COVID-19 and Immigrants: An exploratory study of immigrant experiences

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Abstract

This exploratory study sought to discover immigrant experiences during the COVID-19 pandemic. It was carried out in collaboration with a community service agency in the state of New Jersey in the United States of America between August 2020 and July 2021. Participants were clients at the agency and the survey was completed via Qualtrics using non-probability convenience and snowball sampling methods. SPSS version 28 was utilized in conducting descriptive and chi square analysis. 55 individuals participated many of whom were women (83%). Approximately half were of Latino origin (47.3%). Nineteen participants reported having citizenship. Results indicated that non-citizens significantly were more likely to experience barriers in areas of access to health insurance, food security, rent or mortgage payments and safety in the community. No significant differences were noted between citizens and non-citizens with regards to the areas of employment and healthcare. This could be due to the nature of jobs where both groups were in areas of essential work during the COVID-19 pandemic. This data adds to the body of existing research and a resounding call to action around a "one health" policy especially in times of a global pandemic.

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Introduction

According to 2020 estimates, there were 280.6 million global migrants (Batalova, 2021). They represent approximately 4% of the world population. During the COVID-19 pandemic migrants were exposed to vulnerabilities and abuses such as access to healthcare, housing, employment, and food security. Immigration status also contributed to these inequalities. This paper reports on an exploratory survey conducted at a local social service agency to understand migrant experiences during the COVID-19 pandemic.

Literature Review

A Global Crisis

Immigration policy is a global problem, which was further exacerbated during the COVID-19 pandemic. Out of 169 million migrant workers, 24.2% were working in Northern, Southern, and Western Europe while another 22.1% were working in North America (Migration Data Portal [MDP], 2022).Migrants are overrepresented in the informal market, accessing low paid jobs (Cramarenco, 2020). During the COVID-19 pandemic, data indicated that over 2 in 5 migrants were affected by layoffs, movement restrictions, and lockdowns. In 2020, unemployment rates of migrants increased significant-

ly in over 75% of all OECD countries (MDP). Data on COVID-19 related infection, hospitalization, and deaths clearly indicate that migrants and citizens of ethnic minorities were overrepresented (Guadagno, 2020). Additionally, migrant vulnerabilities became apparent with the intersectionality of class, race, and status. Low-income and discriminated minorities encountered challenges in access to healthcare and were excluded from welfare programs while also experiencing fear of stigmatization and facing arrest or deportation (Cramarenco, 2020). This was especially so for migrants with irregular status or on short-term visas who were then not eligible to access to healthcare and other welfare programs. Irregular migrants harbored fear to the extent that they were afraid to seek medical attention in apprehension of deportation (Guadagno, 2020; Popp, 2020).

Impact of Immigration Policies during COVID-19

The underpinnings of rugged individualism (Alesina et al., 2001; Walsh, 2019) such as white people's fear of minority group's advancement at their expense, has negatively impacted immigration policiesand consequently the lives of immigrants living in the United States. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRRIRA)was enacted to strengthen legislation on illegal immigration at the border, workplace,

and in the criminal justice system (Kerwin, 2018).Removal processes became "informalized" and "expedited removals" meant a lack of due process (Miller et al., 2020).The "public charge" rule introduced by the Department of Homeland Security in February 2020, provided a basis for immigration enforcers to reject applications where individuals received need-based benefits which included Supplemental Nutrition Assistance Program (SNAP), Medicaid and housing assistance (Gelatt, 2020; Gonzales, 2020; Page et al., 2020). Undocumented individuals and legal immigrants within the first five years of status are ineligible for federal means-tested assistance. Migrants disenrolled in fear of not being able to meet the requirements to apply for residency status, and although the "public charge" rule was overturned during the Biden administration, immigrants and their children continue not to access much-needed services for the same reason (Gonzales, 2020; Langellier, 2020). U.S. Immigration and Customs Enforcement (ICE) continued enforcement during the onset of COVID-19 targeting hospitals, court houses and children's schools (Miller et al., 2020; Parmet, 2020). Although ICE announced the cease in all enforcement actions during COVID-19 in March 2020, with the exception of those with a criminal offence or posing a threat to public safety, data indicated that ICE continued immigration raids in California, New York, Ohio, and Michigan (Miller et al., 2020).

Immigration policy changes in the United States are constant, unpredictable- and have a direct negative impact on resource accessibility (Parmet, 2020). During 2020, the first year of the COVID-19 crisis, President Trump continued his harsh policies and rhetoric around immigration which had negative impacts on migrants' overall wellbeing (Miller et al., 2020; Sanchez, 2020; Wieling et al., 2020;). Federal responses during this time weighted heavily on immigration-based restrictions such as travel bans anddeportation of non-citizens including those with the COVID-19 virus (Parmet, 2020). Another culminating factor was that government offices were not processing applications for extensions of DACA and Temporary Protected Status due to service reductions (Gonzales, 2020). Many non-citizens were unable to access cash assistance under the Coronavirus Aid, Relief and Economic Security (CARES) Act which was limited to citizens and immigrants who filed taxes using a Social Security number. Although non-citizens and families with mixed immigration status use the taxpayer identification number to pay their taxes, or have taxes deducted from their paychecks, they were unable to receive federal cash benefits during the crisis (Clark et al., 2020; Gee et al., 2017; Parmet, 2020).Efforts to mitigate this such as New Jersey Governor's request in 2022 to the state legislature to use $53 million of unused COVID-19 funds towards a one-time $500 grant program for house-

holds who file taxes with an individual tax payer identification number typically used by immigrants who are not American citizens was not approved. (Livio, 2022). This reflected the broader ideology regarding migrant status and documentation during this time period as discussed earlier.

Data availability during COVID-19

Lack of data was an issue on a global level that had implications during the COVID-19 pandemic with respect to accessing services such as healthcare, and social provisions (Popp, 2020). There was a void in data collection in the United States where citizenship and nativity data were not being collected by the Centers for Disease Control and Prevention's (CDC's) forms. This meant that data on the spread in immigrant groups were missing,which became especially criticalduring the second wave which was the sustained community spread (Langellier, 2020; Piece, 2020; Solis et al., 2020).Thisinformation is vital in addressing the racial and ethnic disparities of the disease, and intervention strategies (Laurencin & McClinton, 2020). Additionally, there is a need for understanding the representation of migrant documented and undocumented workforce in the seasonal job market in order to put in place protections especially during such times (Cramarenco, 2020; Laurencin & McClinton, 2020; Popp, 2020).

Housing during COVID-19

Loss of employment and reduced hours during the COVID-19 pandemic had an impact on being able to maintain rent or mortgage payments (Ballard et al., 2020). The fear of losing housing was powerfully noted among providers who served the immigrant community in the study. Additionally, some clients also expressed that they were being threatened with eviction during the rent moratorium period (Ballard et al., 2020). Housing conditions such as overcrowding, unstable housing, and neighborhoods that do not have access to protective equipment were barriers to health safety for immigrants during this time (Falicov et al., 2020; Greenaway, 2020).

Employment during COVID-19

Immigrants faced an onslaught of problems globally around employment. Although immigrant workers contributed to the social security systems in the country of employment, their jobs did not typically have social and labor protections and therefore, they werepredisposed to exploitation (Cramarenco, 2020). The nature and scope of their type of employment (seasonal and low paid) such as agriculture, construction work, logistics, and deliveries which had to continue in-person, placed them at greater risk (Guadagno,

2020; Popp, 2020).

In the United States, immigrants have labor participation rates at approximately 4 percentage points higherthan U.S. natives (Orrenius et al., 2019). The Migration Policy Institute (MPI) reported during the COVID-19 pandemic, 6 million immigrants were represented in frontline industries such as healthcare and social services (17%), essential retail and wholesale (18%), transportation (34%), and manufacturing (26%) (Gelatt, 2020). In addition to this substantial representation, there was also immigrant over-representation in industries where there were huge declines due to efforts to mitigate the pandemic. These included accommodation and food services (22%), personal services and private households (30%), and building services (38%).Additionally, non-citizens represented more than half of the workers in hardest-hit industries Gelatt (2020). This was not accounting for those undocumented.

At the onset of the COVID-19 pandemic with the presence of public health mitigation efforts such as masking, social distancing and various levels of lockdowns, it became very clear that immigrants were greatly impacted due to the nature of their employment. During the pandemic, research indicated that immigrants experienced higher rates of job loss. Ballard et al., (2020)

indicated that an average of 70% of providers clients had lost their jobs or had their hours reduced.

Healthduring COVID-19

Internationally, migrants on the move, especially irregular migrants or those with short-term visas did not have access to healthcare and therefore were not covered for COVID-19 test or treatment (Guadagno, 2020). Additional barriers to accessing healthcare during this time included language, limited knowledge of the host country, and fear of being reported and subsequently deported.

Research in the United States clearly showed that the COVID-19 virus disproportionately impacted African Americans, Hispanic immigrants regardless of documentation and First Nations people (Greenaway et al., 2020; Piece, 2020). The main reason being the high prevalence of pre-existing health conditions such as obesity, cardiovascular disease, and diabetes all of which were contributing factors for severe COVID-19 and death (Piece, 2020; Solis et al., 2020).Restrictive immigration laws impacted access to healthcare, and so non-citizens were less likely to work for employers who provided healthcare (Parmet, 2020). Immigrants who were on a path to-

wards citizenship reported being afraid to access healthcare due to concerns that using Medicaid would impede their citizenship application. Additionally, clients were forgoing care and less likely to participate in contact tracing due to fear of ICE enforcement (Ballard et al., 2020; Parmet, 2020).

Undocumented immigrants were afraid of job loss and so continued working in spaces such as meat-processing plants and as a result contracted the virus with many deaths reported in states such as Georgia, Colorado, and Pennsylvania (Clark et al., 2020; Piece, 2020).In another study, providers who served immigrants informed that their clients were not always offered safety precautions during the pandemic (Ballard et al., 2020). They also encountered difficulty paying for regular medication. Language barriers were brought to the forefront where a lack of translated information about the COVID-19 virus were barriers in accessing vital information (Clark et al., 2020; Clarke et al., 2020; Falicov et al., 2020; Sieffien et al., 2020). A lack of understanding around mental health, and the need for increasing community support around this problem was compounded by the need to social distance. Immigrants also experienced increased levels of mental health concerns due to the impact of fear and stress experienced around immigration policies and enforcement (Cabral & Cuevas 2020). Social determinants

of health were also brought to the forefront during this pandemic where institutional barriers supported inequity of the most vulnerable (Cabral & Cuevas, 2020; Watson et al., 2020).

Food Securityduring COVID-19

Immigrant families continue to experience food insecurity at higher rates than US-born households even if they have lived in the United States for over 10 years (Clark et al 2020). Although eligible, immigrants including undocumented did not apply for Pandemic Electronic Benefit Transfer (EBT) in fear of deportation and loss of status in the application process. Additionally, many immigrants disenrolled from the Supplemental Nutrition Assistance Program (SNAP) in fear that it would impact obtaining legal status (Page, et al, 2020). Limited transportation, restaurant restrictions, reduced grocery supply, increased price of food and most importantly diminished supplies at foodbanks were some reasons for further limiting food availability (Ballard et al., 2020; Clark et al 2020).

Preparedness Planduring COVID-19 and beyond

There is a resounding call to action globally, nationally, and locally for a preparedness plan (Guadango, 2020;Wickramage et al., 2018). There is a

need to comply with international human rights law where states should provide essential services such as disease prevention and health equity for all (Machado & Goldenberg, 2021). In 2011, the World Health Organization's review of Pandemic Influenza Preparedness Plans (PIPPs), revealed that only 13 out of the 119 countries had strategies in place to address the needs of minority, including immigrant groups. Thailand, Papua New Guinea, and the Maldives were the only countries to identify a migrant group within their national plan, where Thailand undertook an integrated "one health" (Wickramage et al., 2018 p. 252) approach as a broader national strategy in tackling infectious diseases beyond the viral flu.Currently, there is a call for temporary solutions to be made permanent due to the sheer success of such policies (Mixed Migration Center [MMC] 2020). These have aligned with the Global Compact for Safe, Orderly and Regular Migration (GCM). For example, many countries provided access to healthcare, food and nutrition and shelter programs regardless of immigration status during the crisis. There were also windows of opportunities for countries to regularize with pathways to citizenship in Canada, while Australia, Argentina and Paraguay extended visas. In the United States, there was some suspension of enforcement against farm workers (MMC, 2020). These examples point to the urgent need for us to act on creating PIPPs that are inclusive of

everyone.

The following research was carried out to explore migrant experiences during the COVID-19 pandemic. Early information identified the vulnerabilities migrants encountered, especially those who were irregular and undocumented. Agencies serving migrants expressed the need to document their clients' experiences during this time.

Method

This is an exploratory study that was carried out in collaboration with a community service agency in the local area, close to the University. The agency wanted to understand the experiences of their clients during the COVID-19 pandemic as they were hearing ad hoc client experiences around access to healthcare and concerns at the workplace. Agency staff also collaborated with the faculty member in the development of the survey, as there were specific topic areas and questions that were important for the agency to understand in their work with clients. The survey had seven sections which included questions on housing, employment, health (including mental health), food security, safety, coping, and general questions including demographic information. Upon university IRB approval, the survey was made available

to the agency via Qualtrics.The sampling method was non-probability convenience sample as the agency had existing contact within the population of interest. The agency shared the survey link with their clients via social media and posters. Snowball sampling also took place as clients who received services from the agency were also encouraged to share the link with their friends. Data collection took place during the period of August 2020 to July 2021. 55 participants responded to the survey. The survey data was exported from Qualtrics to SPSS. Data analysis was carried out with SPSS version 28, beginning with frequencies and case summaries. Variables involving ordinal scales (e.g. Not a barrier to Extreme barrier) were recoded in (Not a barrier vs Barrier). This was followed by chi square test results to understand if a relationship existed between the independent variables around housing, employment, health, food security, safety, and the dependent variable citizenship status.

Results

Characteristics of Participants

A total of 55 individuals completed the survey. Participants were mostly women (N = 34, 84%), and of Latino origin (N = 26, 47.3%). Participants'

age ranged from 18 years to 63 years (Table 1). As indicated in Table 1, majority were from Mexico (N = 16, 43.2%) and the United States (N = 10, 27.0%). Most participants had lived in the United States for more than 10 years (Table 1).Nineteen participants reported being citizens while eight individuals described having some legal status such as a green card, refugee status or some type of visa. A case summary was conducted between job description and citizenship status. Aligning with the US Census Bureau's (2020) occupation classification codes, citizens were in the fields of community, and social services occupations, healthcare practitioners and technical occupations, or food preparation and related services. Non-citizens were in the fields of constructions trades, and building, grounds cleaning and maintenance occupations. Non-citizens were unlikely to respond to this question where out of 21 participants, only 11 individuals described their occupation.

Relationship between Housing and Citizenship

A chi-square test of independence examined the relation between one's difficulty to pay their mortgage or rent during the COVID-19 pandemic and citizenship status (Table2). Significance was noted between these variables, χ^2 (1, 39) = 4.311, p<.05. Non-citizens (66.7%) were more likely to have

difficulty paying rent or mortgage when compared to citizens (33.3%). Although not significant, non-citizens were slightly more likely to experience risk of becoming homeless and experience instability in housing (Table 2).

Relationship between Employment and citizenship

Survey participants were asked about their employment status, and if they were at risk of losing their jobs during the COVID-19 pandemic. Although no statistical significance (Table 3) was noted between these variables and citizenship, non-citizens were more likely to be unemployed (28.6%) than citizens (10.5%). Non-citizens (60%) were also more likely to feel a lack of job security during this time when compared with citizens (17.6%). Regardless of a lack of statistical significance (Table 4), non-citizens perceived that they were more likely to be moderately (45%) or highly (40%) exposed to the COVID-19 virus in the workplacewhen compared with citizens respectively (36.8%, 31.6%). Similarly, in Table 5, non-citizens (60%) were less likely to report that there were measures taken in the workplace to reduce the risk of the COVID-19 virus when compared with citizens (84.2%).

Relationship between Physical and Emotional Health and Citizenship

Citizens were significantly more likely to have health insurance when compared with non-citizens, χ^2 (1,40) = 10.566, p<.05. Data showed that there was no difference in citizenship with regards to needing medical attention during the pandemic (Table 6). 35% of non-citizens were more likely to have existing health concerns than 21.1% of citizens. It was also observed that the COVID-19 pandemic was more likely to impact citizens' (31.6%) abilities to address their physical health concerns than non-citizens (11.1%). With regards to mental health, citizens (26.3%) were more likely to have been diagnosed with a mental health condition than non-citizens (0%). However, the same number of individuals are currently seeking mental health treatment irrespective of citizenship status (Table 6).

When asked about specific mental health symptoms, non-citizens (40.0%) were more likely to report feeling sad compared to citizens (21.1%). 31.6% of non-citizens were also more likely to feel depressed when compared to citizens (22.2%). Besides these two indicators where a pattern was noted, other indicators as shown in Table 7 did not reveal a difference in experience with respect to citizenship status.

Relationship between Food Security and Citizenship

Table 8 indicates that non-citizens experienced a significant level of food insecurity. Non-citizens (66.7%) reported being unable to purchase sufficient food for themselves and their families when compared to citizens (100%) with a significance of χ^2 (1, N=40) = 7.677, p<.05. Non-citizens were also significantly more likely to struggle to access food during the pandemic at a significance of χ^2 (1, N=40) = 4.607, p<.05. They were also significantly more likely to obtain assistance from food pantries, χ^2 (1, N=40) = 5.414, p<.05.

Relationship between Safety and Citizenship

No significant differences were noted when comparing safety in the household and experience of violence in the community with citizenship status (Table 9). Significance was noted where non-citizens (30%) were more likely to feel unsafe in the community when compared to citizens (100%),χ^2 (1, N=39) = 6.736, p<.05.

Relationship between Areas of Barriers and Citizenship

At the end of the survey, participants were asked if they experienced any barriers or challenges during the COVID-19 pandemic. Results indicated

that non-citizens were significantly more likely to experience challenges in the areas of employment, housing, food security, language, and access to internet and computers (Table 10). Although no significance was noted in barriers in health and citizenship status, 33.3% of citizens experienced a barrier when compared to 55.6% of non-citizens. This was also the case with transport, where 21.1% of citizen reported experiencing barriers with transport when compared with 42.1% of non-citizens.

Table 1

Demographic Characteristics of Participants		
Participant Characteristics	N	%
Age Grouping of Participants		
18 to 21 Years	6	15.4
22 to 31 Years	10	25.6
32 to 41 Years	9	23.1
42 to 51 Years	10	25.6
52 Years and Older	4	10.3
Country of Origin		
Mexico	16	43.2
United States	10	27.0
Other	11	29.7
Years lived in USA		
Up to 9 Years	5	13.5

10 to 20 Years	18	48.6
21 to 30 Years	8	21.6
31 or more Years	6	16.2

Table 2

Housing Variables by Citizenship

Housing Variables		Citizenship		
		Yes	No	χ^2 ,Significance
Difficulty paying rent or mortgage?	Yes	6	14	4.311
		(33.3%)	(66.7%)	p=.038*
	No	12	7	
		(66.7%)	(33.3%)	
At risk of becoming homeless?	Yes	1	4	1.733
		(5.3%)	(19.0%)	p=.188
	No	18	17	
		(94.7%)	(81.0%)	
How stable has housing been?	Yes	16	16	0.401
		(84.2%)	(76.2%)	p=.572
	No	3	5	
		(15.8%)	(23.8%)	

*= p le .05

Table 3

Employment Variables by Citizenship

Employment Variables		Citizenship		
		Yes	No	χ^2 ,Significance
Are you currently Working?	Yes	17	15	2.030
		(89.5%)	(71.4%)	p=.154
	No	2	6	
		(10.5%)	(28.6%)	
Do you think you are at risk of losing your job due to COVID-19?	Yes	3	6	1.970
		(17.6%)	(40.0%)	p=.160
	No	14	17	
		(82.4%)	(60.0%)	

Table 4

Perceived Risk of Exposure to COVID-19 by Citizenship

		Citizenship	
		Yes	No
Perceived Risk of Exposure	Low	6	3
		(31.6%)	(15.0%)
	Moderate	7	9
		(36.8%)	(45.0%)
	High	6	8
		(31.6%)	(40.0%)

χ^2 (2) = 1.511, p= .470

Table 5

Workplace Measures to reduce risk related to COVID-19 by Citizenship

		Citizenship	
		Yes	No
Workplace Measures	Never	2	3
		(10.5%)	(15.0%)
	Sometimes	1	5
		(5.3%)	(25.0%)
	Every time	16	12
		84.2%	60.0%

χ^2 (2) = 3.415, p= .181

Table 6

Health Variables by Citizenship

Health Variables		Citizenship		
		Yes	No	χ^2 ,Significance
Do you have health insurance?	Yes	16	7	10.566
		(84.2%)	(33.3%)	p=.001***
	No	3	14	
		(15.8%)	(66.7%)	
Have you needed medical attention during COVID-19?	Yes	9	10	0.026
		(50.0%)	(52.6%)	p=.873
	No	9	9	
		(50.0%)	(47.4%)	
Do you have any existing health concerns?	Yes	4	7	0.936
		(21.1%)	(35.0%)	p=.333
	No	15	13	
		(78.9%)	(65.0%)	
Has the COVID-19 virus impacted your ability to address physical health concerns	Yes	6	2	2.285
		(31.6%)	(11.1%)	p=.131
	No	13	16	
		(68.4%)	(89.9%)	
Have you been diagnosed with any mental health conditions?	Yes	5	0	6.316
		(26.3%)	(0.0%)	p=0.12
	No	14	21	
		(73.7%)	(100.0%)	
Are you currently receiving mental health services?	Yes	2	2	0.27
		(11.1%)	(9.5%)	p=.871
	No	16	19	
		(88.9%)	(90.5%)	

*** = p le .001

Table 7

Mental Health Symptoms by Citizenship

Mental Health Symptoms		Citizenship		
		Yes	No	χ^2 ,Significance
Feeling sad	Not at all	7	8	2.709
		(36.8%)	(40.0%)	p=.258
	To some extent	8	4	
		(42.1%)	(20.0%)	
	To a large extent	4	8	
		(21.1%)	(40.0%)	
Feeling anxious	Not at all	5	6	0.755
		(26.3%)	(33.3%)	p=.685
	To some extent	5	6	
		(26.3%)	(33.3%)	
	To a large extent	9	6	
		(47.4%)	(33.3%)	
Feeling depressed	Not at all	7	10	2.504
		(38.9%)	(52.6%)	p=.286
	To some extent	7	3	
		(38.9%)	(15.8%)	
	To a large extent	4	6	
		(22.2%)	(31.6%)	
Feeling stressed	Not at all	3	7	3.628
		(15.8%)	(38.9%)	p=.163
	To some extent	6	2	
		(31.6%)	(11.1%)	
	To a large extent	10	9	
		(52.6%)	(50.0%)	
Feeling isolated	Not at all	10	8	0.338
		(52.6%)	(44.4%)	p=.844
	To some extent	3	4	
		(15.8%)	(22.2%)	
	To a large extent	6	6	
		(31.6%)	(33.3%)	
Unable to sleep	Not at all	8	8	0.188
		(42.1%)	(42.1%)	p=.910
	To some extent	4	5	
		(21.1%)	(26.3%)	
	To a large extent	7	13	
		(36.8%)	(34.2%)	
Lack of appetite	Not at all	11	12	0.155
		(57.9%)	(63.2%)	p=.926
	To some extent	5	4	
		(26.3%)	(21.1%)	
	To a large extent	3	3	
		(15.8%)	(15.8%)	
Concerned about family health	Not at all	3	5	2.690
		(15.8%)	(26.3%)	p=.260
	To some extent	3	6	
		(15.8%)	(31.6%)	
	To a large extent	13	8	
		(68.4%)	(42.1%)	

Table 8

Food Security during the COVID-19 pandemic by Citizenship

Food Security		Citizenship		
		Yes	No	χ^2 ,Significance
Are you able to buy enough food for yourself and your family?	Yes	19	14	7.677
		(100.0%)	(66.7%)	p=.006**
	No	0	7	
		(0.0%)	(33.3%)	
Have you struggled to access food?	Yes	3	10	4.607
		(15.8%)	(47.6%)	p=.032*
	No	16	11	
		(84.2%)	(52.4%)	
Have you sought assistance from food pantries?	Yes	4	12	5.414
		(21.1%)	(57.1%)	p=.020*
	No	15	9	
		(78.9%)	(42.9%)	

* = p le .05; ** = p le .01

Table 9

Safety during the COVID-19 pandemic by Citizenship

Safety		Citizenship		
		Yes	No	χ^2 ,Significance
Do you feel safe from violence and or abuse around others in your household?	Yes	17	17	0.307
		(89.5%)	(94.4%)	p=.580
	No	2	1	
		(10.5%)	(5.6%)	
Do you feel safe from violence, abuse, or theft in your community?	Yes	19	14	6.736
		(100.0%)	(70.0%)	p=.009**
	No	0	6	
		(0.0%)	(30.0%)	
Have you experienced any kind of violence during the COVID-19 virus	Yes	0	1	0.928
		(0.0%)	(4.8%)	p=.335
	No	19	20	
		(100.0%)	(95.2%)	

** = p le .01

Country of Origin		
Mexico	16	43.2
United States	10	27.0
Other	11	29.7
Years lived in USA		
Up to 9 Years	5	13.5
10 to 20 Years	18	48.6
21 to 30 Years	8	21.6
31 or more Years	6	16.2

Discussion

Although a trend was noted regarding the detailed questions on employment, it did not yield significance between citizens and non-citizens. This compounds with the fact that non-citizens reported experiencing barriers around employment at the end of the survey. These mixed results could be due to the nature of the work done by both groups, which were considered essential. More research is required on what specific barriers were encountered by non-citizens. As expected, non-citizens were less likely to have health insurance. This aligns with other data where irregular migrants and those with short-term visas do not have access to healthcare and were more likely to work for employers who did not provide healthcare (Guadagno,

2020; Parmet, 2020). As the virus does not discriminate on the grounds of citizenship, immigrants were experiencing physical and emotional health symptoms. The nature of work carried out by citizens and non-citizens in this study could be reflective of the health needs experienced in both groups. Non-citizens were struggling to pay rent or mortgage during the pandemic which was also noted in earlier research (Ballard et al., 2020; Falicov et al., 2020; Greenaway, 2020). It was evident that non-citizens were struggling with food security during this time. Barriers such as the cost of food prices, diminished supply, and limited transportation along with the lack of government aid could have increased food insecurity during this time (Clarck et al., 2020; Ballard et al., 2020). Non-citizens were more likely to report being unsafe in the community. Those who do not have status are more likely to be fearful in accessing services or moving freely in general due to the implementation of immigration policies (Gelatt, 2020; Gonzales, 2020; Kerwin, 2018; Sanchez, 2020).

At the end of the survey, participants were asked if they experienced barriers in different aspects of their lives during the COVID-19 pandemic. In addition to employment, housing and food security, non-citizens also reported experiencing barriers in the areas of language, internet access and computer

during the pandemic.Prior studies have indicated that language was a barrier in accessing health information and services (Clark et al., 2020; Clarke et al., 2020: Falicov et al., 2020; Guadagno, 2020; Sieffien et al., 2020). More research needs to be done to better understand the barriers that exist around internet, and computer access.

This study was conducted in partnership with a social service agency. There are limitations to the data as the method of data collection was convenience and snowball. There were many more questions that would have contributed to the analysis but were omitted due to the length of the survey. There would have been a higher chance of a drop in response rates with a longer survey. The sample size was also not large enough to be able to carry out further statistical analysis. Regardless, this study adds to the existing body of research with regards to the human right needs of immigrants especially during a pandemic.

Data from this study adds to existing research with regards to the critical barriers immigrants have experienced during the COVID-19 pandemic. There is an urgent call to action for the United States to have a preparedness plan during pandemics such as the “one health” approach, which includes all people regardless of citizenship or status. There is a pressing need for

data collection to be inclusive of all people, asdata is key for policy formation and implementation. There were temporary policies put into place nationally and globally during the COVID-19 pandemic which aligned with the GCM objectives and have been successful (MMS, 2020). These policies need to be made permanent to be inclusive of everyone as it is our human right.

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