Racism and the Health of Latina/Latino Communities

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Latinas/Latinos in the United States experience a persistent context of racism and xenophobia.[1–3] For example, the 2016 presidential election cycle and the subsequent change in presidential administrations were filled with anti-immigrant and anti-Latina/Latino ideologies, policy proposals, and policy spectacles that have continued unabated.[4–6] Such discourse and its associated policy proposals and policy changes continue a trend that casts Latinas/Latinos as perpetual foreigners, creates hostile conditions for immigrant communities, and criminalizes those suspected of undocumented migration, dehumanizing Latinas/Latinos in the process.[1,7,8] These dynamics are critical components of racialization processes (see Box 21-1) that have important implications for the current and future health and well-being of Latina/Latino communities. Previous research has paid limited attention to the role of racism in shaping the health of Latinas/Latinos. Instead, it has often focused on cultural factors and language use; though these factors are important and contextually specific, they paint an incomplete picture. This chapter seeks to broaden the conversation on Latina/Latino health by providing an overview of the ways in which race and racism narrate the experiences of Latinas/Latinos and how these, in turn, affect their health. We acknowledge the need to engage in analysis that considers race along other axes such as class, gender, and sexuality. Given that this chapter does not center sexuality or gender as our primary analytical lens, we have decided to use Latina/Latino (as opposed to Latinx) throughout the chapter (see Box 21-2).

Box 21-1. Racialization
Racialization refers to social processes that vary over time and place, through which racial meanings and differences are constructed and reconstructed by society at large.[9,10] Such meanings are used to justify the assigning of groups to unequal social statuses within racial hierarchies. A fundamental aspect of racialization processes is "othering"—that is, dominant groups establish the existence of an "other" group, thereby creating differences between themselves and the "others." In the case of the racial hierarchy of the United States, White people constitute the dominant group.[10,11] "Othering" involves devaluing those ascribed to the "other" group, in turn establishing a lower social status for the "other" group relative to the dominant social group.[9,10] Institutions and social agents leverage "othering" to justify or reinforce inequitable access to resources for groups deemed to be the "other."[11,12] Racialization processes thus result in inequities in status, power, and resources, thereby limiting access to goods, services, and opportunities along racial/ethnic lines.[11,12] These processes are not static nor uncontested. Members of stigmatized groups may engage strategies to resist racialization and to construct identities in the context of stigmatizing and dehumanizing conditions.[9,10,13]

In public health, racialization processes are often reflected in policy and institutional discussions of who is "deserving" of access to health-promoting resources.[14] These processes are also found in public health scholarship and discourses that construct the behaviors or practices of those assigned the status of "other" as "deviant" when their practices or outcomes differ from those of the "dominant" group. Instead, scholars and practitioners may consider that such practices or outcomes may reflect community strategies for negotiating systems of social stratification, and for promoting well-being.

Box 21-2. Hispanic, Latina, Latino, Latinx: What's in a Name?

An understanding of the distinctions between pan-ethnic terms and/or references to national origin/descent and the range of perspectives these terms carry is important for public health institutions to best serve Latina/Latino populations. In particular, racial categories reflect the historical and contemporary consequences of social, political, and economic opportunities and exclusion.[9,15] To this end, we highlight several key points:

- The terms "Latina/Latino" and/or "Hispanic" are often used to refer to persons from or with familial ties to Latin American countries or territories. For decades, US governmental entities have used the pan-ethnic term Hispanic. However, the term "Latina/Latino" has been used more commonly by advocates, practitioners, scholars, and sometimes governmental entities.

- The term "Latina/Latino" centers Latinas'/Latinos' position in the US racial/ethnic classification system within the history of colonization of Latin American countries or territories and within contemporary foreign policies that shape the migration of persons of Latin American origin or descent.

- Use of the term "Latina/Latino" (relative to the term "Hispanic") is often a response on the part of scholars, advocates, and other community members to government-driven racial/ethnic labels. This response embraces Latinas'/Latinos' collective political status and history, rather than elevating the identity of the colonizing country (i.e., Spain).[16,17]

- Of note, in recent years, the term "Latinx" (commonly pronounced "La-teen-ex") has been used more frequently in an effort to practice more inclusive, nonbinary, gender-neutral language. In particular, the term seeks to create new language and alternative spaces that move away from rigid conceptions of gender and sexuality.[18] The power of the term "Latinx" lies in making nonconforming genders and sexualities visible and centering the experiences of those who have been marginalized along these lines.

- It is also important to consider the opportunities and limitations of pan-ethnic labels (e.g., Hispanic, Latina, Latino, Latinx) and/or references to individuals or groups according to national or territorial origin or descent. According to a national survey, Latinas/Latinos generally preferred to identify with their country or territory of origin or descent, rather than pan-ethnic terms such as "Hispanic" or "Latina/Latino."[19]

- Recognizing important heterogeneity in the histories and contemporary circumstances of Latinas/Latinos, we recommend that public health practitioners and scholars inquire as to how populations they are working with prefer to name themselves and, when appropriate, refer to Latina/Latino subgroups by their national origin or descent. Otherwise, we risk overlooking important differences in historical, social, political, and economic conditions that shape the social experiences and health of Latina/Latino subgroups in the United States.

We caution against the sweeping use of labels without attention to the gender, sexuality, class, and racially based inequities that specific terms seek to highlight.[18]

This chapter begins with a summary of the limits of cultural explanations for understanding the health of Latinas/Latinos and discusses the need to distinguish between cultural and racism-related determinants of health. Next, we discuss how racialization processes function to place Latinas/Latinos in a particular social location within the racial hierarchy of the United States and the public health consequences of these processes. We place within historical context the ways in which Latina/Latino subgroups are defined as well as the ways they self-identify and negotiate systems of racial classification; in so doing, we consider the implications of these processes for social inequities and their subsequent impact on Latina/Latino health. Because racism has historically been embedded within the US immigrant policy system, we then discuss 21st century immigrant policies as a component of racism[20] and consider the implications of these policies for the health of Latinas/Latinos. We conclude by proposing strategies that public health institutions and practitioners can incorporate as they work to advance population health and health equity.

THE LIMITS OF CULTURAL EXPLANATIONS IN PUBLIC HEALTH

Cultural explanations for Latina/Latino health outcomes—that is, explanations that attribute health outcomes to so-called traditional Latina/Latino cultural norms and behaviors—are common in public health. However, such explanations draw attention away from historical and structural forces that have shaped the long-standing presence of Latinas/Latinos in the United States and their subsequent experiences of marginalization, including racism. In fact, as Zambrana and Carter-Pokras explain, the "[p]ersistent use of individual- or culture-driven models in public health ignores the effect of residence in low-resource communities, low socioeconomic position, the social construction of marked cultural identities, and institutional patterns of unequal treatment, all of which contribute to health disparities."[21] That is, if Latina/Latino health inequities are defined as being a matter of culture, then individuals and their so-called cultures become the source of the problem, leaving the larger structural forces that place them at risk of ill health untouched.

In addition, uncritical cultural explanations collapse complex and diverse Latina/Latino experiences, resulting in the homogenization of entire populations and the treatment of Latina/Latino cultures as monolithic. In turn, these explanations risk perpetuating racial/ethnic stereotypes and essentializing the varied values, beliefs, and practices of Latinas/Latinos. The use of cultural explanations is especially evident when scholars and practitioners attempt to explain certain more favorable health patterns found among specific Latina/Latino subgroups and under specific conditions. Importantly, Latina/Latino health advantages, when they have been documented, are not generalizable across social conditions or Latina/Latino subgroups. Indeed, when comparisons are made by immigrant generation and, for immigrants, length of time in the United States, health patterns for Latinas/Latinos suggest a deterioration of health status over time in the United States and across immigrant generations.[22,23]

Although culture is sometimes invoked in romantic, positive ways to explain favorable health patterns, the opposite can easily follow, as when cultures are blamed for negative health outcomes. For instance, a common explanation for better-than-expected birth outcomes observed among Mexican women is often attributed to their dietary practices or family support networks.[24,25] This practice invokes culture in positive ways—that is, as health-protective, culturally driven factors. However, culture is also used to explain deleterious health behaviors, such as drinking among men; in such instances, individuals and communities are then blamed for such outcomes.[26] In other words, cultural explanations can easily devolve into victim-blaming explanations instead of pointing to the inequities that place communities and individuals at increased risk of ill health.

Notably, the romanticizing of social networks and cultural traditions results in narratives of cultural hyperresilience as it relates to the health of Latinas/Latinos. What such narratives miss are the structural causes that shape the deterioration of health over the life course and across generations. When scholars and/or practitioners construct Latinas/Latinos as hyperresilient, the complex interplay of structural inequities on health becomes obscured.

In short, cultural explanations detract from the need to examine and intervene on societal-level ideologies, practices, and policies that produce and reproduce inequities by class, race, gender, sexuality, citizenship and legal status, and other social statuses, all of which have implications for health, above and beyond cultural traits. Shifting the lens from cultural explanations to structural inequities is of utmost importance because how a problem is defined sets the stage for finding a solution.

IF LATINAS/LATINOS ARE CONSIDERED AN ETHNIC GROUP, DO THEY EXPERIENCE RACISM?

Some people have questioned whether Latinas/Latinos even experience racism, given their categorization as an “ethnic” group by the Office of Management and Budget.[27] To begin addressing this question, it is important to understand racism and how it functions. Racism is the result of a long history of structural inequities and ideological understandings of race as having immutable, static meanings. At its core, racism functions to uphold power structures that (re)inforce one racial group as dominant over “other” racial groups.[9] Racism is a feature of a

society that systematically marginalizes those who have been assigned a "minority racial status" through prejudicial actions at the individual level, institutional practices and policies, and societal-level ideologies and representations. As such, racism shapes access to life opportunities and fundamental health-promoting resources, including access to employment and educational opportunities, economic resources, housing, and the opportunity to reside in the United States, among others.[9–11,15,28,29]

Racism relies on assigning meaning to racial/ethnic categories, even as such meanings vary across time and context (see Box 21-2). There is a long history of classifying Latinas/Latinos on the basis of sociocultural markers, such as language, Spanish surname, and the like.[30] The US government created the category "Hispanic" to characterize people with origins in Spain or in any of the 19 different Spanish-speaking Latin American countries.[30] First used in the 1980 Census, there have since been only some small variations on how the category has been used in subsequent years of the Census, all of which have followed the trend of categorizing Latinas/Latinos on the basis of sociocultural markers in the process of collecting racial classification data.[30,31] As such, this government-introduced label and construct is meant to denote ethnicity, with Latinas/Latinos being the only group considered an ethnic group (as opposed to a racial one) in the Census. Nevertheless, as Rumbaut explains, the terms "Hispanic" or "Latino" are "used routinely and equivalently alongside 'racial' categories such as Asian, black, and non-Hispanic white, effecting a de facto racialization of the former."[31] That is, in practice, these labels are used to denote a racial category in the reporting of data; more importantly, the ethnicity-only meaning ascribed to the label is at odds with Latinas'/Latinos' historical and contemporary experiences of racialization-related exclusion and marginalization, as discussed in the following paragraphs.

The presence of Latinas/Latinos in the United States dates back to the 1800s and is the result of the country's foreign, economic, political, and military policies from the 19th century to the present. For instance, the presence of Mexicans in the United States resulted from its efforts at territorial conquest in the 19th century, when the United States annexed almost half of Mexico's territory into what is now the Southwest. Mexicans living in the region then became citizens of what is now the United States; however, as Gutiérrez explains, "within two decades of the American conquest it had become clear that, with few exceptions, Mexican Americans had been relegated to a stigmatized, subordinate position in the social and economic hierarchies."[32]

In another example, Puerto Rico became a US territory in 1898 when the United States annexed the island in the settlement of the Spanish–American War. However, Puerto Rico's status as a colony produced political and economic disenfranchisement, a trend that continues to this day, despite the island's official commonwealth status. Furthermore, though Puerto Ricans are US citizens by birth, like many other Latinas/Latinos, they experience racism, which has historically restricted their access to life opportunities.[3,33,34] The governmental neglect of Puerto Rico leading up to and following Hurricane Maria in 2017 is a powerful example of the historical and contemporary political and economic disenfranchisement of Puerto Rico and a reminder that colonial practices are ongoing and affect matters of life and death.

Although a detailed discussion of each Latina/Latino subgroup's history is beyond the scope of this chapter, it is important to note each Latina/Latino subgroup has a unique history with the United States' foreign policies that were directed at their countries of origin or descent. These histories have implications for each subgroup's experiences of economic, political, social, and racial marginalization. Indeed, Andrade and Viruell-Fuentes observe, "[t]hese histories are reflected in each group's current social and economic position, as well as in the group's access to resources, including health care."[35]

These historical and contemporary processes have positioned Latinas/Latinos in specific, disadvantaged locations within the US ethnoracial hierarchy. While in theory Latinas/Latinos are considered an ethnic group, in practice, they have historically been marginalized along racial/ethnic lines. On average, such marginalization is evident in Latinas'/Latinos' limited access to life opportunities, such as education and employment, that are well-known social determinants of health.[36,37]

IMMIGRANT POLICIES AND RACISM

Latinas/Latinos have lived in what is now the United States for more than two centuries; in some cases such as in the Southwest, they had lived in the area before the formation of the United States as a nation-state.[3,32] Nevertheless, in the popular imagination, Latinas/Latinos are thought of as newcomers.[1,3,32] Thus, the dominant narrative often conflates Latina/Latino identity with legal and citizenship status. Such conflations and erasure of history result in Latinas/Latinos continuously being thought of as perpetual "foreigners" and treated as such.[1,28]

Immigration policies refer to the rules and regulations concerning who is eligible to migrate and to the migration processes available to those who are eligible to migrate. The historical trend in which immigrant policies—those that regulate the lives of immigrants—have produced and reproduced practices and ideologies that define national belonging along racial/ethnic lines has resulted in rendering entire groups of people, as is the case of Latinas/Latinos, as racialized "others."[2,28] Because this trend continues to the present day and the health implications are many,[5,28,38] immigrant policies are an expression of structural racism.[9,20]

The Construction of "Illegality"

That undocumented immigrants from Latin American and other countries have been racialized as "illegal" has major implications for their health and well-being. The experience of undocumented immigrants is one that is produced through social, political, and legal processes that create nonneutral immigrant policies. These policies, for example, restrict access to pathways to legalization and citizenship according to national origin and socioeconomic position and, in the process, delimit access to the social and economic resources that are increasingly linked to legal and citizenship status.[39,40] In other words, "illegal" is a label and category that is not inherent in an individual's status, but rather it is one that has been created and assigned through exclusionary policies, practices, and ideologies.

The processes that give rise to "illegality" and its attendant consequences constitute a form of legal violence. These processes not only take the form of policies that do not recognize the United States' contribution to political and economic migration from Latin American countries, but they also limit legal protections for immigrants and enhance immigrant vulnerability to multiple forms of exploitation and exclusion.[41,42] (See Box 21-3.)

Box 21-3. No Human Being Is "Illegal"!

In the United States, immigrants can hold different legal statuses over their life course. Access to tourist, student, or work visas and temporary protected statuses as well as access to more secure legal or citizenship statuses (e.g., legal permanent residency or naturalized US citizenship) is severely restricted for many undocumented immigrants, particularly racial/ethnic minority immigrants. Such lack of access, coupled with anti-immigrant policies and societal discourses toward immigrants, affects treatment of immigrant communities and their access to other health-promoting resources.

Immigration discourse often uses language that criminalizes undocumented immigrants. Discussions on immigration often include references to "legal" versus "illegal" legal status or citizenship status, reflecting the social and juridical production of an "illegal" legal status through nonneutral policies that criminalize undocumented status.[7,40] Some policymakers, and many practitioners, advocates, and community members use the term "undocumented" to refer to individuals who do not have an authorized US presence. Reflecting the social construction of legal statuses and the realities that immigrant policies are not neutral, in 2018, US Attorney General Sessions mandated that US attorneys use the term "illegal alien" rather than "undocumented."[43] Inscribed in US immigrant policies, the term "illegal" serves to criminalize immigrants who are undocumented. These policies and practices shape societal discourse toward and treatment of immigrant communities.

Furthermore, this label is often extended to anyone perceived to be an immigrant on the basis of racialized phenotypes. The use of the term perpetuates the criminalization and dehumanization of undocumented immigrants and anyone else perceived to be so. Given that language confers important meanings about the values placed on individuals and groups, advocates seriously caution against its use.

Successful public health practice depends on building trust and working in partnership with immigrant and Latina/Latino communities that have been affected by restrictive immigrant policies. Accordingly, it is incumbent upon public health professionals and institutions to avoid using terminology and practices that criminalize and dehumanize individuals and peoples.

Undocumented immigrants experience the threat of deportation. This threat serves to maintain racial stratification, in part through economic exclusion and exploitation, restricted occupational opportunities, and enhanced vulnerability for exploitative work and living conditions. The uncertainties that result from this exclusionary status produce an exploitable labor force. Notwithstanding the vulnerability and exploitation of undocumented immigrants, they are

characterized as undeserving of social, economic, political, and health-related resources, which further exacerbates their vulnerability.[14,44]

The reaches of the construction of "illegality" and the deleterious experiences that accompany it are, however, not restricted to undocumented immigrants. "Illegality" also affects those with less vulnerable legal or citizenship statuses, such as those with legal permanent residency status, naturalized citizens, and US-born Latina/Latino citizens. For instance, because individuals of varying legal or citizenship statuses are most often members of the same families and communities, the effects of anti-immigrant policies are felt throughout social networks.[44] In addition, because the racialization of Latinas/Latinos is closely linked with perceptions of Latinas/Latinos as perpetual foreigners, and social stratification processes homogenize Latina/Latino communities, the anti-immigrant policies create a hostile environment for Latinas/Latinos as a whole, regardless of their legal or citizenship status. The racialized experience of "illegality" and its spillover effects have multiple implications for health that occur through at least four pathways outlined next.

Citizenship, Legal Status, and Health

Immigrants of Latin American origin represented more than 90% of individuals deported in the early part of the 21st century.[45] Deportation, along with other immigration-enforcement practices, profoundly affects the lives of individuals, and they also produce social, economic, and political inequities that shape the day-to-day experiences of immigrants, their families, and immigrant communities. These restrictive immigrant policies may shape the health of Latina/Latino communities through several pathways.

First, federal- or state-level restrictive immigrant policies constrict access to health-promoting resources, including job opportunities and workplace conditions,[39] housing,[46] social welfare support,[47] access to a government-issued ID (see Box 21-4),[49] health care,[50] and the opportunity to reside in the United States.[45]

Box 21-4. Government-Issued Identification Policy as Immigrant Policy and Health Policy

I got close to see what they were giving out, and it was water. And the first thing they asked me for was my license. --Resident of Flint, Michigan[48]

The need to show government-issued identification (ID) to access bottled water during the lead water contamination crisis in Flint, Michigan,[48] illustrates the interconnections among environmental injustices, immigrant policies, and policies regarding photo identification issued by US governmental agencies.

In 2008, as an interpretation of the federal 2005 REAL ID Act, the Michigan Secretary of State began denying driver's licenses and state IDs to residents who could not prove their authorized presence in the United States. In the years following this decision, many immigrant residents in Michigan experienced barriers to renewing or applying for a driver's license or state ID. Accordingly, ID policy became immigrant policy.

Simultaneously, multiple policies have made access to health-promoting resources contingent upon the ability of individuals to present a current government-issued ID.[49] In the case of Flint, initial requirements for accessing clean, bottled water included presenting a government-issued ID; as a result, undocumented immigrant communities were reticent to engage with water-distribution centers and/or the National Guard members who distributed water.

Thus, the lack of driver's license and state ID became important symbols of illegality that carried clear health implications. That is, ID policy is also health policy. The experience in Flint teaches us that institutions charged with promoting public health need to develop policies and protocols that do not violate community trust or restrict access to health-promoting resources based upon having ID and/or official documentation.

Second, these processes also undermine trust in institutions charged with promoting the public's well-being. For example, in a national sample of adults, Latinas/Latinos who lived in counties with higher levels of immigrant policing expressed lower levels of trust in the government as a source of health information than those who lived in areas with less-intense immigrant policing.[51] Another study found that, in a national sample of Latina/Latino adults, exposure to subtle cues on immigration were linked with reports of reticence to engage with health care providers.50 This scholarship suggests spillover effects of institutional racism from one set of institutions (immigration enforcement and criminal justice systems) toward community mistrust in public health and health care institutions.

Third, recent studies have also documented health declines in Latina/Latino communities following immigration raids. Immigration raids constitute large-scale, acute "shocks" to immigrant communities that not only constrict access to health-promoting resources (as described previously) and threaten the opportunity to live in the United States, but they also exact trauma.[52,53] The threat of deportation and vigilance toward experiences that may lead to contact with police or immigration enforcement agencies contribute to fear, anxiety, and trauma, as documented by a growing qualitative literature.[44,54–56] A sizable body of literature documents the health consequences of stressful life conditions, highlighting how stress impacts the dysregulation of multiple physiological systems, including immune, cardiovascular, and metabolic systems.[57,58] In the context of a protracted period of restrictive immigrant policies, these threats to self, family, and community well-being may be experienced as acute and chronic stressors, with long-term implications for health.

Fourth, exposure to institutional and personally mediated discrimination may be another pathway through which restrictive immigrant policies affect the health of Latinas/Latinos.[59] Analysis of a 2013 survey of Latina/Latino adults (with a final analytical sample of 716) found that those living in states that had implemented a greater number of restrictive immigrant policies between 2005 and 2011 reported higher levels of exposure to discrimination than those living in states implementing fewer restrictive immigrant policies during that period.[60] These findings suggest that state-level anti-immigrant policies have intensified the context of discrimination for many

Latinas/Latinos, regardless of immigrant generation, legal status, or citizenship status. These findings build on a robust literature documenting linkages between experiences of discrimination and adverse health outcomes.[61] Extending this evidence base, another study found that US-born and immigrant Latinas/Latinos reported increases in institutional discrimination during a period in which immigrant policing, immigrant detentions, and deportations increased substantially (2002–2008).[38] These increases in self-reported institutional discrimination were linked to greater rises in blood pressure elevation for Latina/Latino immigrants, relative to US-born Latinas/Latinos.[38]

ADDRESSING RACISM IN PUBLIC HEALTH PRACTICE

Despite a long history of marginalization on the basis of their status as racialized "other," the categorization of Latinas/Latinos as an ethnic group has had implications for understandings of, and approaches to, Latina/Latino health. In particular, it has meant that scholars and practitioners have most often been concerned with the cultural dimensions of Latina/Latino lives, which, as mentioned previously, risks obscuring the structural conditions that impinge on their health and well-being. In the following paragraphs, we discuss strategies by which public health practitioners can consider and address the health implications of racism for Latinas/Latinos to promote population health and health equity. These strategies include intraorganizational reflection and intervention as well as external-facing engagement and intervention as it relates to public health's charge to promote population health and health equity. Each of these strategies has implications for epidemiological as well as other public health research, policy, and programming.

Consider Structural Conditions and Their Impact on Health

First, although national, state, or local health data may suggest more favorable health profiles of Latinas/Latinos for some health conditions at a given moment in time, our understanding may be obscured by limited or missing data. For example, injuries and illnesses are produced by restrictive immigrant policies that create an exploitable labor force and restrict access to health care. This, in turn, enhances the risk for occupational injury and illness for immigrant workers[39,62]; however, these patterns may not yet be reflected in available health data. To address this issue, public health practitioners can consider the role of social, economic, and health care policies in shaping life-course opportunities and access to health-promoting resources. Such consideration will position public health practitioners to anticipate the implications of current sociopolitical contexts for the health of Latina/Latino communities later in their life course and across generations. In addition, we recommend that practitioners and institutions engage in an analysis of how the policies and day-to-day practices of institutions serve to reinforce a group's status as the racialized other and the impact such processes and practices have on the health of the populations they serve. This critical analysis, rooted in an acute understanding of the structural contexts in which individuals and communities are embedded, is particularly important because such knowledge can help reshape the resources that public health institutions allocate to promote community health.

Implement Structural Competency

Second, public health institutions and practitioners can embrace the praxis of structural competency (as opposed to cultural competency), [63,64] which "calls on health care providers and students to recognize how institutions, markets, or health care delivery systems shape symptom presentations and to mobilize for correction of health and wealth inequities in society."[65] This practice has been advanced in health care professions training through structural competency curricula that strengthens structural understanding of race/ ethnicity, health inequities, the social determinants of health, and health politics. [65] This model of critical consciousness can be extended to the practice of public health. The Dismantling Racism organizational intervention provides one such model for public health and health care settings. [66] In addition, Part V of this book provides examples of public health strategies to address racism. Several reputable organizations (e.g., Bay Area Regional Health Inequities Initiative; Community Toolbox) provide self-assessment and process-evaluation tools for local health departments to identify the institutional values, policies, and practices and skill sets needed to ensure that their organization is equipped to guarantee and practice equity and justice, and thereby promote health equity.

Build Partnerships With Latina/Latino Communities

Third, public health institutions must engage in authentic partnership with Latina/Latino communities. The field of community-based participatory research[67] provides a well-established process through which communities and universities or public health institutions can develop and sustain trusted relationships and engage in the process of understanding and/ or addressing the contributions of racism to health, with each serving as equal partners in these processes (as opposed to lip-service partnerships that replicate unequal power relations). Along these lines, universities can commit to working in partnership with health departments to support this process; doing so trains emerging public health professionals in community-based participatory research, evaluation, and practice, as well as in the social determinants of health. Such community-academic and/or community-health department partnerships institutionalize opportunities for public health leaders and scholars and the communities served by public health institutions to meaningfully engage with each other as equal partners. Authentic collaborations will support the identification of health needs, assets, and resources, as well as opportunities for systems, policy, and structural change.[67--70] Such partnerships hold promise for decreasing the structural space between communities and the health-related institutions designed to serve them.

Assess Community Needs and Resources

Fourth, the 2010 Patient Protection and Affordable Care Act and public health accreditation processes mandate nonprofit hospitals and health departments to engage community members in the process of assessing community health needs and resources to inform community health improvement activities. An underlying expectation of these requirements is that hospitals and health departments learn from and work in partnership with communities. While such policies and accrediting processes encourage community engagement, it is important to be vigilant toward distinctions between authentic engagement and symbolic engagement. Wolff et al. [68]

provide important recommendations for centering community-engaged, equity-oriented practices around the experiences and priorities of communities disparately affected by racism.

Review and Revise institutional Protocols

Fifth, being mindful that institutional practices can give the incorrect impression of collaborating with immigration enforcement agencies, public health institutions should review intake protocols, application forms, and website information to ensure they do not solicit more information than needed, protect community members' information, and emphasize they do not share data with immigration authorities or police.[50]

CONCLUSIONS

This chapter discusses ways in which race and racism shape the experiences and health of Latina/Latino communities and populations and considers implications for public health practice. Public health practitioners are poised to play a key role in helping address the effects of racism on health. Because exclusionary immigrant policies perpetuate structural racism, an important first step in the direction of addressing such effects involves fostering increased awareness of immigrant policies unfolding at the national, state, and local levels, and then considering the implications of these policies for the health and well-being of Latina/Latino populations and immigrant communities. Importantly, when exclusionary immigrant policy proposals surface, public health practitioners can recognize that immigrant policy is health policy. We recommend that practitioners examine immigrant policies, consider their health impacts, design interventions that prevent and/ or mitigate such health impacts, and work closely with advocates to propose policies that support integration and community well-being. Finally, when restrictive immigrant policies render already vulnerable populations more so, public health practitioners have the opportunity to look within their organizations to identify ways in which they can build and/or protect the community's trust of their institution, and thus promote population health and health equity.

REFERENCES

[1] Chavez L.: The Latino Threat: Constructing Immigrants, Citizens, and the Nation. Stanford, CA: Stanford University Press; 2013.

[2] Sanchez G J.: Face the nation: race, immigration, and the rise of nativism in late twentieth century America. Int Migr Rev. 1997; 31(4): 1009–1030.

[3] González J.: Harvest of Empire: A History of Latinos in America. New York, NY: Viking Press; 2000.

[4] Johnson K R.: Race and immigration laws: the need for critical inquiry. In: Valdes F, Culp J M, and Harris A P: eds. Crossroads, Directions and a New Critical Race Theory. Philadelphia, PA: Temple University Press; 2002: 187–198.

[5] Cruz Nichols V, LeBrón A MW, and Pedraza F I.: Policing us sick: the health of Latinos in an era of heightened deportations and racialized policing. Polit Symp. 2018; 51(2): 293–297.

[6] Flores R D.: Can elites shape public attitudes toward immigrants?: Evidence from the 2016 US presidential election. Soc Forces. 2018; 96(4): 1649–1690.

[7] Cacho L M.: Social Death: Racialized Rightlessness and the Criminalization of the Unprotected. New York, NY: New York University Press; 2012.

[8] Inda J X and Dowling J A.: Introduction: governing migrant illegality. In: Governing Immigration Through Crime: A Reader. Stanford, CA: Stanford University Press; 2013: 1–35.

[9] Omi M and Winant H.: Racial Formation in the United States. 3rd ed. New York, NY: Routledge; 2015.

[10] Schwalbe M, Godwin S, and Holdern D et al.: Generic processes in the reproduction of inequality: an interactionist analysis. Soc Forces. 2000; 72(2): 419–452.

[11] Jones C P.: Levels of racism: a theoretic framework and a gardener's tale. Am J Public Health. 2000; 90(8): 1212–1215.

[12] Williams D R and Collins C.: Racial residential segregation: a fundamental cause of racial disparities in health. Public Health Rep. 2001; 116(5): 404–416. [PMID: 12042604]

[13] Viruell-Fuentes E A.: "It's a lot of work:" racialization processes, ethnic identity formations, and their health implications. Du Bois Rev. 2011; 8(1): 37–52.

[14] Willen S S.: Migration, "illegality," and health: mapping embodied vulnerability and debating health-related deservingness. Soc Sci Med. 2012; 74(6): 805–811. [PMID: 22257746]

[15] Almaguer T.: Racial Fault Lines: The Historical Origins of White Supremacy in California. Berkeley, CA: University of California Press; 2009.

[16] Alcoff L M.: Latino vs. Hispanic: the politics of ethnic names. Philos Soc Crit. 2005; 31(4): 395–407.

[17] Hayes-Bautista D E and Chapa J.: Latino terminology: conceptual bases for standardized terminology. Am J Public Health. 1987; 77(1): 61–68. [PMID: 3789240]

[18] Rodríguez R T.: X marks the spot. Cult Dyn. 2017; 29(3): 202–213.

[19] Taylor P, Lopez M H, Martinez J, and Velasco G.: When labels don't fit: Hispanics and their views of identity. Pew Research Center. 2012. Available at: http://www.pewhispanic.org/2012/04/04/when-labels-dont-fit-hispanics-and-their-views-of-identity . Accessed January 1, 2013.

[20] Gee G C and Ford C L.: Structural racism and health inequities. Du Bois Rev. 2011; 8(1): 115–132. [PMID: 25632292]

[21] Zambrana R E and Carter-Pokras O.: Role of acculturation research in advancing science and practice in reducing health care disparities among Latinos. Am J Public Health. 2010; 100(1): 18–23. [PMID: 19910358]

[22] Acevedo-Garcia D, Bates L M, Osypuk T L, and McArdle N.: The effect of immigrant generation and duration on self-rated health among US adults 2003–2007. Soc Sci Med. 2010; 71(6): 1161–1172. [PMID: 20624666]

[23] Acevedo-Garcia D, Soobader M J, and Berkman L F.: Low birthweight among US Hispanic/Latino subgroups: the effect of maternal foreign-born status and education. Soc Sci Med. 2007; 65(12): 2503–2516. [PMID: 17764796]

[24] Cobas J A, Balcazar H, Benin M B, Keith V M, and Chong Y.: Acculturation and low-birthweight infants among Latino women: a reanalysis of HHANES data with structural equation models. Am J Public Health. 1996; 86(3): 394–396. [PMID: 8604766]

[25] Fuentes-Afflick E, Hessol N A, and Pérez-Stable E J.: Testing the epidemiologic paradox of low birth weight in Latinos. Arch Pediatr Adolesc Med. 1999; 153(2): 147–153. [PMID: 9988244]

[26] Abraído-Lanza A F, Chao M T, and Flórez K R.: Do healthy behaviors decline with greater acculturation?: Implications for the Latino mortality paradox. Soc Sci Med. 2005; 61(6): 1243–1255. [PMID: 15970234]

[27] Revisions to the standards for the classification of federal data on race and ethnicity. Washington, DC: US Office of Management and Budget; 1997.

[28] Viruell-Fuentes E A, Miranda P Y, and Abdulrahim S.: More than culture: structural racism, intersectionality theory, and immigrant health. Soc Sci Med. 2012; 75(12): 2099–2106. [PMID: 22386617]

[29] Williams D R and Mohammed S A.: Racism and health: pathways and scientific evidence. Am Behav Sci. 2013; 57(8): 1199–1216.

[30] Rodríguez C E.: Changing Race: Latinos, the Census, and the History of Ethnicity in the United States. New York, NY: New York University Press; 2000.

[31] Rumbaut R G.: The making of a people. In: Tienda M and Mitchell F: eds. Hispanics and the Future of America. 1st ed. Washington, DC: National Academies Press; 2006: 16–65.

[32] Gutiérrez D G.: Walls and Mirrors: Mexican Americans, Mexican Immigrants, and the Politics of Ethnicity. Berkeley, CA: University of California Press; 1995.

[33] Rodríguez C E.: A summary of Puerto Rican migration to the United States. In: Romero M, Hondagneu-Sotelo P, and Ortiz V: eds. Challenging Fronteras: Structuring Latina and Latino Lives in the US. New York, NY: Routledge; 1997: 101–114.

[34] Oboler S.: Ethnic Labels, Latino Lives: Identity and the Politics of (Re)Presentation in the United States. Minneapolis, MN: University of Minnesota Press; 1995.

[35] Andrade FCD and Viruell-Fuentes E A.: Latinos and the changing demographic landscape: key dimensions for infrastructure building. In: Buki L P and Piedra L M: eds. Creating Infrastructures for Latino Mental Health. New York, NY: Springer; 2011: 3–30.

[36] Adler N E and Rehkopf D H.: US disparities in health: descriptions, causes, and mechanisms. Annu Rev Public Health. 2008; 29(1): 235–252.

[37] Link B G and Phelan J.: Social conditions as fundamental causes of disease. J Health Soc Behav. 1995; (spec no): 80–94.

[38] LeBrón AMW, Schulz A J, and Mentz G B et al.: Impact of change over time in self-reported discrimination on blood pressure: implications for inequities in cardiovascular risk for a multi-racial urban community. Ethn Health. 2018: 1–19.

[39] Abrego L.: Sacrificing Families: Navigating Laws, Labor, and Love Across Borders. Stanford, CA: Stanford University Press; 2014.

[40] De Genova N.: The legal production of Mexican/migrant "illegality". Lat Stud. 2004; 2(2): 160–185.

[41] De Genova N P.: Migrant "illegality" and deportability in everyday life. Annu Rev Anthropol. 2002; 31(1): 419–447.

[42] Menjívar C and Abrego L J.: Legal violence: immigration law and the lives of Central American immigrants. Am J Sociol. 2012; 117(5): 1380–1421.

[43] Kopen T.: Justice Department: use "illegal aliens," not "undocumented." CNN. July 24, 2018. Available at: https://www.cnn.com/2018/07/24/politics/justice-department-illegal-aliens-undocumented/index.html . Accessed July 31, 2018.

[44] LeBrón AMW, Schulz A J, Gamboa C, Reyes A, Viruell-Fuentes E A, and Israel B A.: "They are clipping our wings": health implications of restrictive immigrant policies for Mexican-origin women in a northern border community. Race Soc Probl. 2018; 10(1): 1–19.

[45] Golash-Boza T and Hondagneu-Sotelo P.: Latino immigrant men and the deportation crisis: a gendered racial removal program. Lat Stud. 2013; 11(2013): 271–292.

[46] Rugh J and Hall M.: Deporting the American Dream: immigration enforcement and Latino foreclosures. Sociol Sci. 2016; 3: 1077–1102.

[47] Toomey R B, Umaña-Taylor A J, Williams D R, Harvey-Mendoza E, Jahromi L B, and Updegraff K A.: Impact of Arizona's SB 1070 immigration law on utilization of health care and public assistance among Mexican-origin adolescent mothers and their mother figures. Am J Public Health. 2014; 104(suppl 1): S28–S34.

[48] Lee E YH.: How the Flint Water Crisis is impacting undocumented immigrants. ThinkProgress. 2016. Available at: https://thinkprogress.org/how-the-flint-water-crisis-is-impacting-undocumented-immigrants-70b25a1a4abe . Accessed January 31, 2016.

[49] LeBrón AMW, Lopez W D, and Cowan K et al.: Restrictive ID policies: implications for health equity. J Immigr Minor Health. 2018; 20(2): 255–260. [PMID: 28391499]

[50] Pedraza F, Cruz Nichols V, and LeBrón AMW.: Cautious citizenship: the deterring effect of immigration issue salience on health care use and bureaucratic interactions among Latino US citizens. J Health Polit Policy Law. 2017; 42(5): 925–960. [PMID: 28663179]

[51] Cruz Nichols V, LeBrón AMW, and Pedraza F I.: Spillover effects: immigrant policing and government skepticism in matters of health for Latinos. Public Adm Rev. 2018; 78(3): 432–443.

[52] Novak N L, Geronimus A T, and Martinez-Cardoso A M.: Change in birth outcomes among infants born to Latina mothers after a major immigration raid. Int J Epidemiol. 2017; 46(3): 839–849.

[53] Lopez W D, Kruger D J, and Delva J et al.: Health implications of an immigration raid: findings from a Latino community in the Midwestern United States. J Immigr Minor Health. 2017; 19(3): 702–708. [PMID: 27041120]

[54] Hacker K, Chu J, and Leung C et al.: The impact of Immigration and Customs Enforcement on immigrant health: perceptions of immigrants in Everett, Massachusetts, USA. Soc Sci Med. 2011; 73(4): 586–594. [PMID: 21778008]

[55] Ayón C, Gurrola M, Salas L M, Androff D, and Krysik J.: Intended and unintended consequences of the employer sanction law on Latino families. Qual Soc Work. 2012; 11(6): 587–603.

[56] Rhodes S D, Mann L, and Simán F M et al.: The impact of local immigration enforcement policies on the health of immigrant Hispanics/Latinos in the United States. Am J Public Health. 2015; 105(2): 329–337. [PMID: 25521886]

[57] McEwen B S and Wingfield J C.: What is in a name? Integrating homeostasis, allostasis and stress. Horm Behav. 2010; 57(2): 105–111.

[58] Picard M, Juster R -P, and McEwen B S.: Mitochondrial allostatic load puts the “gluc” back in glucocorticoids. Nat Rev Endocrinol. 2014; 10(5): 303–310.

[59] LeBrón AMW and Viruell-Fuentes E A.: Racial/ethnic discrimination, intersectionality and Latina/o Health. In: Martinez A and Rhodes S D: eds. New & Emerging Issues in Latinx Health. New York, NY: Springer; 2019.

[60] Almeida J, Biello K B, Pedraza F, Wintner S, and Viruell-Fuentes Edna: The association between anti-immigrant policies and perceived discrimination among Latinos in the US: a multilevel analysis. SSM Popul Health. 2016; 2: 897–903.

[61] Lewis T T, Cogburn C D, and Williams D R.: Self-reported experiences of discrimination and health: scientific advances, ongoing controversies, and emerging issues. Annu Rev Clin Psychol. 2015; 11: 407–440. [PMID: 25581238]

[62] Horton S B.: They Leave Their Kidneys in the Fields: Illness, Injury, and Illegality Among US Farmworkers. Oakland, CA: University of California Press; 2016.

[63] Hester R J.: Cultural competency training and indigenous cultural politics in California. Lat Stud. 2015; 13(3): 316–338.

[64] Hester R J.: The promise and paradox of cultural competence. HEC Forum. 2012; 24(4): 279–291. [PMID: 23111444]

[65] Metzl J M, Petty J L, and Olowojoba O V.: Using a structural competency framework to teach structural racism in pre-health education. Soc Sci Med. 2018; 199: 189–201. [PMID: 28689630]

[66] Griffith D M, Mason M, and Yonas M et al.: Dismantling institutional racism: theory and action. Am J Community Psychol. 2007; 39(3-4): 381–392. [PMID: 17404829]

[67] Israel B A, Schulz A J, Parker E A, and Becker A B.: Review of community-based research: assessing partnership approaches to improve public health. Ann Rev Public Health. 1998; 19(1): 173–202. [PMID: 9611617]

[68] Wolff T, Minkler M, and Wolfe S M et al.: Collaborating for equity and justice: moving beyond collective impact. Nonprofit Q. 2016; Winter: 42–53.

[69] Cacari-Stone L, Wallerstein N, Garcia A P, and Minkler M.: The promise of community-based participatory research for health equity: a conceptual model for bridging evidence with policy. Am J Public Health. 2014; 104(9): 1615–1623. [PMID: 25033119]

[70] Bruna S, Stone L C, Wilger S, Cantor J, and Guzman C.: The role of community health centers in assessing the social determinants of health for planning and policy: the example of frontier New Mexico. J Ambul Care Manage. 2014; 37(3): 258–268. [PMID: 24887527]

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