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Legal Violence, Health, and Access to Care: Latina Immigrants in Rural and Urban Kansas

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Abstract

Using interviews and ethnography started in 2016 in rural and urban Kansas, we examine the consequences of an amplified immigration enforcement combined with a local limited health care infrastructure that reproduce legal violence manifesting on Latina immigrants' health, access to care, and community participation. We highlight the conditions rooted in place that generate short- and long-term negative impacts for Latina immigrants' health. Fear and anxiety about the deportation of themselves and their family members make them ill and also generate apprehension about contacting medical institutions, driving, and spending time in public spaces. These circumstances coalesce in women's lives to block access to medical care and undermine women's roles in their communities. Following gendered expectations, women turn to their informal networks to seek health care for their families. In the context that the enforcement regime has created, these ties can turn exploitative.

Keywords

gender; immigration enforcement; Latinas; legal violence; place

Increasingly harsh U.S. immigration policies have amplified the level of threat for the well-being of immigrants and their families, especially for Latinas/os who are the preeminent targets of enforcement today. Scholarship has pointed to the consequences of anti-immigration policies on immigrants' health (Asad and Clair 2018; Vargas, Sanchez, and Júarez 2017). Research also finds Latinas/os encounter structural barriers to access health care (Jacquez et al. 2015). Relying on interviews with 40 Latina immigrant women and ongoing ethnographic fieldwork that started in 2016 in urban and rural Kansas, we explore the short- and long-term consequences of internal immigration enforcement on Latina immigrants' health and access to care in a locality that lacks an organizational infrastructure for immigrants to obtain health care.

We use the legal violence lens (Menjívar and Abrego 2012) to unearth the social suffering in immigrant communities resulting from a dense web of immigration enforcement strategies and implementation practices during a time of heightened *deportability* (De

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Genova 2002) in contexts with limited social infrastructure to address the health needs of Latina/o immigrants. Legal violence points to the less visible but deeply damaging laws and policies that cause suffering in a class of people (Menjívar and Abrego 2012) along with the direct harm produced by physical and sexual violence that immigrants experience through enforcement measures such as detention facilities (see Ellmann 2019). We focus on the nonphysical but equally harmful effects of internal enforcement policies on health-related aspects of everyday life for Latina immigrant women living in Kansas. We call attention to the importance of place because disadvantages accrue in conditions of magnified enforcement and in localities where people are geographically distant from institutional infrastructures that urban areas offer. A specific configuration of adverse circumstances rooted in place, we contend, can create short- and long-term negative impacts for Latina immigrants' health. We further examine Latina immigrants' responses, through their informal networks, to such conditions.

We argue that the same laws that create conditions for immigrants to become mentally and physically ill also restrict their mobility outside the home and their access to medical care, thus creating possibilities for co-ethnic exploitation. Legal violence, embedded in enforcement practices, hinders Latina immigrants' health through creating both (a) fear and anxiety about detention and deportation of themselves and family members, which harms their physical and mental health and constrains their mobility, and (b) conditions that make it nearly impossible to access formal medical attention due to fear of spending time in public, driving, and contacting health care institutions. This predicament leads women to activate their informal networks, which produces immediate although temporary and minimal solutions but can amplify exploitation through the reproduction of inequalities (Del Real 2019; Menjívar 2000; Rosales 2014).

This article is divided as follows. We first describe the legal violence lens as it relates to amplified immigration enforcement and the consequences for immigrants' health. Following, we focus on the role of place in shaping health outcomes and summarize Latina immigrants' thinning roles as "community builders," which we argue is a consequence of an amplified interior enforcement regime (see also Simmons, Menjívar, and Valdez 2020). A section on data and methods follows, and then we discuss health care in Kansas. In the three empirical sections, we analyze the ramifications of living in a context of legal violence coupled with a limited health care infrastructure on Latina immigrants' health and effects on their roles in their Kansas communities. We conclude with a discussion on the intersection of legal violence and place in shaping Latina immigrant women's health.

BACKGROUND

Legal Violence and Amplified Immigration Enforcement

Immigration laws constitute legal violence (Menjívar and Abrego 2012) when they contain legislation that generates social suffering and harm for immigrants, deny them access to alleviate their predicament, and create conditions for immigrants to exploit one another. Such laws interact with existing racial hierarchies that differentially impact immigrant groups by race and other social markers (Gómez Cervantes 2019). Immigration law and public health policies have severely restricted public benefits for immigrants across legal

statuses, especially for Latinas/os given that they are immigration enforcement's primary target today (Abrego et al. 2017).

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 banned immigrants with lawful permanent residency ("green card" holders) from federally funded programs for their first five years in the country and banned undocumented immigrants altogether. PRWORA allowed individual states to determine eligibility criteria for public assistance programs (Hagan et al. 2003); Kansas made undocumented immigrants ineligible for state-subsidized health insurance. The 2010 Affordable Care Act blocked undocumented immigrants from federally subsidized health insurance (Joseph and Marrow 2017; Waters and Pineau 2015).

The Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) 287(g) provision established collaborations between federal, state, and local governments to enforce federal immigration law. The Secure Communities Program (SCP) relied on integrated databases across jails to enhance deportation capacity and produced the most deportations recorded in U.S. history (Abrego et al. 2017; Gramlich 2020). In 2014, the Priority Enforcement Program (PEP) replaced SCP to focus on detaining and deporting immigrants who had committed serious crimes; thus, PEP decreased interior apprehensions. The 287(g) was phased out due to concerns with racial profiling, but the Trump administration's 2017 Executive Order 13768 resurrected it, broadening deportability criteria to *any* person deemed undocumented (Simmons et al. 2020). Thus, in 2017, internal[1] removals increased 27% from the previous year, accounting for 36% of all removals in 2017 (U.S. Immigration and Customs Enforcement [ICE] 2017) and an additional 17% in 2018 (U.S. ICE 2018). In 2019, ICE introduced the Warrant Service Officer Program to encourage local sheriffs to bypass state laws and apprehend undocumented immigrants (Immigrant Legal Resource Center 2019).

Amplified enforcement has led to increased interior detentions and to an expanded fear of detention and deportation. In 2019, 85% of deported immigrants were detained (U.S. ICE 2019). Detention-mandated minimum bed capacity grew from 30,539 in 2015 (Department of Homeland Security 2014) to 52,000 in 2019 (Department of Homeland Security 2018). Amplified enforcement included hypermilitarized strategies at the U.S.–Mexico border (Davis 2018) and in the interior of the country (Dickerson and Kanno-Youngs 2020), such as "zero-tolerance" policies, bans on migrants from Muslim-majority countries, restrictions to refugee and asylum eligibility, the threat of ending some temporary statuses, and the creation of denaturalization agencies (Pierce 2019). In 2019, the New Public Charge Rule changed new immigrants' admissibility requirements and deportability rules for established noncitizens (U.S. Citizen and Immigration Services 2019). Thus, although immigration enforcement has a long history and the infrastructure for today's policies has been in the works for at least two decades (Menjívar, Gómez Cervantes, and Alvord 2018), the period of our research, from 2016 to 2020, saw significant amplification of interior enforcement across the country.

1. This percentage does not account for detentions and deportations at the border.

Legal violence, as Menjívar and Abrego (2012) theorized, involves both structural and symbolic violence, that is, the systemic inequalities and suffering rooted in structures and institutions (Galtung 1969). It also includes the symbolic violence (Bourdieu 1998) embedded in institutions and practices that normalize the everyday functioning of the enforcement system because it is "the law;" thus its neutrality and naturalness go unquestioned. Furthermore, immigration laws, through the production of variegated legal statuses, create a hierarchy of barriers to access resources. Together with enforcement practices, laws create a precarious class of immigrants managed and surveilled by the threat or risk of (although not actual) deportation, that is, *deportability* (De Genova 2002).

Building on Menjívar and Abrego's (2012) conceptualization, Van Natta (2019:1) introduced the concept "medical legal violence" to capture immigrants' legal exclusion from and mistrust of health institutions. In contrast to Van Natta (2019), who examined immigrants' access to care through the lens of medical facilities, our examination starts with a broader group of immigrants, including those who do not interact directly with health care providers. We illuminate the processes and interactions that perpetuate the structural and symbolic violence embedded in the original conceptualization of legal violence (see Menjívar and Abrego 2012). Informed by Van Natta's work and using the original legal violence lens, we seek to capture the broader social context and experiences from the immigrants' point of view. We reveal how immigration laws and enforcement make immigrants ill and at the same time prevent them from seeking care. We add to this theoretical framework the key role of gender and place as both factors interact with legal violence. Thus, we highlight women's roles in seeking care outside formal institutions and point to the symbolic and structural violence that seeps through to their informal networks and manifests in exploitative social ties. These are the harmful consequences of living in a context of legal violence coupled with the structural violence of limited health infrastructure for women's roles as seekers of care.

Thus, we expand Van Natta's (2019) work and apply the original legal violence lens to highlight the symbolic and structural violence embedded in the broader context to: (a) call attention to specificities of place and geography as these intersect with enforcement practices locally to make immigrants ill and push them to seek treatment outside of formal institutions and (b) reveal how forcing immigrants outside formal institutions to activate informal ties within an amplified system of enforcement can turn exploitative (see also Del Real 2019). Like Van Natta (2019), we examine legal violence in the context of health; like Menjívar and Abrego (2012), we reveal how broader contexts of symbolic and structural violence (Bourdieu 1998, 2003) seep through to harm immigrants directly and inflect their informal social ties with meaning in place-specific spaces of enforcement.

Place and Health in Kansas

Building on the scholarship on place and health, we examine *processes* and *interactions* (Cummins et al. 2007:1828) that develop under an amplified immigration regime at the federal and local levels in conjunction with shrinking public services at the state level. In 2012, Kansas implemented the largest tax cuts in its history, which consisted of tax elimination to passthrough businesses and a 25% tax decrease for the highest earners (Buder

2018). These cuts deeply hurt the education sector and safety-net programs. In 2013, Kansas privatized state Medicaid services while simultaneously denying its extension (Woodall 2017). The combination of tax cuts with a shrinking and privatizatized Medicaid ultimately slashed the existing health care infrastructure across the state, hurting rural health care the most (McLean 2019). Rural residents fared worse in preventable diseases and risk behaviors due to limited health care infrastructure, poverty, and environmental factors (Cosby et al. 2018).

Following Singer (2004), we categorize Kansas as an "emerging destination" given its demographic trends in recent decades. Prior to 1990, the proportion of Latinos in the Kansas population was below 3%; by 2000, it had doubled to 7%. In 2010, it was 10.5%, and it reached 12% in 2019 (Gibson and Jung 2002; U.S. Census Bureau 2019). Approximately 2.5% of the Kansas population was undocumented in 2017 (75,000 people), with the majority originating in Mexico and Central America (American Immigration Council 2017). Notably, nontraditional destinations are often unprepared to address newly arrived immigrant patients' needs; these contexts generally lack bilingual providers or interpreters, face limited budgets for uninsured patient care, and/or have inadequate cultural competency (Viruell-Fuentes, Miranda, and Abdulrahim 2012).

Immigration policy also shapes immigrants' health (Acevedo-Garcia and Almeida 2012). Latinas/os living in states with low- or medium-level punitive immigration laws report better self-rated health than immigrants in states with high levels of anti-immigrant laws (Vargas et al. 2017). And the deleterious health consequences associated with interior immigration enforcement are multi-generational (Rabin 2018). Novak, Geronimus, and Martinez-Cardoso (2017) found that mothers' exposure to an immigration workplace raid led to lower birthweight of Latina immigrants' newborn babies but did not affect babies born to white mothers. Availability of resources in a locality can ameliorate these detrimental consequences; Hainmueller and colleagues (2017) found that Deferred Action for Childhood Arrival (DACA) eligibility for mothers decreased anxiety disorders among their children.

In a context of amplified enforcement, Latina/o immigrants who fear deportation for themselves or their family members tend to not only avoid contacting institutions, including hospitals or health care providers, but also driving to obtain care (Kline 2017). Fear of driving stems from enforcement programs that rely on traffic stops to identify immigrants who may be undocumented because they do not have a driver's license (Castañeda and Melo 2019). In Kansas, undocumented immigrants are ineligible for driver's licenses, and driving without one is punished with a class B misdemeanor (see Kansas Statute 2017, § 21–6602). If charged with this misdemeanor, immigrants are sent to court, increasing their visibility to ICE. The stress of living in a context of immigration enforcement manifests physically; Latina/o immigrants report chronic headaches, stomachaches, and loss of appetite and sleep due to deportability (Gonzales and Chavez 2012). Under these conditions, Latina immigrants' roles are altered, and their previously reported centrality in their communities may diminish (Simmons et al. 2020).

Latina Immigrants in the Community

Early research shows that Latina immigrants play a significant role in their families' social integration processes, particularly in accessing institutional resources, as "community builders" (Hondagneu-Sotelo 1994; Menjívar 2000) and advocates for their families (Martinez 2010; Terriquez 2012). Following patriarchal norms that place women as providers of care and gendered motherhood expectations, Latina immigrants have been the designated family member to access social institutions such as schools, health care, assistance centers, and public spaces (Abrego and Schmalzbauer 2018; Hondagneu-Sotelo 1994). As women actively seek resources in community organizations, government offices, and assistance programs, this role provides them with insights and knowledge that immigrant men lack (Menjívar 2000, 2002).

The intensified anti-immigrant environment today has altered Latina immigrants' experiences within their families and communities, increasing their material and economic vulnerability (Doering-White et al. 2016). As Latino immigrant men are deported, women must navigate this "gendered and raced deportation regime" (Golash-Boza and Hondagneu-Sotelo 2013) alone in ways that affect their quality of life, material possibilities, social lives, and network engagement (Doering-White et al. 2016). This situation is particularly acute in contexts with fewer institutional resources for immigrants. Yet women's roles as mothers continue to shape their everyday lives and ways of managing illegality (Abrego and Schmalzbauer 2018; Bickham Mendez 2020).

Amplified internal immigration enforcement curtails women's interactions with formal institutions, undermining their roles as community builders and negatively affecting their families' social integration.[2] This limits women's interactions with formal institutions and participation in public spaces (Schmalzbauer 2014) and their connections to organizations that provide assistance for immediate needs, such as police protection from abuse and access to health care (Reina and Lohman 2015). Thus, today's enforcement regime is reconfiguring immigrant women's roles as conduits to institutions (Simmons et al. 2020).

Under these conditions, Latina immigrants and their families get sick and must seek care. But rather than creating institutional links, which can become conduits for social integration, under current enforcement conditions, Latina immigrants expand their informal networks to locate medical treatments (including prescriptions and traditional remedies; Menjívar 2002). This network expansion, however, in contexts of enforcement and fear, only provides temporary, truncated relief and is often accompanied by exploitation.

DATA AND METHODS

We drew on two sources of data. First, we relied on ongoing ethnographic fieldwork that started in 2016 in a small Kansas town we call Heartlandville and where we conducted in-depth interviews with 28 Latino immigrants as well as Anglo residents. The Heartlandville project investigates Latino immigrants' integration in a rural, white-majority community.

[2]Men, in their roles as fathers, are also affected by this enforcement context (Berger Cardoso et al. 2016). However, we focus on women in this article because of the specific effects for women that our research calls attention to.

The second project involved 64 in-depth interviews with Latina/o members of mixed-status immigrant families in urban areas of Kansas conducted between 2016 and 2019. This project investigated the role of immigration status in family dynamics. Given the similarities in women's health and health care experiences in the urban and rural contexts captured in our projects and that these were undertaken during the same period of time and with the same immigrant population, we combined the data from both projects on Latina immigrant women to analyze their health care predicament through a legal violence lens.

We relied on a total of 40 study participants—Indigenous and non-Indigenous Mexicans and Central Americans—15 of whom lived in Heartlandville and the rest in urban areas of Kansas. The Indigenous-origin women included Maya (n = 16), Tlapaneco (n = 7), and Mixteco (n = 3), and the rest were mestizas (n = 14). There are important socioeconomic, demographic, and cultural differences between Indigenous and non-Indigenous Latinas (see Blackwell, Boj Lopez, and Urrieta 2017), with Indigenous migrants having lower socioeconomic and educational levels. Given space constraints, we focused on their shared experiences regarding their health, only noting differences in the analysis when they emerged.

The semistructured interviews usually lasted between 30 minutes to 2.5 hours and were conducted in a location of the participants' choice, mostly at their homes or in public spaces such as coffee shops or parks. All the interviews were conducted in Spanish, recorded, and later transcribed verbatim. Verbal consent was obtained and recorded before all interviews. When participants preferred their interviews not be recorded, extended notes were taken at the time of the interview. To maintain participants' confidentiality, we use pseudonyms throughout, including the name of the rural town, and omit the names of urban areas.[3] Interview participants were recruited through snowball sampling that developed after we contacted several institutions that serve Latino communities in urban areas of Kansas. In these urban areas, Gómez Cervantes first met four key informants through church leaders and another three through immigrant advocacy groups. After conducting interviews for the project, these participants connected Gómez Cervantes with other study participants. We also contacted informants after spending time in public spaces such as grocery stores or fast food restaurants. In Heartlandville, we started recruiting participants after spending four months in the field, attending events in churches and schools, and visiting grocery stores, the library, public events, and the park. Thus, we had multiple forms of entry to the field in both projects with the goal of reaching a heterogenous group.

In Heartlandville, we conducted ethnographic observations in parks, churches, libraries, restaurants, court houses, general stores, and grocery stores; at holiday events and parades, family gatherings, birthday parties, weekend barbecues, and hang outs on front porches; and during health care–related activities. We volunteered at health clinics and hospitals in both Heartlandville and urban areas of Kansas. In Heartlandville, we attended "wellness community gatherings" where medical providers met to discuss the community's health concerns. We took detailed notes during events and encounters or immediately after they

[3]Total population in urban area one is around 80,000. In urban area two, the total population is around 145,000 (U.S. Census Bureau 2019).

ended. Although in some instances note-taking flowed naturally, such as during school or similar meetings, sometimes it seemed inappropriate, such as in churches or at birthday parties; in these cases, a detailed account of the event was audio-recorded promptly after it ended and later transcribed. All protocols were approved and are on file with the University of Kansas and with the authors' respective universities' Institutional Review Board offices.

The majority of participants in our projects were from Mexico (22) and Guatemala (16); additionally, in the urban areas, one was from El Salvador and one from Honduras. The women's immigration statuses in urban areas included naturalized citizens (2), Lawful Permanent Residents (1), DACA (5), and Temporary Protected Status (TPS; 1), whereas the rest were undocumented (16). Almost all the women in Heartlandville were undocumented (14), and one was naturalized. Ages ranged between 18 and 50 years old. Most were married or cohabiting in heterosexual relationships (27), and the rest were single or separated (13). Most (32) had one or more children or no children (8), and most (33) worked outside the home. Women's occupations include food processing plants (8), restaurant services (8), child care (2), cleaning services (8), professional jobs (3), university services (3), and sales (1). Only seven women were not employed; three were looking for work at the time of the interview, and four considered themselves stay-at-home mothers.

We used Atlas.ti software to code the interviews and fieldnotes, relying on inductive analysis and grounded theory (Charmaz 2006) to conduct line-by-line coding. Given the semistructured nature of the interviews, the main themes in this article emerged unprompted. Importantly, following anti-colonial feminist methodologies (Hales 2006), study participants guided much of the conversations during our interviews, telling us what was most important to them in their lives. Thus, we centered the analysis on women's perceptions of their experiences and the world around them.

To analyze the data, we employed codes for interactions with health care institutions and public spaces that are otherwise characterized as community building to develop our major themes. Codes included "fear of driving," revealing fear to drive due to the possibility of apprehension; "fear of going outside," expressing fear of leaving their homes; and "fear of institutions;" or fear of contacting institutions such as the health care system. Other codes included "access to health care," describing participants' engagement with health care institutions. From these codes, three major themes developed: (1) health consequences of interior enforcement, resulting from the women's constant fear, limiting their time driving and in public spaces, and their contact with health care institutions; (2) access to care, revealing the barriers that women encountered; and (3) use of informal networks as alternatives to formal care. We found that the legal violence embedded in immigration enforcement coupled with limited health care resources across Kansas undermined Latina immigrants' well-being and that of their families. Latina immigrants react to such conditions by locating resources in their networks (Hagan 1998; Menjívar 2000, 2002), which can turn into exploitative ties, adding another layer of symbolic (and legal) violence to interpersonal relationships (see also Del Real 2019).

RESULTS

The Kansas Context

The Kansas legal context for immigrants has been mixed. Since the early 2000s, state policies have limited the benefits and rights of undocumented immigrants, including denying them access to state IDs or driver's licenses, employment benefits, and state-funded health insurance. Since 2004, undocumented students have had access to in-state college tuition, but this benefit is regularly threatened in the Kansas legislature.

In Kansas, only U.S. citizens or lawful permanent residents are eligible for state-funded nonemergency medical assistance, KanCare[4] (Kansas Department of Health and Environment [KS DHE] 2018). Under the Sixth Omnibus Budget Reconciliation Act, a federal law signed in 1986, undocumented immigrants are eligible for financial assistance for life-threatening emergencies, labor, and delivery (KS DHE 2009), but eligibility varies by case. In 2007, 51% of nonlabor or delivery requests were denied in Kansas (KS DHE 2009). Pregnant women who can provide proof of state residency, income, and identity are eligible for Women and Infants and Children (WIC) nutritional services for their U.S.-born babies (KS DHE 2018). In 2014, 26% of Latinas/os in Kansas were uninsured compared to only 8% of whites, and uninsured rates are highest among foreign-born Latinas/os (49%; Pew Research Hispanic Trends Project 2014).

Health Consequences and the Legal Violence of Interior Enforcement

Internal immigration enforcement constitutes legal violence because it creates suffering in the lives of Latina immigrants by instilling perpetual fear of family separation—which can make these immigrants ill—and creating fear of driving and of contacting medical institutions. Like men, immigrant women are afraid to drive (Schmalzbauer 2014), a vital aspect of life in Kansas. Driving links people to resources, organizations, and work, especially in remote areas with limited or nonexistent public transportation (Castañeda and Melo 2019). Together, these factors harm immigrant women's health and alter their roles in their communities.

Fear of family separation.—Key to amplified enforcement strategies is deportability, or the *risk* of deportation (De Genova 2002), which becomes an efficient tool to control immigrant populations through fear. Thus, enforcement agencies do not have to be present to create pervasive fear, which becomes a psychological threat with negative effects on the individual's sense of self (Willen 2007). Sharing her thoughts about living in Kansas during the 2016 election, Sofia, a 24-year-old undocumented Mexican mother of a one-year-old U.S. citizen, said she felt "fear that they will kick me out, that they kick out all of us, and that I won't be able to bring my son [to Mexico if she is deported]." The fear expressed in Sofia's quote negatively impacts women's mental well-being and contributes to physical ailments in the long term, as extant research shows (cf. Gonzales and Chavez 2012). As other scholars have observed, fear alone (due to deportation) is a chronic stressor that

[4]KanCare is the state privatized version of Medicaid. Kansas contracts three private health insurance companies to provide subsidized health care plans to income-eligible families. Eligibility includes proof of citizenship and income.

hinders immigrants' mental well-being (García 2018) and their physical health (Torres et al. 2018).

Yareni's case further highlights this point. She is a 39-year-old undocumented Mexican Tlapaneco woman who has lived in urban Kansas for seven years. Gómez Cervantes met Yareni at her house after her sister, who also participated in the study, connected us. As we chatted at her kitchen table, Yareni feared that if she were deported, her U.S. citizen daughter will end up alone or under state custody and her two older children who live in Mexico will lose the financial support that she provides through regular remittances. Yereni had well-founded reasons to agonize over possible deportation; both her husband and brother had been deported previously. Her husband managed to return to Kansas, which meant that he was now at risk of imprisonment if apprehended because reentry after deportation has been reclassified as a felonious offense. Yareni confessed, "I am afraid that they will deport me," so she avoids leaving her house. During a conversation, we asked her what she does for fun, to which she responded, "We don't go out, we are *encerrados* [locked inside], I am afraid to leave … to be deported." The legal violence embedded in the enforcement regime, which creates a state of "hyperawareness," risk, and fear, shapes the lens through which immigrants see and interpret the world around them (Menjívar 2011). This is the mechanism through which deportability works so efficiently in the control of immigrant populations.

Similarly, during an informal conversation in the trailer where Ofelia, an undocumented Mayan Guatemalan woman in Heartlandville, lived, she shared, "in Guatemala we are free, but here" Ofelia explained that in the United States, she might earn some money from her work providing child care to other co-ethnic women in the town, but she lives *encerrada*, locked inside her house. From her point of view, at least she could leave her house and go outside in Guatemala. She and her family rarely leave their home because they fear being apprehended and deported. As Yareni and Ofelia's cases highlight, the legal violence of the enforcement system instills a constant sense of fear and risk that produces social isolation, distancing women from public spaces and hindering their previous roles as community liaisons.

Given the racialized nature of immigration enforcement that equates being Latina/o with being undocumented, Latina immigrants across immigration statuses (Gómez Cervantes 2019; Menjívar, Simmons et al. 2018) reported fearing the possibility of a family member's deportation, which could, among other consequences, translate into financial instability. Natalia, a 21-year-old Mexican woman with DACA, worried about her undocumented parents. Talking about the changes to immigration legislation and amplified enforcement after the 2016 election, Natalia shared, "Now, with everything that's happening, my parents are like making plans." She recounted that shortly after the 2016 election, her parents created a plan in case they were deported; Natalia and her sister were to sell their home and belongings. She said she was afraid of her father's possible apprehension because he has to drive to work every day without a driver's license. Indeed, her fears of family separation created emotional pain that flooded our interview as she, unprompted, shared details of her situation. Amid sobs, Natalia stated, "My dad, he could be pulled over any moment and anything could happen….So, it's scary." Similarly, Erica, a 37-year-old Honduran

woman with TPS and the mother of a 19-year-old DACA recipient, was anguished with the possibility that her son could be deported even with semilegal status. She said, “They have to go out, they have to drive, so my fear is that immigration will grab him.” This constant fear of apprehension and family separation, recognized by other scholars as “toxic stress” or “chronic stress,” directly harms Latinas’ physical and mental well-being across immigration statuses. Examining these consequences through a legal violence lens allows us to unveil the harmful effects of the interior enforcement apparatus on immigrants’ health (see also Van Natta 2019).

Fear of contacting medical institutions.—An indirect consequence of amplified immigration enforcement is that spaces previously considered “safe,” such as medical facilities, are no longer perceived as secure by undocumented immigrants (or even by their documented family members; see also Kline 2017). Amelia, a 30-year-old Mexican woman who has lived undocumented in the United States for 12 years, said that fear of detection limited her access to health care and is one of the biggest struggles of living undocumented: “There are a lot of difficulties here about this [living undocumented], for example when my husband or I get sick.” She explained that when she and her husband get sick, they are apprehensive about where to seek care, partly because they fear that health facilities can check their immigration status in the process of providing care:

> We didn’t know where to go, so we had to go to the hospital and at first, *well if they ask us for our papers* [immigration status]…. So then well we didn’t know what to say and then we decided that when we get sick, it’s better if we don’t go [to the hospital] we heal alone, we heal ourselves here at home or we would go to the Mexican store asking about medicines that we knew from Mexico or here in the stores.

As Amelia’s words indicate, fear of revealing one’s status while seeking care can keep people from contacting medical institutions, which automatically places the ill person (or their family members) at risk. Although Amelia and her partner knew where the local hospital was located, like other immigrants in a similar situation, they sought treatment outside formal health care facilities when possible, even in emergency situations. This exemplifies how the legal violence of interior enforcement manifests in harmful consequences for Latina immigrants’ health.

On a cold wintery day, Gómez Cervantes received a phone call late at night. It was Dolores, a 26-year-old undocumented Mexican Mixteco woman. Amid panic and sobs, Dolores asked for a ride to the emergency room because one of her children had been experiencing a high fever for several days. Her husband, also undocumented, could not take the child to the hospital because he could not leave work at a restaurant kitchen; he feared being fired and could not afford losing their only source of income. Dolores feared driving without a license, and there is no public transportation at night where she lives. Gómez Cervantes picked up Dolores and her five children at their small house and drove them to the emergency room. At the hospital’s main entrance, Dolores froze; she did not want to leave the car. As the kids sat quietly in the back seat looking terrified, Dolores asked if they (the hospital) could call *la migra* (ICE) and take her away given that she is undocumented and separate her from

her children, who are U.S. citizens. Gómez Cervantes could not reassure Dolores; it was not clear what the hospital's relationship with immigration enforcement (ICE) was. After parking the car, Gómez Cervantes accompanied Dolores and the children to the emergency unit. Gómez Cervantes interpreted for Dolores and the desk clerk and helped fill out the child's paperwork. Observing closely, Gómez Cervantes noticed that hospital workers did not ask Dolores for her immigration status but did request the social security number of the sick child as part of routine intake. As a U.S. citizen, the child had one. After a couple of hours, Gómez Cervantes had to leave because it was past midnight. Dolores and the children had to stay overnight to monitor the child's fever. Dolores shared that she remained apprehensive about the hospital sharing her contact information with ICE, thus illustrating how the immigration regime's legal violence shapes Latina immigrants' health but also that of their U.S.-born children.

As in Amelia's and Dolores's cases, Latina immigrants were fearful of detection at medical facilities, a situation with short- and long-term consequences (Kline 2017). Fear of contacting medical institutions deters some immigrants from accessing care altogether, as Amelia's case showed, harming their health in the short term because they have no access to treatment for immediate illnesses as well as in the long term as they avoid routine care. Others may delay care and, as in Dolores's case, feel apprehensive when seeking care in emergency situations, adding stress to the already worrisome circumstances of having a child in the hospital. Additionally, delayed and foregone treatment directly impact Latina immigrants' health and can alter these women's connections to institutional services.

Limited mobility.—Policies that deny driver's licenses to undocumented immigrants enact legal violence given that avoiding driving has multiple harmful consequences for immigrants' lives; it constrains women's mobility and their financial stability, and it hampers their access to health care institutions and public spaces. Although a few study participants, mainly those who lived in rural Heartlandville, avoided driving altogether, most explained that to conduct their everyday activities, such as going to work or grocery shopping and taking their children to school or doctor's appointments, they had to drive or find someone to drive them. Public transportation in rural Kansas is almost nonexistent (there was no public transportation in Heartlandville), and in urban areas, it is inefficient and limited. The risks of driving without a driver's license provoked anxiety among our study participants. Saturnina, an undocumented Mexican Mixteco immigrant in urban Kansas, explained,

> I was afraid to [go to] work. The first day the police stopped me, they said that if I did not pay [the ticket for driving without a driver's license] they would send me to jail, and then I could be deported.

Like other study participants, Saturnina did not use ride share services such as Uber or Lyft for transportation (these were unavailable in Heartlandville and too expensive in urban areas). We observed that the bus service in the urban area where Saturnina lived ended as early as seven in the evening and ran inconsistently during the weekends. To get to work, Saturnina had to drive, always aware that doing so exposed her to detection. Generally, undocumented Latina immigrants who drove limited their driving to their workplace and

running errands in their neighborhoods, always avoiding highways. Carolina, a 37-year-old undocumented Mexican Tlapaneco woman in urban Kansas, said that she only drives "for work, for necessity, because I am afraid." The fear of driving due to deportability limits Carolina's mobility, restricting her contact with institutions and participation in the community as she avoids spending time in public spaces.

Fear of apprehension related to driving is a chronic stressor that women experience in everyday life and hinders their health directly (Ayón 2018; García 2018). Our findings parallel Schmalzbauer's (2014) study of Mexican women in Montana who lacked transportation in a place where driving is vital due to long distances and unreliable or nonexistent public transportation.

Latina immigrants in Kansas find other ways to solve this problem, which brings an added layer of symbolic violence that enforcement makes possible: They rely on their informal networks to obtain rides, for which they must pay other Latinas/os who have driver's licenses (and some adventurous undocumented who do not), turning this need into a business. This situation opens multiple opportunities for co-ethnic exploitation and solidifies ethnoracial divides (see also Del Real 2019). Co-ethnic exploitation (see also Menjívar 2000) adds a layer of stress, further harming immigrant women's health. Flor exemplifies this point.

Flor is a 19-year-old undocumented Guatemalan Maya woman in Heartlandville and mother to a newly born U.S. citizen and a 3-year-old undocumented girl. Like others, Flor is afraid to drive. When she was pregnant, she needed to attend a prenatal check-up at the local doctor's office. Although the clinic is less than a mile away, Flor would have to walk across a highway (there are no sidewalks there) in the humid 100° Kansas summer weather. Flor asked Tania, a naturalized mestiza (non-Indigenous) Mexican woman, for a ride "only because nobody else [could] take me." Flor's partner was at work, and the other Mayan women in her neighborhood could not risk driving without a driver's license. Flor described the short car ride, "Here in the clinic, here with the doctor. … Just here, and when I came [back] and I asked her, 'how much do I owe you?' I only had $20, 'Give me $40' she said." Flor paid Tania $40 for her five-minute ride to and from the clinic. Flor also had to pay $100 out-of-pocket for the prenatal check-up because she is uninsured and WIC did not cover the appointment.

Like Flor, other Indigenous Maya women in Heartlandville often mentioned that non-Indigenous Latinas—who possessed driver's licenses and had semilegal, lawful, or citizenship statuses—provide the rides for cash, often at exorbitant prices. Importantly, an Indigenous Maya man would also charge for rides to other Maya co-ethnics. The Indigenous women would pay between $10 to $40 for rides in town and up to $400 for rides outside of town (to an urban center about three hours away where several women needed to go for ICE check-ins). Nearly all the Indigenous Maya women we met in Heartlandville mentioned having to pay Indigenous co-ethnic men or mestiza Latinas for rides at one point or another, whether to take their children to medical or school appointments or to go grocery shopping. One morning, Gómez Cervantes was driving Daniela, a Maya Guatemalan Indigenous woman, to Daniela's son's parent-teacher conference and observed Tania, the mestiza

Mexican woman, knocking on the door of a Mayan Guatemalan family's home. Daniela said that Tania was there to collect money for the rides she would be providing the next day. Daniela explained that she and other Maya Guatemalan women had to rely on *raiteros*, co-ethnic ride providers, monopolized by mestizo/non-Indigenous Latinos (and one Indigenous Maya man) who, like Tania, had driver's licenses. A few months earlier, Daniela had paid Tania over $250 for a ride to a nearby city for an appointment with her immigration lawyer; Daniela had also used Elena's (another mestiza Mexican woman) driving services to take her son to medical appointments in town.

The legal violence embedded in policies that deny driver's licenses to undocumented immigrants, the geographical and physical location of Heartlandville, women's limited social ties, and the narrow range of health care options harm Latina immigrants' health. In remote areas, and especially among the Indigenous Maya women, transportation becomes a critical barrier to accessing health care due to the scarcity of transportation and the high costs of the rides that other Latinas/os in town provide.

Women's vulnerability and anxiety are amplified when they need transportation but do not have the money to pay for the ride. The legal violence of immigration policies and enforcement practices permeates interpersonal relationships (Del Real 2019; Menjívar and Abrego 2012), undermining the potential of co-ethnic ties and women's possibilities. Thus, Del Real (2019) argued, immigrant ties become toxic due to the uneven distribution of legal resources within immigrant networks. We find that in addition to an uneven distribution of legal resources, ethnoracial and gendered divides further amplify the effects of legal violence within Latina immigrants' social ties, giving rise to exploitative ties. Such ethnoracial divides exemplify the anti-Indigenous discrimination Indigenous groups face across Latin America, which travels with immigrants and becomes augmented under an immigration regime that racializes illegality (Gómez Cervantes 2019; Menjívar et al. 2018). This situation harms women's health directly by generating fear of driving and limiting their contact with institutions and indirectly by exploiting those fears and reproducing long-term consequences visible in chronic stress (see García 2018). Co-ethnic exploitation adds a layer of vulnerability that negatively affects undocumented Maya Indigenous women's health the most.

Lack of Access

The effects of legal violence embedded in immigration enforcement are also visible in the cumulative barriers to access care and health insurance that immigration and public health policies create (Hagan et al. 2003; Van Natta 2019). Even under conditions of increased immigration enforcement, following gendered motherhood expectations, Latina immigrants felt responsible for locating resources for their families' and children's health care (Abrego and Schmalzbauer 2018). Although at first glance this resembles previous work that points to immigrant women's roles as bridging their families and institutions (Hondagneu-Sotelo 1994; Menjívar 2000), Latina immigrants in Kansas can no longer be the conduits to institutions because they now face structural barriers and fear spending time in public spaces (see Simmons et al. 2020). The legal violence of immigration enforcement impedes access to health care based on legal status and, with the limited health care context in Kansas,

undermines the roles that Latina immigrants used to hold, which afforded them a modicum of empowerment or respect in their families and communities. This is exemplified as Latina immigrants in Kansas, such as Nina, attempt to enroll their U.S.-born children in social services.

Nina, an undocumented Guatemalan Maya woman in rural Heartlandville, asked Gómez Cervantes for help to enroll her U.S.-born children in KanCare. Sitting on an old couch in the bright pink living room of her trailer home, Nina brought out a pile of folders containing each child's social security number and birth certificate. As Gómez Cervantes filled out the forms for the three children, we encountered a section requesting the parents' proof of income. Neither parent could provide proof of income because both worked under a different name (using a fake social security card) and the potential discovery of this situation could put them at immediate risk of deportation. In some instances, immigrants use letters from their employers as proof of income (Hagan 1994). However, Nina and her husband Lalo could not do this because it would expose their undocumented status to their employer and they could end up losing their jobs and even face deportation. Gómez Cervantes connected Nina with an experienced case worker who used her professional networks to help with the process. The approval for the children's insurance took over a year. During this time, if the children needed to see a physician, they had to pay out of pocket, which meant they would only seek care for emergency situations. However, not all families in Heartlandville were as lucky. When Agustina, also an undocumented Mayan Guatemalan woman, went to the same case worker to ask for help with insurance paperwork for her U.S.-citizen children, the case worker's connection in the main office was unavailable and Agustina's children were denied subsidized insurance.

The Immigration Reform and Control Act of 1986 penalizes employers who willingly or knowingly hire undocumented immigrants, pushing immigrants to use "fake" or "borrowed" documents to work. This practice can now be penalized as identity theft and can constitute "aggravated felony" punishable with deportation and two years of prison even when immigrants are not *knowingly using someone else's identity.*[5] The immigration regime, with ever fewer avenues to secure legal status, thrusts immigrants into using fake documents to obtain employment, yet these same practices criminalize immigrants, with multiple consequences, including difficulty with enrolling their U.S.-born children in programs children are entitled to. Given their parents' insecure legal status and fear of detection in institutional spaces, U.S.-born children may be kept out of educational programs, remain uninsured, and their health care be (barely) met at community clinics, costly private clinics, or emergency rooms. Fearful undocumented parents are unable to access nutritional services for their children (Vargas and Pirog 2016), producing long-term effects on their children's health. Thus, legal violence has multigenerational consequences (see Enriquez 2015).

Although immigrant women encounter barriers to accessing care, some continue to seek formal health care (Armenta and Sarabia 2020), particularly when pregnant. Estefanía, a

[5]As of this writing, the U.S. Supreme Court heard arguments for *Kansas v. Garcia 17–834* to vote whether the Immigration Reform and Control Act of 1986 prevents the state of Kansas from prosecuting workers utilizing someone else's social security number as identity fraud.

17-year-old undocumented Guatemalan Maya woman, was pregnant with her first child when we first met her in Heartlandville's community health clinic. Her care was transferred to Heartlandville's private clinic because she needed specialized OB-GYN services as her pregnancy developed. The community clinic had an uncertified Spanish language interpreter and a pay scale for uninsured patients; the private clinic, on the other hand, charged $100 for weekly prenatal appointments and did not have in-person interpreters at the time of the observation in the summer of 2018. Estefanía asked for our help interpreting during an appointment at the private clinic, explaining that in her previous appointment she had difficulties communicating with the health providers. Indigenous women, particularly those who do not speak Spanish or English, face added language barriers when seeking care given that clinics rarely provide Indigenous language interpretation services in new destinations (Semple 2014). For clinics with shrinking budgets, Indigenous language interpretation is not a priority.

Unlike Estefanía, Ileana, also an undocumented Guatemalan Maya woman in Heartlandville, delayed seeking prenatal care and did not go to a medical facility until she was ready to give birth. As we ate popsicles in her living room, Ileana explained that she could not afford the cost of weekly appointments at the private clinic; in addition to the clinic fee, she had to pay for rides and for the interpreter's fee (the clinic did not have an interpreter). Similar to the *raiteros* (those who charge for car rides), English–Spanish bilingual co-ethnics, most of whom are mestiza/non-Indigenous women, would charge Indigenous women for interpreting services. Thus, Indigenous women seeking care in rural Kansas encounter multiple barriers—out-of-pocket payments, lack of health insurance, and limited transportation and interpretation resources—all of which aggravate their conditions and those of their family members. Estefanía's and Ileana's cases illustrate how the legal violence of the enforcement regime and restrictive access policies manifest in women's health through layers of exploitation of Indigenous women, including from mestizo Latinas/os.

Immigrant women in urban areas also reported delaying care for lack of health insurance. For Rita, a 22-year-old Salvadoran immigrant woman, the biggest struggle of living undocumented is "not being able to go to the doctor," and even when receiving care, she said, "the care is not that good." After delaying care due to lack of health insurance and the high costs of private care, to the point that her body turned yellow and she was in unbearable pain, Rita finally went to a community health clinic. She noted, "They would just give me an injection and charge me $50 and that is it." After months of continuous abdominal pain, she found another community clinic where she was diagnosed with kidney stones. In the fall of 2016, Rita shared, "They put me on a waiting list for surgery." A year after the interview, Rita remained on the waiting list. Costs and access intersect with immigration status given that undocumented immigrants are excluded from programs such as KanCare and the Affordable Care Act; private insurance options are unaffordable. Thus, for Latina immigrants in a place like Kansas, the following factors work in cumulative fashion to narrow their access to care: (a) a health care infrastructure that excludes them formally, (b) a lack of affordable community clinics and resources that exist in other immigrant destinations, and (c) an amplified immigration enforcement. Women end up enmeshed in toxic ties (Del Real 2019) as they pay co-ethnics to provide vital services that are scarce

in the Kansas context, such as interpreters and transportation, that medical facilities do not provide. As they delay formal care, their health suffers and deteriorates.

Alternatives to Formal Care

With blocked access to formal care, women find alternatives by turning to other women and co-ethnics for resources and self-medication (see Menjívar 2002). These medications, including traditional remedies and prescription drugs such as antibiotics or penicillin, are taken without supervision and are "prescribed" by family members, coworkers, neighbors, friends, and acquaintances (see Menjívar 2002). Ofelia, a 37-year-old undocumented Guatemalan Maya woman in Heartlandville, exemplifies this point.

During visits to Ofelia's home starting in 2016, she often mentions recurrent headaches, acute pain in her lower abdomen and back, and difficulty breathing at night. During one of our visits, Ofelia's pain was so severe that her husband asked us for help making an appointment with a doctor because they do not speak English and medical facilities lack interpreters. Gómez Cervantes accompanied Ofelia to her appointment at the local hospital and helped interpret during the visit; Gómez Cervantes observed that the physician only prescribed Ofelia over-the-counter medication after asking if Ofelia had health insurance (she did not). Ofelia had to pay out of pocket; it cost her over $300 for the appointment and a blood test, and she remained in pain. During another visit with Ofelia and her family in the summer of 2018, Ofelia said the pain on her lower abdomen had worsened. She stated, "It was a week of pain…. I couldn't do anything." Ofelia, however, did not want to go back to the doctor or hospital; she explained, "I don't have money, they send me lots of bills." She added, "Two days in bed, I felt that I was going to die." She turned to her sister-in-law, a known *sobadora* (massage healer), for help. After a week of massages, for which she paid her sister-in-law, she felt better, but the pain remained. The *sobadora* diagnosed Ofelia with "drop of the womb" due to spending long periods of time standing when Ofelia worked in Guatemala; she recommended Ofelia continue the weekly massages, thus ensuring that she would continue to pay. Months later, Ofelia and her sister-in-law parted ways after a serious argument. The *sobadora* sister-in-law denied future services to Ofelia, leaving Ofelia in severe pain and without access to care. Last time we saw Ofelia in July 2019, she had a phone consultation with a medical provider in her Guatemalan hometown to address her ailments. Ofelia sent $200 to her sister in Guatemala to purchase and mail her the medicine that the Guatemalan provider prescribed. Her brother-in-law, who also lives in Heartlandville, administered the seven penicillin injections that arrived from Guatemala. Ofelia said that after the injections she could breathe better at night and the abdominal pain had subsided. However, she now had severe sores in the places where she had been injected because her brother-in-law had no medical training to administer the injections.

Like many Latina/o immigrants who rely on traditional healing practices and medicines from co-ethnics (González-Vázquez, Pelcastre-Villafuerte, and Taboada 2016; Menjívar 2002), Ofelia also turned to these options given her lack of health insurance, legal status, and extremely limited health care options in Kansas. Thus, immigrant women relied on co-ethnics to access medicines (including antibiotics and penicillin) bought in ethnic stores or ordered from their countries of origin (see Menjívar 2002). On their face, these practices

may signal the strength of women's social ties. However, given the scarcity and fear in which women live, these ties become exploitative and are a form of control. Women thus become dependent on others for their health care while being unable to access formal medical providers in places such as rural Kansas. The interior enforcement regime amplifies women's vulnerability in a context of scarce institutional resources, placing additional constraints and pushing these women to rely more heavily on potentially exploitative informal ties for the procurement of health care.

DISCUSSION

Using the legal violence lens, we unearth the deleterious consequences of a system of laws and policies on Latina immigrants' health in a geographical context with limited health care infrastructure. Based on indepth interviews and ethnographic research in rural and urban Kansas, we inductively identified the intersection of the amplified apparatus of interior immigration enforcement with the specificities of place and gender, demonstrating how the legal violence of laws and enforcement practices manifest in Latina immigrants' health and interpersonal lives. First, today's ramped-up interior and localized enforcement of policies in place for three decades (Abrego et al. 2017) create a perpetual state of fear of deportability (De Genova 2002), family separation, and contact with social service institutions. Fear produces chronic stress, harming Latina immigrants' health, constraining their mobility, and limiting their presence in public spaces and contact with health care providers, thus, undermining women's previously held roles as bridges between their families and institutions (Simmons et al. 2020). Second, public health, immigration policies, and state-level laws that formally exclude undocumented immigrants and their family members from health insurance make health care inaccessible for immigrants in vulnerable legal statuses. Thus, Latina immigrants delay or forgo care altogether, with potential short- and long-term negative consequences for their health. Third, Kansas's poor health care infrastructure for immigrants, including lack of language interpretation or payment options for uninsured patients, heightened in rural areas, redirects women away from formal health care institutions to alternative, informal forms of care. Relying on social ties where resources are distributed unequally (Menjívar 2000) can breed exploitation within immigrant networks, further solidifying ethnoracial and immigration status divides. Legal violence not only creates suffering for this population in general but also facilitates the conditions for the exploitation of Indigenous immigrants by mestizo/non-Indigenous Latinas/os who have relatively more access to rights and resources, further hindering undocumented Indigenous women's health (Gómez Cervantes 2019). Legal violence harms Latina immigrants' health directly and cements intraethnic discrimination, hampering interpersonal relationships and integration potential in their Kansas communities.

The COVID-19 pandemic has exacerbated already vulnerable conditions for Latina immigrants' health, especially in rural communities with limited health care resources. Through follow-up phone conversations in May 2020, Nina, introduced earlier, said that several co-ethnics in Heartlandville had contracted COVID-19 and worried about what to do. Like Nina, immigrants in Heartlandville were unsure whether local health facilities would provide health services to them because they lack health insurance and income to cover the costs of hospitalization. Regardless, due to a growing number of infections, Nina went to

the local hospital to be tested. She explained, “First they told me no, and then they told me yes, and then they told me no.” Whether this exchange was miscommunication due to limited interpretation services, Nina was left wondering if she was infected. Crying over the phone, she shared that she was afraid of infecting her children and worried about cooking for them, feeding or bathing them, or carrying out other caring parental responsibilities. An amplified fear of deportation and of contacting medical institutions and lack of health insurance, all made possible by legal violence, intensify an already menacing health crisis for Latina immigrant women.

Our findings engage different strands of the immigrant health scholarship. Theories of immigrant selectivity in health (see Feliciano 2020), for instance, highlight immigrants’ social positioning and access to resources before migration to understand health outcomes postmigration. Instead, we focus on the receiving context, on immigration policies and their enforcement, as these impact immigrants’ health and access to care (Kline 2017; Rabin 2018; Van Natta 2019; Vargas et al. 2017). Our research aligns with the social determinants of immigrants’ health (SDH) scholarship, which emphasizes the effects of immigration status on health disparities (Asad and Clair 2018; Castañeda et al. 2014; Vargas et al. 2017). SDH scholars highlight legal status as the gatekeeper to protections and health care services. Although some studies in this vein find that immigrants’ disadvantaged status may not be harmful to their health (Hamilton, Hale, and Savinar 2019), we find that the many barriers and institutional discrimination that are byproducts of immigration status create stress that hinders women’s physical and mental health while at the same time blocking their access to treatment. Our findings lend support to the SDH scholarship that has shown immigration legal status as negatively impacting immigrants’ mental and physical health (Cabral and Cuevas 2020; Kline and Castañeda 2020; Torres et al. 2018). Additionally, as Asad and Clair (2018) demonstrated, given the racialization of legal status, Latino immigrants who fit stereotypes of illegality are particularly vulnerable to these harmful conditions.

We contribute the legal violence lens to SDH work to uncover the structural and symbolic violence reproduced and embedded in place-specific policies and local infrastructure. Thus, our study also adds to the scholarship that centers place in immigrants’ health outcomes (Acevedo-Garcia and Almeida 2012). As funding for rural health care across the United States continues to decline, rural areas see poorer health and diminished quality of care. And rural destinations, with jobs in food processing, attract immigrant labor. As we show, place matters; immigrants’ health in those regions suffers.

Furthermore, whereas the scholarship that examines immigrants’ access to institutions pointed to women’s role as central (Abrego and Shchmalzbauer 2018; Menjívar 2000), we find that as Latina immigrants are pushed away from formal institutions, either through fear or policy, they seek care in their informal ties (Bickham Mendez 2020). However, turning to informal ties presents a complex story. Immigrant ties can become exploitative in contexts of legal violence and racial hierarchies (Del Real 2019; Menjívar 2000), reshaping interpersonal relationships and adding a layer of harm to immigrant women’s mental and physical health.

Some of the limitations in our study can become fruitful avenues for future research. This article is based on ethnographic fieldwork; thus, we did not set out to measure or test for the health outcomes of a specific piece of legislation. We detected these effects in our recorded observations. However, our findings support research highlighting the chronic stress of deportability (Ayón 2018; García 2018; Lopez et al. 2018; Novak et al. 2017). As our results indicate, intersections between immigration status and ethnoracial background are critical, especially in the context of a pandemic when these inequalities are amplified. Thus, we urge scholars to dedicate research to the experiences of undocumented and semilegal Indigenous and Afro-Latinas to attend to the internal heterogeneity of Latina/o immigrants' health.

A context of intensified fear in an amplified anti-immigrant sociopolitical context can directly and indirectly harm Latina immigrants' health and weaken their institutional links and informal ties. Immigration laws and the enforcement context today coupled with laws that restrict access to social services in a context of an already weak health care infrastructure constitute legal violence as this cumulatively harmful predicament impacts Latina immigrant's health in the short and long term. The health consequences of this legal violence are undoubtedly augmented under extraneous circumstances such as the COVID-19 pandemic.

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