Trump-Era Immigration Politics and Preventive Health: HPV Vaccination Ambivalence Among Latinx Immigrants in Florida

Silvana Montanola
smontanolaayala@rollins.edu

Follow this and additional works at: https://scholarship.rollins.edu/honors

Part of the Other Anthropology Commons, and the Social and Cultural Anthropology Commons

Recommended Citation
https://scholarship.rollins.edu/honors/106

This Open Access is brought to you for free and open access by Rollins Scholarship Online. It has been accepted for inclusion in Honors Program Theses by an authorized administrator of Rollins Scholarship Online. For more information, please contact rwalton@rollins.edu.
TRUMP-ERA IMMIGRATION POLITICS AND PREVENTIVE HEALTH:

HPV VACCINATION AMBIVALENCE AMONG LATINX IMMIGRANTS IN FLORIDA

Silvana Montañola
“Anthropology that doesn’t break your heart just isn’t worth doing.”

-Ruth Behar
# Table of Contents

*Abstract* ............................................................................................................................................. 4

*Acknowledgements* .............................................................................................................................. 5

*CHAPTER 1: Introduction* ....................................................................................................................... 7

*CHAPTER 2: Literature Review* ............................................................................................................. 10
  I. Latinx Structural Vulnerability in the United States ........................................................................... 10
  II. Anti-Immigrant Policies and Fear .................................................................................................... 11
  III. Public Charge .................................................................................................................................. 18
  IV. Barriers to Healthcare and HPV Vaccination .............................................................................. 20
  V. HPV Vaccination and Cancer Prevention ....................................................................................... 22

*CHAPTER 3: Ethnographic Background and Methods* ......................................................................... 24
  I. Latinx in Central Florida .................................................................................................................. 24
  II. SB-168 and raids .............................................................................................................................. 26
  III. Apopka ........................................................................................................................................... 27
  IV. Community Partners ...................................................................................................................... 28
  V. Approach: Activist Anthropology ..................................................................................................... 29
  VI. Sources of Data Collection ........................................................................................................... 31
      Operationalizing the Research Question ......................................................................................... 31
      Participant Observation ................................................................................................................... 32
      Focus Groups .................................................................................................................................. 33
      Ethnographic Surveys ...................................................................................................................... 34
      Key-Informant Interviews ............................................................................................................... 35
  VII. Recruitment .................................................................................................................................... 36
  VIII. Methodological Challenges ......................................................................................................... 36
  IX. Community Participation: Short and Long-Term Results ............................................................ 38
  X. Positionality ....................................................................................................................................... 39

*CHAPTER 4: Findings* ............................................................................................................................ 42
  I. Politics of Fear .................................................................................................................................... 43
      Infiltrated Fear in Everyday Life ......................................................................................................... 44
      The Trifecta: Fear, Anti-immigrant Rhetoric, and the Trump Administration ................................... 47
      Stay Inside: Fear to Leave the House and Essential Services ....................................................... 54
  II. Medical Racism .................................................................................................................................. 58
      Language and Racism ...................................................................................................................... 59
      Healthcare Status ............................................................................................................................. 63
      Refusing Medical Information ........................................................................................................... 72
  III. Lack of Knowledge .......................................................................................................................... 76
  IV. Optional vaccination is not necessary for school entrance ............................................................. 82
Abstract

Human Papillomavirus (HPV) is the most common sexually transmitted infection. The spread of HPV can be prevented through vaccination; however, vulnerable Latinx populations do not get vaccinated at the same rates as other populations in America (Luque et al., 2012). In my research, I investigated the impact that the current administration’s politics and policies have on access to preventative healthcare, particularly the HPV vaccination, for the Latinx community. I looked at the populations’ understanding of the vaccine, their ambivalence towards its application, and their perceptions of the effect of policies on access to that specific medication. Looking at these structural problems through the lens of activist anthropology, I developed a set of guiding questions that were distilled through ethnographic surveys, focus groups, and key-informant interviews. With the support of two local community organizations that advocate for immigrant rights, I was able to gather significant evidence that suggests several trends in the lack of access to HPV vaccination for the Latinx population. Respondents reported having minimal knowledge of the HPV vaccination due to the doctors and nurses’ lack of explanation about medical procedures. Interestingly, those who reported knowing about the vaccination suggested a lack of vaccination for the particular infection because it was not necessary for school entrance. Moreover, they connected this lack of information to instances of medical racism at clinics and hospitals that trickle down from anti-immigrant rhetoric during the Trump Administration. Finally, many reported having increased fear to leave the household for noncritical activities due to stricter immigration politics which I correlate to further structural vulnerabilities that exacerbate access to HPV vaccination. Based on these findings, I suggest that the Trump’s Administration use of immigration politics as a form of fear exacerbates access to HPV vaccination for undocumented Latinx in Central Florida.
Acknowledgements

I am forever grateful to every single person that motivated me through the 1.5 years that this thesis was in the works. Without you, none of the words in this document would be possible.

A huge thank you to my advisor, mentor, and guiding light, Dr. Nolan Kline. Thank you for the weekly meetings, Starbucks runs, and the countless hours of discussion on articles and frameworks I had never encountered before. Thank you for helping me find my passion in Medical Anthropology and supporting my decisions as I applied to PhD programs. But most of all, thank you for introducing me to anthropology that first semester of Freshmen year. I hope that, ten years down the line, I can come back to Rollins and tell you all the amazing things I have accomplished thanks to your guidance.

To my committee, Dr. Kistler, Dr. Brown, Dr. Parziale, and Dr. Kline, thank you for spending hours upon hours reading these pages and providing the feedback necessary to make it a worthy anthropology piece. Without your feedback, this first draft would have never seen the light of day.

I am also indebted to the Student Faculty Collaborative Research for funding my fieldwork in the Summer of 2019. The pieces of evidence here encased all come from those eight weeks of research.

To Mary Vickers, thank you for being the best co-researcher and partner in the field. Thank you for reminding me about the deadlines I constantly forgot, for reminding me how valuable my research and input was when I did not believe in it myself, and for motivating me on a daily basis. I will never forget the two months we drove back and forth to Apopka, answering calls at FWAF, teaching at HOPE, and eating $2 tacos in the heart of Apopka. Con todo mi corazón, gracias!
Thank you to every person who I met and worked with at both HOPE and FWAF. You taught me so many valuable lessons, not only about my research topic and the community, but about life itself. Thank you for allowing me to talk with the community you are in contact with every day and for letting me share eight weeks at your organizations.

Finally, to every individual who shared their stories with me, *infinitas gracias*. Thank you for taking time out of your hectic days to make this thesis possible. Thank you for being brave and sharing your experiences. Thank you for speaking for those whose voices have been lost.

It takes a village. Thank you for being mine.
CHAPTER 1: Introduction

Human Papillomavirus (HPV) is the most common sexually transmitted infection. It has been linked to several cancers including cervical, anal, vaginal, throat and penile (Luque et al., 2010, Barnack-Talvaris et al., 2014, Casper and Carpenter, 2008). HPV-related warts and cancers can be prevented through vaccination; however, vulnerable Latinx\(^1\) populations do not get vaccinated at the same rates as other populations in the United States (Luque et al., 2012). Existing literature on HPV demonstrates that vaccination rates are related to barriers to accessing services including transportation constraints, knowledge, and time constraints (Luque et al., 2012; Luque et al., 2010; Casper and Carpenter, 2008). However, further research needs to be done on how sociopolitical factors influence HPV vaccination, specifically in the Latinx migrant community, which faces unique structural and situational barriers to preventive health services (Castañeda et al., 2010; Grzywacz et al., 2010; Kline, 2012; Vamos et al., 2018). Apopka, Florida, a city 30 minutes away from Orlando, has a Latinx population that our community partners identified could benefit from research on such obstacles to HPV vaccination.

This thesis builds off of a collaborative student-faculty summer research experience with Dr. Nolan Kline to investigate the impact of the Trump administration’s politics and policies on access to preventative healthcare, particularly HPV vaccination, for Latinx immigrants. In that collaborative work, we examined the population’s understanding of HPV vaccines, their ambivalence towards vaccination, and their perceptions of the effect of policies on access to the vaccines. Looking at these structural problems through the lens of activist anthropology, Dr. Kline and I developed a set of guiding questions that were distilled through ethnographic surveys, focus groups, and key-informant interviews. In collaboration with two local community organizations

\(^{1}\) I utilize the gender-neutral term “Latinx” to indicate a community that is diverse in its geographic origins, nationality, race, and gender.
that advocate for immigrant rights, we were able to collect qualitative data that suggests several structural barriers that prevent access to HPV vaccination for the Latinx population. Firstly, participants reported a lack of assistance from medical providers at clinic and hospitals, tying it back to instances of medical racism. Moreover, respondents reported having minimal knowledge of the HPV vaccine due to the doctors and nurses’ lack of explanation about medical procedures. Interestingly, those who reported knowing about the vaccination suggested a lack of vaccination for the particular infection because it was not necessary for school entrance. Finally, many reported having increased fear to leave the household for noncritical activities due to stricter immigration politics which comprise part of the structural vulnerabilities that exacerbate access to HPV vaccination. In all these themes, the anti-immigrant sentiment of the current administration played a significant role. In tandem, these barriers consistently prevent the Latinx migrant community from seeking basic preventive health services. Because the HPV vaccination is recommended by providers but not required by law, it adds a layer of assumed agency for the individuals to have access. Hence, this ‘optional’ vaccine becomes the ideal lens to examine the how these structural barriers consistently deny access to healthcare for the Latinx migrant population in the United States and remove the individual agency to seek services.

In this thesis, I examine the structural barriers, underscored by the stricter immigration policies under President Trump, that prevent access to preventive healthcare measures such as HPV vaccination. I start by providing a background on previous literature that examines HPV vaccination among the migrant Latinx community, immigration policies in the United States, structural vulnerabilities, and access to healthcare. Then, I describe the methodology that led me to collect the information here disseminated. Moreover, I analyze the practices utilized to keep Latinx migrants in a state of fear that constrains their access to basic healthcare needs. Overall, I
will explain how the fear caused by immigration politics and policies exacerbates access to healthcare as seen through the particular case study of HPV vaccination. Finally, I will suggest further research on the topic and provide a basis for deliverables on HPV vaccination healthcare practices.
CHAPTER 2: Literature Review

I. Latinx Structural Vulnerability in the United States

In the United States, undocumented immigrants are frequently denied access to health services (Quesada et al., 2011). This problem is exacerbated by the current economic state and politics, which do not allow undocumented immigrant from gaining citizenship or working lawfully in the country. In turn, these politics disfavor the Latinx population through anti-immigrant rhetoric. Combined, the social, political, economic, and health-related challenges Latinx immigrants constitute what Quesada et al. call structural vulnerability (2011). Structural vulnerability is the set of political, economic, and social constraints that causes emotional and physical suffering on particular populations and individuals (Bourgois et al., 2017). More importantly, structural vulnerability underlines the constrained agency of the individual caused by the state in regard to personal health. This framework emphasizes the hidden barriers within a society that make access to resources, especially healthcare, harder for vulnerable populations.

The concept of structural vulnerability broadens the lens of medical anthropology to create an emphasis on reciprocal ‘insults’ that force individuals into ill health (Bourgois et al., 2017). As Quesada et al. understand it, an insult is defined as a societal, psychological, political, or economic stimulus that causes an exposure to shift into a disease. This terminology is used to focus on the importance of community pressures, which are inherently social, as opposed to biological, genetic, or environmental factors that exist in a vacuum (Quesada et al., 2011). AIDS, for example, is caused by an exposure to HIV, but the rate of disease occurrence is co-dependent on the individual’s access to proper treatment medication (Bourgois et al., 2017). Assuming that everyone who contracts HIV will survive a period of time through medical interventions before developing AIDS accepts the incorrect assumption that healthcare is a universality not affected by outside
social, political, and economic pressures. The same scenario happens with HPV and related cancers. Hence, structural vulnerability provides an ideal lens to view complex, multifaceted illnesses in a holistic manner that focuses on more than just biological factors in order to define the insults that exacerbate the outcome.

II. Anti-Immigrant Policies and Fear

The structural factors that create unique vulnerabilities for Latinx migrant populations has a basis in anti-immigrant politics perpetuated by the United States government. These politics date to the United States’ independence and creation of a system for citizenship. In 1790, the Naturalization Act allowed people who were white, free, and had lived for two years in the United States to become American citizens, while excluding all populations that did not fit the “white” criteria (Cohn, 2015). 1795, 1798, and 1802 saw changes to this legislation with regards to the residency time requirement; however, the extent of discrimination against anybody who was racially different remained strict with this regulation. The Naturalization Act is, thus, informed by racist rhetoric that excluded those living in America that did not fit a racial stereotype. Although not explicitly anti-immigrant, this act begins to heighten the rhetoric of ‘legality’ on who is allowed to stay and who is not, which ultimately leads to discrimination against immigrant populations in the United States.

Most of the 19th century saw a series of anti-immigrant restrictions concerning Asian immigration. At the turn of the century, immigration enforcement moved towards a rhetoric of control in which those who were not deemed fit enough to economically and socially support themselves were not allowed entry (Fairchild, 2004). In 1903, this language was heightened by the United States’ Public Health Services designating certain diseases as indicatory of immigrants likely to create a burden rather than a profit for the state economy; if people had these diseases,
they could not be a successful input for the expanding industrial America, effectively limiting those immigrants from accessing services in the United States (Fairchild, 2004). Moreover, those immigrants deemed of “inferior races” were also denied access, converging health issues with racial stereotypes (Fairchild, 2014; Kline, 2019). As such, instances of public charge (described in the next section) were initiated and trickled down to the policies we know today.

Although the previous regulations affected which Latinx immigrants could enter the United States, they did not limit how many could enter the country. The Immigration Act of 1924, which instated quota systems on many countries, did not cap immigrations numbers for Latin Americans (Cohn, 2015). Up to 1963, in fact, citizens from the Western Hemisphere were allowed to enter the United States within a series of limited regulations focused mostly on their working capabilities and their health status; those with chronic health issues were discouraged from entering due to the previously mentioned public charge rhetoric. In 1964, the Bracero Program, which allowed seasonal workers mainly from Mexico to work in the country, was terminated by the United States (Fussell, 2014). At that time, all Mexican workers who remained in the country became unauthorized (Fussell, 2014). This was the first instance that Latinx immigrants, who had otherwise been allowed to work in the United States, were deemed ‘illegal’ (Calavita, 1992). By 1976, quotas for Latin American countries were instated, effectively limiting Latinx immigration to the United States. (Ewing, 2012). Together, the end of the Bracero Program and the quotas both limited and controlled immigration for the Latinx population to the United States.

The following 20 years saw an unusual trend towards a seemingly reduced anti-immigrant rhetoric led by IRCA, IRIRA, and TPS. These are moments of inclusion in an otherwise exclusionary immigration system. The first instance of inclusion was a law passed in 1986 to grant a legal path to citizenship for millions of undocumented immigrants, mainly from Latin America,
that had work authorization in the United States (Cohn, 2015). The Immigration Reform and Control Act (IRCA), naturalized more than a million workers in the United States that had arrived before 1982 (Ewing, 2012), but it also criminalized the work of undocumented folks. IRCA prohibited employers from knowingly hiring undocumented immigrants and imposed sanctions on those corporations that did not actively perform immigration background checks on their workers (Ewing, 2012). This ‘double-edged sword’ law limited work for the undocumented Latinx community while attempting to portray a pro-immigration shift. Nevertheless, IRCA showcased a heightened immigration control that marginalized undocumented individuals with the negative terminology of ‘illegal’ (Ewing, 2012). Moreover, it added a layer of structural vulnerability to those who were no longer authorized to work. Companies would still hire those employees, but they would no longer have to act on the same values, legalities, and ethics that they did when the workers were authorized. IRCA, hence, became a form of oppression and improper working practices for those termed ‘illegal’. Finally, it added a structural barrier directly associated to healthcare, since most workers got their insurance benefits from the companies they were working with (Barnett and Vornovitsky, 2016). IRCA actively denied proper conditions for immigrants, deemed them ‘illegal’, and further marginalized them.

In 1990, “Temporary Protective Status” (TPS) was created to allow citizens from countries in Central America that were facing natural disasters and military instability from being deported (Cohn, 2015); this did not, however, give them a path to citizenship but rather a relief of deportation similar to the DACA program today. Still, it allowed thousands of Latinx to stay in the United States at a time of great political and environmental strife in their home countries. In the present, TPS has been revoked for Central Americans, but validity of minimal TPS documentation will be allowed until 2021 (USCIS, 2020). Therefore, TPS was an effective law that allowed for
the Latinx community to remain in the United States for a specified amount of time, but it did not ultimately create an ideological shift characterized by greater acceptances of immigrants. Instead, it added a layer of vulnerability because it showcased a seemingly welcoming environment that appeased those looking for changes in immigration, yet it acted like a band-aid that attempted to cover a bigger structural issue.

In 1996, the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) implemented inadmissibility protocols of 5-10 years for any person unlawfully entering the country or staying past visa expiration dates (Hardy, et al., 2012). Moreover, IIRIRA expanded the list of offenses that lead to deportation in order to include minor offenses such as possession of drugs. At the same time, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 made it impossible for the undocumented population to receive access to federal aid such as food stamps (Hardy, et al., 2012). Together, these two acts worsened the already hostile environment in the United States towards vulnerable populations like the Latinx migrant community.

During the Obama administration, pressure from Republicans led to heightened immigration controls across the nation, which got Obama the nickname “deporter-in-chief” (PBS, 2018). His two terms saw higher numbers of ICE officers on the streets, as well as stricter protocols (PBS, 2018). Moreover, President Obama considered a family separation protocol at the border similar to the one utilized by the Trump administration today; however, the Obama administration quickly shut down the idea (PBS, 2018). Even though President Obama resorted to higher immigration controls, many in his administration suggested his decisions were not ‘anti-immigrant’ (Wolf, 2019). Cecilia Muñoz, then a domestic policy adviser for the Obama administration, argued that although, statistically, President Obama had a higher number of
deportations than previous administrations, his ‘removals’ strictly included people with criminal records or recent arrivals (Wolf, 2019). Unlike his predecessors, President Obama attempted to keep those immigrants who had been in the United States for longer periods of time (PBS, 2018). As a way to provide a policy of inclusion, President Obama instated the Deferred Action for Childhood Arrivals (DACA).

DACA was first introduced by the Secretary of Homeland Security under the Obama administration on June 15, 2012 to allow a temporary reprieve from deportation for a designated set of individuals that meet the criteria. According to the USCIS (2020), a person may request DACA if he or she was under the age of 31 and present in American soil by the date it was instated, moved to United States before the age of 16, and has resided in the country since 2007. Moreover, a person seeking this status must not have committed any felonies and must be completing high school or a GED. All of these, however, are rendered useless if the person does not have ample documentation to back the claims up (Kline, 2019). Furthermore, DACA is not a path to citizenship or a law in the United States; therefore, the temporary nature of the DACA program means that thousands of immigrant youth are in a constantly vulnerable position. In my previous conversations with Latinx individuals in Apopka, participants have described DACA as a band-aid solution to a much deeper wound. Although DACA is meant to provide a reprieve of deportation, it does not provide a reprieve of fear. In fact, individuals still feel vulnerable within the immigration system of the United States because DACA can be ended at any time. Such was the case when the Trump Administration ended the program in 2017 (Kline, 2019). Thus, DACA is a form of inclusion in an otherwise hostile immigration climate, but it still leaves its recipients in a structurally vulnerable position.
Similarly, the Obama administration extended a reprieve of deportation for parents of U.S citizens through the Deferred Action for Parents of Americans (DAPA). DAPA’s requirements mirrored DACA’s strict admissibility prerequisites. Parents had to have lived in the U.S since January 1, 2010, graduated from high school and have completed or will complete a GED, and have not convicted any felonies (Department of Homeland Security, 2019). Moreover, the parents had to prove through legal documentation that all these requirements have been completed. DAPA faced challenges during the Obama administration, and it was rescinded by President Trump when he took office (Kline, 2019). This reprieve of deportation attempted to create a moment of inclusion during the Obama administration, but it ended up failing the thousands of undocumented parents of American citizens. Together, DACA and DAPA were meant to relieve instability and fear from the already vulnerable immigrant community, including the Latinx immigrant subpopulation, yet both executive orders have failed in their apparent efforts to create a more inclusive environment.

In 2017, President Donald Trump instated multiple Executive Orders that increased deportation and authorized the construction of a US-Mexico border wall (Torres, et al., 2018). These were paired with increased policing, border security protection, and ICE raids. After these changes in immigration law at the executive level, Latinx immigrants reported increased levels of discrimination in their neighborhoods, schools, and workplaces (Torres, et al., 2018). Furthermore, families started reporting heightened levels of stress related to immigration status that led to an induced fear of deportation (Torres, et al., 2018). Having even one family member with an undocumented status generated fear in the entire family unit. According to Chavez et al. (2012), the fear of deportation has created a new lifestyle for the Latinx community in which everyday activities are limited to survival events only. Parents no longer allow their kids to be involved in
their communities due to an overall fear of anti-immigrant politics and policies. This heightened terror in their everyday lives has led Latinx families to change the way they seek health services (Chavez et al., 2012).

Recent research suggests that the fear caused by anti-immigrant policy can lead to exclusionary practices for undocumented families (Allen and McNeely, 2017). For example, American children of undocumented parents have legal access to Medicaid, but the increased family-fear of deportation has led to parents not seeking those services for their kids (Castañeda, 2019). Moreover, Trump’s policies perpetuated already-existing notions of some Latinx immigrants as detrimental to the United States’ economy and society which trickled down from the 1900’s public charge rhetoric (Torres, et al., 2018). Hence, immigration policies in the United States may exacerbate the issues of access to health care for migrant communities (Kline, 2017), which ultimately create more barriers to treatments such as the HPV vaccination. The current administration’s politics and policies perpetuate and heighten a form of fear-based governance that pressures undocumented immigrants, as well as other vulnerable populations, to avoid certain forms of health services (Kline, 2017). Nolan Kline (2019) terms this fear a “politics of fear”. By studying HPV vaccination efforts under the scope of the current anti-immigrant policies, sociopolitical, cultural, and economic barriers inherently become elements of structural vulnerability perpetrated by the Trump administration.

The laws and politics here describe encompass the most relevant immigrant policies in the past two-hundred years, which directly affect the Latinx migrant community. Ultimately, the current immigration politics are not unique to the Trump administration. In fact, they are an extension of years of anti-immigrant rhetoric. However, the Latinx population studied in this research did not discuss any anti-immigrant tropes before the Trump administration. Moreover,
the Trump administration has actively and explicitly heightened anti-immigrant rhetoric nation-wide creating an increase in fear (Torres et al., 2018). Hence, the President Trump’s push against immigration exacerbates the existing problem and affects access to preventive healthcare for immigrant communities.

III. Public Charge

Latinx migrant families’ vulnerability is aggravated by the notion of immigrants being a potential “public charge” (Berk and Schur, 2001). The concept of public charge dates back to the immigration politics of the 19th century. According to public charge exclusion, an alien\(^2\) who is economically unlikely to care for themselves or hold a legal working position in the United States is seen as a drain in the economy and, thus, a public charge (Berk and Schur, 2001). The guidelines account for people who are dependent on the government for more than half their income through the use of cash assistance and government-funded care (Perreira, Hirokazu, and Oberlander, 2018). Medicaid, Medicare, the SNAP program, and other non-cash programs are not included in this consideration, nor is the use of such benefits by dependents (Perreira, Hirokazu, and Oberlander, 2018). If an immigrant is considered a public charge upon arrival to the United States, they could be denied entry. Moreover, if they are deemed a public charge within five years of entry into the United States, the designation can lead to deportation (Perreira, Hirokazu, and Oberlander, 2018). Public charge designation can also affect a change in immigration status, such as a permanent residency. This has been instated as a “public charge exclusion” in immigration law (Berk and Schur, 2001) since it is assumed people unable to take

\(^2\) According to the United States Code 8 Section 1101, an alien is defined as “any person not a citizen or national of the United States.” Under this definition, all undocumented Latinx immigrants are considered aliens and, as such, are part of the population that can be deemed a public charge.
economic action will become a problem for the government and public funding. Hence, undocumented Latinx families consistently try to avoid being deemed a public charge for fear of their status in the country (Bleich and Fleischhacker, 2019). This fear has only increased since the Trump Administration came into power (Bleich and Fleischhacker, 2019).

In 2018, the Department of Homeland Security drafted a rule on public charge to expand the definition and increase exclusionary practices (Castañeda, 2019). Under this change, the determinations for public charge would include any alien who has used any form of public benefits, not only cash services (Perreira, Hirokazu, and Oberlander, 2018). This expansion takes into consideration the use of Medicaid and SNAP. Moreover, the Trump Administration’s rule also included background checks on family members and their usage of public benefits to identify if a person is deemed a public charge (Bleich and Fleischhacker, 2019). In a mixed-status family, for example, a parent who is undocumented may be deemed a public charge if their child, a legal citizen, is enrolled in the Medicaid program. The Department of Homeland Security’s reasoning behind this exclusionary practice is to prevent a decline in the economy and a protection of American taxpayer money (Bleich and Fleischhacker, 2019). In reality, this proposed draft is meant to increase fear in an already vulnerable population and effectively lead to lesser use of publicly funded benefits (Castañeda, 2019).

In the months following the publication of the proposed change, the Latinx community reported a “chilling effect” (Duncan and Horton, 2020). A chilling effect is described as a fear of being penalized that leads to a change in behavior. For the undocumented immigrant community, the chilling effect relates to a fear of deportation or an inability to shift immigration status (Duncan and Horton, 2020). With the proposed change on public charge ruling, the chilling effect extended to the Latinx immigrant community not utilizing healthcare benefits for
fear of deportations (Duncan and Horton, 2020). Even if their American-born children have every legal right to use those services, parents reported being less likely to enroll their children in order to avoid penalty in their future immigration status (Castañeda, 2019). This notion consistently prevents immigrants from attending public services for fear of categorization as a liability for the American society (Ku and Matani, 2001). As a result, the change in public charge expansion, although not passed at the time of my research, created a ‘chilling effect’ that led to a change in willingness to seek healthcare services. On February 24, 2020, the public charge rule went into effect, limiting access to services through an induced fear for thousands of undocumented Latinx (Manna, 2020).

Public charge exclusionary practices have shifted the way undocumented Latinx in the United States seek all healthcare services. With this change in public charge ruling, they are less likely to even enroll their children in Medicaid programs. According to research, 8.3 million children who currently have Medicaid are at risk of losing it due to the expansion on public charge (Zallman et al., 2019). Thus, without a healthcare plan, they will have little to no access to preventive healthcare methods which includes HPV knowledge and vaccination. As a result, the concern over becoming a public charge heightens existing structural vulnerability that create another barrier for Latinx migrant populations to receive basic preventive health services and, for the purpose of this research, HPV vaccination.

IV. Barriers to Healthcare and HPV Vaccination

Anthropologists have identified that the Latinx immigrant population in the United States has limited access to services mainly due to their immigration status. Socio-political and economic factors such as income, transportation, perceived racial status, healthcare status, and language are among the barriers that impede access to general healthcare practices (Luque et al., 2010).
Moreover, researchers have identified specific barriers to HPV vaccination, but none have specifically examined the role of structural vulnerability in shaping HPV-related prevention efforts.

Mirroring and expanding on the general access barriers to healthcare, the most common difficulties in accessing HPV vaccinations and cervical cancer treatments for the immigrant population include: 1) the inability to leave the job for the day due to patron’s lack of understanding (Barnack-Tavlaris, et al., 2014; Luque et al., 2010), 2) legal status (Barnack-Tavlaris et al., 2014, Luque et al., 2012; 2016, Furgurson et al., 2018), 3) access to health insurance (Barnack-Tavlaris et al., 2014), 4) lack of transportation (Luque et al., 2010; 2012; 2016), 5) language barriers (Luque et al., 2010; 2012; 2016), 6) general miseducation (Barnack-Tavlaris, et al., 2014; Luque et al., 2016), and 7) misconception of price (Barnack-Tavlaris, et al., 2014; Luque et al., 2010; 2012; 2016). Extensive research has been done on HPV vaccination, as is the case with scholars like Luque et al (2010; 2012; 2016) who considered barriers to HPV at an individual and interpersonal level. Moreover, there is a plethora of knowledge on the cases of application and retention. However, these social determinants have not been analyzed in the context of structural vulnerability and the current public policy context that may have a “chilling effect” on Latinx immigrants’ use of services (Viladrich, 2012). This “chilling effect” is directly related to the immigrants feeling of undeservingness as a result of anti-immigrant rhetoric which, in turn, leads to them not using services that they (or their families) might have legal access to (Viladrich, 2012). Overall, existing research underscores how the HPV vaccination among Latinx migrants hinges on a number of social factors, but existing research has insufficiently considered the current political context as a health determinant. Accordingly, my research examines how contemporary political factors can exacerbate Latinx migrants’ health-related structural
vulnerability and focuses specifically on HPV vaccination. This vaccination becomes the ideal lens to examine anti-immigrant politics due to its unique positionality as an optional form of preventive health.

V. HPV Vaccination and Cancer Prevention

As previously noted, HPV vaccination is a preventive health method used in the prevention of HPV-related warts and cancers. In the United States alone, 42,700 cases of HPV-associated cancers occur every year (CDC, 2018). The first HPV vaccine, Gardasil, became available in 2006 (Barnack-Tavlaris et al., 2016) and since then, the Centers for Disease Control and Prevention (CDC) as well as the Advisory Council on Immunization Practices (ACIP) recommend that all vaccine-eligible children commence and terminate the three-application treatment (CDC, 2018). Gardasil was shown to be nearly 100% effective in preventing Human Papilloma Virus; statistics also show low side effects and good tolerance levels (Viscidi and Shah, 2007). Currently, the eligible age range starts as young as 9 and ends as old as 45 years. However, the CDC recommends the first dose be administered at ages 11-12. Even though international health care organizations such as the CDC and the World Health Organization (WHO) have tried to educate the population regarding the HPV vaccination, less than 40% of eligible teenagers have completed the dosage (Furgurson, 2018). This, in part, relates to the HPV vaccination’s status as an optional vaccination.

In the United States, HPV vaccination is not considered mandatory per public health policies. For the past three decades, a set of vaccines have been mandated for school entrance (Viscidi and Shah, 2007). These include measles, mumps, and rubella, polio, and diphtheria. In order to qualify as a mandatory vaccination, the virus has to be contracted through ‘casual contact’ which includes shaking hands, hugging, and other forms of skin-to-skin contact. Because HPV is
transmitted through sexual contact and exchange of bodily fluids, it does not constitute enough reason to be mandatory for school entrance. Moreover, due to HPVs nature as a sexually transmitted virus, there has been a political pushback to make HPV vaccination required (Viscidi and Shah, 2007). Therefore, low dosage completion of HPV vaccination in the United States is related to it not being mandated for school entry, and hence, optional. Without a completed dose, a person is not immune to HPV and HPV related cancers.

HPV-related cervical cancer disproportionately affects the Latinx population in the United States (Luque et al., 2010; 2012; 2016). Latina women have the highest rate of cervical cancer (with an age-adjusted rate of 9.1 per 100,000 persons) as compared to non-Hispanic/Latina women (with an age-adjusted rate of 6.9 per 100,000) or other minorities (CDC, 2018). Moreover, they have the highest cervical cancer mortality rate (92.7 per 100,000). These data make HPV-related cervical cancer the third most common cause of death for Latina women in the United States (Furgurson, 2018). HPV vaccination is also affected by the existing lack of access to basic services for the Latinx migrant community. As mentioned above, for fear of public charge and anti-immigrant policies, many migrants do not utilize basic services (Chavez et al., 2012). At the same time, the lack of insurance provided due to their undocumented status further limits their access to basic care. If they do not have access to essential and emergency care practices, they also do not have access to preventive health measures. Given the cancer-related disparities and the social and political factors that exacerbate health-related inequalities, it is imperative to increase the research on HPV vaccination and the structural barriers behind access to vaccination for the Latinx immigrant population.
CHAPTER 3: Ethnographic Background and Methods

While existing literature identifies vaccination completion obstacles for Latinx migrant families, such research insufficiently examines how access barriers exacerbate HPV vaccination rates and how sociopolitical factors play a role in HPV vaccine completion. Therefore, there is a need to analyze the influence of these factors in HPV vaccination, specifically among Latinx migrant farmworkers. To do this, I advanced the following research questions:

1) What structural barriers exist for HPV vaccination among Latinx immigrants?
2) What role do current immigration politics and policies have on HPV vaccination intention?
3) What role does knowledge play in shaping vaccine acceptability and initiation?
4) How do individual communities respond to policy and politically driven factors of structural vulnerability?

To advance these questions, I collaborated with Nolan Kline, PhD, MPH, CPH in the Student Faculty Collaborative Research program during the summer of 2019. I worked alongside two immigrants’ rights organizations, HOPE, and Farmworkers Association of Florida in Apopka who assisted with recruitment and data collection. These two community organizations serve the Latinx population in Central Florida.

I. Latinx in Central Florida

The term Latinx has been in use since 2004 (Merriam-Webster, 2018), by activists who do not want the term Latino to dominate the academic sphere. Spanish is a gendered language, and as such, terms like Latino for men and Latina for women assume that there is a binary that people need to ascribe to. Instead, a push has been made by LGBTQ+ groups to embrace the term “Latinx” for people who have a Latin American heritage and identify as gender neutral (Simon, 2018). For the purpose of this thesis, I expand the term Latinx as a form of overall inclusion for any person,
gender non-conforming or otherwise, that has Latin American heritage. Hence, the Latinx community I discuss in my thesis is the group of people that live in Apopka and identify as Latin American, regardless of their specific gender, age group, citizenship, country of origin, or immigration status. However, it is important to mention that, although the term Latinx is used to encompass a multitude of people, not all Latinx people have the same experiences. As a matter of fact, every Latinx community’s experiences are unique. Moreover, contrary to the stereotype that all Latinx are undocumented, the term Latinx does not equate to an immigration status. In this research, the Latinx families were mixed status families including undocumented, DACA recipients, naturalized citizens, and second-generation Latin Americans.

According to the Hispanic Federation’s most recent report, based on the data from the US Census Bureau, the third largest Latinx population in the United States is found in the state of Florida (Gutierrez, 2016). In 2016, over 4.9 million Latinx lived in Florida, and the trend suggests those numbers will keep rising. In Central Florida specifically, more than half of the Latinx population is female; 56% is female compared to 44% male (Gutierrez, 2016). This is at odds with Latinx populations in other states, where the percentages are closer to an equal 50-50 distribution. Occupation-wise, Central Florida Latinx are more likely to work in blue-collar jobs, which is contrary to other states’ data (Gutierrez, 2016). Income-wise, 70% of Latinx households in Central Florida earn less than $50,000 per year (Gutierrez, 2016). Moreover, Central Florida stands out in the state for having the biggest Latinx youth population in the state. Orlando’s Latinx population, for example, is 47% people aged 18-34 years old (Gutierrez, 2016). This information is particularly relevant to our research, since the age for HPV vaccination application starts at 9 but extends all the way to 34 years, which includes the subset of the population described above. Hence, there is
a significant amount of Latinx in Orlando that could benefit from the results achieved through this research.

II. SB-168 and raids

The Latinx in Central Florida, at the time of the research, dealt with two pressing immigration issues in the state of Florida. Both the Senate Bill 168 (SB-168) and President Trump’s announcement of nation-wide raids perpetrated anti-immigrant rhetoric that added to the structural barriers described in the results sections. SB-168 is an anti-sanctuary bill that forces the Florida community to cooperate with ICE officials in their attempts to deport undocumented immigrants (Gruters, 2019). According to the bill, if undocumented people are detained by police, the authorities have to inform ICE of their legal status and retain them for a period of 48 hours to allow ICE ample time to question them. Moreover, this bill disallows any law enforcement entity, governmental agency, or state university from having a “sanctuary policy,” which used to give protection to undocumented migrants in the state of Florida (Gruters, 2019). In the summer of 2019, SB-168 was in the process of getting approved, which created great fear for the community we were studying. At FWAF, community leaders held a panel with police officers, lawyers, and other grassroots organizations to provide information on the changes this senate bill provided as well as to remind the community of their rights. On July 1, 2019, SB-168 was put in effect, solidifying the fear that is still present in the Apopka population.

On Friday, July 12, 2019, President Donald Trump announced via Twitter that raids were going to start nationwide (Hughes, 2019). These raids, which are vastly different from routine ICE detentions, are meant to find, detain, and deport people accused of staying illegally in the United States. According to grassroots organizations across the country, these raids were to happen in Atlanta, Baltimore, Chicago, Houston, New York, and four hours away from Central Florida in
Montañola

27

Miami (Gomez and Hughes, 2019). Immediately, these raids instilled fear in the Apopka community we worked with. During that week, we got calls at FWAF everyday asking what the community leaders had to say about this, and if they thought the raids were going to happen. The chaos caused by the Trump raids in Central Florida is akin to that which ensues when a hurricane occurs. Even though the raids did not end up taking place in Orlando that week, hundreds of people in the community were fearful to leave their homes, instating their own 48-hour curfews. The raids accomplished exactly what they were meant to do: create a rhetoric of fear among the Latinx community and, more specifically, the population studied in Apopka.

III. Apopka

Apopka, Florida is a 25-minute drive from Orlando, yet the physical and social landscape is vastly different. Apopka is home to Lake Apopka, the most contaminated lake in the state (Kahrs, 2016). It is also home to an ever-increasing plant industry that utilizes chemicals and toxic pesticides since its installation in the 1960s (Kahrs, 2016). Together, these two detrimental environmental factors ensure subpar living conditions for the people in the area. Moreover, due to the economic monopoly held in Apopka by farms and nurseries, a significant sector of South Apopka works for these big corporations; as a result, people expose themselves to long hours in the sun and toxic pesticides in the air.

The social landscape in Apopka is highly gentrified. According to the most recent U.S. Census (2010), 73.85% of the population is White, 15.56% is African American, and 18.08% identified as Hispanic or Latinx. Most of the Hispanic population is largely Central American and Mexican (U.S Census Bureau, 2010). However, most of the African American and Hispanic population lives in South Apopka, while the White population lives in North Apopka (Farmworkers Association of Florida, 2019). According to local community organizations, the
number of Hispanics in the census are wildly underestimated given their legal status (Farmworkers Association of Florida, 2019). Hence, it can be assumed that the percentages are higher, and Apopka, thus, more gentrified. This is the physical and social environment the Latinx population resided in at the time of our research.

IV. Community Partners

This thesis builds off of a collaborative effort with two community partners in South Apopka: Hope CommUnity Center (HOPE) and the Farmworker Association of Florida. Both of them started in tandem in the 1970s when the leaders of the community began identifying ways to protect the rights of immigrant families in Central Florida.

HOPE was created by Sisters Gail Grimes, Ann Kendrick, and Cathy Gorman. They moved to Apopka to work with the farm working community and provide resources on social justice that could alleviate their economic and social needs (HOPE, 2019). The Sisters of Notre Dame began, as any anthropologist would, by learning from the day to day life of the community. They worked alongside Latinx and African Americans on the fields, picking oranges and lemons. Over time, they identified the need for social reform in the fields, as well as correction to the injustices present by the legality of many of the farmworkers (HOPE, 2019). This led the sisters to start HOPE, a non-profit service-learning community whose main goal is to empower and advocate for the immigrant communities in Central Florida. HOPE does so through a variety of services, such as citizenship classes, ESOL classes, immigration counsel, youth groups, mom’s groups, and college and career access. I was able to experience many of these services first-hand during my participant observation periods, and the impacts are clear. People actively seek their services because they trust HOPE as a guiding light in the community.
The Farmworkers Association of Florida (FWAF). FWAF was created in 1986 under the name Farmworkers Association of Central Florida (FACF) by farmworkers who were experiencing damage to their crops and as a result losing their jobs (Farmworkers Association of Florida, 2019). That same year, an office was opened in Apopka, Florida, where it still stands today. Several offices opened around the Florida area, but this particular office was rebranded Farmworkers Association of Florida because of the assistance it provided outside of Central Florida for farmworker families after Hurricane Andrew in 1992 (Farmworkers Association of Florida, 2019). Today, FWAF’s mission goes beyond environmental assistance for farm working families. Although it still advocates for farmworker rights related to environmental factors such as pesticide and chemical use in the fields, FWAF has also identified wage theft, worker abuse, and other socio-political issues that affect the community. Moreover, they have identified that the Apopka community has a huge need for immigration counsel, which is why they bring an immigration lawyer once a month to talk to the community. Finally, in recent years, they have educated Latinx migrants about new policies such as SB-168, and immigration raids under the Trump administration. Without FWAF, the community we learned from would not have easy access to complex immigration information, which is essential to their living situation in the United States.

V. Approach: Activist Anthropology

My research was informed by activist anthropology and community-based participatory methods. Activist anthropology invites anthropologists to embrace their political agenda, biases, and ideologies in order to drive their research (Vivanco, 2018) while sharing a common goal with participants (Erickson and Murphy, 2017). Moreover, it ensures that the community being studied is taken into account in an active manner every step of the way. Instead of a one-way street, the
research done by the anthropologist becomes a reciprocal arrangement between researcher and community. Community-based participatory research aligns with activist anthropology because it guarantees that the research is beneficial for the community (Vivanco, 2018). Often, this partnership happens before the research is commenced so as to keep the needs of the population, rather than the researchers’, at the forefront. By the end of the research, a report is provided to the organizations in order to produce tangible deliverables that can be formatted for educational and social justice purposes.

By utilizing these frameworks, I ensured that the research aligned with the mission and purpose of the community-based organizations Dr. Kline and I were working with as well as the community we were learning from. Moreover, I utilized activist anthropology because I explicitly share the viewpoints of the communities being studied. Dr. Kline and I started the conversations with both HOPE and FWAF before submitting a proposal to be funded so we could have an accurate idea of what the community was interested in knowing. Both partners found the project beneficial in elucidating the underlying causes that prevent access to healthcare in the immigrant communities. These organizations were an important agent in the recruiting and selection process, since they have ties to the Apopka community and can identify the people who want their stories to be told. In exchange, I worked alongside their teams for a period of 8 weeks, in which I assisted with their programming, attended the front desk and created tangible educational materials on HPV vaccination. This exchange of information and service made my research reciprocal and beneficial for my work and the Apopka Latinx community. As a deliverable, we submitted a report to HOPE and FWAF for dissemination.
VI. **Sources of Data Collection**

I conducted two key-informant interviews, four ethnographic surveys and four focus groups with a total of sixteen participants. Each interview and focus group averaged an hour each, for a total of six hours, while the ethnographic surveys averaged twenty minutes each for a combined total of one hour. I supplemented this data with over 150 hours of participant observation. These hours were divided among HOPE ESOL classes (20 hours), volunteering with the Farmworkers Association of Florida (~120 hours), community activities at both organizations (10 hours), and educational experiences (2 hours).

*Operationalizing the Research Question*

From the research questions, I collaborated with Dr. Kline and leaders from the community-based organizations to prepare an interview guide that was aimed at understanding how people accessed certain health services, such as the HPV vaccination. The guide started out with basic demographic questions. The purpose of this section was two-fold: we were able to get basic demographic information to be used when analyzing data while at the same time using their commonalities as a starting point for conversation. Moreover, given my positionality within the Latinx community, these questions about demographics would allow me to establish rapport with many of the women who were from Central America. Then, the guide moved towards questions about the health services available to undocumented folks in Apopka. These sets of questions were aimed at discovering what the participants identified as individual barriers to all types of healthcare services. Most of my information regarding healthcare and HPV vaccination comes from the responses given to these questions, which, although not directly linked to HPV vaccination, expressed a lack of access to all forms of healthcare benefits. The next set of questions prompted responses about the current immigration politics in the United States. From these responses, I was
able to discern the greater sense of fear that has been instilled in the community since the election of the current administration. The guide shifted from healthcare and immigration to discuss HPV vaccination. Many of our participants, as will be further outlined below, were not fully knowledgeable about the HPV vaccination, so these specific questions about HPV vaccination and access would often be quickly overlooked. However, our interest in the barriers that affected access to HPV vaccination was already discussed in the greater access to all healthcare services. Finally, a set alluded to any visible connections between these immigration policies and access to healthcare services as experienced by the participants. This same guide was reformatted to serve as the ethnographic survey and the key informant interview set.

Participant Observation

The most integral part of my research methodology was participant observation. This type of data collection ensures the anthropologist learns from the daily experiences of the community without imposing on their lifestyle or culture (Jorgensen, 2015). Often, this looks like assisting in daily tasks, attending social events, and becoming acquainted with the community as a whole. In order to do so, I spent five hours a day on-site at FWAF helping out at the main desk that was missing a secretary in the early morning hours. I would answer phone calls, direct the community to the correct services, and collect information necessary for the organization. Moreover, I assisted in their youth group alongside student and researcher Mary Vickers to create and direct their social programming. I also learned how to create Medicaid and food stamp applications in order to assist the people who needed to fill out these forms but could not do so at their homes. At HOPE, I helped with their ESOL classes as an assistant teacher for two-and-a-half hours every week. For both organizations, I attended social events, such as a mother’s luncheon and a graduation celebration where I served food for the community. I also attended information sessions for FWAF regarding
the diverse immigration protocols that were being implemented during the time of my research. Finally, I attended a Counter Rally during Donald Trump’s re-election campaign in Orlando.

Through this first-hand contact with the community, I was able to gain a basic understanding of the lived experiences of the Latinx migrant families in Apopka and discern basic themes for our research. I was also able to establish a rapport with people that would later share their more personal stories with me. Through carefully kept field notes, I documented the experiences that served as instrumental data in the analysis process. Most importantly, I ensured that my research reciprocated a small-term deliverable for the people who were sharing their stories with me.

*Focus Groups*

In addition to participant observation, Dr. Kline and I completed four focus groups with a total of sixteen participants. The bulk of the information was gathered through this medium. A focus group is aimed at gathering a set of people from a specific community and interviewing them in a group setting. As opposed to an interview in which only one person’s voice is heard, a focus group facilitates communication and leads to community motivation and understanding. If a person feels scared or unsure of a question, another person’s response can easily prompt an idea in the mind and lead to a conducive environment for conversation. As a result, the individuals in a focus group tend to feel less stressed about the methodology behind an interview and consider the scenario a chat between friends (Jorgensen, 2015). Ultimately, this method allows for unprompted, unplanned responses.

In collaboration with Dr. Kline, I did four focus groups with people recruited by both FWAF and HOPE. Originally, the focus groups were estimated to be six to eight people, but due to external circumstances, most focus groups ended up being three to four people. Only one group
was six people. Nevertheless, I discovered that the conversation was more productive in a smaller scenario since people felt prompted to say something as a consequence of others’ responses while at the same time ensuring everyone was responding to every question. In the bigger group, some people felt like it was not necessary to give their stories because others were saying the same things, and as a result some valuable data was left unsaid. Although it was hard to put together given the logistics behind group collaboration, we were able to have a successful conversation with people who were truly passionate about being a voice for the community.

*Ethnographic Surveys*

Another source of data collection included ethnographic surveys. This method consisted of fifteen to twenty-minute structured interviews with people who awaited services at FWAF. In order to avoid the formality of recording information via audio, the conversations are recorded on paper, following the same focus group guide. Ethnographic surveys differ from online or paper surveys in the quality of their data and information and that they are informed by first-hand ethnographic fieldwork (S. Schensul, J. Schensul, and LeCompte, 1999). Further, surveys often measure quantitative data, whereas ethnographic surveys can gather qualitative data are used for rapidly collecting data in a setting with time constraints and sensitive topics. Moreover, ethnographic surveys do not follow a format that consist of a limited number of answers. Instead, the questions are open-ended in order to prompt conversation. Ethnographic surveys are more in line with interviews since they create the chance for participants to tell their stories (S. Schensul, J. Schensul, and LeCompte, 1999). However, they are not directly identified as interviews because the ethnographic survey tends to be of shorter duration and in an informal setting. As a result, ethnographic surveys get the quality of qualitative data while keeping the short duration of a survey, making it an ideal method of data collection for ethnography.
For this thesis, I did four ethnographic surveys with people who were awaiting services at FWAF. Most of them needed their Medicaid or Medicare renewed, so I would often sit with them and have a conversation until it was their turn. I got verbal consent to perform the ethnographic survey like I did for all other methods of data collection. The conversations were extremely productive because the participants did not feel stressed about being recorded or about the information being given since it was in the form of an unscripted conversation. Moreover, they represent a section of the population which I might not have reached through the focus groups alone. Although I did my best effort to recruit people who came into the office for services, many of the mothers who ended attending the focus groups were those that have a stronger connection with the organizations and attend their programs more frequently. With the ethnographic survey, I was able to talk to mothers who may not be fully active with the organization but are still an integral part of the community. Hence, the ethnographic surveys were ideal methods of ensuring a holistic representation of the population in Apopka.

*Key-Informant Interviews*

Finally, Dr. Kline and I had 2 key-informant interviews with community leaders. In order to ensure that the research was reaching different subsets of the population, we decided to interview people who have a long connection and partnership with these associations. They are qualified by their own lived experiences and the ones they have heard through their positions in the community; they became a voice for those we missed in the focus group interviews.

Throughout each interview, I heard the same rhetoric over and over again, which solidifies the data as more than just anecdotal. By the end of the data gathering process, Dr. Kline and I both felt confident that the project had reached saturation and had gotten an accurate representation of the community I had strived to learn from. In total, I talked to sixteen participants through
ethnographic surveys, focus groups, and key-informant interviews. I also gathered 150 hours of participant observation. Together, these multiple sources served to triangulate the findings in order to lessen the possible consequences of the methodological challenges.

VII. Recruitment

My data collection for this thesis started the summer of 2019 through the Student-Faculty Collaborative Scholarship Program. The community partners recruited through various avenues. They asked involved members of the organization, committee members, and staff members to assist in the focus groups. HOPE asked the mother’s group while FWAF asked the mothers of the kids who attended Youth Group. There were no physical advertisements (i.e. posters, flyers), since all recruitment occurred through word of mouth. For eligibility, participants had to be 18+, be vaccine eligible or have children who are vaccine eligible, speak English or Spanish, be willing to participate, and self-identify as Hispanic or Latinx. They were informed that they could leave the study at any time and their relationship with the organization, Rollins, or the personal investigators would not be affected. Since Dr. Kline and I were working with a population that might have limited literacy skills and fears signing documentation because of their immigration status, I obtained informed consent orally through a consent script (See Appendix A) which was also given to participants in a printed format for them to keep. Consent was obtained in the language that was most comfortable for the participants.

VIII. Methodological Challenges

Given the unique situation taking place in Orlando on the summer of 2019, there were a series of methodological challenges worth noticing. At the time of my interviews, the Trump administration had announced raids country-wide. However, these raids would often change location, date, and time, creating an increased fear of leaving the household for my participants.
Many felt like it was not safe to leave their houses if they did not know when the raids were actually happening. As a result, they would be unwilling to commit to a focus group because they did not know if they could actually attend. In the same vein, there was an increased discussion of SB-168 and public charge policy expansion which further increased the community’s fear. This led to my focus groups being smaller than the average set of six to seven. Nevertheless, I believe that was helpful in the long-term because I was able to fully engage with all participants in all focus groups and document their full stories.

At the same time, president Trump announced his reelection campaign in Orlando. This led to a confusing couple of days in Orlando. Community members reported either being too busy attending counter rallies or too fearful to attend focus groups. Those who were fearful explained that they could not attend because they were worried Trump allies would attack or protest the community organizations. I had already planned a focus group for the day of the reelection campaign, and as a result that focus group was the least attended one. Regardless, as mentioned above, I believe all focus groups still provided enough information and had the appropriate amount of people to create meaningful dialogue.

Apart from the particular political situation in Orlando, I had a tough time finding people to respond to the ethnographic surveys in situ. Many mothers who attended the community organizations for immigration-related information were uncomfortable discussing politics with an outsider. Even though I had been volunteering at the main desk, the mothers knew I did not have the same relationship with them that other members of the community organization did. Their fear was related to the heightened anti-immigrant rhetoric. My key-informant interviewee explained that many members are hesitant of negatively discussing the current president for fear that someone will listen to the conversation and alert the authorities. Therefore, I did not get the ideal
number of surveys I would have wanted. Still, the information related to me in the four ethnographic surveys gave clear indications of the position the community has regarding these issues.

A final methodological challenge included finding parents of all genders to attend focus groups or respond to ethnographic surveys. Firstly, mostly women seek services from the community organizations. Through my weeks of participant observation, I mostly engaged with mothers who requested help filling out Medicaid and food stamp applications. The only men who would come into the organization were mostly younger workers who did not have children or did not have enough time in their breaks to answer questions. Finally, in the focus groups, women were the ones who attended the most because, according to the key-informant and workers of both community organizations, they are the ones that make decisions in the household. Since HPV vaccination is an optional vaccination, my community partners believed that mothers would be the most willing to discuss those vaccination options. This meant that my male pool was not strong enough.

IX. Community Participation: Short and Long-Term Results

An integral part of activist anthropology is creating tangible outcomes that are useful for the leaders involved in the research. I did this in a variety of ways that had both short- and long-term results. On a short-term scale, I was able to assist on a daily basis at FWAF and HOPE. At FWAF, I helped more than 50 people with Medicaid and food stamp applications. Without my presence during the summer, it would have been hard for the one-person team to provide that service for so many people. Julissa, who worked for FWAF, told me so on a daily basis. She wanted to make sure that I was aware of the direct impact I was creating in the community. In the Youth Group, I was also able to create an impact that I hope causes a ripple effect. I taught lessons
on voting, the census, and SB-168 to students aged 6-18 years. This is the youth that will later have a say in the future of the country, which is why it is imperative that they are educated about such issues. At the end of the research, each of the students expressed the particular ways they had benefitted from our attendance at the group. The same type of short-term results took place at HOPE. By helping at the ESOL classes, I was able to teach the methods I used as a child to learn the language. Many of the students, who were mostly adults, commented that they were grateful for the tips and tricks. Overall, I was able to create small deliverables that immediately affected the community in a positive manner.

Long-term results are still an ongoing project. Dr. Kline and I identified early in the research stage that parents were not knowledgeable about HPV vaccination. They also mentioned that they wished doctors had available information that was in Spanish and easy to understand. Hence, I created a flyer that elucidated the basic information related to HPV vaccination in a distilled manner (see Appendix D). I gave these informational sheets to parents at the focus groups and surveys. They were also given in PDF and paper format to both HOPE and FWAF, so they can actively distribute them to the population in Apopka. In the future, I will be sending a report to both of these organizations that explains the results from the research and offers ways to implement this research in a meaningful way for the community. These short and long-term results are consistent with the main goal of activist anthropology since they ensure the community receives tangible results of problems it had originally identified.

X. Positionality

Positionality is a fundamental part of any anthropological study since it identifies how the personal investigators identify in relation to the group they study. It takes into account gender, race, sociopolitical status, economic status, citizenship, and place of origin (Sanchez, 2010).
Moreover, it accounts for the personal biases and viewpoints that shape the way the personal investigator rationalizes the world around them (Sanchez, 2010). In my case, particularly, my positionality created an array of surprising responses from my interviewees, which I believe facilitated my rapport with them. As a Latinx individual born and raised in Honduras, I have first-hand understanding of certain cultural, religious, and political aspects that affected the community I was studying. Since most of the participants were born in Central America, I was able to appeal to them through my citizenship and cultural upbringing. The same was the case with my gender affiliation as a woman. Many of the mothers felt comfortable talking to me ‘woman-to-woman’ about a sexually charged topic such as HPV vaccination. One mother even told me her personal struggle with the infection. They also felt that as a female I could understand their motherhood struggles, even if I was not a mother myself. Moreover, my Spanish made it easy to communicate with them since most participants did not speak English. Overall, as a Honduran Latinx woman, I identified closely with the group I was studied, which immediately created rapport with the community.

However, my racial background shocked participants when they discovered I could speak Spanish. I identify as white, and many people that I came in contact with at both community partners assumed I was a gringa. “Someone speak Spanish,” said one of my participants, Sara, when I first met her. “Yo hablo español,” I told her in my best Honduran accent. This immediately left her speechless. “¿Pero si eres blanca, como hablas español? (If you are white, how do you speak Spanish?)” More often than not, I would get the same response from people who came to FWAФ asking for Medicaid and food stamp assistance. They would ask Julissa if they could have a Spanish speaker when they saw me, and Julissa would laugh at the assumption she had also made the first time she saw me. I would then have to explain my family background and the reason
behind my curious *whiteness*. At first, I thought it humorous that people would mislabel my cultural background, but I soon understood that it created a unique positionality that led the community to open up in a way never thought of before.

When participants first saw me, they labeled me as a *gringa* and immediately boxed me with all the other ‘white saviors’ they have encountered. This led them to rationalize that they would respond in a closed-off manner to an outsider. Many even vocalized these thoughts by stating, “I was imagining I was going to have to lie to the *gringa.*” However, once I spoke Spanish, I was immediately taken out of that box. The only other box to place me in was that of the American-born Latinx who came to learn from a community she has not fully been a part of. Julissa mentioned this to me after one of the surveys I administered. She commented that it was uncommon to have an undocumented or an international anthropologist come into FWAF and ask questions. So, if I spoke Spanish but I had the privilege of asking questions, I had to be American in some way. But because the color of my skin did not match the language I spoke, and I explained I was actually born and raised outside of the United States and have no ties to the country, the participants could not box me in this category either. By the time I told the story of my parents’ arrival to Honduras and my subsequent decision to study in the United States, participants had lost track of which box to place me in. Therefore, I was left in a limbo in which I did not fit the notions they have been used to in a research setting. Positioned in this limbo allowed the community to suspend all their biases and offer genuine responses to my questions. In my personal opinion, the unique positionality that my ethnicity, culture, race, language, and phenotype placed me in allowed for an honest conversation that would not have been equally pivotal otherwise.
CHAPTER 4: Findings

Through focus groups, ethnographic surveys, key informant interviews, and participant observation, I found several themes that suggest sociopolitical factors influence HPV vaccination, specifically in the Latinx migrant community, and exacerbate existing structural vulnerabilities for receiving basic health services. As existing literature shows, vaccination rates are related to barriers to accessing services including transportation constraints, knowledge, and time constraints (Luque et al., 2012; Luque et al., 2010; Casper and Carpenter, 2008). In tandem, I noticed that sociopolitical factors further exacerbate the already-researched individual barriers. In this section, I explain and analyze the four most common themes pointed out by the people in the community. First, participants reported an increase in instances of fear due to the Trump Administration’s enhanced immigration control and anti-immigrant rhetoric. This clearly racist language promoted by President Trump motivated public workers, like police officers and doctors, to actively discriminate against those deemed a racialized other. In turn, this led to instances of medical racism that directly affected access to HPV vaccination. Moreover, my participants described a lack of support from medical centers, medical providers, doctors, and nurses which is related to this increased medical racism. Participants also reported a low or basic understanding of HPV vaccination associated to doctors’ disregard for questions regarding medication. Furthermore, many stated a hesitance towards the particular vaccination since it is not necessary for admission into the American school system. Finally, the interviewees identified a fear to leave the household for non-pressing manners due to increased policing, which in turn leads to less visits to the doctor for non-urgent procedures. In summation, these themes emphasize the effects of sociopolitical barriers that prevent communal access to HPV vaccination and create further structural vulnerabilities for the Latinx community.
I. Politics of Fear

During interviews and participant observation experiences, I regularly heard participants refer to miedo, temor, and terror. Every participant expressed a heightened sense of stress, anxiety, and generalized fear since moving to the United States that has worsened since Trump has taken office. Their experiences are instances of the politics of fear concurrent with current literature on immigration and deportation (Kline, 2019). The fear my participants expressed often directly affected the way they experience their day-to-day lives, as well as the way they seek and classify services as essential and nonessential. In the case of HPV vaccination, the preventive healthcare effort was deemed nonessential and, therefore, not necessary during a time of such fear. As mentioned before, this heightened fear is linked to the current anti-immigrant rhetoric coming from the government of the United States. Thus, access to HPV vaccination is consistently denied through socio-political factors, like immigration, that create a removal of agency for the individual. This further exacerbates their already vulnerable positions.

In this section, I analyze themes that emerged in our conversations of fear since the Trump administration took office, effectively demonstrating the connection to HPV vaccination and the structural barriers created through fear. Firstly, my interviewees explained that fear has become the focus of the lives of undocumented Latinx in the United States. For many, it is all they can discuss with their families and loved ones on a daily basis. Furthermore, many directly related their heightened fear to the anti-immigrant rhetoric of the Trump administration. They claim that although fear is not a new concept for undocumented Latinx and mixed status families in the United States, the election of President Trump has moved fear from a general worry to a consuming force. For many, this fear is directly linked to SB-168, the raids that were being held during the time of my fieldwork, and Trump’s attempts to broaden public charge language. Moreover, and
because of public charge rhetoric, my participants feared changes to their families’ healthcare status which then directly affected access to HPV vaccination for the community. All this fear of uncertainty, increased anti-immigrant rhetoric, and deportation culminated in a fear of leaving the household for any activities that were deemed non-essential. HPV vaccination, an optional form of preventive health service, was identified as non-essential and hence put at the back of the mind of most of the parents I interviewed. As a result, fear became a structural barrier to accessing HPV vaccination that is directly linked to a rhetoric of immigration that affects the entire Latinx community of Apopka, Florida.

_Infiltrated Fear in Everyday Life_

The overall sentiment expressed by the Latinx community regarding President Trump was that this anti-immigrant rhetoric and blatant discrimination increased racist instances that heightened the already present fear. Almost every question in the research guide was related back to that increased panic of the unknown future presented by immigration regulation in the United States. In my first focus group Mariela commented that regardless of each person’s individual immigration status, everyone in the household had some degree of panic regarding deportation: “the community is fearful. We have a lot of fear even if our kids are born here. We have fear.” This reiteration of fear was a common conversation among the mothers, to the point that it felt like the sentiment overflows every aspect of their daily lives. Regardless of the discussion being about routine activities such as grocery shopping, medical services, sports, or leisure, the heightened feeling of panic was there. Hence, there is an increased fear of accessing all types of medical services, including HPV vaccination.

My key-informant from the Farmworkers Association of Florida confirmed that fear was the one topic of conversation no one ever stopped discussing, regardless of outside factors. She said, “there has been, there is, and for the foreseeable future there will be fear.” When prompted
for more specifics, she simply stated that the fear is related to everything. Since they are already in a vulnerable position based on their immigration status, not a single aspect of their lives is free from that panic. It has been engrained into their social, mental, and physical circumstances, effectively creating a politics of fear (Kline, 2019). The comment made by my key-informant underscores the Trump Administration’s push for harsher immigration control which continues to exacerbate this fear. Fear is nothing new for this community, but it has been heightened by the Trump administration to the point that the undocumented Latinx population is uncertain of when the fear will cease in the future. According to some mothers, even when they try to avoid fear, they are often incapable of doing so. One mother in my ethnographic survey said she tried to cope with that fear by not listening to the news: “I have not heard about the raids Donald Trump has tried to do. But that is because I try to not listen to the news because they fill me with fear. And then I do not want to do anything. Although I try, the fear is still there. But I will continue to try”. Hence, their experiences suggest that fear has become a chronic result in their lives due to immigration law, and that fear extends to the use of medical services which are a part of the population’s necessities.

In another of my focus groups, two mothers tried to pin-point specific instances of fear as they related to police and racial biases. Natalia stated that police, normally a source of security for people, had turned into a front for fear: “instead of feeling comfortable with the police. We run from them. Why? Because the panic is too much to handle.” Isabel followed Natalia’s comment with, “yes, and we fear them because if they see us as a different color, they will search for us. That’s the little details people sometimes miss.” Both mothers alluded to a seemingly normal event such as seeing a police officer as a clear initiator of fear. Castañeda defines this stereotyping of undocumented based on phenotypical differences, which Isabel discussed with me, a “phenotypic
passport” (Castañeda, 2019). Those who have a “phenotypic passport” and fit the ‘white’ criteria in the United States are less likely to be considered undocumented (Castañeda, 2019). However, those who do not have such features are more likely to be discriminated against based on a perceived undocumented status (Castañeda, 2019). In this case, both mothers alluded to the way heightened immigration protocols have given leeway to police for stereotyping and stopping people based on a lack of a phenotypic passport. And this overall panic of being stopped based on a racial bias suggest fear is engrained in the Latinx community of Apopka.

Finally, a mother from Honduras explained that, even though she fears for her future every day, she was forced by circumstances at home to come to the United States. Nicole said,

I did not move here because I wanted to, but because I was forced to. Right now, a lot of people are traveling from Honduras, from Central America, because the situation in those countries is extremely hard. And we come running from there and we come here, and we are still running. We come here to seek a greater freedom because this is supposed to be a country where people are safer. But instead here we are, hiding forever in the shadows. But before we could at least walk in the streets and go get lunch. Now I leave my house and I leave in fear. With that fear that I left my children at home and I have no clue if I will go back.

Nicole verbalized what most of my mothers were thinking. She reiterated the instances of fear I had heard across the groups, but she also alluded to that increased lack of agency behind most Latinx’s moves to the United States. Nicole was structurally vulnerable in Honduras. The pressure forced her out of the country into another one that she wholeheartedly believed would provide her with a higher degree of freedom. Instead, she found another place in the shadows. Her
agency has still been revoked, but she must remain in this vulnerable state for the sake of her children. Hence, all these recurrences of fear suggest that anti-immigrant rhetoric has effectively created an institutionalized politics of fear that aggravates the Latinx population’s lifestyle in the United States. Accessing medical services is also a part of those everyday activities that have been affected by instances of fear.

*The Trifecta: Fear, Anti-immigrant Rhetoric, and the Trump Administration*

Besides a generalized fear of deportation and immigration law, the community members reported feeling a heightened sense of fear and hopelessness since the election of the current administration. Their experiences mirror the previous literature which suggests that the Trump administration’s clear exclusionary practices lead to increase fear in the Latinx community and stigmatization by other populations (Torres, et al., 2018). In one such conversation, a mother stated feeling an increase in racism due to new legislation. Andrea commented, “With these new laws the problem with racism and the differentiation between races has increased almost at a national level. And with these new laws we all have more fear. Why? Because we are facing a much harder situation. And we know it is not everyone. But there are a lot that are racist.” Similarly, in another focus groups, Emma explained how current immigration law has given leeway for people to disrespect minorities: “There used to be more respect before. Now people say whatever they think. And that makes me fearful to interact with others. They do not care if they will offend you.” Emma’s comment aligns with what Kline (2019) terms a “license to discriminate”. Based on the increased immigrant exclusionary language used by the current administration, people feel entitled by their own government to make assumptions of immigration status based on phenotypical differences and act in a hostile manner towards a racialized ‘other’. Following Emma’s comment, Marcela stated, “what happens is that since this
new president came in, there has been a lot of racism.” Andrea, Emma, and Marcela’s commentary on the Trump administration to racism mirrors other experiences I heard on the field. The heightened anti-immigrant rhetoric used by the president in both official and non-official addresses has led to an increased confidence in other United States citizens to utilize that same language and employ a phenotypic passport to decide which should be discriminated and which should not. As a result, like my participants mentioned, there has been an increased fear of racism within the Latinx community.

One mother even connected the Trump administration to her hesitation to go to the hospital: “since Trump, it does not feel comfortable to go to the hospital. I have to go to the hospital soon for a check-up, and I am mentally preparing. I am already dreading it.” This mother’s example starts alluding to the Trump administration becoming a structural barrier to healthcare, discussed farther below. She felt that because of the increased racism, she will not have access to the same quality of care she did before at the hospital, so she has to prepare ahead of time for the possibility of being discriminated. This is again related to a license to discriminate which culminates in instances of medical racism. If there is fear to attend the hospital for a check-up, this fear becomes a barrier towards accessing multiple types of healthcare services, including the HPV vaccination.

At the time I was doing my fieldwork, thorough discussions on the raids, SB-168, and the revision on public charge rule were happening. As a result, many of the comments about both the Trump administration and fear related to these changes that heightened anti-immigrant rhetoric. The raids increased the sense of confusion and overall anxiety for the population since official reports announced raids for a specific day in a specific city and then proceeded to change those specifications the next day. Hence, many of the participants in my focus groups lived in a state of
turmoil. Valeria explained that her routine schedule had been suspended once the raids were announced: “the raids have changed my day-to-day life. There is more stress. More fear of living. More tension.” Similarly, Paola explained that she felt as if the government was playing with their brains by instating and then shifting the raids. Paola narrated, “It is more fear. The community is afraid. And they [the government] say, ‘this week we will start’. And then, ‘no, next week’. They are playing with our emotions. We are in a complete state of fear. That is anguish. That is playing with our heads. And that makes us sick.” Finally, my key-informant interviewee stated, “those raids have everyone like crazy. Because they are happening all around us. And I do not know if you have heard, but Trump said something about sending even more raids, so that is getting a lot worse.” The stories from these three community members showcase the increased uncertainty created by the raids. Moreover, as Paola explained, the ambiguity of specific dates for the raids becomes a tactic from the government to play with the emotions of those marginalized communities. In a perfect example of the politics of fear, the current administration has crafted a new layer of structural vulnerability that forces people to remain in a cycle of fear due to uncertainty about a raid that may never happen. As a result, many participants felt their lives were being placed in a limbo until a new change to the raids happened. In this state of uncertainty, they are unable to access essential services, like medical assistance.

The same iteration of fear mentioned above happened with discussions of SB-168 being passed. People in the community stated they had an increased fear of driving or leaving their houses since the senate bill was passed. Gabriel commented he felt an increased terror every time he saw the police: “with the whole thing they are discussion about immigration, well I worry about it. Now they say the police can stop you and ask you about your papers. That now the
same police officer can send you case to ICE. So, when I see one of them, I panic.” In the same manner, another mother mentioned the SB-168, stating, “now everyone in the federal sector can report you in Florida.” Although many of them had not heard the particularities behind SB-168, the passing of the bill heightened a fear to perform daily activities because it had been portrayed as further anti-immigrant rules passed by the current administration. In an effort to quell those fears, the Farmworkers Association planned an immigration forum to explain the specifics of the bill. However, many parents still felt like they would have to make adjustments to their daily routines, showcasing the fear not as an individual stressor, but rather a facet of a bigger structural issue that cannot be simply solved with information.

My key-informant interviewee from HOPE expressed that workers will no longer stop at their usual grocery or gas stations because they have seen more police agents since the bill was passed. She said, “some of them do not stop at 7/11 anymore because they are parked there. They [police] now that they [workers] start early, so they start early, too. So, at 5 in the morning, 7/11 is packed with a bunch of workers. And that is when they will show up outside of 7/11.” She ended our conversation on SB-168 with the comment, “que Dios nos proteja, porque la SB-168 empezó (may God protect us, because SB-168 has started).” Overall, the passing of SB-168 incremented the already tangible fear in the lives of the undocumented Latinx community in Apopka. Because of this imminent fear of deportation, many shifted the way they performed daily activities. As the key-informant mentioned, some participants would no longer meet at 7/11, where they were normally picked up, because of the feeling of uncertainty attached to SB-168. Even with information and clarification on the specifications, the community felt the fear did not cease. Thus, SB-168, like the raids, aided in the marginalization of the Latinx community
effectively enforcing a politics of fear. With such a state of fear, it became hard for parents to consider seeking anything outside emergency services.

Finally, related directly to the Trump administration, participants discussed the public charge rhetoric as an agent of increased fear. Although many did not call it by name, they stated an increased fear of accessing essential services like Medicaid and food stamps because they did not want their future in the United States to be jeopardized. This sentiment comes directly from Trump’s desire to extend public charge language to include an entire family being deemed a public charge. As a result, this consideration\(^3\) instilled fear in people to get the services their kids and family members have always had a right to. Moreover, the public charge exclusionary language leads to instances of undeservingness. Emma mentioned the people in her community fear requesting Medicaid: “most people here fear getting Medicaid for our children because they are supposedly passing a law that if the child’s father is undocumented or an immigrant, they won’t extend Medicaid for the kid.” Another mother, Alejandra, feared that some sort of legislation had passed because she was no longer getting the same benefits in Medicaid and food stamps services which her children are legally allowed to receive. “Before he [Trump] came into power, I applied for the food stamps and received them. And now I have like six months that I came to renew my Medicaid and the food stamps, but I did not qualify. Many people are saying that the government is revoking those privileges. But I need the Medicaid. Why? Because I am a single mother and have no other way of getting that service.” Public charge rhetoric does not express that Medicaid and food stamp services will be revoked. However, it does state that if parents choose to utilize those services for their kids, they might be considered a public charge. Hence, for the community this is the equivalent of revoking those

---

\(^3\) At the time this study was performed, Trump’s attempts to expand public charge rhetoric had not been approved. On February 24, 2020, the change went into effect.
services. If their family’s status in the United States is suddenly jeopardized by this ruling, they consider access to those services not a priority. Their priority is to stay in the country to allow a better future for their children. Public charge, thus, becomes a sociopolitical barrier heightened by the Trump Administration’s use of fear to prevent access to necessary services, healthcare included. In the case of HPV vaccination, the added factor of not being a mandated vaccination means that it is further removed as a form of preventive healthcare that the population does not have access to.

Alejandra and Emma’s stories are similar to those expressed by Gabriel and other regarding SB-168. Even though they do not know the details of the changes the Trump administration is attempting to pass regarding public charge, they know that those alterations will entail greater limitations for those in the community who are already vulnerable. As a result, many have stopped accessing services that are still within their legal rights for fear of an uncertain future. My key-informant from HOPE mirrored the sentiments of many parents, stating that they are actively not getting essential services like food stamps due to the potential of public charge rhetoric shifting: “right now, like the food stamps and even all that stuff that they give to the kids. I know that some of them are not taking it anymore. And I know they need it. But they won't take it because it has been said about the public charge that they are going to affect you the day you try to legalize your status. So, because of that, and again because of the Administration, many of them are not applying for food stamps.” Similarly, my FWAF informant expressed that their fear is related to their desire to keep hope of one day becoming legal in the United States. She commented, “I think it is just the general fear [of public charge], you know, cause low-key everyone still has hope that one day there is going to be a change in their status, but is also like, not being 100% informed but is also like seeing it so much on the news and people talking about
“and the people in the community ask me, ‘do I take my kid to the hospital, get food stamps, or not? Just because of this public charge? I can’t tell anymore’”. Both of my key informants agreed that, since the Trump administration has tried to broaden public charge rhetoric, the community’s fear of using essential services has risen. Interestingly, no law or change has actually been instated by the current government, yet the notion of a possible change has created enough fear of governance that the Latinx community has already made changes to the way they seek services. Hence, these stories suggest that public charge is a form of politics of fear that directly affects essential aid, such as Medicaid, further marginalizing the Latinx community and removing their agency.

When asked how she felt the overall community’s emotions and lives had shifted since the Trump administration, my informant from HOPE concluded, “the fear and you know giving up. So that has taken a toll in a lot of them, and it is also, from what I talked to my host families, it’s the fact that some of their kids didn’t know what was going on. ‘And we are still in fear, and now we don’t know’. And it sucks because it is even like a trauma. They say to me, ‘why would he do something like that to us’”. The Trump administration’s use of raids, SB-168 and public charge rhetoric as a politics of fear forces the Latinx community to change the way they lead their daily lives. Many have an overall heightened fear to drive, leave the house, or go to work. Others have resorted to not utilizing healthcare and essential services for fear of becoming a liability. Most of the participants fear the possibility of change, like raids and public charge, even if they have not become a reality. As a result, the anti-immigrant rhetoric used by the Trump administration turns into an added socio-political barrier that makes the Latinx community structurally vulnerable.
**Stay Inside: Fear to Leave the House and Essential Services**

In my conversations with the Latinx immigrant community in Apopka, my participants discussed another iteration of fear directly tied to Trump’s anti-immigrant language and increased immigration protocols. They emphasized dreading to leave the house for anything not deemed an essential activity. Sports, fresh air, shopping, and spending time with friends were categorized as nonessential by the families at this time of generalized state of uncertainty. Mirroring the current literature on fear for the Latinx community, my participants stated that they resorted to a ‘survival-only’ (Chavez et al., 2012) approach in which they would leave the house for the most basic physiological needs. Forms of preventive healthcare, such as HPV vaccination, are not a part of those essential activities. Hence, this heightened fear to leave the household, unless it is for ‘survival-only’ activities, is a sociopolitical factor instilled by the politics of fear of the Trump administration that becomes a barrier to accessing HPV vaccination.

In my ethnographic surveys with the community, all participants stated experiencing fear to leave the house. Delmira said, “I fear going on the street. So sometimes I don’t want to go out unless the situation is dire.” Similarly, Patricia commented, “people live sheltered. They go out like they used to anymore. We just don’t see people walking around the neighborhood anymore.” All four of the mothers clearly expressed that leaving the threshold of the family household was a reason for increased panic of uncertainty for the families. As a result, they attempt to stay within their realm of security as much as possible.

Moreover, this fear of leaving the house affected the way the parents made decisions about their daily lives and interactions with the outside world. The most shocking confession was made by a Guatemalan mother, Sara. Sara stated, “I live a simple life. I leave my home. I take my kids to school. I go to work. I come back from work. I pick my kids up from school. And we head home. And we wake up the next day and do the exact same thing. And once a week, I leave my
house to get groceries. And I come back. And we do it all over again.” She has committed to a life in which only essential activities are done and going to the doctor has become unessential if it is not related to an emergency. In this same manner, Kristal commented on not knowing if she would even return home after a day of essential activities: “it creates a lot of fear. Out of necessity we have to leave the house to get food, to get what the house needs. And if you work you also have to leave the house. And you fear that you have to leave the house and take the kids to daycare and go to work and pick them up. And you do not know if you will come home again.” Still, another mother, Paola, reiterated, “well with the new laws now, you leave your house and you have no clue if you will return home. And that is scary.” In our final interview, Laura, a mother of two, confessed, “you know, I live day by day. Cause I might not be here tomorrow.” These mothers’ experiences with fear drastically change the way they perform daily activities. As Sara mentioned, she has committed to just leaving the house if she needs essential products or services. Kristal defined it as leaving for necessities only, reiterating a survival mode. Furthermore, when leaving the house, their fear of not returning to their haven is increased. These politics of fear that have been instilled in the Latinx community drastically alter the ways they seek all services, healthcare included.

My FWAF key-informant expressed that this fear of leaving the house has led to families not sending their kids to school. She reiterated, “the social worker from Headstart came over and she was telling me, ‘I need you to help me. The parents are not bringing their kids to school. Because they are fearful. Because they heard they [ICE] were taking people away when they are driving.’ I tell them that we cannot fear to the point we never leave the house. But it is hard.” Similarly, my key-informant from HOPE suggested this trend also extends to not wanting to go to the hospital: “one of the things that I remember one of the families saying is like ‘oh, we just
don’t go to the hospital, because the police is outside’. And I was like, but if you need to go you can go. And they were like, ‘no because the fear”’. A mother also explained people are deciding to leave their jobs given the increased anti-immigrant rhetoric: “people are abstaining from work. There are people who say, I will just stay at home instead. It’s better if I do not go to work. People have taken the decision to be laid off of work. And it is much worse with hospitals too. We have to think if we should go or not” The experiences my key-informants and this mother have heard suggests that, even in cases such as hospital visits and school attendance which are deemed essential, parents are hesitant to leave the security of their homes. They also insinuated that if this fear continues to increase, families might decide to further push their ‘survival-only’ lifestyle to not include education and medical check-ups unless an emergency occurs. This is a clear example of how the socio-political barrier caused by anti-immigrant rhetoric has created a lack of agency for the Latinx community.

Other participants suggested that their fear also related to increased racism. This racism is further tied to the politics of the Trump administration which, as discussed before, have given a leeway for people to replicate racist remarks towards certain minority groups. Maria explained she felt compelled not to leave her house because people in the streets were evidently racist: “so we are living in the shadows. And now? In the darkness even more because of the situation. Because people have risen. Racism has risen. Because people used to not attack you before. Now the people on the streets insult you because you are an immigrant.” In the same manner, another mother stated, “It’s mainly about discrimination. Even if it is just based on your profile as Latino. People consider you undocumented. It generates fear to go out of the house. I do not want to go out of the house”. In these two experiences, racist remarks said in the past have further instilled this fear to leave the house. Paired with the laws that are meant to oppress the
Latinx community into a state of panic, these racists remarks become forms of ‘insults’ that generate structural vulnerabilities.

Another iteration of fear to leave the house was linked to a fear of driving without documentation and not being allowed to return home. “One leaves in the morning with fear,” said Maya. “Even worse if one lives far away. Like one goes on the streets, runs [the car] on the streets and the truth is one goes without the license. So, one goes with fear. The fear is that one has kids. The kids stay inside, and one leaves. What if, Dios no lo permita, one is stopped, something happens on the way, and who are the kids staying with? That is the fear one has.”

After this comment, a mother followed with, “now with transportation. With the fear that they will stop you, you do not even know if going to work is worth it. If you should continue working or not. You don’t know if you will return to work or not.”

Finally, most parents were saddened that this heightened fear directly affects the childhood of their kids. They wish they could provide a safe and free environment for them to learn in. However, the fear of being separated permeates their thoughts to the point that they have to submit to a life in fear. Marcela stated:

when the president won, my kids were like, ‘mom what will happen now’. And I said, ‘we will see what happens. We do not know if they will detain us. We do not know anything’. And they are always worried about what will happen with the reelection or the deportations. It is bad that they live in the stress of uncertainty. ‘What will happen to me? What comes afterwards’ and that is no way to live day-to-day. They live with anxiety. And since they announced the raids, we have told them not to open the door. Even if it is the police So now when I am not at home, they call me and they say, ‘ma somebody came over
and knocked’. I think it is not fair because, in the end, they should be having a normal childhood and should not be worrying about living.

Overall, this generalized fear has caused Latinx migrant families to shift the way they live to a survival basis, which in turn affects the way they access their children’s healthcare. If they do not feel comfortable taking their kids to the doctor, how can they begin to think about vaccination such as the HPV vaccination that is considered by many to be nonessential? Yet, parents stay in this cycle of oppression because, as many stated, “my kids future is here. They get to study here. They have the possibility not to be like us that grew up without knowledge. And I do not want that for my children”. Even through the multiple layers of structural vulnerabilities, parents remain in the United States for the care and the protection of their children. However, these structural issues that prevent them from getting food, essential services, nonessential services, healthcare, and forms of preventive health efforts like HPV vaccination keep marginalizing them to the point of not living life apart from a survival standpoint. All these compounded structural barriers exacerbate the overall lived experiences of the Latinx community in the United States.

II. Medical Racism

As existing literature indicates, there is a plethora of individual barriers that affect access to HPV vaccination for the Latinx community. Many of those are related to language, transportation, and working conditions. However, in my research I found that one of the biggest barriers related to a lack of assistance at medical centers from part of the medical providers. Most participants alluded to individual barriers like language and immigration status as connected to the bigger issue of racism, which has been heightened by the current administration. As a result, many argued that doctors, nurses, and other medical providers would judge their patients based on their
ability to speak the language, their phenotypical differences, and their healthcare plan. Through discussions about the patients ‘undocumented’ status as well as an unwillingness of the medical providers to give information, this form of medical racism became apparent. Finally, medical racism was present through an overall lack of assistance from doctors and nurses that created a structural barrier for the Latinx patients to easily access the services.

Language and Racism

The overall sentiment regarding the language barrier was that doctors and receptionists would use this barrier as an excuse to not provide assistance or clarification on particular procedures. In my first focus group, Mariela⁴, a mother of four, commented that the lack of a communal language led to her not being able to ask questions:

And we go to the clinic and we want to ask question and I cannot because the [female] doctor does not understand us. And we do not understand her. So, we cannot understand each other. With my pregnancy I had a really hard time. I would just go, and I did not even have an idea of what they were doing to me. I did not know, and I did not ask because they refused to give me the right services with the proper information.

In another focus group, a mother reiterated the same sentiment, emphasizing that doctors are ‘unwilling to understand’ which would lead to erroneous diagnosis:

The language. Because sometimes when you go to the doctor, you get there and they take your vital signs and the nurse asks you all your details before the doctor gets there. But you cannot express it. And there is not always somebody that speaks Spanish. There isn’t always somebody that speaks Spanish and it

⁴ All names have been switched to pseudonyms to protect the identity of the people we interviewed.
might be an emergency. And I think in this country that has such a high demand of Hispanics there should be somebody that speaks Spanish, at least in the emergency unit. And yes, I have clashed with not being able to express what I really feel and that’s why we have erroneous diagnosis. Because we cannot understand each other. Because you cannot express what you are feeling accurately, and the doctor is not willing to understand you.

In these two cases, the mothers expressed a frustration at not having a translating service which would remove the barrier to their mutual understanding. As I discussed with my key-informant, doctors can have a phone service which allows for simultaneous language translation for patients with limited English proficiency. Under the Obama Administration, this language line was required by all medical providers who received federal funds, including those from Medicare and Medicaid (Regenstein and Andres, 2014). In fact, Title VI of the Civil Rights Act instructs all doctors to have proper translation methods for patients (Regenstein and Andres, 2014). However, according to previous research, this mandate is often disregarded by medical providers (Ollove, 2019). Recently, the Trump Administration has made a push to relax this Obama federal ruling on the grounds that it is not cost-effective for the government (Ollove, 2019). If passed, this change would still allow people to request translation services, but they would not be told about their existence. Hence, research suggests number of translation services usage will drop drastically due to a lack of knowledge. At the time of publication, this ruling is still being discussed, but the reasoning behind the change is part of the bigger anti-immigrant rhetoric of the Trump administration.

Many clinics and hospitals in the area I studied did not have the service. As a result, the medical providers’ denial of treatments that fit the language needs for the community was
perceived by the participants as a clear unwillingness to cooperate and provide proper medical assistance. This unwillingness to mention the language line as a possibility for people relates to the current administration’s desire to minimize such assistance. Therefore, this becomes an instance of medical racism which adds a structural barrier for those seeking healthcare services. If they cannot communicate with their providers, the quality of their treatment is diminished, and if the providers are actively ignoring the patients’ rights to a language line, they are limiting essential services. The mother who reiterated the story above experienced this form of medical racism at an emergency care unit. Ultimately, if patients are not receiving assistance during emergency situations, they are also not having access to such services as language lines to understand preventive healthcare methods like HPV vaccination.

Furthermore, one of the participants, Isabel, stated that the language barrier would lead to medical providers seeing the patients as ignorant and would not respond to their basic questions regarding medical procedures. She explained, “One can speak the basics [of English] […] When they told me about HPV, I asked what the vaccine meant. And they see it up to a point as ignorance. ‘Why are you asking me that and you have no clue what it is’ And the way they put their faces when you ask. Like saying, ‘how dare you waste my time with this ignorant question’”. Isabel’s experience aligns with those discussed by other participants which suggests that doctors utilized that inability to understand their patients as a way not to respond to questions. Isabel’s experience is directly related to her social status as undocumented. Coming from a Latin American country, she never had access to a bilingual education. Once in the United States, she had little time to attend classes due to work pressures that did not let her leave the job site. Moreover, the doctor’s discrimination based on language relates to his perceived notion that those who do not speak English are, therefore, not United States citizens.
The participants’ initial comments on the language barrier causing a lack of information and assistance from the doctors led to a clear connection to racism for other participants. After Isabel’s comment, Alejandra, a mother of two, explicitly mentioned that her lack of English would lead to ‘racist’ medical providers that would become impatient with questions: “When I started to attend the clinic there would sometimes be people that are racist in the fact that because I do not know English they get mad. They are mad because we cannot understand them or explain to them. They became impatient and did not want to try and explain things to me”. For Alejandra, the doctor’s reactions to their language barrier was a response based on racism. This is in line with other participants’ feelings about medical providers’ attitudes towards Spanish. Another participant added that, even if some people seem to know the language, they refuse to understand it. She also tied it to the phenotypical differences medical providers use to judge patients. Paola, in that same focus group, explained:

There are also people that, even though they understand, because sometimes there are some of us who do not know how to speak English, but we try to explain things in English. But there are people that for, let’s say ‘personal reasons’, do not want to understand you. When I speak to somebody that has no issues against immigrants or the individual person due to their physical appearance being Latino, they understand you. And then there are other people that you say the same thing, but they refuse to understand you. Hence, it is a sort of racial type that is being judged.

These mother’s personal experiences with medical providers and language barriers showcase that language is more than just an individual barrier or an isolated case. Instead, as many of the participants pointed out, the lack of a communal language was used as a justification for
medical providers not to offer exemplary care for their patients. The interviewees felt that doctors and nurses did not want to find alternative ways to provide proper care, instead limiting themselves to doing the medical job without letting the patients know of their conditions. Consequently, the participants, themselves, identified these instances as a form of racism in the medical sector. Being judged on their language differences and consistently treated in a dissimilar way to other patients is a clear form of medical racism. Hence, what is often considered an individual barrier for people accessing medical services is, in fact, a sociopolitical factor tied to the increased anti-immigrant rhetoric in the United States. The language impediment heightened by the medical providers’ lack of assistance and substitute methods of communication becomes a structural barrier that further exacerbates access to care for the Latinx community. As a result, it becomes increasingly harder for people in the Latinx community to access HPV vaccination when they are systematically removed from any type of medical assistance based on medical racism.

*Healthcare Status*

Apart from the language difference leading to instances of medical racism, the participants identified that medical providers would refuse to give proper medical attention and support based on whether they identified the patient had Medicaid, another healthcare plan, or nothing at all. Undocumented people are often denied healthcare through their workplace⁵, and they do not qualify for government-funded options such as Medicaid and Medicare (Armenta and Sarabia, 2020). Thus, many undocumented immigrants access health services through out-of-pocket payments, clinics, and community organization health clinics (Armenta and Sarabia, 2020) such as the annual UCF clinic at FWAF. However, parents whose kids are United States citizens are legally entitled to government-funded assistance. The medical providers my participants described

---

⁵ The workplace accounts for a major part of access to healthcare for United States citizens. 49% of citizens get their healthcare through group health insurance. This is not a possibility for undocumented immigrants that do not have work authorizations.
as refusing proper care for the patients worked at both hospitals and clinics, where some of the
kids had healthcare through Medicaid. Identifying which patients had insurance and which did not
was often related to the doctors’ perceived status of patients as undocumented based on phenotype.
This stereotyping relates back Castañeda’s concept of a ‘phenotypic passport’ (2019). Those who
do not have a ‘phenotypic passport’ are not only discriminated and stopped by police, such as was
explained in the ‘Politics of Fear’ section, but they are also often denied services (Castañeda,
2019). Hence, they stand in a vulnerable position such as the one my participants experienced.

When asked if their experiences with healthcare and medical providers had shifted since
the Trump administration, most of the participants worried about their Medicaid benefits and some
proceeded to express how the use of Medicaid made doctors treat the patients differently. Emma
a mother of three talked about her experiences with Medicaid:

> We have always had problems with the medical sector since before the new
> president [Trump] but now it is much worse. They want to remove Medicaid
> for a lot of people. Besides, when one takes the kids to get their exams and they
> [the doctors] know that we have an insurance that is through Medicaid. So, they
> have like a different treatment with the kids at the time they are taking care of
> them. Especially in the hospitals, when they see the health insurance is
> Medicaid. It has bothered me greatly. One time the lady [nurse] came by to
> vaccinate my kid. I asked what it was for. She said, ‘the doctor told me to do
> it’. I insisted on what the purpose was. And they just don’t want to respond to
> us. They have such a racist way of dealing with it.

Emma’s story hints at another form of medical racism based on assumptions of who uses
certain healthcare services. She felt that she is not receiving proper care even when her children
are legally entitled to it because of the type of insurance she has. Emma directly linked the unwillingness to assist and the Medicaid insurance to judgements based on race. Thus, she experienced medical discrimination based on a lack of ‘phenotypical passport’ which would have made her less likely to experience racist biases. According to Emma, her medical provider classified her as undocumented based on the child’s insurance being Medicaid and proceeded to treat the medical situation with less care. Although I did not hear many instances of clear discrimination based solely on Medicaid use, Emma’s story suggests doctors fail to provide assistance even when the patients have a form of insurance because they pass judgement on their immigration status and/or race. This form of structural vulnerability extends to all forms of healthcare, including preventive healthcare efforts. HPV vaccination is covered as a preventive form under Medicaid, yet this shift in medical providers’ perceived notions of undocumented immigrants, heightened under this administration, creates a structural barrier that limits access to the vaccination.

In my first focus group, Sara, a mother of two, opened up the discussion about healthcare and medical racism by narrating the time she was told to return home to seek attention: “and something we have not mentioned is the lack of health insurance. That is also important in not allowing us to have the best care. They once said to me, ‘we cannot assist you here. Because you have no health insurance. You have to find another place. Or just go back to your country and have them take care of you there’. As simple as that.” Sara was denied assistance because she had no health insurance. However, she was also stereotyped and discriminated with the comment that she should just go home, even though the medical provider had no knowledge of her actual immigration status. Thus, her doctor passed judgement on her citizenship status based on a lack of “phenotypic passport”. Moreover, the doctor’s comment to return home relates back to a ‘license
to discriminate’ (Kline 2019) which entitled him to actively deny a service based on her deemed status as undocumented. Her story was a clear instance of medical racism and refusal to assist a patient based on healthcare and perceived immigration status. Mariela followed Sara’s anecdote by remarking that she assumes her son’s lack of HPV vaccination is related to him not having a health insurance. Mariela stated, “and imagine us that we do not have an insurance. I think that is the reason my son doesn’t have that [HPV] vaccination. Because he doesn’t have insurance. He has no insurance and hence no vaccination.” Both Mariela and Sara’s experience mirror to the comments I heard throughout my fieldwork that indicate a good sector of the community is being marginalized and profiled as undocumented based on their healthcare status.

In another focus group, the mothers stressed how significantly different the treatment at clinics and hospitals was when they knew a patient had insurance. Paola commented, of course, the person who has medical insurance has an easier time with the attention given and how they are treated. For example, if you have medical insurance them [medical providers] will immediately perform all exams. Because there is a health insurance that will pay for it. On the other hand, if you go and you do not have insurance, they will limit the number of exams they will do. They will not extend and investigate the real cause that brought you to the emergency room.

In a similar manner, another participant emphasized that the medical providers cannot legally deny services in certain settings (such as ERs) based on healthcare status, but the quality and care of assistance is diminished. Termed insurance-based discrimination, this form of biased treatment directly relates to whether patients have a private insurance, Medicaid, or no insurance (Han et al., 2015). For instance, medical providers may treat those with a private insurance first,
leaving those with Medicaid or no insurance to be treated last (Han et al., 2015). This is a disregard to medical practices which stipulate patient sorting based on level of emergency and level of pain (Han et al., 2015). According to previous research, many providers change the quality of care they provide to those who have no healthcare plan because there is little to no reimbursement rate for the providers (Han et al., 2015). As mentioned before, most undocumented Latinx immigrants and children of immigrants either have no insurance or have Medicaid. Hence, they lie in a vulnerable position based on their healthcare plan which leads to a diminished quality of care.

Speaking of this insurance-based discrimination, Ana related her experience with medical provider. “The first thing they ask for is the health insurance,” said Ana. “If you do not have one, they have to legally take care of you. They cannot send you home. But the attention is not the same. The quality of care is just not there. I saw it with my two children, one undocumented, one not.” Ana proceeded to explain that when they got in a car accident a couple of years ago, the child who was documented received proper treatment at the emergency care; all of his exams were carefully revised to make sure he did not have a head injury. On the other hand, the other son did not even get a head scan. Both had been in the backseat of the car, and she still to this day cannot comprehend a valid reason for the different approaches to their care. Ana reiterated, “the only thing I can think of is that one has insurance and the other does not.” Ana was never told why her children were treated differently. However, she assumes it is directly related to their citizenship status in the United States, which ultimately leads to a different access to healthcare. Castañeda terms this a notion of ‘deservingness’ (Castañeda, 2019). Under this understanding, some groups are more worthy of having access to medical services as opposed to others (Castañeda, 2019). Most often, those who are deemed less deserving are already vulnerable populations like the undocumented Latinx group. This idea of ‘deservingness’ is not an individual train of thought, but rather an
induced lack of agency perpetrated by a politics of fear. In Ana’s mind, she has rationalized that her children had to be treated differently because one ‘deserved’ care and the other did not. This reiteration of deservingness is directly tied to a lack of agency created by the structural vulnerabilities exacerbated by anti-immigrant rhetoric. Ana does not see any agency in her situation, which is demonstrated by her not asking the provider why one of the children was not properly taken care of. The politics of fear have forced a state of undeservingness that limits access to healthcare services, particularly forms of preventive healthcare like HPV vaccination. After Ana’s comment, Alejandra confirmed the feeling of medical racism based on health insurance by stating, “Like she [Ana] says, one cannot go there [the hospital] because the attention is different. And it is because we do not have a health insurance and they always assist those who have health insurance first.”

Paola, Ana, and Alejandra all had similar experiences with their medical providers. They felt like they could not get the quality of care necessary for their children because they had no health insurance. In Ana’s case, she experienced how drastic the difference was between her two children due to their respective healthcare plans. Although neither of them tied their experiences to racial profiling, their stories are still linked to medical racism. Being denied proper care during an emergency based on medical insurance is a form of medical malpractice. And for undocumented Latinx, the ability to get a health insurance directly relates to their immigration status. Hence, although not directly categorized as racism, the experiences these women shared showcase an unwillingness from medical providers to offer proper care which becomes a form of vulnerability for this community.

Finally, one participant told her story on being denied services while others were being treated based on ‘assumptions’ that they had insurance. “A couple of years ago, a neighbor and I
went to the hospital, and they left us on the corridor. And we saw how other people showed up that had insurance. Well, they did not know if they had insurance, but they looked like they did. Because they are from here, and white. And the medical providers led them to rooms, and we waited in the corridor.” In this case, the interviewee’s story was closely tied to a racist assumption that, because her and her neighbor did not phenotypically resemble the stereotype of an American citizen, they were being denied services. This participant’s story is another reiteration of the ‘phenotypic passport’ playing a role in the doctors’ perceived ideas of undocumented status and, as a consequence, healthcare status. My participant mentioned she was never even asked if she had insurance. However, that did not matter because the medical providers had already passed judgement at the hospital on who was deserving of care based on notions of race. This instance of medical racism suggests that, even in emergency cases, undocumented Latinx immigrants are denied healthcare services. Furthermore, this limitation is related to prejudice based on immigration status, which trickles down from the ‘license to discriminate’ furthered by anti-immigrant rhetoric. As a result, undocumented immigrants’ access to healthcare, which includes preventive methods like HPV, is exacerbated by these instances of medical racism.

Similarly, Maya, a Mexican mother of two told me she was medically discriminated at a clinic for being undocumented and not having a health insurance. However, Maya never made a comment about either her insurance or her immigration status. At the clinic, she was told there were no available slot for her daughter who was suffering a dangerously high fever. Maya said she would have to take her daughter to the hospital, which the nurse laughed about. Maya narrates:

The nurse said to me, ‘I cannot recommend that you go to the emergency room.
Because if you go that emergency visit is going to cost like $2.000 or $3.000.
One of those emergencies you ‘illegal folk’ utilize’. I responded, ‘but my child
was born here, *señora.*’ The nurse said, ‘no. It is a strain on all of us American. You should not be allowed to use it’ After the entire argument, the nurse reiterated, ‘as an American citizen it is my duty to let you know that when you take your child to the ER it takes a toll on the all of our American economies.’ And I still go to that clinic. Because it is the most convenient one. And I do not know what to do.

As Maya’s experience reveals, not only were the nurse’s claims discriminatory, but they also exhibited medical negligence based on both health insurance and perceived immigration status. Because Maya and her child did not fit the criteria for a phenotypic passport, they were immediately assumed to be undocumented, and by proxy, have no health insurance. Even after Maya clarified her child’s citizenship, the nurse proceeded to recommend care be denied because it would cost the United States’ taxpayers money. This iteration of ‘undeservingness’ according to the nurse is further aggravated by the Trump administration. The ‘license to discriminate’ created by anti-immigrant rhetoric has entitled United States citizens, including the nurse, to racially stereotype populations, like the Latinx immigrant group, and neglect care. Along with the other stories in this section, Maya’s experience suggests medical providers in Apopka are defining access to medical services based on both a phenotypical bias and healthcare status that is, for many Latinx people, directly tied to their immigration status. Hence, these instances of medical racism are tied to the heightened anti-immigrant sentiment of the current administration that creates barriers to healthcare through discriminatory practices. And these barriers make the Latinx community structurally vulnerable to receiving benefits, including preventive health measures like the HPV vaccination.
Hearing all these stories of clear instances of medical racism led me to wonder if people become discouraged from receiving any type of medical care, including preventive efforts like HPV vaccination, due to constant racist behaviors. I asked one of the key-informants if these instances of medical racism are a common theme discussed by people who attend HOPE. She said she wished these experiences were not happening, but it is a sad reality they are all forced to face:

I wouldn’t think about it much about racism, the word, because I would be like you know like, you kind of hope it is not for you, you know, you kind of hope that you don’t go through it, but sadly we are in America, and it is happening, so I think Raquel mentioned this about one of her host moms, how she was like diagnosed with cancer. They like said it to her so blunt, and they were like, “we can’t take care of you here”. It was… it was crazy.

My key-informant related that indeed it is something everyone in the community faces and worries about. Like many of the mothers pointed out, these constant comments that people should return home, that they are illegal and should not be using services, and that ‘we simply cannot take care of you here’, deters them from accessing healthcare services. For Raquel’s host mom, who was diagnosed with cancer, going to the hospital included being constantly bombarded with reiterations of her deemed status as a burden or public charge. Hence, she wanted to minimize those encounters, but she had to receive chemotherapy to survive. In the case of PHV vaccination, that is often cited as an optional vaccination, there is more discouragement to attend medical provider visits. Moreover, because the HPV vaccination requires three dosages, patients have to submit themselves to three instances of medical visits and three instances of possible
medical racism. As a result, they are deterred from accessing proper care based on past medical racism.

Latinx immigrants in Apopka, Florida have constantly been discriminated against in medical settings based on conflated notions of race and citizenship. For many, that includes being mistreated based on a phenotypical difference that leads to medical providers making assumptions of their status and their healthcare. In turn, these racial bias and anti-immigrant sentiment has led to instances of medical racism. Even if services have not been denied to them, they have expressed a lower quality of care during their clinic and hospital visits. Those participants who experienced discrimination based on insurance also related it to a greater racial bias on part of the medical providers. For those who do have Medicaid for their kids, their experiences are still similar. They have been marginalized in the quality of services because of their perceived immigration status. As a result, the lived experiences of this community suggest that medical racism related to health insurance, citizenship, and phenotypical appearance have converged to create a unique form of structural vulnerability that prevents proper access to medical services. Ultimately, if the community cannot access those emergency services, they cannot access preventive healthcare services such as HPV vaccination.

Refusing Medical Information

A final iteration of medical racism and lack of assistance by medical providers related to the refusal of medical information provided to the patients. When patients would ask for medical data or explanation on medication or procedures, many doctors, nurses, and medical providers would give a surface answer, not respond, or provide a complicated answer via paper and refuse further questioning. Castañeda terms this denial to provide mandated services ‘bureaucratic disentitlement’ (Castañeda, 2019). Bureaucratic disentitlement can take many forms in which
government, medical, or administrative agencies refuse services that have been provided as rights to citizens (Castañeda, 2019). This is further tied to notions of a ‘license to discriminate’ which has been heightened under the Trump administration. As a result, this bureaucratic disenitlement directly affects access to healthcare, and thus HPV vaccination, for the Latinx immigrant community. In the case of many of my participants, bureaucratic disenitlement happened to United States children whose parents were undocumented.

For example, discussing the HPV vaccination, Maya mentioned that she was provided no information about the vaccines her child had been given in the United States: “in my case, with the vaccines I did not even know which vaccines they were giving him. In Mexico when they gave him the vaccines they would say, ‘this is for this. This is for that.’ Here, they do not give me any information at all”. Although Maya’s child is a United States’ citizen and, thus, entitled to access medical information, the doctors refused information, committing a form of bureaucratic disenitlement. Because the Trump administration encourages such behaviors under a ‘license to discriminate’, doctors feel entitled to withdraw information whenever they choose. As a result, Maya experienced a structural barrier to information on HPV vaccination that left her in a structurally vulnerable position.

For those who were given information, it was usually confusing data via paper that was not useful for the parents. Maria, mother of two said:

one time they gave me the information and said, ‘read it. This is what we gave him, and this is how you can take care of him’. But they have already vaccinated him. And they did not tell me things beforehand. And not only beforehand but also spoken. Explained. So, I can know what is happening when it is happening.
Because they always give it to you written and sometimes you do not know how to read. And the opportunity to understand what they did to your child is gone.

A father of two, Gabriel, reiterated Maria’s comments. “When you ask them questions, they [doctors] say, ‘the nurse is coming. She has my sheet. In the evaluation sheet is my response. And they do not do that with everyone. Just some of us.” Maria and Gabriel’s stories showcase a disregard for proper explanation of the medical procedures being implemented by medical providers. Although my participants received some degree of information, the information was in paper, often complicated, and given after examinations and procedures had been performed. As a result, both Maria and Gabriel did not feel like the information was relevant or that it helped in the access of health services. This is another form of bureaucratic disenfranchisement in which doctors give certain types of information but disregard the actual needs of the patients to comprehend that information. Moreover, the information post-procedure removed their agency to choose services, emphasizing the structural vulnerability associated with medical interventions.

Participants also stated doctors would be annoyed with questions about medication and would often refuse to give proper answers, making it harder for parents to know about any type of medical procedures. Natalia from Mexico told me about her experience with vaccines and her medical provider:

So, I asked him, ‘what vaccines are you giving her today’. He simply responded ‘these are the vaccines. Just sign here.’ I insisted, ‘but which ones are they. What are they for?” After he refused to tell me again, I stated, ‘you are not giving him all of those vaccines. If you are unwilling to explain bring the book that has his information so I can see it.’ He got extremely mad about this. This was the nurse. When the doctor came up, I explained the problem. When they
checked, my daughter was only missing one vaccine. And this was the time I asked and asked. What about the days I did not ask?

Natalia felt her medical providers were pushing her aside and refusing to respond to relevant questions regarding her child’s medical procedures. Moreover, they felt annoyed at being asked questions which led her to feel like she could not continue to request information. Natalia was exhibiting a feeling of undeservingness which trickles down from the discriminatory tropes of the Trump administration. Natalia mentioned that she would often stop asking if she saw a hesitation to provide information, because the doctors would just leave the room and stop the care they were providing; this was a unique situation in which she was able to get some clarity. However, Natalia now lives in fear of not knowing how many instances of medical negligence have happened with her child’s medication, showcasing the lack of information as a removal of agency and knowledge.

Finally, a mother from Honduras perfectly explained what most of my participants had been thinking regarding their experiences in the United States, the medical sector, and medical racism: “we trust in this country. Since we are in Honduras, or in our native countries, we know the United States is the best with medicine. And so, when we come here, we trust the doctors. We believe in them, but now with how the laws are, a lot of people are going to the hospital and they have no idea how they will get treated, or if they will get treated, and at what cost.”

The medical provider’s unwillingness to offer accurate and timely information of medical procedures showcased a form of medical negligence. The participants, like Gabriel, pointed out that they felt that hesitance to give information and respond to questions did not happen to everyone who came to the clinic. Instead, it seemed only certain groups, the Latinx subpopulation specifically, were being mistreated. Being marginalized based on ethnicity to receive improper
information on medical procedures is a form of medical racism. Moreover, this lack of information continues to create structural barriers that exacerbate access to healthcare because the Latinx community is not being allowed any agency in the medical decisions. As a result, if they do not receive information on procedures at hospitals and clinics, they are also not receiving specific information about other forms of care, such as the HPV vaccination.

Overall, participants’ experiences suggest a lack of assistance and an unwillingness to provide proper medical care from doctors, nurses, and other medical staff at hospitals and clinics alike. This reluctance is showcased through improper medical services based on language differences, healthcare status, and access to information. Moreover, medical providers are using the aforementioned excuses to pass racial judgement and assume the immigration status of their patients. As a result, the people in the Latinx community are being marginalized by the workers in the medical sector through multiple instances of medical racism. In turn, these instances remove the individual agency of the patients and create sociopolitical barriers that prevent an overall access to proper medical services. This form of structural vulnerability was cited multiple times by my participants as a barrier to HPV vaccination, the main topic of this study. In conclusion, medical racism directly creates an impediment for the Latinx community in Apopka, Florida to receive HPV vaccination, among other medications.

III. **Lack of Knowledge**

Through my focus groups, I discovered that parents have little knowledge of the Human Papilloma Virus vaccination. Existing evidence indicates this population may not have significant knowledge barriers related to HPV vaccination (Vamos et al., 2018) and I therefore expected this study to reflect existing research. Although the levels of understanding related to prevention, application, and side effects are slightly varied, most parents seemed to have little to no knowledge
of the vaccination. Moreover, they associated their lack of knowledge to the doctors’ reluctance to provide information which has been thoroughly described in the previous section. While some parents never thought to ask and were not given any information, others asked and still did not receive proper knowledge to make a decision. Finally, those who did have thorough knowledge of the vaccination know people who have the disease, gained their knowledge through family and friends, or learned it in their home countries. Hence, my conversations suggest that access to HPV vaccination is directly linked to a void in information created not by individual circumstances but by a removal of agency and knowledge caused by the medical providers.

In order to kickstart the discussion of HPV vaccination, I started with a simple question, “What do you know about the HPV vaccination?” I was surprised to encounter more blank stares than I was originally expecting. However, most of my participants, when prompted about HPV, would ask “what is that?” or mention, “I may have heard the name, but I do not know what it is.” One of the mothers, Valeria, even joked, “what? (Laughs). Hablame en castellano (Speak to me in plain Spanish).” Many would just stay quiet. These responses led me to further question the reasons behind the lack of knowledge about the vaccination.

Sara, a Guatemalan mother of two kids, elucidated the role doctors and nurses played in this vacuum of concrete information:

They [doctors and nurses] do not give us any information about the vaccine. I, for example, take my kid and they tell me, ‘it’s time for his vaccine’. What if I do not ask what it is and what if they have already vaccinated him and I still don’t know? How am I supposed to know if it is not written and they have not let me know? And what if I am not a mother that demands information and grabs the papers and starts reading what they did to my child.
Similarly, Gabriel, in another focus group, mentioned that doctors would have parents sign the forms for vaccination without telling them the basic information of the vaccine: “they say, ‘sign this.’ And we sign it without knowing what it is for. And they don’t say anything. And we are left wondering, ‘would it be good that they are just giving my child all vaccines? Is this even an important vaccine?’” Both Sara and Gabriel realize that doctors are not providing any specific information regarding any of the vaccines their children are getting. In fact, they are denying the patients basic knowledge of their medical services and procedures. My participants related those experiences to the reason they are unaware of the HPV vaccination. If they are not getting information on the mandatory vaccinations, they are also not getting the information for the optional ones. According to Sara, some parents are not even certain if their kids have the HPV vaccination or not.

Furthermore, Emma explained her daughter, who was born in the United States, was given the vaccine, yet the doctor did not give her information when she asked for it. Emma said, “The doctor gave her the vaccine a while back. But she did not explain what it was for when I asked. She only said it was to prevent cervical cancer. And she did not give me an option on whether I wanted it or not.” Following that comment, Laura stated, “I have heard about the Papilloma virus. But not the vaccine. And my doctors have not mentioned either of them.” Both of these mothers have some basic knowledge of the virus and the cancers it can cause, but neither got clarification from their doctors. Even when Emma asked for further information, her question remained unanswered. Their stories align with the instances of general lack of information regarding medical services that medical providers offer. As such, the medical providers’ reluctance to give information about vaccination both removes agency from the parents and creates a void of knowledge that further marginalizes the community’s access to HPV vaccination.
When we asked one of HOPE’s community leaders, Rebecca, she commented that she had discussed HPV with some mothers at the mom’s group after our initial conversations on the project. She asked, “did you guys know about this? Like I haven’t heard about this either”, to which most mothers said, “I don’t even know if I have it. That’s crazy.” She later commented her thoughts on the lack of knowledge, “who plays a role in that? Is it the clinic, or is it us that we should know about this stuff? Which is kind of hard but also goes back to the whole, if they [doctors and nurses] barely translate for them [parents and patients], how are they even going to explain to them about this vaccine and whether their kids need it or not?” Rebecca’s understanding and contact with the community showed the negative role doctors and nurses, as well as the language barrier, play in access to information about HPV vaccination for Latinx families.

However, it is important to notice that not every community member we interviewed had little to no knowledge of the HPV vaccination. Natalia, a mother of three, stated:

I know the vaccine for Human Papilloma virus is a vaccine that is given to kids starting at the age of nine. I think it is three doses. I think one at nine, the other at twelve, if I am not mistaken. I do not remember how they apply them, but they are to prevent certain strands of the virus that leads to Human Papilloma. And this can turn into cervical cancer. So, it is a way to prevent girls from getting this in their adulthood.

Natalia had a vast knowledge about the vaccination, as well as its doses and purpose. Nevertheless, she mentioned that she had received that knowledge at home in Mexico because her niece was getting the vaccinations. From her doctors in the United States, she had not received any information:
When the vaccine started, I had my niece who was eight so my sister was worried because somebody told her it could have bad side effects. Because there is always wrong information going around and one tends to listen to information that we shouldn’t. When it had just started, I was in Mexico. So, my sister and I started looking stuff up and asking our doctors. And they clarified our questions. I am not fully sure because I am not a scientist, but I think it is a vaccine that should be applied to our kids.

Natalia’s story alludes to the distinction between the care her family received in Mexico and the care many people from Latin America receive here. In Mexico, she was getting the information that empowered her to make decisions. In the United States, her agency is again lost to the doctor’s medical negligence. Had she not known the information from Mexico, she would be in a structurally vulnerable position that diminishes her access to HPV vaccination in the United States.

Finally, some people acknowledged that they feared the side effects and did not quite know what they were. This led many to just ignore the option for vaccination. This relates to medical racism, bureaucratic disentitlement, and feelings of undeservingness which are all heightened by the tropes of the Trump Administration. Doctors are often refusing information because they feel entitled by the president’s anti-immigrant rhetoric to deny services based on immigration status. This is in turn a form of medical racism. Moreover, parents do not feel comfortable requesting that information because they do not feel entitled to request the same services that other populations in the United States receive. As a result, they have little to no access to information regarding HPV vaccination and its side effects. Maria, for example, clearly states, “I am afraid of it”. In the same focus group, another mother said, “I do not know the side effects. You know, since they are
injecting the virus inside you. So, it can make you have the disease or not. That’s why I fear my girls getting it.” A third mother, Nicole, said “One of my friends made sure her daughter had the first two doses. But not the third one. For fear. Because she does not know what the effects are.” Although none of these three women tied their stories to the doctors’ failure at providing information, their confusion at side effects could be easily solved if the doctors offered facts on HPV and the vaccination. However, due to tropes of immigrants as public charge and anti-immigrant rhetoric from the Trump Administration, doctors are disregarding the patients’ rights to basic services like medical information. Clearly, in Nicole’s case, her friend was assisted by a doctor because the child was given the first two doses. However, she did not get enough information on side effects since she did not bring the girl back for the final dose. Once again, the individual barrier of misinformation becomes a section of a bigger structural issue related to medical negligence at the clinics and hospitals which is emphasized by the racist tropes of the administration. This information gap creates a barrier for preventive healthcare like HPV vaccination.

After these focus groups, I had a conversation with one of my key-informant interviewers about efforts made by FWAF to educate the community on HPV vaccination. I was happy to encounter a positive response. Claudia said, “we bring people that discuss the topic to the community organization. We think it is an important topic that we, as mothers, should become familiar with. And not many of us know. In general, the community is not familiar with the vaccination.” Although efforts, such as the one stated by Claudia, have been made at a communal level, further attempts need to be made to reach more people. As one of my deliverables, I provided a quick and simple fact sheet in Spanish for every participant to take home. Both community partners kept a digital copy of the fact sheet to email and print for the community.
Regardless of the community level efforts to educate the community in Apopka, there is still a structural barrier that needs to be reversed. Medical providers are denying the patients basic knowledge of their medical services and procedures. This form of medical racism is directly tied to a ‘license to discriminate’ perpetuated through anti-immigrant rhetoric under the Trump Administration. As stated by my participants, medical providers are evidently withholding information directly related to the HPV vaccination. Hence, the issue of a knowledge vacuum is not a case-by-case problem, but a hidden sociopolitical barrier that is preventing entire communities from accessing information. Moreover, the medical providers’ decisions are directly impacting the agency parents have regarding this optional vaccination. As a result, some parents do not know about the vaccine, some have erroneous information, and others have no knowledge of whether the vaccine was applied to their children or not. All of them, nevertheless, are structurally vulnerable because of the lack of knowledge provided by their doctors.

IV. **Optional vaccination is not necessary for school entrance**

Another theme in my fieldwork was that vaccination, in general, had a direct connection to school entrance for many parents. Although they still wanted to know the information of the vaccination their children were getting, they also saw the preventive measure as a barrier to school entrance and, hence, education. As I mentioned before, HPV vaccination is not a mandated vaccination; the Florida Health Department does not require it for any level of education. As such, it is often not printed as an option in vaccination cards. Thus, most mothers who did know about the HPV vaccination, did not feel the need to vaccinate their kids. Many believed that, since the vaccination was not compulsory for entry into the school system, the children did not necessitate the vaccination. This is also tied to the parents’ notions that optional vaccinations, as a preventive
health measure, are not a form of essential activity, which will be further discussed in the next section. Furthermore, due to increased anti-immigrant rhetoric brought forth by the Trump Administration, there are increased instances of medical racism and a ‘license to discriminate’ which discourages parents from seeking optional services. Therefore, the optionality becomes part of social-political factor related to heightened discriminatory practices both politically and medically that ultimately affect the decision to request more information and vaccinate for this virus.

The first person who suggested parents in the community saw vaccination as a barrier for school entrance instead of a form of preventive care necessary originally asked, “well, do they need it for school?” Once the investigators stated it was optional and not compulsory for school entrance, she proceeded, “then why would I?” To her, vaccinations had the primary purpose of giving access to an education. Furthermore, given the instances of medical racism discussed in the same focus group, this mother had no reason to submit herself to racial biases for an optional service. When she was asked if she would vaccinate her kids to prevent diseases, particularly cancer with HPV, she responded, “I have not really thought about it.” This participant’s experience with vaccination came as an unexpected response to me. I did not consider the role vaccinations played in the legalities of access to other essential activities until she mentioned it to me. From this point forward, I asked other parents what their thoughts of vaccinations were as they related to school entrance. I also prompted to how this optional category related to determent to seek services based on medical racism.

Without discussing the specificity of HPV vaccination, most parents alluded to the importance of vaccines as a pre-requisite for school entry. Some discussed the hardships of getting their home countries’ vaccines approved in the United States. One mother, Andrea, explained her
experience with vaccination: “you had to… to be admitted into the school system… you had to have all official records of the vaccines. If not, they would stop you to vaccinate you. You would come over, and you told officials your kid would be going to school, and you had to bring the record from back home. And they would evaluate which vaccines they gave my child there and which ones they did not”. One of my key-informants also suggested that their main concerns when it comes to vaccination is for school entry: “the most important thing is the documents. If they are missing those vaccines. For them to go into the school system they have to have their vaccines. They sometimes have to send for the official records from home in order to proceed forward in their education.” Both of these narrations indicate that, for many of the parents in the community, vaccination goes beyond a preventive healthcare measure. It becomes a definer for education and knowledge. Because HPV is not one of those mandatory preventive measures, it does not become a point of discussion. Moreover, because it is far removed from an essential activity, HPV vaccination does not merit a visit to a medical provider that might be racist towards the Latinx population based either on a phenotypic passport or a license to discriminate perpetrated by the Trump Administration. If the HPV vaccination was necessary for school entrance, parents might consider administering the dose as a way to complete legal requirements for education. That, however, would not reduce the instances of medical racism that make them fearful to attend necessary healthcare services. Ultimately, the legality of other vaccinations as a form of admittance to further education and the fear of instances of racism in the medical sectors converge to exacerbate access to HPV vaccination for this population. Again, this theme is tied to a tendency to perform only essential activities which will be further outlined.

In another ethnographic survey a mother, Jasmin, stated, “I mean, come on, it is not a requisite. But if it came [in the vaccination card] I would vaccinate her”, again suggesting that
obligation is the main reason for vaccination. It is important to notice that in Jasmin’s case, she did want to hear more about the vaccine, side effects, and purposes, proving that she was interested in the knowledge behind it. However, her general thoughts towards vaccination still remain within the legal side, as if the preventive effort of them is an added plus. In Jasmin’s particular experience, wanting to know more about the vaccination but not having the avenue to get that information relates to the medical racism discussed in the previous sections. She is still interested in gaining the knowledge, but it does not cross her mind as a reality to attend a doctor’s visit because it would imply encountering those racist remarks which have become a norm under this current president. As a result, Jasmin is not only considering the HPV vaccination as a non-essential because it is not related to school entrance, but she is also being furthered placed in a status of undeservingness of information due to anti-immigrant sentiment. Therefore, both barriers converge to exacerbate Jasmin’s already vulnerable position.

Similarly, another mother reported not having the vaccination in the card and hence not considering it essential. Ana commented, “if it does not come there… well I think it is optional and that is why it is not in the card. You have the right to take the vaccine or not. It is not like a requirement.” Ana’s observation was neutral and suggested she could choose either to vaccinate or not. Regardless, the optionality removed the vaccination from her immediate concerns, creating no need for further information and no necessity for vaccination. At the same time, the lack of an immediate concern allowed her to rationalize an excuse for not attending the doctor for the HPV vaccination. If it is not necessary at the present moment, there is no need to risk leaving the house, risking deportation, and additionally being submitted to unfair treatment at the clinic based on a deemed immigration status.
When I interviewed a key informant at HOPE, she reiterated the responses above. “And from what I hear mostly about the families, because this issue is like about school, you know, some of our families don’t even know how to read a report card. So, to them, the vaccines that the kids have are the vaccines the schools require you to have. Or whatever they tell you that you need to have that’s it.” This informant’s comment again suggests that vaccination is directly correlated to parents necessitating them as a requirement for school entrance, and as such, essential for everyday activities. Moreover, with vaccination opening access to education, it also becomes an avenue for their kids to achieve a better social and economic status in the United States. As a result, parents saw the vaccinations as education first and preventive healthcare second. This train of thought alleviates the need to attend an already unfair system that is often encountered with medical providers. Because it is not deemed essential, there is no necessity to risk a potentially detrimental visit to the doctor.

Overall, the theme suggests that vaccination among the community I studied is done chiefly as a necessity for school entrance and secondarily as a response to health. Moreover, due to its nature as an optional vaccination, and due to the discriminatory instances of medical racism by medical providers, it becomes harder to find information related to it. As parents in this study mentioned, the vaccination does not come in the vaccination card, and they would rather not go ask about healthcare elements that are not deemed necessary. This rationalization of optionality as an alleviation of the fear associated with medical racism directly correlates to an increased politics of fear perpetrated by President Trump. If medical providers feel entitled by anti-immigrant language to disregard proper care for their patients, the undocumented Latinx patients that already feel vulnerable would rather not attend visits that are not completely necessary. Therefore, an
optional vaccination, like HPV vaccination, does not demand enough importance to risk instances of medical racism, anti-immigrant remarks, and even deportation.
Limitations

My research was limited by several factors. To begin with, the participant research and interviews happened through the Summer of 2019, allowing for only eight weeks of research. Additionally, some potential interviewees were hesitant of describing their experiences for fear of the Trump Administration and deportation, so many abstained from giving follow-up information regarding discrimination and bias. Instances of interview bias and recall bias should also be taken into consideration in the focus group setting. Regarding the gender of the participants, I was only able to recruit female participants (for the exception of Gabriel), given that they were the ones who mostly utilized the community organizations’ services. As a result, I did not have enough men to have their voices heard in this research. Finally, the results here described should not be generalized across the United States. Certain particularities, like SB-168, are unique to the state of Florida. Therefore, the context and time frame of the research should be considered.

Next Steps

Future research should continue to investigate how anti-immigrant politics and policies create multiple access barriers to forms of preventive healthcare, including HPV vaccination. With the expansion to public charge ruling being instated in February, 2020, the instances of fear, medical racism, and feelings of undeservingness have probably increased. Moreover, given the Covid-19 pandemic, the rule in public charge, President Trump’s run for second term, and increased instances of racism have further affected the way the Latinx immigrant community accesses medical amidst the chaos. Relating to the structural vulnerability, future research should showcase how community organizations, such as HOPE and FWAF, play a role in curving and reducing vulnerability. As shown in this research, FWAF has assisted in the knowledge aspect of
HPV vaccination in an attempt to empower Latinx immigrants to receive the vaccination.

However, that is only the beginning of a very long battle to remove all the other structural barriers that exacerbate access to HPV vaccination. Ultimately, a change in immigration policies that heighten fear and curb the way people access their healthcare and medical services would be needed to reverse the vulnerability present in the lives of the people I encountered in Apopka.
Conclusion

As previous research suggests, the Latinx immigrant community in the United States does not get vaccinated for HPV at the same rates as other populations. However, this is not due to the individuals desire to vaccinate or not. Multiple structural barriers have been erected that consistently prevent this population from accessing preventive forms of healthcare like HPV vaccination. Through this research, I suggest that the current anti-immigrant rhetoric, backed up by heightened immigration control, on behalf of the Trump administration has left the Latinx immigrant community in a structurally vulnerable status when it comes to vaccination for HPV. President Trump’s blatantly racist remarks have entitled United States’ citizens to discriminate against those deemed a racial ‘other’. This hostile environment has led to an increase in fear for Latinx immigrants, which affects the way they seek services. As this research shows, families in Central Florida live in a generalized state of fear that leads to them not leaving the household unless activities are deemed necessary. HPV vaccination, a non-mandatory vaccination, does not fall under that category. Moreover, the entitlement to discriminate based on a general increase in anti-immigrant sentiment leads to multiple instances of medical racism in clinics and hospitals. My participants indicated a main form of medical racism was a refusal to give medical information which ended in instances of medical malpractice. Finally, the nature of the HPV vaccination as optional decreased the patients desire to attend medical centers to get vaccinated for fear of medical racism. Ultimately, the fear instilled by the Trump Administration on Latinx immigrants based on increased anti-immigrant rhetoric has effectively established multiple sociopolitical barriers that exacerbate access to a very important preventive healthcare effort: HPV vaccination.
This research is important given the current changes to healthcare in the United States. With the Trump Administration recently passing an expansion in public charge, there will be an increase of fear to utilize services that individuals are entitled to. Many parents had already discussed unenrolling their kids from Medicaid services, and with the ruling successfully passed, those discussions are now at the forefront. Moreover, the Covid-19 pandemic in the United States has forced the Trump Administration to reconsider the way it limits services to different populations in the United States. A quick search for ‘public charge’ in the Department of Homeland Security’s website shows an important information briefing telling all undocumented immigrants to ignore public charge expansion for the remainder of the pandemic. If they have symptoms, they should attend the nearest hospital for a checkup. Now, suddenly, the health of all United States citizens can be jeopardized because of the Trump Administration’s push to limit healthcare services to those who might be a drain in the economy. As a result, government officials are scrambling for ways to ensure their blatant disregard for undocumented health is not going to, in fact, end up creating the one thing they were trying to avoid: a drain to the economy and a decrease in the health of the United States’ citizens. HPV might not be at the forefront as a form of preventive healthcare in the following years given the heightened need to find a vaccination for Covid-19. However, the structural barriers presented in this research will extend to application of Covid-19 vaccination when it becomes readily available. The Trump Administration will finally realize the extent that their anti-immigrant rhetoric has erected a wall to all forms of preventive healthcare methods. And that, will be the perfect time to fight for change in the healthcare of undocumented immigrants.
References


Appendix A- Informed Consent

Rollins College

Consentimiento para Participar

Los investigadores de Rollins College estudian una variedad de aspectos. Para hacerlo, necesitamos la ayuda de gente que quiere participar voluntariamente en las investigaciones. El propósito de esta investigación es para entender como el acceso a la vacuna del virus del papiloma humano (VPH) esta obstruido por variables fuera de su alcance. Estamos pidiéndole a usted que participe en esta investigación. No tiene que participar si no quiere. Por favor, pregúnteme a mi o a mi colega en cualquier momento si no entiende algo que tiene que ver con esta investigación. Si quiere participar, sepa que en ningún momento vamos a hacer uso de su nombre o identificación. La persona que esta en cargo de esta investigación es el Dr. Nolan Kline de la universidad Rollins.

Como mencionamos, queremos discutir sus percepciones e ideas sobre la vacuna de VPH y sus razones por aplicarla/no aplicarla a sus hijos. Si quiere participar, vamos a hablar en un grupo por una hora. Con su permiso, también quisiéramos grabar la conversación para apuntar notas mas tarde. Solamente Dr. Nolan Kline y yo vamos a tener acceso a las notas y grabaciones.

En cualquier momento puede dejar la conversación y no habrá ninguna penalización por dejarla. Su relación con HOPE, la universidad de Rollins y los investigadores no se vera negativamente afectada en ningún motivo si deja la investigación.
Es posible que esta entrevista sea transcrita profesionalmente por un servicio confidencial. Si no se siente cómodo con la transcripción de la entrevista, por favor, mencíóneselo al Dr. Nolan Kline. No debe sentir ninguna presión de participar en el estudio. Puede participar en esta investigación o dejar de participar en cualquier momento. Si tiene preguntas o inquietudes sobre este estudio, llame al Dr. Nolan Kline al (248) 568-2042

¿Quiere participar en la conversación?
Appendix B - Demographic Information Survey

Demográficos

1. Edad: ________________________________

2. Genero: ________________________________________________________________

3. Ciudad donde vive: _______________________________________________________

4. ¿Cuántos años ha vivido en los EE. UU.? __________________________________

5. ¿Cuántos años ha vivido en Florida? ________________________________________

6. ¿Dónde vivía antes de mudarse a los EE. UU.? ________________________________

7. ¿Qué hace por trabajo? ____________________________________________________

8. ¿Tiene niños? □ Sí   □ No
9. Edades de niños:________________________________________________________

10. ¿Nacieron en EEUU los niños?  ☐ Sí  ☐ No  ☐ Algunos de ellos
Appendix C - Ethnographic Survey Guides

Ethnographic Survey Guide

June 5, 2019 Version

Start by providing overview of research

1. (Ice breaker) How long you lived here? ________ years ________ months

2. How many children do you have? _______

   Ages _____________________________________________________________

3. Are you working at the moment?  ☐ Yes  ☐ No
   a. If so, where?

      ☐ Construction      ☐ Agriculture      ☐ Nursery

      ☐ Cleaning Houses   ☐ Food Service      ☐ Hospitality (e.g. hotel)

      Other: __________________________________________________________

Health Services and Relationship to Policy/Politics

4. Where can you go if your children are sick and need health care?

      ☐ Community Health Centers/7th Street Clinic  ☐ FWAF

      ☐ Hospital

      Other: __________________________________________________________________________

5. What makes it difficult to get services for your child?
a. Probe: time off work, language, transportation

☐ Time off work  ☐ Transportation  ☐ Language challenges

☐ Lack of insurance  ☐ Police/Immigration

Other: __________________________________________________________

6. What makes it easy?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

As we mentioned, one thing we’re interested is knowing more about how recent policies and politics have affected the local community, and we’d like to ask you some questions about that now.

7. Since Donald Trump has taken office, have you seen any changes in your community or at home? What are those changes?

________________________________________________________________________
________________________________________________________________________

8. Have you seen people change how they seek/find health services for their kids?

a. Prompt: do you or anyone avoid seeking health services in certain places or at certain times? Avoiding care all together?
Have you heard anything about the proposed changes to “public charge” policy?

☐ Yes    ☐ No

9. What have you heard?

___________________________________________________________________________
___________________________________________________________________________

Are there any services you might avoid or not seek as a result of these policies/politics?

___________________________________________________________________________
___________________________________________________________________________

---

**HPV Vaccination**

Changing the topic, a bit, let’s talk about the Human Papillomavirus vaccine.

10. Have you heard of Human Papillomavirus vaccination?  ☐ Yes  ☐ No

   a. Explain HPV is an STI that can cause some cancers that are preventable through vaccine

   b. Explain the vaccine requires 3 doses.

   c. The vaccine isn’t required for school entry and is an optional vaccine/not mandatory

11. Thinking a bit about what we’ve been talking about with the current policy climate, would you still be willing to get the vaccine for your kids? Why or why not?
12. Is there anything else you want to share about this topic or anything you would like to discuss that we haven’t talked about yet?
Focus Group Guide

Focus Group Guide

Start by providing overview of research

1. (Ice breaker) Para empezar, nos pueden hablar sobre sus familias: ¿hace cuánto viven en los Estados Unidos, cuántos hijos tienen?

Health Services and Relationship to Policy/Politics

2. ¿A dónde pueden ir si sus hijos se enferman y necesitan asistencia médica?

3. ¿Hay algo que les dificulte obtener servicios para sus hijo(s)?
   a. Sugerencia: pedir tiempo fuera del trabajo, idioma, transporte

4. ¿Qué lo hace fácil?

Como mencionamos, algo en lo que estamos interesados en estudiar es como la política y las leyes han afectado la comunidad local en el centro de Florida, y queríamos preguntarle un poco más al respecto.

5. ¿Desde que Donald Trump tomó posesión de su cargo, han notado algún cambio en su comunidad o en sus casas? ¿Qué son esos cambios?
   a. ¿Han notado que la gente cambia como busca y encuentra servicios de salud para sus niños?
   b. ¿Ustedes o alguien que ustedes conocen evita servicios de salud en ciertos lugares o en ciertos momentos? ¿Evitan los servicios completamente?
   c. Hay algunas leyes específicamente que les preocupan? Cuáles son?
      i. SB 168, carga pública
6. ¿Hay algún servicio que puede que eviten o no busquen activamente como resultado de estas leyes y políticas?

**HPV Vaccination**

Cambiando un poquito el tema, hablemos de la vacuna del virus del papiloma humano

7. ¿Alguna vez han escuchado sobre la vacuna del VPH?
   a. Explica que VPH es un VTS que puede causar ciertos cánceres prevenibles a través de la vacunación
   d. Explica que la vacuna requiere tres dosis
   e. Esta vacuna no es necesaria para entrar a la escuela y es opcional/no obligatoria

8. ¿Pensando un poco acerca de lo que hemos discutido sobre el clima político en la actualidad, usted cree que la gente en la comunidad se sentiría cómoda poniendo la vacuna a sus hijos? ¿Por que o porque no?

9. ¿Hay algo más que quisieran compartir al respecto de este tema o algo que no hayamos discutido todavía?
Key Informant Interview Guide

June 26, 2019 Version

Start by providing overview of research

13. (Ice breaker) To begin with, tell me a bit about yourself. How long have you lived here?
   How long have you been at (Name of Organization)? What’s your role here?

Health Services and Relationship to Policy/Politics

14. Tell me about the families that you all see here.

15. Thinking about the families you see here, where can families go if their children are sick
   and need health care?

16. What makes it difficult for them to get services for their children?
   a. Probe: time off work, language, transportation

17. What makes it easy?

As we mentioned, one thing we’re interested is knowing more about how recent policies and
politics have affected the local community, and we’d like to ask you some questions about that
now.

18. Since Donald Trump has taken office, have you seen any changes in the community or
   among parents here?
   f. Have you seen people change how they seek/find health services for their kids?
   g. Prompt: does anyone you know avoid seeking health services in certain places or
      at certain times? Avoiding care all together?

2. Are there any laws or policies that have made people concerned?
19. How do you think this might affect people’s lives?
   a. Willingness to seek health services?

**HPV Vaccination**

Changing the topic a bit, let’s talk about the Human Papillomavirus vaccine.

20. Have you heard about the Human Papillomavirus vaccination?
   b. Explain HPV
   c. Requires 3 doses.
   d. The vaccine isn’t required for school entry and is an optional vaccine/not mandatory

21. Thinking a bit about what we’ve been talking about with the current policy climate, do you think people would be able to get the vaccine for their children? Why or why not?

22. Is there anything else you want to share about this topic or anything you would like to discuss that we haven’t talked about yet?
Montañola 113

Appendix D – HPV Vaccination Informational Sheet

¿QUÉ ES VPH?
El Virus del Papiloma Humano es la enfermedad de transmisión sexual (ETS) más común. Esta asociado a ciertos tipos de cánceres, como el cáncer cervicouterino. Vacunar para VPH protege en contra de los tipos de VPH que causan estos cánceres.

¿DÓNDE PUEDE CONSEGUIR LA VACUNA?
Si su hijo/a tiene Medicare, Florida KidCare, CHIP o otra forma de seguro puede recibir su vacuna de gratis.
Si su hijo/a es menor de 18 años y no está asegurado, puede ponerse la vacuna en un community health center o departamento de salud gracias a la “Vaccines for Children Program”
Pregúntele a su doctor en la siguiente visita.

¿DÓNDE PUEDE ENCONTRAR MÁS INFORMACIÓN?
La CDC tiene una hoja informativa que puede encontrar en:
https://www.cdc.gov/std/spanish/vph/stdfact-hpv-s.htm
También, pregúntele a su médico en la próxima visita sobre maneras de conseguir la vacuna.

¿QUIÉN SE PUEDE VACUNAR?
Todas las personas (hombres y mujeres) de entre 9 y 45 años pueden vacunarse para VPH,
9-14 años: dos dosis con la segunda aplicación 6 meses después de la primera
15-45 años: tres dosis con la segunda aplicación 2 meses después y la tercera 4 meses después.

¿POR QUÉ SE VACUNA TAN JOVEN?
Se recomienda vacunar a los niños entre 9-14 años para que estén completamente protegidos años antes de convertirse en personas sexualmente activas.

Todo este información fue obtenida de la página de la CDC www.cdc.gov y la página de Planned Parenthood www.plannedparenthood.org