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Counternarratives of Mexican-Origin Women with Breast Cancer

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Little is known about cancer health disparities among undocumented Latino immigrant populations, who represent a rapidly growing sector in the United States. Federal and state legislative reforms to control immigration have increased significantly over the past year. Although the effects of immigration reforms are being documented in housing, education, and public service industries, no data have been found examining the impact on the health of immigrant communities. In this article, we identify the consequences of recent immigration legislation enacted in Arizona, which has created barriers to accessing cancer treatment and continued follow-up care among a sample of Latina breast cancer survivors. **Key words:** *access to care*, *breast cancer*, *health disparities*, *health policy*, *immigration*, *Latino*, *undocumented*

If I don't have a way to pay, they'll throw me out to Mexico.

Mrs Neya, seeking breast cancer treatment

Proportionally, immigrants living in the United States make up a small segment (13%) of the total population. The majority (69%) of immigrants reside legally in the United States, while about one-third, or an estimated 10 million to 12 million, are undocumented and reside illegally.[1] The primary reason immigrants come to the United States is to seek employment, and the majority (83%) of noncitizen immigrants living in the United States are working families with at least 1 employed member in the household.[1] People from Mexico, representing the largest immigrant group in the nation, accounted for more than half of the total US undocumented immigrant population[2] in 2002.

Immigrant citizens and foreign-born legal residents in the United States are eligible for federal and state healthcare benefits, but undocumented immigrants are not. In some circumstances, they may be able to access emergency medical care through Medicaid; however, this does not extend to follow-up care.[3] By far, the majority (78%) of people without healthcare insurance are US citizens, although noncitizens—both legal and undocumented—accounted for 22% of the uninsured population[1] in 2006. Because noncitizens are less likely to have access to a primary care provider and have lower utilization of emergency department services,[1] they have lower annual per capita healthcare expenditures ($1797) as compared with US citizens ($3702). Of the estimated 10 million noncitizens who are without healthcare insurance,[4] undocumented immigrants represent a particularly vulnerable group because they are more likely to be employed in low-income positions or under the threat of losing

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employment because of their legal status and thus may lack the means to pay out of pocket for healthcare services.[1]

A national response to the influx of immigration to the United States can be seen in new legislation. In 2007, there were 244 new laws related to immigration enacted across 46 states.[5] Arizona has the distinction of being the first state in the nation to control immigration through employer sanctions legislation and has served as a model for other states that have since considered similar legislation.[6] Health-related implications of immigration legislation remain relatively unexplored in the nursing literature. The purpose of this article is to (1) discuss broad effects of recent immigration legislation in Arizona and (2) describe the experiences of women from Mexico, who resided in Arizona as immigrants without legal authorization, in accessing treatment for breast cancer. Although the term *undocumented immigrant* is used in this article, we refer to our participants as women from Mexico, recognizing that common descriptive terms such as "undocumented immigrant" or "illegal alien" are legal and sociological identifiers thrust upon people that have dehumanizing effects and serve to reify notions of differentness.

BACKGROUND

The first wave of migration to the United States occurred between 1850 and the 1880s, when 1.9 million people from Germany, 1.8 million people from Ireland, 1 million people from China, and 0.5 million people from Italy entered the country.[7] During the second wave (1880–1920), 3.3 million people from western Europe, 2.9 million people from eastern Europe, and 1.9 million people from southern Europe migrated to the United States. Visas or legal documentation for immigrants coming to the United States were not required until the Immigration Act of 1924, and in 1929, it became a misdemeanor to enter the United States without legal authorization.[8] The third migration wave occurred after the Immigration Act of 1965, when 4 million people from Asia and 4.3 million people from Latin American entered the United States. It is unknown how many illegal immigrants were accommodated into US society during these periods. Yet, after each of these waves, as now, negative public rhetoric emerged characterizing immigrants as overrunning the country, lowering wages, and draining public benefits systems.[8] In the current context of national and global economic downturns, immigration becomes an even more highly contested issue. Social science scholars claim that immigration is a "key civil rights issue of the twenty-first century in the US and a human rights issue worldwide."[9]

Profile of Arizona immigration

Arizona is the first state in the nation to implement legislation that penalizes businesses for knowingly hiring unauthorized immigrants. The Legal Arizona Workers Act (LAWA) was enacted in July 2007, but because of legal challenges from business and civil rights groups, it did not become effective[5] until March 2008. LAWA suspends or revokes the business licenses of employers who knowingly hire undocumented workers and is intended to reduce economic incentives for immigrants to enter the state illegally. One of the reasons this employer sanctions legislation has emerged is because Arizona experienced a growth in its foreign-born population of more than 200% between 1990 and 2004, the majority (68%) being from Mexico.[10] The Udall Center for Studies in Public Policy estimates that there were approximately half a million unauthorized immigrants living in Arizona in 2005, most of them coming from Mexico.[10]

Fear and hostility toward Latino communities in Arizona is illustrated by recent and continuing use of police force and public harassment efforts directed at suspected undocumented immigrants. Law enforcement officers of the Chandler Police Department (a suburb of the Phoenix metro area), in collaboration with the US Border Patrol, conducted random stops of people in retail stores, parking lots, and pedestrians walking on the street, as well as forced entry into homes without search warrants, demanding proof of citizenship such as social security cards and birth certificates.[9] A driver's license was not accepted as proof of citizenship in these immigration raids, and those without the required documentation were arrested. Only people who were suspected immigrants were targeted, a determination based solely on physical appearance as being Mexican or speaking Spanish. Thus, through racial profiling, the "draconian immigration law-enforcement practices"(p32) ended up also targeting US citizens who had been born and raised in Arizona.[9] The US and Arizona Attorney General's Office is investigating the immigration raids for civil rights violations and litigation related to such practices.

People from Mexico have long been viewed as both a national threat to American values and a commodity for cheap labor. Latino noncitizens in Arizona represent 11% of the state's labor force, which is double the national average.[11] In 2004, more than half (55%) of Arizonans without a high school education were noncitizens, most often employed in low-skill jobs.[12] Arizona relies heavily upon the labor skills of foreign-born immigrants, who comprise approximately 35% of the state's construction-industry workforce and 59% of the farming workforce.[10] Despite growing state budget deficits, the Arizona legislature allocated more than $2.4 million solely for enforcement[10] of LAWA in 2007–2008. While several businesses within the state are under investigation, the authors are not aware of any businesses that have had their license suspended or revoked because of LAWA violations. However, there have been multiple deportations of individuals as well as exodus of undocumented workers from the state.[13]

A consequent negative impact of LAWA has occurred in the loss of jobs in construction, hotel, agriculture, and landscaping industries and in falling school enrollment.[6] In addition, housing and apartment vacancies have increased beyond that attributed to the current mortgage crisis and slowing economy. The loss of immigrant populations to the state, and ultimately the nation, has important implications when one considers their tax contributions from employment. In 2004, immigrant workers contributed $2.4 billion ($1.5 billion for noncitizens and $840 million for naturalized citizens) to the total state tax revenue.[10] After accounting for costs incurred from education, emergency healthcare and law enforcement, Arizona immigrant workers contributed $940 million to state services such as libraries, road maintenance, and public safety.[10] It is estimated that the impact of LAWA could result in a decrease of $29 million or 8.2% of the state's economic output due to loss of noncitizen immigrant worker contributions.[10] While effects of LAWA are being documented in housing, education, and public service industries, there have been no data to examine the impact of the law on the health and well-being of immigrant communities.

Breast cancer disparities

The term "cancer health disparity" refers to the lack of adequate cancer care and treatment and includes differential rates in screening, incidence, or mortality.[14] Breast cancer is a leading cause of death among women in the United States, and among Latinas, it is the most commonly diagnosed type of cancer.[15] Compared with non-Latina white women, Latinas are 20% more likely to die of breast cancer when diagnosed at a similar age and stage of cancer.[16] Furthermore, breast cancer mortality rates over the past decade have not decreased at the same level for Latinas as for non-Latina whites.[17,18] Lack of access to healthcare, which contributes to late-stage diagnosis, is a significant factor in racial and ethnic disparities in cancer morbidity and mortality rates.

Studies have found that Latina breast cancer survivors reported the lowest levels of health-related quality of life (HRQOL) when compared with African American and white survivors[19] and compared with Asian survivors.[20] Analysis revealed, however, that ethnicity was a proxy for socioeconomic status, because women with lower income scored lower on HRQOL as compared with women with higher income across ethnic groups.[21] Very little is known about how women who are immigrants cope with a cancer diagnosis and the unique challenges they face in survival. A focus group study with 24 Latina breast cancer survivors found that 40% had been terminated from employment after their breast cancer diagnosis or during treatment.[22] Other women skipped cancer treatment appointments for fear of losing their jobs. In this same study, two-thirds of the women experienced healthcare discrimination in the form of perceived physician indifference and denial of services because of legal status. Fear of deportation among women who were undocumented residents inhibited their continuation of cancer treatments. Another focus group study that included Latina immigrants also found fear of deportation as an inhibition to seeking treatment for breast-health problems.[23]

Current immigration legislation in Arizona provides a unique position from which to examine the indirect effects of immigration policy and anti-immigration sentiment on immigrant breast cancer survivors. Findings from this study uncover the human struggles at the margins of the healthcare system and hidden underneath the immigration debates and legislative reforms. These local experiences are important to document because Arizona's immigration control policy may be replicated by other states.

CONCEPTUAL FRAMEWORK

The conceptual framework guiding this study was critical race theory (CRT).[24,25] CRT is based on the premise that socially constructed identities such as race, ethnicity, and culture are contextual phenomena that cannot be separated from people's everyday experiences and meanings. CRT provides a framework for understanding the intersection of socially constructed identities and how systems of power and inequity operate within the dominant society. The framework is useful in understanding power dynamics existent in healthcare delivery systems and provides insight into potential barriers that impede intercultural health relationships.

While the name implies a focus on race, CRT emphasizes the intersection of racism with other forms of discrimination such as sexism, classism, and monolingualism. Major tenets of CRT include (1) recognition of discrimination based on socially constructed identities (such as race and ethnicity) as an endemic facet of American society; (2) experience of simultaneous forms of discrimination related to class, sex, and language in addition to race and ethnicity; and (3) discrimination as understood by listening to the experiential knowledge of people who are recipients of discrimination.

A methodological strategy employed by CRT scholars is the use of counternarratives, which are testimonials or stories that challenge hegemonic rhetoric and stereotypic assumptions.[24] Framing the stories of undocumented Mexican immigrant breast cancer survivors as counternarratives is appropriate because "...counternarratives of subordinated groups serve to confirm their experiences and bear witness to their lived reality in the face of a dominant culture that distorts, stereotypes and marginalizes that reality."[26] Giving voice to the perceptions and experiences of people who are in marginalized or subordinated positions sheds light on how accepted policies and practices of the dominant culture create injustice. Bell points out that counternarratives permit the telling of experiences that critique dominant forms of injustice, which are stories that people in marginalized contexts would not otherwise be safe to tell.[26]

METHODS

The data for this study were collected during a broader study exploring perceived racial and ethnic discrimination in cancer care delivery. A sequential, triangulated, qualitative design was used to provide an in-depth understanding of cancer care experiences. An interdisciplinary team of racial and ethnic minority and nonminority researchers and oncology consultants was involved in data collection, planning, analysis, and interpretation. All study procedures and materials were approved by the institutional review board of the university sponsoring the project. This article focuses on the participant group that included Mexican-origin, Spanish-speaking, immigrant breast cancer survivors, recruited from a variety of community-based organizations and health centers in the metropolitan area of Phoenix, Arizona.

As noted writer De Mello has stated, "You have to understand . . . that the shortest distance between truth and a human being is a story."[27] A fundamental CRT tenet is that listening to the experiential knowledge of subordinated individuals provides valid insight into oppressive social norms. Therefore, the research team chose to report these findings as brief stories or counternarratives of the women's personal struggles of living in the midst of immigration policies, attitudes, and stances that not only limited their ability to seek and receive healthcare, but also could potentially threaten their lives.

Sample and data collection procedures

All the women in this cohort ($N = 10$) were monolingual Spanish speakers who migrated to the United States within the past 7 years to 15 years. Participants were diagnosed with breast cancer (stages I–IV) within the past 4 years, and all had surgery (lumpectomy or mastectomy) and a combination of chemotherapy and/or radiation. Data collection methods used included an in-depth, semistructured interview with participants to explore perceptions and experiences in cancer care delivery and a self-administered demographic questionnaire. All data were collected by a Spanish-speaking Mexican American nurse researcher. The researcher did not inquire about participants' citizenship status; however, the women brought up the subject themselves during the interview. All study materials were translated into Spanish using established backward and forward translation procedures[28] and assessed for accuracy and cultural equivalence by a Mexican American oncology nurse consultant and a bilingual Mexican American nurse co-investigator. The nurse researcher conducting the interview made arrangements with participants to determine an interview time and location convenient for the participant. Most interviews were conducted in participants' homes, by their choice.

Analysis

Interview transcripts were translated verbatim by a Spanish-speaking Mexican American research assistant, transcribed into text, and verified by the researcher for accuracy.

The investigator prepared for data analysis by listening repeatedly to the tapes as well as reading and reflecting upon the transcribed data. To ensure quality of the data and interviewer consistency, the investigators utilized multiple open coding whereby each investigator coded portions of 2 randomly selected interviews from the cohort group. Emerging *emic* codes were identified and discussed. Discrepancies in codes resulted in a return to the data and subsequent iterations until 90% interrater reliability was obtained. Economic and healthcare access issues emerged prominently during open coding for most of the women in this group. For the purposes of this article, only the *emic* data contained in the economic and healthcare access categories will be presented. These data were selected as testimonials that clearly illustrate the challenges in breast cancer survivorship that are unique to those who lack the privilege of wealth and healthcare insurance benefits. Further thematic analysis of data from participants in the broader study is ongoing.

RESULTS

Participants' ages ranged from 36 years to 64 years ($M = 48$, SD = 4.8). All were educated in Mexico, and 70% completed less than a ninth-grade education. Most of the women

(70%) were homemakers and 63% reported a yearly household income of $20 000 or less. All of the participants were diagnosed with breast cancer within the past 4 years. The majority (70%) were uninsured and reported receiving an average of 18 healthcare visits over the past two years. All were residing illegally in the United States, except for a participant who was a legal resident and owner of a small business. Because of their illegal status, most of the participants were ineligible for state-sponsored healthcare insurance and had been paying out of pocket for cancer care treatment.

The majority (75%) of the women described significant psychological distress related to their economic situation and have experienced an interruption or cessation of cancer care related to inability to pay for healthcare services. The women's undocumented status, lack of health insurance, and economic hardship were factors that coalesced into added burdens in their struggle of living with cancer. Because there had been considerable local public debate about Arizona's employer sanction immigration legislation prior to its enactment, the new law had become common knowledge in the city of the study site, particularly among immigrant communities. Some participants made specific reference to anti-immigration rhetoric that they had heard. The next section presents 4 exemplar cases, or counternarratives, that illustrate findings from this cohort related to economic and immigration issues. Pseudonyms are used in all participant quotations.

Portraits of struggle

Mrs Bolleta. Mrs Bolleta is a 47-year-old homemaker and a 3-year breast cancer survivor. She had been living in the United States for the past 10 years. She did not know the tumor stage at the time of diagnosis in 2005, but she received a mastectomy, chemotherapy, and radiation therapy. Mrs Bolleta was previously insured for healthcare services through her husband's employment, but he lost his position last year, as she explains: "My husband was working and we had insurance, but right now, it got taken away, it's been like 8, 9 months since he doesn't work, so I don't have insurance anymore." Since her husband's job loss, she depended on the incomes of several other employed family members to pay the $150 fee for an office visit to see an oncologist. She reports, however, that in recent months all but one of these family members have lost their jobs because of LAWA legislation. While her surgeon told her she was a good candidate for reconstructive surgery, the family lacks funds for the procedure. She claims she is not receiving any follow-up treatment, such as tamoxifen, but does have mammography screening every 6 months. In speaking about the US healthcare system, she remarks, "Well, it's like whoever has more money, it's logical that he's going to get better service, right?" She remains hopeful, nevertheless, and expressed gratitude for the treatment that she was able to obtain: "Right now, science is really advanced, thank God. And, well. . .just pray a lot to God. . .and the doctors are angels for us, that are helping us."

Mrs Neya. Mrs Neya is a 50-year-old homemaker with a fifth-grade education. Arriving in the United States in 2005, she explained that she sought treatment for a breast lump at a local community health clinic that was recommended to her by a niece. She was then diagnosed with breast cancer (she did not know the tumor stage) and received a mastectomy, chemotherapy, and radiation therapy. When first diagnosed, Mrs Neya had wanted to delay the surgery by several months to return to Mexico, as she explained to the nurse:

> If it's cancer, I'm going to Mexico. I have my daughters in Mexico. . . . I'll have the operation there. I do remember that I said, "I don't have money" and she [nurse] told me, "What we want is for you to get better, what we want is to do the operation," the important thing she said is "your health." And I accepted . . . thanks to God, I'm here [alive].

Although Mrs Neya obtained approval for legal residency shortly after her surgery, a 5-year residency is then required to be eligible for free healthcare insurance. She had been dependent solely upon employed family members to help pay for cancer treatment. However, several of these family members lost their jobs because they were undocumented workers, and subsequently, she was no longer able to pay out of pocket for healthcare services, such as the $60 office fee to have a chemotherapy catheter removed. After 2 months of chemotherapy completion, the catheter was still in place and was posing a significant risk for local or systemic infection. She described feeling "tormented" over economic stressors, which included calls from collection agencies seeking payment for previous healthcare treatment and inability to pay for rent and other household expenses. Mrs Neya, like every other participant in this cohort, made a distinction between healthcare providers who delivered the cancer treatment and financial services staff who restricted access to further healthcare or demanded payments. She described treatment from oncology physicians and nurses as "very good," yet worried that she could face deportation from authorities if she did not meet her financial obligations: "If I don't have a way to pay, they'll throw me out to Mexico."

Mrs Lopez. Mrs Lopez is a 42-year-old business owner who graduated from a high school in Mexico and had been residing in the United States for the past 11 years. Although her husband was employed and she owned her own business, the family was without healthcare insurance. Diagnosed with stage II breast cancer in 2005, she received a mastectomy, chemotherapy, and radiation therapy. She described feeling "really traumatized" by the costs of cancer treatment, such as paying $5000 for surgical insertion of a catheter for chemotherapy. Because she and her husband were in the process of applying for legal residency at the time of her cancer treatment, she was not eligible for healthcare insurance and was paying out of pocket. Facing the possibility of paying over $13 000 for chemotherapy, she and her husband were preparing to sell their family home, as she explained:

> My husband said, "You know what? I'm going to say that I have money so they can take care of you. We'll sell the house, we'll sell whatever we have to," he told me. We didn't have cash but, well, we could get it.... If they diagnose you with cancer, you want to do everything, everything you can to live. I mean take any resource available.... If the doctor tells you, you have to do this treatment, you do it because you want to live for your family, for your daughters.

Just at that time, their legal residency requirements were met, and she was able to obtain healthcare insurance through the Arizona Healthcare Cost Containment System (AHCCCS), a program similar to Medicaid, available to state residents. She had also been referred to a local organization that donated the chemotherapy drug for her treatment. As is common with many cancer survivors, Mrs Lopez worries about possible recurrence, and should this happen, she wonders if it would be because of receiving a free chemotherapy medication. "I wasn't in the position to ask for the best," she says.

Mrs Lomas. Mrs Lomas is a 58-year-old college graduate who came to the United States from Mexico 9 years ago. In 2004, she was diagnosed with stage I breast cancer. A mastectomy was recommended because there were multiple tumors involved, but she instead chose lumpectomy and radiation because she didn't want to "be mutilated." (The women's treatment decision-making process will be discussed in a separate article.) Mrs Lomas's husband, who was also residing without legal authorization, had lost his job at the time she was diagnosed, so they were "going through a tough time economically." She felt there was "no negotiation" regarding the $1000 magnetic resonance imaging test fee and $5000 radiation therapy fee required before obtaining services. She relayed with frustration how the oncology office staff member would call her to remind her of appointments but then refuse to see her if she could not pay for services. She knows that she should be taking tamoxifen or another adjuvant treatment, but she is unable to afford it. In this participant's experiences, "[if] you don't have insurance and you're Hispanic, you're not going to have very good treatment, so you hope not to get sick." Having been a breast cancer survivor for 4 years, she has been able to obtain cancer screening every 6 to 12 months, but when ill and in need of primary care, she resorts to home remedies such as teas or "bears it out at home." At the time of the interview, Mrs Lomas was relying on food donations from her church to sustain her and her husband, and they were contemplating returning to Mexico to live.

Mrs Lomas was keenly aware of the anti-immigration rhetoric in the US media and political issues surrounding her undocumented status, as she explained:

> Everywhere in the news, everywhere you hear that because you're Hispanic, you have no right to medical services.... It's part of the risk you take when you're in these conditions...sometimes you have to come to other countries, not because you think it's the best option at that moment...if you stay in your own country, you run almost the same risks because the same position that your country is in makes you want to go to another place.

DISCUSSION

To the best of our knowledge, this article describes the first study documenting the effects of immigration policy on the health and well-being of Mexican immigrant breast cancer survivors. Findings from this study revealed that immigration policy indirectly affected access to healthcare, thereby creating substantial barriers to adequate cancer treatment and continued follow-up care. The experiences of women described in this study are not meant to be representative of all immigrants who are breast cancer survivors, but rather, to serve to highlight the similarities as well as unique aspects of the many challenges faced by people living with cancer.

Lack of access to healthcare and the economic burdens involved with cancer treatment, as experienced by these study participants, are challenges shared among other low-income, uninsured, or medically underserved cancer survivors. Costs associated with initial cancer diagnosis and treatment such as surgery may be available to uninsured people if viewed as an emergency, but the cost of continued cancer treatment, such as a recommended Tamoxifen regimen for 5 years, would be prohibitive for many families. For example, a study of the average Medicare expenditure for a breast cancer survivor at 3 years is estimated to be approximately $5000/month.[29] For the women in this study, the availability of healthcare insurance would have undoubtedly made a difference in their lives. Healthcare insurance coverage, however, is not a panacea to reduce cancer health disparities. Recent research by Ward and colleagues demonstrates that patients with Medicaid insurance were more likely to be diagnosed at later stages of cancer than those with private insurance, indicating the presence of barriers to screening and follow-up care within public healthcare insurance systems.[30]

The multiple social and cultural barriers to adequate healthcare for these study participants, including limited English proficiency, lack of healthcare insurance, and low income levels, are consistent with findings from other studies of Mexican immigrant women who were residing in the United States without legal documents. As reported by Marshall and colleagues,[31] undocumented Latinas are more likely to face barriers to healthcare access than Latinas who have legal residency, and they may be more reluctant to seek health or social services because of fear of deportation. Indeed, the added psychological burden associated with anti-immigration rhetoric and the threat of police intervention at any moment are challenges that are unique to breast cancer survivors who are undocumented. Living under the umbrella of such threats may interfere with the formation of trusting relationships with healthcare providers, potentially increasing their perceived vulnerability and need for secrecy.[8] Data from this study indicate that despite their vulnerability, the women trusted their healthcare providers and attempted to seek cancer treatment as much as possible. Having lived in the United States for a substantial number of years, the participants were connected with local community-based healthcare services and sought out assistance when available. Yet, inadequate cancer care treatment and follow-up was the norm among these participants. Lack of access to adequate cancer care has implications beyond the women's individual cases. Deterioration in health status that remains untreated could result in a serious or emergency health crisis, which would place far greater strain on local and state healthcare resources than if standard protocols for cancer care treatment and follow-up were available to these women.

Immigration reform is a complex and hotly contested issue nationally and particularly in states bordering Mexico. The effects of national and local public debate over immigration reform are felt by both Latino citizens and immigrants. Recent polls indicate that 72% of foreign-born Latinos and 53% of US-born Latinos believe that the nation's debate over immigration policy has made life more difficult for them.[11] A study of over 3000 adults of Mexican origin found that perceived racial or ethnic discrimination was associated with poorer physical health, particularly job-market stress/discrimination.[32] Among Spanish-speaking foreign-born Latinos, 19% have experienced increased difficulty in finding or keeping employment because of increased attention to the immigration issue.[11] For any family facing a serious illness such as cancer, loss of employment would create further burdens on coping, as well as a possible threat to continued healthcare access. For immigrant populations, as these results indicate, attempts at self-sufficiency in accessing cancer care may become thwarted when employment opportunities are reduced or blocked. Furthermore, reliance on extended family members may be restricted by heightened US-Mexico border enforcement, thereby creating increased risk for the ill person to cross to Mexico for medical care or to access family support.

Concerns over the broader economic impact of Arizona's immigration legislation have been voiced in the public realm and in academia, while the health consequences of immigration legislation have largely been ignored. Nurses are in key positions to identify and address health-related consequences of social policies that target and potentially bring harm to people living in their communities. Whether at the clinical level as healthcare providers or as research investigators, nurses need to consider opportunities to fulfill their ethical obligation to enhance the well-being of individuals and communities. For example, the principal investigator of this study located local cancer care services that, although sparse, were available regardless of citizenship status or ability to pay and communicated these to participants. The principal investigator also shared the findings of this study with the city's mayor during a public forum on immigration. Nurses, social workers, and other healthcare professionals need to employ targeted interventions for those experiencing financial burdens in healthcare. These interventions may include (1) expansion of referrals to nontraditional resources, such as pharmaceutical companies that provide low-cost or free medications to certain individuals; (2) encouraging discussion of the financial burden between the family and treatment team to identify potential solutions; and (3) education of families about public assistance programs that they may not be utilizing to the fullest.[33] Broad and systemic interventions to eliminate racial and ethnic disparities in cancer morbidity and mortality rates are also needed at the national level. Comprehensive national goals identified in the Intercultural Cancer Council's Agenda for Action are examples of policy-level efforts aimed at improving cancer prevention, screening, treatment, and follow-up care in culturally responsive ways.[14]

CONCLUSION

Latino immigrant populations may be especially vulnerable to health disparities because of lack of access to social and healthcare resources, as well as prejudice and misunderstanding toward immigrant groups by the dominant society.[3] Although multiple barriers to healthcare for immigrant populations have been described,[2] little is known about the unique challenges faced by cancer survivors who are residing without legal authorization. Findings from this study revealed that uninsured breast cancer survivors of Mexican origin living in employed households had some degree of self-sufficiency in seeking cancer treatment and health maintenance, which became interrupted by familial job loss. It is unknown how many other cancer survivors living in the United States—whether immigrant or citizen—are struggling with unmet cancer care needs because of their inability to pay for services or other access issues. The cancer survivorship challenges described in the exemplar cases from this study demonstrate unique difficulties faced by the women as well as challenges that may be shared with other people who are medically underserved and marginalized. Indeed, cancer survivors of any race, ethnicity, or legal status who face poverty, injustice, or discrimination demonstrate struggles that are reflective of "the complexity of suffering as a multicultural cancer experience."[14] Nurses undoubtedly have opportunities to play a key role in shaping more equitable and humane healthcare policies and services. The question remains if, as a profession, we have the will.

REFERENCES

1. Kaiser Family Foundation. *The Kaiser Commission on Medicaid and the Uninsured*. Washington, DC: The Henry J. Kaiser Family Foundation; 2008. www.kff.org. Accessed April 25, 2008.
2. Carr DD. Implications for case management: ensuring access and delivery of quality healthcare to undocumented immigrant populations. *Lippincotts Case Manag*. 2006;11(4):195–204.
3. Kaiser Family Foundation. Five basic facts on immigrants and their health care. www.kff.org/medicaid/7761.cfm. Accessed March 12, 2008.
4. Holahan J, Cook A. The U.S. economy and changes in health insurance coverage, 2000–2006. 2008;27(2): w135–w144.
5. Plascencia L. Knowingly employing sanctions: Arizona's regulation of migration through employer sanctions. Paper presented at: North American Center for Transborder Studies Workshop on Deep Integration Post Bush, Arizona State University; April 17, 2008; Tempe, Arizona.
6. Pitzl ML. Sanctions law ruling will ripple across U.S. *Arizona Republic*. June 8, 2008:A1-A6.
7. Bryce JD. Coming to America: the story of immigration. Fam Ther. 2008;7(1):10–14.
8. Messias DK. Concept development: exploring undocumentedness. *Sch Inq Nurs Pract*. 1996;10(3):235–252.
9. Romero M. Crossing the immigration and race border: a critical race theory approach to immigration studies. *Contemp Justice Rev*. 2008;11(1):23–37.
10. Gans J. *Immigrants in Arizona: Fiscal and Economic Impacts*. Tucson, AZ: Udall Center for Studies in Public Policy; 2008.
11. Pew Hispanic Center. *National Survey of Latinos: As Illegal Immigration Issue Heats Up, Hispanics Feel a Chill*. Washington, DC: Pew Hispanic Center; 2007. www.pewhispanic.org. Accessed May 10, 2008.
12. Gans J. Arizona's economy and the Legal Arizona Workers Act. Tucson, AZ: Udall Center for Studies in Public Policy, 2008.
13. Associated Press. New Arizona law pressures Latinos to move. http://www.msnbc.msn.com/id/23411209. Accessed February 29, 2008.
14. Barton-Burke M, Barreto R, Archibald LS. Suffering as a multicultural cancer experience. *Semi Oncol Nurs*. 2008;24(4):229–236.
15. American Cancer Society. *Breast Cancer Facts and Figures 2007–2008*. Atlanta, GA: American Cancer Society; 2007.
16. American Cancer Society. *Cancer Facts and Figures for Hispanics 2006–2008*. Atlanta, GA: American Cancer Society; 2006.
17. Clegg LX, Li FP, Chu K, Edwards BK. Cancer survival among U.S. whites and minorities: SEER (Surveillance, Epidemiology, and End Results) Program population-based study. *Arch Intern Med*. 2002; 162(17):1985–1993.
18. Jemal A, Clegg LX, Ward E, et al. Annual report to the nation on the status of cancer, 1975–2001, with a special feature regarding survival. *Cancer*. 2004;101(1):3–27.
19. Ashing-Giwa K, Tejero J, Kim J, Padilla G, Hellemann G. Examining predictive models of HRQOL in a population-based, multiethnic sample of women with breast carcinoma. *Qual Life Res*. 2007;16:413–428.
20. Lim J, Gonzalez P, Wang-Letzkus M, Ashing-Giwa K. Understanding the cultural health belief model influencing health behaviors and health-related quality of

life between Latina and Asian-American breast cancer survivors [published online ahead of print December 3, 2008]. *Support Care Cancer*. 2008:3.

21. Ashing-Giwa K, Won J. Examining the impact of socioeconomic status and socioecological stress on physical and mental health quality of life among breast cancer survivors. *Oncol Nurs Forum*. 2009; 36(1):79–88.
22. Ashing-Giwa K, Padilla G, Bohoroquez D, Tejero J, Garcia M. Understanding the breast cancer experience of Latina women. *J Psychosoc Oncol*. 2006;24(3):19–52.
23. Facione N, Giancarlo C. Narratives of breast symptom discovery and cancer diagnosis: psychologic risk for advanced cancer at diagnosis. *Cancer Nurs*. 1998;21(6):430–440.
24. Delgado R, Stefancic J. *Critical Race Theory: An Introduction*. New York: New York University Press; 2001.
25. Pizarro M. Chicana/o power: epistemology and methodology for social justice and empowerment in Chicana/o communities. *Qual Stud Educ*. 1998; 11(1):57–80.
26. Bell LA. Telling tales: what stories can teach us about racism. *Race Ethn Educ.* 2003;6(1):3–28.
27. De Mello A. *One Minute Wisdom*. New York, NY: Bantam Dell; 1985.
28. Phillips L, Hernandez IL, de Ardon TE. Strategies for achieving cultural equivalence. *Res Nurs Health*. 1994;17:149–154.
29. Brown M, Riley G, Schussler N, Etzioni R. Estimating health care costs related to cancer treatment from SEER-Medicare data. *Med Care*. 2002;40(8)(suppl): IV-104–IV-117.
30. Ward E, Halpern M, Schrag N, et al. Association of insurance with cancer care utilization and outcomes. *CA Cancer J Clin*. 2008;58:9–31.
31. Marshall KJ, Urrutia-Rojas X, Mas FS, Coggin C. Health status and access to healthcare of documented and undocumented immigrant Latino women. *Health Care Women Int*. 2005;26:916–936.
32. Finch B, Hummer R, Kolody B, Vega W. The role of discrimination and acculturative stress in the physical health of Mexican-origin adults. *Hisp J Behav Sci*. 2001;23(4):399–429.
33. Francoeur R. Reformulating financial problems and interventions to improve psychosocial and functional outcomes in cancer patients and their families. *J Psychosoc Oncol*. 2001;19(1):1–20.