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"But who takes care of the mom?": The daily experiences of immigrant mothers navigating health in family life

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ABSTRACT

This study qualitatively explores US immigrant mothers' daily experiences navigating health in the context of the family budget and wider sociopolitical climate. We conducted semi-structured interviews from 9/2020-1/2021 in English and Spanish with 30 immigrant mothers of young children. Interviews were analyzed using both inductive and deductive analytic strategies. Five themes were identified:1) economic strain is persistent; 2) government support alleviated some economic strain but brought other problems; 3) mothers developed strategies drawing on community and creativity to mitigate economic strain; 4) racism and anti-immigrant sentiment harm maternal well-being and shape access to healthcare and social service; 5) mothers prioritized children's healthcare. The findings tie together structural vulnerability, immigration policy, and economic constraint, illuminating how these issues collide in daily life for mothers of young children. Further, each of these long-standing challenges were exacerbated by the dual crises of the pandemic and Trump administration policies. Moreover, the confluence of experiences was intensified by additional pressures at the intersections of race, ethnicity, gender, and immigrant identity, extending work on structural vulnerability and slow violence. The complex mental gymnastics mothers enacted to ensure children and immediate family members had their needs met in the face of unique threats like deportation, often came at the expense of their own well-being. Solutions to these challenges require respectful discourse, equitable, immigrant-inclusive policy and practice changes at state, federal, and health systems levels.

1. Introduction

Immigrants in the United States (US) encompass a diverse group, representing various immigration statuses, including naturalized US citizens, Legal Permanent Residents (LPRs), refugees, asylees, and those who are undocumented(Migration Policy Institute, 2024). Researchers have used the concept of structural vulnerability to describe economic and political processes that impose physical and emotional suffering on specific groups in a structured manner(Rivera et al., 2019; Viruell-Fuentes et al., 2012). In the context of immigrants in the US, structural vulnerability highlights the way immigrants, and particularly immigrants of color, are singled out in racialized patterns through laws and policies excluding them from resources that could protect their health and help them advance economically(Armin, 2019; Logan et al., 2021).

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Immigrants with no or precarious documentation status, who have recently arrived in the US, or are Latino and Black immigrants from non-English-speaking nations compared to white immigrants generally have a harder time meeting basic needs like housing, utilities, and food (Blewett et al., 2010; Hernandez, 2012; Miller et al., 2018; Slopen et al., 2016).

Immigration status can be seen as a social determinant of health, shaping access to jobs, wages, and basic needs assistance. People who are undocumented and those who have been in the US for <5 years are in most cases excluded from healthcare and some nutrition programs (Castañeda et al., 2015; Gostin and O Cathaoir, 2017; Perreira and Ornelas, 2011). These underlying exclusionary structures in turn drive harm to both child and adult health(Cabral and Cuevas, 2020; Glied and Oellerich, 2014; Logan et al., 2021; Yoshikawa, 2011). As a result, children of immigrants are disproportionately more likely to live in households struggling with material hardship, including inadequate food, shelter, and healthcare and to experience worse health (Bovell-Ammon et al., 2018; Chilton et al., 2009; Hernandez and Napierala, 2012; Vargas and Ybarra, 2017). As over a quarter of children in the US have at least one immigrant parent, intergenerational immigrant health is crucial for advancing national health (Migration Policy Institute, 2024).

States have substantial discretion in public policy(Hawes and McCrea, 2018). Therefore, immigrants navigate healthcare within widely varying state environments, from immigrant-inclusive to restrictive(Broder et al., 2015; Vargas and Ybarra, 2017; Wilson and Stimpson, 2020). However, even in immigrant-inclusive states, federal immigration policy and rhetoric exert an influence. The political and social atmosphere in the first Trump administration was exceedingly hostile to immigrants(Batalova et al., 2018, 2018; Callaghan et al., 2019; Ettinger de Cuba et al., 2023; Lê-Scherban et al., 2023; Page and Polk, 2017). Fear of proposed changes, especially regarding which kinds of public supports could have a detrimental effect on immigrants' efforts to become LPRs and later US citizens (Bernstein et al., 2019; Love et al., 2020), caused a chilling effect on immigrant family healthcare use and public program participation(Barofsky et al., 2020; Batalova et al., 2018; Cervantes and Walker, 2017; Ettinger de Cuba et al., 2023; Lê-Scherban et al., 2023; Page and Polk, 2017).

The hostility was compounded by the COVID-19 pandemic, further exposing immigrant community vulnerabilities and gender bias (Allen, 2022; Clark et al., 2020; Samari et al., 2024a). Immigrant families grappled with severe economic hardship putting families under severe stress, afraid of accessing support(Ashbrook, 2021; Straut-Eppsteiner, 2020), and less able to provide and be emotionally present for their children(Artiga et al., 2018; Cervantes et al., 2018, 2020). Immigrant women bore the brunt of these conditions, which increased tension between work and caregiving roles, shifted healthcare decision-making, and complicated leaving unhealthy relationships.(Bruhn, 2022; Samari et al., 2020, 2024b; Wurtz and Samari, 2025). COVID relief policies that further shut out immigrants affected immigrant women's economic well-being and in turn their mental health(Samari et al., 2024a).

Studies of these effects have not focused specifically on families with very young children. The pressures and stresses of parents with children in the first few years of life are distinct from parents with older children. Younger children are highly dependent on their parents for everything from eating to dressing and bathing(Wikle and Cullen, 2023). They need close supervision (Dunning and Giallo, 2012; Office of Child Care, 2012) and have specific material needs (e.g. diapers) that are expensive(Austin and Smith, 2017) and must be balanced with other household needs, like food(Smith et al., 2013).

A holistic family-level understanding can deepen understanding of the interplay across needs(Knowles et al., 2016; Kushel et al., 2006). Yet studies of family material hardship typically focus on relationships between a subset of needs, like housing and food(Huang and King, 2018; Kushel et al., 2006) or housing and utilities(Hernández et al., 2016). Comparatively few studies have focused on the household economy as a whole and the interplay of decisions around healthcare, housing, food, and other basic needs by low-income immigrant mothers of young children(Cuevas, 2019; Knowles et al., 2016; Yoshikawa, 2011). Similarly, studies have explored how external forces like structural vulnerability shape women's mental health(Wurtz and Samari, 2025) and personal healthcare decisions(Samari et al., 2024b) but few have understood these holistically in the context of a family with young children (Artiga and Ubri, 2017; Bruhn, 2022; Cuevas, 2019).

Young children's health, growth, and development are intertwined particularly with maternal health and well-being(Glied and Oellerich, 2014; Logan et al., 2021; Yoshikawa, 2011). The World Health Organization's (WHO) Nurturing Care Framework (NCF) recognizes these intertwined relationships through five components of childhood well-being: 1) adequate nutrition, 2) learning opportunities, 3) healthcare, 4) safety and security, and 5) responsive caregiving. If one component is missing or inadequate, children may not receive the care necessary for healthy development. Parent well-being is central to the NCF as many NCF components are delivered through parents(Black et al., 2016).

Thus, informed by the NCF, this study used a structural vulnerability lens to understand how immigrant mothers of young children navigate health for themselves and their families against the demands of other household needs, constrained resources, and the wider political and social climate. We argue that experiences of immigrant mothers of young children illuminate how structural vulnerabilities and polices play out in their everyday lives, often at the expense of the mothers. Their experience of balancing the family budget each month takes a slow, violent toll on mothers' bodies and psyches.(Wurtz and Samari, 2025).

2. Materials and methods

We used a qualitative study design to examine how immigrant mothers with young children navigate healthcare in the context of everyday life. Participants were recruited from Children's HealthWatch, a multisite, repeat cross-sectional study of caregivers who sought emergency department (ED) for their young child aged 0–48 months (Ettinger de Cuba et al., 2019). Participants were eligible for the present study if they were biologic mothers born outside of the US, spoke English or Spanish, and had previously participated January 2018 and March 2020 in the quantitative survey in the pediatric ED of a Northeast US urban safety-net hospital. The Children's HealthWatch survey consent includes permission to be re-contacted. The local Institutional Review Board approved all study procedures.

We sent opt-out flyers September 2020 and January 2021. Mothers who did not respond were invited to participate. During recruitment, we noted underrepresentation of Latina mothers. The final two months of recruitment focused on this subset. Verbal informed consent was obtained. Participants received a $30 gift card.

We interviewed 30 immigrant mothers of young children from diverse regions, including Mexico, Central and South America (n = 8); the Caribbean and West Indies (n = 16); and West and Southern Africa (n = 6). Seventy-three percent of mothers had legal immigration status (Table 1). Several mothers lived in multigenerational households, simultaneously caring for young children and elders or other extended family members. The majority of mothers had two or more children – half had three or more. By the time we conducted the interviews, children ranged in age from 13 months to 6 years old; 63 % of the children were <4 years, and most of these were <3 years old. Most mothers and nearly all children had public health insurance. The state provides a limited public insurance plan for people whose insurance status restricts their access to more comprehensive coverage. We used a semi-structured, qualitative interview guide, informed by NCF concepts. The interviewer (SEdC) is a white, first-generation American, bilingual (English/Spanish) woman with qualitative expertise. Telephone interviews lasted between 60 and 90 min. The interviews were conducted

Table 1
Participant & household characteristics (n = 30).

	#	Range or %
Maternal Characteristics		
Maternal Age, years (mean, range)	36.4	(22–45)
Maternal self-report of depression, sadness, anxiety	7	23.3 %
Language of Interview		
English	20	66.7 %
Spanish	10	33.3 %
Marital Status		
Married/Partnered	19	63.3 %
Single	8	26.7 %
Divorced/Separated	3	10.0 %
Immigration Status at Time of Interview		
Naturalized US Citizen	15	50.0 %
Legal Permanent Resident (LPR or "green card")	5	16.7 %
Undocumented	4	13.3 %
Asylee	2	6.7 %
Visa, unspecified	2	6.7 %
Tourist Visa	1	3.3 %
Deferred Action for Childhood Arrivals (DACA)	1	3.3 %
Length of US Residence, years (mean, range)	14.4	(2.5–34)
Employment & Student Status		
Employed	19	63.3 %
Current Student	5	16.7 %
Lost Job due to COVID Pandemic	7	23.3 %
Others Employed in Household	14	46.7 %
Health Insurance		
Public	25	83.3 %
Private	5	16.7
Child & Household Characteristics		
Child Age, months (mean, range)	41.1	(15–72)
Number of Children	3.2	(1–6)
Health Insurance		
Public	27	90 %
Private	3	10 %
Basic Needs & Income Assistance		
SNAP Participation		
Current Participant	13	43.3 %
Past Participant	3	10.0 %
WIC Participation		
Current Participant	15	50.0 %
Past Participant	6	20.0 %

in either language depending on participant preference. Core topics addressed included meeting family needs, healthcare coverage and experience for young children and others, and political climate. Interviews began with demographic questions, including birth country and self-identified race and ethnicity and, if not already volunteered, questions about immigration status. The guide was used flexibly, based on the course of the conversation to cover current context and home country formative experiences.

Interviews were professionally transcribed verbatim and uploaded to NVivo (Version 12, QSR International). Spanish-language transcripts were coded in Spanish. We used both inductive and deductive analytic strategies, informed by NCF concepts. Two authors (SEdC, GMF) reviewed and discussed transcripts looking for general themes, using tenets of grounded theory(Charmaz, 2014). Data were organized using an analytic synthesis template to capture both emergent themes and broad framework-informed constructs(Hamilton et al., 2025). The template was iteratively developed by to systemically capture key themes and constructs. The template included a précis for each interview, with a brief participant summary, key demographics, NCF constructs, and emergent codes. The team discussed the initial transcripts, developed codes, and iteratively updated the template. The lead author continued to review transcripts and discuss with the analytic team (GMF, DKJ)) until consensus was reached.

3. Results

We identified five themes related to how immigrant mothers of young children navigate health as part of everyday life: 1) Economic strain is persistent; 2) Government support alleviated some economic strain but brought other problems; 3) Mothers developed strategies drawing on community and creativity to mitigate economic strain; 4) Racism & anti-immigrant sentiment harm maternal well-being and shape access to healthcare and social service; 5) Mothers prioritized children's healthcare.

1. Economic strain is persistent

Mothers uniformly described economic strain as an ongoing way of life — some for their whole lives and for others since US arrival. The particular strain varied, with some mothers describing being in imminent danger of losing housing or regularly struggling to provide food. A mother from Nigeria described how she could not afford to fill the family heating oil tank so instead used space heaters. However, when the utility bill arrived it was $2000. She described the intense stress:

> "when I open [bills] on my email, I feel stressed. Like, I just freak out. I don't even know how to deal with that. I would like to pay it all, but you know, I really can't afford it right now. … So, just even like seeing the email is super stressful."

The "slow violence" of poverty was palpable in her recounting. Slow violence is a concept from environmental justice that is "violence of delayed destruction" (Davies, 2022) Applied here it describes the unrelenting nature of economic hardship with roots in sociopolitical decisions that create barriers to families' economic stabilization. The COVID pandemic and resulting economic recession exacerbated these precarious situations. Many mothers or their partners lost jobs or had work hours drastically reduced. For example, a Dominican mother of three stopped her mobile hairdresser business. Her husband continued working. The economic impact forced them to reduce expenses and take on boarders.

> "[My husband], for example, pays the rent, which is $2400, I put in for the gas, we have two rooms rented and with that it helps pay the rent and … the gas. And I, since I do hair, but I'm not doing it now because of COVID … I can't go to people's houses to visit and I also can't accept people in my house."

Mothers described a heavy cognitive load - constantly making mental calculations, like needing to balance rent costs with heat, electricity, food, healthcare, transportation, and costs specific to young children - childcare, diapers, formula.

2. Government support alleviated some economic strain but brought other problems.

To mitigate financial hardships, many mothers participated in federal programs designed to support low-income families, like the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP). Others applied for energy assistance for utility bills, housing assistance for rent, and childcare vouchers. When asked which public programs they participated in, none mentioned Medicaid. During the pandemic, many mothers also received assistance from Pandemic Electronic Benefit Transfer (EBT). It provided a card replacing the value of missed meals in childcare and school.

Descriptions of assistance frequently accompanied a discussion of how one targeted benefit, like nutrition assistance, allowed them to redirect resources to other needs, like healthcare, housing, utility, phone or internet payments. A mother from Haiti described how receiving energy assistance helped cover other expenses.

> "[The energy assistance helps] because like all the money that you are paying … was that heat bill. You can save that amount and then keep paying a different bill like, let's say, like water and all that. …. If you are going to pay like $200, $300, or $400 for the heat bill, …if

[energy assistance is] paying $200 or $300 … you can save that and then complete different bills that you have to pay; so you are ahead of everything … and then we can be on top of the bill because we only don't like to stay behind and … at least paying everything on time and then be free."

Nevertheless, approximately half of the mothers described challenges with public assistance. Some noted program rules were unfair or benefits insufficient. Several recounted losing their jobs, which qualified them for Federal Pandemic Unemployment Assistance(CBPP, 2023). However, the extra funds in turn disqualified them from SNAP. Mothers described feeling trapped by these experiences. When they earned less, they got more help. As soon as they earned more, the assistance was taken away, but the increased income was still insufficient to meet basic needs. One mother from El Salvador explained her frustration with rules that felt arbitrary despite meeting assistance income guidelines,

"I feel it's a little unjust because anyway they have a range of what one has to earn; but despite the fact that one is earning in the range they demand, it's not enough just the same [to get benefits]. It's a little disproportional because I've never understood how they do the math."

Mothers expressed feeling conflicted; they wanted support from public assistance but also acknowledged that it came with an emotional burden. Medicaid was not mentioned in this context. Some of the mothers described balancing feeling shame with a commitment to their children's well-being. A mother of three from Antigua talked about participating in WIC. *"That's the only one I've participated in and — how do I feel about public assistance? If I need it — I guess once I started having children, my pride went out the window."*

3. Mothers developed strategies drawing on community and creativity to mitigate economic strain

Mothers developed workarounds to stretch the family budget. A commonly described strategy was paying a little bit toward all bills to demonstrate good faith. A mother from Nigeria described her process, *"what I try to do is, when I get paid, I put some money into those, half of what we're supposed to pay and put that out there and then the fuel, at least half of it also, because that's like every three months. So, before the time runs out, I've paid off."* Many discussed how they would weigh which expenses could be put off without serious repercussions. Some discussed their circumstances with their landlord and negotiated extra time for rent. Others used similar strategies with cellphone bills or utilities, by asking for forbearance or a payment plan.

Another common strategy was resource sharing and planning within family groups or communities. A mother of three from Cape Verde described living with multiple family members. She lived on the second floor with her husband, children, and sister. Another sister, brother-in-law and their children lived on the first floor. All the adults except the interviewee had lost their jobs due to the pandemic and economic downturn, changing their household from five incomes to a single, part-time income. The mother called a family meeting about pooling resources:

"We don't have to waste - we try to help each other. We always do that. We always help each other anyway. Whatever needs, we just help each other. And then, with the COVID and all that stuff, we did a meeting and everything. We started saving, not let food go to the trash."

Other mothers got help from family members who periodically paid for food, shared meals, or provided food from their emergency food assistance boxes. One mother from El Salvador recounted asking a distribution site to be given extra boxes to bring to friends who were afraid to leave the house because of COVID.

4. Racism and anti-immigrant sentiment harm maternal well-being and shape access to healthcare and social services

Though mothers sought public assistance to care for their children, they worried about the consequences. Family separation was repeatedly raised. Many mothers expressed a pervasive fear of being removed from the US by immigration authorities from their homes or workplaces, leaving their children behind. Mothers who had legal status (i.e., asylum or permanent residency) or citizenship, and thus were not at risk of deportation, similarly raised this fear. One mother who had been granted asylum said, *"My biggest fear is being separated from them. That's one thing that I wouldn't be able to handle."* Anti-immigrant sentiment on the news and in local areas fomented the fear. Stories of children being pulled from their mothers' arms at the US-Mexico border (an image commonly seen in the media at the time of these interviews) also were cited as increasing their fear. Several had friends who had been deported, and thus had witnessed the aftermath of family separation and resulting anguish for children and other family members.

Fears of children being taken impeded accessing healthcare. A mother from St. Lucia who was a US Citizen recounted that she had avoided healthcare for her older son because she feared repercussions against her as a parent due to his blood lead level.

"… when he was younger, he had lead, but my name was not on the lease. When I took my kids off to like regular doctor's appointments and basic stuff, they say he had high lead levels, they wanted to find out … where was I living, and how … he got it. And then my aunt was saying, oh yeah, they can take the kids from you … …that scared me to think that they would have take[n] my son from me. I did not go back and … I ended up looking for a little home remedy thing for him to help him out … for the lead level to go down."

Mothers expressed frustration with the image of immigrants in the press, contrasting with descriptions of pride in their culture. One mother from Antigua said, *"It's disheartening that so many immigrants are being accused of stealing jobs and being people who they aren't, and they're just trying to survive, and they'll do any job."* A mother from Uruguay was resigned, *"… we contribute to this country. We do our part, but we don't get any benefit."* She expressed that though she and others worked hard and paid taxes, they were unable to get financial support. The perceived hostility toward immigrants made mothers question the safety of seeking healthcare or public benefits, though many felt their children deserved these.

Mothers feared that receiving public assistance would make them more vulnerable. Only the Latina mothers had heard the term public charge. However, a majority of mothers, including those unfamiliar with the term, feared the impact of seeking help on their or family members' immigration status. This fear mixed with broader shame and stigma related to needing assistance. A mother from Haiti recounted her long and emotional process in deciding not just to seek SNAP, but also to use the benefits once her SNAP EBT card had been issued.

"if I fill [out the application] and then people will look at me differently or think of me differently. That took me a year and a half before I did it, because I didn't want people to look at me differently or people will think that, "Okay, because she came from this country that she's so poor that she needs [help] to have eat." So, …that was really a battle for me. And then I was afraid that will affect whatever I have to do in the future."

This mother refused to use her benefits until a caseworker convinced her that using SNAP would not harm her immigration status. Though few of the mothers actually avoided applying for assistance or taking their children to the doctor, they talked about the stress and anxiety around the repercussions of seeking help.

Several mothers expressed that characteristics, like their accents and/or dark skin tone, seemed to signal they were not US-born, opening them to criticism. A mother from Nigeria reported that coworkers said to

her: "*you're from Africa, you're a dog, you don't know anything." "Oh, I saw you guys live on trees and bushes."* A mother from Haiti who worked second shift described multiple instances of personal aggressions, including several working as a supervisor at a large hospital garage, requiring her to be outside in all weather.

> "I respect myself, I do good, I respect people, even though sometimes people … want to put me down, like the nurse, the doctor, they said that, 'Look at the job that you are doing, it's in the cold all year. Look at you, why you don't go back to your country?' Well, yeah, sometimes I used to cry."

She explained how it affected her emotionally, but that she resolved not to let them hurt her, knowing she was working hard with a purpose for being here—giving her children a better life.

Experiences of racism and xenophobia intensified mothers' mental and emotional burdens. A mother from South Africa explained, *"You already have so much to deal with as a human being or as a mother and then, your race is another issue again."*

Concerns about their children being harmed because of their race or ethnicity was a further source of fear and anxiety, particularly for mothers from Haiti and Africa. A mother from South Africa talked about how she managed these worries, already thinking about her young son being a man.

> "*When you have children, Black children, Black men essentially, that are going to be Black men. It affects you even more especially, if they're going to be gunned down for no reason. I'm not saying that they are going to, [I'm worrying about it]. So, you constantly have to have your children guarded, and you have to monitor their every move, et cetera, et cetera. … it's mental gymnastics."*

She concluded by explaining how she tried to ensure her children were realistic but not living in fear, by instilling pride in their origins with strong connections to their culture through food and music. *"We are not trying to raise kids that have to recover from their childhood."* All but one of the mothers who had to cut the interview short consistently and repeatedly described how they provide a foundation of cultural pride through speaking their native languages, preparing traditional foods, celebrating holidays and playing music from their home countries.

5. Mothers prioritized children's healthcare

Mothers prioritized healthcare of household members. Children - particularly young children-and elderly family members were deemed more important. A mother from Haiti said, trailing off in thinking about her own mental health: *"I … make sure that [my son] sees the doctor. My dad and my mom, and then I don't do anything for myself, but I need to start doing that; but to be honest, mentally …"* Even with this multi-generational pressure, children's healthcare took precedence. During our interviews, they described being willing to anger employers, lose income, or incur debt, if their child needed healthcare. They called on their networks, asking friends for rides and family members for financial help. Adaptations to structural vulnerability had impacts beyond the family unit, rippling out to the community for solutions to gird against these larger challenges. Asked about the role of cost or time when seeking care for her children, a pregnant Guatemalan mother of three emphatically answered: *"No, truthfully, no. [My children] always come first and the time or the money are beside the point."*

Mothers connected their own childhood experiences with their approach to their children's healthcare, linking current resource allocations to their own histories. A majority of mothers were from areas without healthcare access, including rural areas without local healthcare and/or systems that required out-of-pocket payments that put healthcare beyond reach. Even those who had access to healthcare in childhood framed their experience as an exception in their home countries. Given this personal history, mothers were determined to ensure that their children would not face the challenges they had growing up.

A third of the mothers had a child with a special healthcare need. Mothers described a variety of conditions, including having a child who was born preterm and children with asthma or other serious health issues, like a heart murmur. These children required recurrent therapy and interventions. A mother from Uruguay whose son had severe asthma said, *"if [my son is] doing badly, then I have to go to the doctor. I can't - I don't have an option."* These parents repeatedly stressed the prioritization of their children's healthcare, noting they needed more healthcare than the average child. This brought stresses but also focused their attention, since not receiving care could have especially serious consequences.

In contrast, mothers deprioritized themselves. Mothers described minimizing their own healthcare use, the exhaustion of raising young children, and allowing needs to go unmet, affected their mental health. Several mothers reported depression, yet few received mental healthcare. Many mothers who did not specifically name depression nevertheless described the toll of intense mental stress, often without relief. They attributed their stress to feeling responsibility, fear, anxiety, and the constant "*mental gymnastics*" of meeting everyone's needs in a resource-constrained context. In response to a question about how she coped, a mother from South Africa explained,

> "Especially parents, you have to be everything to your children from the moment they wake up until they go to sleep. You're the friend, you're the teacher, you're the doctor, you're the nurse, you're a zookeeper, you're this, you're that, you're this. And then in a normal day, that's absolutely perfectly okay. But who takes care of the mom?"

Mothers related forgoing their own needs for household or child needs. This ranged from skipping getting a haircut, buying clothing, shoes, or other personal items. A mother of three from Nigeria talked about how there was nothing left for herself after all the household expenses were paid.

> "I don't even have money to pay for self-care as a woman, you know, do your hair, go to salon, do manicure, pedicure. I've never, never done that because of the want, but I feel like I don't have enough to do it. All I have do [sic] is once a week at $40 because when you pay your water, your electricity, your gas, your insurance, both car and other insurance, then your house, the money is gone."

Further, mothers described delaying their own healthcare to balance the household budget, ensuring there was money to cover their children's healthcare.

Transportation costs were often a consideration—ranging from public transit, taxis, and/or parking fees. For mothers, healthcare costs—copayments for visits or, more often, for medication - were also raised as considerations. This was particularly salient for the five mothers who had private insurance copays. A mother from Nigeria who worked as a nurse talked about how her medication cost was high. She halved her blood pressure pills to stretch her prescription.

> "I have commercial insurance, [copays] could be kind of high for me, for my medications. If I feel like I don't have [the money], so what I do, …I'll pick it up, I'll split [the pill] in half. Half of it is good for me … that one little bottle … For me, I say, that is too much for me. I'm gonna save, …I'll [make] half my medications [last] 12 monthly."

A notable exception was a mother of four from Jamaica who talked about how prioritizing her own healthcare was a way to care for her family.

> "There's just one you. Whichever way, if I need care … then I'll get it … you're not coming back, so if you need your care, go get your care. Because there's no coming back after you go six feet underground."

4. Discussion

Our work builds on a robust body of work on structural racism and vulnerability, immigration policy, and economic constraint by tying it all together and illuminating how these issues collide in daily life for mothers of young children. Further, each of these longstanding challenges were exacerbated by the dual crises of the pandemic and Trump administration policies. Moreover, we found that the confluence of experiences were intensified by additional pressures at the intersections of race, ethnicity, gender, and immigrant identity, extending work on structural vulnerability and slow violence.

We interviewed 30 immigrant mothers of young children about their experiences navigating health in everyday life, including healthcare within the context of the family budget and sociopolitical environment. Mothers reported severe economic strain in their families' daily lives, impacting many aspects, including their children's healthcare. Like other studies, simply having health insurance was insufficient to ensure that children received healthcare(Wisk et al., 2020; Wisk and Witt, 2012). Family healthcare spending operated essentially as its own budget to balance within the larger family economy for daily needs. Often children's healthcare came at the expense of their mothers'. The cost of their own visit was not the only barrier, given inherent time, transportation and opportunity costs of unearned income. Despite economic challenges, mothers applied creative workarounds to ensure children's medical and basic needs were met, including drawing on community connections, resource sharing, and government support.

Despite the assumption that these experiences might vary by legal status, they were similar across participants. This matters in that legal status may not be protective from the emotional toll of mothers' multiple identities in a hostile political context, extending work on mental load and gender theory. However, we also found that state-level public benefits may indeed matter because they are tangible in everyday life and not just abstract policy. Notably, when asked in which public programs they participated, mothers did not mention Medicaid, seemingly not considering it to be public assistance. Yet, most children and many of their mothers were insured by Medicaid. Several mothers participated in a state program that provides limited public healthcare coverage to adults whose immigration status does not allow them to qualify for coverage. The feelings of shame, anger, and apprehension mentioned for other assistance programs did not extend to Medicaid—perhaps because of the near universal nature of coverage in the state or hospitals' financial incentive to help patients enroll in health insurance. Another factor may be that healthcare is accessed in the same places and fashion regardless of coverage source. While discrimination against those using Medicaid is certainly known(Duchon et al., 2009), the well-documented stigma of other program participation did not seem to apply to Medicaid. In states without such expansive coverage, immigrant mothers' perceptions of Medicaid may be different. Future work should explore these differences by status, especially for mothers of children with special healthcare needs.

Aligned with the NCF(Black et al., 2020), we take a household view, illuminating how healthy outcomes for children of immigrants and their families flow from integrated attention to parental well-being, basic needs, and safety. Our work extends the NCF framework in multiple ways, beyond the original conception of safety and security to include interpersonal and structural racism's role and, incorporating immigration policy, further to structural vulnerability, including slow violence done to whole populations through policy(Kaufmann, 2018; Pearce et al., 2019; Rivera et al., 2019; Viruell-Fuentes et al., 2012). The daily lives of immigrant mothers of young children can be better understood when contextualized in the US's history of racism and racist immigration policies and the contemporary political and social climate. While the NCF acknowledges policy's foundational importance to underpinning the five NCF elements in shaping child health, including the element 'safety and security' originally conceptualized as freedom from community violence and war, NCF elements do not directly address the role of racism and xenophobia as forms of violence. The anti-Black and anti-Latino immigrant racism described by some of the mothers is additional and distinct, needing recognition as an integral threat to US immigrant families' security and ability to thrive(Hyman, 2009; McKanders, 2019). Maternal experiences of racism and discrimination reflect a deeper and long-standing societal problem of structural racism (Calzada et al., 2019; Johnson, 2016; Lê-Scherban et al., 2025; Morey, 2018; Samari et al., 2024a; Viruell-Fuentes et al., 2012) bounding life choices, including job quality, availability and benefits, and public assistance rules(Ayalew et al., 2021; Bailey et al., 2017; Stuesse, 2018). These findings add to the literature on anti-Black immigrant sentiment by demonstrating how constraints imposed by immigration policies creates unique and additional structural vulnerability that puts Black and Latino, especially Afro-Latino, immigrant families at high risk of poor health outcomes through extreme othering, whether or not they have legal status(Ifatunji, 2024; Lê-Scherban et al., 2025; Rivera et al., 2019; Stuesse, 2018).

Gee and Ford describe this limit-setting aspect of immigration policy as a type of segregation policy, in that the US continues to use quotas, screen for undesirable traits (e.g. health conditions), and exclude those likely to be public charges, each a direct legacy of xenophobic and racist policies dating to colonial times(Gee and Ford, 2011). While economic strain, concern about stigma, frustration with conflicting rules in public assistance programs, and experiences of racism are not unique to immigrant families, the added pressure of structural vulnerability - fears about family separation, immigrant-specific limits to accessing assistance, legal consequences of accessing healthcare and social services, and experiences of xenophobia - meant mothers' daily lives were seen through a prism of risk-weighing that differs from US-born families (Langellier et al., 2021; Viruell-Fuentes et al., 2012). Structural racism and structural vulnerability operate in concert to have wide-ranging impacts, often via governmental and institutional policies that are purportedly blind to race or immigration status and in concert with gender bias that further restricts women's choices and increases the work burden they carry(Bruhn, 2022; Olfman, 1994; Samari et al., 2024a). Maternal disillusion at 'playing by the rules' (working, paying taxes) but still feeling vulnerable to being ripped out of their daily lives and away from their children intensified an underlying sense of anxiety and uncertainty, giving them pause about participating in their communities (Capps et al., 2007; Simmons et al., 2021). This limbo, including among those with citizenship or legal status, was widespread. Structural vulnerability's slow violence, unseen by those not affected(Davies, 2022; Wurtz and Samari, 2025), had a toxic effect on mothers' well-being as they were tasked with holding up their families across multiple dimensions.

Aligned with prior work on structural gendered racism(Samari et al., 2024a; Simmons et al., 2021), our analysis demonstrates how in addition to the constant physical demands related to mothering young children, especially for those with children with special healthcare needs(McCann et al., 2012; Zick and Bryant, 1996), low-income immigrant mothers must conduct specific and additional mental labor in managing both economic and security threats from the political and social environment(Randles, 2021; Robertson et al., 2019). Regardless of immigration status, they were also navigating emotional tasks, managing their own fear and anxiety while trying to present calm, positive environments for their children(Delaney et al., 2023). This combination of invisible emotional and cognitive alongside physical labor is known as mental load, a direct result of ongoing patriarchal foundations of society(Olfman, 1994). The mothers were doing what so many other women did, especially during the pandemic(Brannon and Wiant Cummins, 2023; Bruhn, 2022)–taking on planning, directing, and soothing to care for their families, the "*mental gymnastics*" as one participant so eloquently stated. Contrasting with middle class white mothers in this period who certainly also faced stresses but had other resources to buffer them(Delaney et al., 2023), we extend and expand the concept of women's mental load to immigrant mothers coping with extreme burdens whose unique dimensions are driven by

direct and indirect policy violence. Mothers were gatekeepers to the home, bearing the brunt of these slow, but pervasive, violent insults to navigate caring for themselves and their families. In our study, mothers sought to ensure whole family health taking on significant mental burdens on behalf of their families, all while showing strength and resilience.

This strength proved to be a cross-cutting narrative through several themes, with mothers relying on strong social networks (Theme 3 and 5), deploying ingenuity and collective spirit (Theme 3 and 4), and using pride in their origins (Theme 4) to buoy them in challenging times (Ornelas and Perreira, 2011), essentially turning community vulnerability on its head by staying connected(Cui et al., 2022). Mothers purposefully worked to instill a deep sense of pride and cultural connection, passing on language, culinary and other traditions, to ground their children and offset the harm they anticipated their children would suffer. The mothers we spoke with deeply loved their children, prioritizing them in the face of financial hardships, personal sacrifice, and safety concerns. These findings echo other studies that examined undocumented mothers, immigrant mothers with older children, and poor women more generally, noting the sacrifices they made for children's higher education and school success(Bruhn, 2022; Cuevas, 2019; Knowles et al., 2016; Randles, 2021). While their perseverance and inventiveness are to be admired and celebrated, the fact that mothers had to work so hard and go to such lengths to protect and prioritize their children points to system failures that allow this situation to exist.

This study builds on others' work examining undocumented immigrant women, including those who experienced strained intimate partner relationships(Cuevas, 2019; Samari et al., 2024b; Wurtz and Samari, 2025; Yoshikawa, 2011) by exploring the perspectives of immigrant women from a diversity of origins, yet a shared unique setting at the intersections of a global pandemic and the first Trump administration, layered onto a multifaceted window into the daily lives of immigrant mothers with young children. The findings highlight how deeply into the home structural vulnerability permeates, even among mothers with legal status, affecting how mothers navigate the deeply personal and already heavy mental load of caring for their children. Using a unique household lens to examine intrafamily decisions about resource allocation and interrelationships between daily needs provides an oft-missed and essential view into how families with young children make decisions around health and healthcare. The household lens implies, at minimum, approaching healthcare with a dyadic scope (e.g. mother/-child). This approach expands to the family unit and integrated multi-generational care(Ayalew et al., 2021; Skouteris et al., 2021). Using this view, children's medical visits may present an opportunity to care for mothers. Given maternal delays with their own healthcare and the strong research base demonstrating the importance of maternal health for child health(Glied and Oellerich, 2014), expecting mothers to return for separate appointments may be unrealistic(AAP, 2021; "Centering Parenting," 2021; Gallas, 2019).This approach could be extended by adding 'structural competence'(Rivera et al., 2019) for healthcare providers, in other words understanding familial vulnerability(Logan et al., 2021) through deliberate engagement with the external sociopolitical forces immigrant mothers navigate.

This study has strengths and limitations. Strengths include the diversity of study participants in documentation status, country of birth, English language proficiency, and occupation. We recognize parents as experts about their own lives. They deepen our understanding of immigrant parents' experiences at a time of great political and societal change. Current circumstances, like the return of the Trump administration, may leave families particularly vulnerable. The unique state health insurance coverage for undocumented immigrants in this study may have facilitated these mothers seeking healthcare for their child, while their connection to the larger study may have influenced participants' willingness to be interviewed. Future research should examine if and how these dynamics vary by immigration status. Interviews were conducted during the pandemic, necessitating conducting interviews by phone, rather than in-person. During this period, economic hardship was widespread and disproportionately impacting immigrant communities(Clark et al., 2020). However, while the pandemic and resulting economic downturn loomed over conversations, mothers in our study clearly expressed that their experience of economic strain, the sociopolitical context of many of their fears, and maternal workarounds predated the pandemic.

Our findings underscore the need for federal and state policy approaches that are nuanced, equitable, and immigrant-inclusive, and consider healthcare, immigration, and social policy in integrated fashion (Bovell-Ammon et al., 2022b). When leaders do not align these domains, consequences can be dire for immigrant communities, effectively deepening structural vulnerability. In the pandemic's early days, stimulus payments explicitly excluded immigrants, without consideration for millions of US citizen children of immigrants, and those families received no relief(Horton, 2021; Ettinger de Cuba et al., 2023; Lê-Scherban et al., 2023). While subsequent legislation fixed some eligibility holes and COVID policy got closer to a whole-family approach with the implementation of the advanced Child Tax Credit (CTC), immigrants were never fully included(Bovell-Ammon et al., 2022a). The advanced CTC expanded the existing CTC to become a monthly child allowance for households with children with increased benefits especially for those with children age <6, monthly disbursement, and inclusion of families with the lowest incomes, arguably those most in need. But it continued to exclude nearly one million children who lacked a Social Security number, though they had been included pre-pandemic (Crandall Hollick et al., 2023).

Equitable, immigrant-inclusive policy changes include using respectful language, extending meaningful healthcare coverage to immigrant adults, removing waiting periods for eligible immigrant households for health insurance and nutrition assistance, instituting income support policies that include all children regardless of child or family immigration status, and creating pathways for families to regularize their status. Healthcare and social service providers, policymakers, and researchers must work together with immigrant parents to ensure healthcare, social needs, and immigration policy decision-making is coordinated, respectful, just and equitable across multiple dimensions (race, ethnicity, gender) to build family strengths and sustain optimal outcomes for young children and their families(Perreira and Pedroza, 2019).

CRediT authorship contribution statement

Stephanie Ettinger de Cuba: Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **David K. Jones:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Diana Cutts:** Writing – review & editing, Supervision, Conceptualization. **Allison Bovell-Ammon:** Writing – review & editing, Resources. **Félice Lê-Scherban:** Writing – review & editing, Conceptualization. **Megan Sandel:** Writing – review & editing, Resources. **Eduardo Ochoa:** Writing – review & editing, Conceptualization. **Ana Poblacion:** Writing – review & editing, Conceptualization. **Deborah A. Frank:** Writing – review & editing, Conceptualization. **Maureen M. Black:** Writing – review & editing, Resources, Conceptualization. **Gemmae M. Fix:** Writing – original draft, Supervision, Methodology, Investigation, Formal analysis, Conceptualization.

Ethics statement

This study was approved by the relevant Institutional Review Board and was carried out in accordance with ethical research standards.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Data availability

The authors do not have permission to share data.

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