

“We’re Worse off Now Than During COVID”: Community Health Workers’ Perspectives on Intensifying Immigration Enforcement as Cascading Crisis

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Abstract

Scholars have not conventionally examined the COVID-19 pandemic and immigration enforcement together or as having similar dimensions. We use the framework of cascading crisis to assess the impact of the cascading pandemic-immigration enforcement crisis on Latine immigrants' health from the perspectives of community health workers (CHWs) deeply embedded in immigrant communities. This qualitative study was carried out in a large metropolitan region across two phases: December 2024-January 2025 (focused on the pandemic period, January 2020-May 2023) and April-May 2025 (focused after the official end of the public health emergency in May 2023). We conducted 41 semi-structured interviews with CHWs recruited from four local organizations and analyzed data using thematic analysis. CHWs described immigration enforcement as an extension of the pandemic in terms of immigrants' lockdown mentality and decreased access to services, elevated distrust of the government, and barriers with information-sharing. Although CHWs effectively forged trust-building strategies during the pandemic that carried forward beyond its official end, this trust is now being undermined. In response, CHWs have had to innovate to adapt to immigrants' new circumstances and reaffirm trust. A multi-faceted approach to addressing the pandemic-immigration enforcement cascading crisis will be necessary, including health care professional advocacy, health care delivery innovation, the passage of inclusionary state-local policies, and alternate models of community care.

Background

The escalating war on immigrants—bolstered by all three branches of the federal government and some state and local governments—is indeed a public health crisis [1]. Since January 2025, the new administration has seized latent powers within immigration law, reanimated laws whose enactment predates the contemporary immigration system, and asserted entirely new powers [2]. Immigration enforcement is pervasive throughout the country, excessively violent, and deliberately cruel. U.S. Immigration and Customs Enforcement (ICE) agents have had little oversight and accountability, and their militarized arrests are commonly referred to as kidnappings and disappearances [3]. Though undocumented immigrants are the nominal targets, asylum seekers, lawful permanent residents, and non-immigrant people of color are also ensnared in them since the U.S. Supreme Court enabled expanded use of ethnoracial profiling in its September 2025 emergency ruling [1].

The administration has also intentionally escalated actions in inclusionary local jurisdictions like Los Angeles, Washington D.C., Chicago, and Minneapolis through the deployment of military, ICE, and Border Patrol personnel as courts weigh the legality of such actions. In 2026 thus far, there have been three fatal shootings involving ICE agents (one black and two white U.S. citizens), underscoring the far reach of enforcement; meanwhile six immigrants died in federal immigration detention—an unusually rapid pace of annual enforcement-related deaths [4]. The One Big Beautiful Bill Act signed into law in July 2025 provides \$170.7 billion in additional funding for immigration enforcement with limited mechanisms for Congressional oversight, paving the way for a massive expansion of enforcement and state surveillance [5].

Scholars have long chronicled the public health effects of immigration policies and enforcement practices in operation since the mid-1990s, spanning both Democrat and Republican administrations and Congresses. They have tracked the implications of augmenting border enforcement [6–8] and its expansion into the interior U.S. [9–10], proliferating state and local policies [11–12], and accelerating immigrant detention and deportation [3]. These developments have impacted targeted immigrants but also mixed-status families and communities [6, 7, 9, 14] and had profoundly detrimental effects on the physical and mental health of immigrants and their children [6, 7, 9, 14, 15, 16].

Given the urgency of escalating enforcement, scholars have called for a research and policy agenda that chronicles its on-the-ground health impacts [1]. Our study provides an early window into the immediate impacts of intensifying immigration enforcement in a large metropolitan region in early 2025 from the vantage point of community health workers (CHWs). CHWs are frontline public health workers who serve as liaisons between health care systems and local communities to promote health equity [17, 18]. In late 2024, we conducted the first phase of the study (20 interviews) examining CHWs' experiences during the pandemic. By the second phase in April-May 2025 (21 interviews) focused on the post-pandemic period, CHWs explicitly linked their experiences to intensifying immigration enforcement, leading us to focus on this interconnection.

Conceptual Framework

Although scholars have not conventionally examined the COVID-19 pandemic in tandem with immigration enforcement, Latine immigrant communities describe them as interrelated and view them through the same lens: crisis. The contemporary era is increasingly characterized by what risk and crisis management scholars define as mega-crises: sets of interacting crises that are severe and complex, overwhelming conventional response systems [19, 20]. Mega-crises create deep uncertainty and evoke a sense of urgency, partially because they lack distinguishable start or end points [20]. The COVID-19 pandemic has been characterized as the 'big one,' epitomizing the mega-crisis phenomenon [19]. Yet scholars have also called for a reframing of crisis, moving away from seeing it as exceptional and short term to describing cascading crises that extend across time and space [21] and situating crisis as part of a longer trajectory of structurally-produced inequalities endemic to racial capitalism [22].

The pandemic laid bare these structurally-produced inequalities; immigrants were disproportionately impacted due to economic and legal barriers to accessing health care and public programs [23–26]. They also confronted heightened risk due to systemic factors like occupational exposure, financial strain and unemployment, exclusion from pandemic economic relief, substandard housing and housing instability, and food insecurity [23–25, 27]. Immigrants' vulnerabilities were also compounded by anti-immigrant policies undergirded by structural racism [28] and political discourses that magnified status-related stressors and challenged their coping strategies [29].

During the pandemic, CHWs effectively bridged system gaps by providing a broad range of services to their immigrant neighbors including testing, contact tracing, outreach, education, and vaccine promotion

[30, 31]. They also lent mental health support, addressed social determinants like housing and food insecurity, and countered mis/disinformation [32–33]. As the U.S. government declared the official end of the pandemic in May 2023, the 2024 Presidential election was well underway, with anti-immigration rhetoric as a prominent feature of the campaign. By early 2025 after the new administration took office, scholars started referring to immigration enforcement as a new “fear pandemic” [34], explicitly linking the pandemic and immigration enforcement. We instead view them as intertwined, cascading crises that extend and intensify immigrants’ structural vulnerabilities [35].

Methods

Our University’s Institutional Review Board approved the study protocol. The study was conducted in a large metropolitan region by an interdisciplinary research team of public health, anthropology, and communication scholars. We collaborated with four organizations that partner with CHWs to serve the region’s large and diverse Latine population. We conducted research in two phases: I) December 2024–January 2025, focusing on the pandemic period (January 2020–May 2023) and II) April–May 2025, focusing on the period after the official end of the public health emergency (post-May 2023). These data are from a larger project examining CHWs’ crisis communication during and after public health crises [36, 37].

We used purposive and snowball sampling recruitment strategies, supported by flyers containing QR code that linked to a Qualtrics eligibility screener available in English and Spanish. Participants were required to have worked as CHWs during or after the COVID-19 pandemic and be 18 + years old. Bilingual researchers conducted semi-structured interviews (offered in-person and on Zoom). We obtained verbal informed consent before each interview, and participants received \$50 in compensation via Tango. Interviews ranged from 51–151 minutes ($M = 91.7$, $SD = 18.9$) and were recorded using Zoom’s built-in tool and PLAUD audio device (version 2.7.5). We transcribed and translated interviews using Enterprise ChatGPT, which the bilingual researchers manually reviewed for accuracy.

In Phase I, 20 CHWs participated, ranging in age from 25–65 years ($M = 49.4$, $SD = 13.8$). Nineteen identified as female and one as male, and all self-identified as Hispanic/Latino, with one participant identifying as Latino/Asian. Phase I interviews ranged from 37–104 minutes ($M = 69.5$, $SD = 16.8$). In Phase II, 21 CHWs participated, ranging in age from 25–65 years ($M = 50.2$, $SD = 10.0$). Twenty participants identified as female and one as male, and all self-identified as Hispanic/Latino, with one additionally selecting Latino/Other. Nine individuals participated in both phases. We replaced participant names with pseudonyms to protect their identities.

We took a thematic analysis approach [38] and used the NVivo qualitative analysis program (version 15.3.1) to code transcripts. Our Phase I approach was more deductive, featuring parent codes on health care delivery, CHW roles, social identities, information sources, trust, relationship building, and communication strategies; however, we also identified an emerging inductive code related to immigration. Phase II necessitated new parent codes to capture responses to the shifting sociopolitical

climate including fear, government mistrust, and health-related impacts. These results principally focus on the Phase II codes.

Results

CHWs described how immigration enforcement cascaded from the pandemic in the following dimensions: lockdown and decreased access, elevated distrust in government, and challenges in information-sharing. They also shared their emerging strategies for addressing these challenges.

Lockdown and Decreased Access

CHWs described the all-consuming fear that immigrant communities were confronting and how it resulted in them once again being “locked down.” As Juliana shared, “People’s needs haven’t disappeared—they’re still there. But people are living in fear, so they avoid going out and stay home as much as they can.” As during the pandemic, people consolidated shopping trips, missed school and work, and skipped appointments for conditions like diabetes. CHWs talked about how fear resulted in deliberate avoidance, but also unintentional forgetfulness; as Luz noted, “With everything going on immigration-wise, people are scared, which really affects them. They forget appointments, forget to pay bills, and miss medical visits. Many things get disrupted.”

In terms of their initiatives, CHWs found that attendance at food distributions, health fairs, and once-popular exercise classes (like walking groups) had dwindled because, as Lucia indicated “people are afraid to be in a public or enclosed space where immigration could show up.” CHWs highlighted a heightened concern about crowds, like Camila who noted, “We used to do food distribution at an apartment complex and people lined up for the truck. But you don’t see those big crowds anymore. They’re scared ICE might come if they’re outside, in a big crowd, standing in line.” Importantly, these fears were shared by residents and citizens too, given ICE’s indiscriminate policing.

CHWs described their interactions with community members decreasing and lamented that the trust they worked so hard to forge during the pandemic was now being undermined [36]. Yet CHWs are well known for being adaptable, and described how practices like food distribution have changed. Maria observed, “Before, you’d notice a long line outside and know they were handing out food. Now we bring people inside and close the doors. People are coming again because they know they won’t be visible. That’s made a big difference.” CHWs have also shifted focus from health topics to legal topics of urgent concern, like knowing your rights and emergency contingency planning—yet also indicated that they felt underprepared in providing these services.

Elevated Distrust in Government

CHWs described how distrust in the government manifested in familiar and new ways. The “chill effect” of immigrants withdrawing from government health care services was prevalent once again. These fears

extended to services that were previously considered “safe,” like pregnancy and post-natal care. Teresa explained, “People are afraid to take their newborns to pediatric appointments because they hear sensationalist news that mothers who give birth here are being arrested.” Community members also withdrew from resources given reanimated concerns about being classified by the government as a public charge.

CHWs indicated that community members were highly distrustful of official offices—even county offices in local immigrant-inclusive jurisdictions. As Camila noted, “We explain it, but when it involves a government office, they’re scared to go because it’s an official office—even if it’s the county.” Community members had amplified concerns about new information-sharing practices; as Lorena explained, “they trust the programs, but they’re scared of giving out their personal information because they know that it could be accessed by the government.” However, some of the distrust shifted towards community health clinics (CHCs), especially those with federal funding. Lorena expressed that community members worried that clinics might be functioning as a “trap” set by the government. Several CHWs also reported that community members thought they might be “undercover immigration agents,” as Isabel revealed, saying “They think if they admit they don’t have documents, I might turn around and report them.” Ironically, some of the CHWs were actually undocumented, and facing increased risk themselves.

Because of this distrust, Isabel indicated that it is critical to address concerns directly, saying, “We identify ourselves. I say, ‘I’m not from immigration—I work here. You can find me on Wednesdays in this location. You can check my social media and see that I’m a regular person.’ We do everything to try to build that trust—but it’s not easy.” They also found that sharing information on what to do in ICE encounters helped allay community members’ fears. As Gabriela shared, “We managed to get copies of a judge’s order from immigration court—what immigration might show someone. We made copies without names, just so people can recognize the document. We explain that it must have the full name of the individual and an official seal.”

New Barriers with Information-Sharing

Because of community members’ concerns about being in public and distrust, Juliana lamented, “the community is just not engaging.” CHWs in our study often worked in public settings doing outreach with new community members. Whereas during the pandemic they effectively built trust to share patient education and make referrals, now, Veronica commented, “People are afraid to share even a phone number or a ZIP code. How can you tell them which hospital or clinic is closest to them”[36]? Mariana pointed out how trust had shifted, saying, “During COVID, it was very different...people didn’t distrust as much. They had insecurity about the vaccine, but understood once someone explained it to them. Now, it’s different.”

CHWs also reported challenges with community members’ reliance on social media, which was full of rumors. Valentina experienced this firsthand, sharing, “I was on Facebook one day and I saw a post saying that immigration had been in the exact area where I was working. I thought, ‘That’s strange—I was

just there!’ The post said, ‘This happened about two hours ago,’ but I had just gotten home an hour before. I had been in that exact parking lot and I didn’t see anything. But with all the fear people have right now, it’s easy for them to believe anything.”

Because of these information sharing barriers, CHWs have changed their approach to only sharing information selectively [36]. Natalia, for instance, shared, “We used to hand out flyers to everyone we came across. But because of the current political situation we’re not sharing all of the information about where we will be for safety reasons—we don’t want to expose our community. But if we know the person and trust them, we send them the flyer or invitation to their phone.” Another strategy is leveraging online formats and digital literacy they built during the pandemic to share a “virtual action plan.” As Paola explained, “We created a program that brought together more than 12 organizations over 12 weeks. We covered health, immigration, legal topics, rights. Over 300 people registered for the sessions and we recorded the sessions. It was a space where the community could talk to experts. That’s where we began to rebuild trust, safely from home.”

Discussion

Our study demonstrates that immigration enforcement is a cascading crisis that, on the heels of the pandemic, is squarely shaped by political determinants of health [39]. While this is a “new” immigration crisis in its intensity and unpredictability, it is also an extension of exclusionary immigration and health policy making stemming back to the mid-1990s [15, 16]. CHWs likened this crisis to the pandemic in terms of the lockdown mentality it produced and decreased access to services; elevated distrust of the government (extending to CHCs and even CHWs); and barriers with information-sharing.

Although CHWs effectively forged trust-building strategies during the pandemic that carried forward beyond its official end, this trust is now being undermined. In response, CHWs have had to innovate to adapt to immigrants’ new circumstances and reaffirm trust, such as finding and sharing legal resources, which falls outside of the scope of their normal health-related work. Yet many of the CHWs themselves are also legally and economically precarious, and are also now being exposed to greater risk for psychosocial, physical, and institutional harms stemming not only from their legal vulnerability, but also from lack of valuation of their work [40]. Our study shines a light on the need for deeper investment in CHWs as frontline workers whose jobs have become ever-more risky [40] against a backdrop of increasing immigration enforcement and decreasing post-pandemic resources.

While CHWs are critical first responders in this cascading crisis, a multi-pronged approach to addressing different facets of it will be essential. Health professionals should take an unequivocal stand against immigration enforcement and its ripple effects (particularly in clinical settings), as some professional organizations have already modeled [41–42], and leverage their experience and professional status to advocate for immigrants and inform policy [3, 43]—especially those who are less vulnerable to enforcement actions. CHCs will also need to innovate and exhibit organizational flexibility to mesh with immigration enforcement realities [44]; some CHCs nationwide have responded to immigrants’

withdrawal from services by ramping up telehealth services developed during the pandemic [34]. CHWs are well positioned to advise on emerging best practices, as they are already deeply engaged in developing them. However, health care staff must also receive appropriate training in areas like local policies and immigrant rights [43]. Some CHC systems in the region in which the study was conducted have recognized this critical need, and folded in legal services to their comprehensive care approach—a strategy that should be adopted more widely.

In terms of policy-making, although some jurisdictions have expanded immigrants' access to care, even these state and local resources cannot fully buffer immigrants from federal enforcement and address immigrants' reluctance to enter any official office and/or CHC and heightened suspicion of those who work in those spaces. Yet state and local policy-making also remains a site of untapped potential for advancing protective policies; by mid-2025, some jurisdictions already took steps to restrict enforcement in sensitive locations and strengthen data privacy and protection for immigrants [45].

Conclusion

Our study demonstrates the ingenuity CHWs have exhibited in adapting to their clients' circumstances by shifting to legal referrals and resources and building trust by clearly situating themselves in opposition to enforcement as well as narrowing their communications to trusted channels and holding sessions in private online formats [36, 37]. Scholars have begun describing alternate models of community care that have been developing outside of health care systems, consisting of actions in which community members show up for, learn about, connect with, and advocate on behalf of one another [3]. Deep in the throes of the pandemic, people forged and relied on new forms of connection that mitigated anxieties stemming from distrust of the federal government [46] and community-based organizations practiced a politics of care to keep each other safe while continuing to address structural determinants of health inequities [3, 22, 44]. Our data also demonstrates these connections and orientation, mirroring broader care practices emerging nationwide as advocates and everyday activists [47] cultivate, share, and model best practices for addressing this urgent cascading crisis.

Declarations

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Author Contribution

BFL is the principal investigator of the study. CMG, DLU, and AAS originally conceptualized the article drawing from the larger study with the full research team of BFL, DLU, AAS, and LMC. DLU carried out data collection for the project. CG, BFL, DLU, AAS, and LMC carried out data analysis for the larger

project, while CMG, DLU, and AAS led the analysis of data specifically for this article. CMG and DLU drafted independent sections of the manuscript and BFL and AAS contributed to the conceptual framing. All team members reviewed and edited the manuscript to polish it into the submission version.

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Data Availability

All data used in this paper was generated by the authors.

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