

MIXED-IMMIGRATION-STATUS HOUSEHOLDS IN THE CONTEXT OF ARIZONA'S ANTI-IMMIGRANT POLICIES: IMPLICATIONS FOR HEALTH CARE DISPARITIES

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Introduction

In this article, we highlight some of the results from a study in which researchers working on both sides of the U.S.-Mexican border addressed related questions about reproductive health care strategies of migrant and immigrant women. The research was contextualized within the broader developments on a global scale, which increasingly engage women by integrating them into global labor markets. Paralleling these trends are recent policy developments in Arizona. We thus focus this article on some of the results of the research on the Arizona side of the border, as this state's legislative history since 2004 provides the opportunity to examine the impact of an "anti-immigrant" climate on immigrant populations that have settled there (O'Leary 2009a). In turn, this examination can be used to predict the widening of health care disparities through the "disentitlement" politics of social welfare policy reform (Marchevsky and Theoharis 2008, 90) that began as early as 1986 with California's unsuccessful Prop 187. The concept of the mixed-immigration-status household is a useful analytical approach for explaining how emerging anti-immigrant policies adversely impact more than those who have been singled out because of their immigration status to include non-immigrants who share intersecting ethnic and racial characteristics.

Key to our argument is the concept of the mixed-immigration-status household. In this domestic unit, the immigration status of at least one member is different from that of the others. This may include family members who are "undocumented," legal residents, U.S.-born, or naturalized citizens (Romero 2008; Talavera 2008). Although the category of undocumented is in itself ambiguous, it has both real and symbolic consequences for immigrants (Plascencia 2009). In the United States, the growing category of undocumented immigrants has become the focus of state-level immigration enforcement policies. Because there are different ways for individuals to fall under this label, for our research we relied on Cornelius to help us formulate the following description:

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The undocumented are those individuals who enter the United States without inspection (at a place other than a port of entry) and are present without authorization. They may have entered legally but subsequently overstayed the term limit of their visa. They may have entered legally and are legally present but are not legal residents and, therefore, not entitled to public benefits. They may be present without the legal authorization but not apprehended at the time of the interview, nor are they under suspension of deportation orders at the time they are studied. (1982, 378)

While it is difficult to ascertain how prevalent the mixed-immigration-status household is, its development is rooted in history and the adaptive processes of Mexican families in the border region (Heyman 1991; Sheridan 1992).

Migration's Global Stage

Understanding how women have come to be increasingly impacted by anti-immigrant policies stems from our grasp of how macro-economic policies have increasingly driven them into the global labor market for survival, eventually to migrate to the U.S. To be sure, the neoliberal economic philosophies that have worked to callously disrupt subsistence economies in sending communities in Mexico also underpin the political philosophies that steadily work to undermine migrants' integration in their new destinations.

Neoliberalism is a market-driven approach to economic and social policy based on a private enterprise sector allowed to operate unfettered by government regulations. Not confined to mere economic principles, neoliberalism has been instrumental in setting both political and social priorities of the state. In this way, neoliberal approaches often parallel social conservative views that include the belief that governments should not run large economic deficits due to public spending. Neoliberals consider government subsidized entitlement programs such as services for the poor, primary education, public transportation, and publicly funded health care programs to be wasteful, and that they place undue tax burdens on individuals and businesses. In fact, international economic aid for developing countries in the form of loans from the International Monetary Fund (IMF) and the World Bank are contingent on the adoption of neoliberal principals (Pomeroy and Jacob 2004). Thus, it should not come as a surprise that the wide adoption of neoliberal plans such as the North American Free Trade Agreement (NAFTA) by a state such as Mexico in 1994 would adversely impact the economically disadvantaged. Indeed, the literature is replete with scholarly analysis of how neoliberal economic changes resulted in the disruption of rural and agriculture-based communities (Hing 2010; McCarty 2007a). For example, with NAFTA, Mexican smallholders could not compete with U.S. subsidized corn on the market and were forced to migrate in search of jobs, resulting in eventual greater migration in general. Given these conditions, women especially have been compelled to migrate (Andrews, Ybarra, and Miramontes 2002; McCarty 2007b; McGuire 2007; Pomeroy and Jacob 2004; White 2004).

The adoption of neoliberal policies in Mexico has been blamed for increased poverty and less support for those devastated by the changes. Moreover, although migration in general to the United States from Mexico and Latin America as a result of these policies has steadily increased, the most significant change has been the greater participation of women (Marcelli and Cornelius 2001). This is due in part to the implementation of structural adjustment programs (SAPs), the conditions for loans set up by the IMF and World Bank. Also known as the Washington Consensus (McGuire 2007), some of these free-market-oriented conditions include cutting social welfare expenditures, the deregulation of labor relations, and the devaluation of a nation's currency to remain globally competitive (Canales 2000). In this way, SAPs result in harsher conditions for Mexico's poor, especially for women who increasingly contend with rising education and health care costs for their families (McCarty 2007b), diminishing employment opportunities, and declining purchasing power (Crummett 2001; Labrecque 1998; Marchand and Runyan 2000). To compensate for this, an unprecedented number of women have entered the labor market through migration, a combination known to produce the feminization of migration (McGuire 2007; Sadasivam 1997).

The disruption of local economies and the ensuing migration undermines the process whereby social cohesion is preserved. Characterized as a "fracturing experience," migration places burdens on both those who leave their communities and those who stay (McGuire 2007). Splintering families can lead to negative health outcomes while at the same time offering hope of finding better opportunities. In tracing the migration of women engaged in the tomato industry, Barndt (2001) relies on the explanatory power of the Marxist concept of "alienation" to advance our understanding of how, over time and geography, industrial agriculture, fueled by free trade principles, capitalizes on the displacement of subsistence farmers. As men and women are dislodged from the land as their means of production, they become distanced from the elementary process that defines households: production, reproduction, and consumption (Netting, Wilk, and Arnould 1984). However, the process of alienation pertains not only to workers but also to the "deeper separation of us all, producers and consumers alike, from the social dynamics, context, and conditions that bring things into being (Barndt 2001: 35). How labor is reproduced and reinvented in terms of U.S. needs is one example.

Migration intensifies the changes for women and moves them toward greater independence (Hirsch 2002; Safa 1999). With the distancing of labor and production, immigrant women are also distanced from their reproductive roles. This includes choosing to have fewer children (Lindstrom and Saucedo 2002; Wilson and McQuiston 2006), marrying later in life (Raley, Durden, and Wildsmith 2004), and having less time to devote to other reproductive activities such as the socialization of family members and the care and monitoring of dependent children, the elderly, and the infirm (Wilson 2000). Flexible employment patterns also fracture hours worked for wages from the costs of reproducing the labor force, to the advantage of businesses (Barndt 2001; Canales 2000; O'Leary 2006). Anti-immigrant policies advance this fracturing process by helping the state determine and

institutionalize differences *among* family members through the construction of legal categories (Romero 2008, 132), many of which support a state-regulated process in which immigrants benefit industry.

Anti-Immigration Policies: Implications for Widening Health Disparities

Anti-immigrant policies and the public discourse that promotes and advances them have only recently come to the attention of researchers. A previous publication by one of the authors of this article traces Arizona's legislative actions from 2004 to show how political pressures to restrict immigrants from accessing social welfare programs have intensified (O'Leary 2009a). California's unsuccessful Proposition 187 proposing limits to health care program access (Chavez 1988; Chavez, Cornelius, and Jones 1986) and the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) (Inda 2006) were premised on the idea that immigrants were imprudent and incapable of behaving ethically (Inda 2006, 24). Indeed, many anti-immigrant propositions have gained traction from the circulation of myths that malign immigrants to justify support for the measures. King (2007) lists these myths as:

- U.S. public health insurance programs are overburdened with immigrants.
- Immigrants consume large quantities of limited health care resources.
- Immigrants come to the United States to gain access to health care services.
- Restricting immigrants' access to the health care system will not affect U.S. citizens.
- Undocumented immigrants are "free-riders" in the U.S. health care system.

In Arizona, House Bill 2030 (known as "Public Programs, Citizenship") was premised on misrepresenting Latinos as welfare-seeking intruders. Although vetoed by Arizona's governor in 2005, it passed in 2006 by focusing the electorate's attention on immigrants' access to public programs. This bill requires Arizona state government employees to verify an applicant's immigration status with the Department of Homeland Security's Secure America with Verification and Enforcement (SAVE) program before providing services.

Conventional wisdom holds that the lack of health care and health care access has a negative impact on all facets of life: from economic productivity and educational attainment to the prevention of crime and the spread of disease. However, health care and health care access is a particular problem for Latino populations. Many Latino immigrants arrive in the United States undocumented, already markedly poor, less healthy, less educated, and less connected to the rest of society (Andrews, Ybarra, and Miramontes 2002). Latinos are more likely to be engaged in high-risk occupations, such as construction and farm labor. Latinos are also likely to face obstacles to access caused by poverty and the lack of culturally competent, Spanish-

language-proficient medical service providers (Brown and Yu 2002). Because of the high cost of premiums and Latino employees' limited access to employer-based health insurance (EBHI), the group also has low rates of health insurance coverage (Brown and Yu 2002; King 2007). Despite Latinos' high employment rates—the unemployment rate reached a historic low of 4.9 percent at the end of 2006 (Kochhar 2008)—the lack of EBHI significantly contributes to Latinos' limited access to health care. Many Latinos work in Latino-owned businesses, which cannot afford to offer their employees EBHI. The type of jobs they hold is another factor. A disproportionate number of Latinos work in formal and informal service-sector jobs (as janitors, domestics, and care-givers), construction, and food-service occupations and are, therefore, more likely to be employed part-time, temporarily, or seasonally, making them ineligible for EBHI. Even when they are eligible, such occupations and the low wages they earn are not enough to pay their portion of cost-sharing health insurance plans (Brown and Yu 2002). Many Latinos are thus unable to meet their most basic health care needs: regular check-ups, routine immunizations, and necessary medications.

The Research

In this section, we highlight results from a study that examined immigrant women's access to reproductive health care programs in the climate created by Arizona's anti-immigrant legislation. For this reason, we focus here on the results from the U.S. field work, which necessarily encompasses important historical and geographical realities that have given rise to the mixed-immigration-status household.

The household is the most fundamental unit of social organization and a well established scientific unit of analysis (Netting, Wilk, and Arnould 1984). Households are strategic groupings of individuals who may be, but are not necessarily related by blood. As the most basic of decision-making structures, individual decisions inevitably impact the entire unit (Hackenberg, Murphy, and Selby 1984). For our research, a special effort was made to include study participants whose households were of a mixed immigration status. Ferreira-Pinto (2005) suggested that the application of policies aimed at excluding those who were undocumented would, in practice, have a generalized adverse "chilling effect" on health care access (Marchevsky and Theoharis 2008, 82). Since individuals do not live in isolation but are part of social groupings, we examined households where by definition individuals share a multitude of task-oriented and symbolic activities with others. In this way, we relied on the scientific understanding of the household as a "locus of negotiation" (Hackenberg, Murphy, and Selby 1984, 187), where collective decision-making necessarily weighs its interest in light of the often conflicting interests of its individual members. This is essential to understanding why policies of attrition will fail to achieve their stated goals and work instead to undermine the basic rights and the health and human capital development of an incalculable number of the state's residents who are not by definition undocumented immigrants.

RESEARCH DESIGN AND METHODS

The research project “A Multidisciplinary Binational Study of Migrant Women in the Context of a U.S. Mexico Border Reproductive Health Care Continuum” was designed to document and analyse the reproductive health care strategies of immigrant women, and their access to reproductive health care services.¹ Conducted in 2008-2009, the study shows that the reproductive health care strategies immigrant women adopt are couched within increased exposure to various types of risks associated with the migratory process, including the risk of death (Cornelius 2001; Goldsmith et al. 2006; O’Leary 2008, 2009b), sexual assault (Falcon 2001), and illness when health care services in settlement communities are restricted, denied, or under-utilized (Marchevsky and Theoharis 2008; Talavera 2008). Such services are seen as critical to women’s health and safety in the course of migration, and ultimately, to their well-being in destination communities.

Fieldwork in Tucson, Arizona, consisted of survey research using a short demographic- and health-indicators survey with both open- and closed-ended questions to immigrant women. Once permission was obtained from respondents, interviews were recorded for accuracy.

Researchers partnered with the Mexican Consulate’s health referral program, “*Ventanilla de Salud*” (A Window on Health), and El Rio Community Health Center to help recruit an initial 40 respondents (for subsample C) who had solicited reproductive health care services. A snowball sampling process was chosen to produce another 40 respondents for subsample D, women who might be responsible for the health care needs of at least one undocumented individual, which by definition might complicate their receiving services. No direct questions about respondent’s legal status were asked. Instead, proxy questions were used as indicators for behavior consistent with efforts to avoid attention, and specifically in terms of accessing health care services. In other words, questions about the difficulties immigrants might deal with for accessing health care programs for family members were used to determine if respondents were assigned to subsample C or D. Upon analysis of the responses, certain questions and answer combinations allowed us to claim with reasonable certainty that we had met our goal of interviewing and identifying at least 40 respondents in which at least one member of the household was undocumented. We used the statistical program SPSS for quantitative analysis, and open-ended questions were transcribed for later content analysis.

FINDINGS

To determine if the anti-immigrant climate in Arizona had an impact on a respondent’s access to health care, researchers in Tucson, Arizona, where the U.S. com-

¹ The research was funded by the Programa de Investigación de Migración y Salud (Migration and Health Research Program) (PIMSA) in 2008-2009, administered by Health Initiatives of the Americas (HIA).

ponent of the bi-national study was conducted, gathered data from two purposeful subsamples of immigrant women. The first subsample (C) represented those situations where eligibility for health services posed no problem. The second subsample (D) represented a situation where health care eligibility, presumably due to immigration status of at least one family member, posed a problem for accessing health care. Issues for accessing health care generally arise from an immigration status that makes the applicant ineligible, such as the category “undocumented.”

To test if there were differences between the two subsamples (C and D) with regard to the ability to access some form of health care plan or program, respondents from both samples were asked if they had any type of *aseguranza* (health insurance). Because it was anticipated that many might not be able to afford commercial forms of health insurance, the definition of health insurance included any health care program in which they were enrolled. Consistent with the notion that the combined anti-immigrant rhetoric and the ensuing policy restrictions produce a “chilling effect” on health care access (Ferreira-Pinto 2005; Marchevsky and Theoharis 2008), our null hypothesis posited that there is no difference between subsamples C and D. Table 1 shows the X^2 (Chi-Square) test results of the comparison of these two groups. The Pearson X^2 and Fishers tests yield significant differences between subsamples C and D. The difference between the two samples is informed by the research context, and it suggested that for those respondents who live in households with at least one undocumented member, access to health care programs is a problem.

TABLE 1
CHI-SQUARE TESTS FOR SUBSAMPLE (C AND D)
DIFFERENCES IN ACCESS TO INSURANCE

	<i>Value</i>	<i>df</i>	<i>Asymp. Sig. (2-sided)</i>	<i>Exact Sig. (2-sided)</i>	<i>Exact Sig. (1-sided)</i>
Pearson Chi-Square	7.622 ¹	1	.006		
Continuity correction ²	6.338	1	.012		
Likelihood ratio	7.893	1	.005		
Fisher's exact test				.008	.005
Linear-by-Linear association	7.514	1	.006		
Number of valid cases	71				

¹ 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.68.

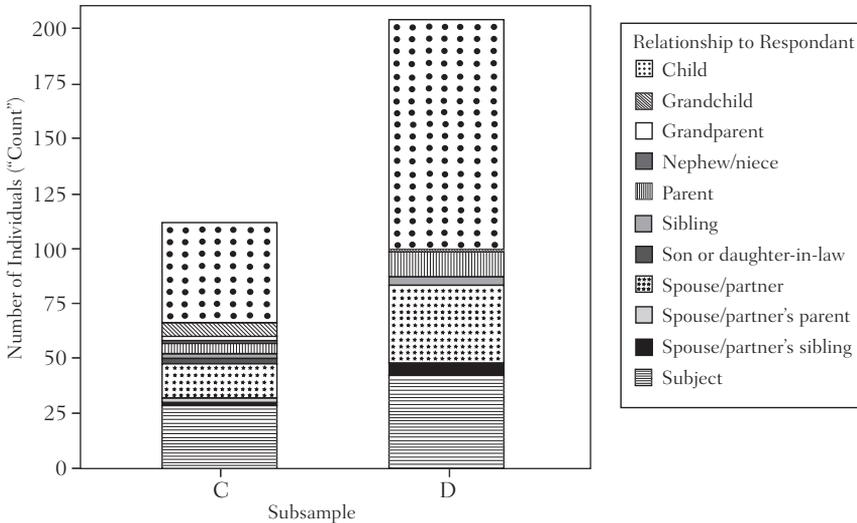
² Computed only for a 2 x 2 table.

SOURCE: Developed by the authors based on O'Leary (2008-2009).

A content analysis of the narratives of women interviewed in the study confirms this assertion. For those unable to access health care programs, reasons noted included that they did not have the documents necessary for the application, or that they did not have *all* of the documentation necessary with them at the time they applied for assistance. Fifty-nine percent stated that they had difficulty in accessing services, while 41 percent did not report having issues. In addition, a majority of the respondents (65 percent) stated they had felt in some way unwelcome, discriminated against, or otherwise made to feel uncomfortable by medical staff. These accounts are consistent with findings by Marchevsky and Theoharis (2008) and Talavera (2008).

The application of such measures is predicted to be sure to have a “ripple effect” throughout the broader immigrant community. The two subsamples of respondents recruited are shown in Chart 1, which compares the overall size of those impacted when all household members are considered. Comparing subsamples C and D, this chart shows that as the sample size goes up, even a small difference in the number of respondents becomes significant. The lower number of women who were categorized as subsample C (n=30), where immigration status does not seem to be an issue, translates into a total of 107 household members. By contrast, the slightly larger number of women who were categorized as subsample D (n=41), where at least one member of the household is thought to be undocumented, translates into a total of 209 household members who are potentially impacted

CHART 1
HOUSEHOLD COMPOSITION BY TOTAL NUMBER OF INDIVIDUALS
BY CATEGORY (“COUNT”) AND SUBSAMPLE



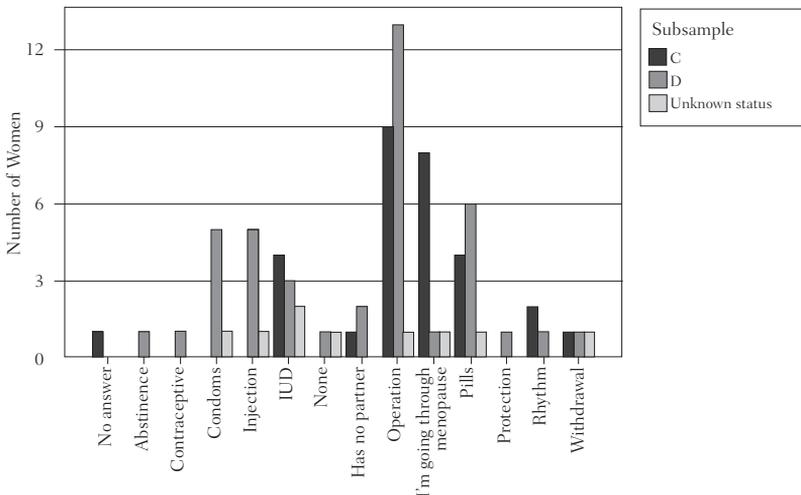
SOURCE: Developed by the authors based on O'Leary (2008-2009).

by household decisions. For example, if household heads in this category decide for any reason not to apply to a health service program, nearly twice the number of individuals, including a total of 105 U.S.- and foreign-born children, are more likely to be affected by these decisions.

The data also reveals that 55 percent of the immigrant women interviewed had children born in the United States. This is broken down by women in each of the two subsamples, showing that women belonging to subsample D (mixed immigrant-status households) were more likely to have U.S.-born children. By the same token, about half of the immigrant women interviewed (48 percent) had children born outside the United States. In practice, then, women who live in households where at least one household member is undocumented may engage in household decisions to seek health care made difficult because of the fear that their application will invite additional scrutiny and possible reporting to authorities. As such, these decisions may result in *de facto* restrictions to health care services for members who are eligible for them, including children.

One way in which women are seen as contending with the cost of reproductive health care services when restrictions cannot be negotiated is avoiding them altogether. Although more research in this area is needed, some of the evidence from the current study suggests that choosing permanent sterilization as a contraceptive method may be a solution. Chart 2 shows that among the women surveyed in Tucson, those who belonged to mixed-immigration-status households were more likely to opt for this method of contraception.

CHART 2
CURRENT METHOD OF CONTRACEPTION



SOURCE: Developed by the authors based on O'Leary (2008-2009).

Discussion

In sheltering populations from —and forming resistance to— the emerging discourse of intolerance, the research by Vélez-Ibáñez (1996) is useful for showing that households are not strictly economic adaptive mechanisms, but also key to reproducing value systems that directly or subtly oppose the non-collective nature of the capitalist mode of production. To be sure, the mixed-immigration-status households are not the ideal family model that is at the heart of the U.S. legal structure, as Heyman points out (1991, 197). However, this household make-up, which takes advantage of cross-border movement and the mounting restrictions to the free movement of people, commerce, and ideas, is representative of a cultural reality of the U.S.-Mexico border region (Vélez-Ibáñez 1996) and beyond (McCarty 2007a). Related by marriage, friendship, and children, vast networks of households straddle the border and fluctuate over time in terms of size, composition, and functions consistent with cooperative arrangements, such as the care of children and the elderly, borrowing, lending, and the cultural ideologies that give them meaning. In this way, households build up and restore social bonds. Above all, bonds of trust (*confianza*) also work to buffer its members from symbolic violence, i.e., the use of denigrating language, labels (e.g., “illegals”), and images (e.g., criminals) that reproduce and legitimize relations of domination (Bourdieu 1989), and other assaults on their dignity. Thus, devastation to households and families on the U.S. side of the border inflict “collateral damage” to those on the Mexican side (McCarty 2007, 106).

Perhaps such resistance has resulted in a backlash in the form of virulent anti-immigrant sentiment and overt hostility. Marchevsky and Theoharis (2008, 76) report that states with large minority populations (black and Latino) have adopted stricter policies for accessing social welfare programs and have higher sanction rates than states where their clientele is white. The consequences of such acrimony on the health and human development of immigrants and non-immigrants alike has only recently stimulated academic interest and public outrage. Research by O'Leary and Romero (2011) shows that university students, a quarter of whom had immigrant parents, experienced stress produced by anti-immigrant rhetoric. A 2007 report by the National Council of La Raza raised concerns about the damage to families caused by intensified workplace raids in 2006 and 2007 that terrified and separated small children —many U.S.-born— from parents (Capps et al. 2007). The report presents the implications of these raids: long- and short-term learning problems in children due to the fear they triggered. Romero has argued that such state practices serve to “intimidate and stigmatize mixed-status families, deter political, social, and cultural integration of communities, and socialize citizens to a second-class status” (2008, 132). The public intimidation exhibited by police during immigration raids in Chandler, Arizona, in the form of unwarranted stops and searches of presumed undocumented immigrants serve to normalize disrespect and contempt for immigrants. The public spectacle, often in front of other immigrants or family members, in shopping areas and neighborhoods contributes to the socialization and identity formation processes. This argument is consistent with the

findings from the research by Goldsmith, Romero, Rubio Goldsmith, Escobedo, and Khoury (2009), who find that policing authorities mistreat barrio residents who exhibit more Mexican ethno-racial characteristics than those with Anglo characteristics, and that citizenship, class, and educational level offer them little protection, which is useful in light of criticisms of SB1070 for its potential to encourage racial profiling (also see Short and Magaña 2002). More to the point, although there are real differences between legal and “illegal immigrants,” the ability of the public and the media to make this distinction is less clear, making Latinos in general more susceptible to prejudice and discrimination because they share many phenotypical and cultural traits with immigrants (Short and Magaña 2002, 709; Plascencia 2009). Therefore, although the proposed policies are directed at restricting *undocumented* immigrants, they are expected to have broader ramifications throughout the communities where immigrants live—often heavily Latino—regardless of legal status.

Conclusion

Anti-immigrant sentiment normalizes generalized disrespect for and suspicion of immigrants. This encourages their being policed by social service agents. As more women enter the labor force through migration, they initiate a process whereby productive activities are separated from their reproductive activities (Wilson 2000). The distancing from these two activities is institutionalized with outward acts of disrespect, such as those articulated and effected by anti-immigrant sentiment. In 2011, Arizona’s legislators debated a proposal to deny birthright citizenship to the children of undocumented parents born in the United States. This was also debated in the U.S. Congress in spring 2011. In addition to articulating contempt for immigrants, this debate delineated the relationship between the state and the reproduction of its immigrant work force. Although the idea never gained meaningful traction, the political discourse it engendered represented one more in a long list of attempts to separate immigrant workers from the social context that ultimately brings the work force into being. A “deeper separation” (Barndt 2001, 35) of worker from family ensures more profit for the employer because the costs of reproduction remain foreign and thereby the responsibility of the foreign state. More importantly, this attempt to further separate the productive from the reproductive counters the historical use of birthright citizenship to encourage assimilation, unity, and allegiance among children of immigrants to their country of birth (Ngai 2007). As U.S. citizens, the costs of educating them and keeping them healthy would fully reside in their country of birth *and* the site of production, expenses that fundamentally counter the neoliberal agenda.

Such disciplining becomes internalized as household members contend with the possibilities of being an object of suspicion and subjected to such treatment. This results in opting out of health care services. For women, a logical outcome of this internalized understanding of their situation may include their unwillingness to expose themselves to the scrutiny of official agents charged with administering

or accessing health care. Indeed, in the research by Marchevsky and Theoharis (2008), case workers perceived Latina immigrants as undeserving of the same benefits as U.S. citizens. Latina immigrant women reported being misinformed, humiliated, and harassed by case workers. For those whose families included a person ineligible for health care, the lack of health care program participation can be explained by the fear of being openly scrutinized and perhaps even denied service. However, it is important to realize that such decisions also impact those legally entitled to receive such services, many of whom are children of immigrant parents; in turn, many of these children are U.S. citizens. Community reports such as those examined by Marchevsky and Theoharis (2008) suggest growing disparities between immigrants and citizens in terms of their access to public assistance programs. When combined with other anti-immigrant policies, progress for human development is stifled. Take for example, Arizona's Prop 300, which became law in 2007. This legislation affected adult education programs and immigrant students' access to institutions of higher learning. The adult education provisions restricted eligibility for state-funded services offered by the Arizona Department of Education Division of Adult Education. Adult education programs were targeted because of a perception that Spanish-speaking undocumented immigrants were the bulk of the students taking these English classes. The law now requires state-funded programs in school districts and other institutions and agencies to provide adult education services only to U.S. citizens, legal residents, or people otherwise lawfully present in this country. Prop 300 also prohibits adults who are not U.S. citizens or legal residents from receiving childcare assistance from the Arizona Department of Economic Security.² Thus, just when English became the state's official language, creating legal impediments to conducting official business in Arizona, the state legislature mandated obstacles to learning English.

Prop. 300 also restricted access to public higher education. Previously, students only had to prove local residency to qualify for in-state tuition rates at Arizona's colleges and universities and for state financial aid. Now, with Prop 300 in place, immigrant students in Arizona are impacted in several ways:

- A student with unauthorized immigration status does not qualify for in-state tuition.
- A student in this country unlawfully is not entitled to state-funded financial assistance.
- A student whose immigration status is unauthorized cannot be classified as an in-state student or a county resident.

On January 1, 2008, Arizona's employer-sanctions law went into effect. It targeted businesses that intentionally or knowingly employ unauthorized immigrants

² One particularly insidious stipulation of Prop 300, a third component that received little attention during the November 2006 elections, was that in addition to addressing eligibility requirements for education, it also restricts eligibility for childcare assistance to parents, guardians, and caregivers.

and largely replicated provisions of the 1996 Immigrant Responsibility and Immigrant Reform Act. Under the Arizona law, any employer who employs unauthorized workers—not just those who provide services to the state—can have their business licenses suspended for up to 10 days and be put on probation. Although the long-term economic impact of the law on Arizona's economy is not yet clear, there are historic indications that people with a tenuous hold on social and economic life, like immigrants, will suffer the ramifications of the implementation of anti-immigrant legislation. This could include increased policing by employers, and embolden racial profiling of newcomers from cultures increasingly perceived as problematic.

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