COVID-19 and Immigrants' Access to Sexual and Reproductive Health Services in the United States

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In recent months, some of the impacts of the coronavirus disease 2019 (COVID-19) on sexual and reproductive health (SRH) care needs, decisions and access across the globe have become evident.[1,2] In the United States, the Trump administration has unjustly blamed migrants for the COVID-19 pandemic, exploiting this public health crisis to further its long-standing xenophobic agenda and prompting a de facto shutdown of the U.S. immigration system. Yet immigrant communities—particularly those of color—are among the hardest hit by this virus, largely as a result of intersecting inequities based on migration status, race and socioeconomic position, all of which contribute to unequal access to quality health care.[3] The perilous health impact of COVID-19 on immigrants in the country has been highlighted by the fact that Latinx individuals, one-third of whom are immigrants,[4] are becoming infected and hospitalized at substantially higher rates than are U.S.-born White individuals.[5]

Noticeably absent from the public discussion is an intersectional consideration of how the public health response to the pandemic may affect access to SRH care for immigrants in the United States. Immigrants represent 14% (44.4 million people) of the U.S. population and account for 17% of women of reproductive age and 23% of births.[6] Although immigrants' SRH is not currently well documented, many immigrant groups face intractable social, economic and political barriers to obtaining SRH care,[7] and are now being largely overlooked in COVID-19 relief efforts. Public health experts, policymakers and advocates need to anticipate and mitigate the SRH risks of COVID-19 and the potential consequences for immigrants, whose SRH needs are often invisible even in nonpandemic times. The simultaneous exclusion of immigrants from the COVID-19 response and from SRH care in the United States violates a key public health commitment to leaving no one—especially those who are most marginalized—behind.

Social Contexts and Determinants of SRH Care

The context of immigrants' health care in the United States is shaped by multilevel factors, including a patchwork of policies and practices that condition access to health care on issues such as documentation and citizenship status, English proficiency and income.[8,9] The COVID-19 pandemic has exacerbated existing discrimination and exclusions in our social and health care systems, which are already fragmented and difficult to navigate, and often fail to account for immigrants' SRH needs and experiences.

•***Exclusion from public health programs.*** Even under nonpandemic circumstances, many noncitizens and their families are unable to obtain affordable SRH care. Immigrants have limited access to public health insurance programs, largely because of rules that prohibit enrollment on the basis of their legal status or duration of residence in the United States.[10] These programs provide essential coverage for SRH care, such as family planning services, pregnancy-related care, and STI and reproductive cancer screening. Among women of reproductive age, the proportion of noncitizens who are uninsured is nearly three times as high as the corresponding proportion of their naturalized or U.S.-born counterparts, and this disparity is amplified among low-income individuals.[11] Aside from some state-level exceptions, undocumented immigrants have essentially no access to public health care programs.[12] Similarly, participants in the Deferred Action for Childhood Arrivals (DACA) program—all of whom are of reproductive age—are barred from nearly all public coverage. During this pandemic, political efforts to repeal the DACA program further threaten the rights of many young immigrants (although a recent Supreme Court decision will protect the program for now).[13] Furthermore, publicly funded family planning centers often serve as the main source of primary care for low-income and uninsured immigrant women,[14] and with the 2019 "domestic gag rule" restrictions to the Title X program,* the capacity of publicly funded family planning providers to meet people's contraceptive needs has been reduced by half and the ability to serve their patients, including immigrants, has been seriously threatened.[15] In this time of heightened health risk and social and economic stress, and as these bans on health coverage persist, we can expect that access to comprehensive SRH services will continue to be restricted for immigrants and their families.

•***Employment, residence and xenophobia.*** In the context of the COVID-19 pandemic, restrictions on health coverage can intersect with employment to make some immigrant groups systematically more vulnerable to obstacles to SRH care. For example, noncitizen immigrants represent more than half of workers in the industries most immediately devastated by mass lay-offs (e.g., accommodation and food services, building services). However, because of their documentation status, these immigrant workers have limited or no access to federal COVID-19 relief support, including unemployment

*The "domestic gag rule," which prohibits abortion referrals and requires coercive counseling standards for pregnant patients, has effectively barred clinics from providing abortions using nonfederal funds. As a result, many providers have left the Title X network.

benefits and existing public insurance programs.[16] In the absence of adequate income and health coverage, obtaining needed SRH services will be increasingly difficult.

Immigrants' access to comprehensive health care, especially SRH services, is also dependent on residence and local health systems.[17] A growing share of recent, noncitizen immigrants reside in "new-destination" locales, including suburban and rural areas across the central and southern regions of the country (e.g., South Carolina, Alabama and Kentucky).[9] These locations are less likely than others to have strong and effective health and human services, as well as culturally and linguistically diverse health care providers—all factors that have been documented to constrain SRH service use, especially among recent immigrants or those with limited English proficiency.[18] These areas may also face chronic physician shortages, particularly for obstetrician-gynecologists and reproductive health service providers.[19] The added health system burdens of COVID-19 will likely only increase the challenges that immigrants in these areas encounter in their efforts to obtain crucial SRH services.

Finally, the social environment of xenophobia and racism in the United States undoubtedly contributes to immigrant groups' reduced access to and receipt of SRH care. Xenophobia has been described as an insidious byproduct of the pandemic, associated with politically motivated attempts to blame and stigmatize immigrant groups for the crisis. Moreover, as immigration raids continue even in the midst of this public health emergency, such conditions could impede immigrants from seeking SRH care.[20] In this historic moment of global crisis, we can be certain that exclusionary practices and policies will only increase many immigrants' fear of obtaining needed SRH services.

Immigration Policy and Enforcement

Existing exclusionary migration policies already jeopardize the health and safety of many immigrants and their families in the United States by impacting access to public benefits, limiting SRH care at the country's borders and exacerbating already inhumane conditions in immigration detention centers. These policies have escalated during the COVID-19 pandemic and systematically curb or deny many immigrants' access to SRH care.

•***"Public charge" rule.*** For those immigrants who are lawfully present and those who live in mixed-status households, recent changes to the "public charge" rule* have further threatened access to obtaining SRH care. Although only a small proportion of immigrants will be affected by this rule, advocates fear that millions of noncitizens may drop their Medicaid coverage or not apply for coverage for fear of endangering their chances to stay in the country.[21] Medicaid benefits received by pregnant women are not subject to this rule, but there are no exceptions for other reproductive health services, such as family planning and STI care under full-benefit Medicaid coverage, state Medicaid family planning expansion programs, or Medicaid's breast and cervical cancer treatment program. As a result, a chilling effect—already documented across a range of preventive services—will likely extend its reach to SRH care.[22] Immigrants and their families who fear seeking SRH services because of this rule may continue to forgo obtaining any care, for both COVID-19 treatment and their basic SRH needs.

•***"Remain in Mexico" policy.*** For refugees and asylum seekers, access to basic health care, including vital SRH services, is essentially nonexistent.[23] Indeed, the Trump administration's "Remain in Mexico" policy (known as the Migration Protection Protocols) has forced more than 2,000 asylum seekers to live in camps at the U.S.–Mexico border as they await humanitarian relief.[24] Even prior to the pandemic-related shutdown of the U.S. asylum process, pregnant asylum seekers were being prevented from entering the country for their court dates and, in some cases, newborns were being separated from their mothers after births in U.S. custody. A COVID-19 outbreak in these border camps could further destabilize the health system for migrants who already face serious health vulnerabilities.

•***Immigration detention.*** Immigration enforcement through detention centers also continues to be a threat to public health and SRH care. For example, in 2017 and 2018, some 28 women had miscarriages in U.S. Immigration and Customs Enforcement custody after being shackled† across the arms, legs and stomach,[25] and reports suggest that detained pregnant people are being shackled during labor and immediately postpartum.[26] While the effects of COVID-19 on pregnant individuals are not yet known,[27] the inhumane standards of SRH care in detention are well established.[28,29] Given these demonstrated abuses of human rights, including a complete lack of SRH services, the decarceration of all asylum seekers in detention is the only just way forward both now and after the pandemic abates.

Eroding Access to SRH Care

Amid a health care, social and policy environment that appears to systematically undermine and ignore the needs of many immigrant groups under nonpandemic conditions, we expect that the COVID-19 outbreak will further erode these groups' access to SRH care and rights. As the nation's health care systems prioritize responses to the COVID-19

*The "public charge" rule has long been part of harmful U.S. immigration policy. Originally, it designated an immigrant as a "public charge" (and thus ineligible for entry into the United States or permanent legal residency) if that person was currently or expected to be reliant on governmental cash assistance. A recent update to the regulation now counts many noncash benefits, including Medicaid, against immigrants, making it even more difficult for those with low or moderate incomes to enter or stay in the country. The Department of Homeland Security acknowledges the health-damaging effects of this rule, noting on its website that it will not consider seeking preventive services or treatment for COVID-19 as part of their public charge analysis. This means that immigrant families should seek the care they need for COVID-19 treatment.

†Shackling is an inhumane and dangerous practice that has been universally condemned by medical experts, including the American Medical Association and the American College of Obstetricians and Gynecologists.

caseload, publicly funded family planning providers may be tapped to offer pandemic-related care.[30] This disruption in services and further diversion of resources away from essential SRH care could interrupt many immigrants' main source of medical care and constrain their access to SRH services, especially among individuals with limited health coverage. Further, because some states have exploited the coronavirus crisis to restrict access to abortion services, delays in receiving abortion care will become more common.[31] Individuals in these states may be forced to continue unwanted pregnancies or obtain later-gestation abortions, which can impose additional health risks and lead to increased costs. To avoid postponing their abortions, many individuals may need to travel farther, manage time-off and child care logistics, and potentially navigate stay-at-home orders.[32] For example, in Texas, where one in six residents is foreign-born and 60% of these individuals are noncitizens, the threat of abortion bans and the chaos and confusion they have introduced during this pandemic pose serious and real barriers to care for many immigrants.[33]

Now more than ever, we cannot afford to overlook the immigration dimensions of obtaining SRH services. As societal responses to COVID-19—such as extensive layoffs and unemployment, disruptions and destabilizations in health care, and the diversion of resources on a massive scale—spread and intersect with the far-reaching impacts of xenophobic rhetoric, unjust immigration policies and attacks on reproductive rights, immigrants may be left with even fewer opportunities to access and afford comprehensive and compassionate SRH care. As a result, we may see dramatic and harmful increases in stress among immigrant families, with consequences for their maternal, sexual and reproductive health.[34] COVID-19 has laid bare existing health challenges for many immigrant groups and exacerbated long-standing inequities in care. Increasing insecurity and xenophobia, growing health care barriers, exclusionary migration policies and the secondary effects of the COVID-19 response all interact to severely limit access to SRH care and rights for many immigrants.

Recommendations

Moving forward, we must commit to centering the SRH needs and rights of immigrants during the COVID-19 response and more broadly. Crucial health care services, such as SRH care, must remain accessible to all populations, including immigrants, even when resources from an already overextended health system are redirected for the pandemic response. Furthermore, the demonstrated intersection between immigration policies, health care and reproductive rights demands that these issues be addressed together.[21]

Policymakers and advocates have a central role in prioritizing immigrants' SRH and human rights, even while working to control and end the pandemic. For example, the U.S. Congress should repeal anti-immigrant policies that threaten the SRH of immigrant communities and enact legislation such as the Health Equity and Access under the Law (HEAL) for Immigrant Women and Families Act, which would expand immigrants' insurance eligibility and access to SRH services.[35] Further, all asylum seekers should be provided access to SRH care. Now and after the pandemic has passed, we must ensure that all people—regardless of immigration status—are able to access comprehensive maternal, reproductive and sexual health services safely, freely and with dignity.

Public health solutions to the COVID-19 pandemic—clinical services and programs, surveillance and evaluation research, advocacy and policy—must address the health and needs of immigrants. Additional resources must be directed to—not diverted from—the SRH workforce (e.g., clinicians, public health practitioners and policymakers) to meet the needs of all U.S. communities. Critical preventive SRH services, including abortion care, contraceptive care and supplies, pregnancy-related care, and STI screening and treatment, will alleviate health care demand and the potential overburdening of systems down the line. In addition, advocates and policymakers must continue to fight the exploitation of the COVID-19 crisis to further a politically motivated agenda that targets immigrants and restricts access to essential SRH services, particularly abortion care.

These efforts to advance the sexual and reproductive health and rights of immigrants must also directly engage immigrant communities. A community-driven approach will ensure that the needs, priorities and experiences of those who are most impacted inform and anchor any vision for change; that evidence is rapidly translated into action for maximum health care system, policy and community impact; and that clear, consistent and updated public health information is developed and disseminated by the collective expertise of practitioners, advocates and communities.

In any pandemic, our health is only as good as that of our neighbors. It is time we recognize that immigrants are not only our neighbors, but an essential and integral part of our increasingly diverse communities and country. Keeping our communities, our families and ourselves safe and healthy is a basic human right that should be supported by policies and programs at every level, for immigrants and U.S.-born individuals alike. A unified approach to sexual and reproductive health for all—regardless of citizenship, national origin, race, ethnicity or wealth—is the only inclusive response to the COVID-19 pandemic that will safeguard the health and well-being of all individuals.

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