health service providers?
12. Can you please describe a bad experience you have had with accessing health service providers?
    a. Is this common in your community?
13. Furthermore, if applicable, what was done to remedy that bad experience from the health care service provider?
14. Who advocates for you and your family's health needs?

Language

15. Do you speak an Indigenous language?
    a. If so, which one?
    b. How fluent are you in the language?
    c. Are there any resources that you know of that cater to your specific mode of communication and/or language?
16. What language is predominately spoken in your household?
17. Have you ever been discriminated or judged for speaking your native language?
18. Has anyone ever denied service to you because of the language you speak?

Political Climate

19. What is your perception of the current political climate towards immigrants?

20. What are your perceptions of Immigration, Customs, and Enforcement (ICE)?
21. Does news about ICE raids affect whether or not you leave your home?
22. Have you or a family member ever had a confrontation with ICE?
    a. If so, what was your experience?
23. Has anyone in your family ever been deported?
    a. If so, when and how?
24. Has your family talked about family separation?
25. How would you say the current political climate affects your health?

Conclusion

26. What do you believe is best approach to partnering with Latinx immigrant community members to better understand and address their health concerns?
27. How do you believe we can achieve health equity for immigrant groups?
28. How would you define a culture of health?
29. Do you have any other comments, suggestions, or questions for me?

Demographic Survey for all participants

1. What gender do you identify as?
    a. Cisgender Man
    b. Cisgender Woman
    c. Transgender Man
    d. Transgender Woman
    e. Genderqueer
    f. Not Listed, Write-in response:
2. What is your race?
    a. White
    b. Black or African American
    c. Latina/o/x or Hispanic
    d. American Indian or Alaska Native
    e. Asian or Asian American
    f. Native Hawaiian or Other Pacific Islander
    g. Biracial or Multiracial
    h. Not Listed, Write-in response:
3. *If you identify as Latinx*, what is your ethnicity?
    a. Argentinian
    b. Belizean
    c. Bolivian
    d. Brazilian
    e. Chicana/o/x
    f. Chilean
    g. Colombian
    h. Costa Rican
    i. Cuban
    j. Dominican
    k. Ecuadorian
    l. Guatemalan
    m. Haitian
    n. Honduran
    o. Jamaican
    p. Mexican
    q. Mexican American
    r. Nicaraguan
    s. Panamanian
    t. Paraguayan
    u. Peruvian
    v. Puerto Rican
    w. Salvadorian
    x. Uruguayan
    y. Venezuelan
    z. Other Caribbean, Write-in:
    aa. Multicultural, Write-in:

bb. Not Listed, Write-in:

4. Do you identify as Indigenous?
    a. Yes
    b. No
5. *If you identify as Indigenous*, what tribal or national affiliation(s) do you associate with?
    a. Write-in response:
6. *If you identify as Indigenous*, do you identify as Two-Spirit or other similar identity?
    a. Yes
    b. No
7. What is your sexual orientation?
    a. Gay
    b. Lesbian
    c. Straight or Heterosexual
    d. Bisexual
    e. Pansexual
    f. Queer
    g. Decline to state
    h. Write-in response:
8. What is your age?
    a. Write-in response:
9. *For Latinx immigrant participants:* In what year did you first arrive to the United States?
    a. Write-in response:

Preguntas Para Miembros De La Comunidad De Inmigrantes Latinx

Preguntas De Calentamiento

1. ¿Qué haces para trabajar?
2. ¿Vives con tu familia?
3. ¿Tienes hijos?

Necesidades De Salud / Activos

4. Pregunta principal: ¿Cuáles son las barreras que las personas experimentan para acceder a servicios de salud formales o informales?
5. ¿Cuál es la clínica más cercana a usted y ha enfrentado personalmente obstáculos para acceder a su clínica o los servicios que brinda?
6. ¿Usted o alguien en su hogar tiene seguro médico o médico?
7. ¿Tiene acceso al transporte?
    a. ¿Cómo ha afectado el transporte su acceso a los servicios de salud?
8. En su experiencia, ¿cuáles son las situaciones comunes en las que las personas en su comunidad buscan servicios de salud?
9. ¿Cuáles son los servicios formales de atención médica que visita habitualmente?
    a. Servicios informales?
10. ¿Cómo ha impedido el estado documentado de las personas dentro de la comunidad su capacidad de buscar nuestros servicios de salud formales o informales?
11. ¿Puede describir una buena experiencia que haya tenido al acceder a los proveedores de servicios de salud?
12. ¿Puede describir una mala experiencia que ha tenido al acceder a los proveedores de servicios de salud?
    a. ¿Es esto común en tu comunidad?
13. Además, si corresponde, ¿qué se hizo para remediar esa mala experiencia del proveedor de servicios de salud?
14. ¿Quién defiende sus necesidades de salud y las de su familia?

Idioma

15. ¿Hablas una lengua indígena?
    a. ¿Si es así, Cuál?
    b. ¿Qué tan fluido eres en el idioma?
    c. ¿Hay algún recurso que conozca que se adapte a su modo específico de comunicación y / o idioma?
16. ¿Qué idioma se habla predominantemente en su hogar?
17. ¿Alguna vez ha sido discriminado o juzgado por hablar su idioma nativo?
18. ¿Alguna vez alguien le negó el servicio por el idioma que habla?

Clima Político

19. ¿Cuál es su percepción del clima político actual hacia los inmigrantes?

20. ¿Cuáles son sus percepciones de inmigración, aduanas y cumplimiento (ICE)?
21. ¿Las noticias sobre las redadas de ICE afectan si abandonas o no tu hogar?
22. ¿Alguna vez usted o un miembro de su familia han tenido una confrontación con ICE?
    a. Si es así, ¿cuál fue su experiencia?
23. ¿Alguien en su familia ha sido deportado alguna vez?
    a. Si es así, cuándo y cómo?
24. ¿Ha hablado su familia sobre la separación familiar?
25. ¿Cómo diría que el clima político actual afecta su salud?

Conclusión

26. ¿Cuál cree que es el mejor enfoque para asociarse con miembros de la comunidad de inmigrantes latinx para comprender y abordar mejor sus problemas de salud?
27. ¿Cómo cree que podemos lograr la equidad en salud para los grupos de inmigrantes?
28. ¿Cómo definirías una cultura de salud?
29. ¿Tiene algún otro comentario, sugerencia o pregunta para mí?

Encuesta Demográfica Para Todos Los Participantes.

1. ¿Con qué género te identificas?
    a. Hombre Cisgenero
    b. Mujer Cisgenero
    c. Hombre transgénero
    d. Mujer transgénero
    e. Genderqueer
    f. No listado, respuesta de escritura:
2. ¿Cuál es tu raza?
    a. Blanco
    b. Negro O Afroamericano
    c. Latina / O / X O Hispana
    d. Indio Americano O Nativo De Alaska
    e. Asiático O Asiático Americano
    f. Nativo De Hawai U Otra Isla Del Pacífico
    g. Birracial O Multirracial
    h. No Listado, Respuesta De Escritura:
3. Si te identificas como Latinx, ¿cuál es tu etnicidad?
    a. Argentino
    b. Beliceño
    c. Boliviano
    d. Brasileño
    e. Chicana/o/x
    f. Chileno
    g. Colombiano
    h. Costarriqueño
    i. Cubano
    j. Dominicano
    k. Ecuatoriano
    l. Guatemalteco
    m. Haitiano
    n. Hondureño
    o. Jamaiqueño
    p. Mexicano
    q. Mexicano-Americano
    r. Nicaragüense
    s. Panameño
    t. Paraguayo
    u. Peruano
    v. Puertorriqueño
    w. Salvadoreño
    x. Uruguayo
    y. Venezolano
    z. Otro Caribe (por escrito):
    aa. Multicultural (por escrito):
    bb. No Listado (por escrito):

4. ¿Te identificas como indígena?
    a. Sí
    b. No
5. Si se identifica como indígena, ¿con qué afiliaciones tribales o nacionales se asocia?
    a. Respuesta por escrito:
6. Si te identificas como indígena, ¿te identificas como Doble-Espíritu otra identidad similar?
    a. Sí
    b. No
7. ¿Cuál es tu orientación sexual?
    a. Gay
    b. Lesbiana
    c. Heterosexual
    d. Bisexual
    e. Pansexual
    f. Queer
    g. Rechazo de declarar
    h. Respuesta por escrito:
8. ¿Cuál es tu edad?
    a. Respuesta por escrito:
9. Para los inmigrantes Latinx: ¿en qué año llegó por primera vez a los Estados Unidos?
    a. Respuesta por escrito:
    b. Rechazo de declarar

Advocates Focus Group Questions

Warm-up/ice-breaking Questions

1. What are your names?
2. What are you passionate about and why?

Health Needs/Assets

3. What common issues arise in your advocacy work?
4. How does the work you do impact health advocacy?
5. How is your community included in addressing their health concerns?
6. What strategies have been successful in advancing health equity for the Latinx immigrant community?
7. How do you strategize for varying health needs when they arise?
8. Have any of your efforts impacted health policy?
    a. If so, how and when?

Language

9. Does language have an effect on the way you organize for your advocacy efforts?
10. Are there any language barriers that get in the way of your advocacy work?
11. How do you overcome language barriers?
12. What tools could aid in overcoming language barriers?

Political Climate

13. What role does Immigration, Customs, and Enforcement (ICE) play in your advocacy efforts?
14. How would you say the current political climate affects immigrant health advocacy?
15. What effect does the political climate have on your constituencies?

Conclusion

16. What advice would you give someone who is advocating for immigrant health rights?
17. What do you believe is the best approach to partnering with Latinx immigrant community members to better understand and address their health concerns?
18. How do you believe we can achieve health equity for immigrant groups?
19. Do you have any other comments, suggestions, or questions for me?

Preguntas Del Grupo De Enfoque De Defensores

Preguntas De Calentamiento / Para Romper El Hielo

1. ¿Cómo te llamas?
2. ¿Qué te apasiona y por qué?

Necesidades De Salud / Activos

3. ¿Qué problemas comunes surgen en su trabajo de apoyo?
4. ¿Cómo impacta el trabajo que hace en la defensa de la salud?
5. ¿Cómo se incluye a su comunidad para abordar sus problemas de salud?
6. ¿Qué estrategias han tenido éxito en el avance de la equidad en salud para la comunidad de inmigrantes Latinx?
7. ¿Cómo se elaboran estrategias para las diferentes necesidades de salud cuando surgen?
8. ¿Alguno de sus esfuerzos ha afectado la política de salud?
    a. Si es así, ¿cómo y cuándo?

Idioma

9. ¿El lenguaje tiene un efecto en la forma en que se organiza para sus esfuerzos de promoción?
10. ¿Existen barreras idiomáticas que se interponen en su trabajo de defensa?
11. ¿Cómo superas las barreras del idioma?
12. ¿Qué herramientas podrían ayudar a superar las barreras del idioma?

Clima Politico

13. ¿Qué papel juega Inmigración, Aduanas y Cumplimiento (ICE) en sus esfuerzos de defensa?
14. ¿Cómo diría que el clima político actual afecta la defensa de la salud de los inmigrantes?
15. ¿Qué efecto tiene el clima político en sus circunscripciones?

Conclusión

16. ¿Qué consejo le darías a alguien que defiende los derechos de salud de los inmigrantes?
17. ¿Cuál cree que es el mejor enfoque para asociarse con miembros de la comunidad de inmigrantes Latinx para comprender y abordar mejor sus preocupaciones de salud?
18. ¿Cómo cree que podemos lograr la equidad en salud para los grupos de inmigrantes?
19. ¿Tiene algún otro comentario, sugerencia o pregunta para mí?

Community Focus Group Questions

Warm-up/ice-breaking Questions

1. What are your names?
2. What are you passionate about and why?
3. What is your hometown?
4. What do you do for work?

Health Needs/Assets

5. What are the barriers people in your community experience in accessing formal or informal health services?
6. What does your community need to live a healthy life?
7. How do you address your health and well-being outside of a formal setting?
8. Who advocates for your community's health needs?
9. What local health resources are available to your community?
    a. How did you learn about these?
10. How do you address health needs when they arise?
11. How can others help to advocate for immigrant health rights?

Language

12. Have you ever been discriminated or judged for speaking your native language?
13. Has anyone ever denied service to you because of the language you speak?
    a. What was that like?
    b. What changed for you after?
14. What do you do when you need help with translation?
15. How do language barriers affect your health?

Political Climate

16. What is your perception of the current political climate towards immigrants?
17. What are your perceptions of Immigration, Customs, and Enforcement (ICE)?
18. How would you say the current political climate affects Latinx immigrant health?
19. Are there any conversations happening that focus on politics in your community?
20. Where do you look for your political news?
21. What motivates you to follow the political climate?

Conclusion

22. What advice would you give someone who is advocating for immigrant health rights?
23. What do you believe is the best approach to partnering with Latinx immigrant community members to better understand and address their health concerns?
24. How do you believe we can achieve health equity for immigrant groups?
25. Do you have any other comments, suggestions, or questions for me?

Demographic Survey for all participants

1. What gender do you identify as?
    a. Cisgender Man
    b. Cisgender Woman
    c. Transgender Man
    d. Transgender Woman
    e. Genderqueer
    f. Not Listed, Write-in response:
2. What is your race?
    a. White
    b. Black or African American
    c. Latina/o/x or Hispanic
    d. American Indian or Alaska Native
    e. Asian or Asian American
    f. Native Hawaiian or Other Pacific Islander
    g. Biracial or Multiracial
    h. Not Listed, Write-in response:
3. *If you identify as Latinx*, what is your ethnicity?
    a. Argentinian
    b. Belizean
    c. Bolivian
    d. Brazilian
    e. Chicana/o/x
    f. Chilean
    g. Colombian
    h. Costa Rican
    i. Cuban
    j. Dominican
    k. Ecuadorian
    l. Guatemalan
    m. Haitian
    n. Honduran
    o. Jamaican
    p. Mexican
    q. Mexican American
    r. Nicaraguan
    s. Panamanian
    t. Paraguayan
    u. Peruvian
    v. Puerto Rican
    w. Salvadorian
    x. Uruguayan
    y. Venezuelan
    z. Other Caribbean, Write-in:
    aa. Multicultural, Write-in:
    bb. Not Listed, Write-in:

4. Do you identify as Indigenous?
    a. Yes
    b. No
5. *If you identify as Indigenous*, what tribal or national affiliation(s) do you associate with?
    a. Write-in response:
6. *If you identify as Indigenous*, do you identify as Two-Spirit or other similar identity?
    a. Yes
    b. No
7. What is your sexual orientation?
    a. Gay
    b. Lesbian
    c. Straight or Heterosexual
    d. Bisexual
    e. Pansexual
    f. Queer
    g. Decline to state
    h. Write-in response:
8. What is your age?
    a. Write-in response:
9. *For Latinx immigrant participants:* In what year did you first arrive to the United States?
    a. Write-in response:

Preguntas Del Grupo De Enfoque Comunitario

Preguntas De Calentamiento / Para Romper El Hielo

1. ¿Cómo te llamas?
2. ¿Qué te apasiona y por qué?
3. ¿Cuál es tu ciudad natal?
4. ¿Qué haces para trabajar?

Necesidades De Salud / Activos

5. ¿Cuáles son las barreras que las personas en su comunidad experimentan para acceder a servicios de salud formales o informales?
6. ¿Qué necesita su comunidad para vivir una vida saludable?
7. ¿Cómo aborda su salud y bienestar fuera de un entorno formal?
8. ¿Quién aboga por las necesidades de salud de su comunidad?
9. ¿Qué recursos locales de salud están disponibles para su comunidad?
    a. ¿Cómo te enteraste de esto?
10. ¿Cómo aborda las necesidades de salud cuando surgen?
11. ¿Cómo pueden otros ayudar a defender los derechos de salud de los inmigrantes?

Idioma

12. ¿Alguna vez ha sido discriminado o juzgado por hablar su idioma nativo?
13. ¿Alguna vez alguien le negó el servicio por el idioma que habla?
    a. ¿Como fue eso?
    b. ¿Qué cambió para ti después?
14. ¿Qué haces cuando necesitas ayuda con la traducción?
15. ¿Cómo afectan las barreras del idioma a su salud?

Clima Político

16. ¿Cuál es su percepción del clima político actual hacia los inmigrantes?
17. ¿Cuáles son sus percepciones de inmigración, aduanas y cumplimiento (ICE)?
18. ¿Cómo diría que el clima político actual afecta la salud de los inmigrantes Latinx?
19. ¿Hay alguna conversación que se centre en la política de su comunidad?
20. ¿Dónde buscas tus noticias políticas?
21. ¿Qué te motiva a seguir el clima político?

Conclusión

22. ¿Qué consejo le darías a alguien que defiende los derechos de salud de los inmigrantes?
23. ¿Cuál cree usted que es el mejor enfoque para asociarse con miembros de la comunidad de inmigrantes Latinx para comprender y abordar mejor sus problemas de salud?
24. ¿Cómo cree que podemos lograr la equidad en salud para los grupos de inmigrantes?
25. ¿Tiene algún otro comentario, sugerencia o pregunta para mí?

Encuesta Demográfica Para Todos Los Participantes.

1. ¿Con qué género te identificas?
    a. Hombre Cisgenero
    b. Mujer Cisgenero
    c. Hombre transgénero
    d. Mujer transgénero
    e. Genderqueer
    f. No listado, respuesta de escritura:
2. ¿Cuál es tu raza?
    a. Blanco
    b. Negro O Afroamericano
    c. Latina / O / X O Hispana
    d. Indio Americano O Nativo De Alaska
    e. Asiático O Asiático Americano
    f. Nativo De Hawai U Otra Isla Del Pacífico
    g. Birracial O Multirracial
    h. No Listado, Respuesta De Escritura:
3. Si te identificas como Latinx, ¿cuál es tu etnicidad?
    a. Argentino
    b. Beliceño
    c. Boliviano
    d. Brasileño
    e. Chicana/o/x
    f. Chileno
    g. Colombiano
    h. Costarriqueño
    i. Cubano
    j. Dominicano
    k. Ecuatoriano
    l. Guatemalteco
    m. Haitiano
    n. Hondureño
    o. Jamaiqueño
    p. Mexicano
    q. Mexicano-Americano
    r. Nicaragüense
    s. Panameño
    t. Paraguayo
    u. Peruano
    v. Puertorriqueño
    w. Salvadoreño
    x. Uruguayo
    y. Venezolano
    z. Otro Caribe (por escrito):
    aa. Multicultural (por escrito):
    bb. No Listado (por escrito):

4. ¿Te identificas como indígena?
    a. Sí
    b. No
5. Si se identifica como indígena, ¿con qué afiliaciones tribales o nacionales se asocia?
    a. Respuesta por escrito:
6. Si te identificas como indígena, ¿te identificas como Doble-Espíritu otra identidad similar?
    a. Sí
    b. No
7. ¿Cuál es tu orientación sexual?
    a. Gay
    b. Lesbiana
    c. Heterosexual
    d. Bisexual
    e. Pansexual
    f. Queer
    g. Rechazo de declarar
    h. Respuesta por escrito:
8. ¿Cuál es tu edad?
    a. Respuesta por escrito:
9. Para los inmigrantes Latinx: ¿en qué año llegó por primera vez a los Estados Unidos?
    a. Respuesta por escrito:
    b. Rechazo de declarar

Key Informant Photovoice Protocol

Participants will be given the option to use a personal digital camera (e.g. cellphone camera) or two disposable cameras (provided by researcher) to document their perceptions of accessing health care, the political climate, and localized knowledge of healing practices. This will provide participants with symbolic and discursive resources to use in their own direct advocacy efforts, as well as important knowledge about the community context in which anti-immigrant health barriers are reproduced. You must be an adult (18+) and identify as an immigrant and/or an advocate for immigrant health to participate in this Photovoice project.

Confidentiality

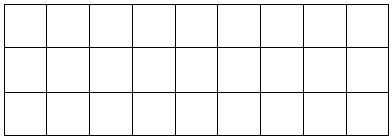
As noted in the informed consent, all photos are considered confidential and will only be used for the purposes of advancing research on health equity and policy. As key informants, you will have already had the option to elect a pseudonym for your participation in this study. As an additional measure, the researcher asks that you please do not photograph any images that may contain personal information and to refrain from photographing in private spaces. Private spaces include workplaces, people's homes, private offices, etc. To protect your confidentiality, and that of others', only photograph in public spaces.

Instructions

Please only use either your own personal camera (e.g. cellphone camera) or the two disposable cameras given to you for the purposes of this study (Fuji 35mm QuickSnap Single Use Camera). Each camera contains 27 exposures (camera shots). Utilize one entire camera per script. One photo per day is recommended. Please answer the specific scripts for this project and explain your photos in your own words:

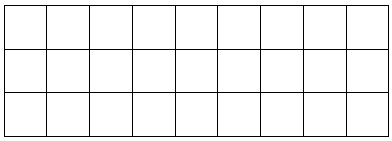
Script 1. Health Care and Healing Practices

How do you access health care services and practice healing? This can include any public place where you perceive that services are related to health care, such as a garden, dental office, gym, or pharmacy. In addition, please photograph any relevant methods of healing that you use for self-care and combatting illness. Only photograph what you are comfortable sharing in public. Healing practices are usually related to homeopathic, natural, or traditional/indigenous modes of care. Check each box to keep track of the photos you take.



Script 2. Political Climate

How do you perceive the current political climate? This questions asks you to photograph public spaces that you perceive to be related to the United States' political climate. For example, political slogans, television shows, and public demonstrations are often related to the political climate. Please try to answer, by photograph, the following question: In what ways do politics and policy affect your day-to-day life? Check each box to keep track of the photos you take.



Upon completion of your scripts, please call Mario Espinoza-Kulick at (805) 904-9225 or mvespinoza@ucsb.edu to arrange for pick up and an interview. Thank you.

NOTES

Protocolo De Fotovoz

Los participantes pueden usar su camera personal (e.g. cámara de celular) o elegir a recibir dos cámaras desechables cada una para documentar sus percepciones sobre el acceso a la atención médica, el clima político y el conocimiento localizado de las prácticas curativas. Esto proporcionará a los participantes recursos simbólicos y discursivos para usar en sus propios esfuerzos de defensa directa, así como un conocimiento importante sobre el contexto comunitario en el que se reproducen las barreras de salud antiinmigrantes. Debe ser un adulto (mayor de 18 años) e identificarse como inmigrante y / o defensor de la salud de los inmigrantes para participar en este proyecto de fotovoz.

Confidencialidad

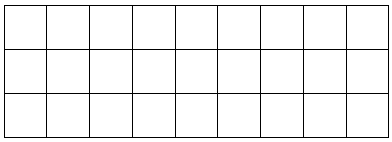
Como se señala en el consentimiento informado, todas las fotos se consideran confidenciales y solo se utilizarán con el fin de avanzar en la investigación sobre equidad y políticas de salud. Como informantes de clave, ya habrá tenido la opción de elegir un seudónimo para su participación en este estudio. Como medida adicional, el investigador le pide que no fotografíe ninguna imagen que pueda contener información personal y que se abstenga de fotografiar en espacios privados. Los espacios privados incluyen lugares de trabajo, hogares de personas, oficinas privadas, etc. Para proteger su confidencialidad y la de los demás, solo fotografíe en espacios públicos.

Instrucciones

Utilice solo su cámara personal (e.g. cámara de celular) o las dos cámaras desechables que se le entregaron para los fines de este estudio (Cámara desechable Fuji QuickSnap de 35 mm). Cada cámara contiene un máximo de 27 exposiciones (Fotos). Utilice una cámara completa por cada guión. Recomiendo una foto por día. Responda a los guiones de abajo y explique las fotografías con sus propias palabras:

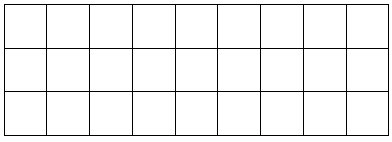
Guión 1. Cuidado de la salud y prácticas curativas

¿Cómo accede a los servicios de atención médica y practica la curación? Esto puede incluir cualquier lugar público donde perciba que los servicios están relacionados con la atención médica, como un jardín, consultorio dental, gimnasio o farmacia. Además, incluya cualquier método relevante de curación que utilice para cuidarse y combatir enfermedades. Solo fotografíe lo que se siente cómodo compartiendo en público. Las prácticas de curación generalmente están relacionadas con los modos de atención homeopáticos, naturales o tradicionales / indígenas.



Guión 2. Clima político

¿Cómo percibe el clima político actual? Esta pregunta le pide que fotografíe espacios públicos que usted percibe que están relacionados con el clima político de los Estados Unidos. Por ejemplo, los lemas políticos, los programas de televisión y las manifestaciones públicas a menudo están relacionados con el clima político. Por favor intente responder, por fotografía, la siguiente pregunta: ¿Cómo afecta el clima político a tu vida?



Al completar sus guiones, llame a Mario Espinoza-Kulick al (805) 904-9225 o mvespinoza@ucsb.edu para organizar la recogida y entrevista. Gracias.

NOTAS

Community Report: Preliminary Findings

June 24, 2020

By: Mario Espinoza-Kulick, MA, PhD Candidate (UCSB – Sociology)

Survey

The health needs/assets survey is fully live in both English and Spanish, and recruitment is ongoing. You can view and take the survey at the following link: <https://tinyurl.com/Immigrant-Health-Survey>. I am planning on expanding the reach of this survey to include at least 100-150 respondents. As it stands, the survey has collected approximately 74 participants with 42 complete responses. Using the data collected among this group, I have investigated the validity and basic descriptive statistics for each item. Although the increased sample will provide important specificity and accuracy in terms of the statistical findings, this report shows important preliminary findings as it relates to the dire health needs of immigrant health movement stakeholders.

Who are the respondents?

A total of 74 respondents have taken the survey between 9/16/2019-06/17/2020. Of this group, 16 respondents declined to participate after viewing the informed consent. Further, 42 respondents completed more than 95% of the survey. There was a reduced completion rate overall, because the final question is the optional click-through for the incentive raffle. Respondents who opt-out of the raffle are marked as "incomplete".

7 respondents completed the Spanish version of the survey (9.5%).

52 respondents identified as an advocate for immigrant health (89.7%)

28 respondents identified as an immigrant community member (48.3%)

24 respondents were present in both groups. Notably, the vast majority of immigrant community members also identified as advocates. [From the interview data, we know that many immigrant community members self-advocate for individual healthcare and family members, as well as larger structural changes.]

Where do folx live?

40 respondents did not answer the city where they lived. This indicates a distrust in sharing information. Sorted by county, those who disclosed are summarized in the Table below.

County or Region	***n***
Santa Barbara	10
San Luis Obispo	18
Ventura	1
Monterey	1
Bay Area	2
Southern California	2

Identity

In terms of gender, the sample is majority cis-women (n = 36) and also includes cis-men (n = 8), one trans person (n = 1) and another genderqueer individual (n = 1).

The sample is majority Latina/o/x or Hispanic (n = 38) and also includes Black, American Indian, and White respondents. Respondents were allowed to select multiple categories, and 4 respondents affirmed their identity as biracial or multiracial.

Within the larger category of Latina/o/x ethnicity, folx provided their primary ethnic identity. This included Belizean (n = 2), Chicana/o/x (n.= 4), Cuban (n = 1), Dominican (n = 2), Mexican (n = 22), Mexican American (n = 16), Peruvian (n = 1), Salvadorian (n = 1), Multicultural [write-in: Mestiza] (n = 1).

A group of 6 respondents self-identified as Indigenous, including Acoma Pueblo, Aztec, Karuk, Oaxaca, Purépecha, and without affiliations (n =2). Among the Indigenous respondents, one individual identified as Two-Spirit [write-in: Nonbinary, trans*, Indigequeer].

Many respondents were heterosexual or straight (n = 36). Respondents also identified as bisexual (n = 2), gay (n =3), queer (n = 2), and one individual declined to state.

The sample includes a range of age diversity, from 20 years old to 66. The range of experiences also included differing relationships to immigration. The age of first arrival to the US for immigrant respondents is summarized in the table below.

Year of arrival	***n***
1973	1
1980	1
1987	1
1989	2
1996	3
1997	1
1999	1
2001	1
2005	1
2006	1
2010	1
2011	1

Language and Citizenship

Many indicated they speak two or more languages, including both Spanish and English (n = 33). Only seven individuals indicated they are monolingual (n = 5 English, n = 2 Español).

When asked to indicate which language they primarily use, many respondents affirmed that they use both English and Spanish or combine them regularly (n = 12). More respondents primarily used English (n = 26) compared to Spanish (n = 4).

6 individuals were not US citizens at the time of taking the survey, and all of these individuals identified as immigrant community members. As well, 4 non-citizens also identified as advocates, in addition to both respondents who declined to state their citizenship (n = 2).

Health Outcomes

Respondents were asked a modified version of the 22-item "Mexican Immigrant Assets Scale" (Lopez 2014). Specific references to Mexican identity were removed from the scale items and replaced with more general statements relevant to Latinx immigrant groups. Overall scores were high, with a mean of 5.86 on a scale from 1-6. This means that most respondents indicated an exceedingly high level of resiliency across the board. Similarly, when asked to self-report their overall quality of health, the majority of respondents indicated good health (53.7%) and many also indicated excellent health (24.4%).

Respondents also reported a relatively moderate level of anxiety, measured using the General Anxiety Disorder (GAD-7) scale (Spitzer et al. 2006). Nearly 1 in 5 respondents indicated anxiety symptoms above the mid-point (18.4%).

Access to Healthcare Services and Systems

Like most of the U.S., the most common health insurance coverage came from employer-provided plans (n = 22). In addition, others who had insurance coverage received it from privately purchased sources (n = 4), or government programs: Medi-Cal (n = 4), Medicare (n = 1), or Emergency Medi-Cal (n = 2).

Moderate trust is reported for Western healthcare providers (including general physicians [n = 19], specialists [n = 24], and nurses [n = 16]). As well, only some trust was accorded to medical assistants (n = 14) and health educators (n = 14).

Notably, there was a reported pattern of distrust (i.e., "Do not trust at all") directed toward alternative healthcare services, include doulas/midwives (n = 3), curanderos (n = 11), sobadoras (n = 6), oracionistas (n = 13), yerberos (n = 13), and "Other" non-western healthcare providers (n = 8). Across these groups, it was self-identified advocates who consistently ranked low trust in these forms of healthcare. It may be that some individuals are motivated to advocate, because they view alternative healthcare practices as sub-standard for maintaining healthy lifestyles.

This is a serious issue for the community, as adequate trust between various types of healthcare providers is necessary to ensure health and healing. In particular, health educators must take responsibility for building trusting relationships with the community, establishing a rigorous and results-focused pattern of education, and healing past traumas of negative health education experiences.

Top-5 barriers to healthcare

The outstanding barriers to healthcare access identified by respondents were that appointments are not available (n = 23) and services are too expensive (n = 15). When viewed in light with qualitative data, it is obvious that some basic questions of healthcare access worry this community. Specifically, the number of available providers and the cost of those providers does not align with the capacity of the community.

In addition, some other identified patterns of barriers were discrimination or hostility when attempting to access healthcare (n = 6), unable to get time off work (n = 5), and insurance policy did not cover what I need (n =5).

Top 5 perceived barriers to healthcare (split by advocate/community member)

Overall, the perception of barriers to healthcare for this community was that there are a number of major problems. In particular, the most commonly identified were: services are too expensive (n = 24); lack of insurance (n = 21) and inadequate insurance coverage (n = 20); providers unable to speak patients' language (n = 17), and a culture of fear toward immigration enforcement (n = 16).

When asked what language they speak with their own healthcare providers, most respondents indicated English (n = 30), while a small group indicated Spanish (n = 4).

There was agreement between both community members and advocates from outside groups about some of these barriers. For example, the concern about cost of services and coverage by insurance policies were shared evenly across both groups. Community members were more likely to identify language barriers and having insurance as major problems facing this community. By contrast, advocates who were not community members were somewhat more likely to identify fear of immigration enforcement as a major problem.

Top 3 experiences of adversity in healthcare

The most commonly reported direct experiences of adversity, discrimination, and harassment were discrimination on the basis of race/ethnicity (n = 21) and death of a loved one (n = 21). As well, many respondents had witnessed discrimination on the basis of race / ethnicity (n = 18), immigration status (n = 15) or gender / sexuality (n = 18).

One respondent took the time to write-in and explain an instance of discrimination they witnessed: "i am a certified enrollment counselor for covered ca. I had a transgender male come to me needing help with insurance and he had to select a gender he did not identify with to confirm his identity and continue his application for insurance."

As well, many respondents had knowledge of others' experiences of discrimination on the basis of race / ethnicity (n = 14) and immigration status (n = 18).Similarly, a substantial number of respondents knew someone who had directly experienced family separation (n = 14), deportation (n = 13) and/or incarceration (n = 12).

Formal/informal health services

In terms of formal healthcare access, the most common points of entry were picking up a prescription (n = 19), getting care for illness (n =14) and general physical exam (n = 12). Despite the negative appraisals of some respondents about the trustworthiness of alternative healthcare experiences, informal healthcare was very common. Respondents indicated that they communicated with friends/family about health (n = 29), took herbal medicines (n = 18), used over the counter medicine (n = 18) and used dietary supplements for health reasons (n = 17). This would suggest that respondents trust their own decisions and practices with alternative medicine rather than putting their trust into a homeopathic practitioner.

In terms of accessing various services and spaces for healthcare, the only resources that was indicated as “Very Easy” to access by more than 5 respondents was, “Outdoor spaces for recreation and socializing”. It is great to have parks on the Central Coast, but this will not suffice for adequate healthcare.

There was an alarming rate of difficulty reported with access basic health needs. Originally, it was intended to present the top-5, but the data indicate a veritable crisis in health access among this community, which warrants a full description:

- Affordable housing (n = 31), with n = 29 indicating “Very difficult”
- Legal counseling (n = 28)
- Well-paying jobs (n = 27)
- Financial aid and income support (n = 27)
- Specialty doctors (n = 27)
- Mental health services (n = 26)
- In-home caregivers (n = 24)
- Gender-affirming care for transgender individuals (n =23)
- Substance abuse services (n = 23)
- Public transportation (n = 22)
- Sexual health services (n =20)
- Healthy food (n = 19)
- Hospitals (n = 18)
- General doctors (n = 18)
- Maternal health services (n = 18)

At this rate, it appears to be near impossible to access healthcare for most respondents. Individuals are being forced to resort to individualized self-care practices, despite the potential for hospitals, physicians, and other healthcare providers to contribute to the overall quality of life and wellbeing within these communities.

When separated by county, a few of these variables indicated specific patterns worth noting. Specifically, it appears that housing is particularly difficult in both SLO and SB counties. 90% of respondents in SB county and over 90% of respondents in SLO county indicated that it was difficult to access housing, and no respondents indicated that it was “Very Easy” to access housing. As well, there was a particularly high rate of difficulty identified in finding general doctors in SB county with 42.9% indicating it is “very difficult” to do so. Lastly, many respondents also indicated a pressing issue of lack of healthy food resources in SLO county (53.3%).

Write-in responses: How can society support immigrant health needs?

The final questions of the survey offered space for respondents to bring about their own ideas and write-in longer responses about these issues. Notably, the primary vectors of risk and vulnerability were undocumentedness, gender, sexuality, and working in the fields.

Further: How do we address these complex problems? When asked in their own words, here is some of the wisdom respondents had to share about how society can support immigrant health needs:

- "By recognizing no person is illegal on stolen lands and working to rebuild Indigenous and Latinx life ways that allow immigrants to have self-determination over their bodily autonomy and health needs."
- "Fomentar el no tener temor a ir a un doctor de cualquier tipo"
- "Really understand and believe that 'We are all in this together' 'It is OUR COMMUNITY'"
- "Proveyendo mas servicios y haciendo mas outreach para que la comunidad sepa de ellos, muchas veces si hay servicios pero la gente no esta informada y/o no saben que existen esos servicios"
- "Listen to understand and execute timely operations for better health access and policy change"

These data are from a 3-month collection period and I will be focusing on boosting recruitment efforts to give us a clearer and more generalizable sample on health needs and assets for each county in the central coast. If there are any questions or you would like to follow-up on any of these findings or participate in an interview or focus group, contact me via email at mvespinoza@ucsb.edu and I can also be reached at 805-904-9225.

References

Lopez, Susana Ayala. 2014. "Assets Associated with Well-Being among Mexican Immigrants: The Development and Psychometric Evaluation of the Mexican Immigrant Assets Scale." Ph.D., University of California, Santa Barbara, United States -- California.

Spitzer, Robert L., Kurt Kroenke, Janet B. W. Williams, and Bernd Löwe. 2006. "A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7." *Archives of Internal Medicine* 166(10):1092–97.

Informe de la comunidad: resultados preliminares

24 de junio de 2020

Por: Mario Espinoza-Kulick, MA, PhD Candidato (UCSB - Sociología)

Encuesta

La encuesta de necesidades / activos de salud se realiza en vivo en inglés y español, y el reclutamiento está en curso. Puede ver y completar la encuesta en el siguiente enlace: <https://tinyurl.com/Immigrant-Health-Survey>. Estoy planeando expandir el alcance de esta encuesta para incluir al menos 100-150 encuestados. Tal como está, la encuesta ha reunido aproximadamente 74 participantes con 42 respuestas completas. Utilizando los datos recopilados entre este grupo, he investigado la validez y las estadísticas descriptivas básicas para cada ítem. Aunque el aumento de la muestra proporcionará una especificidad y precisión importantes en términos de los hallazgos estadísticos, este informe muestra hallazgos preliminares importantes en relación con las graves necesidades de salud de las partes interesadas del movimiento de salud de los inmigrantes.

¿Quiénes son los encuestados?

Un total de 74 encuestados han respondido la encuesta entre el 9/16/2019 - 6/17/2020. De este grupo, 16 encuestados se negaron a participar después de ver el consentimiento informado. Además, 42 encuestados completaron más del 95% de la encuesta. Hubo una tasa de finalización reducida en general, porque la pregunta final es el clic opcional para el sorteo de incentivos. Los encuestados que opten por no participar del sorteo están marcados como "incompletos".

7 encuestados completaron la versión española de la encuesta (9.5%).

52 encuestados identificados como defensores de la salud de los inmigrantes (89.7%)

28 encuestados identificados como miembros de la comunidad inmigrante (48.3%)

24 encuestados estuvieron presentes en ambos grupos. Cabe destacar que la gran mayoría de los miembros de la comunidad de inmigrantes también se identificaron como defensores. [A partir de los datos de la entrevista, sabemos que muchos miembros de la comunidad inmigrante abogan por la atención médica individual y los miembros de la familia, así como por grandes cambios estructurales.]

¿Dónde Viven los Encuestados?

40 encuestados no respondieron la ciudad donde vivían. Esto indica una desconfianza al compartir información. Ordenado por condado, los que revelaron se resumen en la Tabla a continuación.

Condado o Región	***n***
Santa Barbara	10
San Luis Obispo	18
Ventura	1
Monterey	1
Bay Area	2
Southern California	2

Identidad

En términos de género, la muestra es mayoritariamente mujeres cis (n = 36) y también incluye hombres cis (n = 8), una persona trans (n = 1) y otra persona de género queer (n = 1).

La muestra es mayoritariamente latina / o / x o hispana (n = 38) y también incluye encuestados negros, indios americanos y blancos. A los encuestados se les permitió seleccionar múltiples categorías, y 4 encuestados afirmaron su identidad como birracial o multirracial.

Dentro de la categoría más amplia de etnia latina / o / x, folx proporcionó su identidad étnica primaria. Esto incluía beliceño (n = 2), chicana / o / x (n. = 4), cubano (n = 1), dominicano (n = 2), mexicano (n = 22), mexicoamericano (n = 16), Peruana (n = 1), salvadoreña (n = 1), multicultural [escrito: Mestiza] (n = 1).

Un grupo de 6 encuestados se autoidentificaron como indígenas, incluidos Acoma Pueblo, Azteca, Karuk, Oaxaca, Purépecha y sin afiliación (n = 2). Entre los encuestados indígenas, un individuo identificado como Two-Spirit [escrito: No binario, trans *, Indigequeer].

Muchos encuestados eran heterosexuales o heterosexuales (n = 36). Los encuestados también se identificaron como bisexuales (n = 2), homosexuales (n = 3), queer (n = 2) y un individuo se negó a declarar.

La muestra incluye un rango de diversidad de edades, desde los 20 años hasta los 66 años. El rango de experiencias también incluyó diferentes relaciones con la inmigración. La edad de la primera llegada a los EE. UU. Para los inmigrantes encuestados se resume en la tabla a continuación.

Año de llegada	***n***
1973	1
1980	1
1987	1
1989	2
1996	3
1997	1
1999	1
2001	1
2005	1
2006	1
2010	1
2011	1

Lengua y ciudadanía

Muchos indicaron que hablan dos o más idiomas, incluidos español e inglés (n = 33). Solo siete individuos indicaron que son monolingües (n = 5 inglés, n = 2 español).

Cuando se les pidió que indicaran qué idioma usan principalmente, muchos encuestados afirmaron que usan inglés y español o los combinan regularmente (n = 12). Más encuestados utilizaron principalmente inglés (n = 26) en comparación con español (n = 4).

6 personas no eran ciudadanos estadounidenses al momento de realizar la encuesta, y todas estas personas se identificaron como miembros de la comunidad inmigrante. Además, 4 no ciudadanos también se identificaron como defensores, además de los dos encuestados que se negaron a declarar su ciudadanía (n = 2).

Los Resultados De Salud

Se pidió a los encuestados una versión modificada de la "Escala de activos de inmigrantes mexicanos" de 22 ítems (López 2014). Las referencias específicas a la identidad mexicana se eliminaron de los ítems de la escala y se reemplazaron con declaraciones más generales relevantes para los grupos de inmigrantes latinx. Las puntuaciones generales fueron altas, con una media de 5,86 en una escala del 1 al 6. Esto significa que la mayoría de los encuestados indicaron un nivel de resistencia extremadamente alto en todos los ámbitos. Del mismo modo, cuando se les pidió que informaran sobre su calidad general de salud, la mayoría de los encuestados indicaron buena salud (53.7%) y muchos también indicaron una excelente salud (24.4%).

Los encuestados también informaron un nivel relativamente moderado de ansiedad, medido utilizando la escala de trastorno de ansiedad general (GAD-7) (Spitzer et al. 2006). Casi 1 de cada 5 encuestados indicó síntomas de ansiedad por encima del punto medio (18.4%).

Acceso A Servicios Y Sistemas De Salud

Como la mayoría de los Estados Unidos, la cobertura de seguro de salud más común provino de los planes proporcionados por el empleador (n = 22). Además, otros que tenían cobertura de seguro la recibieron de fuentes privadas (n = 4) o programas gubernamentales: Medi-Cal (n = 4), Medicare (n = 1) o Medi-Cal de emergencia (n = 2) .

Se informa una confianza moderada para los proveedores de atención médica occidentales (incluidos médicos generales [n = 19], especialistas [n = 24] y enfermeras [n = 16]). Además, solo se otorgó cierta confianza a los asistentes médicos (n = 14) y a los educadores de salud (n = 14).

En particular, hubo un patrón de desconfianza informado (es decir, "No confíes en absoluto") dirigido a servicios de salud alternativos, que incluyen doulas / parteras (n = 3), curanderos (n = 11), sobadoras (n = 6), oracionistas (n = 13), yerberos (n = 13) y "Otros" proveedores de servicios de salud no occidentales (n = 8). En todos estos grupos, fueron los defensores autoidentificados quienes constantemente clasificaron la baja confianza en estas formas de atención médica. Puede ser que algunas personas estén motivadas para abogar, porque ven las prácticas alternativas de atención médica como un estándar inferior para mantener estilos de vida saludables.

Este es un problema grave para la comunidad, ya que es necesaria la confianza adecuada entre varios tipos de proveedores de atención médica para garantizar la salud y la curación. En particular, los educadores de salud deben asumir la responsabilidad de construir relaciones de confianza con la comunidad, establecer un patrón de educación riguroso y centrado en los resultados, y sanar los traumas pasados de experiencias negativas de educación en salud.

Las 5 Principales Barreras Para La Atención Médica

Las barreras pendientes para el acceso a la atención médica identificadas por los encuestados fueron que las citas no están disponibles (n = 23) y los servicios son demasiado caros (n = 15). Cuando se ve a la luz de los datos cualitativos, es obvio que algunas preguntas básicas sobre el acceso a la atención médica preocupan a esta comunidad. Específicamente, el número de proveedores disponibles y el costo de esos proveedores no se alinean con la capacidad de la comunidad.

Además, algunos otros patrones de barreras identificadas fueron la discriminación o la hostilidad al intentar acceder a la atención médica (n = 6), no poder obtener tiempo libre en el trabajo (n = 5), y la política de seguro no cubrió lo que necesitamos (n = 5).

Las 5 Principales Barreras Percibidas Para La Atención Médica (Divididas Por Defensor / Miembro De La Comunidad)

En general, la percepción de las barreras a la atención médica para esta comunidad fue que hay una serie de problemas importantes. En particular, los más comúnmente identificados fueron: los servicios son demasiado caros (n = 24); falta de seguro (n = 21) y cobertura de seguro inadecuada (n = 20); proveedores que no pueden hablar el idioma de los pacientes (n = 17) y una cultura de miedo hacia la aplicación de la ley de inmigración (n = 16).

Cuando se les preguntó qué idioma hablan con sus propios proveedores de atención médica, la mayoría de los encuestados indicó inglés (n = 30), mientras que un pequeño grupo indicó español (n = 4).

Hubo acuerdo entre los miembros de la comunidad y los defensores de grupos externos sobre algunas de estas barreras. Por ejemplo, la preocupación sobre el costo de los servicios y la cobertura de las pólizas de seguro se compartió de manera uniforme entre ambos grupos. Los miembros de la comunidad tenían más probabilidades de identificar las barreras del idioma y tener seguro como los principales problemas que enfrenta esta comunidad. Por el contrario, los defensores que no eran miembros de la comunidad tenían más probabilidades de identificar el miedo a la aplicación de la ley de inmigración como un problema importante.

Las 3 mejores experiencias de adversidad en salud

Las experiencias directas más comúnmente reportadas de adversidad, discriminación y acoso fueron la discriminación por motivos de raza / etnia (n = 21) y la muerte de un ser querido (n = 21). Además, muchos encuestados habían presenciado discriminación por motivos de raza / etnia (n = 18), estado migratorio (n = 15) o género / sexualidad (n = 18).

Uno de los encuestados se tomó el tiempo para escribir y explicar un caso de discriminación que presenciaron: “Soy un consejero de inscripción certificado para ca. cubierto. Tuve un hombre transgénero que acudió a mí y necesitaba ayuda con el seguro y tuvo que seleccionar un género con el que no se identificaba para confirmar su identidad y continuar con su solicitud de seguro ”.

Además, muchos encuestados tenían conocimiento de las experiencias de discriminación de otros en función de la raza / etnia (n = 14) y el estado de inmigración (n = 18). De manera similar, un número sustancial de encuestados conocía a alguien que había experimentado una separación familiar directa (n = 14), deportación (n = 13) y / o encarcelamiento (n = 12).

Servicios de salud formales / informales

En términos de acceso formal a la atención médica, los puntos de entrada más comunes fueron recoger una receta (n = 19), recibir atención por enfermedad (n = 14) y un examen físico general (n = 12). A pesar de las evaluaciones negativas de algunos encuestados sobre la confiabilidad de las experiencias alternativas de atención médica, la atención médica informal era muy común. Los encuestados indicaron que se comunicaron con amigos / familiares sobre la salud (n = 29), tomaron hierbas medicinales (n = 18), usaron medicamentos de venta libre (n = 18) y usaron suplementos dietéticos por razones de salud (n = 17). Esto sugeriría que los encuestados confían en sus propias decisiones y prácticas con la medicina alternativa en lugar de depositar su confianza en un profesional homeopático.

En términos de acceso a varios servicios y espacios para el cuidado de la salud, los únicos recursos que fueron indicados como "Muy fácil" para acceder por más de 5 encuestados fueron, "Espacios al aire libre para recreación y socialización". Es genial tener parques en la costa central, pero esto no será suficiente para una atención médica adecuada.

Hubo una alarmante tasa de dificultad reportada con el acceso a las necesidades básicas de salud. Originalmente, tenía la intención de presentar el top 5, pero los datos indican una verdadera crisis en el acceso a la salud entre esta comunidad, lo que garantiza una descripción completa:

• Vivienda asequible (n = 31), con n = 29 indicando "Muy difícil"
• Asesoría legal (n = 28)
• Trabajos bien remunerados (n = 27)
• Ayuda financiera y apoyo a los ingresos (n = 27)
• Médicos especializados (n = 27)
• Servicios de salud mental (n = 26)
• Cuidadores en el hogar (n = 24)
• Atención afirmativa de género para personas transgénero (n = 23)
• Servicios de abuso de sustancias (n = 23)
• Transporte público (n = 22)
• Servicios de salud sexual (n = 20)
• Comida sana (n = 19)
• Hospitales (n = 18)
• Médicos generales (n = 18)
• Servicios de salud materna (n = 18)

A este ritmo, parece ser casi imposible acceder a la atención médica para la mayoría de los encuestados. Las personas se ven obligadas a recurrir a prácticas de autocuidado individualizadas, a pesar de la posibilidad de que hospitales, médicos y otros proveedores de atención médica contribuyan a la calidad de vida y el bienestar general dentro de estas comunidades.

Cuando se separaron por condado, algunas de estas variables indicaron patrones específicos que vale la pena señalar. Específicamente, parece que la vivienda es particularmente difícil en los condados SLO y SB. El 90% de los encuestados en el condado de SB y más del 90% de los encuestados en el condado de SLO indicaron que era difícil acceder a la vivienda, y ninguno de los encuestados indicó que era "Muy fácil" acceder a la vivienda. Además, se identificó una tasa de dificultad particularmente alta para encontrar médicos generales en el condado de SB, con un 42,9% que indica que es "muy difícil" hacerlo. Por último, muchos encuestados también

indicaron un problema apremiante de falta de recursos alimenticios saludables en el condado de SLO (53.3%).

Respuestas Escritas: ¿Cómo Puede La Sociedad Apoyar Las Necesidades De Salud De Los Inmigrantes?

Las preguntas finales de la encuesta ofrecieron espacio para que los encuestados presentaran sus propias ideas y escribieran respuestas más largas sobre estos temas. En particular, los principales vectores de riesgo y vulnerabilidad fueron los indocumentados, el género, la sexualidad y el trabajo en el campo.

Además: ¿Cómo abordamos estos problemas complejos? Cuando se les preguntó en sus propias palabras, aquí hay algo de la sabiduría que los encuestados tuvieron que compartir sobre cómo la sociedad puede apoyar las necesidades de salud de los inmigrantes:

- "Al reconocer que ninguna persona es ilegal en tierras robadas y trabajar para reconstruir las formas de vida de los indígenas y latinx que permiten a los inmigrantes tener autodeterminación sobre sus necesidades de salud y autonomía corporal".
- “Fomentar el no tener temor es un médico de cualquier tipo”
- "Realmente entiendo y cree que" estamos todos juntos en esto "," es NUESTRA COMUNIDAD"
- "Probar mas servicios y hacer mas alcance para la comunidad separada de ellos, muchas veces si hay servicios pero la gente no esta informada y / o no saben que existen esos servicios"
- “Escuchar para comprender y ejecutar operaciones oportunas para un mejor acceso a la salud y cambios en las políticas”

Estos datos son de un período de recolección de 3 meses y me enfocaré en impulsar los esfuerzos de reclutamiento para darnos una muestra más clara y más generalizable sobre las necesidades y los activos de salud para cada condado en la costa central. Si tiene alguna pregunta o desea hacer un seguimiento de cualquiera de estos hallazgos o participar en una entrevista o grupo focal, contácteme por correo electrónico a mvespinoza@ucsb.edu y también me pueden contactar al 805-904-9225.

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Latinx Immigrant Health in San Luis Obispo County: A Report from the La Gente Unida Project
Mario Alberto V. Espinoza-Kulick, MA, PhD Candidate

Introduction

Within the county of San Luis Obispo, Latina/o/x and Hispanic individuals make up the largest minority group as 23% of the population. As well, there are significant healthcare resources in this community, including the pristine natural environment. However, health inequities persist including low access to dental care, mental health concerns, lack of affordable housing and lack of services for the Spanish-speaking community (San Luis Obispo County Public Health Department 2018). Respondents from San Luis Obispo report serious concerns, especially mental health and breast cancer, as well as barriers to care due to the cost of services themselves, insurance, language barriers, and fear of immigration enforcement. The report concludes with recommendations for expanding access to culturally competent healthcare services and advocating for racial justice.

Key Findings from San Luis Obispo

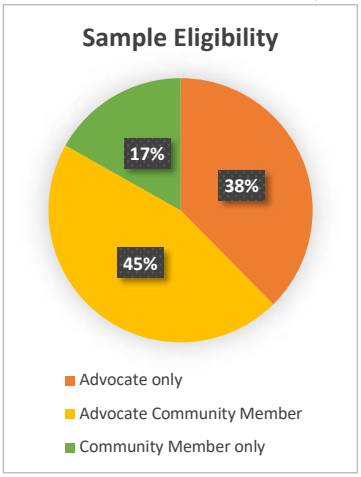

Figure 1. Sample Eligibility

This report is based on a larger project examining Latinx immigrant health and advocacy across California's Central Coast. A survey of Latinx immigrant health, healthcare, and advocacy was developed in collaboration with community leaders. In total, 177 eligible respondents were recruited between September 2019 – September 2020. The survey was shared with help from groups like Community Action Partnership San Luis Obispo (CAP-SLO), Cuesta College, Cal Poly SLO, RISE, Central Coast Coalition for Undocumented Student Success (CCC-USS), Immigrant Support Network (list-serve), Transitions-Mental Health Association (T-MHA), Access Support Network, and Gala Pride and Diversity Center, through paid social media advertisements, and by supportive individuals. This report includes 72 respondents from San Luis Obispo County (31) and those who did not disclose their location (41). Individuals were eligible to participate in the study if they were an immigrant community member (Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen), or as an advocate (individuals that actively participate in social change efforts toward advancing immigrant health equity). As seen in the first figure: Sample Eligibility (above-left), the largest group in the sample was those who occupied both positions: advocate and community member (46%), followed by advocates from outside the community (38%), and community members who did not consider themselves advocates (17%).

Demographics

In terms of race and ethnicity, the majority of the people surveyed self-identified as Latina/o/x or Hispanic (62%). However, that is not to say that the community is monolithic. The remainder of the sample identified as white (26%) or multiracial (12%). Multiracial included anyone who selected two or more races, such as Latinx and Black/African American or American Indian/Alaskan Native. Among those who self-identified as Latinx, the largest national group was "Mexican" (32%), "Mexican-American" (19%), or Chicana/o/x (5%). This is summarized in the second figure (next page). Other identities represented within the sample were: Belizean, Chilean, Cuban, Dominican, Guatemalan, Peruvian, Salvadorian, Other Caribbean, Multicultural

and Not Listed. Further, 12% of the sample identified as Indigenous, including a range of tribal and national affiliations.

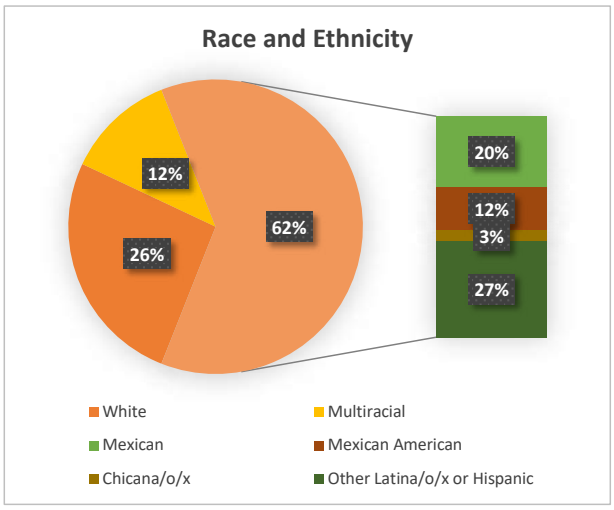

Figure 2. Race and Ethnicity

Beyond race and ethnicity, the sample also reflects additional intersecting identities. About three quarters of the sample were U.S. citizens (78%). The sample was also mostly women (77%). In addition, 17% were cisgender men and 6% were genderqueer or a not listed gender identity. In terms of sexual orientation, the majority of respondents were heterosexual/straight (83%), and the survey also included individuals who identified as bisexual (5%), gay (5%), queer (5%), or a not listed sexual orientation (2%).

Health Needs and Concerns

In the survey, individuals were asked to report about their own perceptions of health concerns, as well as their beliefs about the issues facing the larger community. Those health concerns that were rated, on average, above the mid-point (3) are presented in the third figure: Most Pressing Health Concerns (below-right). The top-rated amongst these were **mental health** ($M = 3.8$, $SD = 1.5$) and **breast cancer** ($M = 3.6$, $SD = 1.3$). Breast cancer is the leading cause of cancer death for Latina women in the United States. Specifically, Latinas disproportionately experience later diagnoses and more severe cases than non-Hispanic whites (American Cancer Society 2018). Even though overall incidence of breast cancer is lower for Latinas, issues of access to healthcare exacerbate disparities in breast cancer treatment and outcomes.

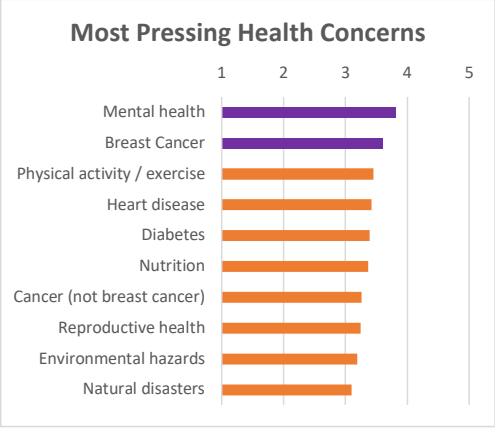

Figure 3. Most Pressing Health Concerns

Further, at the individual level, we also asked individuals if they had delayed or gone without healthcare within the past 3 months for a number of reasons. **Over half of the sample had avoided healthcare within the past 3 months because appointments were not available (61%).** As well, cost was a substantial barrier. For over a third of the sample (35%) had avoided healthcare because services are too expensive. The third highest ranked

reason for avoiding healthcare was also indirectly related to cost, as 16% reported that they were unable to get time off of work.

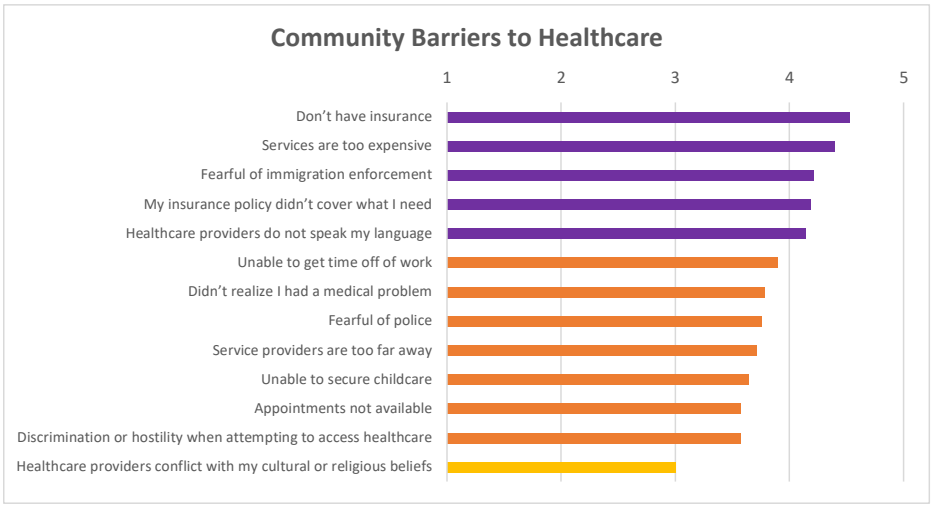

Figure 4. Community Barriers to Healthcare

In terms of obstacles in accessing care among Latinx immigrants, respondents identified a range of issues. The items ranked above the mid-point (3) are presented in the fourth figure (above): Community Barriers to Healthcare. The most pressing were that **individuals don't have insurance** ($M = 4.5$, $SD = 0.8$), **services are too expensive** ($M = 4.4$, $SD = 0.9$), **fear of immigration enforcement** ($M = 4.2$, $SD = 1.0$), **inadequate insurance coverage** ($M = 4.2$, $SD = 1.1$), and that **healthcare providers do not speak an individual's language** ($M = 4.1$, $SD = 1.0$). Past researchers have found that immigrant groups are **systematically excluded** from opportunities for health insurance (Gold 2005; Ku and Matani 2001; McGuire 2014). Relatedly, Francisco Pedraza and Lin Zhu (2015) have named the "**chilling effect**" to describe the wide-ranging impacts of punitive immigration enforcement policies on immigrant communities and mixed-status families.

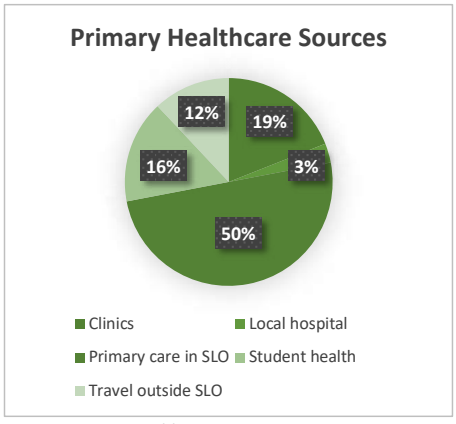

Figure 5. Primary Healthcare Sources

Community Assets

Participants showed a high level of resiliency. On an adapted version of the "Mexican Immigrants Asset Scale" for Latinx communities, the average resiliency score was 3.4 out of 4 ($SD = 0.4$) (Lopez 2014). In spite of significant barriers, discrimination, and systematic exclusion, immigrant community members and advocates create opportunities for

healthcare. The fifth figure (previous page), summarizes the location where respondents access primary health services. Half of the sample (50%) have a primary care provider in San Luis Obispo county. Notably, a substantial group of respondents (12%) travel outside of SLO in order to access affordable, specialty, and/or culturally competent healthcare services.

Recommendations

There is an urgent need to address the multi-layered issues affecting Latinx and immigrant health in San Luis Obispo. One respondent summarized the need for systemic change in this area in responding to the question "What are the most pressing health needs for this community?": "Access and equitable treatment from healthcare professionals, systems that allow undocumented and uninsured folx to still access care. Spanish and Mixtec translation/interpretation so the care that *is* [received] is actually meaningful."

Within the city of San Luis Obispo, there are opportunities to address these inequities in health through expanded free and low-cost healthcare services and upgrading medical technology used at low-income health clinics. As breast cancer was identified as a major concern, high-quality screening services are needed. To address gaps in early detection, these services must be promoted in culturally responsive ways in both English and Spanish, as well as through Indigenous language interpretation. Additional funding is also needed to expand existing mental health services, including through community agencies like T-MHA and specialty providers at Sierra Vista Regional Medical Center and French Hospital Medical Center.

Beyond direct healthcare services, the community also identified larger structural issues that must be addressed through collaboration across sectors. The city has identified that racism is a public health crisis (Wilson 2020) and declared itself as a "sanctuary" for immigrants (Cal Coast News 2017). However, there is vocal resistance in the community to these issues (see for example: Crockett 2018 and McGuinness 2019). Creative strategies are needed to address the identified inequities in health and make a more inclusive and welcoming space for the Latinx community in San Luis Obispo.

Author Note

Mario Espinoza-Kulick (he/him/his) is a Doctoral Candidate in the department of Sociology at the University of California, Santa Barbara and a lecturer in the Ethnic Studies and Women's and Gender Studies departments at California Polytechnic State University, San Luis Obispo. He researches the ways in which healthcare agencies and social movement organizations can advocate for marginalized groups in culturally appropriate ways and through implementation of equitable health policies. Mario draws from his own experience as an HIV+, Queer, Latinx and Indigenous person to raise awareness around health inequities. For more information about this study, please visit our website at https://tinyurl.com/LaGenteUnida You can contact Mario at mvespinoza@ucsb.edu or by phone at (805) 904-9225.

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Acknowledgments

This study was supported by the Robert Wood Johnson Foundation through the Health Policy Research Scholars program and by the Health Policy Research Scholars Dissertation Award. Thanks to the participants in both the survey and to the research assistants at California Polytechnic State University, San Luis Obispo for the "La Gente Unida" project.

Suggested Citation

Espinoza-Kulick, Mario Alberto V. 2020. *Latinx Immigrant Health in San Luis Obispo County: A Report from the La Gente Unida Project*. Santa Maria, CA: La Gente Unida.

Salud de Inmigrantes Latinx en el Condado de San Luis Obispo: Un Informe del Proyecto LGU

Mario Alberto V. Espinoza-Kulick, MA, PhD Candidate

Introducción

Dentro del condado de San Luis Obispo, las Latinas/o/*x y* las personas hispanas constituyen el grupo minoritario más grande con el 23% de la población. Además, existen importantes recursos de atención médica en esta comunidad, incluido el entorno natural prístino. Sin embargo, persisten las desigualdades en la salud, incluido el bajo acceso a la atención dental, problemas de salud mental, falta de viviendas asequibles y falta de servicios para la comunidad de habla hispana (Departamento de Salud Pública del Condado de San Luis Obispo 2018). Los encuestados de San Luis Obispo informaron serias preocupaciones, especialmente la salud mental y el cáncer de mama, así como las barreras para la atención debido al costo de los servicios en sí, el seguro, las barreras del idioma y el temor a la aplicación de leyes de inmigración. El informe concluye con recomendaciones para ampliar el acceso a servicios de salud culturalmente competentes y abogar por la justicia racial.

Hallazgos de San Luis Obispo

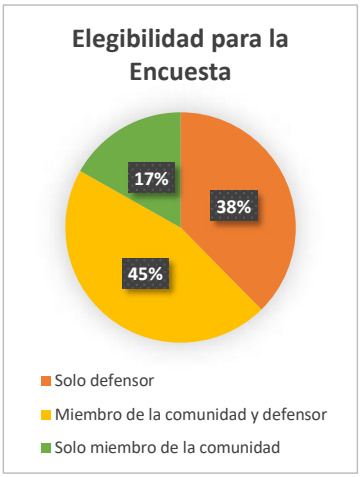

Figura 1. Elegibilidad para la Encuesta

Este informe se basa en un proyecto más amplio que examina la salud y la defensa de los inmigrantes latinos en la costa central de California. Se desarrolló una encuesta sobre la salud, la atención médica y la promoción de inmigrantes latinos en colaboración con líderes comunitarios. En total, se reclutaron 177 encuestados elegibles entre septiembre de 2019 y septiembre de 2020. La encuesta se compartió con la ayuda de grupos como Community Action Partnership San Luis Obispo (CAP-SLO), Cuesta College, Cal Poly SLO, RISE, Central Coast Coalition for Undocumented Student Success (CCC-USS), Immigrant Support Network (lista de servicios), Transitions-Mental Health Association (T-MHA), Access Support Network y Gala Pride and Diversity Center, a través de anuncios pagados en las redes sociales y por personas de apoyo. Este informe incluye 72 encuestados del condado de San Luis Obispo (31) y aquellos que no revelaron su ubicación (41). Las personas eran elegibles para participar en el estudio si eran miembros de la comunidad inmigrante (indocumentados, soñadores, familiares de estatus mixto, residentes y / o ciudadanos naturalizados) o como defensores (personas que participan activamente en los esfuerzos de cambio social para avanzar equidad en salud de los inmigrantes). Como se ve en la primera figura: Elegibilidad de la muestra (arriba a la izquierda), el grupo más grande de la muestra fue el de quienes ocuparon ambas posiciones: defensor y miembro de la comunidad (46%), seguido por defensores de fuera de la comunidad (38%), y miembros de la comunidad que no se consideraban defensores (17%).

Demografía

En términos de raza y etnia, la mayoría de las personas encuestadas se auto-identificaron como latinas / o / x o hispanas (62%). Sin embargo, eso no quiere decir que la comunidad sea monolítica. El resto de la muestra se identificó como blanco (26%) o multirracial (12%). Multirracial incluía a cualquier persona que seleccionara dos o más razas, como Latinx y negro / afroamericano o indio americano / nativo de Alaska. Entre los que se auto-identificaron como Latinx, el grupo nacional más grande fue “mexic

o chicana / o / x (5%). Esto se resume en la segunda figura (abajo). Otras identidades representadas dentro de la muestra fueron: beliceña, chilena, cubana, dominicana, guatemalteca, peruana, salvadoreña, otra caribeña, multicultural y no cotizada. Además, el 12% de la muestra se identificó como indígena, incluida una variedad de afiliaciones tribales y nacionales.

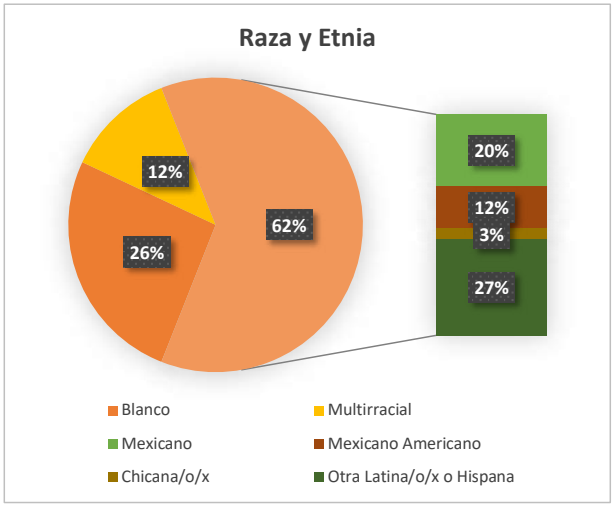

Figura 1. Raza y Etnia

Más allá de la raza y la etnia, la muestra también refleja identidades adicionales que se cruzan. Aproximadamente las tres cuartas partes de la muestra eran ciudadanos estadounidenses (78%). La muestra también fue mayoritariamente mujeres (77%). Además, el 17% eran hombres cisgénero y el 6% eran genderqueer o una identidad de género no incluida en la lista. En términos de orientación sexual, la mayoría de los encuestados eran heterosexuales / heterosexuales (83%), y la encuesta también incluyó a personas que se identificaron como bisexuales (5%), homosexuales (5%), queer (5%) o no incluidos en la lista orientación sexual (2%).

Necesidades y Preocupaciones de Salud

En la encuesta, se pidió a las personas que informaran sobre sus propias percepciones de los problemas de salud, así como sus creencias sobre los problemas que enfrenta la comunidad en general. Los problemas de salud que se calificaron, en promedio, por encima del punto medio (3) se presentan en la tercera figura: Problemas de salud más urgentes (a la derecha). Los mejores calificados entre ellos fueron la salud mental (M = 3.8, DE = 1.5) y el cáncer de mama (M = 3.6, DE = 1.3). El cáncer de mama es la principal causa de muerte por cáncer entre las mujeres latinas en los Estados Unidos. Específicamente, las latinas experimentan de manera desproporcionada diagnósticos tardíos y casos más graves que las blancas no hispanas (American Cancer Society 2018). Aunque la incidencia general de cáncer de mama es

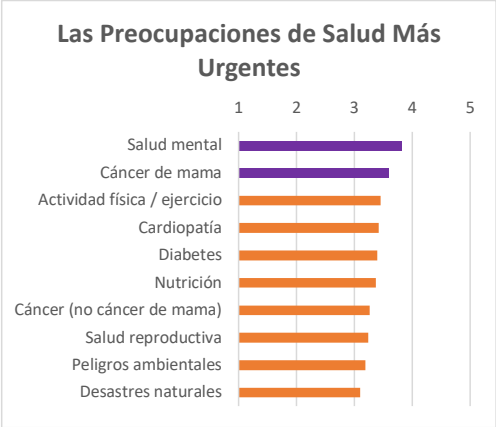

Figura 2. Las Preocupaciones de Salud Más Urgentes

más baja para las latinas, los problemas de acceso a la atención médica exacerban las disparidades en el tratamiento y los resultados del cáncer de mama.

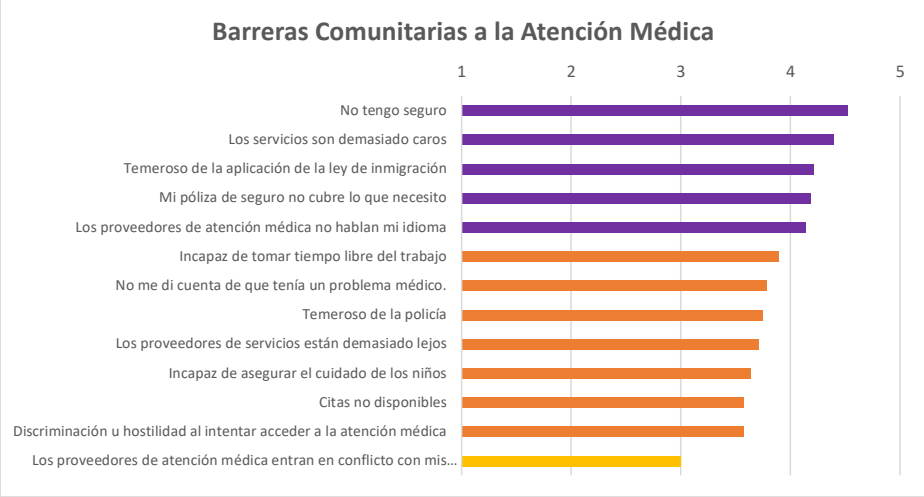

Figura 3. Barreras Comunitarias a la Atención Médica

Además, a nivel individual, también les preguntamos a las personas si se habían retrasado o se habían quedado sin atención médica en los últimos 3 meses por varias razones. Más de la mitad de la muestra había evitado la atención médica en los últimos 3 meses porque no había citas disponibles (61%). Además, el costo fue una barrera sustancial. Más de un tercio de la muestra (35%) había evitado la asistencia sanitaria porque los servicios son demasiado caros. La tercera razón más alta para evitar la atención médica también se relacionó indirectamente con el costo, ya que el 16% informó que no podía obtener tiempo libre del trabajo.

En cuanto a los obstáculos para acceder a la atención entre los inmigrantes latinos, los encuestados identificaron una variedad de problemas. Los elementos clasificados por encima del punto medio (3) se presentan en la cuarta figura (arriba): Barreras comunitarias para la atención médica. Los más urgentes fueron que las personas no tienen seguro (M = 4.5, DE = 0.8), los servicios son demasiado costosos (M = 4.4, DE = 0.9), miedo a la aplicación de la ley de inmigración (M = 4.2, DE = 1.0), inadecuados cobertura de seguro (M = 4.2, DE = 1.1), y que los proveedores de atención médica no hablan el idioma de una persona (M = 4.1, DE = 1.0). Investigadores anteriores han encontrado que los grupos de inmigrantes son excluidos sistemáticamente de las oportunidades de seguro médico (Gold 2005; Ku y Matani 2001; McGuire 2014). De manera relacionada, Francisco Pedraza y Lin Zhu (2015) han denominado el "efecto escalofriante" para describir los impactos de las políticas punitivas de aplicación de la ley de inmigración en las comunidades de inmigrantes y familias de estatus mixto.

Activos de la Comunidad

Los participantes mostraron un alto nivel de resiliencia. En una versión adaptada de la "Escala de activos de inmigrantes mexicanos" para comunidades Latinx, el puntaje promedio de resiliencia

fue 3.4 de 4 (DE = 0.4) (Lopez 2014). A pesar de las barreras importantes, la discriminación y la exclusión sistemática, los miembros y defensores de la comunidad de inmigrantes crean oportunidades para la atención médica. La quinta figura (a la derecha) resume la ubicación donde los encuestados acceden a los servicios de salud primaria. La mitad de la muestra (50%) tiene un proveedor de atención primaria en el condado de San Luis Obispo. En particular, un grupo sustancial de encuestados (12%) viaja fuera de SLO para acceder a servicios de salud asequibles, especializados y / o culturalmente competentes.

Figura 4. Servicios de Atención Primaria de Salud

Recomendaciones

Existe una necesidad urgente de abordar los problemas de múltiples niveles que afectan la salud de los latinos y los inmigrantes en San Luis Obispo. Un encuestado resumió la necesidad de un cambio sistémico en esta área respondiendo a la pregunta "¿Cuáles son las necesidades de salud más urgentes para esta comunidad?": "Acceso y tratamiento equitativo por parte de los profesionales de la salud, sistemas que permiten que las personas indocumentadas y no aseguradas sigan teniendo acceso a la atención". . Traducción / interpretación al español y mixteco, por lo que la atención que * se * [recibe] es realmente significativa ".

Dentro de la ciudad de San Luis Obispo, existen oportunidades para abordar estas inequidades en la salud mediante la ampliación de los servicios de atención médica gratuitos y de bajo costo y la actualización de la tecnología médica utilizada en las clínicas de salud de bajos ingresos. Dado que el cáncer de mama se identificó como un problema importante, se necesitan servicios de detección de alta calidad. Para abordar las deficiencias en la detección temprana, estos servicios deben promoverse de manera culturalmente receptiva tanto en inglés como en español, así como a través de la interpretación en idiomas indígenas. También se necesitan fondos adicionales para expandir los servicios de salud mental existentes, incluso a través de agencias comunitarias como T-MHA y proveedores especializados en Sierra Vista Regional Medical Center y French Hospital Medical Center.

Más allá de los servicios de atención médica directos, la comunidad también identificó problemas estructurales más importantes que deben abordarse mediante la colaboración entre sectores. La ciudad ha identificado que el racismo es una crisis de salud pública (Wilson 2020) y se declaró a sí misma como un "santuario" para los inmigrantes (Cal Coast News 2017). Sin embargo, existe una resistencia vocal en la comunidad a estos problemas (ver por ejemplo: Crockett 2018 y McGuinness 2019). Se necesitan estrategias creativas para abordar las inequidades identificadas en salud y hacer un espacio más inclusivo y acogedor para la comunidad latina en San Luis Obispo.

Nota del autor

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Luis Obispo. Investiga las formas en que las agencias de salud y las organizaciones de movimientos sociales pueden abogar por los grupos marginados de maneras culturalmente apropiadas y mediante la implementación de políticas de salud equitativas. Mario se basa en su propia experiencia como persona VIH +, queer, Latinx e indígena para crear conciencia sobre las inequidades en salud. Para obtener más información sobre este estudio, visite nuestro sitio web en https://tinyurl.com/LaGenteUnida. Puede comunicarse con Mario en mvespinoza@ucsb.edu o por teléfono al (805) 904-9225.

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Expresiones de Gratitud

Este estudio fue apoyado por la Fundación Robert Wood Johnson a través del programa Health Policy Research Scholars y por el Health Policy Research Scholars Dissertation Award. Gracias a los participantes tanto en la encuesta como a los asistentes de investigación de la Universidad Politécnica Estatal de California, San Luis Obispo por el proyecto "La Gente Unida".

Cita Sugerida

Espinoza-Kulick, Mario Alberto V. 2020. *Salud de Inmigrantes Latinx en el Condado de San Luis Obispo: Un Informe del Proyecto LGU*. Santa Maria, CA: La Gente Unida.

Introduction

There are significant healthcare resources in California's Central Coast, including the pristine natural environment. However, health inequities persist including mental health concerns, lack of affordable housing, and lack of services for the Spanish-speaking community (San Luis Obispo County Public Health Department 2018). This report provides an in-depth examination of the self-reported health needs and assets of Spanish-speaking Latinx Immigrant communities on the Central Coast. Pressing concerns were related to COVID-19, cancer, cost of healthcare, and language barriers. The report concludes with recommendations for increasing breast cancer screening and prevention, providing access to care through multilingual interpretation services, investing in healthcare capacity in underserved communities, and ensuring culturally relevant health communication about the COVID-19 vaccine.

Key Findings from the Spanish-Speaking Immigrant Community

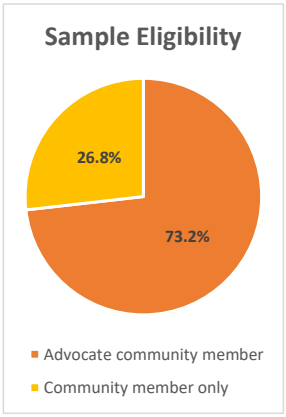

Figure 1. Sample Eligibility

This report is based on a larger project examining Latinx immigrant health and advocacy across California's Central Coast. A survey of Latinx immigrant health, healthcare, and advocacy was developed in collaboration with community leaders. In total, 177 eligible respondents were recruited between September 2019 – September 2020. The survey was shared with help from community organizations throughout the central coast, including Central Coast Coalition for Undocumented Student Success, Central Coast United for a Sustainable Economy, Mixteco Indigena Community Organizing Project, Immigrant Support Network (list-serve), Transitions-Mental Health Association, the FUND for Santa Barbara, House of Pride and Equality (HOPE), and California Immigrant Policy Center, through paid social media advertisements, and by supportive individuals. This report includes 82 respondents whose primary language was Spanish. Individuals were eligible to participate in the study if they were an immigrant community member (Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen), or as an advocate (individuals that actively participate in social change efforts toward advancing immigrant health equity). As seen in the first figure: Sample Eligibility (above-left), the largest group in the sample was those who occupied both positions: advocate and community member (73.2%), followed by community members who did not consider themselves advocates (26.8%). None of the Spanish-speaking respondents identified as advocates from outside of the community.

Demographics

In terms of race and ethnicity, virtually all of the Spanish-speaking community surveyed self-identified as Latina/o/x or Hispanic (94.4%). The remainder of the sample identified as multiracial (5.6%). Multiracial included anyone who selected two or more races, such as Latinx and Black/African American or American Indian/Alaskan Native. Among those who self-identified as Latinx, the largest national group was "Mexican" (80.3%). The second largest national group was Guatemalan (8.5%) and additional identities among this community are: Dominican, Honduran, Mexican American, Salvadorian, and Caribbean (not listed). Further, 19.7% of the sample identified as Indigenous, including a range of tribal and national affiliations.

Beyond race and ethnicity, the sample also reflects additional intersecting identities. Almost three quarters of the sample were not U.S. citizens (73.8%). Women accounted for 81.5% of respondents. In addition, 5.7% were cisgender men and 12.9% were a not listed gender identity. In terms of sexual orientation, the majority of respondents were heterosexual/straight (58.2%), and the survey also included individuals who identified as bisexual (12.7%), gay (1.8%), or a not listed sexual orientation (18.2%). An additional 10.9% declined to state.

Health Needs and Concerns

In the survey, individuals were asked to report about their own perceptions of health concerns, as well as their beliefs about the issues facing the larger community. Those health concerns that were rated, on average, above the mid-point (3) are presented in the second figure: Most Pressing Health Concerns (below-right). The top-rated amongst these were COVID-19 / coronavirus (M = 4.16, SD = 1.31), breast cancer (M = 3.57, SD = 1.47), and other types of cancer (M = 3.58, SD = 1.42). Breast cancer is the leading cause of cancer death for Latina women in the United States. Specifically, Latinas disproportionately experience later diagnoses and more severe cases than non-Hispanic whites (American Cancer Society 2018). Even though overall incidence of breast cancer is lower for Latinas, issues of access to healthcare exacerbate disparities in breast cancer treatment and outcomes.

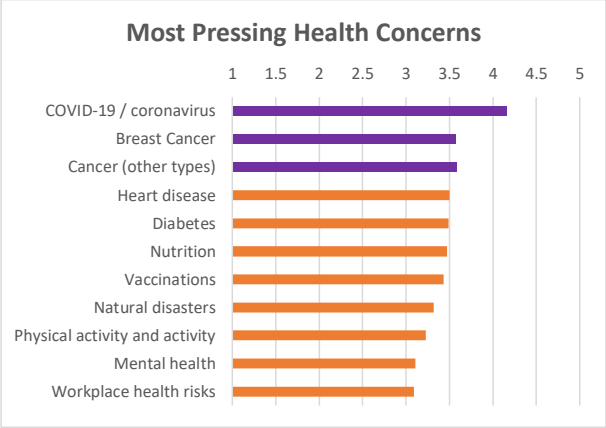

Figure 2. Most Pressing Health Concerns

Further, at the individual level, we also asked individuals if they had delayed or gone without healthcare within the past 3 months for a number of reasons. **Nearly half of the sample had avoided healthcare within the past 3 months out of fear of getting COVID-19 / coronavirus (45%).** Similarly, over a quarter had delayed healthcare due to health service closings related to the pandemic (31%). However, unrelated issues of cost and access are also present among this community. Nearly half of the sample had avoided healthcare because appointments were not available, and **over a third were unable to access care due to the cost being too expensive (39%)**. Finally, about one in five respondents indicated that they avoided healthcare because they specifically did not have insurance due to their documentation status (19%).

In terms of obstacles in accessing care among Latinx immigrants, respondents identified a range of issues. The items ranked above the midpoint (3) are presented in the fourth figure: Community Barriers to Healthcare (next page). The highest ranked issue was fear of getting COVID-19 / coronavirus (M = 4.26, SD = 1.25). Relatedly, community concerns also included fear of spreading COVID-19 (M = 3.18, SD = 1.80) and health services closures due to the pandemic (M = 3.40, SD = 1.27). Beyond this virus, the community also identified a high degree of concern about services being too expensive (M = 3.69, SD = 1.21), inadequate insurance coverage (M = 3.62, SD = 1.42), and appointments not being available (M = 3.51, SD = 1.12). Past researchers

have found that immigrant groups are **systematically excluded** from opportunities for health insurance (Gold 2005; Ku and Matani 2001; McGuire 2014).

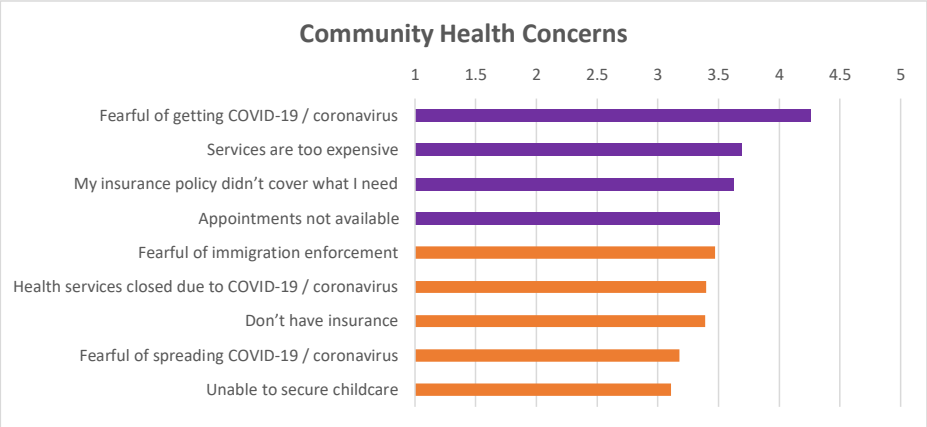

Figure 3. Community Health Concerns

Community Assets

Participants showed a high level of resiliency. On an adapted version of the "Mexican Immigrants Asset Scale" (Lopez 2014) for Latinx communities, the average resiliency score was 3.06 out of 4 (*SD* = 0.70). In spite of significant barriers, discrimination, and systematic exclusion, immigrant community members and advocates create opportunities for healthcare. Over three quarters of Spanish-speaking respondents access healthcare at a clinic or community health center (84.1%). The remainder of the sample (15.9%) get their healthcare at a hospital or primary care provider nearby, including travel to the Los Angeles area.

Recommendations

There is an urgent need to address the multi-layered issues affecting Latinx and immigrant health in the Central Coast. One respondent summarized the need for systemic change in this area in responding to the question "What are the most pressing health needs for this community?": "Access and equitable treatment from healthcare professionals, systems that allow undocumented and uninsured folx to still access care. Spanish and Mixtec translation/interpretation so the care that *is* [received] is actually meaningful."

1. Within the Central Coast region, there are opportunities to address these inequities in health through expanded free and low-cost healthcare services and upgrading medical technology used at low-income health clinics. For Spanish-speaking respondents, access and quality of care in breast cancer prevention are crucial areas for interventions like risk screenings, culturally relevant health education, and free mammogram services.
2. In general, multilingual and culturally responsive health promotion strategies help to close equity gaps in care, prevention, and treatment. Initiatives like Herencia Indigena are bringing Indigenous language interpretation to providers at Dignity Health. Other groups like the Center for Health Research Mobile Health Unit from California Polytechnic State University, San Luis Obispo are also partnering directly with Indigenous advocates and

interpreters to bridge the gaps between health resources and communities. All stages of the healthcare process should include options for multilingual interpretation.

3. Beyond access, the findings of this report also indicate the gaps in healthcare capacity in the communities where Spanish-speaking respondents live. More healthcare providers and services are needed, especially those from Spanish speaking communities in the Central Coast. Healthcare leaders and elected officials must step up to invest in the health and wellbeing of underserved communities.
4. The layers of fear and mistrust present among this community are also salient for the distribution of a COVID-19 vaccine. As respondents indicated, there is a high level of fear about getting the virus and spreading it. For successful uptake of the vaccine, educational campaigns will need to address these fears in a culturally responsive manner. For example, visual campaigns and multilingual communications can be used to build awareness about the vaccine itself and safety protocols in place to avoid exposure to COVID-19.

Principal Investigator (PI) Information

Mario Espinoza-Kulick (he/him/his) is a Doctoral Candidate in the department of Sociology at the University of California, Santa Barbara and a lecturer in the Ethnic Studies and Women's and Gender Studies departments at California Polytechnic State University, San Luis Obispo. He researches the ways in which healthcare agencies and social movement organizations can advocate for marginalized groups in culturally appropriate ways and through implementation of equitable health policies. Mario draws from his own experience as an HIV+, Queer, Latinx and Indigenous person to raise awareness around health inequities. For more information about this study, please visit our website at https://tinyurl.com/LaGenteUnida You can contact Mario at mvespinoza@ucsb.edu or by phone at (805) 904-9225.

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Acknowledgments

This study was supported by the Robert Wood Johnson Foundation through the Health Policy Research Scholars program and by the Health Policy Research Scholars Dissertation Award. Thanks to the participants in both the survey and to the research assistants at California Polytechnic State University, San Luis Obispo for the "La Gente Unida" project: Jodene Takahashi and Elisa González.

Suggested Citation

Espinoza-Kulick, Mario Alberto V. 2020. *Latinx Immigrant Health on the Central Coast: A Report on Spanish-Speaking Communities from the La Gente Unida Project.* Santa Maria, CA: La Gente Unida.

Introducción

Hay importantes recursos de salud en la costa central de California, incluido el prístino entorno natural. Sin embargo, persisten las iniquidades en la salud, incluidas las preocupaciones de salud mental, la falta de viviendas asequibles y la falta de servicios para la comunidad de habla hispana (Departamento de Salud Pública del Condado de San Luis Obispo 2018). Este informe proporciona un examen en profundidad de las necesidades de salud y los activos auto informados de las comunidades de inmigrantes Latinx de habla hispana en la costa central. Las preocupaciones urgentes estaban relacionadas con el COVID-19, el cáncer, el costo de la atención médica y las barreras del idioma. El informe concluye con recomendaciones para aumentar la detección y prevención del cáncer de mama, brindando acceso a la atención a través de servicios de interpretación plurilingüe, invirtiendo en la capacidad de atención médica en comunidades desatendidas y asegurando una comunicación de salud culturalmente relevante sobre la vacuna COVID-19.

Resultados clave de la comunidad de inmigrantes de habla hispana

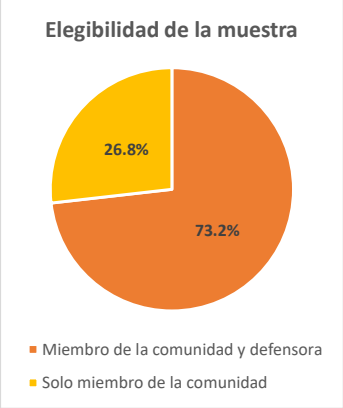

Figura 1. Elegibilidad de la muestra

Este informe se basa en un proyecto más amplio que examina la salud y la defensa de los inmigrantes latinos en la costa central de California. Se desarrolló una encuesta sobre la salud, la atención médica y la defensa de los inmigrantes latinos en colaboración con líderes comunitarios. En total, se reclutaron 177 encuestados elegibles entre septiembre de 2019 y septiembre de 2020. La encuesta se compartió con la ayuda de organizaciones comunitarias en toda la costa central, incluida la Coalición de la Costa Central para el Éxito de los Estudiantes Indocumentados, la Costa Central Unidos por una Economía Sostenible, la Organización Comunitaria Indígena Mixteco Project, Immigrant Support Network (list-serve), Transitions-Mental Health Association, FUND for Santa Barbara y California Immigrant Policy Center, a través de anuncios pagados en las redes sociales y por parte de personas de apoyo. Este informe incluye 82 encuestados cuyo idioma principal era el español. Las personas eran elegibles para participar en el estudio si eran miembros de la comunidad inmigrante (indocumentados, soñadores, familiares de estatus mixto, residentes y / o ciudadanos naturalizados) o como defensores (personas que participan activamente en los esfuerzos de cambio social para avanzar equidad en salud de los inmigrantes). Como se ve en la primera figura: Elegibilidad del estudio (arriba a la izquierda), el grupo más grande de las encuestadas fue el de quienes ocuparon ambas posiciones: defensor y miembro de la comunidad (73.2%), seguido por los miembros de la comunidad que no se consideraban defensores (26.8%). Ninguno de los encuestados de habla hispana se identificó como defensores de fuera de la comunidad.

Demografía

En términos de raza y origen étnico, prácticamente toda la comunidad de habla hispana encuestada se auto identificó como Latina/o/x o Hispana (94,4%). El resto de la gente se identificó como multirracial (5,6%). Multirracial incluía a cualquier persona que seleccionara dos o más razas, como Latinx y negro / afroamericano o indio americano / nativo de Alaska.

Entre los que se auto identificaron como Latinx, el grupo nacional más grande fue el de "mexicano" (80,3%). El segundo grupo nacional más grande fue el guatemalteco (8.5%) y las identidades adicionales entre esta comunidad son: dominicana, hondureña, mexicoamericana, salvadoreña y caribeña (no listada). Además, el 19,7% de la gente se identificó como indígena, incluida una variedad de afiliaciones tribales y nacionales.

Más allá de la raza y la etnia, la gente también refleja identidades adicionales que se cruzan. Casi tres cuartas partes de la gente no eran ciudadanos estadounidenses (73,8%). Las mujeres representaron el 81,5% de los encuestados. Además, el 5,7% eran hombres cisgénero y el 12,9% tenían una identidad de género no incluida en la lista. En términos de orientación sexual, la mayoría de los encuestados eran heterosexuales / heterosexuales (58,2%), y la encuesta también incluyó a personas que se identificaron como bisexuales (12,7%), homosexuales (1,8%) o una orientación sexual no incluida en la lista (18,2%). Un 10,9% adicional declinó declarar.

Necesidades y preocupaciones de salud

En la encuesta, se pidió a las personas que informaran sobre sus propias percepciones de los problemas de salud, así como sus creencias sobre los problemas que enfrentan la comunidad en general. Los problemas de salud que se calificaron, en promedio, por encima del punto medio (3) se presentan en la segunda figura: Problemas de salud más urgentes (abajo a la derecha). Los mejores calificados entre estos fueron COVID-19 / coronavirus (M = 4.16, SD = 1.31), cáncer de mama (M = 3.57, SD = 1.47) y otros tipos de cáncer (M = 3.58, SD = 1.42). El cáncer de mama es la principal causa de muerte por cáncer entre las mujeres latinas en los Estados Unidos. Específicamente, las latinas experimentan de manera desproporcionada diagnósticos tardíos y casos más graves que los blancos no hispanos (American Cancer Society 2018). Aunque la incidencia general de cáncer de mama es menor para las latinas, los problemas de acceso a la atención médica exacerban las disparidades en el tratamiento y los resultados del cáncer de mama.

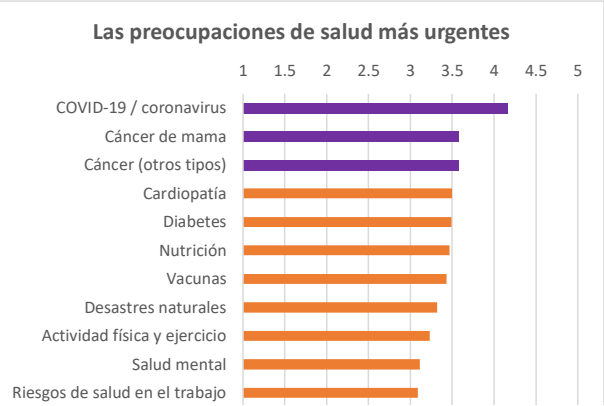

Figura 2. Las preocupaciones de salud más urgentes

Además, a nivel individual, también preguntamos a las personas si se habían retrasado o no habían recibido atención médica en los últimos 3 meses por varias razones. Casi la mitad de la muestra había evitado la atención médica en los últimos 3 meses por temor a contraer COVID-19 / coronavirus (45%). Del mismo modo, más de una cuarta parte había retrasado la atención médica debido a cierres de servicios de salud relacionados con la pandemia (31%). Sin embargo, problemas no relacionados de costo y acceso también están presentes en esta comunidad. Casi la mitad de la muestra había evitado la atención médica porque las citas no estaban disponibles, y más de un tercio no pudo acceder a la atención debido a que el costo era demasiado alto (39%).

Finalmente, aproximadamente uno de cada cinco encuestados indicó que evitaba la atención médica porque específicamente no tenía seguro debido a su estado de documentación (19%).

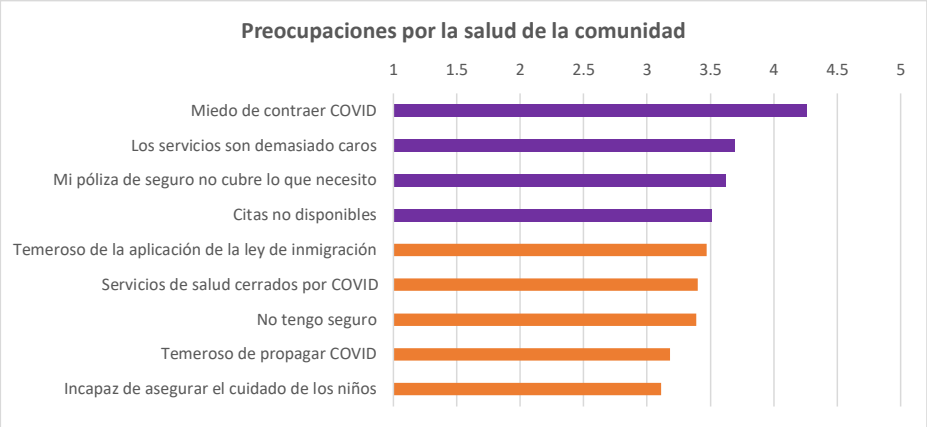

Figura 3. Preocupaciones por la salud de la comunidad

En cuanto a los obstáculos para acceder a la atención entre los inmigrantes latinos, los encuestados identificaron una variedad de problemas. Los elementos clasificados por encima del punto medio (3) se presentan en la cuarta figura: Barreras comunitarias para la atención médica (página siguiente). El problema de mayor clasificación fue el miedo a contraer COVID-19 / coronavirus (M = 4.26, SD = 1.25). En relación con esto, las preocupaciones de la comunidad también incluyeron el temor de propagar COVID-19 (M = 3.18, SD = 1.80) y cierres de servicios de salud debido a la pandemia (M = 3.40, SD = 1.27). Más allá de este virus, la comunidad también identificó un alto grado de preocupación acerca de que los servicios son demasiado costosos (M = 3.69, SD = 1.21), cobertura de seguro inadecuada (M = 3.62, SD = 1.42) y citas no disponibles (M = 3.51 , SD = 1,12). Investigadores anteriores han encontrado que los grupos de inmigrantes son excluidos sistemáticamente de las oportunidades de seguro médico (Gold 2005; Ku y Matani 2001; McGuire 2014).

Activos de la comunidad

Los participantes mostraron un alto nivel de resiliencia. En una versión adaptada de la "Escala de activos de inmigrantes mexicanos" (Lopez 2014) para comunidades Latinx, el puntaje promedio de resiliencia fue 3.06 de 4 (DE = 0.70). A pesar de las barreras importantes, la discriminación y la exclusión sistemática, los miembros y defensores de la comunidad inmigrante crean oportunidades para la atención médica. Más de las tres cuartas partes de los encuestados de habla hispana acceden a la atención médica en una clínica o centro de salud comunitario (84,1%). El resto de la muestra (15,9%) recibe atención médica en un hospital o proveedor de atención primaria cercano, incluido el viaje al área de Los Ángeles.

Recomendaciones

Existe una necesidad urgente de abordar los problemas de múltiples niveles que afectan la salud de los latinos y los inmigrantes en la costa central. Un encuestado resumió la necesidad de un cambio sistémico en esta área respondiendo a la pregunta "¿Cuáles son las necesidades de salud más urgentes para esta comunidad?": "Acceso y tratamiento equitativo por parte de los

profesionales de la salud, sistemas que permiten que las personas indocumentadas y no aseguradas sigan teniendo acceso a la atención. Traducción / interpretación al español y mixteco, por lo que la atención que se recibe es realmente significativa ".

1. En general, las estrategias de promoción de la salud plurilingües y culturalmente sensibles ayudan a cerrar las brechas de equidad en la atención, la prevención y el tratamiento. Iniciativas como Herencia Indigena están llevando la interpretación de lenguas indígenas a los proveedores de Dignity Health. Otros grupos como la Unidad Móvil de Salud del Centro de Investigación en Salud de la Universidad Politécnica Estatal de California, San Luis Obispo, también se están asociando directamente con defensores e intérpretes indígenas para cerrar las brechas entre los recursos de salud y las comunidades. Todas las etapas del proceso de atención médica deben incluir opciones de interpretación plurlingüe.
2. Más allá del acceso, los hallazgos de este informe también indican las brechas en la capacidad de atención médica en las comunidades donde viven los encuestados de habla hispana. Se necesitan más proveedores y servicios de atención médica, especialmente los de las comunidades de habla hispana en la costa central. Los líderes de la atención médica y los funcionarios electos deben esforzarse para invertir en la salud y el bienestar de las comunidades desatendidas.
3. Las capas de miedo y desconfianza presentes en esta comunidad también son sobresalientes para la distribución de una vacuna COVID-19. Como indicaron los encuestados, existe un alto nivel de temor a contraer el virus y propagarlo. Para una aceptación exitosa de la vacuna, las campañas educativas deberán abordar estos temores de una manera culturalmente sensible. Por ejemplo, las campañas visuales y las comunicaciones plurilingües se pueden utilizar para crear conciencia sobre la vacuna en sí y los protocolos de seguridad establecidos para evitar la exposición al COVID-19.

Información del investigador principal (PI)

Mario Espinoza-Kulick (él / él / su) es candidato a doctorado en el departamento de Sociología de la Universidad de California, Santa Bárbara y profesor en los departamentos de Estudios Étnicos y Estudios de las Mujeres y Género de la Universidad Politécnica Estatal de California, San Luis Obispo . Investiga las formas en que las agencias de salud y las organizaciones de movimientos sociales pueden abogar por los grupos marginados de maneras culturalmente apropiadas y mediante la implementación de políticas de salud equitativas. Mario se basa en su propia experiencia como persona VIH +, queer, Latinx e indígena para crear conciencia sobre las iniquidades en salud. Para obtener más información sobre este estudio, visite nuestro sitio web en https://tinyurl.com/LaGenteUnida. Puede comunicarse con Mario en mvespinoza@ucsb.edu o por teléfono al (805) 904-9225.

Referencias

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Expresiones de gratitud

Este estudio fue apoyado por la Fundación Robert Wood Johnson a través del programa Health Policy Research Scholars y por el Health Policy Research Scholars Dissertation Award. Gracias a los participantes tanto de la encuesta como a los asistentes de investigación de la Universidad Politécnica Estatal de California, San Luis Obispo por el proyecto "La Gente Unida": Jodene Takahashi y Elisa González.

Cita sugerida

Espinoza-Kulick, Mario Alberto V. 2020. *Salud de inmigrantes Latinxs en la costa central: Un informe sobre comunidades hispanohablantes del proyecto La Gente Unida.* Santa Maria, CA: La Gente Unida.

Legislator Name	Dist	Region	Party	Chamber	Cmtes	Background Info (Their policy interests, past voting records, etc)	Contact	Conversation?	Support Interest	Meeting Notes
Monique Limon	19	Santa Barbara, Oxnard	D	Senate	Health	For Monique, education has always been a priority. A UC Berkeley graduate with a Masters degree from Columbia University, Monique served two terms on the Santa Barbara Unified School Board and as Assistant Director for the McNair Scholars Program at the University of California, Santa Barbara prior to serving in the Senate. Women's issues are also a priority for Monique. As former Commissioner on the Santa Barbara County Commission for Women she helped connect private and public resources with women in the community. Monique has a passion for bringing community groups together and building strong coalitions among local nonprofit organizations and civic groups.	Yes	Yes! Interested in working together on more issues moving forward.	In Favor, but not Co-Author/ Sponsor	Scheduled with Vianey Lopez Friay 3/5 at 10 AM

Legislator Name	Dist	Region	Party	Chamber	Cmtes	Background Info (Their policy interests, past voting records, etc)	Contact	Conversation?	Support Interest	Meeting Notes
Richard Pan	6	Sacramento	D	Senate	Health	Chair - Health Committee, Member of Budget subcomittee on Health < Voted in Favor of SB 75 (Medi-Cal undocu immigrants <26 expansion) in 2015	Yes			
Melissa A. Melendez	28	Murrieta, Indio	R	Senate	Health	Vice Chair - Health Committee, Member of Budget Subcommittee on Health	Yes			
Susan Talamantes Eggman	5	Stockton	D	Senate	Health	< Voted in Favor of SB 75 (Medi-Cal undocu immigrants <26 expansion) in 2015, Chair of Budget Subcommittee on Health	Yes			
Jim Wood	2	Santa Rosa, Eureka, Ukiah	D	Assembly	Health	Chair - Health Committee < Voted in Favor of SB 75 (Medi-Cal undocu immigrants <26 expansion) in 2015	Yes			
Chad Mayes	42	Rancho Mirage	I	Assembly	Health	Vice Chair - Health Committee	Yes			
Brian Maienschein	77	San Diego	D	Assembly	Health	Health4All target (Health Committee)	Yes	Email exchange with Shanna Ezzell to share more readings		

Legislator Name	Dist	Region	Party	Chamber	Cmtes	Background Info (Their policy interests, past voting records, etc)	Contact	Conversation?	Support Interest	Meeting Notes
Nancy Skinner			D	Senate	Budget and Fiscal Review	Chair - Budget and Fiscal Review	Yes	Yes! With staffer (Angela Yip), expressed interest and support, sent a thank you email.	In Favor, but not Co-Author/ Sponsor	Scheduled with Angela Yip for Thursday 3/4 at 4 PM
Jim Nielsen			R	Senate	Budget and Fiscal Review	ViceChair - Budget and Fiscal Review	Yes	Yes! With stafer (Israel Sotelo), expressed interest and desire to speak more in May when Budget decisions are happening	In Favor, but not Co-Author/ Sponsor	Scheduled with Israel Sotelo for Friday 3/12 at 10 AM
Philip Y. Ting	19		D	Assembly	Budget	Chair - Budget < Voted in Favor of SB 75 (Medi-Cal undocu immigrants <26 expansion) in 2015	Yes			
Vince Fong	34		R	Assembly	Budget	Vice Chair Budget	Yes			

Legislator Name	Dist	Region	Party	Chamber	Cmtes	Background Info (Their policy interests, past voting records, etc)	Contact	Conversation?	Support Interest	Meeting Notes
Dr. Joaquin Arambula	31		D	Assembly	Budget	Chair of Budget Subcommittee on Health, Has a solid record on expanding Medi-Cal and healthcare capacity (https://a31.asmdc.org/health-care) Flag for California Medicine Scholars Program	Yes	Yes! Very appreciate of the research and how it can support Health4All as well as other issus related to healthcare capacity. The Assemblymember shared more information about related bills and how these are built from longstanding commitments to healthcare reform. I will be following up with two staffers to continue the conversation moving forward.	Primary Author/ Sponsor	Scheduled with the Assemblymember (!) for 3/19 at 11:30 AM

Legislator Name	Dist	Region	Party	Chamber	Cmtes	Background Info (Their policy interests, past voting records, etc)	Contact	Conversation?	Support Interest	Meeting Notes
Steve Bennett	37		D	Assembly	Budget	Did Townhall with Sen. Monique Limon	Yes	Yes! Very appreciative of research and wants to learn more about SB county in particular, grateful for the advice from a community perspective.	In Favor, but not Co-Author/ Sponsor	Scheduled with Atticus Reyes for Tuesday 3/9 at 4 PM
Jim Wood	2		D	Assembly	Budget	< Voted in Favor of SB 75 (Medi-Cal undocu immigrants <26 expansion) in 2015 Budget Subcommittee on Health	Yes			
Anthony J. Portantino	25	Glendale	D	Senate	Appropriations	Chair - Appropriations Supporter of Mental Health. Authored SB 562 this session to expand the definition of behavioral health treatment for health insurance coverage.	Yes			
Patricia C. Bates	36	Laguna Hills	R	Senate	Appropriations	Vice Chair - Appropriations Voted NOT IN Favor of SB 75 (Medi-Cal undocu immigrants <26 expansion) in 2015	Yes			

Legislator Name	Dist	Region	Party	Chamber	Cmtes	Background Info (Their policy interests, past voting records, etc)	Contact	Conversation?	Support Interest	Meeting Notes
Steven Bradford	35	Inglewood	D	Senate	Appropriations		Yes			
Sydney Kamlager	30	Los Angeles	D	Senate	Appropriations	She just switched to the Senate from Assembly on 3/11/21	Yes			Circling back after office transition to set a meeting time
John Laird	17	San Luis Obispo	D	Senate	Appropriations		Yes	Met with Sam Samuelson - They are very supportive of these efforts and we talked about other ways to expand access to healthcare like the universal healthcare proposal in California.	In Favor, but not Co-Author/ Sponsor	Scheduled with Health Consultant Sam Samuelson for 3/24 at 2 PM
Bob Wieckowski	10	Fremont	D	Senate	Appropriations	< Voted in Favor of SB 75 (Medi-Cal undocu immigrants <26 expansion) in 2015	Yes			

Legislator Name	Dist	Region	Party	Chamber	Cmtes	Background Info (Their policy interests, past voting records, etc)	Contact	Conversation?	Support Interest	Meeting Notes
Jordan Cunningham	35	San Luis	R	Assembly	Agriculture Jobs, Economic Development and the Economy (VC)	Interests - Human Trafficking, Education, Data Privacy, Law Enforcement, Energy, Small Business, Veterans Voting Record - Voted in favor of AB 81 (COVID-19 Rent Relief) Bill Sponsor - AB 32 (in committee) (Telehealth) - Bill would repeal exemption of Medi-Cal managed health care plans (and county organized health systems that provide services under Medi-Cal) from Knox-Keene Act (among other things - requires health care plans to reimburse the provider for telehealth services of an enrollee on the same basis as in person services.	Yes	Unclear what their level of support will be. They were open to having the conversation and discussing the issue.		Meeting with Noah Bilyeu on 4/26 at 10 AM

Official Name	Title	Region	Part	Background Info (Their policy interests, past voting records, etc)	Contact	Conversation?	Meeting Notes
Gavin Newsom	Governor	California	D		Yes		
Eleni Kounalakis	Lieutenant Governor	California	D		Yes	Yes	Met with two members of the Lt. Gov. staff. They supported these policies and were receptive to hearing more. They had questions about digital divides and were open to hearing how the Lt. Gov. can support these broader goals.

Advancing Health Equity for Latinx Immigrant and Indigenous Communities in California's Pandemic Emergency Response

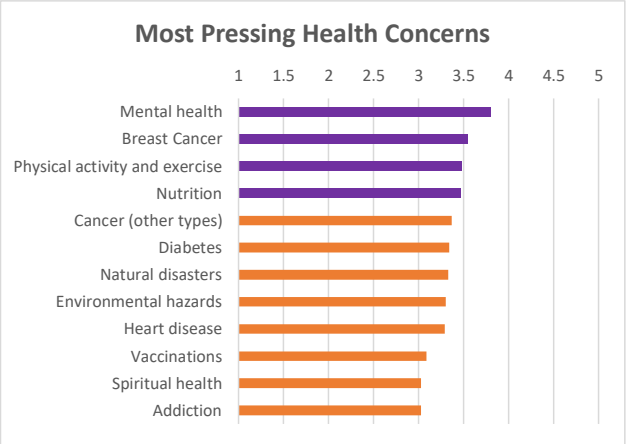
There are significant healthcare resources in California's Central Coast, including the pristine natural environment. However, **health inequities** persist for Latinx Immigrant and Indigenous communities, and these disparities have been made worse by the COVID-19 pandemic (Munroe 2020). Latinx people are more likely to contract COVID-19 (Gil et al. 2020) and mortality rates are nearly twice as high for the Latinx population compared to non-Hispanic whites (Gross et al. 2020). **Structural racism** is the fundamental cause of these disparities, especially for older adults (Garcia et al. 2020; Page and Flores-Miller 2020). Systematic exclusion from healthcare due to language barriers, mistrust, and a culture of fear creates challenges in testing, treating, and vaccinating for COVID-19.

This report describes the findings of a study with Latinx Immigrant and Indigenous groups in **Santa Barbara and Ventura Counties**, located in the southern portion of California's Central Coast. By working with community leaders, nonprofit organizations, and service providers, the data provides a unique look into the experiences of underserved communities. Along with these findings are relevant legislative actions currently being considered in the state of California.

Key Findings from Santa Barbara and Ventura Counties

Despite systemic inequality, Latinx Immigrant and Indigenous communities cultivate internal resources that can contribute to positive health. On a scale from 1-4 (Consoli et al., 2011; Lopez 2014), the average resilience score among the sample was 3.2 (SD = 0.65), indicating that **Latinx Immigrant and Indigenous respondents have high levels of resilience and community connectedness**. As well, more than half the sample (61%) rated their overall health positively, as excellent (19.%), or good (41.5%). By contrast, **over one third rated their health as fair** (34.1%), with a small minority ranking their health as poor (4.9%). Some of the key **drivers that contribute to negative health include exclusion from services, marginalization, and lack of access to healthy environments**.

When asked to identify the most pressing health concerns in their lives, on a scale from 1-5, respondents rated most highly issues of **mental health** (*M* = 3.80, *SD* = 1.27), **breast cancer** (*M* = 3.55, *SD* = 1.30), **physical activity** (*M* = 3.48, *SD* = 1.33), and **nutrition** (*M* = 3.47, *SD* = 1.24). Additional health concerns ranked above the mid-point (3) are shown in the Figure to the right.



Mental health concerns were reflected in the high rates of anxiety present among this sample. On the General Anxiety Disorder scale, the average responses among this sample was **experiencing anxiety symptoms, "more than half the days" in the past two weeks** (*M* = 2.15, *SD* = 0.88). Mental health burden is linked to a range of factors, including having experienced discrimination. The most common form of **discrimination** in the past three months among this group was that based on race or ethnicity (26.8%), gender or sexuality (15.5%), and immigration status (11.3%).

Current Mental Health Legislation
SB-293 Medi-Cal specialty mental health services (Limón). Streamlines processes for local providers, which could free up time and funds to focus on language accessibility and interpretation services for mental health settings.
AB-741 Helping Mentally Ill Defendants (Bennett). Will connect persons suffering from mental illness to community resources upon exiting county jail.

Resources for mental health and overall wellness are typically linked to insurance coverage. Among this group, a disparate number of individuals are uninsured or underinsured. In the survey, **over one-third 35.1% of the sample reported having no insurance**. In addition 14.8% of respondents rely on Emergency Medi-Cal and 20.8% of respondents reported being at risk for becoming uninsured within the next three months. The most pressing issues of insurance access are faced by undocumented community members. For undocumented adults, they are not currently eligible for Medi-Cal benefits, meaning that undocumented individuals over the age of 26 cannot be covered through this program. Ensuring access to affordable and high quality health insurance is a necessary step for the state of California, as proposed in SB-56. Medi-Cal: Eligibility (Durazo).

Current Health Insurance Legislation
SB-280 Health insurance (Limón). Large group health insurance. Expands requirements for healthcare coverage and prevents discrimination in advertising.
SB-368 Health care coverage (Limón). Deductibles and out-of-pocket expenses. Require monthly reporting by insurance agencies on balance toward deductibles.
SB-535 Biomarker testing (Limón). Expanding access to insurance for people with cancer.

Lack of insurance has real consequences for health, including our public health and the spread of preventable disease. Unfortunately, additional issues facing Latinx Immigrant and Indigenous communities in Santa Barbara and Ventura counties. Among the individuals survey, over half (55%) indicated that they had delayed or going healthcare within the past three months, because **appointments were not available**. Further, almost half of the respondents (48%) had similarly avoided healthcare because **services are too expensive**.

When asked to reflect on their communities, respondents indicated how much they perceived barriers in healthcare to affect Latinx Immigrant and Indigenous people on the Central Coast. The top-ranked concerns were **fear of immigration enforcement** (*M* = 4.16, *SD* = 1.00), services are too expensive (*M* = 4.10, *SD* = 1.19), don't have insurance (*M* = 4.07, *SD* = 1.13), insurance policy was inadequate (*M* 3.94, *SD* = 1.21), **fear of police** (*M* = 3.84, *SD* = 1.32), and **healthcare providers do not speak my language** (*M* = 3.68, *SD* = 1.33).

Recommendations

There is an **urgent need** to address the multi-layered issues affecting Latinx and immigrant health in the Central Coast. One respondent summarized the need for systemic change in this area in responding to the question "What are the most pressing health needs for this community?": "Access and equitable treatment from healthcare professionals, systems that allow undocumented and uninsured folx to still access care. Spanish and Mixtec translation/interpretation so the care that *is* [received] is actually meaningful."

1. Build and Sustain Healthcare Capacity. COVID-19 has brought renewed interest in our healthcare infrastructure. Some of the strategies that work for COVID implementation, like **partnerships with community organizations, interpretation services in Indigenous languages, mobile healthcare providers, and telehealth** can help to bridge gaps in care that have plagued our society. Initiatives like Herencia Indígena are bringing Indigenous language interpretation to providers at Dignity Health. Other groups like the Center for Health Research Mobile Health Unit from California Polytechnic State University, San Luis Obispo are also partnering directly with Indigenous advocates and interpreters to bridge the gaps between health resources and communities.
2. Expand Access to Health Insurance. Restrictions to health insurance have ripple effects. By **establishing access to health insurance for undocumented communities**, we invest in our collective health and build a new generation of trust between service providers and community members. Further, all individuals, regardless of income or documentation status have a right to health, and a single-payer healthcare system would expand access to healthcare services. This proposal is currently proposed by Kalra, Lee, and Santiago in AB-1400 Guaranteed Health Care for All.
3. Address the Upstream Factors that drive Disparities in Health. Even prior to the pandemic, a number of structural factors contribute to persistent health disparities. Both clinical and public health approaches have embraced partnerships with community and political leaders to addresses these disparities. Detailed below are a set of bills that address major areas affecting **health, including labor, childcare, education, housing, immigration, gender-based violence, and women's health**.

Farmworkers

- AB-941 Farmworker assistance: resource centers (Bennett). Establishes Multilingual, community-partnered centers to increase access to services related to, among other things, education, housing, payroll and wage rights, and health and human services.

Childcare

- AB-22 Childcare: preschool programs and transitional kindergarten: enrollment (McCarty). Pre-K for all
- AB-92 Developing an intervention to alleviate burden on low-income families (Reyes). Lowering family fees for preschool and childcare and development services.
- SB-50 Early learning and care: California Early Learning and Care Program (Limón). Subsidized programs for infancy to age 13, inclusive

Women's health

- SB-613 Maternal health: neonate wrap (Limón). Requires neonate wraps after c-sections

Gender-based violence

- AB-673 Domestic violence (Salas). Expedite payment of funds to emergency DV service providers.
- SB-53 Unsolicited images (Leyva). Would make it a crime to knowingly send unsolicited pornographic images.

Broadband access

- AB-14 Communications: broadband services: California Advanced Services Fund (Aguiar-Curry). Allows counties to take action to expand access to students and communities

Education

- SB-540 Pupil instruction: improving pupil success: grant program (Limón). Improve equity gaps in K-12 by hiring key experts to support schools.
- SB-737 California Student Opportunity and Access Program (Limón). Increase access to financial aid and college for underserved communities
- AB-824 Student School Board Members (Bennett). Allows students to petition to add a Student Board Member to County Boards of Education and charter school governing boards.

Foster youth

- AB-674 Dependent children: Documents (Bennett). Increases former foster youth participation in Calfresh by requiring counties to provide information regarding CalFresh eligibility to young adults exiting the foster youth system.
- AB-1051 Foster Youth Presumptive Transfer (Bennett). Requires counties to maintain responsibility for a foster youth whenever they are transferred to a different county for specialty services, unless the foster youth is going to be permanently moved to the new county, or the transfer of responsibility would result in better care.

Housing Protections for Low-Income Communities

- AB-80 Taxation: Coronavirus Aid, Relief, and Economic Security Act: Federal Consolidated Appropriations Act, 2021 (Burke). Establishes and continues protections for renters that have been financially affected by COVID.

Undocumented immigrants and mixed-status families

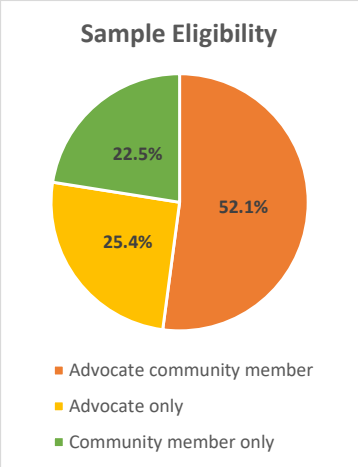
- SB-452 State government: Immigrant and Refugee Affairs Agency: Office of Immigrant and Refugee Affairs (Gonzalez). Streamlines all state services for immigrants and refugees in a single Office

Principal Investigator (PI) Information

Mario Espinoza-Kulick (he/him/his) is a Doctoral Candidate in the department of Sociology at the University of California, Santa Barbara. He researches the ways in which healthcare agencies and social movement organizations can advocate for marginalized groups in culturally appropriate ways and through implementation of equitable health policies. Mario draws from his own experience as an HIV+, Queer, Latinx and Indigenous person to raise awareness around health inequities. For more information about this study, please visit https://tinyurl.com/LaGenteUnida

Methodology Note

This report is based on a larger project examining Latinx immigrant and Indigenous health across California's Central Coast. A survey of health assets and needs was developed in collaboration with community leaders. In total, 177 eligible respondents were recruited between September 2019 – September 2020. The survey was shared with help from community organizations throughout the central coast, including Central Coast Coalition for Undocumented Student Success, Central Coast United for a Sustainable Economy (CAUSE), Mixteco Indigena Community Organizing Project (MICOP), Just Communities, promotora/x (community health worker) networks, United Way, Transitions-Mental Health Association, the FUND for Santa Barbara, House of Pride and Equality (HOPE), California Immigrant Policy Center, by colleges and universities, and through paid social media advertisements. This report includes 89 respondents who lived in Santa Barbara or Ventura counties.



Individuals were eligible to participate in the study if they were an immigrant community member (Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen), or as an advocate (individuals that actively participate in social change efforts toward advancing immigrant health equity). As seen in the first figure: Sample Eligibility (left), the largest group in the sample was those who occupied both positions: advocate and community member (52.1%), followed by advocates who did not consider themselves community members (25.4%), and community members who did not consider themselves advocates (22.5%). The sample was majority Latina/o/x or Hispanic (81.6%), and women (81.8%). About one-third of the sample's primary language was Spanish (35.2%), and over one in five were Indigenous (22.9%). The average age of respondents was 37 years old (SD = 13.48).

For questions about the study, you can contact Mario at mvespinoza@ucsb.edu or by phone at (805) 904-9225.

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April 13, 2021

TO: Supervisor and Chair, Bob Nelson, Fourth District
Supervisor and Vice Chair, Joan Hartmann, Third District
Supervisor Das Williams, First District
Supervisor Gregg Hart, Second District
Supervisor Steve Lavagnino, Fifth District
CC: County Executive Officer, Mona Miyasoto

Dear Supervisors Nelson, Hartmann, Williams, Hart, and Lavagnino,
I am Mario Espinoza-Kulick, a Doctoral Candidate in Sociology at the University of California, Santa Barbara, and a Health Policy Research Scholar with the Robert Wood Johnson Foundation. Over the past five years, I have worked as a researcher and community leader with Latinx Immigrant and Indigenous groups throughout the Central Coast region. I write to share my views as a constituent of Santa Barbara County's Fourth District.

In the wake of this pandemic, it is of the highest importance that we make substantial investments in healthcare infrastructure and health equity. My research has shown that existing healthcare systems continually underserve immigrant communities and Indigenous peoples. These disparities impact our public health, leading to preventable illness and death, drive up healthcare costs, and deteriorate our economic workforce's productivity.

Many immigrants are excluded from health insurance programs, resulting in an undue burden on emergency healthcare providers in our communities. The County can help decrease these costs by funding access to free and accessible healthcare services that are not attached to documentation status. Community organizations and churches are critical partners for offering these services as they have already built trusting relationships with communities that tend to avoid government agencies.

In a survey of Latinx Immigrant community members on the Central Coast, nearly 3 in 4 respondents (71%) had avoided healthcare even before the pandemic because appointments were not available. Even when services do exist, language barriers can prevent community members from accessing meaningful care. Our County must invest in Indigenous language interpretation services to make healthcare accessible and other programs, resources, and services offered by the County.

As One County, with One Future, equity must guide our investments in public health and safety net systems that can help to prevent and mitigate the effects of future environmental threats. With increased funding from our local community through cannabis tax revenue and support from federal pandemic recovery sources, now is the time to commit to a budget that serves our most vulnerable community members' needs.

Sincerely,
Mario Espinoza-Kulick, MA, PhD Candidate

April 5, 2021

The Honorable Jim Wood
Chair, Assembly Health Committee
State Capitol, P.O. Box 942849
Sacramento, CA 95814

Re: AB-4 (Arambula) – Health4All - SUPPORT

Dear Assemblymember Wood,
My name is Mario Espinoza-Kulick, and I am a Doctoral Candidate in Sociology at the University of California, Santa Barbara, and Health Policy Research Scholars program. I write today to share my own views on AB-4, which are based on my experiences working as a researcher with Latinx Immigrant and Indigenous communities throughout the Central Coast region.

I wholeheartedly support AB-4 (Arambula), which would bring California one step closer to universal coverage by expanding full-scope Medi-Cal to income-eligible seniors ages 65+, regardless of immigration status. On the Central Coast, we are proud of our robust agricultural industry and the working people who ensure that we have access to nutritious food. Undocumented people are overrepresented in jobs deemed "essential" during the pandemic,[1] including field workers, who are among the most likely to die from the virus.[2] In 2018, undocumented Californians contributed $3.7 billion in state and local taxes and over $40 billion in spending power to our economy.[3] Yet, they are blocked from relief funding and adequate support from safety net programs.

My research findings highlight the negative impacts of excluding undocumented individuals from publicly funded health insurance programs. Of the Spanish-speaking respondents in my study, nearly 1 in 5 had delayed healthcare within the past three months, because their documentation status blocked them from accessing health insurance (19%). These unnecessary barriers have contributed to illness and death, including the preventable spread of COVID-19 by blocking individuals from life-saving care. One advocate shared with me in an interview, "90% of the community that we help, they work in the fields. We see they come to our workshops with health problems, they have a family member that has asthma because where they live, with the pesticides and everything. The fear of them seeking medical help was preventing them to get the help that they needed." These experiences have ripple effects throughout families. Preventing communities from accessing primary healthcare services contributes directly to negative health outcomes, and it pushes clients into emergency services, which creates an unnecessary burden for providers and higher costs for treatment.

I strongly urge you to support AB-4 (Arambula). It is a needed step in securing our collective health.

Sincerely,
Mario Espinoza-Kulick, MA, PhD Candidate

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[1] https://immigrantdataca.org/indicators/industries-and-occupations#/
[2] https://www.nbcbayarea.com/news/coronavirus/ucsf-research-shows-industries-in-which-workers-are-most-likely-to-die-from-covid/2450833/
[3] https://immigrantdataca.org/indicators/economic-contributions#/?immig=3

April 5, 2021

Honorable Mark Stone
California State Assembly Member
Chair, Assembly Judiciary Committee
State Capitol
Sacramento, CA 95814

RE: Support for AB 1007 (Carrillo) – Compensation for Survivors of Forced or Involuntary Sterilization Act

Dear Chairman Stone:

My name is Mario Espinoza-Kulick, and I am a Doctoral Candidate in Sociology at the University of California, Santa Barbara, and Health Policy Research Scholars program. I write today to share my own views on AB-1007, which are based on my experiences working as a researcher with Latinx Immigrant and Indigenous communities throughout the Central Coast region.

I strongly support AB-1007, a bill that would provide reparations to survivors of forced sterilization under California's eugenics laws from 1909 to 1979 and survivors of involuntary sterilizations in women's state prisons after 1979. These egregious violations of human rights are unfortunately a significant part of our state's history. This legislation would take a step in the right direction by providing compensation and recognition for the women who survived eugenicist and white supremacist oppression. The bill also includes an outreach and sterilization notification program, in consultation with community-based organizations to raise awareness of the unjust sterilization of thousands of people. This effort is necessary to halt and prevent the practice of forced sterilization from continuing into the future.

Between 1909 and 1979, California forcibly sterilized 20,000 people in state institutions. It was the most aggressive eugenics sterilizer in the nation, accounting for one-third of the 60,000 sterilizations that were performed nationwide. All people sterilized under eugenics laws were classified as having disabilities and deemed "unfit to reproduce." The average age of sterilization was 17 years old; some individuals were as young as 12 years old. Women and girls were 14% more likely to be sterilized than their male counterparts, and Latina patients were 59% more likely to be sterilized than non-Latinas.

Although these laws were repealed in 1979, a subsequent state audit revealed that at least an additional 144 people were sterilized during labor and delivery without required consents and authorization in California's women's prisons between 2006 and 2010. Sixty-five percent of forced sterilization survivors included in the state audit described themselves as Black, Hispanic, Mexican, or other. Many of the people identified by the audit were never notified of the harm that was done to them.

Enacting this bill will be an important action for our country and make a real difference in the lives of women who have been affected state-sanctioned violence. Following North Carolina (2013) and Virginia (2015), California will become the third state to compensate survivors of forced sterilizations.

Sincerely,
Mario Espinoza-Kulick, MA, PhD Candidate

CC: Assembly Member Wendy Carrillo
` Members and Committee Staff, Assembly Judiciary Committee

March 3, 2021

The Honorable Richard Pan, Chair
Senate Health Committee
State Capitol, Room 2191
Sacramento, CA 95814

Re: SB 56 (Durazo) – Health4All [SUPPORT]

Dear Senator Pan,
My name is Mario Espinoza-Kulick, and I am a Doctoral Candidate in Sociology at the University of California, Santa Barbara, and Health Policy Research Scholars program. I write today to share my own views on SB-56, which are based on my experiences working as a researcher with Latinx Immigrant and Indigenous communities throughout the Central Coast region.

I wholeheartedly support SB-56 (Durazo), which would bring California one step closer to universal coverage by expanding full-scope Medi-Cal to income-eligible seniors ages 65+, regardless of immigration status. On the Central Coast, we are proud of our robust agricultural industry and the working people who ensure that we have access to nutritious food. Undocumented people are overrepresented in jobs deemed "essential" during the pandemic,[1] including field workers, who are among the most likely to die from the virus.[2] In 2018, undocumented Californians contributed $3.7 billion in state and local taxes and over $40 billion in spending power to our economy.[3] Yet, they are blocked from relief funding and adequate support from safety net programs.

My research findings highlight the negative impacts of excluding undocumented individuals from publicly funded health insurance programs. Of the Spanish-speaking respondents in my study, nearly 1 in 5 had delayed healthcare within the past three months, because their documentation status blocked them from accessing health insurance (19%). These unnecessary barriers have contributed to illness and death, including the preventable spread of COVID-19 by blocking individuals from life-saving care. One advocate shared with me in an interview, "90% of the community that we help, they work in the fields. We see they come to our workshops with health problems, they have a family member that has asthma because where they live, with the pesticides and everything. The fear of them seeking medical help was preventing them to get the help that they needed." These experiences have ripple effects throughout families. Preventing communities from accessing primary healthcare services contributes directly to negative health outcomes, and it pushes clients into emergency services, which creates an unnecessary burden for providers and higher costs for treatment.

I strongly urge you to support SB-56 (Durazo). It is a needed step in securing our collective health.

Sincerely,
Mario Espinoza-Kulick, MA, PhD Candidate

[1] https://immigrantdataca.org/indicators/industries-and-occupations#/
[2] https://www.nbcbayarea.com/news/coronavirus/ucsf-research-shows-industries-in-which-workers-are-most-likely-to-die-from-covid/2450833/
[3] https://immigrantdataca.org/indicators/economic-contributions#/?immig=3

March 15, 2021

The Honorable Anthony J. Portantino, Chair
Senate Appropriations Committee
State Capitol, Room 2206
Sacramento, CA 95814

Re: SB 56 (Durazo) – Health4All [SUPPORT]

Dear Senator Portantino,
My name is Mario Espinoza-Kulick, and I am a Doctoral Candidate in Sociology at the University of California, Santa Barbara, and Health Policy Research Scholars program. I write today to share my own views on SB-56, which are based on my experiences working as a researcher with Latinx Immigrant and Indigenous communities throughout the Central Coast region.

I wholeheartedly support SB-56 (Durazo), which would bring California one step closer to universal coverage by expanding full-scope Medi-Cal to income-eligible seniors ages 65+, regardless of immigration status. On the Central Coast, we are proud of our robust agricultural industry and the working people who ensure that we have access to nutritious food. Undocumented people are overrepresented in jobs deemed "essential" during the pandemic,[1] including field workers, who are among the most likely to die from the virus.[2] In 2018, undocumented Californians contributed $3.7 billion in state and local taxes and over $40 billion in spending power to our economy.[3] Yet, they are blocked from relief funding and adequate support from safety net programs.

My research findings highlight the negative impacts of excluding undocumented individuals from publicly funded health insurance programs. Of the Spanish-speaking respondents in my study, nearly 1 in 5 had delayed healthcare within the past three months, because their documentation status blocked them from accessing health insurance (19%). These unnecessary barriers have contributed to illness and death, including the preventable spread of COVID-19 by blocking individuals from life-saving care. One advocate shared with me in an interview, "90% of the community that we help, they work in the fields. We see they come to our workshops with health problems, they have a family member that has asthma because where they live, with the pesticides and everything. The fear of them seeking medical help was preventing them to get the help that they needed." Preventing communities from accessing primary healthcare services contributes directly to negative health outcomes, and it pushes clients into emergency services, which creates an unnecessary burden for providers and higher costs for treatment.

I strongly urge you to support SB-56 (Durazo). It is a needed step in securing our collective health that will save money in the long run.

Sincerely,
Mario Espinoza-Kulick, MA, PhD Candidate

[1] https://immigrantdataca.org/indicators/industries-and-occupations#/
[2] https://www.nbcbayarea.com/news/coronavirus/ucsf-research-shows-industries-in-which-workers-are-most-likely-to-die-from-covid/2450833/
[3] https://immigrantdataca.org/indicators/economic-contributions#/?immig=3

April 1, 2021

The Honorable Jim Wood
Chair, Assembly Health Committee
State Capitol, Room 6005
Sacramento, CA 95814

Re: AB-240 (Rodriguez): Local health department workforce assessment
As Introduced January 13, 2021 – **SUPPORT**
Set for Hearing on April 6, 2021 – Assembly Health Committee

Dear Assembly Member Wood:

My name is Mario Espinoza-Kulick, and I am a Doctoral Candidate in Sociology at the University of California, Santa Barbara, and Health Policy Research Scholars with the Robert Wood Johnson Foundation. I write today to share my own views on AB-240, which are based on my experiences working as a researcher with Latinx Immigrant and Indigenous communities throughout the Central Coast region.

I strongly support AB-240, which would require the California Department of Public Health (CDPH) to undergo a comprehensive evaluation of the adequacy of local health department infrastructure, including an assessment of future staffing, workforce, and resource needs. Based on my own research in the Central Coast, there are serious equity gaps in access to healthcare resources, which are made worse by the low availability of services in general.

In a survey of the Latinx Immigrant and Indigenous community, I found that prior to the COVID-19 pandemic, nearly three in four individuals (71%) had avoided healthcare in the past three months because appointments simply were not available. During the pandemic, a similar proportion of respondents (69%) had avoided healthcare because appointments were not available, or offices were closed due to COVID-19. A general lack of healthcare capacity on the Central Coast is made more difficult for Indigenous language speakers and Spanish speakers. The Central Coast needs more healthcare providers, especially specialty care providers in low-income communities. In addition, the healthcare workforce includes certified medical interpreters, who allow for access to care. The COVID-19 pandemic has proven that all of our health is interconnected. Investing in local public health efforts will benefit all communities.

AB-240 would provide an opportunity for state and local governments in California to better understand the gaps in local health department infrastructure, including needs related to local health department staffing, workforce, and resources. In looking to develop our healthcare capacity, we must create systems that are both multilingual and culturally responsive to diverse community members' needs.

It is for these reasons that I support AB-240 and respectfully urge your yes vote on AB-240.

Sincerely,

Mario Espinoza-Kulick, MA, PhD Candidate
Department of Sociology, University of California, Santa Barbara
Health Policy Research Scholars, Robert Wood Johnson Foundation
mvespinoza@ucsb.edu

Tuesday March 30, 2021

The Honorable Dr. Richard Pan, Chair
Senate Committee on Health
State Capitol, Room 2191
Sacramento, CA 95814

Re: Senate Bill 682 – Closing Racial Gaps in Childhood Chronic Disease

Dear Senator Pan,

My name is Mario Espinoza-Kulick, and I am a Doctoral Candidate in Sociology at the University of California, Santa Barbara, and Health Policy Research Scholar with the Robert Wood Johnson Foundation. I write today to share my own views on SB-682, which are based on my experiences working as a researcher with Latinx Immigrant and Indigenous communities throughout the Central Coast region, as well as a constituent of Health Committee Member, Senator Monique Limón (District 19).

I strongly support SB 682, which would ensure that California develop and implements a plan to reduce racial disparities in childhood chronic disease. My research shows the strong impacts of intergenerational trauma on health conditions that last well into adulthood. A culture of mistrust exists for Immigrant and Indigenous communities that prevents families from accessing preventative care, even when resources are available. Further, on the Central Coast, current healthcare capacity is not sufficient for the population's needs. These barriers increase the likelihood of chronic health conditions among children and youth.

These disparities exist on the basis of race and Indigeneity, even when taking into account socio-economic status. Children of color in California are disparately impacted by pediatric asthma, childhood diabetes, youth depression, childhood dental caries, and vaping-related diseases. To address the State's commitment to addressing racism's impact on public health, action is needed now. It is crucial for California to take an early intervention strategy to support health equity for the next generation. SB-682 will ensure that kids have greater opportunities to become healthy adults.

Sincerely,

Mario Espinoza-Kulick
Doctoral Candidate, Sociology, University of California, Santa Barbara
Health Policy Research Scholar, Robert Wood Johnson Foundation
mvespinoza@ucsb.edu | 805-904-9225
www.mespinozakulick.com

cc: Kimberly Chen, Consultant, Senate Committee on Health

March 23, 2021

The Honorable Dr. Richard Pan
Chair, Senate Committee on Health
State Capitol, Room 2191
Sacramento, California 95814

Re: SB 306 – STD Coverage + Care Act – Support as Amended on 3/9/21

Dear Senator Pan,

My name is Mario Espinoza-Kulick, and I am a Doctoral Candidate in Sociology at the University of California, Santa Barbara, and Health Policy Research Scholar with the Robert Wood Johnson Foundation. I write today to share my own views on SB-306, which are based on my experiences working as a researcher with Latinx Immigrant and Indigenous communities throughout the Central Coast region, as well as a constituent of Health Committee Member, Senator Monique Limón (District 19).

I strongly support SB 306 – The STD Coverage + Care Act. SB 306 will improve California's public health infrastructure by expanding access to STD coverage and care. My research shows that inequitable access to sexual health care disproportionately affects Latinx immigrants and Indigenous communities on the Central Coast. Indigenous respondents had, on average, less access to sexual health services (2.18 on a scale of 1-4), compared to non-Indigenous respondents (2.93), at a statistically significant level, $p < .05$ ($n = 177$).

In California, sexually transmitted diseases are a major public health concern. Nearly 340,000 Californians were infected with syphilis, chlamydia, or gonorrhea in 2018 – up 40% since 2013. These numbers reflect systemic inequities that block access to healthcare for youth, immigrants, Indigenous peoples, people of color, and LGBTQ+ people. Currently, Black young women are 500% more likely to contract gonorrhea and chlamydia than their white counterparts.

Our communities need leadership and action to address these disparities. All Californians deserve access to safe, culturally competent, quality health, mental health and substance use treatment services. In addition, incarceration, detention, lack of access to economic mobility and education opportunities, inadequate affordable housing, racial segregation, and racism all create barriers to care.

This law provides a bold step forward for the state of California in building a comprehensive approach to sexual health services and resources. SB-306 would bring more testing to communities, preventing the spread of disease, and it would expand coverage for care. Preventing and treating sexually transmitted disease is an investment in our public health, as well as an opportunity to reduce the billions of dollars spent on STD infections.

For these reasons, I support SB-306 and urge an "AYE" vote when the measure comes before the committee.

Sincerely,
Mario Espinoza-Kulick, MA
Doctoral Candidate, Sociology, University of California, Santa Barbara
Health Policy Research Scholars, Robert Wood Johnson Foundation

April 12, 2021

The Honorable Richard D. Roth
Chair, Senate Business, Professions and
Economic Development Committee
State Capitol, Room 2053
Sacramento, CA 95814
Re: SB 306 – STD Coverage + Care Act – Support as Amended on 3/24/21

Dear Senator Roth,

My name is Mario Espinoza-Kulick, and I am a Doctoral Candidate in Sociology at the University of California, Santa Barbara, and Health Policy Research Scholar with the Robert Wood Johnson Foundation. I write today to share my own views on SB-306, which are based on my experiences working as a researcher with Latinx Immigrant and Indigenous communities throughout the Central Coast region.

I strongly support SB 306 – The STD Coverage + Care Act. SB 306 will improve California's public health infrastructure by expanding access to STD coverage and care. My research shows that inequitable access to sexual health care disproportionately affects Latinx immigrants and Indigenous communities on the Central Coast. Indigenous respondents had, on average, less access to sexual health services (2.18 on a scale of 1-4), compared to non-Indigenous respondents (2.93), at a statistically significant level, $p < .05$ ($n = 177$).

In California, sexually transmitted diseases are a major public health concern. Nearly 340,000 Californians were infected with syphilis, chlamydia, or gonorrhea in 2018 – up 40% since 2013. These numbers reflect systemic inequities that block access to healthcare for youth, immigrants, Indigenous peoples, people of color, and LGBTQ+ people. Currently, Black young women are 500% more likely to contract gonorrhea and chlamydia than their white counterparts.

The CDC estimated that new STD infections acquired in 2018 totaled nearly $16 billion in direct lifetime medical costs nationwide. Chlamydia, gonorrhea and syphilis combined accounted for more than $1 billion of the total cost. Sexually acquired HIV and HPV were the costliest due to lifetime treatment for HIV at $13.7 billion and treatment for HPV-related cancers at $755 million. Approximately $1 billion is spent annually statewide on health costs associated with STDs.

The scope of the STD epidemic requires a bold response. SB 306 will:
- Ensure no-cost STD care for uninsured, low-income LGBT Californians through Family PACT
- Expand ability of health professionals that conduct rapid testing in the community
- Revise current law to support the delivery and increased utilization of Expedited Partner Therapy (EPT); and
- Expand congenital syphilis testing requirements

For these reasons, I support SB-306 and urge an "AYE" vote when the measure comes before the committee.

Sincerely,
Mario Espinoza-Kulick, MA
Doctoral Candidate, Sociology, University of California, Santa Barbara
Health Policy Research Scholars, Robert Wood Johnson Foundation

DE&I Task Force Agenda Correspondence

Date: October 7, 2020

TO: Diversity, Equity and Inclusion Task Force Members

FROM: Dale Magee, DE&I TF Coordinator
Beya Makekau, DE&I TF Facilitator

SUBJECT: October 08 Meeting Supplemental Information

Hi TF Members,

Below are additional documents that our community members asked us to send along to you all for tomorrows meetings. Note that the 2018 Cultural Competence Plan is a county wide document but in it may contain strategies or ideas that could be beneficial when thinking about your recommendations.

- 2018 Cultural Competence Plan (this document is quite large): https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-Documents/Cultural-Competence-Committee/SLO-Behavioral-Health-Cultural-Competence-Plan.pdf

https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/

- A report on Latinx Immigrant health in San Luis Obispo is attached.

https://www.slocounty.ca.gov/Departments/Health-Agency/Behavioral-Health/Forms-

https://

Our community leaders include Mario Espinoza, Faculty in Ethnic Studies Cal Poly, Erica Ruvalcaba, Director of Program Promotores, and Nestor Veloz-Passalacqua Ethnic Services Manager Behavioral Health Department. Unfortunately, Fransisco Ramierez is not able to join us.

Look forward to seeing you all tomorrow.

Best,
Beya

Latinx Immigrant Health in San Luis Obispo County: A Report from the La Gente Unida Project
Mario Alberto V. Espinoza-Kulick, MA, PhD Candidate

Introduction

Within the county of San Luis Obispo, Latina/o/x and Hispanic individuals make up the largest minority group as 23% of the population. As well, there are significant healthcare resources in this community, including the pristine natural environment. However, health inequities persist including low access to dental care, mental health concerns, lack of affordable housing and lack of services for the Spanish-speaking community (San Luis Obispo County Public Health Department 2018). Respondents from San Luis Obispo report serious concerns, especially mental health and breast cancer, as well as barriers to care due to the cost of services themselves, insurance, language barriers, and fear of immigration enforcement. The report concludes with recommendations for expanding access to culturally competent healthcare services and advocating for racial justice.

Key Findings from San Luis Obispo

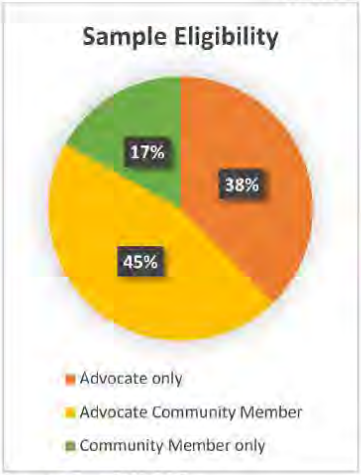

Figure 1. Sample Eligibility

This report is based on a larger project examining Latinx immigrant health and advocacy across California's Central Coast. A survey of Latinx immigrant health, healthcare, and advocacy was developed in collaboration with community leaders. In total, 177 eligible respondents were recruited between September 2019 – September 2020. The survey was shared with help from groups like Community Action Partnership San Luis Obispo (CAP-SLO), Cuesta College, Cal Poly SLO, RISE, Central Coast Coalition for Undocumented Student Success (CCC-USS), Immigrant Support Network (list-serve), Transitions-Mental Health Association (T-MHA), Access Support Network, and Gala Pride and Diversity Center, through paid social media advertisements, and by supportive individuals. This report includes 72 respondents from San Luis Obispo County (31) and those who did not disclose their location (41). Individuals were eligible to participate in the study if they were an immigrant community member (Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen), or as an advocate (individuals that actively participate in social change efforts toward advancing immigrant health equity). As seen in the first figure: Sample Eligibility (above-left), the largest group in the sample was those who occupied both positions: advocate and community member (46%), followed by advocates from outside the community (38%), and community members who did not consider themselves advocates (17%).

Demographics

In terms of race and ethnicity, the majority of the people surveyed self-identified as Latina/o/x or Hispanic (62%). However, that is not to say that the community is monolithic. The remainder of the sample identified as white (26%) or multiracial (12%). Multiracial included anyone who selected two or more races, such as Latinx and Black/African American or American Indian/Alaskan Native. Among those who self-identified as Latinx, the largest national group was "Mexican" (32%), "Mexican-American" (19%), or Chicana/o/x (5%). This is summarized in the second figure (next page). Other identities represented within the sample were: Belizean, Chilean, Cuban, Dominican, Guatemalan, Peruvian, Salvadorian, Other Caribbean, Multicultural

and Not Listed. Further, 12% of the sample identified as Indigenous, including a range of tribal and national affiliations.

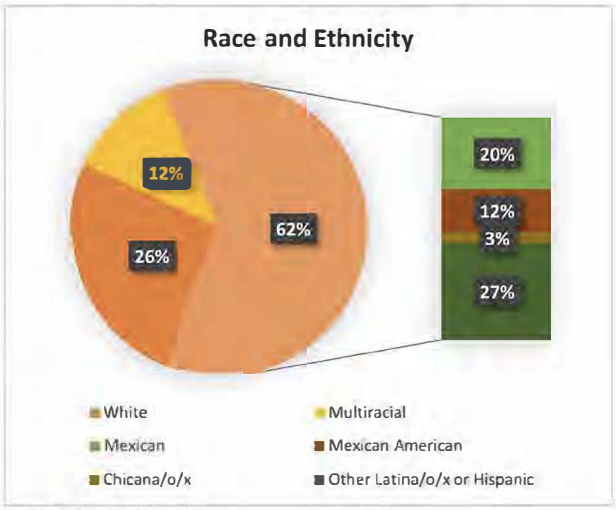

Figure 2. Race and Ethnicity

Beyond race and ethnicity, the sample also reflects additional intersecting identities. About three quarters of the sample were U.S. citizens (78%). The sample was also mostly women (77%). In addition, 17% were cisgender men and 6% were genderqueer or a not listed gender identity. In terms of sexual orientation, the majority of respondents were heterosexual/straight (83%), and the survey also included individuals who identified as bisexual (5%), gay (5%), queer (5%), or a not listed sexual orientation (2%).

Health Needs and Concerns

In the survey, individuals were asked to report about their own perceptions of health concerns, as well as their beliefs about the issues facing the larger community. Those health concerns that were rated, on average, above the mid-point (3) are presented in the third figure: Most Pressing Health Concerns (below-right). The top-rated amongst these were **mental health** ($M = 3.8$, $SD = 1.5$) and **breast cancer** ($M = 3.6$, $SD = 1.3$). Breast cancer is the leading cause of cancer death for Latina women in the United States. Specifically, Latinas disproportionately experience later diagnoses and more severe cases than non-Hispanic whites (American Cancer Society 2018). Even though overall incidence of breast cancer is lower for Latinas, issues of access to healthcare exacerbate disparities in breast cancer treatment and outcomes.

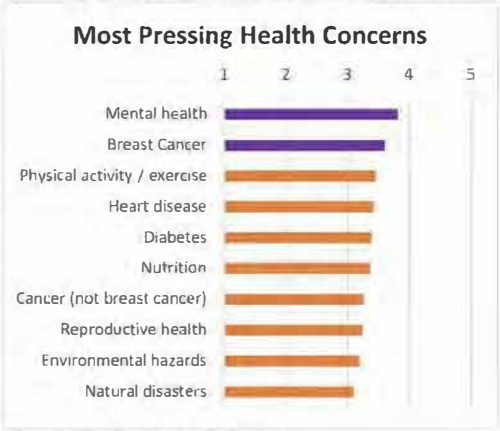

Figure 3. Most Pressing Health Concerns

Further, at the individual level, we also asked individuals if they had delayed or gone without healthcare within the past 3 months for a number of reasons. **Over half of the sample had avoided healthcare within the past 3 months because appointments were not available (61%).** As well, cost was a substantial barrier. For over a third of the sample (35%) had avoided healthcare because services are too expensive. The third highest ranked

reason for avoiding healthcare was also indirectly related to cost, as 16% reported that they were unable to get time off of work.

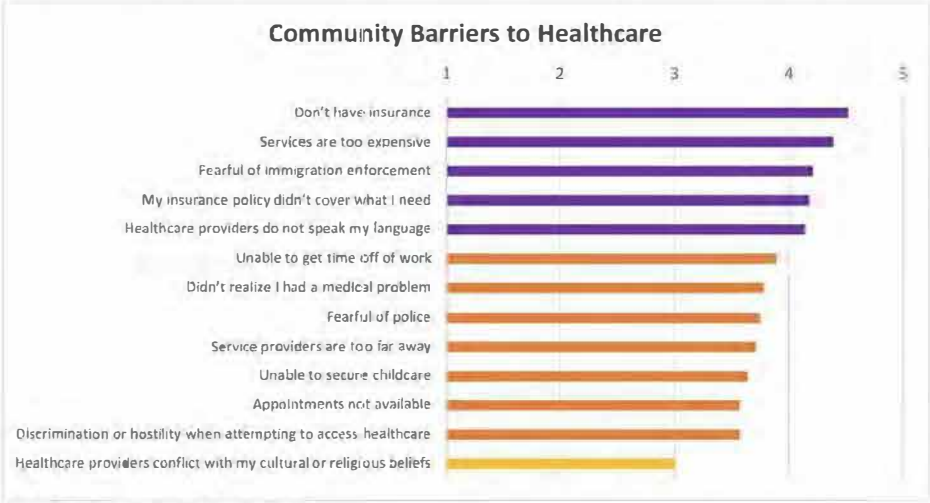

Figure 4. Community Barriers to Healthcare

In terms of obstacles in accessing care among Latinx immigrants, respondents identified a range of issues. The items ranked above the mid-point (3) are presented in the fourth figure (above): Community Barriers to Healthcare. The most pressing were that **individuals don't have insurance** ($M = 4.5$, $SD = 0.8$), **services are too expensive** ($M = 4.4$, $SD = 0.9$), **fear of immigration enforcement** ($M = 4.2$, $SD = 1.0$), **inadequate insurance coverage** ($M = 4.2$, $SD = 1.1$), and that **healthcare providers do not speak an individual's language** ($M = 4.1$, $SD = 1.0$). Past researchers have found that immigrant groups are **systematically excluded** from opportunities for health insurance (Gold 2005; Ku and Matani 2001; McGuire 2014). Relatedly, Francisco Pedraza and Lin Zhu (2015) have named the "**chilling effect**" to describe the wide-ranging impacts of punitive immigration enforcement policies on immigrant communities and mixed-status families.

Figure 5. Primary Healthcare Sources

Community Assets

Participants showed a high level of resiliency. On an adapted version of the "Mexican Immigrants Asset Scale" for Latinx communities, the average resiliency score was 3.4 out of 4 ($SD = 0.4$) (Lopez 2014). In spite of significant barriers, discrimination, and systematic exclusion, immigrant community members and advocates create opportunities for

healthcare. The fifth figure (previous page), summarizes the location where respondents access primary health services. Half of the sample (50%) have a primary care provider in San Luis Obispo county. Notably, a substantial group of respondents (12%) travel outside of SLO in order to access affordable, specialty, and/or culturally competent healthcare services.

Recommendations

There is an urgent need to address the multi-layered issues affecting Latinx and immigrant health in San Luis Obispo. One respondent summarized the need for systemic change in this area in responding to the question "What are the most pressing health needs for this community?": "Access and equitable treatment from healthcare professionals, systems that allow undocumented and uninsured folx to still access care. Spanish and Mixtec translation/interpretation so the care that *is* [received] is actually meaningful."

Within the city of San Luis Obispo, there are opportunities to address these inequities in health through expanded free and low-cost healthcare services and upgrading medical technology used at low-income health clinics. As breast cancer was identified as a major concern, high-quality screening services are needed. To address gaps in early detection, these services must be promoted in culturally responsive ways in both English and Spanish, as well as through Indigenous language interpretation. Additional funding is also needed to expand existing mental health services, including through community agencies like T-MHA and specialty providers at Sierra Vista Regional Medical Center and French Hospital Medical Center.

Beyond direct healthcare services, the community also identified larger structural issues that must be addressed through collaboration across sectors. The city has identified that racism is a public health crisis (Wilson 2020) and declared itself as a "sanctuary" for immigrants (Cal Coast News 2017). However, there is vocal resistance in the community to these issues (see for example: Crockett 2018 and McGuinness 2019). Creative strategies are needed to address the identified inequities in health and make a more inclusive and welcoming space for the Latinx community in San Luis Obispo.

Author Note

Mario Espinoza-Kulick (he/him/his) is a Doctoral Candidate in the department of Sociology at the University of California, Santa Barbara and a lecturer in the Ethnic Studies and Women's and Gender Studies departments at California Polytechnic State University, San Luis Obispo. He researches the ways in which healthcare agencies and social movement organizations can advocate for marginalized groups in culturally appropriate ways and through implementation of equitable health policies. Mario draws from his own experience as an HIV+, Queer, Latinx and Indigenous person to raise awareness around health inequities. For more information about this study, please visit our website at https://tinyurl.com/LaGenteUnida You can contact Mario at mvespinoza@ucsb.edu or by phone at (805) 904-9225.

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Acknowledgments

This study was supported by the Robert Wood Johnson Foundation through the Health Policy Research Scholars program and by the Health Policy Research Scholars Dissertation Award. Thanks to the participants in both the survey and to the research assistants at California Polytechnic State University, San Luis Obispo for the "La Gente Unida" project.

Suggested Citation

Espinoza-Kulick, Mario Alberto V. 2020. *Latinx Immigrant Health in San Luis Obispo County: A Report from the La Gente Unida Project.* Santa Maria, CA: La Gente Unida.

Big Promises for Immigrants

Will Biden-Harris Reverse the Cycle of Institutional Discrimination?

By **Mario Espinoza-Kulick**

Tue Feb 09, 2021 | 3:36pm

Angel Boligan, El Universal, Mexico City, caglecartoons.com

The Biden-Harris administration has already taken swift action on immigration by halting Trump's border wall and strengthening the government's commitment to DACA. However, their approach to the broader issues facing migrants and border communities will depend on the administration's continued efforts and their Democratic allies in Congress. As the administration studies and prepares for its approach to immigration reform, they must recognize all forms of racial and xenophobic discrimination for what they are: a public health hazard. The American Public Health Association is just one of many professional associations and government entities to acknowledge that racism is a public health crisis. These inequities are apparent in disparate diagnosis rates for conditions like asthma, diabetes, cancer, heart disease, and now COVID-19.

The additional burden of labor and risk during the pandemic has stacked on top of the unbalanced odds already facing immigrants. As a doctoral candidate in Sociology at the University of California, Santa Barbara, I worked with community leaders to survey and interview the predominantly Latinx immigrant population on California's Central Coast. My colleagues and I found that discrimination was common, based on immigration status, race, ethnicity, gender, and sexuality. When I spoke to community members about their health-care experiences, they shared stories of mistreatment affecting not only themselves but also their community members and family. One individual called this *el temor migratorio*, a fear that arises from living in precarious circumstances. She said with frustration, "At home they hear this, out there they hear something else. Their parents are full of fear, and the children are being affected, because they're scared too."

For immigrants, institutional discrimination is a constant deterrent to accessing health care, especially when it comes to mental health. Even as restrictive policies are reversed, immigrant community members still wonder, "If I use this service, will this information be used against me later?"

As the Biden-Harris administration gets to the work of governing, immigrant and health advocates are looking to their campaign platform and expecting big changes. Starting to reunify families and ending the practice of family separation are big steps in the right direction, but much damage has already been done. Further, even if Democrats succeed in dismantling the policies put forward by Trump, U.S. immigration law is built on centuries of exclusion and exploitation. Immigrant community members remember well the massive number of deportations under the Obama-Biden administration. And even though Biden issued a pause on all deportations, the courts are already signaling their dissent. Piecemeal reforms will not address the harm caused to immigrant communities and will not build the needed trust between immigrants and social service providers.

Biden has indicated that his administration will expand support for police and local law enforcement, but initiatives like the Customs and Border Patrol Law Enforcement Explorer program must be immediately halted. The majority of border communities already view border officials with mistrust. Rather than tracking young people into unpopular, violent jobs, we must invest in meaningful reform and

expand opportunity for immigrant families. To move beyond a simple reversal to genuine change, we must work at every level to reject xenophobia and enact fair and equitable policies for immigrant communities.

Mario Espinoza-Kulick is a doctoral candidate in Sociology at UCSB and Health Policy Research Scholar with the Robert Wood Johnson Foundation. He draws from his own experience as a Chicanx, Queer, and Indigenous person to raise awareness around health inequities.

Sat Apr 24, 2021 | 06:46am
https://www.independent.com/2021/02/09/big-promises-for-immigrants/

El idioma crea barreras

Por Mario Espinoza Kulick
redaccion@latinocc.com

La pandemia de coronavirus ha revelado la necesidad de comunicación inclusiva y accesible sobre la salud.

Para muchos miembros de nuestra comunidad, las barreras del idioma disminuyen la calidad y el acceso a la atención médica.

Se han realizado esfuerzos importantes para ofrecer recursos y servicios accesibles a los miembros de la comunidad de habla hispana, pero, el acceso al idioma debe expandirse más allá de los servicios bilingües y la traducción.

Se necesitan servicios de interpretación multilingües de alta calidad para comunicarse con los miembros de la comunidad indígena, como Mixteco, y gente de diversos orígenes que no hablan español para garantizar el acceso a la atención médica.

Si bien estos pueden parecer problemas que solo afectan a grupos minoritarios, la pandemia ha puesto de relieve que la salud y la seguridad de la comunidad en su conjunto dependen de la disponibilidad de atención médica de calidad para cada individuo.

En un proyecto llamado "La Gente Unida: Salud y Defensa de los Inmigrantes en la Costa Central de California", entrevistamos a más de 30 miembros de la comunidad y defensores sobre los problemas que enfrentan los inmigrantes latinos, sus familias y la comunidad en general en la Costa Central.

Surgió un tema clave relacionado con las barreras del idioma y la falta de servicios de interpretación asequibles, accesibles y de alta calidad.

Los miembros individuales o los defensores de la comunidad a menudo intervienen para realizar un trabajo de interpretación no remunerado o mal remunerado.

Por ejemplo, un proveedor de atención médica compartió:

"Realmente no tenemos a nadie que hable Mixteco, pero sí tenemos a alguien en la clínica. Cuando nos encontramos con alguien, le decimos que puede llamar a la clínica y que, por lo general, creo que la recepcionista o el asistente médico hablan Mixteco."

En estas situaciones, el acceso está disponible, pero soóo para aquellos que tienen el valor de acercarse y arriesgarse a ser malinterpretados.

> "Es imperativo que la atención médica sea accesible...".

Es por ello, que los líderes de la salud tienen la oportunidad de invertir en servicios de interpretación multilingüe que operan en la comunidad local, apoyando a las personas que ya han estado haciendo este trabajo.

Esto podría tener un efecto en otras industrias, incluidos los proveedores de servicios sociales, la educación y las instituciones culturales, todas las cuales enfrentan sus propias luchas con las barreras del idioma.

Durante una pandemia que continúa demostrando la importancia de la salud comunitaria colectiva, es imperativo que la atención médica sea accesible para todos, independientemente del idioma que hablen. La Gente Unida es un proyecto de investigación que se centra en la salud y la defensa de los inmigrantes en la costa central de California.

Estamos investigando las estrategias que los defensores implementan para transformar las políticas de salud y promover el acceso equitativo a la atención médica para las partes interesadas de los movimientos de salud de inmigrantes. ■

Para más información, contáctenos en lagenteunidacc@gmail.com

Latinx Community Survey Evidence for California Healthcare Bills

Mario Alberto V. Espinoza-Kulick, University of California, Santa Barbara

Racism is an acknowledged public health crisis – but California stands to be a leader among states in addressing the debilitating health effects of racism on Latinx individuals and communities. While expanding Medi-Cal eligibility regardless of age or documentation status would be the highest impact intervention, other effective actions include expanding medical interpretation services; training providers in culturally competent, trauma-informed care; and simply increasing capacity through the creation of a California Medicine Scholars Program.

IS THERE EVIDENCE THAT RACISM AFFECTS THE HEALTH OF LATINX IMMIGRANTS?

Yes. I surveyed over **200 Latinx immigrant community members** and advocates on the central coast of California. They were vocal about the impacts of inequitable access to and quality of health care, and the way discrimination contributed to their health outcomes.

HOW DOES A MEDI-CAL EXPANSION FOR UNDOCUMENTED PEOPLE BENEFIT CALIFORNIA COMMUNITIES?

Including eligible undocumented individuals in **Medi-Cal** coverage will:

Allow more low-income Californians to access necessary health care

Establish trust between service providers and families who would otherwise be wary of interacting with authority figures because of their citizenship status

Lack of coverage contributes to higher rates of:

Needless loss of life

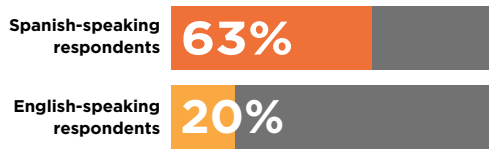
Costly emergency services

Preventable illness

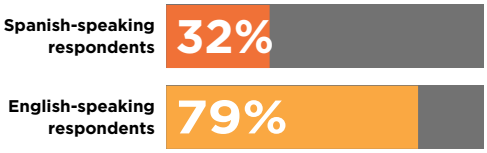
HOW DO LANGUAGE BARRIERS CONTRIBUTE TO POOR HEALTH OUTCOMES?

Language barriers sometimes kept respondents from accessing health care or contributed to them receiving lower quality treatment.

Spanish-speaking respondents were more likely to indicate their health was **"Fair"** (63%), compared to English-speaking respondents (20%).



79% of English-speakers rated their health as **"Good"** or **"Excellent,"** while 32% of Spanish-speakers ranked their overall health positively.

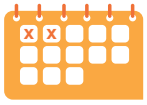


Legislatures should fund interpretation services, employing Indigenous language speakers in addition to English and Spanish speakers – especially in rural areas where it's most needed.

WHAT INTERVENTIONS DIRECTLY ADDRESS THE EFFECTS OF RACISM ON HEALTH, IN ADDITION TO THOSE THAT EXPAND HEALTHCARE ACCESS?

0.76+

Direct experiences of racism were significantly associated with a **0.76-point increase on a 3-point scale** of anxiety scores.



Respondents experienced anxiety symptoms **"nearly half the days"** within the past two weeks.

Funding trauma-informed care training for clinical staff could untangle the effects of discrimination-based anxiety on Latinx patients.

HOW CAN HEALTHCARE WORKFORCE DEVELOPMENT EFFORTS DECREASE DISPARITIES IN ACCESS TO CARE?

The California Medicine Scholars Program proposed in SB-40 would allow for regionally-based healthcare workforce development strategies that grow the provider base in underserved communities.

46%

46% of respondents said they had gone without health care in the past three months because "appointments were not available." Having more healthcare workers and leaders who are from the communities they serve will contribute to closing equity gaps in care.

SCHOLARS STRATEGY NETWORK

scholars.org

Evidencia de una encuesta comunitaria Latinx para las políticas de atención médica de California

Mario Alberto V. Espinoza-Kulick, Universidad de California, Santa Bárbara

El racismo es una crisis de salud pública reconocida, pero California es líder entre los estados para abordar los efectos debilitantes del racismo en la salud de las personas y comunidades latinx. Ampliar la elegibilidad para Medi-Cal sin importar la edad o el estado de la documentación sería la intervención de mayor impacto; otras acciones efectivas incluyen la expansión de los servicios de interpretación médica; capacitar a los proveedores en atención basada en el trauma y competencia cultural; y simplemente aumentar la capacidad mediante la creación de un Programa de becarios de medicina de California.

¿EXISTE EVIDENCIA DE QUE EL RACISMO AFECTA LA SALUD DE LOS INMIGRANTES LATINOS?

Si. Entrevisté a más de **200 miembros** y defensores de la comunidad de inmigrantes latinos en la costa central de California. Expresaron abiertamente los impactos del acceso inequitativo y la calidad de la atención médica, y la forma en que la discriminación contribuyó a su salud.

¿CÓMO BENEFICA UNA EXPANSIÓN DE MEDI-CAL PARA PERSONAS INDOCUMENTADAS DE CALIFORNIA?

Incluir personas indocumentadas elegibles en la cobertura de **Medi-Cal**:

Permite que más californianos de bajos ingresos accedan a la atención médica necesaria

Establece confianza entre los proveedores de servicios y las familias que de otra manera desconfiarían de interactuar con figuras de autoridad debido a su estatus de ciudadanía

La falta de cobertura contribuye a tasas más altas de:

- Pérdidas innecesarias de vidas
- Servicios de emergencia costosos
- Enfermedades evitables

SCHOLARS STRATEGY NETWORK

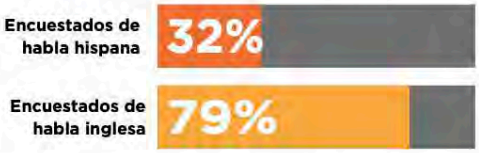
scholars.org

¿CÓMO CONTRIBUYEN LAS BARRERAS DEL IDIOMA A UNA SALUD DEFICIENTE?

Las barreras del idioma a veces impidieron que los encuestados tuvieran acceso a la atención médica o contribuyeron a que recibieran un tratamiento de menor calidad.

Los encuestados de habla hispana eran más propensos a indicar que su salud era **"Regular"** (63%), en comparación con los encuestados de habla inglesa (20%).

El 79% de los angloparlantes calificaron su salud como **"Buena"** o **"Excelente"**, mientras que el 32% de los hispanohablantes calificaron su salud general de manera positiva.



Las legislaturas deberían financiar los servicios de interpretación, empleando hablantes de lenguas indígenas además de hablantes de inglés y español, especialmente en las zonas rurales donde más se necesita.

¿QUÉ INTERVENCIONES ABORDAN DIRECTAMENTE LOS EFECTOS DEL RACISMO EN LA SALUD, ADEMÁS DE LAS QUE EXPANDEN EL ACCESO A LA ATENCIÓN MÉDICA?

0.76+ Las experiencias directas de racismo se asociaron significativamente con un aumento de **.76 puntos en una escala de 3 puntos de puntajes de ansiedad**.

Los encuestados experimentaron síntomas de ansiedad **"casi la mitad de los días"** en las últimas dos semanas.

Financiar la capacitación sobre atención basada en el trauma para el personal clínico podría desenredar los efectos de la ansiedad basada en la discriminación en los pacientes latinx.

¿CÓMO PUEDE EL AUMENTO DE LA FUERZA LABORAL DE SALUD DISMINUIR LAS DISPARIDADES EN EL ACCESO A LA ATENCIÓN?

El Programa de becarios en medicina de California propuesto en SB-40 permitiría estrategias de desarrollo de la fuerza laboral de atención médica basadas en la región que hacen crecer la base de proveedores en comunidades desatendidas.

46% El **46%** de los encuestados dijo que se había quedado sin atención médica en los últimos tres meses porque "las citas no estaban disponibles". Tener más trabajadores de la salud y líderes de las comunidades a las que sirven contribuirá a cerrar las brechas de equidad.

SCHOLARS STRATEGY NETWORK

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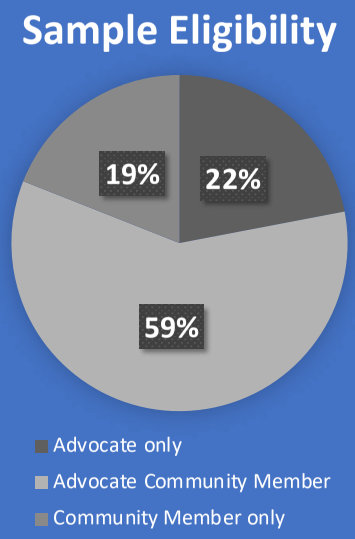
About LGU

- Participant-observation of in-person and virtual events (2018-2020).
- Reflexivity of fieldwork and writing.
- Content Analysis of ethnographic news data (n=148) and systematic sample of the Central Coast, CA (n=9761).
- Interviews with Community Members and Advocates (n=30).
- Survey of Health Needs and Assets
- Public-facing website for dissemination of findings, recruitment, and transparency: https://lagenteunidacc.wixsite.com/recursosdesalud

Research Methods

- Larger ethnographic project
- Community stakeholders in design and distribution of survey
- Survey with Latinx Immigrant community members and advocates (n = 177)
- Supported by Health Policy Research Scholars, Robert Wood Johnson Foundation



Analysis

Upstream Factors

- Social standing: race, gender, Indigeneity, language spoken
- Pre- and Post-COVID (March 2020)

Downstream Factors

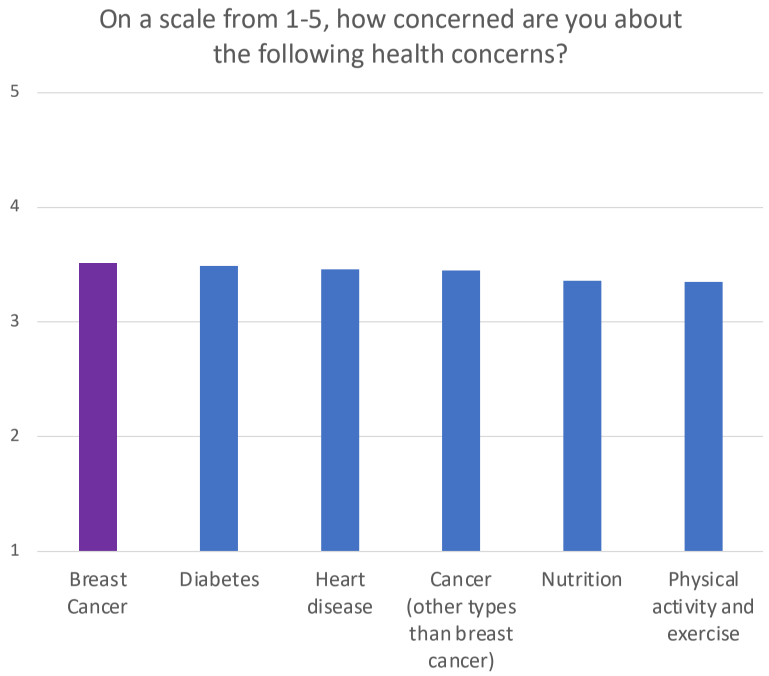
- Delaying healthcare
- Concern for negative health conditions: breast cancer, diabetes, heart disease, cancer, nutrition, physical activity
- Anxiety
- COVID exposure

Findings from the *La Gente Unida* Survey

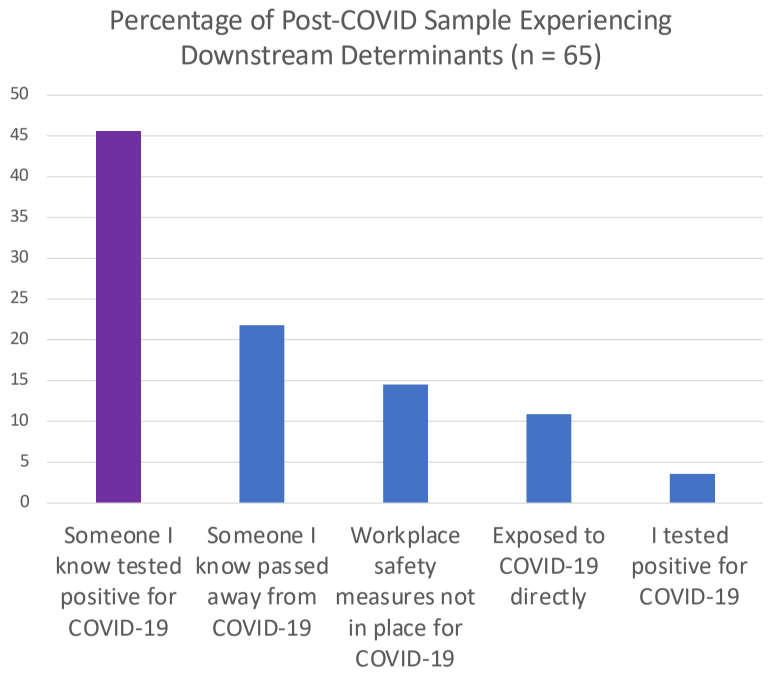
Summary of Demographics (Upstream Factors)		
Race	n	%
Latina/o/x or Hispanic	132	85.7
Other race/ethnicity	22	14.3
Gender		
Womxn	123	82
Other gender	27	18
Indigeneity		
Not Indigenous	125	83.3
Indigenous	25	16.7
Language spoken		
English	95	53.7
Español	82	46.3
Pandemic timing		
Pre-COVID	29	16.4
Post-COVID	148	83.6

Summary of Downstream Factors				
	Min	Max	*M*	*SD*
Healthcare avoidance behaviors	0	10	1.79	1.50
COVID-related healthcare avoidance (n = 65)	0	3	0.82	0.81
Anxiety	1	4	1.91	0.77
Concern for downstream determinants (e.g., heart disease, breast cancer, exercise)	1	5	3.42	1.13

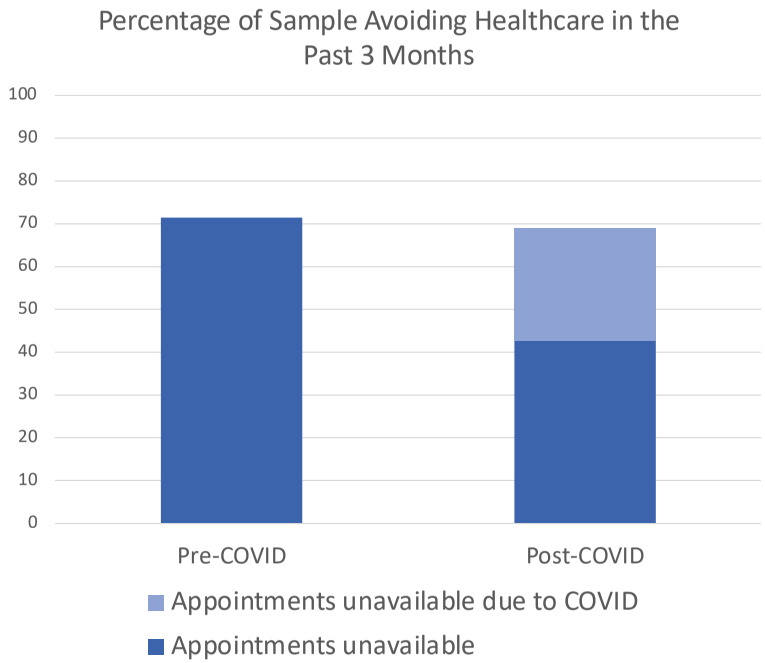
Relative Priorities of Downstream Determinants



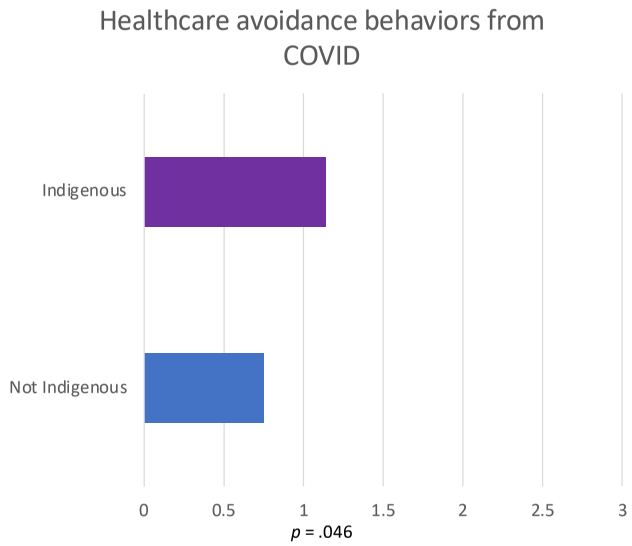
Downstream Experiences of COVID-19

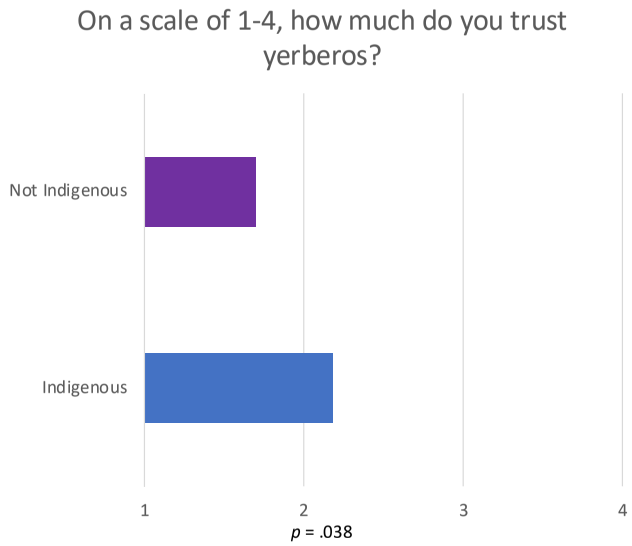


Gaps in Access Before and During COVID-19

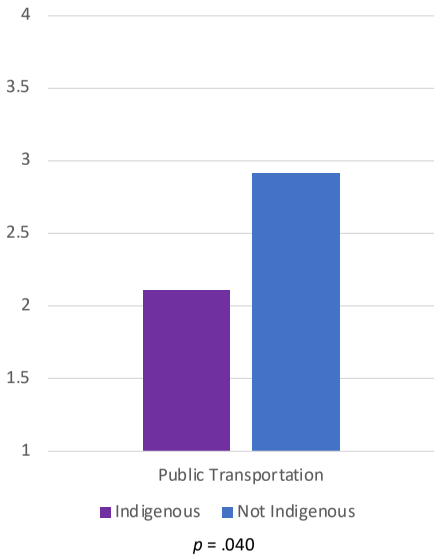


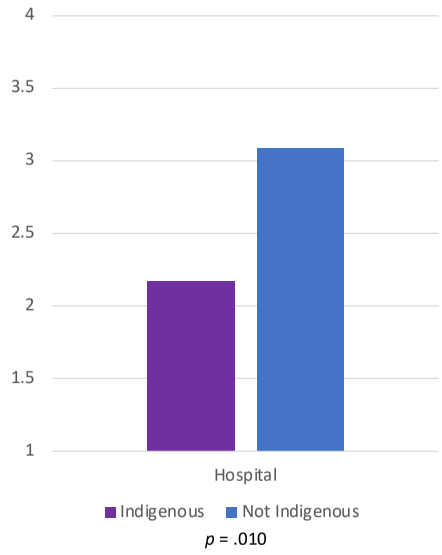
Indigenous Respondents Blocked from Formal Healthcare and Place Trust in Traditional Healers

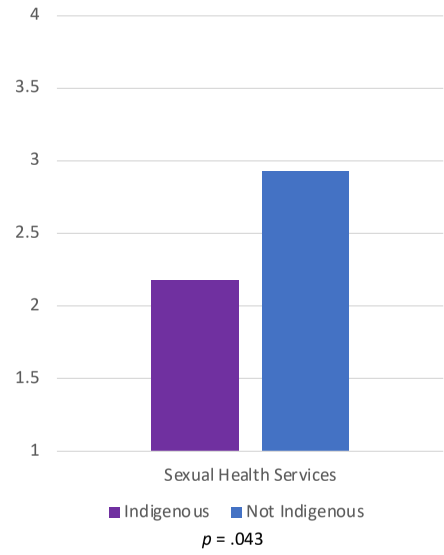


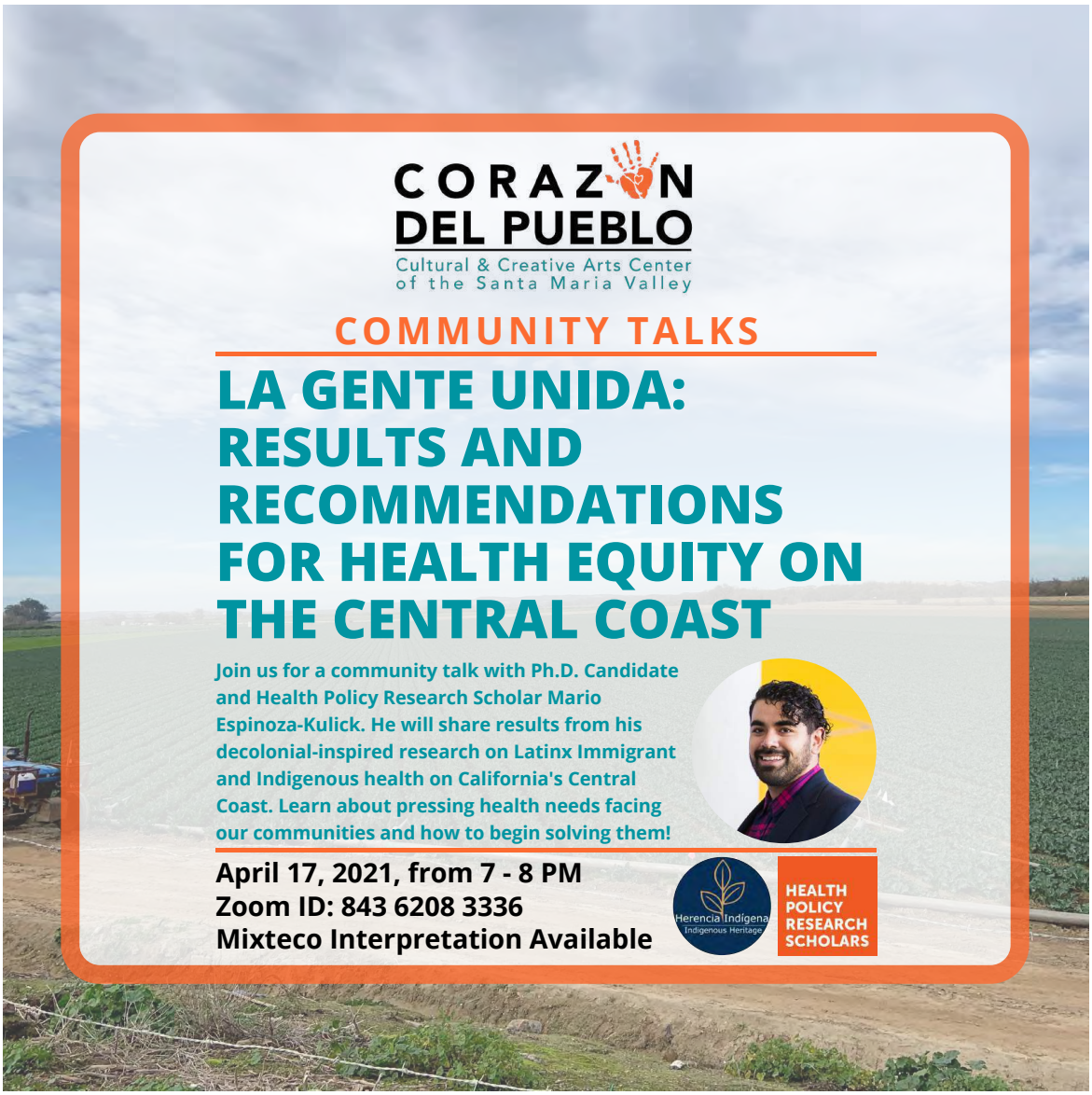


Access Disparities for Indigenous Communities

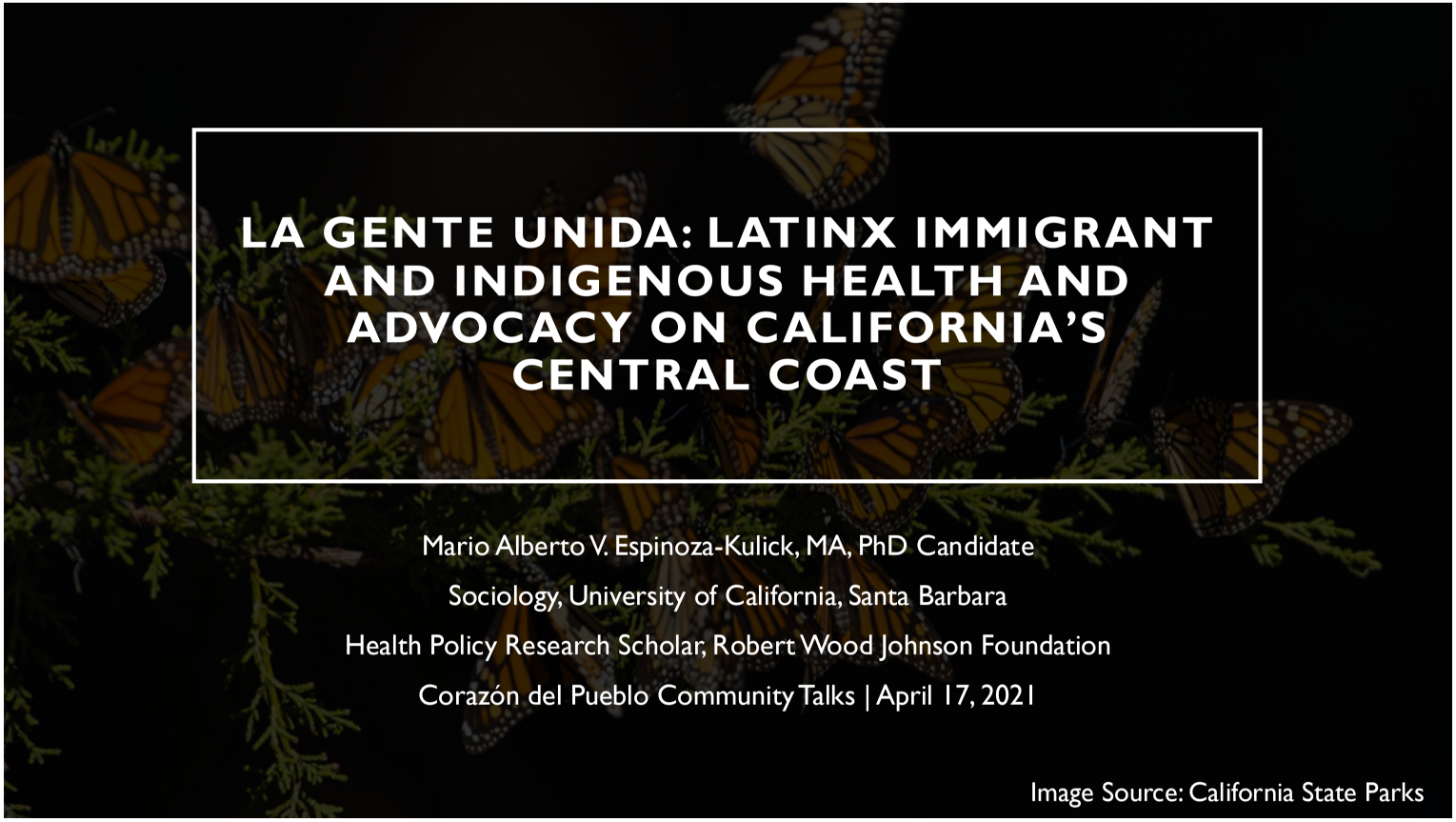







CORAZON DEL PUEBLO
Cultural & Creative Arts Center of the Santa Maria Valley
COMMUNITY TALKS
LA GENTE UNIDA: RESULTS AND RECOMMENDATIONS FOR HEALTH EQUITY ON THE CENTRAL COAST
Join us for a community talk with Ph.D. Candidate and Health Policy Research Scholar Mario Espinoza-Kulick. He will share results from his decolonial-inspired research on Latinx Immigrant and Indigenous health on California's Central Coast. Learn about pressing health needs facing our communities and how to begin solving them!
April 17, 2021, from 7 - 8 PM
Zoom ID: 843 6208 3336
Mixteco Interpretation Available
Herencia Indígena
Indigenous Heritage
HEALTH POLICY RESEARCH SCHOLARS


CORAZÓN DEL PUEBLO
Cultural & Creative Arts Center of the Santa Maria Valley
CHARLAS COMUNITARIAS
LA GENTE UNIDA: RESULTADOS Y RECOMENDACIONES PARA LA EQUIDAD EN SALUD EN LA COSTA CENTRAL
Únase a nosotros para una charla comunitaria con el candidato a doctorado e investigador de políticas de salud Mario Espinoza-Kulick. Él compartirá los resultados de su investigación descolonial sobre la salud de inmigrantes e indígenas latinos en la costa central de California. ¡Aprenda sobre las necesidades de salud urgentes que enfrentan nuestras comunidades y cómo comenzar a resolverlas!
17 de abril desde las 7 - 8 PM
Zoom ID: 843 6208 3336
Interpretación Mixteco Disponible
Herencia Indígena
Indigenous Heritage
HEALTH POLICY RESEARCH SCHOLARS


LA GENTE UNIDA: LATINX IMMIGRANT AND INDIGENOUS HEALTH AND ADVOCACY ON CALIFORNIA'S CENTRAL COAST
Mario Alberto V. Espinoza-Kulick, MA, PhD Candidate
Sociology, University of California, Santa Barbara
Health Policy Research Scholar, Robert Wood Johnson Foundation
Corazón del Pueblo Community Talks | April 17, 2021
Image Source: California State Parks

ANTI-IMMIGRANT POLICIES AND RACISM

There has been a rise in political, xenophobic hostility against immigrants.

Stereotypes about Latina/o/x people as being greedy, lazy, or invasive to U.S. society. These lead to harsh policies like child detention and family separation.

Anti-immigrant policies impose negative health behaviors and effects.

- Reliance on emergency services and disenrollment from public benefits programs (e.g., Medi-Cal, Medicare, WIC) perpetuate inequities in health among families and communities (Perreira, Yoshikawa, and Oberlander 2018).
- Restrictive eligibility policies to government-sponsored health programs like Medi-Cal, Medicare, etc. (LeBrón et al. 2018).
- Violent enforcement, like raids have a negative impact on Latinx communities, especially collaborative raids between ICE and law enforcement (Lopez et al 2017).

INDIGENOUS SOCIAL DETERMINANTS OF HEALTH

- Indigenous peoples have always known that "health is a holistic concept that extends beyond Individual behaviors and genetics" (Lines et al. 2019: 1).
- In contrast with western definitions of social and structural determinants of health; First nation groups include "unique structural (or foundational) determinants such as history, political climate, economics and social contexts."
- Compared to non-Indigenous groups, Indigenous peoples continue to face high rates of illness, suicide, and mortality that are an "additive sum, of cultural wounds affecting the entire community and ways of life" (Lines et al. 2019: 2)

https://www.healthunit.com/indigenous-peoples

KQED

NEWS

California's Working-Age Latinos Are Disproportionately Dying of COVID-19

LISTEN

By Farida Jhabvala Romero Mar 30 Save Article

In Santa Clara County, more than half of the people under age 65 who died of the coronavirus were Latino, even though Latinos make up only a quarter of the population in that age group. *(Anna Vignet/KQED)*

HEALTH DISPARITIES AND COVID-19

- Latinx people are more likely to contract COVID-19 (Gil et al. 2020) and mortality rates are nearly twice as high for the Latinx population compared to non-Hispanic whites (Gross et al. 2020).
- Structural racism is the fundamental cause of these disparities, especially for older adults (Garcia et al. 2020; Page and Flores-Miller 2020).
  - High risk of exposure due to concentration in essential work.
  - Accumulated stress increases risk for serious complications.
  - Barriers to healthcare due to language, trust, and a culture of fear.

Latino Share of COVID-19 Cases by California County

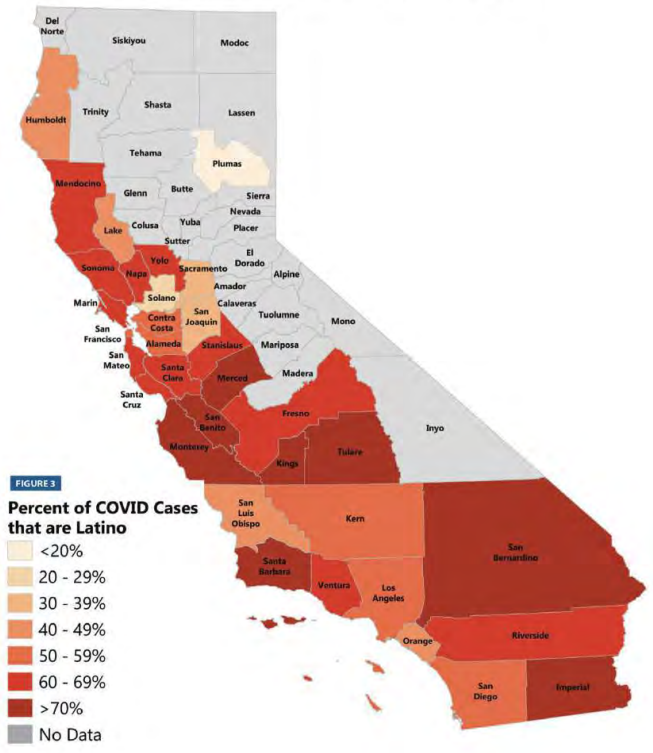


FIGURE 3

Percent of COVID Cases that are Latino

- <20%
- 20 - 29%
- 30 - 39%
- 40 - 49%
- 50 - 59%
- 60 - 69%
- >70%
- No Data

Statewide - 60%

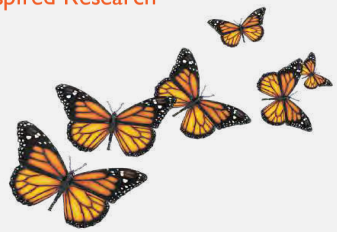
Data Source: COVID-19 reporting by California counties as of November 24-November 30, 2020

PROJECT OVERVIEW

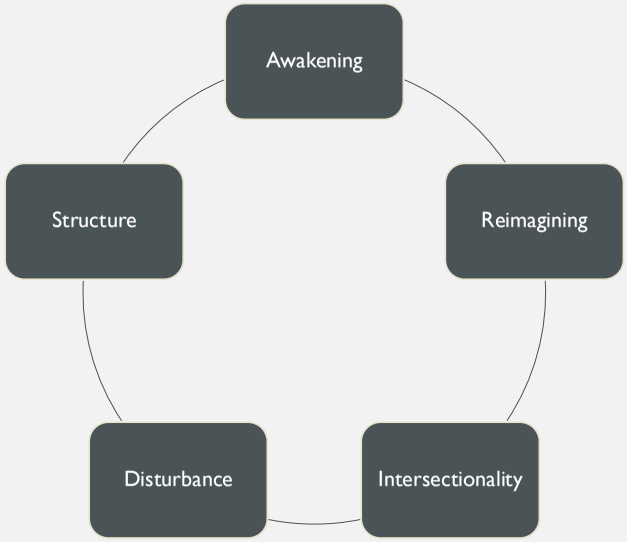
- Survey of Health Needs and Assets (n=177).
- Content Analysis of ethnographic news data (n=148) and systematic sample of the Central Coast, CA (n=4768).
- Interviews with Community Members and Advocates (n=30) and Focus Groups (n=12).
- Participant-observation of in-person and virtual events (September 2018 – September 2020).
- Reflexivity of fieldwork and writing.
- Public-facing website for dissemination of findings, recruitment, and transparency: https://lagenteunidacc.wixsite.com/recursosdesalud

DECOLONIAL-INSPIRED METHODS

- Decolonization (Jacob 2013; Jolivette 2016; Smith 2012).
  - Deconstructs western research methods and privileges the voices of Indigenous knowledge producers.
  - Explores the margins to examine what is not being heard and what is not being spoken in struggle.
- Community input is a primary source of knowledge (Rios, 2011, 2015, 2017a, 2017b; Smith 2012).
- Practices of Decolonial-Inspired Research
  - Reflexivity
  - Collaboration
  - Sharing
  - Community Advice
  - Assessment

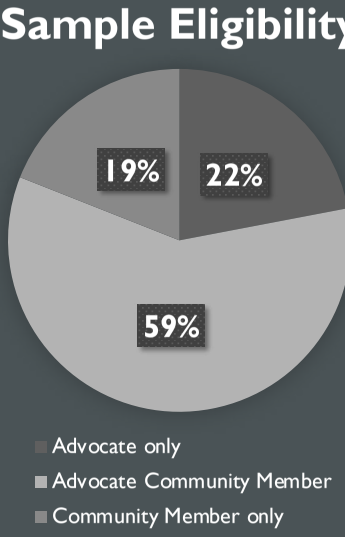


5 Dimensions of Struggle for Decolonization (Smith 2006)

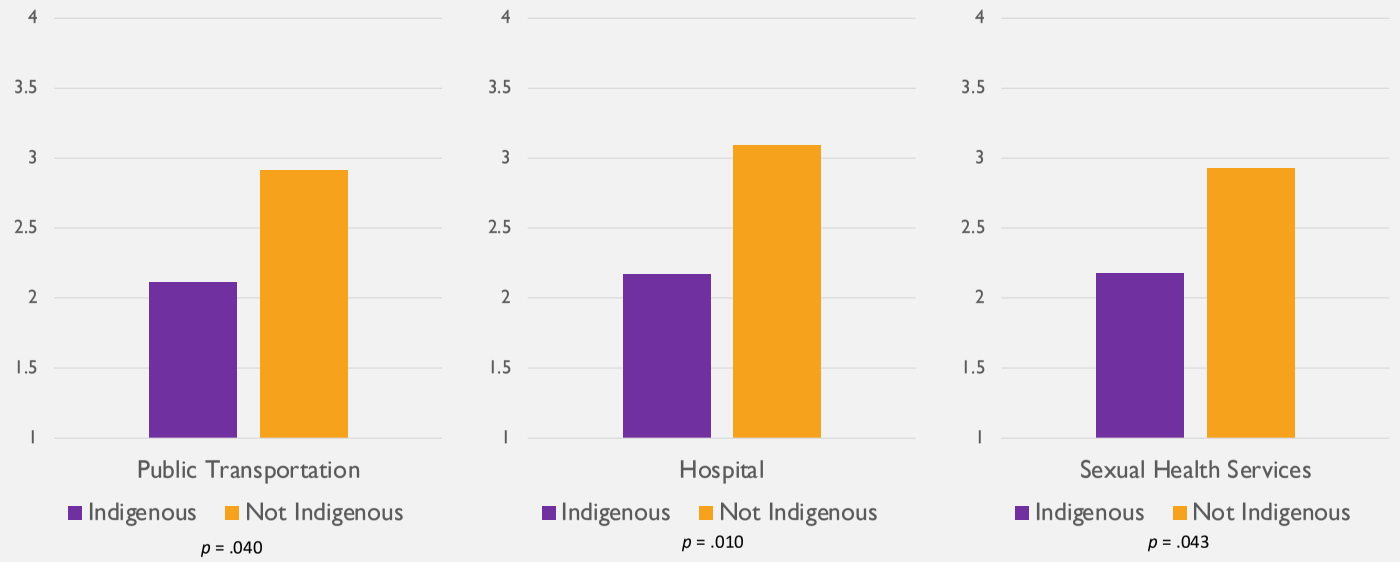


SURVEY METHODS

- Community stakeholders in design and distribution of survey
- Survey with Latinx Immigrant community members and advocates (n = 177)
- Collected between 2019-2020
- Includes women (82%), Spanish-speakers (46%), and Indigenous respondents (17%)



ACCESS DISPARITIES FOR INDIGENOUS COMMUNITIES

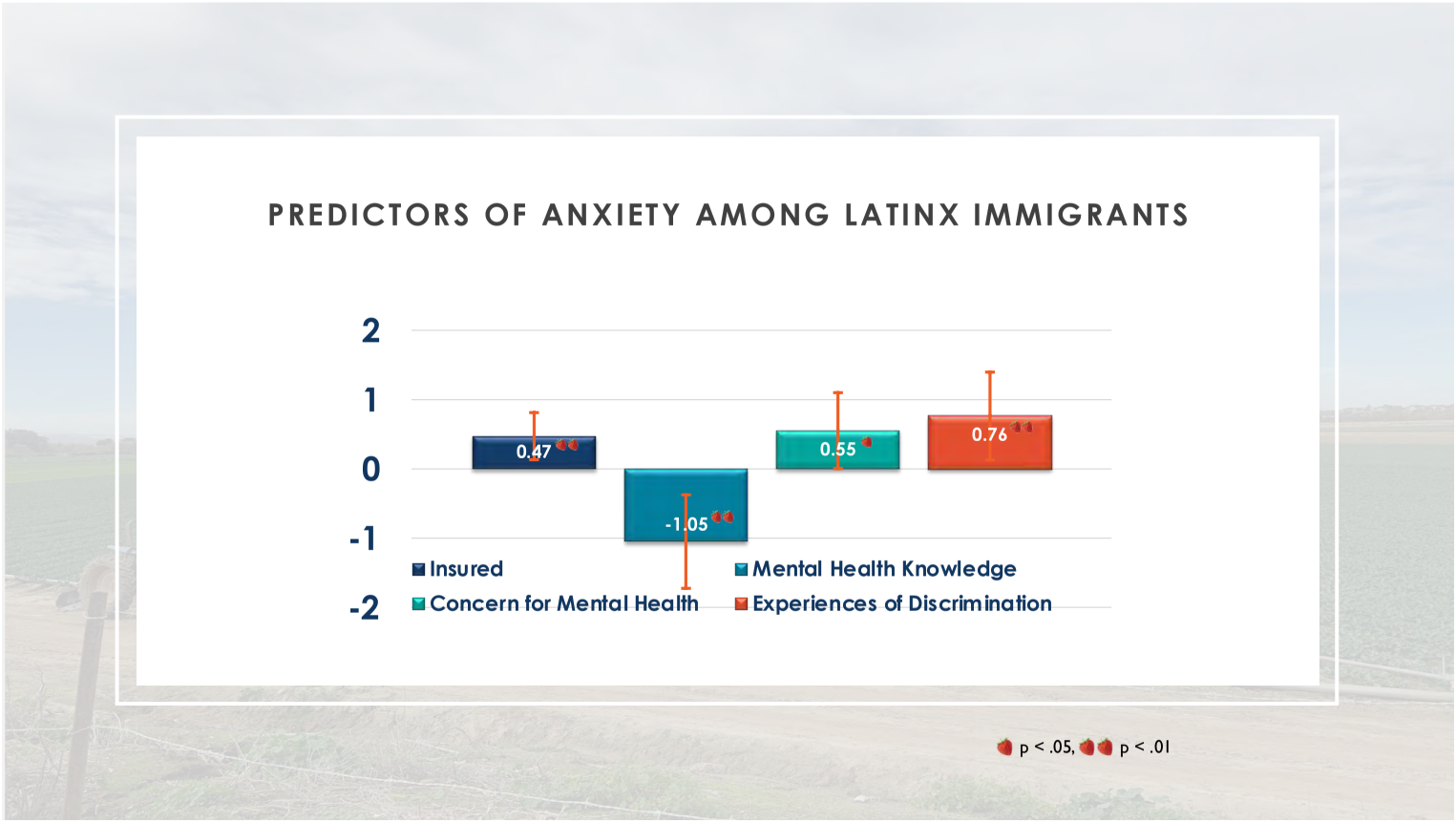


COMMUNITY VOICE: LANGUAGE BARRIERS

- Latinx communities are heterogenous groups, and language extends beyond English and Spanish.
- Interview participants indicated that Indigenous language interpretation is a key need for meaningful health access.

"Even if we fight for policy that encompasses undocumented individuals, we also have to think about the practicality of implementing those policies and how we actually reach our language minority families or our communities that don't have a written language and only have an oral language."

"We don't really have anyone that speaks Mixteco, but we do have someone at the clinic. When we do encounter someone, we do tell them that they could call the clinic and that, usually, I believe the receptionist or the medical assistant, they speak Mixteco."


PREDICTORS OF ANXIETY AMONG LATINX IMMIGRANTS
2
1
0
-1
-2
0.47
-1.05
0.55
0.76
Insured
Mental Health Knowledge
Concern for Mental Health
Experiences of Discrimination
p < .05, p < .01

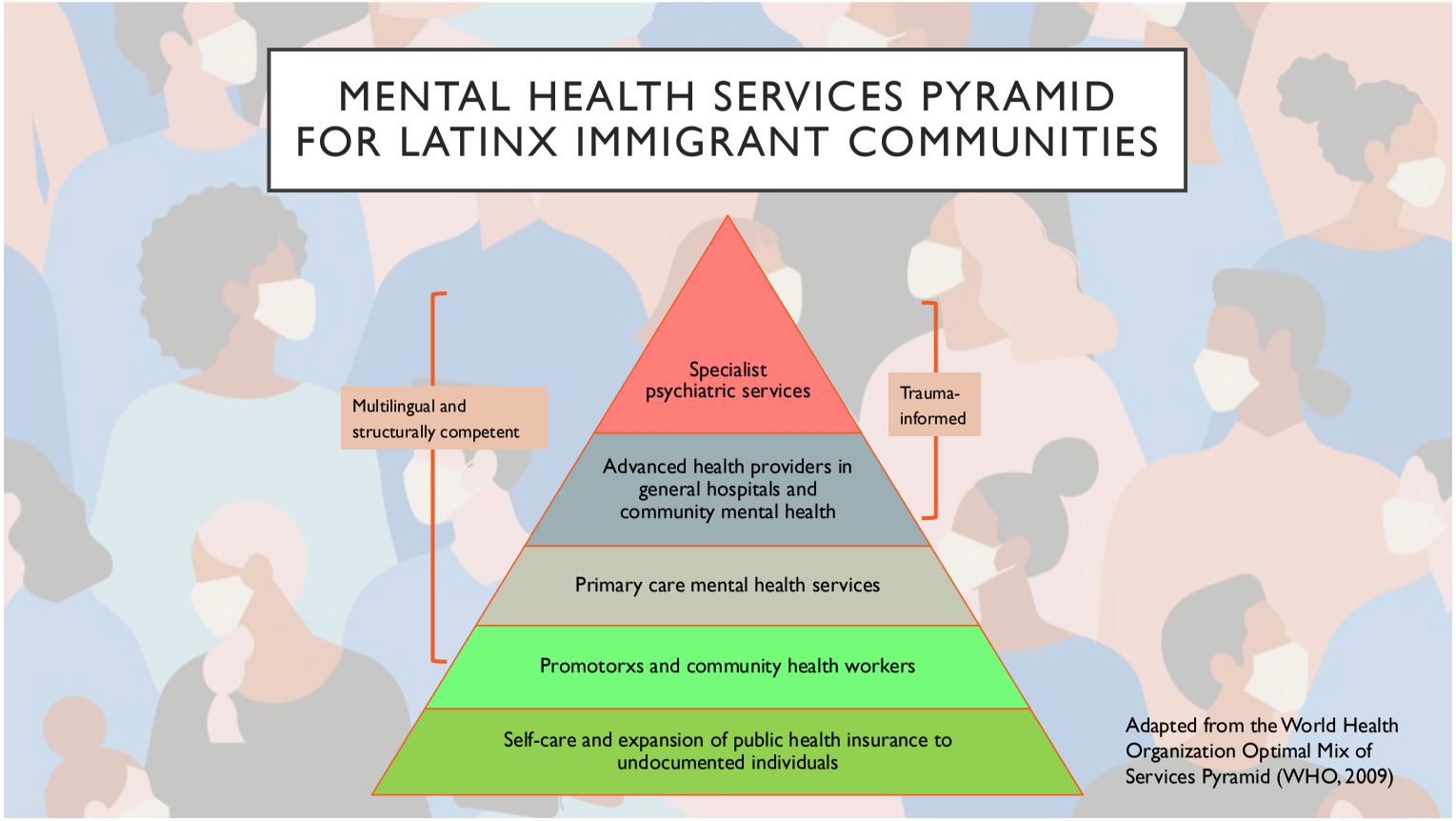
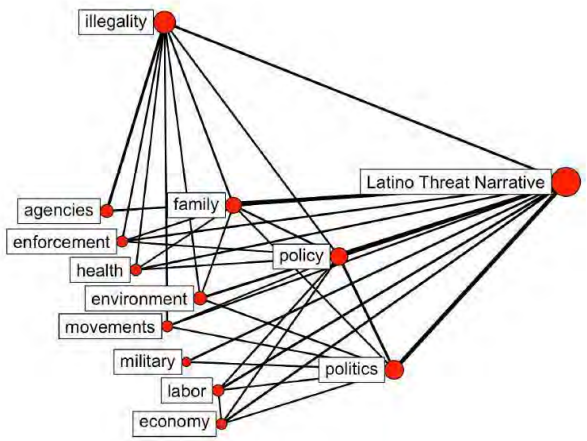

MENTAL HEALTH SERVICES PYRAMID
FOR LATINX IMMIGRANT COMMUNITIES
Specialist psychiatric services
Advanced health providers in general hospitals and community mental health
Primary care mental health services
Promotorxs and community health workers
Self-care and expansion of public health insurance to undocumented individuals
Multilingual and structurally competent
Trauma-informed
Adapted from the World Health Organization Optimal Mix of Services Pyramid (WHO, 2009)

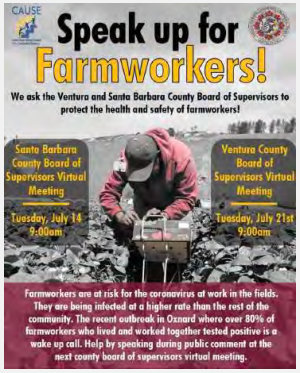
Figure 1. Network of Topics in Immigration News on the Central Coast from 2006 to 2020.



NEWS MEDIA AND LATINO THREAT NARRATIVE

- Messages collectively described as "Latino Threat Narrative" reproduce racist beliefs about Latinx communities (Chavez 2013; Díaz McConnell 2019; López-Sanders and Brown 2019)
  - Undermine trust and produce a "chilling effect" for immigrant communities (Pedraza and Zhu 2015)
- Latino Threat Narrative maintains a link between the construction of illegality and both immigrant and health policies.
  - This leads to negative health behaviors across generations


"What we've noticed actually is a drop in the amount of clients that come to our office [when ICE is in the news]. Normally, our waiting room is pretty packed and there aren't any seats available and lately, people haven't been coming into our office. Also, like I mentioned earlier, we have those community women's classes, and normally there's a high turnout, it's like 50 people, but now only like maybe 10 or 20 will come. That has been because of ICE and all these talks of raids, but it's also been because of the public charge discussion that's been going on. I think people are just really scared."
– Advocate Interview
"My clients see it on the news and hear it on the radio and have had experiences where people are always telling them, 'No, you're wrong. No, you don't know. No, you don't speak the language.' It's like, 'I've been told this in a million different ways in a million different spaces, so it must be true.' … They don't fight back, and they don't utilize the rights that they have."
– Advocate Interview



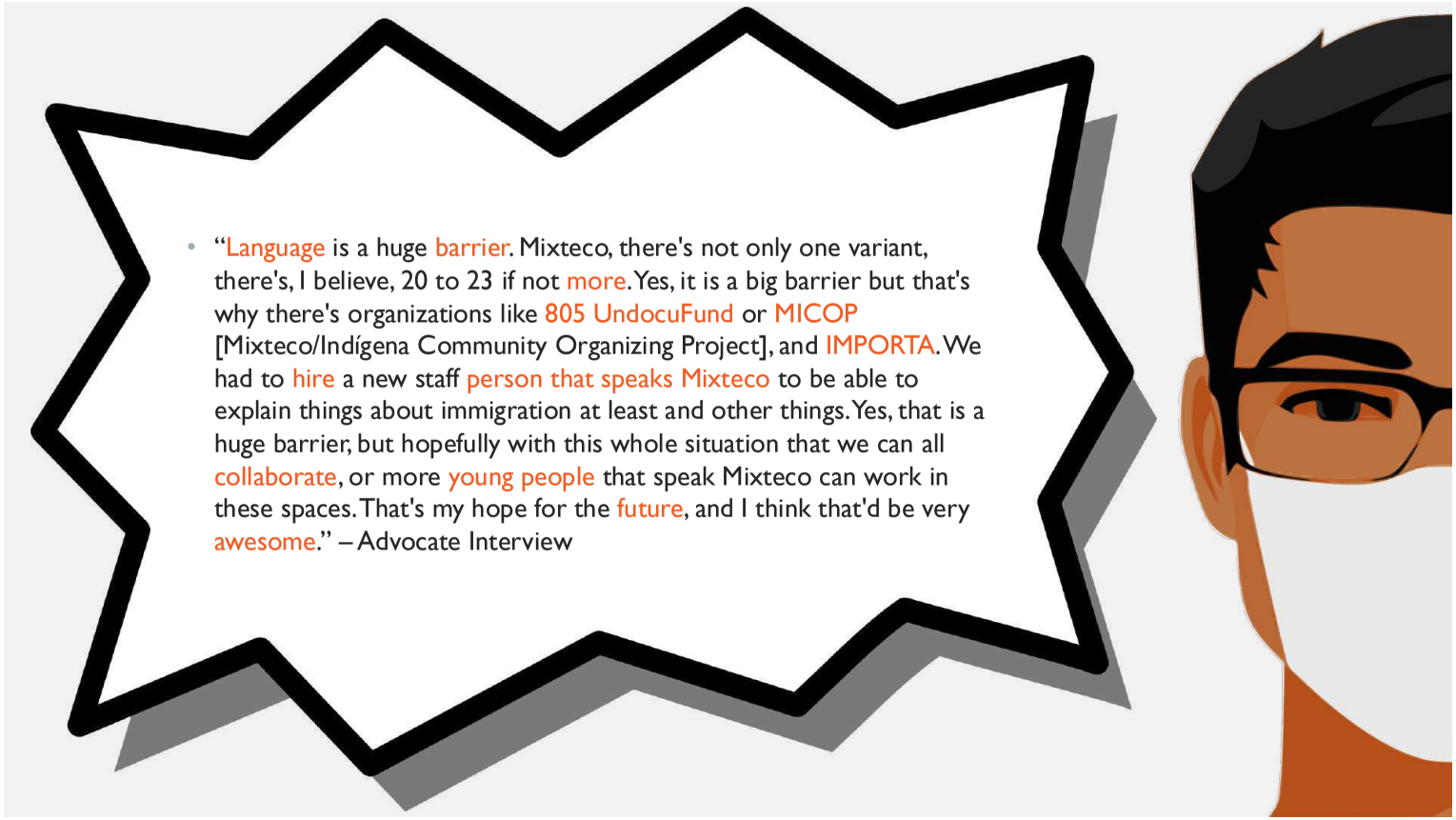
MOVEMENT PANDEMIC ADAPTABILITY

- Advocacy groups draw on pre-existing resources for mobilizing under hostile conditions and with limited resources.
- Movements responded to the exclusion from CARES funding and stimulus payments through mutual aid and crowdfunding.
- Essential work framing was used to advance health policy, gain resources and publicity.


• "Nuestra estrategia es más que nada seguir insistiendo, seguir tocando puertas por puertas, seguir insistiendo dándoles la información correcta. Hay muchos recursos de los que ellos se pueden beneficiar, no importan las opiniones políticas, hay mucha información, muchos beneficios. Eso nos hace más fuertes."
• (Translated: "Our strategy is more than anything to keep insisting, keep knocking door by door, keep insisting, by giving them the correct information. There are many resources for their benefit. Political opinions don't matter. There is plenty of information and many benefits. This makes us all stronger.")

COMMUNITY EDUCATION

- Advocacy groups share key information about pressing health issues and policies, breaking down language barriers in the process.
- Community-led materials are culturally responsive and center youth voices.


• "Language is a huge barrier. Mixteco, there's not only one variant, there's, I believe, 20 to 23 if not more. Yes, it is a big barrier but that's why there's organizations like 805 UndocuFund or MICOP [Mixteco/Indígena Community Organizing Project], and IMPORTA. We had to hire a new staff person that speaks Mixteco to be able to explain things about immigration at least and other things. Yes, that is a huge barrier, but hopefully with this whole situation that we can all collaborate, or more young people that speak Mixteco can work in these spaces. That's my hope for the future, and I think that'd be very awesome." – Advocate Interview

SOLIDARITY & HEALTH POLICY

- Better pay, working conditions, and access to PPE.
- Increased housing & health protections to combat COVID-19.
- Medi-Cal expansion to undocumented young adults (up to age 26).

FIELDWORK EXAMPLE

By Genelle Padilla

Published June 23, 2020 12:41 pm

NEWS CHANNEL 3 FOX 11 12

Hundreds of Santa Maria farmworkers receive raise after over a month of organizing

CAUSE

SANTA MARIA, Calif. - After a month of organizing for better pay and work conditions, over 600 farmworkers will receive a raise from Driscoll's Berries' supplier, Rancho Laguna Farms.

The push for higher pay and improved work conditions began in early May, when over 100 Rancho Laguna farmworkers coordinated a work stoppage.

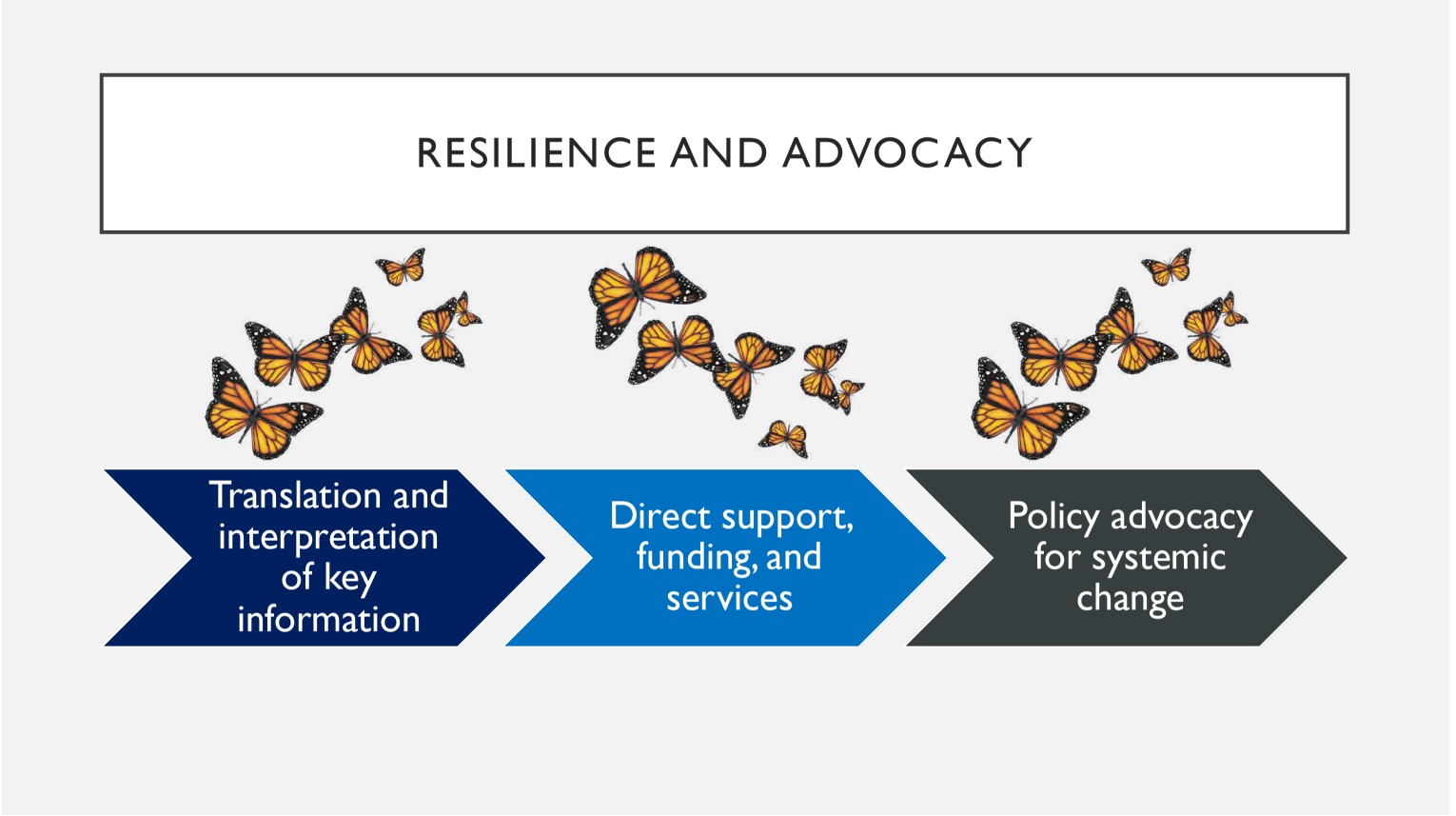
By Jessica Brest

Published February 21, 2021 12:13 pm

NEWS CHANNEL 3 FOX 11 12

More than 200 Santa Maria farmworkers receive settlement checks after facing alleged retaliation while calling for higher wages

Agricultural Labor Relations Board


RESILIENCE AND ADVOCACY
Translation and interpretation of key information
Direct support, funding, and services
Policy advocacy for systemic change

CONCLUSION

- Decolonial-inspired methods are useful for engaging with community collaborations and producing tangible outcomes.
  - Op-Eds, community reports and presentations, website, collaborations, and direct service to communities and Indigenous peoples.
- Structural racism intersects with xenophobia and settler-colonialism to produce unique health vulnerabilities for Latinx immigrant communities.
  - Insurance access, language barriers, and mental health.
- Latinx immigrant health movements have responded to the pandemic by mobilizing for systems change at every level.
  - Access to health resources, adapting to pandemic conditions, and advocating anti-racist change systematically.

RECOMMENDATIONS

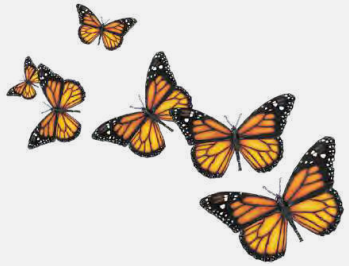
- Policy
  - Expand public health insurance (Medi-Cal) to include undocumented individuals of all ages.
  - Support language access, translation, and interpretation.
  - Affirm that racism is a public health crisis.
- Interventions
  - Build healthcare capacity on the Central Coast, focused on equity.
  - Promote implicit bias and anti-discrimination trainings throughout the community.

WHAT CAN WE DO?

- Support California Legislation
  - SB-56 (Durazo): Health4All Seniors expands Medi-Cal to eligible undocumented adults
  - SB-40 (Hurtado): California Medicine Scholars Program
  - SB-682 (Rubio): Closing Racial Gaps in Childhood Chronic Disease
  - AB-941 (Bennett): Farmworker Resource Centers
- Local Actions
  - Raise awareness about health inequities in our communities.
  - Disallow coordination between County Sheriffs and City Police with Immigration and Customs Enforcement.
  - Create supportive pathways for underrepresented young people to pursue careers in healthcare and policy.
  - Institutionalize funding for multilingual interpretation services.

ACKNOWLEDGEMENTS

- Corazón del Pueblo: The Cultural and Creative Arts Center of the Santa Maria Valley
- Committee Chair: Dr. Victor Rios
- Committee Members: Drs. Verta Taylor and Edward Telles
- Community partners and leaders
- Research Assistants, Elisa González, and Jodene Takahashi
- Partner and Husband, Dr. Alex Espinoza-Kulick



Financial support for this project was provided by the Robert Wood Johnson Foundation through the Health Policy Research Scholars Program, Dissertation Award, and Dissemination. Additional funding for this project was received from the Community Change Leadership Network, Scholars Strategy Network, University of California, Santa Barbara Migration Initiative, and California Polytechnic State University, San Luis Obispo Believe, Educate & Empower, Advocate, Collaborate, and Nurture (BEACoN) grant.

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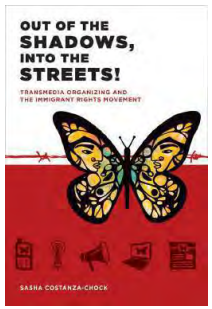
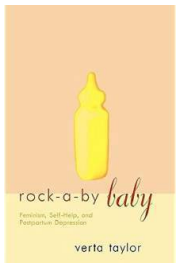
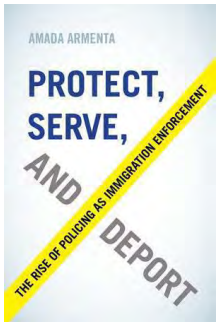
APPENDIX

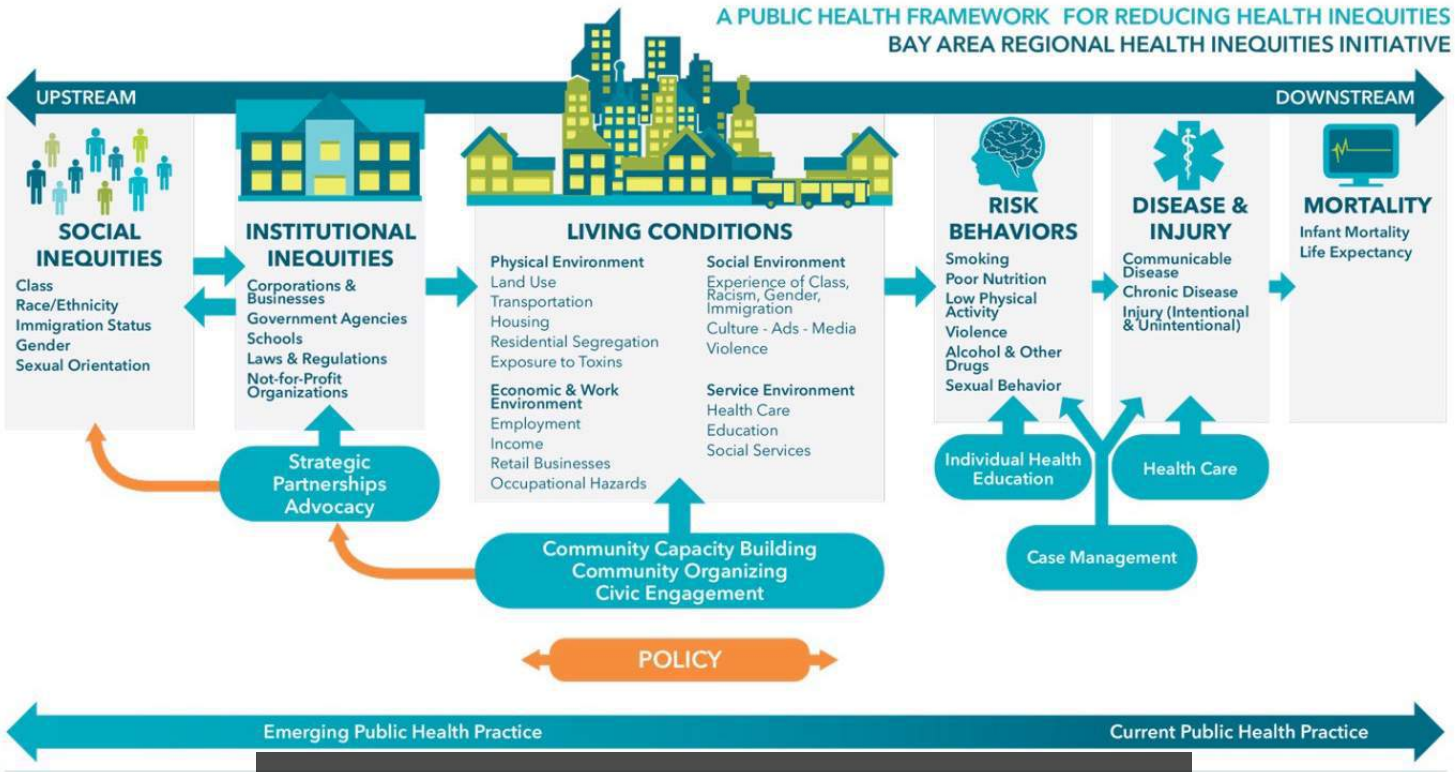




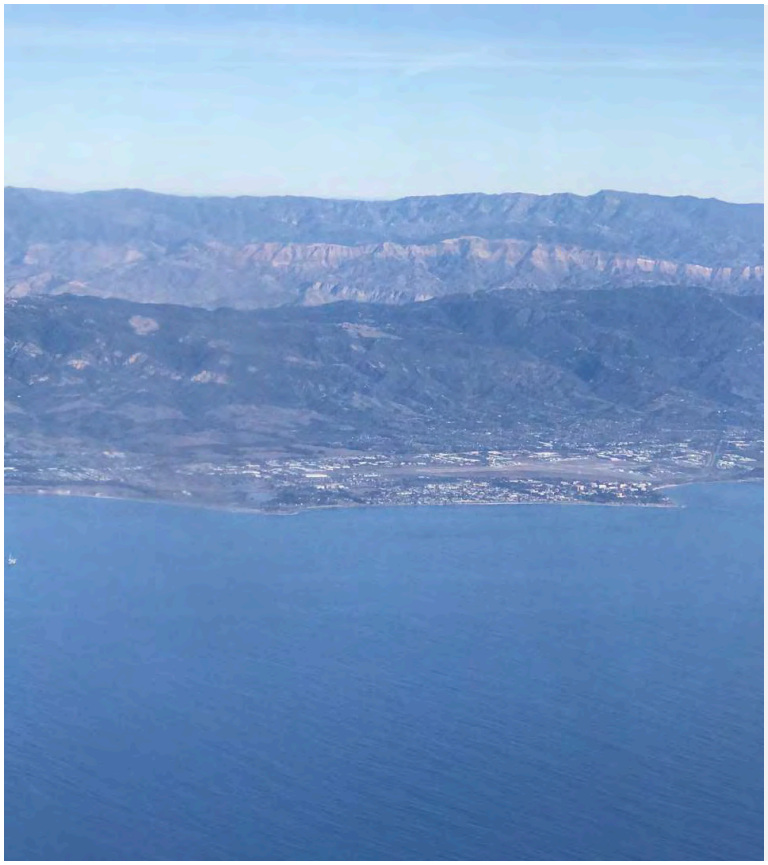


SOCIAL MOVEMENTS FOR IMMIGRANTS AND HEALTH

- Health Social Movements contest norms around illness, diagnosis, medical practice, and government policies (Banaszak-Hall, Levitsky, and Zald 2010; Best 2013; Brown et al. 2004; Brown and Zavestoski 2005; Epstein 2016; Luna 2010; Luna and Luker 2013; Taylor 1996; Taylor and Leitz 2010; Taylor and Zald 2010).
- Immigrant social movements and immigrant health movements strategically address norms of citizenship and rights as they impact inequities among immigrant communities (Baker-Cristales 2009; Bean et al. 2015; Costanza-Chock 2014; Enriquez and Saguy 2016; Gleeson 2015; Milkman and Terriquez 2012; Mora et al. 2018; Nicholls 2013; Robnett 1996; Terriquez 2015; Zimmerman 2012).



THEORY: SOCIAL DETERMINANTS OF HEALTH



RESEARCH QUESTIONS

- What are the characteristics of Latinx immigrant and Indigenous health movements?
- What health conditions are of most concern for these groups? How do they impact health care and health policy?
- What role does culture, specifically Indigenous languages and cultural practices, play both in health and health care advocacy among immigrant health movements?

Image Source: Fieldwork, January 12, 2018

REGRESSION ANALYSIS

- Ordinary Least Squares (OLS) linear regression analysis was used to identify what factors are significantly associated with symptoms of Generalized Anxiety Disorder (0-3 scale, GAD-7, Spitzer et al. 2006).
- Variables in the Model
  - Demographics variables included being an immigrant community member, compared to outside advocates, whether respondents primarily spoke Spanish or English, whether they were Latina/o/x or Hispanic, and whether they were Indigenous.
  - Healthcare context included whether or not they had insurance, trust in biomedical healthcare (1-4 scale), and trust in therapists (1-4 scale).
  - Risk and protective factors included knowledge about mental health (1-5 scale), concern for mental health (1-5 scale), and experiences of discrimination (0-3 scale).

ANALYZING NEWS MEDIA

Ethnographic news data on immigration, health and policy between 2018 - 2020 (n = 148)

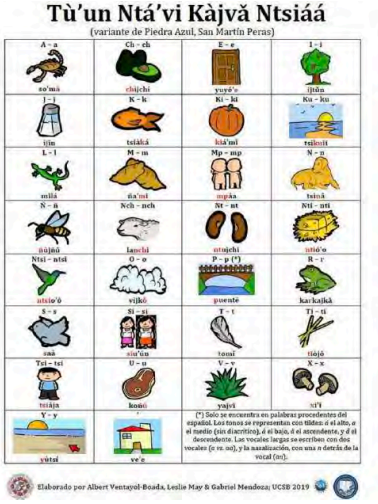
- Analyzed using grounded theory coding for meaningful themes.

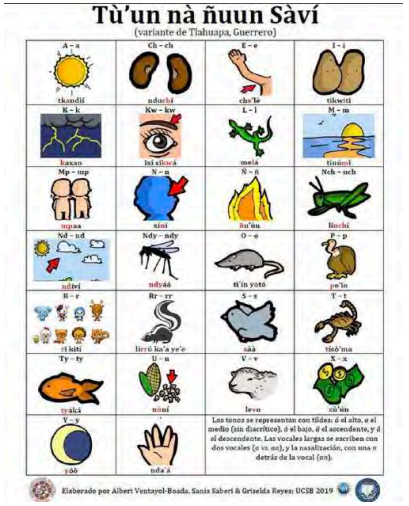
Systematic sample of news on California's Central Coast between 2006-2020 (n = 4,768)

- Ten newspapers from Salinas, Monterey, Morro Bay, San Luis Obispo, Santa Barbara, and Ventura.
- Searched for immigration and health keywords along with immigration policy and enforcement keywords.
- Analyzed using topic modeling and network analysis of topics that regularly appear in the same documents.

Top-4 Most Central Topics among the Systematic Sample

Topic	Top-15 Keywords	Centrality
Latino Threat Narrative	foreign, emergency, crisis, threat, shot, surge, caravan, americans, problem, nation, re, something, article, fact, nothing	1.000
politics	democrats, vote, campaign, election, voters, democratic, candidates, gop, candidate, elected, conservative, voted, democrat, votes, voting	0.648
policy	rights, legislation, daca, amnesty, visa, dreamers, executive order, senate, reform, plan, citizenship, brown, action, passed, lawmakers	0.571
illegality	criminal, jail, policies, crime, crimes, prison, arrest, criminals, sheriff, convicted, guilty, convictions, arrested, authorities, officers	0.534





Variations in Indigenous languages include regional dialects and written / spoken language conventions.

City of Guadalupe

AGENDA

Regular Meeting of the Guadalupe City Council

Tuesday, May 11, 2021 at 6:00 pm
City Hall, 918 Obispo Street, Council Chambers

Pursuant to Governor's Executive Orders N-25-20 and N-33-20: All residents are to heed any orders and guidance of state and local public health officials, including but not limited to the imposition of social distancing measures, to control the spread of COVID-19.

The City Council meeting will be broadcast live on Charter Spectrum Cable Channel 20.

If you choose to attend the City Council meeting in person, you should maintain appropriate social distancing. Seating will be limited. **In addition, all persons attending the City Council meeting are required to wear nose and face masks pursuant to County of Santa Barbara Health Officer Order No. 2020-10.**

If you choose not to attend the City Council meeting but wish to make a comment during oral communications or on a specific agenda item, please submit via email to juana@ci.guadalupe.ca.us no later than 1:00 pm on Tuesday, May 11, 2021. Every effort will be made to read your comment aloud into the record, subject to the 3-minute time limit.

Please be advised that, pursuant to State Law, any member of the public may address the City Council concerning any item on the Agenda, before or during Council consideration of that item. Please be aware that items on the Consent Calendar are considered to be routine and are normally enacted by one vote of the City Council. If you wish to speak on a Consent Calendar item, please do so during the Community Participation Forum.

The Agenda and related Staff reports are available on the City's website: www.ci.guadalupe.ca.us Friday before Council meeting.

Any documents produced by the City and distributed to a majority of the City Council regarding any item on this agenda will be made available the Friday before Council meetings at the Administration Office at City Hall 918 Obispo Street, Monday through Friday between 8:00 am and 4:30 pm, and also posted 72 hours prior to the meeting. The City may charge customary photocopying charges for copies of such documents. Any documents distributed to a majority of the City Council regarding any item on this agenda less than 72 hours before the meeting will be made available for inspection at the meeting and will be posted on the City's website and made available for inspection the day after the meeting at the Administrator Office at City Hall 918 Obispo Street, Monday through Friday between 8:00 am and 4:30 pm.

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, including review of the Agenda and related documents, please contact the Administration Office at (805) 356.3891 at least 72 hours prior to the meeting. This will allow time for the City to make reasonable arrangements to ensure accessibility to the meeting.

1. **ROLL CALL**:

Council Member Liliana Cardenas
Council Member Gilbert Robles
Council Member Eugene Costa Jr.
Mayor Pro Tempore Tony Ramirez
Mayor Ariston Julian

2. **MOMENT OF SILENCE**

3. **PLEDGE OF ALLEGIANCE**

4. **AGENDA REVIEW**

At this time the City Council will review the order of business to be conducted and receive requests for, or make announcements regarding, any change(s) in the order of the day.

5. **PRESENTATIONS**

- La Gente Unida: Results and Recommendation for Health Equity – Mario Espinoza-Kulick

6. **COMMUNITY PARTICIPATION FORUM**

Each person will be limited to a discussion of three (3) minutes or as directed by the Mayor. This time is reserved to accept comments from the public on Consent Calendar items, Ceremonial Calendar items, Closed Session items, or matters not otherwise scheduled on this agenda. Pursuant to provisions of the Brown Act, no action may be taken on these matters unless they are listed on the agenda, or unless certain emergency or special circumstances exist. City Council may direct staff to investigate and/or schedule certain matters for consideration at a future City Council meeting.

7. **CEREMONIAL CALENDAR**

- Oath of Office - Swearing In: Amalia Silva, Police Officer
- Proclamation – Asian American and Native Hawaiian / Pacific Islander Heritage Month – May 2021.

8. **CONSENT CALENDAR**

The following items are presented for City Council approval without discussion as a single agenda items in order to expedite the meeting. Should a Council Member wish to discuss or disapprove an item, it must be dropped from the blanket motion of approval and considered as a separate item.

A. Waive the reading in full of all Ordinances and Resolutions. Ordinances on the Consent Calendar will be adopted by the same vote cast as the first meeting, unless City Council indicates otherwise.

B. Approve payment of warrants for the period ending May 6, 2021.

C. Approve the Minutes of the City Council special meeting of April 19, 2021 to be ordered filed.

D. Approve the Minutes of the City Council regular meeting of April 27, 2021 to be ordered filed.

E. Adopt Resolution No. 2021-30 Notice of Completion – Obispo Street Waterline Project.

F. Adopt Resolution No. 2021-31 approving the list of projects funded by Senate Bill 1 (SB1): The Road Repair and Accountability Act.

G. Adopt Resolution No. 2021-32 to apply for two (2) grants under the Community Development Block Grant program to help the City fund the development of the Royal Theater design-build plans and fund the operation of the LeRoy Park Community Center.

H. Adopt Resolution No. 2021-33 approving the Final Map and Subdivision Improvement Agreement for Tract 29,064, a subdivision of Lot 9 in Tract 29,060 in the D.J. Farms Specific Plan.

I. **MONTHLY REPORTS FROM DEPARTMENT HEADS**

1. Planning Department report for April 2021
2. Building Department report for April 2021
3. Public Works Department / City Engineer report for April 2021

9. **CITY ADMINISTRATOR REPORT**: (Information Only)

10. **DIRECTOR OF PUBLIC SAFETY REPORT**: (Information Only)

PUBLIC HEARING

11. Olivera Multi-Family Housing Development – 2020-095 Design Review.

Written Report: Larry Appel, Planning Director
Recommendation: That the City Council:

a. Receive a presentation from staff; and
b. Conduct a public hearing, including: 1) an opportunity for the applicant to present the proposed project, and 2) receive any comments from the public; and
c. Adopt Resolution No. 2021-34 approving 2020-095DR, including DR Findings, CEQA Class 32 Exemption and Conditions of Approval.

REGUAR BUSINESS

12. Fiscal Year 2021-2022 Budget Review.

Written Report: Lorena Zarate, Finance Director
Recommendation: That the City Council adopt Resolution No. 2021-35 accepting the proposed budget for the fiscal year 2021-2022, along with the Capital Improvement Projects Budget and Capital Facilities Program of Projects.

13. FUTURE AGENDA ITEMS

14. ANNOUNCEMENTS - COUNCIL ACTIVITY/COMMITTEE REPORTS

15. ADJOURNMENT TO CLOSED SESSION MEETING

CLOSED SESSION

16. CONFERENCE WITH LABOR NEGOTIATORS
(Subdivision (a) of Government Code Section 54957.6)
Agency designated representatives: City Administrator and Human Resources Manager;
Employee Organizations: International Association of Firefighters (IAFF), Local 4403 and Service Employees International Union (SEIU), Local 620

17. CLOSED SESSION ANNOUNCMENTS

18. ADJOURNMENT

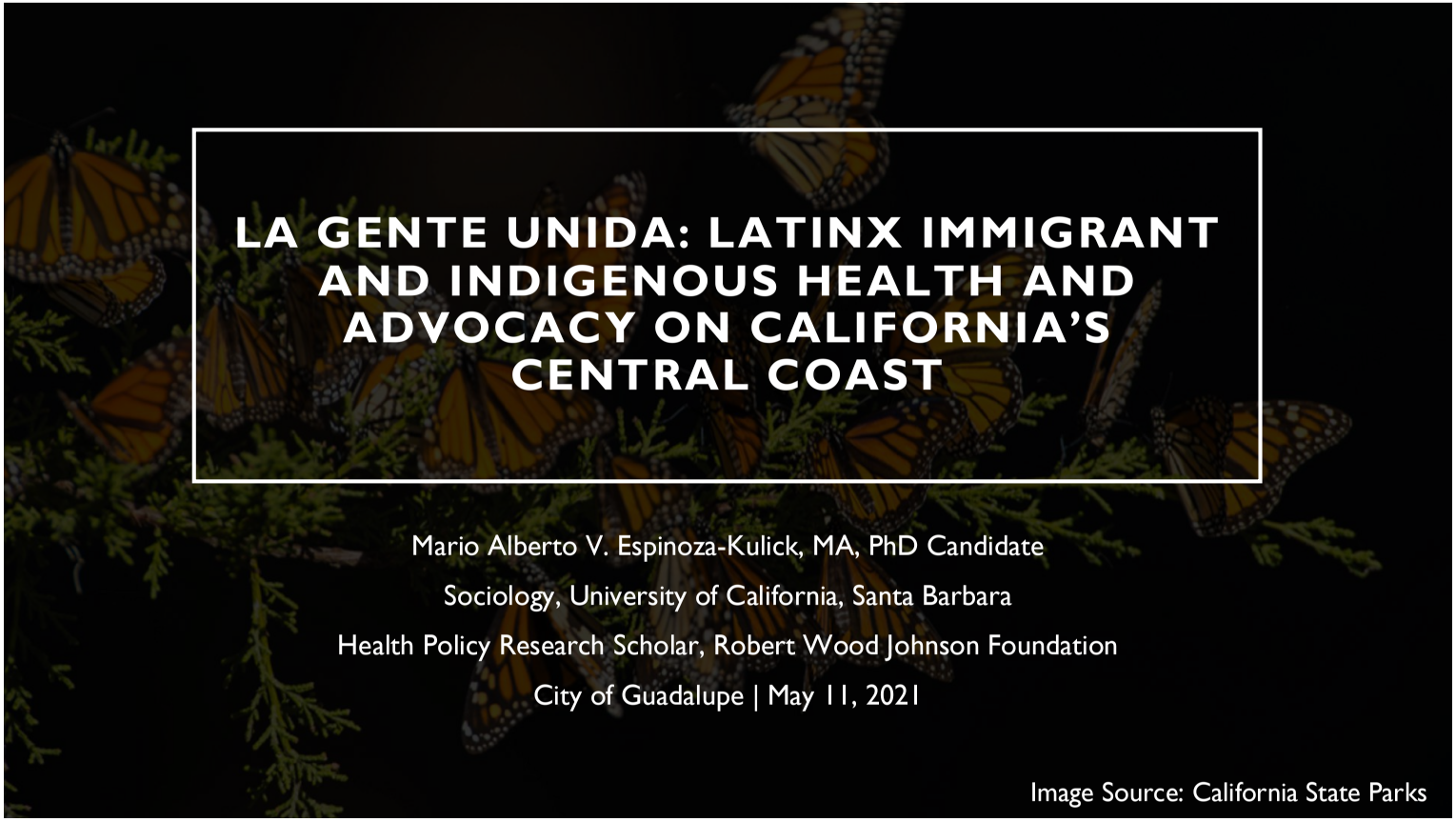
I hereby certify under penalty of perjury under the laws of the State of California that the foregoing agenda was posted on the City Hall display case and website not less than 72 hours prior to the meeting. Dated this 7th day of May 2021.

Todd Bodem
_____
Todd Bodem, City Administrator

PROPOSED FUTURE CITY COUNCIL AGENDA ITEMS

Council Meeting: Date and Subject	Department	Agenda Category
Wednesday, May 12, 2021 at 6:00 pm/ Special Meeting		
Cannabis Education & Outreach Workshop		Workshop
Tuesday, May 18, 2021 at 6:00 pm / Special Meeting		
Introduction of Ordinance No. 2021-494 Cannabis	Administration Dept	Public Hearing
Tuesday, May 25, 2021 at 6:00 pm / Regular Meeting		
Cost Allocation Study FY 21/22	Finance Department	Consent Calendar
Appropriations Limit FY 21/22	Finance Department	Consent Calendar
Investment Policy FY 21/22	Finance Department	Consent Calendar
April 2021 Financial Report	Finance Department	Consent Calendar
Master Fee Schedule CPI	Finance Department	Consent Calendar
Guadalupe Trail to the Park Feasibility Update	Public Works Dept	Consent Calendar
SEIU Labor Agreement	Human Resources Dept	Consent Calendar
Second Reading of Ordinance No. 2021-494 Cannabis	Administration Dept.	Consent Calendar
Tuesday, June 8, 2021 at 6:00 pm / Regular Meeting		
Animal Services Agreement FY 21-22	Administration Dept	Consent Calendar
California Joint Powers Insurance Authority Presentation – Tim Kartz, Risk Management Findings	Human Resources	Presentation
Tuesday, June 22, 2021 at 6:00 pm / Regular Meeting		
May 2021 Financial Report	Finance Department	Consent Calendar

Other Unscheduled Items	**Proposed Date of Item**	**Department**	**Agenda Category**
Urban Footprint Civic Plan		Ariston – Request CC	New Business
City Hall Repairs			New Business
Tree Ordinance		Public Works	New Business
Sidewalk Vending Ordinance		Planning Department	New Business
Guadalupe Leo Club Recognition		Administration Dept	Ceremonial
Vacant Property Ordinance		Administration Dept	New Business
Sign Ordinance		Planning Dept	New Business
Pasadera Public Infrastructure Dedication		Public Works Dept	New Business
Food Truck and Special Event Ordinance		Planning Dept	New Business
Gift Policy		City Attorney	New Business
City of Guadalupe 75th Anniversary – August 3rd Celebration			
Short Term Rentals		City Attorney	New Business
Planning/Building Tracking Software		Planning Dept.	New Business


LA GENTE UNIDA: LATINX IMMIGRANT AND INDIGENOUS HEALTH AND ADVOCACY ON CALIFORNIA'S CENTRAL COAST
Mario Alberto V. Espinoza-Kulick, MA, PhD Candidate
Sociology, University of California, Santa Barbara
Health Policy Research Scholar, Robert Wood Johnson Foundation
City of Guadalupe | May 11, 2021
Image Source: California State Parks

ANTI-IMMIGRANT POLICIES AND RACISM

There has been a rise in political, xenophobic hostility against immigrants.

- Stereotypes about Latina/o/x people as being greedy, lazy, or invasive to U.S. society. These lead to harsh policies like child detention and family separation.

Anti-immigrant policies impose negative health behaviors and effects.

- Reliance on emergency services and disenrollment from public benefits programs (e.g., Medi-Cal, Medicare, WIC) perpetuate inequities in health among families and communities (Perreira, Yoshikawa, and Oberlander 2018).
- Restrictive eligibility policies to government-sponsored health programs like Medi-Cal, Medicare, etc. (LeBrón et al. 2018).
- Violent enforcement, like raids have a negative impact on Latinx communities, especially collaborative raids between ICE and law enforcement (Lopez et al 2017).

INDIGENOUS SOCIAL DETERMINANTS OF HEALTH

- Indigenous peoples have always known that "health is a holistic concept that extends beyond Individual behaviors and genetics" (Lines et al. 2019: 1).
- In contrast with western definitions of social and structural determinants of health; First nation groups include "unique structural (or foundational) determinants such as history, political climate, economics and social contexts."
- Compared to non-Indigenous groups, Indigenous peoples continue to face high rates of illness, suicide, and mortality that are an "additive sum, of cultural wounds affecting the entire community and ways of life" (Lines et al. 2019: 2)

https://www.healthunit.com/indigenous-peoples

KQED

NEWS

California's Working-Age Latinos Are Disproportionately Dying of COVID-19

LISTEN

By Farida Jhabvala Romero Mar 30 Save Article

In Santa Clara County, more than half of the people under age 65 who died of the coronavirus were Latino, even though Latinos make up only a quarter of the population in that age group. *(Anna Vignet/KQED)*

HEALTH DISPARITIES AND COVID-19

- Latinx people are more likely to contract COVID-19 (Gil et al. 2020) and mortality rates are nearly twice as high for the Latinx population compared to non-Hispanic whites (Gross et al. 2020).
- Structural racism is the fundamental cause of these disparities, especially for older adults (Garcia et al. 2020; Page and Flores-Miller 2020).
  - High risk of exposure due to concentration in essential work.
  - Accumulated stress increases risk for serious complications.
  - Barriers to healthcare due to language, trust, and a culture of fear.

Latino Share of COVID-19 Cases by California County

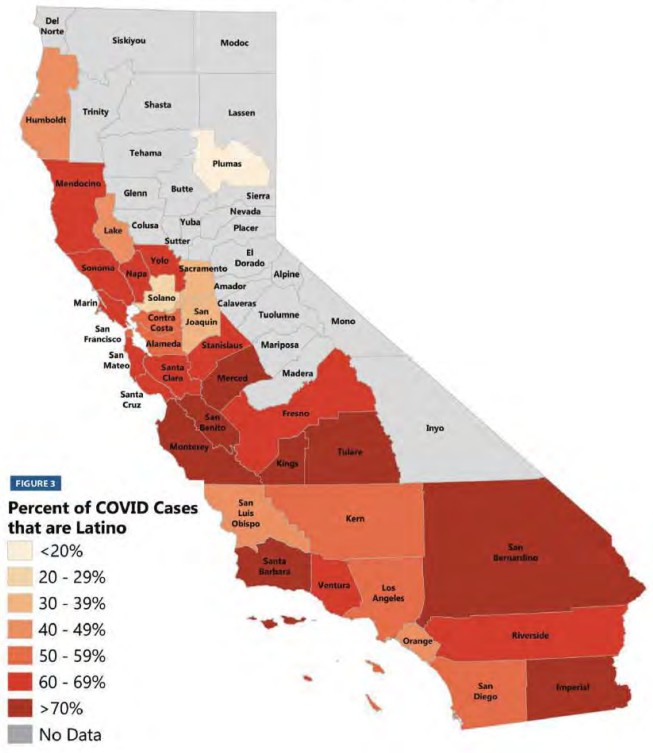


FIGURE 3

Percent of COVID Cases that are Latino

- <20%
- 20 - 29%
- 30 - 39%
- 40 - 49%
- 50 - 59%
- 60 - 69%
- >70%
- No Data

Statewide - 60%

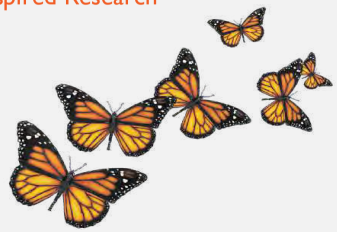
Data Source: COVID-19 reporting by California counties as of November 24-November 30, 2020

PROJECT OVERVIEW

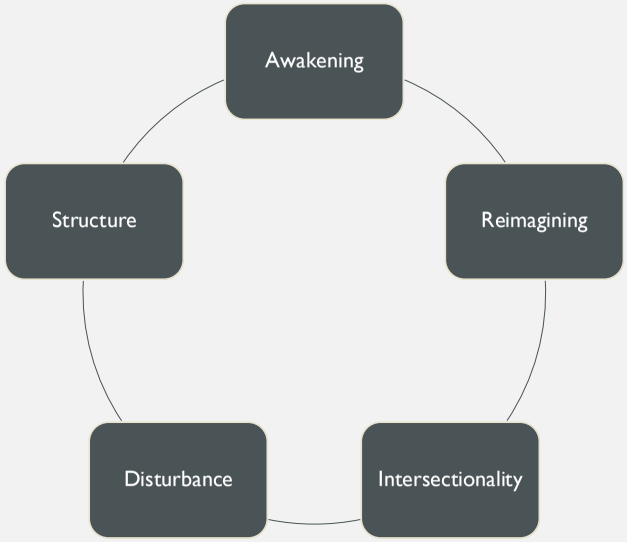
- Survey of Health Needs and Assets (n=177).
- Content Analysis of ethnographic news data (n=148) and systematic sample of the Central Coast, CA (n=4768).
- Interviews with Community Members and Advocates (n=30) and Focus Groups (n=12).
- Participant-observation of in-person and virtual events (September 2018 – September 2020).
- Reflexivity of fieldwork and writing.
- Public-facing website for dissemination of findings, recruitment, and transparency: https://lagenteunidacc.wixsite.com/recursosdesalud

DECOLONIAL-INSPIRED METHODS

- Decolonization (Jacob 2013; Jolivette 2016; Smith 2012).
  - Deconstructs western research methods and privileges the voices of Indigenous knowledge producers.
  - Explores the margins to examine what is not being heard and what is not being spoken in struggle.
- Community input is a primary source of knowledge (Rios, 2011, 2015, 2017a, 2017b; Smith 2012).
- Practices of Decolonial-Inspired Research
  - Reflexivity
  - Collaboration
  - Sharing
  - Community Advice
  - Assessment

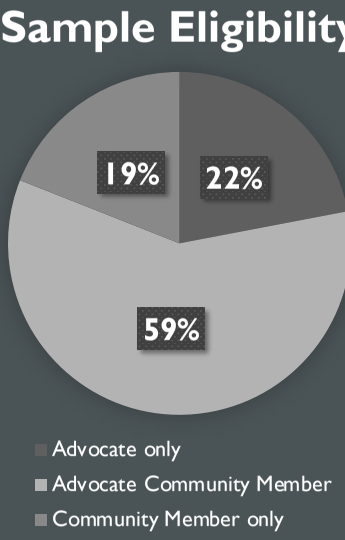


5 Dimensions of Struggle for Decolonization (Smith 2006)

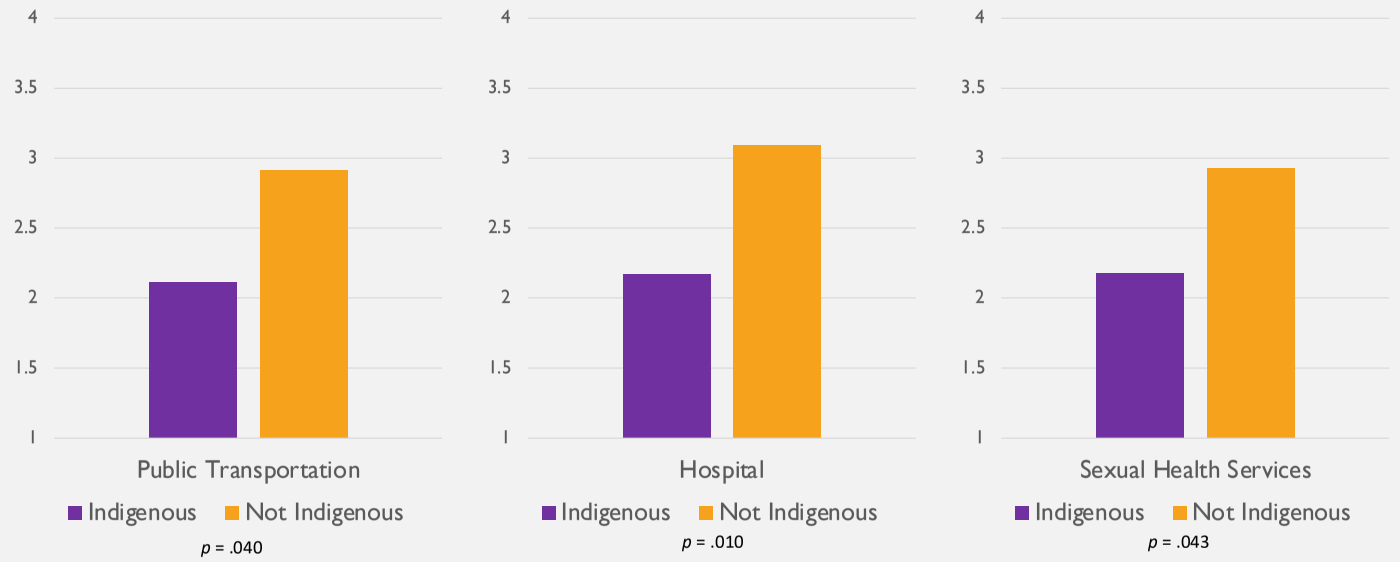


SURVEY METHODS

- Community stakeholders in design and distribution of survey
- Survey with Latinx Immigrant community members and advocates (n = 177)
- Collected between 2019-2020
- Includes women (82%), Spanish-speakers (46%), and Indigenous respondents (17%)



ACCESS DISPARITIES FOR INDIGENOUS COMMUNITIES

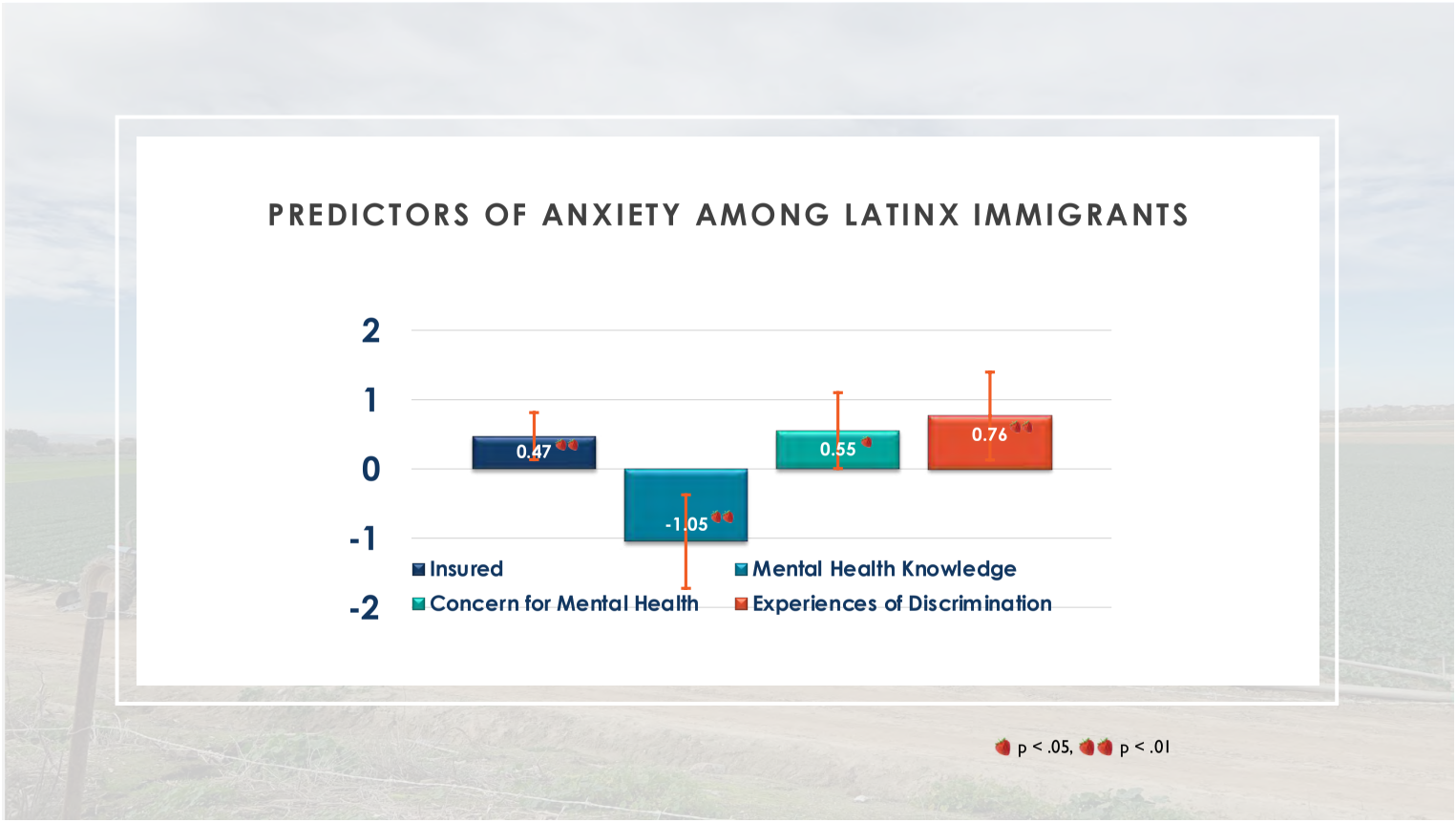


COMMUNITY VOICE: LANGUAGE BARRIERS

- Latinx communities are heterogenous groups, and language extends beyond English and Spanish.
- Interview participants indicated that Indigenous language interpretation is a key need for meaningful health access.

"Even if we fight for policy that encompasses undocumented individuals, we also have to think about the practicality of implementing those policies and how we actually reach our language minority families or our communities that don't have a written language and only have an oral language."

"We don't really have anyone that speaks Mixteco, but we do have someone at the clinic. When we do encounter someone, we do tell them that they could call the clinic and that, usually, I believe the receptionist or the medical assistant, they speak Mixteco."


PREDICTORS OF ANXIETY AMONG LATINX IMMIGRANTS
2
1
0
-1
-2
0.47
-1.05
0.55
0.76
Insured
Mental Health Knowledge
Concern for Mental Health
Experiences of Discrimination
p < .05, p < .01

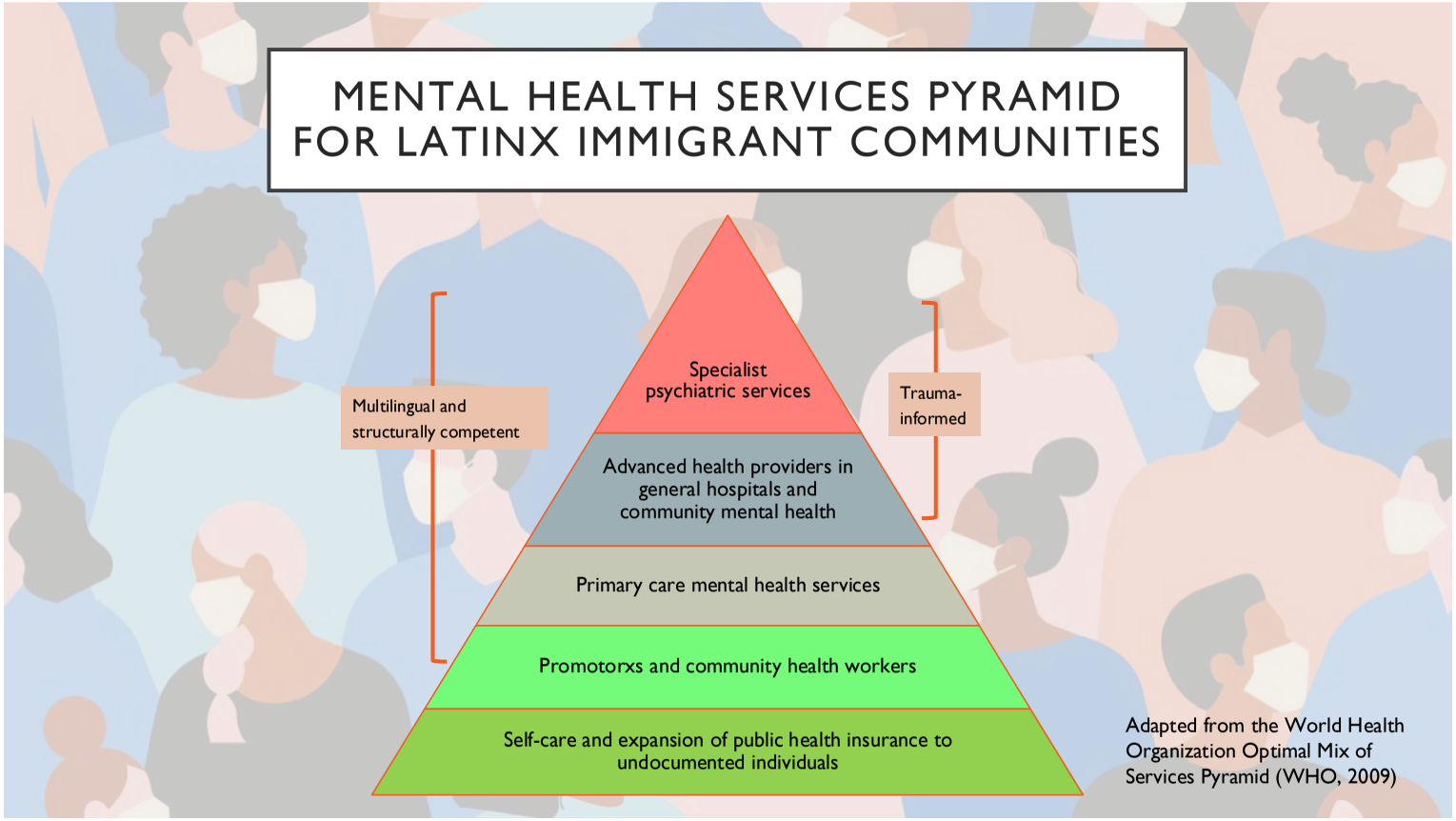
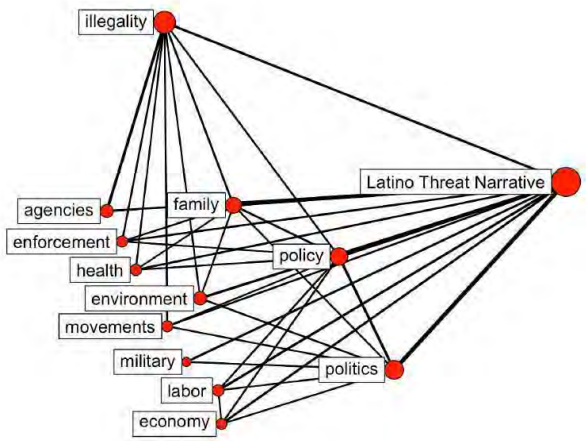

MENTAL HEALTH SERVICES PYRAMID FOR LATINX IMMIGRANT COMMUNITIES
Specialist psychiatric services
Advanced health providers in general hospitals and community mental health
Primary care mental health services
Promotorxs and community health workers
Self-care and expansion of public health insurance to undocumented individuals
Multilingual and structurally competent
Trauma-informed
Adapted from the World Health Organization Optimal Mix of Services Pyramid (WHO, 2009)

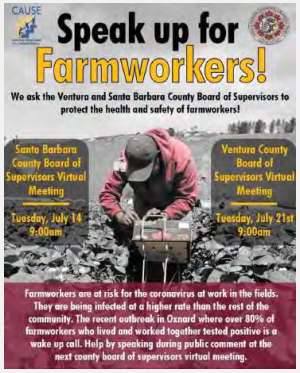
Figure 1. Network of Topics in Immigration News on the Central Coast from 2006 to 2020.



NEWS MEDIA AND LATINO THREAT NARRATIVE

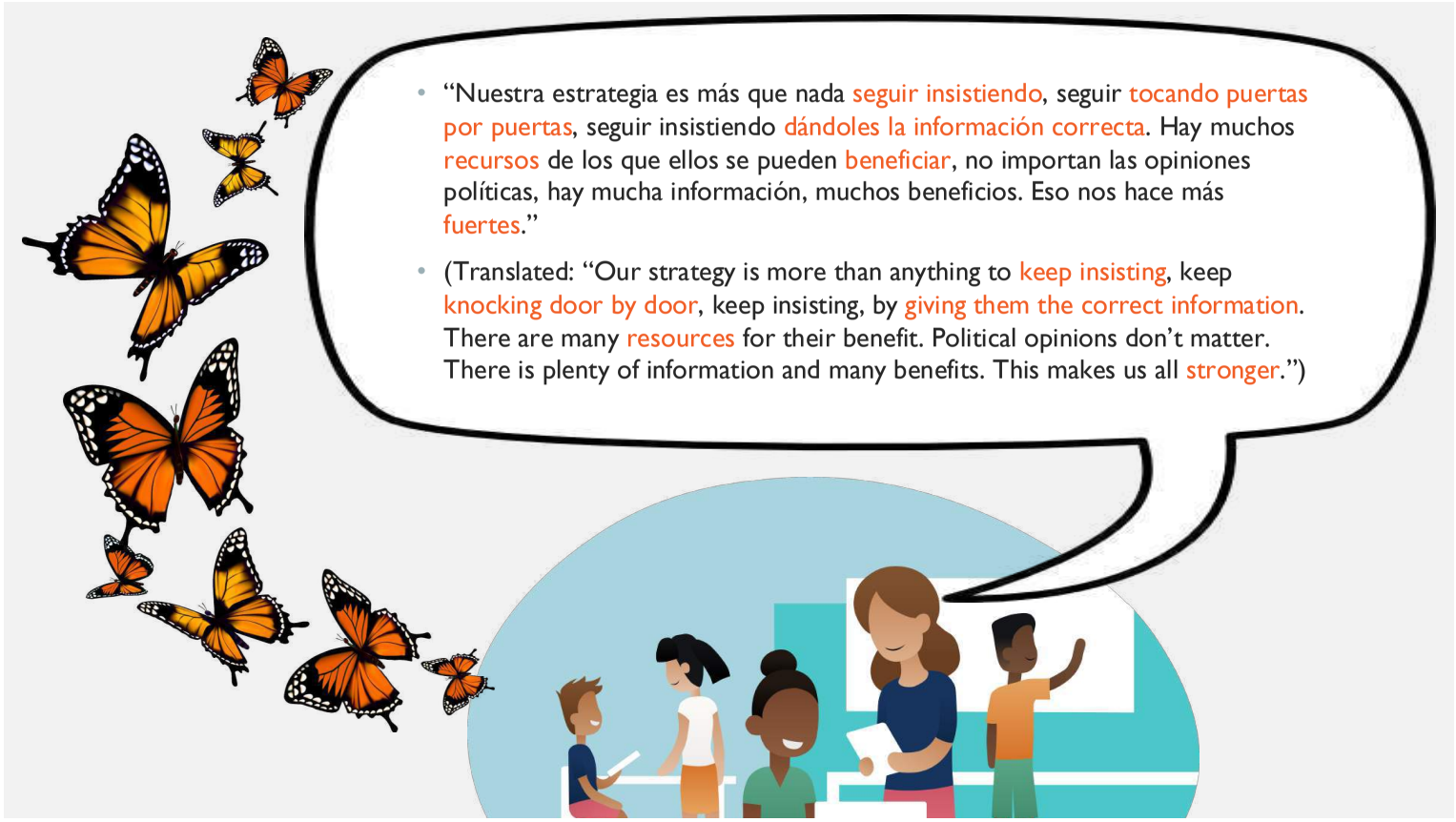
- Messages collectively described as "Latino Threat Narrative" reproduce racist beliefs about Latinx communities (Chavez 2013; Díaz McConnell 2019; López-Sanders and Brown 2019)
  - Undermine trust and produce a "chilling effect" for immigrant communities (Pedraza and Zhu 2015)
- Latino Threat Narrative maintains a link between the construction of illegality and both immigrant and health policies.
  - This leads to negative health behaviors across generations

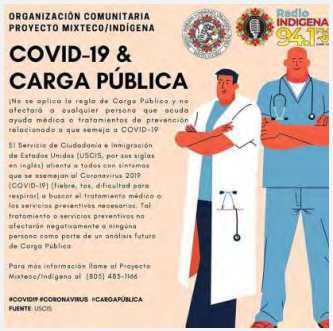

"What we've noticed actually is a drop in the amount of clients that come to our office [when ICE is in the news]. Normally, our waiting room is pretty packed and there aren't any seats available and lately, people haven't been coming into our office. Also, like I mentioned earlier, we have those community women's classes, and normally there's a high turnout, it's like 50 people, but now only like maybe 10 or 20 will come. That has been because of ICE and all these talks of raids, but it's also been because of the public charge discussion that's been going on. I think people are just really scared."
– Advocate Interview
"My clients see it on the news and hear it on the radio and have had experiences where people are always telling them, 'No, you're wrong. No, you don't know. No, you don't speak the language.' It's like, 'I've been told this in a million different ways in a million different spaces, so it must be true.' … They don't fight back, and they don't utilize the rights that they have."
– Advocate Interview



MOVEMENT PANDEMIC ADAPTABILITY

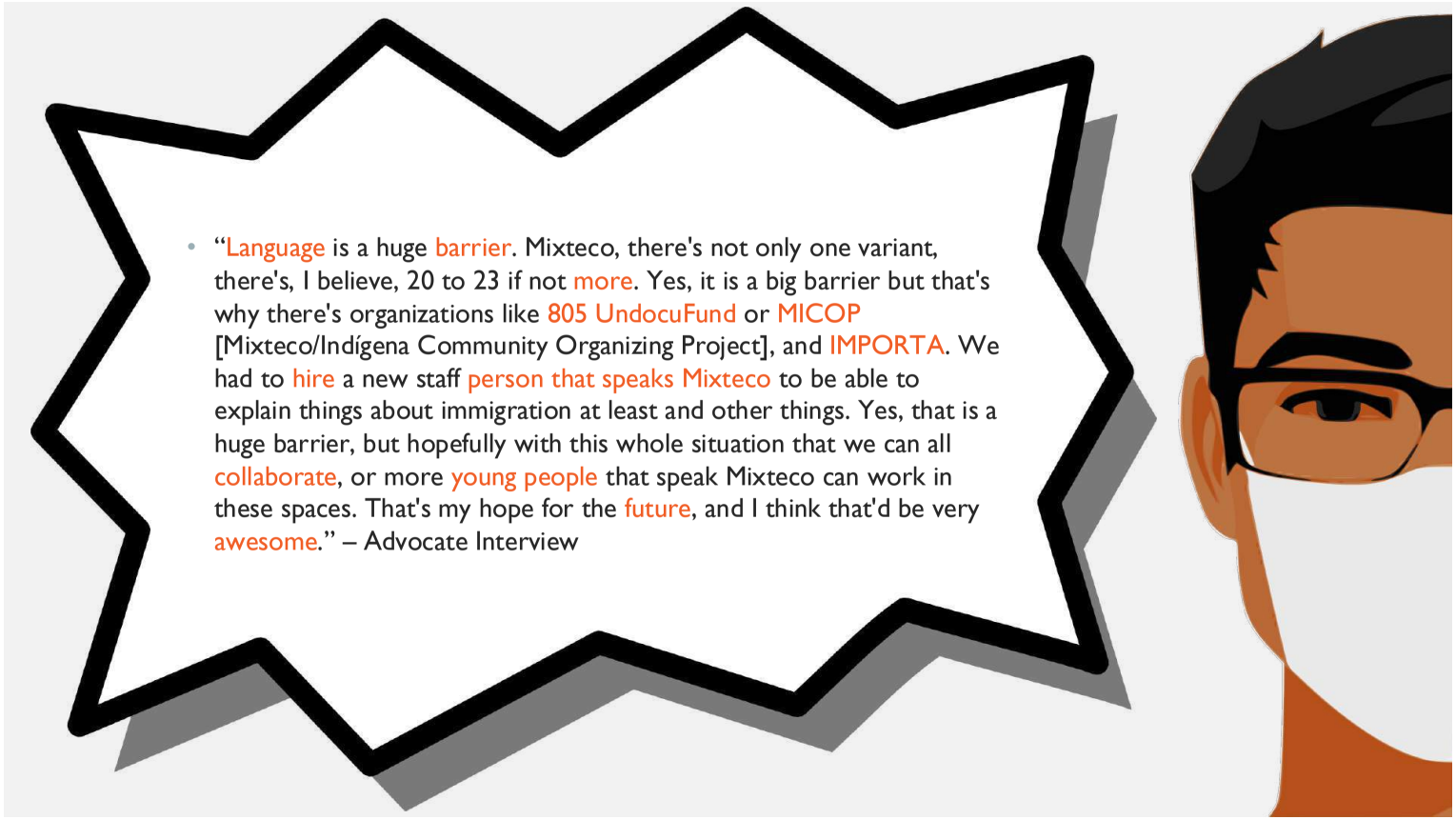
- Advocacy groups draw on pre-existing resources for mobilizing under hostile conditions and with limited resources.
- Movements responded to the exclusion from CARES funding and stimulus payments through mutual aid and crowdfunding.
- Essential work framing was used to advance health policy, gain resources and publicity.


• "Nuestra estrategia es más que nada seguir insistiendo, seguir tocando puertas por puertas, seguir insistiendo dándoles la información correcta. Hay muchos recursos de los que ellos se pueden beneficiar, no importan las opiniones políticas, hay mucha información, muchos beneficios. Eso nos hace más fuertes."
• (Translated: "Our strategy is more than anything to keep insisting, keep knocking door by door, keep insisting, by giving them the correct information. There are many resources for their benefit. Political opinions don't matter. There is plenty of information and many benefits. This makes us all stronger.")



COMMUNITY EDUCATION

- Advocacy groups share key information about pressing health issues and policies, breaking down language barriers in the process.
- Community-led materials are culturally responsive and center youth voices.


• "Language is a huge barrier. Mixteco, there's not only one variant, there's, I believe, 20 to 23 if not more. Yes, it is a big barrier but that's why there's organizations like 805 UndocuFund or MICOP [Mixteco/Indígena Community Organizing Project], and IMPORTA. We had to hire a new staff person that speaks Mixteco to be able to explain things about immigration at least and other things. Yes, that is a huge barrier, but hopefully with this whole situation that we can all collaborate, or more young people that speak Mixteco can work in these spaces. That's my hope for the future, and I think that'd be very awesome." – Advocate Interview

SOLIDARITY & HEALTH POLICY

- Better pay, working conditions, and access to PPE.
- Increased housing & health protections to combat COVID-19.
- Medi-Cal expansion to undocumented young adults (up to age 26).

FIELDWORK EXAMPLE

By Genelle Padilla
Published June 23, 2020 12:41 pm

NEWS CHANNEL 3 FOX 11 12

Hundreds of Santa Maria farmworkers receive raise after over a month of organizing

CAUSE

SANTA MARIA, Calif. - After a month of organizing for better pay and work conditions, over 600 farmworkers will receive a raise from Driscoll's Berries' supplier, Rancho Laguna Farms.

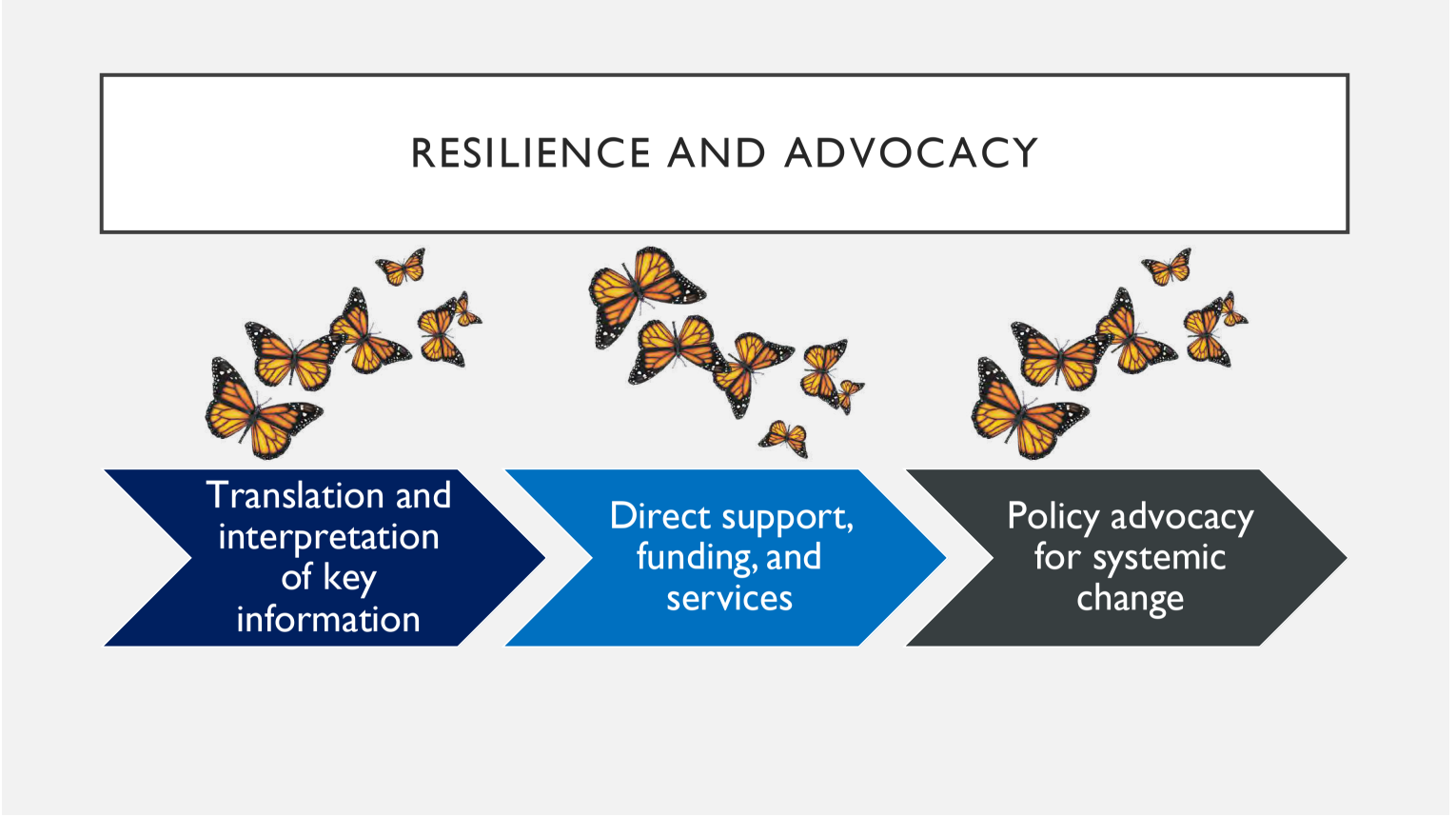
The push for higher pay and improved work conditions began in early May, when over 100 Rancho Laguna farmworkers coordinated a work stoppage.

By Jessica Brest
Published February 21, 2021 12:13 pm

NEWS CHANNEL 3 FOX 11 12

More than 200 Santa Maria farmworkers receive settlement checks after facing alleged retaliation while calling for higher wages

Agricultural Labor Relations Board


RESILIENCE AND ADVOCACY
Translation and interpretation of key information
Direct support, funding, and services
Policy advocacy for systemic change

CONCLUSION

- Decolonial-inspired methods are useful for engaging with community collaborations and producing tangible outcomes.
  - Op-Eds, community reports and presentations, website, collaborations, and direct service to communities and Indigenous peoples.
- Structural racism intersects with xenophobia and settler-colonialism to produce unique health vulnerabilities for Latinx immigrant communities.
  - Insurance access, language barriers, and mental health.
- Latinx immigrant health movements have responded to the pandemic by mobilizing for systems change at every level.
  - Access to health resources, adapting to pandemic conditions, and advocating anti-racist change systematically.

RECOMMENDATIONS

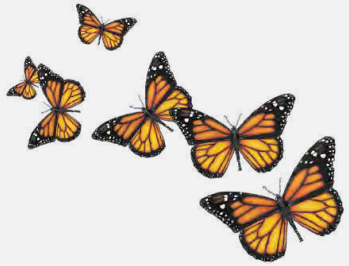
- Policy
  - Expand public health insurance (Medi-Cal) to include undocumented individuals of all ages.
  - Support language access, translation, and interpretation.
  - Affirm that racism is a public health crisis.
- Interventions
  - Build healthcare capacity on the Central Coast, focused on equity.
  - Promote implicit bias and anti-discrimination trainings throughout the community.

WHAT CAN WE DO?

- Support California Legislation
  - SB-56 (Durazo): Health4All Seniors expands Medi-Cal to eligible undocumented adults
  - SB-40 (Hurtado): California Medicine Scholars Program
  - SB-682 (Rubio): Closing Racial Gaps in Childhood Chronic Disease
  - AB-941 (Bennett): Farmworker Resource Centers
- Local Actions
  - Raise awareness about health inequities in our communities.
  - Disallow coordination between County Sheriffs and City Police with Immigration and Customs Enforcement.
  - Create supportive pathways for underrepresented young people to pursue careers in healthcare and policy.
  - Institutionalize funding for multilingual interpretation services.

ACKNOWLEDGEMENTS

- City of Guadalupe
- Committee Chair: Dr. Victor Rios
- Committee Members: Drs. Verta Taylor and Edward Telles
- Community partners and leaders
- Research Assistants, Elisa González, and Jodene Takahashi
- Partner and Husband, Dr. Alex Espinoza-Kulick



Financial support for this project was provided by the Robert Wood Johnson Foundation through the Health Policy Research Scholars Program, Dissertation Award, and Dissemination. Additional funding for this project was received from the Community Change Leadership Network, Scholars Strategy Network, University of California, Santa Barbara Migration Initiative, and California Polytechnic State University, San Luis Obispo Believe, Educate & Empower, Advocate, Collaborate, and Nurture (BEACoN) grant.

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Health Equity

for Immigrant and Indigenous Communities

on California's Central Coast

Existing healthcare systems continually underserve immigrant communities and Indigenous peoples. These disparities impact our public health, leading to preventable illness and death, driving up healthcare costs, and deteriorating our economic workforce's productivity.

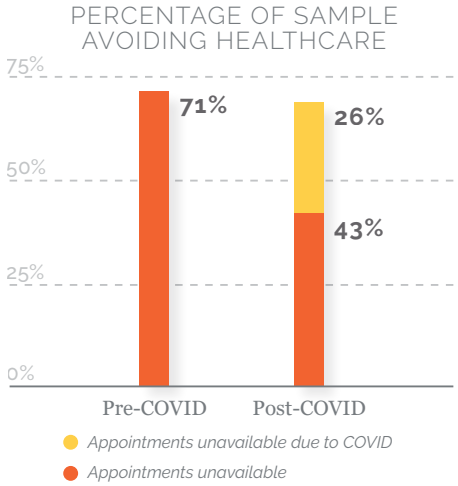
During the COVID-19 pandemic, we have seen the consequences of years of mistreatment and exclusion by the medical system. This research found that mental health burden is high, with Latinx Immigrant and Indigenous communities experiencing anxiety symptoms "nearly half the days" in the past two weeks. Rates were significantly higher for those individuals who experienced discrimination based on race, ethnicity, immigration status, gender, or sexuality.

> ***"El temor migratorio," (fear) that arises from living in precarious circumstances. A community member said frustratedly, "At home they hear this, out there they hear something else. Their parents are full of fear, and the children are being affected, because they're scared too."***

BARRIERS TO HEALTHY COMMUNITIES

When family and community members experience exclusions, this contributes to a pattern of mistrust with healthcare systems and withdrawal from services.

A key barrier to access on the Central Coast is the lack of healthcare capacity, especially for working-class and Latinx communities. Before the pandemic, nearly 3 in 4 respondents (71%) had avoided healthcare because appointments were not available. During the pandemic, a similar portion of the community had to delay healthcare due to unavailable appointments combined with COVID-related closures combined (69%). When speaking with community members in interviews, they identified that specialty providers were especially lacking, including dentists, oncologists, and infectious disease specialists.

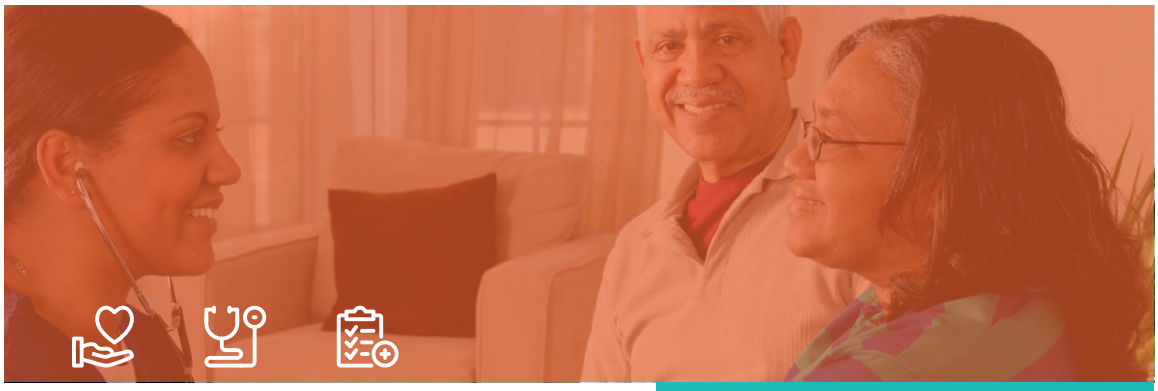


La Gente Unida Immigrant Health and Advocacy

HEALTH POLICY RESEARCH SCHOLARS

HEALTH EQUITY *for* IMMIGRANT *and* INDIGENOUS COMMUNITIES *on* CALIFORNIA'S CENTRAL COAST

Mario Espinoza-Kulick | mvespinoza@ucscb.edu | (805) 904-9225



HEALTH DISPARITIES IN ACCESS TO CARE

Restrictions to healthcare through insurance also create multiple barriers. Undocumented immigrants are excluded from public health insurance programs, like Medi-Cal.

Survey findings show that nearly 1 in 5 Spanish-speaking respondents had avoided healthcare in the last three months because their documentation status prevented them from accessing health insurance (19%). Beyond formal exclusions, immigrant communities are affected by policies like the public charge rule and the fear it creates.

> ***1 in 5*** **Spanish-speaking respondents delayed healthcare within the past 3 months, because their documentation status prevents them from accessing Medi-Cal.**

DOCUMENTATION STATUS AND HEALTH AVOIDANCE

Latinx communities are heterogeneous groups, and language access extends beyond English and Spanish.

Interview participants indicated that Indigenous language interpretation is a crucial need for meaningful health access, in addition to offering bilingual and culturally competent care.

"My parents are immigrants. They don't go to the doctor, they don't go to the dentist, they only go to a clinic when it's like a last-minute resort, like a life-or-death situation... Saying, 'That's not for me because I don't have the money, and two, they'll have my information. I don't want to give out my information.'"

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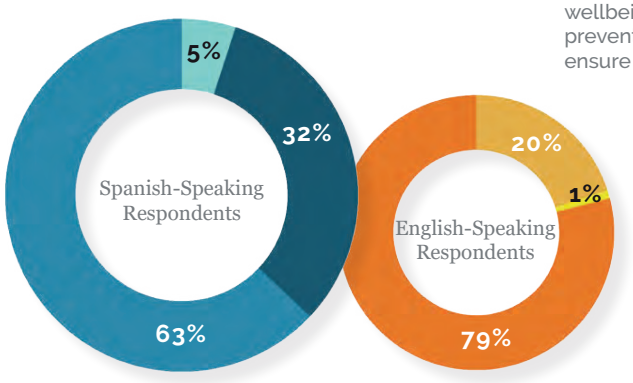
"Even if we fight for policy that encompasses undocumented individuals, we also have to think about the practicality of implementing those policies and how we actually reach our language minority families or our communities that don't have a written language and only have an oral language."

HEALTH DISPARITIES BY LANGUAGE

Barriers to healthcare lead to an undue burden on emergency healthcare providers in our communities. Not accessing preventative services means that healthcare conditions progress into severe and chronic illnesses.

In the pandemic, it has become apparent that barriers to individual health affect collective wellbeing. Equity must guide our efforts to prevent and mitigate public health threats to ensure healthcare as a human right for all.



In terms of overall health, Spanish-speaking respondents were statistically significantly more likely to indicate that their health was "Fair" (63%) compared to English-speaking respondents (20%). By contrast, over three-quarters of English-speakers rated their health as "Good" or "Excellent" (79%), while only a third of Spanish-speakers (32%) ranked their overall health positively.

RECOMMENDATIONS

More and more government institutions recognize racism as a public health crisis, including Santa Barbara County, Ventura County, and the City of San Luis Obispo. These declarations provide essential recognition of the systemic issues facing communities. However, they must be accompanied by concrete actions and policy change to close equity gaps and heal from historical traumas. Policymakers can disallow coordination between County Sheriffs and City Police with Immigration and Customs Enforcement to help work against a culture of fear.

Local leaders can help decrease healthcare costs by investing in access to free and accessible preventative healthcare services. Community organizations and churches are critical partners for offering these services. They have already built trusting relationships with communities that tend to avoid government institutions and healthcare agencies. Mobile healthcare and telehealth are also strategies that can reach rural communities and other underserved groups, along with Indigenous language interpretation. To build healthcare capacity on the Central Coast, we can support pathways for underrepresented young people to pursue healthcare and policy careers.

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PRINCIPAL INVESTIGATOR BIO

Mario Espinoza-Kulick *(he/él)* is a Doctoral Candidate in sociology at the University of California, Santa Barbara. Mario draws from his own experience as an HIV+, Queer, Latinx, and Indigenous person to raise awareness around health inequities.

For more information about this study, please visit our website at https://tinyurl.com/LaGenteUnida.

*You can contact Mario at **mvespinoza@ucsb.edu** or by phone at (805) 904-9225.*

METHODOLOGY NOTE

This report is based on a larger project examining Latinx immigrant and Indigenous health across California's Central Coast, including participant observation, interviews, focus groups, collection of news data, and a survey of health assets and needs. Individuals were eligible to participate in the study if they were an immigrant community member (Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen), or as an advocate (individuals that actively participate in social change efforts toward advancing immigrant health equity). The survey sample was majority Latina/o/x or Hispanic (86%), and women (82%). Over one-third of the sample's primary language was Spanish (46%), and about one in five were Indigenous (17%).

HEALTH POLICY RESEARCH SCHOLARS

The Robert Wood Johnson Foundation provided financial support for this project through the Health Policy Research Scholars Program, Dissemination Award.

Equidad en Salud

para las comunidades indígenas y de inmigrantes

en la costa central de California

Los sistemas de salud existentes continuamente prestan servicios deficientes a las comunidades de inmigrantes y los pueblos indígenas. Estas disparidades impactan nuestra salud pública, provocando enfermedades y muertes prevenidles, aumentando los costos de atención médica y deteriorando la productividad de nuestra fuerza laboral económica.

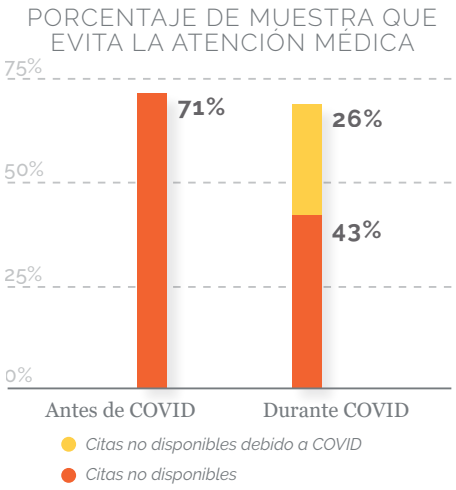
Durante la pandemia de COVID-19, hemos visto las consecuencias de años de maltrato y exclusión por parte del sistema médico. Esta investigación encontró que la carga de salud mental es alta, con comunidades latinas inmigrantes e indígenas experimentando síntomas de ansiedad "casi la mitad de los días" en las últimas dos semanas. Las tasas fueron significativamente más altas para aquellas personas que experimentaron discriminación por motivos de raza, etnia, estado migratorio, género o sexualidad.

BARRERAS PARA COMUNIDADES SALUDABLES

Cuando los miembros de la familia y la comunidad experimentan exclusiones, esto contribuye a un patrón de desconfianza hacia los sistemas de salud y retiro de los servicios.

Una barrera clave para acceder a la Costa Central es la falta de capacidad de los servicios de salud, especialmente para la clase trabajadora y comunidades Latinx. Antes de la pandemia, casi 3 de cada 4 encuestados (71%) habían evitado la atención médica porque las citas no estaban disponibles. Durante la pandemia, una parte similar de la comunidad había para retrasar la atención médica debido a citas no disponibles 0% combinado con cierres relacionados con COVID combinados (69%). Cuando hablé con miembros de la comunidad en entrevistas, identificaron que los proveedores de especialidades eran especialmente deficientes, incluidos dentistas, oncologías y especialistas en enfermedades infecciosas.

> ***"El temor migratorio" que surge de vivir en circunstancias precarias. Un miembro de la comunidad dijo con frustración: "En casa escuchan esto, allá afuera escuchan algo más. Sus padres están llenos de miedo y los niños se ven afectados, porque también tienen miedo."***



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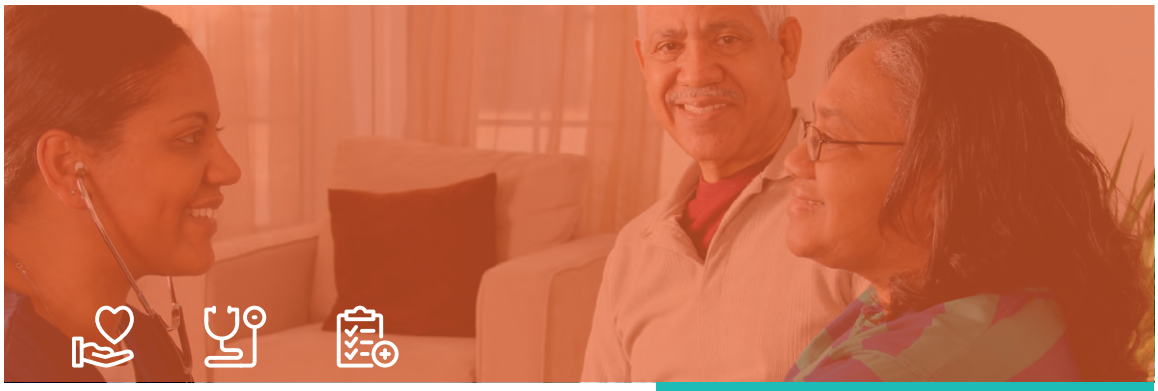

DISPARIDADES DE SALUD EN EL ACCESO A LA ATENCIÓN

Las restricciones a la atención médica a través de seguros también crean múltiples barreras. Los inmigrantes indocumentados están excluidos de los programas de seguro médico público, como Medi-Cal.

Los resultados de la encuesta muestran que casi 1 de cada 5 encuestados hispanohablantes había evitado la atención médica en los últimos tres meses porque su estado de documentación les impedía acceder a un seguro médico (19%). Más allá de las exclusiones formales, las comunidades de inmigrantes se ven afectadas por políticas como la regla de carga pública y el miedo que genera.

> ***1 de cada 5*** **encuestados hispano-hablantes evitó la atención médica en los últimos 3 meses, porque el estado de su documentación les impide acceder a Medi-Cal.**

ESTADO DE LA DOCUMENTACIÓN Y EVITACIÓN DE SALUD

Las comunidades Latinx son grupos heterogéneos y el acceso al idioma se extiende más allá del inglés y el español.

Los participantes de la entrevista indicaron que la interpretación de idiomas indígenas es una necesidad crucial para un acceso significativo a la salud, además de ofrecer atención bilingüe y culturalmente competente.

"Mis papás son inmigrantes. No van al doctor, no van al dentista, solo van a una clínica cuando es como un recurso de última hora, como una situación de vida o muerte ... Diciendo: 'Eso no es para yo porque no tengo el dinero, y dos, ellos tendrán mi información. No quiero dar mi información.'".

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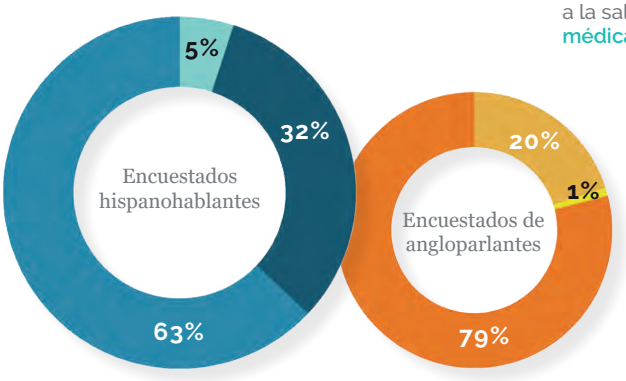
"Incluso si luchamos por una política que incluya a las personas indocumentadas, también tenemos que pensar en la practicad de implementar esas políticas y cómo realmente llegamos a nuestras familias de minorías lingüísticas o nuestras comunidades que no tienen un idioma escrito y solo tienen un idioma oral."

DISPARIDADES DE SALUD POR IDIOMA

Las barreras a la atención médica generan una carga indebida para los proveedores de atención médica de emergencia en nuestras comunidades. No acceder a los servicios preventivos significa que las condiciones de atención médica progresan a enfermedades graves y crónicas.

En la pandemia, se ha hecho evidente que las barreras a la salud individual afectan el bienestar colectivo. La equidad debe orientar nuestros esfuerzos para prevenir y mitigar las amenazas a la salud pública para garantizar la atención médica como un derecho humano para todos.



En términos de salud general, los encuestados hispanohablantes fueron estadísticamente significativamente más propensos a indicar que su salud era "Buena" (63%) en comparación con los encuestados de habla inglesa (20%). Por el contrario, más de las tres cuartas partes de los angloparlantes calificaron su salud como "Muy buena" o "excelente" (79%), mientras que sólo un tercio de los hispanohablantes (32%) calificaron su salud general de manera positiva.

RECOMENDACIONES

Cada vez más instituciones gubernamentales reconocen el racismo como una crisis de salud pública, incluido el condado de Santa Bárbara, el condado de Ventura y la ciudad de San Luis Obispo. Estas declaraciones brindan un reconocimiento esencial de los problemas sistémicos que enfrentan las comunidades. Sin embargo, deben ir acompañadas de acciones concretas y cambios de política para cerrar las brechas de equidad y sanar traumas históricos. Los legisladores pueden impedir la coordinación entre los alguaciles del condado y la policía de la ciudad con el Immigration and Customs Enforcement (ICE) para ayudar a trabajar contra la cultura del miedo.

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BIOGRAFÍA DEL INVESTIGADOR PRINCIPAL

Mario Espinoza-Kulick *(él)* es candidato a doctorado en sociología en la Universidad de California, Santa Bárbara. Mario se basa en su propia experiencia como persona VIH +, queer, Latinx e indígena para crear conciencia sobre las inequidades en salud.

Para obtener más información sobre este estudio, visite nuestro sitio web en https://tinyurl.com/LaGenteUnida.

Puede contactar a Mario en mvespinoza@ucsb.edu o por teléfono al (805) 904-9225.

NOTA DE METODOLOGÍA

Este informe se basa en un proyecto más amplio que examina la salud de inmigrantes e indígenas latinos en la costa central de California, incluida la observación-participante, entrevistas, grupos focales, recopilación de datos de noticias y una encuesta de activos y necesidades de salud. Las personas eran elegibles para participar en el estudio si eran miembros de la comunidad inmigrante (indocumentados, soñadores, miembros de la familia de estatus mixto, residentes y / o ciudadanos naturalizados) o como defensores (individuos que participan activamente en los esfuerzos de cambio social para promover la equidad en la salud de los inmigrantes). La muestra de la encuesta fue mayoritariamente Latina / o / x o Hispana/o (86%) y mujeres (82%). Más de un tercio del idioma principal de la muestra era el español (46%) y aproximadamente uno de cada cinco eran indígenas (17%).

HEALTH POLICY RESEARCH SCHOLARS

La Fundación Robert Wood Johnson brindó apoyo financiero para este proyecto a través del Programa de Becarios de Investigación en Políticas de Salud, Premio a la Difusión.

Policy Advocacy 101 Toolkit

Policy is a powerful tool for addressing issues of inequity in our communities. Laws, ordinances, and regulations can make an important difference in sharing resources and creating opportunities. They also send a message to the community about the value we place on certain issues and what can be done to make a change. This toolkit provides an introductory overview of policy advocacy, focusing on the local level. The information contained in this Toolkit was collected as part of the La Gente Unida study on Latinx Immigrant and Indigenous Health and Advocacy on California's Central Coast.

COUNTY POLICIES

County governments are an important place for policy work. Counties are primarily responsible for carrying out state-funded programs, enrollment into public services, infrastructure, education, and local public health departments. In particular, the County typically oversees things like roads, utilities, permits, and parks for all unincorporated areas – places that are not formally part of any city government.

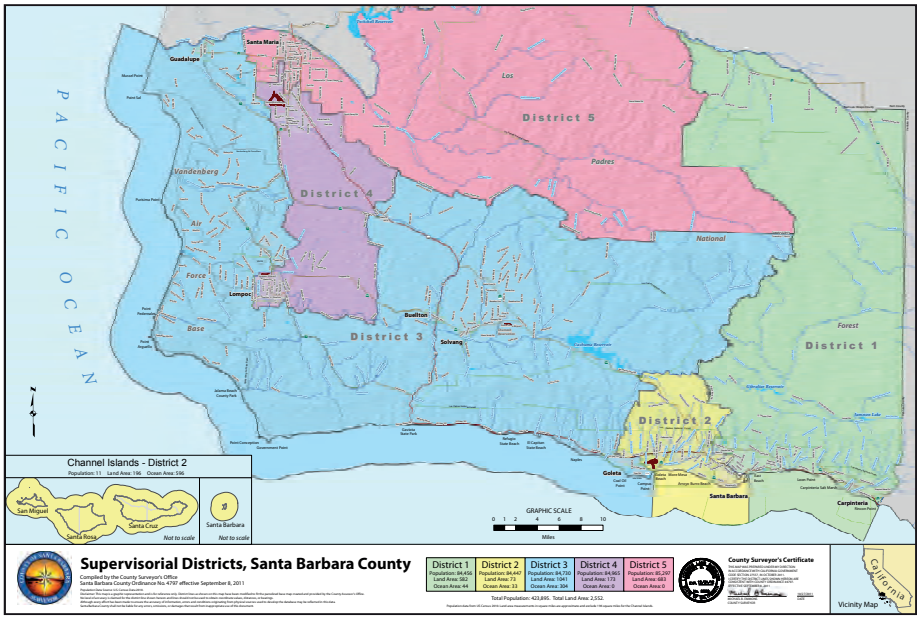

Image Source: Santa Barbara County

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In California, each County is organized into Districts. Each District is then represented by one member on the Board of Supervisors. Supervisors are elected once every four years. The Board of Supervisors is required to hold regular public meetings that include opportunities for residents to share their views on policy issues. Each Supervisor is also expected to be available to residents of their own District to hear concerns, complaints, and issues that may arise. Due to the large number of people in any given District, staff members and legislative analysts are usually involved in collecting this information and sharing it with the Supervisor. In the chart (page 1), you can see the five Districts that make up Santa Barbara County.

In addition to the Board of Supervisors, each County has a Planning Commission. The structure of the Planning Commission is similar, with each District being represented by one individual. These individuals are appointed and approved by the Supervisors. The role of the Planning Commission is to represent the interests of residents in developing a General Plan, investigate policy issues, sit on relevant committees, and provide recommendations on policies that the Board of Supervisors is considering.

While the Planning Commission and Board of Supervisors are in charge of making policy decisions, various officers and agencies carry out the implementation of these policies. The individuals holding these positions are often appointed or hired directly and not elected by the people. However, as public officials, they are required to act in the best interest of the communities they serve.

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CITY POLICIES

Government systems in cities and towns can vary somewhat in their structure, based on the size and political background of the local community. For example, in Santa Barbara County, Goleta was recently incorporated as a city in 2000. The people elect Councilmembers and the Mayor through a city-wide election, and they also take on the role of Planning Commission as well. Up until 2018, the position of Mayor was determined internally by the City Council, who would appoint one Councilmember to the position.

Larger cities, like Santa Barbara and Santa Maria, are set up similar to the County government, with separate District elections and a Planning Commission that the elected officials appoint. City Planning Commissions similarly develop a General Plan, hear from the public, and provide advice to the City Councilmembers, Mayor, and City staff on the formation and implementation of policy.

At the city level, it can make an especially big difference how people vote for their elected officials. For example, in 2018, the City of Santa Maria changed its election format to have residents vote for City Council members within a specific District, rather than being elected city-wide. This switch allows for voters to be represented by someone from their own area and ensures that no single region of the city is determining policy for everyone. In cities that are growing in size, local government can be targeted to make policies, as well as to actually change the way that government works.

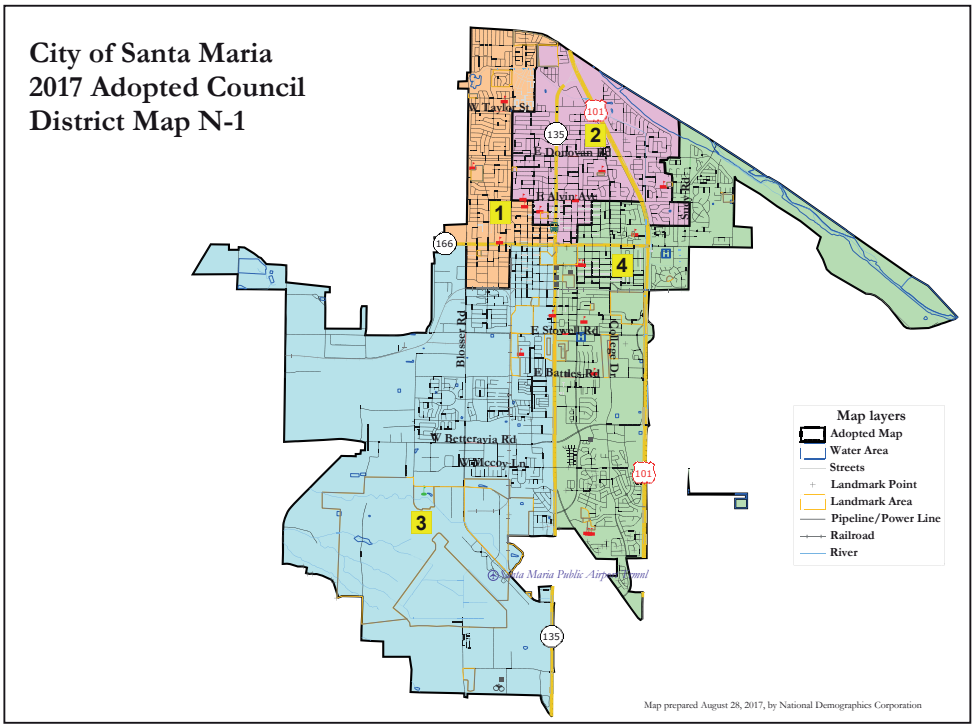

Image Source: City of Santa Maria

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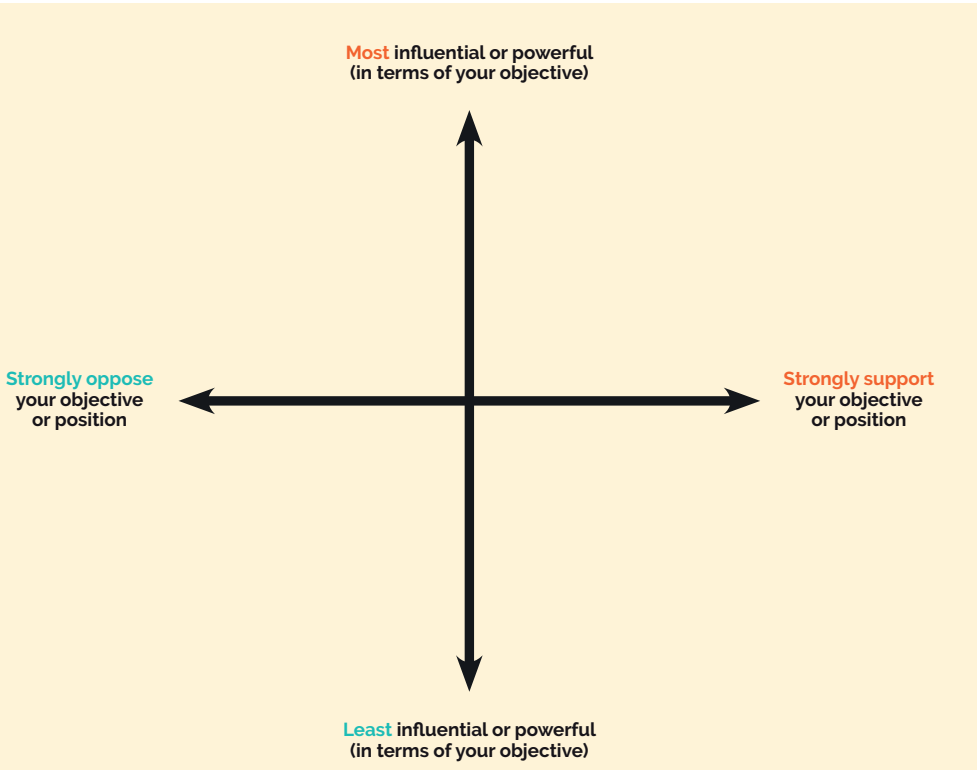
POWER MAPPING

While these government officials are the most directly involved in actually writing and passing local policies, other stakeholders can influence the formation of policy and how well policies are implemented. First off, by influencing everyday people, you can change hearts and minds, impact future voting patterns, and diminish the bias and discrimination that creates unnecessary barriers for minoritized groups. In addition, other organizational decision-makers may be relevant to a specific policy goal, like School Board members, school administrators, hospitals, and business owners.

Power Mapping is a technique that helps to identify the multiple potential targets in a policy campaign. The chart included here is a beginning guide to using this method. First, you evaluate decision-makers in terms of their values. You can use information from the news, their website, and past voting history to estimate whether they will most likely support or oppose your goals. Then, you can place individuals on the included chart by also considering how much influence they have on your specific outcome. Laying this out visually can then help to identify the most effective points of intervention for advocacy work.



ADVOCACY STRATEGIES

There are lots of ways to advocate for new and updated policies that can better serve our communities. The most effective strategies typically combine multiple tactics to target different stakeholders.

TACTICS	*WHEN TO USE*
Voting in government elections. Adult U.S. citizens are eligible to vote and must register to receive a ballot. Although Presidential election cycles every four years are the most popular, important local elections often occur in midterm and off-year elections.	*Every time! Voting is crucial to deciding who will be making laws, bringing about new policies, and ensuring long-term political change.*
Position papers are **letters of support or opposition** that communicate the impact of policies for specific groups. These letters are often written by organizations, but they can also be submitted by individual advocates, community members, and experts.	*When a policy is being proposed or considered, especially when you believe that one or more key votes can influence the outcome of a vote.*
Public comment allows individuals to speak their position aloud during a formal meeting and be heard by a group of policymakers. Public comments can be made during general meetings or hearings focused on a specific issue or topic.	*For contentious policies that you expect will have substantial disagreement, either from the public or among the decision-makers who are voting.*
Legislative briefings are similar to traditional "lobbying" and include times when advocates share information, perspective, and stories with an elected official or their staff. This may include the Legislative Director, Field Representatives, or other staff members.	*Either attempting to propose new policies, providing substantial amendments to a policy that has been proposed, or to gain support for a specific decision on a policy.*
Policy memos are an opportunity to showcase in-depth research that supports one or more policy changes. Policy memos need to be clear, to the point, and well-supported in order to convince a legislative audience.	*To introduce new ideas into policy conversations and shed light on issues that are being ignored by elected officials.*
Direct action includes a range of tactics like **protest**, **marches**, and **strikes**. Direct action relies on creative strategies that can bring attention to a community or perspective that is being excluded from mainstream conversations.	*To hold policymakers accountable, direct action is useful for bringing media attention to a group, issue, or event.*
Community organizing is an approach that focuses on developing solutions to issues that are rooted in community capacity and strength. This may include direct service as well as efforts to develop leaders and community-based organizations.	*Organizing is needed all the time and is especially useful for when policymakers are not receptive to a group's issues, or are actively hostile.*

For more resources and examples of successful advocacy materials, visit
https://tinyurl.com/Advocacy101Toolkit

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PRINCIPAL INVESTIGATOR BIO

Mario Espinoza-Kulick *(he/él)* is a Doctoral Candidate in sociology at the University of California, Santa Barbara. Mario draws from his own experience as an HIV+, Queer, Latinx, and Indigenous person to raise awareness around health inequities.

For more information about this study, please visit our website at https://tinyurl.com/LaGenteUnida.

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METHODOLOGY NOTE

This report is based on a larger project examining Latinx immigrant and Indigenous health across California's Central Coast, including participant observation, interviews, focus groups, collection of news data, and a survey of health assets and needs. Individuals were eligible to participate in the study if they were an immigrant community member (Undocumented, Dreamers, mixed-status family member, resident and/or a naturalized citizen), or as an advocate (individuals that actively participate in social change efforts toward advancing immigrant health equity).

HEALTH POLICY RESEARCH SCHOLARS

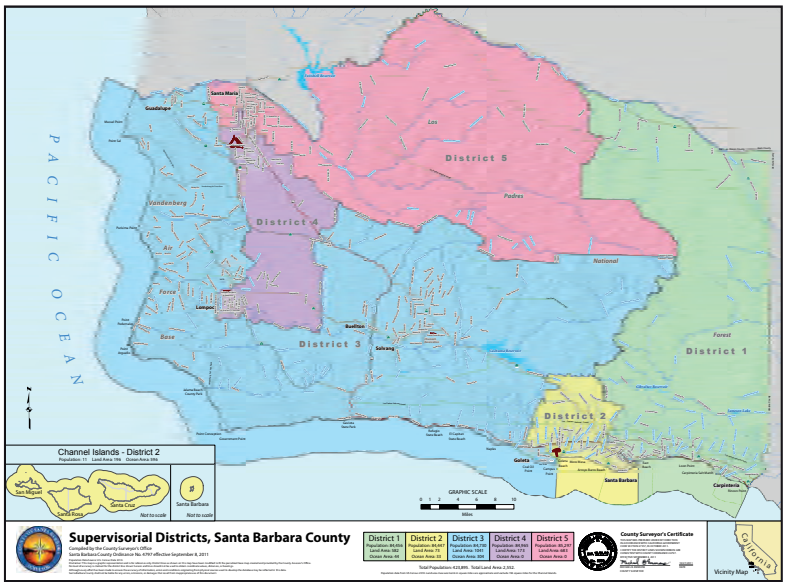
The Robert Wood Johnson Foundation provided financial support for this project through the Health Policy Research Scholars Program, Dissemination Award.

Guía de Promoción de Políticas

La política es un mecanismo poderoso para abordar los problemas de inequidad en nuestras comunidades. Las leyes, ordenanzas y reglamentos pueden marcar una diferencia importante al compartir recursos y crear oportunidades. También envían un mensaje a la comunidad sobre el valor que le damos a ciertos temas y lo que se puede hacer para lograr un cambio. Esta guía proporciona una descripción general introductoria de la promoción de políticas, centrándose en el nivel local. La información contenida en esta guía fue recopilada como parte del estudio La Gente Unida sobre la salud y defensa de inmigrantes e indígenas latinos en la costa central de California.

POLÍTICAS DEL CONDADO

Los gobiernos de los condados son un lugar importante para el trabajo de políticas. Los condados son los principales responsables de llevar a cabo los programas financiados por el estado, la inscripción en los servicios públicos, la infraestructura, la educación y los departamentos de salud pública locales. En particular, el condado generalmente supervisa cosas como **carreteras, servicios públicos, permisos y parques** para todas las áreas no incorporadas, lugares que no forman parte formalmente de ningún gobierno de la ciudad.



Fuente de la imagen: Condado de Santa Bárbara

HEALTH POLICY RESEARCH SCHOLARS

GUÍA DE PROMOCIÓN DE POLÍTICAS

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En California, cada condado está organizado en distritos. Luego, cada distrito está representado por un miembro en la Junta de Supervisores. Los supervisores se eligen una vez cada cuatro años. Se requiere que la Junta de Supervisores celebre reuniones públicas periódicas que incluyan oportunidades para que los residentes compartan sus puntos de vista sobre cuestiones de política. También se espera que cada supervisor esté disponible para los residentes de su propio distrito para escuchar inquietudes, quejas y problemas que puedan surgir. Debido a la gran cantidad de personas en un distrito determinado, los miembros del personal y los analistas legislativos suelen participar en la recopilación de esta información y compartirla con el supervisor. En el gráfico (pagina 1), puede ver los cinco distritos que componen el condado de Santa Bárbara.

Además de la Junta de Supervisores, cada condado tiene una Comisión de Planificación. La estructura de la Comisión de Planificación es similar, y cada distrito está representado por un individuo. Estos individuos son nombrados y aprobados por los supervisores. El papel de la Comisión de Planificación es representar los intereses de los residentes en el desarrollo de un Plan General, investigar cuestiones de políticas, formar parte de los comités relevantes y brindar recomendaciones sobre las políticas que la Junta de Supervisores está considerando.

Si bien la Comisión de Planificación y la Junta de Supervisores están a cargo de tomar decisiones de política, varios funcionarios y agencias llevan a cabo la implementación de estas políticas. Las personas que ocupan estos puestos suelen ser nombradas o contratadas directamente y no elegidas por el pueblo. Sin embargo, como funcionarios públicos, deben actuar en el mejor interés de las comunidades a las que sirven.

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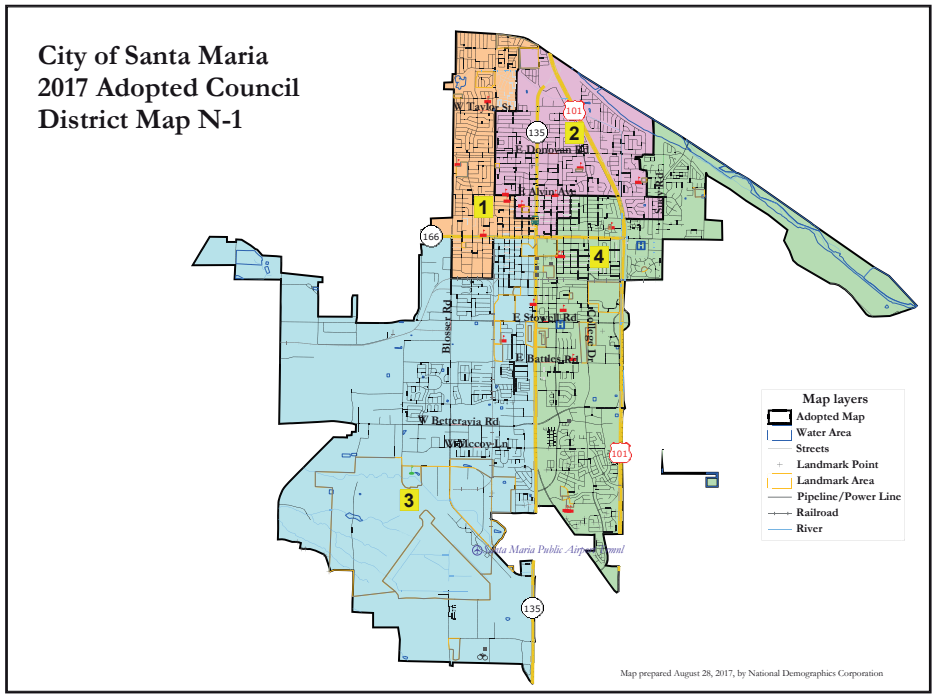
POLÍTICAS DE LA CIUDAD

Los sistemas de gobierno en las ciudades y pueblos pueden variar algo en su estructura, según el tamaño y los antecedentes políticos de la comunidad local. Por ejemplo, en el condado de Santa Bárbara, Goleta se incorporó recientemente como ciudad en 2000. La gente elige a los concejales y al alcalde mediante una elección en toda la ciudad, y también asumen el papel de la Comisión de Planificación. Hasta 2018, el cargo de Alcalde lo determinaba internamente el Concejo Municipal, quien nombraría a un Concejal para el cargo.

Las ciudades más grandes, como Santa Bárbara y Santa María, se establecen de manera similar al gobierno del condado, con elecciones de distrito separadas y una Comisión de Planificación que nombran los funcionarios electos. De manera similar, las Comisiones de Planificación de la Ciudad desarrollan un Plan General, escuchan al público y brindan asesoramiento a los Concejales de la Ciudad, el Alcalde y el personal de la Ciudad sobre la formación e implementación de políticas.

A nivel de la ciudad, la forma en que la gente vota por sus funcionarios electos puede marcar una gran diferencia. Por ejemplo, en 2018, la Ciudad de Santa María cambió su formato de elección para que los residentes votaran por los miembros del Concejo Municipal dentro de un Distrito específico, en lugar de ser elegidos en toda la ciudad. Este cambio permite que los votantes sean representados por alguien de su propia área y asegura que ninguna región de la ciudad esté determinando la política para todos. En las ciudades que están creciendo en tamaño, el gobierno local puede ser el objetivo para formular políticas, así como para cambiar realmente la forma en que funciona el gobierno.



Fuente de la imagen: Ciudad de Santa Maria

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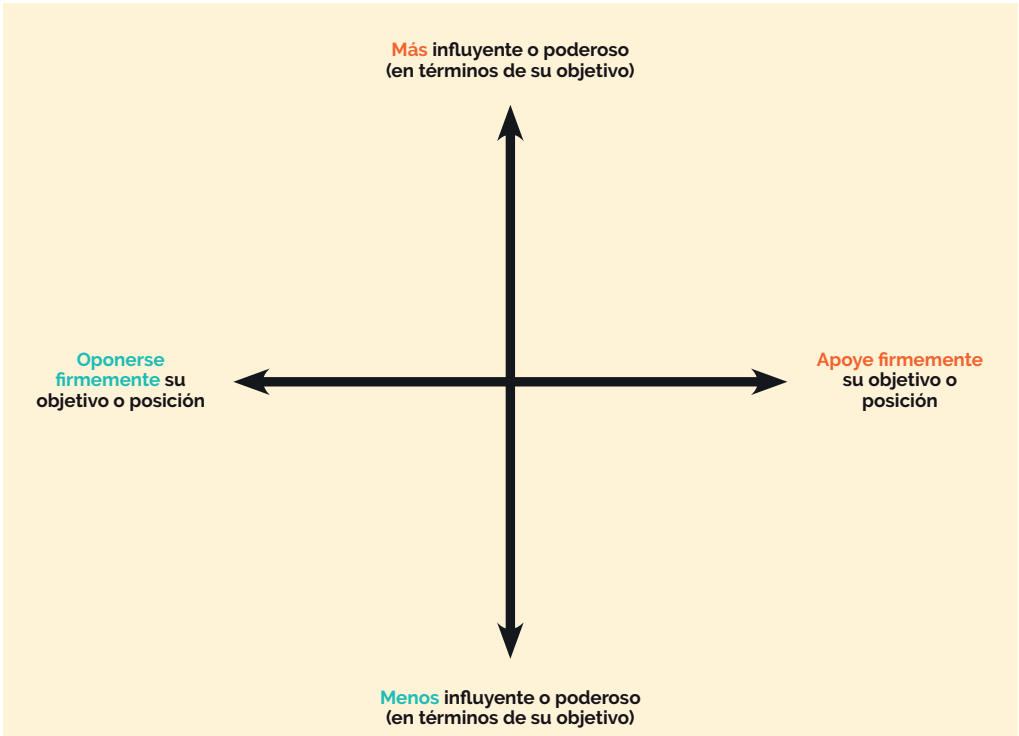
MAPA DE PODER

Estos funcionarios gubernamentales son los que participan más directamente en la redacción y aprobación de las políticas locales. Sin embargo, otras partes interesadas pueden influir en la formulación de políticas y en qué tan bien se implementan las políticas. En primer lugar, al influir en la gente común, puede cambiar los corazones y las mentes, afectar los patrones de votación futuros y disminuir los prejuicios y la discriminación que crean barreras innecesarias para los grupos minoritarios. Además, otros tomadores de decisiones organizacionales pueden ser relevantes para un objetivo de política específico, como miembros de la Junta Escolar, administradores escolares, hospitales y dueños de negocios.

Hacer un ***mapa de poder*** es una técnica que ayuda a identificar los múltiples objetivos potenciales en una campaña política. El cuadro que se incluye aquí es una guía inicial para usar este método. Primero, evalúa a los tomadores de decisiones en términos de sus valores. Puede utilizar la información de las noticias, su sitio web y el historial de votaciones anteriores para estimar si lo más probable es que apoyen o se opongan a sus objetivos. Luego, puede colocar a las personas en el cuadro incluido considerando también cuánta influencia tienen en su resultado específico. Presentar esto visualmente puede ayudar a identificar los puntos de intervención más efectivos para el trabajo de incidencia.



ESTRATEGIAS DE DEFENSA

Hay muchas formas de abogar por políticas nuevas y actualizadas que puedan servir mejor a nuestras comunidades. Las estrategias más efectivas generalmente combinan múltiples tácticas para dirigirse a diferentes partes interesadas.

TÁCTICA	*CUÁNDO USAR*
Votar en las elecciones gubernamentales. Los ciudadanos estadounidenses adultos son elegibles para votar y deben registrarse para recibir una boleta. Aunque los ciclos de elecciones presidenciales cada cuatro años son los más populares, las elecciones locales importantes a menudo ocurren en elecciones de mitad de período y fuera de año.	*¡Cada vez! La votación es fundamental para decidir quién hará las leyes, generará nuevas políticas y garantizará un cambio político a largo plazo.*
Los documentos de posición son **cartas de apoyo u oposición** que comunican el impacto de las políticas para grupos específicos. Estas cartas suelen ser escritas por organizaciones, pero también pueden ser enviadas por defensores individuales, miembros de la comunidad y expertos.	*Cuando se propone o considera una política, especialmente cuando cree que uno o más votos clave pueden influir en el resultado de una votación.*
El **comentario público** permite a las personas expresar su posición en voz alta durante una reunión formal y ser escuchadas por un grupo de políticos. Se pueden hacer comentarios públicos durante las reuniones generales o audiencias enfocadas en un tema o tema específico.	*Para políticas contenciosas que cree que tendrán un desacuerdo sustancial, ya sea del público o entre los tomadores de decisiones que están votando.*
Las **sesiones informativas legislativas** son similares al cabildeo tradicional e incluyen momentos en los que los defensores comparten información, perspectivas e historias con un funcionario electo o su personal. Esto puede incluir al Director Legislativo u otros miembros del personal.	*Ya sea intentando proponer nuevas políticas, proporcionando enmiendas sustanciales a una política que se ha propuesto, o bien para obtener apoyo para una decisión específica sobre una política.*
Los **memorandos de políticas** son una oportunidad para mostrar una investigación en profundidad que respalda uno o más cambios de políticas. Los memorandos de políticas deben ser claros, precisos y estar bien respaldados para convencer a una audiencia legislativa.	*Introducir nuevas ideas en las conversaciones sobre políticas y arrojar luz sobre cuestiones que los funcionarios electos están ignorando.*
La **acción directa** incluye una variedad de tácticas como **protestas**, **marchas** y **huelgas**. La acción directa se basa en estrategias creativas que pueden llamar la atención sobre una comunidad o perspectiva que está siendo excluida de las conversaciones principales.	*Para responsabilizar a los formuladores de políticas, la acción directa es útil para llamar la atención de los medios sobre un grupo, tema o evento.*
La **organización comunitaria** es un enfoque que se enfoca en desarrollar soluciones a problemas que están arraigados en la capacidad y fortaleza de la comunidad. Esto puede incluir servicio directo así como esfuerzos para desarrollar líderes y organizaciones comunitarias.	*La organización es necesaria todo el tiempo y es especialmente útil cuando los legisladores no son receptivos a los problemas de un grupo o son activamente hostiles.*

Para obtener más recursos y ejemplos de materiales de promoción exitosos, visite
https://tinyurl.com/Advocacy101Toolkit

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PRINCIPAL INVESTIGATOR BIO

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HEALTH POLICY RESEARCH SCHOLARS

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MARIO ALBERTO V. ESPINOZA-KULICK
DISSERTATION DEFENSE

LA GENTE UNIDA: LATINX IMMIGRANT AND INDIGENOUS HEALTH AND ADVOCACY ON CALIFORNIA'S CENTRAL COAST

You're invited to the PhD Dissertation Defense of Mario Alberto V. Espinoza-Kulick! His research study shows how health inequities affect Latinx Immigrant and Indigenous groups and analyzes health advocacy strategies. This project developed a framework for decolonial-inspired methods that center Indigenous ways of knowing and community collaborations. The findings highlight overlapping barriers that exclude minoritized communities from opportunities for health. However, health social movements reduce barriers by interpreting key information and advocating for organizational, local, and state policy change.

May 24, 2021 at 9 AM PT
Zoom ID: 827 3929 6888
Mixteco Interpretation Available

Herencia Indígena
Indigenous Heritage

HEALTH POLICY RESEARCH SCHOLARS

MARIO ALBERTO V. ESPINOZA-KULICK
DEFENSA DE TESIS DOCTORAL

LA GENTE UNIDA: SALUD Y DEFENSA DE INMIGRANTES E INDÍGENAS LATINXS EN LA COSTA CENTRAL DE CALIFORNIA

¡Estás invitado a la Defensa de Tesis Doctoral de Mario Alberto V. Espinoza-Kulick! Su estudio de investigación muestra cómo las inequidades en salud afectan a los grupos de inmigrantes e indígenas Latinxs y analiza las estrategias de defensa de la salud. Este proyecto creó un marco para métodos de inspiración decolonial que centran las formas indígenas de conocimiento y las colaboraciones comunitarias. Los hallazgos destacan las barreras que excluyen a las comunidades minorizadas de las oportunidades de salud. Los movimientos sociales de la salud reducen las barreras al interpretar información clave y abogar por cambios en las políticas organizacionales, locales y estatales.

24 de mayo desde las 9 AM PT
Zoom ID: 827 3929 6888
Interpretación Mixteco Disponible

Herencia Indígena
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HEALTH POLICY RESEARCH SCHOLARS