Legal Status as a Social Determinant of Health across Generations: The Impact of Temporary Protected Status on Haitian Mothers' Birth Outcomes

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Short Abstract:
Since 1990, Temporary Protected Status (TPS) has been one of the US's main humanitarian programs providing protection to foreign nationals who cannot safely return to their home countries. In a major shift in international policy, the US will terminate TPS protections for 428,000 migrants – including 58,000 Haitian-born migrants – over the next 18 months. It is likely that loss of legal status will negatively impact the health of TPS recipients and their US-born children. As the first study to examine the health impacts of TPS, this study will use nationwide data from all infants born in the US to Haitian-born mothers (n=93,426) and synthetic control methods to answer the question: Did gaining access to legal status through TPS improve birth outcomes for Haitian-born mothers? Results will provide evidence about the potential negative health effects of terminating TPS.

The current US presidential administration has implemented a multipronged approach to reduce the number of immigrants living in the US, as well as reducing future flows of both legal and unauthorized migration. Included in this approach is a dramatic reduction in major humanitarian programs designed to provide protection to foreign nationals whose home countries are unsafe due to violent conflict or natural disaster. The administration has announced that it will terminate Temporary Protected Status (TPS) for 428,000 Salvadoran, Haitian, Honduran, Nepalese, Nicaraguan, and Sudanese migrants who currently live in the US (Chishti, Bolter, & Pierce, 2017; Cohn & Passel, 2017; U.S. Citizenship and Immigration Services, 2018). These migrants will be required to return home when they lose their TPS status. However, the majority have lived in the US for at least 10–20 years, and many have US-born spouses and children (Chishti et al., 2017; Warren & Kerwin, 2017). It is likely that many will choose to stay in the US, living "in the shadows" as unauthorized immigrants.

What are the potential health consequences of losing TPS status, for TPS holders and their children? Although legal status is recognized as a key social determinant of health for immigrant families (Torres & Young, 2016), most of our understanding of the link between legal status and health is based on observational studies. There have been few studies into the health impacts of changes in legal status, and no studies have examined the health impacts of TPS. This study will address this gap in the literature by asking: Did gaining access to TPS improve prenatal care utilization and birth outcomes for Haitian-born mothers living in the US?

Background: Haitian migrants and TPS

TPS was created in 1990 to provide temporary protection to foreign nationals who are present in the US on temporary visas or as unauthorized immigrants when a natural disaster or violent conflict occurs that makes it unsafe for them to return home. TPS holders have temporary legal authorization to live and work in the US, and cannot be detained or deported solely on the basis of their legal status (although they may be deported if, for example, they are convicted of a felony). TPS is designed to be temporary, with the expectation that individuals will return to their home countries when it is safe to do so. However, for most countries designated for TPS, poverty, repeated natural disasters, and/or ongoing conflicts have resulted in TPS that lasted for years, or even decades (Chishti et al., 2017; Cohn & Passel, 2017; Warren & Kerwin, 2017).

Haiti was designated for TPS on January 21, 2010, after a massive earthquake killed hundreds of thousands of Haitians and devastated the country's infrastructure. Initially, TPS was only open to Haitians who were already in the US as of January 2010; later, the Department of Homeland Security extended TPS to Haitians who entered the US by July 23, 2011 (Schulz & Batalova, 2017).

As of 2017, about 58,000 Haitian migrants (about 8.5% of Haitians living in the US) have TPS (Chishti et al., 2017). Haitian TPS recipients have built lives in the US: on average, they have been in the US for 13 years; 81% live above poverty level; 81% are in the labor force; 75% speak English well; 71% have at least a high school degree; and 23% own their own home. Haitian TPS recipients have about 27,000 US-born children (Warren & Kerwin, 2017). TPS holders from Haiti are scheduled to lose their status and are required to return to Haiti by January 17, 2019 (U.S. Citizenship and Immigration Services, 2018). Most TPS holders who remain after their status expires will be unauthorized immigrants and will be at risk of deportation.

Legal status and health

Legal status is a key social determinant of health for immigrant populations (Torres & Young, 2016). Legal status determines immigrants' access to employment, other economic resources, public benefits and services, and health care. Due to higher poverty rates, higher stress, and worse access to health care, undocumented immigrants and their children have worse health than legally-present immigrants (Oropesa, Landale, & Hillemeier, 2015), including worse birth outcomes (Kelaher & Jessop, 2002).

While a growing literature demonstrates the association between legal status and health, little is known about how *changes* in immigrants' legal status impact their health. To date, no studies have quantified the impacts of TPS on immigrants' outcomes. For hints about the likely health benefits of TPS, we can look to a few studies on the Deferred Action for Childhood Arrivals (DACA) program—another temporary status with similar protections and rights as TPS. After the implementation of DACA, noncitizen young adults have higher incomes and decreased probability of living in poverty (Amuedo-Dorantes & Antman, 2016; Giuntella & Lonsky, 2018; Wong et al., 2017), are more likely to have health insurance coverage and report fewer barriers to accessing health care (Giuntella & Lonsky, 2018); and report better mental health (Giuntella & Lonsky, 2018). Importantly, DACA also has mental health benefits for US-born children with undocumented mothers (Hainmueller et al., 2017). This will be the first study to evaluate the impact of TPS on health outcomes for children of immigrants.

TPS and birth outcomes: Potential pathways

I hypothesize that extending TPS to Haitian immigrants improved birth outcomes for Haitian-born mothers. Improved birth outcomes could occur through two main mechanisms. **First, having access to temporary protection from deportation through TPS should reduce mothers' stress.** Prenatal exposure to stress increases the risk of low birth weight and preterm birth (Bussières et al., 2015; Novak, Geronimus, & Martinez-Cardoso, 2017). For unauthorized Haitian mothers, gaining access to TPS protects migrants from the day-to-day threat of deportation, likely resulting in less stress, anxiety, and psychological distress (Venkataramani, Shah, O'Brien, Kawachi, & Tsai, 2017). **Second, TPS provides access to important health promoting resources:** formal employment opportunities bring higher incomes and (potentially) employer-sponsored private insurance, while TPS makes migrants eligible for public health insurance (e.g., Medicaid) in some states (The Henry J. Kaiser Family Foundation, 2017).

If TPS does improve birth outcomes, this finding has long-term implications for Haitian-American children and for the US overall. Babies born preterm or low birth weight have higher health care costs, worse physical health, more developmental delays, lower educational attainment, and lower income in adulthood (Moster, Lie, & Markestad, 2008). Preterm births costs in the US $26 billion per year (Institute of Medicine, 2007). If providing legal authorization to live and work in the US improves health outcomes for children of immigrants beginning at birth, providing even temporary legal status to the 10.8 million undocumented immigrants in the US (Warren, New York, NY) could have huge potential long-term cost savings. Alternately, removing TPS protections for almost half a million current TPS holders could result in worse health and long-term costs for their future children.

Methods

Data will come from restricted-use 2007–2015 birth record data, obtained from the National Center for Health Statistics. Birth record data is nationally-representative, as it captures the entire population of births occurring in the 50 states and DC. Data are cross-sectional, with all items measured at the time of birth.

The sample will be 93,426 infants born to Haitian mothers. I will examine whether birth outcomes were better for Haitian-born mothers whose pregnancies occurred after January 2010, compared to Haitian mothers who gave birth prior to January 2010. Because the data do not include information about whether any given mother actually has TPS, this is an intent-to-treat analysis: Did TPS lead to improve birth outcomes among the total population of potentially-eligible mothers?

The comparison group will be foreign-born mothers from countries that are not eligible for TPS. Synthetic control methods will be used to construct a weighted comparison group that is similar to Haitian mothers on major demographic, socioeconomic, and pregnancy-related variables, as well as current state of residence at the time of birth. The use of synthetic control to construct a more equivalent control group is an important methodological advance over previous studies of immigration policy impacts. Similar to traditional difference-in-difference methods, I will examine whether there are changes in birth outcomes for Haitian-born mothers after January 2010, compared to the synthetic control group of foreign-born mothers who are unaffected by TPS.

The outcomes will be prenatal care utilization (measured using the modified Adequacy of Prenatal Care Utilization index (VanderWeele, Lantos, Siddique, & Lauderdale, 2009)), preterm birth (a 6 category variable: early preterm, late preterm, early term, full term, late term, post-term), and small for gestational age (defined as below the 10th percentile based on gestational age (Oken, Kleinman, Rich-Edwards, & Gillman, 2003)).

Individual-level covariates will include mother's age, education, marital status, tobacco use during pregnancy, parity, and pregnancy-related health conditions (e.g., gestational diabetes); infant sex; and whether the mother received WIC or Medicaid/CHIP during the pregnancy. Because Haitian immigrants are primarily clustered in a few states, I will control for state-level health policies (e.g., whether the state provides Medicaid coverage for undocumented pregnant women), and models will include state and time fixed effects. Standard errors will be clustered by state of residence.

The main limitation of this analysis is that birth record data includes a limited range of covariates. While I can identify foreign-born mothers, I do not have information about their citizenship or legal status. Our sample of Haitian-born mothers will include citizens, legal permanent residents, TPS recipients, and undocumented immigrants. Because I will be estimating the effect of the TPS policy on all Haitian mothers regardless of legal status,my analysis will underestimate the true impacts of the policy on TPS recipients.

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