ORIGINAL ARTICLE

Reducing the Impact of Immigration Enforcement Policies to Ensure the Health of North Carolinians:
Statewide Community-Level Recommendations

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BACKGROUND Research indicates that fear of immigration enforcement among Latinos in North Carolina results in limited access to and utilization of health services and negative health consequences. This project developed recommendations to mitigate the public health impact of immigration enforcement policies in North Carolina.

METHODS Our community-based participatory research partnership conducted 6 Spanish-language report-backs (an approach to sharing, validating, and interpreting data) and 3 bilingual forums with community members and public health leaders throughout North Carolina. The goals of these events were to discuss the impact of immigration enforcement on Latino health and develop recommendations to increase health services access and utilization. Findings from the report-backs and forums were analyzed using grounded theory to identify and refine common recommendations.

RESULTS A total of 344 people participated in the report-backs and forums. Eight recommendations emerged: increase knowledge among Latinos about local health services; build capacity to promote policy changes; implement system-level changes among organizations providing health services; train lay health advisors to help community members navigate systems; share Latinos' experiences with policy makers; reduce transportation barriers; increase schools' support of Latino families; and increase collaboration among community members, organizations, health care providers, and academic researchers.

LIMITATIONS Representatives from 16 of 100 North Carolina counties participated. These 16 counties represent geographically diverse regions, and many of these counties have large Latino populations.

CONCLUSIONS Immigration enforcement is a public health issue. Participants proposed developing new partnerships, identifying strategies, and implementing action steps for carrying out recommendations to reduce negative health outcomes among Latinos in North Carolina.

North Carolina has become "a new Latino settlement state," with the 6th-fastest-growing Latino population in the country [1, 2]. The North Carolina Latino population increased by 111% between 2000 and 2010 and continues to grow [1, 3].

Latinos in North Carolina and throughout the United States face a range of health disparities. Latinos bear a disproportionate burden of diseases such as diabetes, cancer (eg, stomach and cervical cancer), liver disease, obesity, HIV infection, and other sexually transmitted infections [4-7]. Low levels of access to and utilization of both preventive and acute health care services contribute to negative health outcomes [8-10]. Twenty-seven percent of Latino adults in the United States lack a usual health care provider, making them twice as likely as non-Latino blacks and 3 times as likely as non-Latino whites to not have a usual health care provider [4]. Access is even lower for those living in areas with few other Latinos (eg, new settlement states like North Carolina) rather than in major Latino centers [9].

Numerous barriers limit access to and utilization of health services among Latinos, including limited insurance coverage, lack of bilingual/bicultural services, limited transportation options, and limited knowledge of available health services [8, 9, 11].

Research indicates that US immigration enforcement policies also affect Latinos' health access. Latinos in North Carolina have reported that enforcement policies compound existing distrust of services, condone racism, promote racial profiling, create practical barriers to accessing and utilizing health services, promote reliance on nonmedical sources of care, and negatively impact physical and mental health for both adults and children [12]. Other studies across the United States have found that fears related to potential deportation, lack of required forms of documentation, interactions with law enforcement, and racial profiling are associated with reduced health service utilization and health status among Latinos [13-18]. Thus, Latinos may fail to complete sequences of care [14, 15, 19], withhold informa-

tion from health care providers [14], and/or delay preventive health care measures or treatment for communicable diseases, which can affect both individual and community health [13, 16, 20]. Latinos also tend to experience high levels of stress related to immigration, leading to mental health outcomes such as depression, anxiety, and post-traumatic stress disorder [13, 15, 21].

Section 287(g) of the Immigration and Nationality Act and the Secure Communities program are examples of immigration enforcement policies that have impacted health services access and utilization among Latinos. Section 287(g) allows Immigration and Customs Enforcement (ICE) to enter into agreements that allow local law enforcement officials to perform immigration enforcement activities, including initiation of deportation proceedings [22, 23]. By 2010, 8 counties and 1 city in North Carolina had implemented 287(g) agreements [22, 24]. The program's original intent was to target and remove undocumented immigrants convicted of serious or violent crimes [22]. However, over 80% of immigrants arrested through the program in North Carolina have been charged with misdemeanors, and there is evidence of ethnic/racial profiling associated with Section 287(g) [24-26]. In 2012, ICE began to phase out Section 287(g) agreements in favor of the Secure Communities program; as of November 2015, however, 5 jurisdictions in North Carolina still had active 287(g) contracts [23, 27].

Secure Communities became mandatory for all localities in all states in 2013. Secure Communities required that law enforcement officials send fingerprints of all arrested individuals processed in local jails so that these fingerprints could be checked against ICE and Federal Bureau of Investigation criminal databases. If ICE determined that an individual was potentially deportable, ICE could then take enforcement action [28]. In 2014, Secure Communities was replaced by the Priority Enforcement Program, which also involves collaboration between local law enforcement officials and ICE [29].

Implementation of Section 287(g) and Secure Communities has been shaped by eligibility requirements for state-issued driver's licenses. In 2006, the North Carolina Department of Motor Vehicles stopped issuing licenses to individuals without Social Security numbers; as a result, many immigrant Latinos have been unable to apply for or renew their driver's licenses [30]. Under Section 287(g) and Secure Communities, traffic violations have been the most common charge against arrested immigrants, and the number of immigrants arrested for driving without a license has increased [31]. Given the threat of being stopped by local police who may be involved in immigration enforcement, many Latinos in North Carolina are reluctant to drive, even for the purpose of seeking needed health services [12].

Objective

This study was conducted by our community-based participatory research partnership comprised of representatives from public health departments, community-based organizations (CBOs), academic institutions, and the local Latino community [32]. We sought to develop recommendations to mitigate the public health impact of immigration enforcement policies.

Methods

We used qualitative methods because they provide the opportunity to investigate participant insights and reactions more fully than do quantitative methodologies with predefined response options. Qualitative methods also allow new areas of inquiry to emerge and can reveal perspectives that researchers may not be able to foresee [33-35]. We conducted a series of community report-backs and forums using an empowerment theory-based guided method developed by our partnership [36, 37]. This method involved presenting participants with locally collected data about immigration enforcement and public health, inviting them to respond to these data through a sequence of questions leading from the concrete to the action-oriented, and developing potential recommendations to increase access to and utilization of health services.

This method also ensured the validity of our findings. The internal validity, or credibility, of qualitative research is judged by whether findings show logical relationships to one another, are grounded in rich narrative data, and are considered accurate by participants [38]. The group interactions involved in the report-backs and forums encouraged participants to talk to one another, ask questions, and comment on one another's experiences and perspectives, leading to more nuanced results [39, 40]. Furthermore, the iterative process of holding multiple empowerment-based discussions over time with diverse groups of participants helped refine recommendations and confirm that recommendations correctly reflected participants' ideas.

Data collection

Community report-backs. Between November 2013 and April 2014, we conducted 6 community report-backs in Alamance, Buncombe, Chatham, Gaston, Mecklenburg, and Orange counties. A report-back is an approach sometimes used in community-engaged research in which researchers present data to members of the communities from which these data were collected and then solicit feedback so that community members can validate and interpret these data. To recruit participants for each report-back, we worked with local Latino-serving CBOs and churches that were familiar with and well known within that particular county, and we advertised using Spanish and English flyers and word of mouth. Each report-back lasted approximately 2 hours and was conducted in Spanish. We shared data from a previous study by our partnership, including both quantitative data demonstrating that Latina mothers in North Carolina seek prenatal care later and have inadequate care compared to non-Latina mothers and qualitative data describing pro-

found fear among Latinos in North Carolina about accessing and utilizing services [12]. We facilitated discussions about addressing these issues by asking participants to respond to 2 main questions: "Which of these findings seem most relevant to you?" and "What can we do about this situation?" Note takers documented the discussions.

Statewide and regional forums. We also conducted 1 statewide forum and 2 regional forums. Each forum was planned in partnership with representatives from health departments, Latino-serving CBOs, advocacy groups, churches, medical clinics, and academic institutions. To recruit forum participants, we worked with these partners to develop a list of public health and community leaders and then invited these leaders to participate via e-mail. The forums each lasted a half-day and were bilingual, with simultaneous Spanish-English interpretation. The statewide forum took place in November 2012 in Raleigh. The regional forums took place in April 2014 in Charlotte and in August 2014 in Burlington.

At the forums, we presented local data from our previous study about the impact of immigration enforcement on access to and utilization of health services [12], and participants took part in a facilitated discussion using an expanded version of the process used in the report-backs (see Figure 1) [36, 37]. In a large group, participants shared initial reactions to the presented data and then brainstormed and prioritized potential recommendations. The participants then divided into smaller groups, developed next steps related to one of the identified recommendations, and then presented back to the larger group. When formulating recommendations and action steps, participants were encouraged to consider both importance to public health and feasibility within their regions. We took detailed notes on the discussions.

Data analysis

We analyzed notes from the report-backs and forums using constant comparison, an approach to grounded theory. This analytic method captures a wide array of experiences and builds understanding inductively to generate recommendations that are based on empirical data, rather than beginning the inquiry process with a preconceived notion of anticipated recommendations [33]. Representatives from academic and CBO partners read and reread the notes indi-

vidually, coding and organizing the data into primary recommendations that were common throughout the report-backs and forums. We then convened to compare and refine the recommendations that emerged. We also identified the key next steps that participants highlighted for each recommendation. A consensus approach was used and discrepancies were resolved through discussion, which further contributed to the validity of the findings. In terms of recommendations, there was a high degree of reliability and consistency across the report-backs and forums and among partnership members who analyzed the data.

Results

Description of participants

In total, 115 people representing 9 North Carolina counties participated in the report-backs (see Table 1), with a mean of 19 participants per report-back. Nearly half of all report-back participants were community members (n = 51) and many others (n = 32) represented organizations that provide services to Latinos.

For the forums, 229 people representing 14 counties participated. The number of participants at each forum ranged from 72 to 84. Forum participants included county- and state-level public health personnel (n = 32); representatives from other service providers including health care organizations, social service organizations, schools, churches, advocacy groups, and foundations (n = 140); community members (n = 11); representatives from academic institutions (n = 40); and Spanish-language media representatives (n = 6).

Recommendations

Participants developed 8 primary recommendations to reduce the negative impact of immigration enforcement policies on health access for Latinos (see Table 2).

The first recommendation was to increase knowledge within the Latino community about local health service providers. Participants recommended sharing culturally congruent information about processes for accessing health services to build Latino community members' knowledge of and trust in health systems. Participants emphasized raising awareness about confidentiality standards that protect patients from being reported to immigration enforcement.
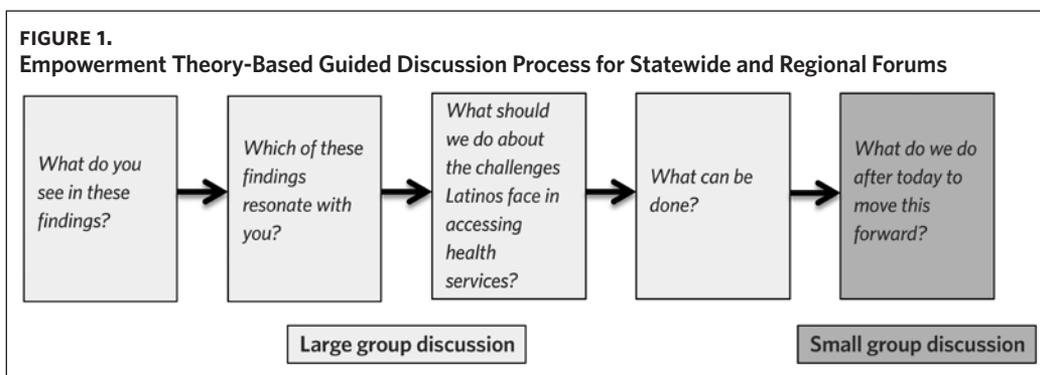
FIGURE 1.

Empowerment Theory-Based Guided Discussion Process for Statewide and Regional Forums

TABLE 1.
Characteristics of Participants at Report-Backs and Forums

Event	Total participants	Public health personnel[a]	Other service providers[b]	Community members	Academic representatives[c]	Media representatives	Counties represented
			Community report-backs				
Alamance County report-back	33	0	5	23	5	0	1 (Alamance)
Chatham County report-back	16	2	4	6	4	0	2 (Chatham, Orange)
Orange County report-back	22	1	6	11	4	0	3 (Chatham, Orange, Wake)
Mecklenburg County report-back	22	1	8	6	7	0	1 (Mecklenburg)
Buncombe County report-back	15	1	6	5	3	0	3 (Buncombe, Henderson, Swain)
Gaston County report-back	7	1	3	0	3	0	2 (Gaston, Mecklenburg)
Total[d]	115	6	32	51	26	0	9
			Statewide and regional forums				
Statewide forum	84	18	40	3	21	2	12 (Alamance, Buncombe, Cabarrus, Catawba, Chatham, Durham, Forsyth, Guilford, Harnett, Mecklenburg, Orange, Wake)
Greater Charlotte/ Mecklenburg County regional forum	72	7	49	7	7	2	5 (Catawba, Forsyth, Gaston, Mecklenburg, Wake)
Central Piedmont regional forum	73	7	51	1	12	2	8 (Alamance, Chatham, Durham, Forsyth, Guilford, Orange, Rockingham, Wake)
Total[d]	229	32	140	11	40	6	14
Overall total (report-backs and forums combined)[d]	344	38	172	62	66	6	16

[a]Includes representatives from county public health departments as well as the North Carolina Department of Health and Human Services.
[b]Includes health care organizations, social service organizations, schools, churches, advocacy groups, police departments, and foundations, as well as representatives from El Pueblo, Inc.
[c]Includes representatives from Wake Forest School of Medicine and other universities.
[d]Some participants attended more than one report-back and/or forum; therefore some participants may be included more than once in the total count.

They also emphasized clarifying eligibility and identification requirements for obtaining services in various health care settings, including pharmacies.

The second recommendation was to train and support Latino community members and organizations to advocate for policies that reduce the impact of immigration enforcement on access to services. Participants stressed the importance of building capacity among community members and Latino-serving CBOs to promote solutions that reduce health access barriers at the local and state levels.

A third recommendation was to implement system-level changes to increase access to care for Latino community members. Participants recommended training frontline, administrative, and clinical staff at health care facilities, as well as students in health professional schools. This training would increase health care professionals' understanding of the impact that immigration enforcement policies have on Latinos' eligibility for and access to health care. Participants also recommended that providers identify funding sources that support models of care that address transportation barriers (eg, home visits and mobile health) and that facilitate referrals to specialist care, particularly prenatal and mental health services.

A fourth recommendation was to partner with or train lay health advisors (LHAs) to share information with the Latino community and help community members navigate systems and processes for accessing services. Participants emphasized LHAs as an effective strategy to connect community members with health services. Participants suggested that health care providers and CBOs identify community leaders and train them on health access.

A fifth recommendation was to share community members' experiences related to immigration and the impact of enforcement policies with policy makers, decision makers, and those who interpret and enforce policies. Participants expressed a need to advocate for policy changes based on data about Latino health access and immigration enforcement. Participants proposed meeting with elected officials and holding community forums or town hall meetings to engage policy makers and decision makers. Participants

TABLE 2.
Actions Recommended by Report-Back and Forum Participants

1. Increase knowledge within the Latino community about local health service providers.
2. Train and support Latino community members and organizations to advocate for policies that reduce the impact of immigration enforcement on access to services.
3. Implement system-level changes to increase access to care for Latino community members.
4. Partner with or train lay health advisors to share information with the Latino community and help community members navigate systems and processes for accessing services.
5. Share community members' experiences related to immigration and the impact of enforcement policies with policy makers, decision makers, and those who interpret and enforce policies.
6. Reduce transportation barriers, including promoting access to driver's licenses.
7. Foster support within schools for Latino families.
8. Build and strengthen networks linking community members, organizations, and researchers to create community change.

indicated that these discussions should include input from diverse sources, including health care providers.

A sixth recommendation was to reduce transportation barriers among Latinos (eg, by promoting access to driver's licenses). Participants reported that it was essential to focus on transportation issues—including restricted driver's license eligibility for immigrants, fear of being stopped by law enforcement while driving, and limited public transportation options—because of their effect on health. Participants urged one another to think creatively and to take a multi-level approach to developing transportation alternatives (eg, advocating for expanded local bus routes or changes in policing protocols regarding whether driving without a license is an arrestable offense). Participants identified policy change around driver's license eligibility as an important next step.

A seventh recommendation was to foster support within schools for Latino families. Potential strategies include raising awareness among school administrators about the realities faced by Latino children and parents, changing existing policies that limit Latino parents' participation in school-related activities, and supporting school health center programs in which health care providers offer services at or near schools.

Finally, participants recommended building and strengthening networks linking community members, organizations, and researchers to create community change. Specifically, participants recommended engaging community members and organizations—including nontraditional partners such as business leaders—to increase Latinos' access to health services. Participants noted that, in some cases, representatives of organizations that provide services to the same communities met one another for the first time at the report-backs and forums. Participants suggested that multisector communication and networking between organizations are needed to share information, combine efforts, examine issues from multiple points of view, and ensure that concerns about Latinos' health access are addressed by a broad range of decision makers and service providers. Holding events that provide opportunities for dialogue, using web-based technology such as listservs, and forming working groups focused on specific priority areas were identified as ways to form diverse partnerships.

Discussion

The report-backs and forums allowed community members and public health leaders to use data on immigration enforcement and health to develop recommendations and next steps for increasing health services access and utilization.

Several promising recommendations were identified. First, participants highlighted the need to increase knowledge among Latinos about available health services. Second, participants emphasized the need for networking among organizations. One approach to addressing these recommendations would be to compile relevant information about health services within specific communities in a central and accessible location. For example, a research team is collaborating with local organizations to develop the Mecklenburg Access Portal (www.the-map.net), an online resource to increase health care access for underserved populations, including Latinos, in Mecklenburg County [41, 42]. The Mecklenburg Access Portal facilitates information exchange among service providers and community members with Internet access and currently includes indexed information about services at over 80 CBOs and government agencies.

Participants also endorsed system-level changes among health care organizations. Staff training could provide information about how immigration enforcement policies affect health and limit access to services, and tailored webinars could reach a broader range of service providers (eg, health care providers, social service providers, and pharmacists). These trainings could provide best practices for increasing access to services for Latinos and could include a checklist of key questions for determining whether an organization's existing processes and protocols facilitate access. There is a lack of research supporting the effectiveness of cultural competency training for health professionals, and more rigorous evaluation of such interventions is needed [43]. However, a pilot study showed that an educational intervention about immigrant rights, immigrant eligibility for health programs, and the needs of immigrant families resulted in positive changes in pediatrics residents' knowledge, attitudes, and behaviors related to helping Latinos overcome immigration-related barriers to accessing services [44]. Development, implementation, and evaluation of trainings could help to further assess effectiveness and build evidence related to this potential strategy.

The use of LHAs was another recommendation. LHAs can establish trust through one-on-one interactions, alleviate fears about accessing services, and facilitate infor-

mation exchange between Latinos and service providers. Additionally, LHAs are based in the community, which reduces transportation barriers [45, 46]. In an existing public health intervention in North Carolina that is included in the Centers for Disease Control and Prevention's Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention, Latino male LHAs reduce barriers preventing Latinos from seeking HIV prevention services by sharing information about what to expect at health care facilities [47, 48]. Similarly, El Pueblo, Inc. builds the capacity of community members in Wake County to connect others to health services and to advocate for improved access [49]. Similar approaches could be used in other communities.

Study participants also suggested communicating with policy makers and decision makers about the challenges faced by Latinos in accessing health services. In particular, transportation barriers were identified as an important issue requiring policy-level action. Increasingly, research indicates that transportation policies are critical to health access and outcomes, and promoting immigrants' access to driver's licenses could be an important structural public health intervention [12, 50]. There are already potential models for increasing access to driver's licenses; as of July 2015, 12 states as well as Washington, DC and Puerto Rico had passed laws providing access to driver's licenses or cards regardless of immigration status [51]. The perspectives of health care providers concerned about the impact of immigration enforcement and transportation policy on community members' ability to use their services may be particularly effective at reaching policy makers.

Limitations

Although efforts were made to engage public health and community leaders throughout the state, only 16 of 100 counties in North Carolina were represented in discussions. However, participating counties represented geographically diverse regions of North Carolina, included 7 of the 10 most populated counties in the state, and represented counties that had higher percentages of Latinos than the state average [52, 53]. Finally, practical limitations challenge our ability to track progress on action steps.

Conclusions

There is a need to address immigration enforcement as a public health issue and to identify solutions that will improve access to care and overall health outcomes. Our processes led to recommendations based on the diverse perspectives and experiences of health care providers, representatives from public health departments, academic institutions, CBOs, and local Latino communities. Participants articulated the need to develop new partnerships, identify strategies, and implement next steps to reduce barriers to health care access and utilization that are related to immigration enforcement. NCMJ

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