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(In)Secure Communities: Assessing the Impacts of Secure Communities on Immigrant Participation in Los Angeles Health Clinics

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(IN)SECURE COMMUNITIES

ASSESSING THE IMPACTS OF SECURE COMMUNITIES ON IMMIGRANT PARTICIPATION IN LOS ANGELES HEALTH CLINICS

by

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Table of Contents

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Abstract

The United States Department of Homeland Security launched Secure Communities in 2009, expanding Immigration and Customs Enforcement's (ICE) jurisdiction and establishing partnerships between federal immigration officers and municipal law enforcement agencies (LEAs) across the country. The effects of Secure Communities have been numerous. While rates of deportations had been rising annually for decades, the program granted ICE with even more power to detain and deport undocumented immigrants and dramatically increased federal collaboration with LEAs. Secure Communities was terminated by then Secretary of Homeland Security Jeh Johnson in 2014; replaced by the comparable, but lesser known, Priority Enforcement Program (PEP); and reinstated in January of 2017 immediately following the inauguration of Donald Trump. This thesis focuses on the greater implications Secure Communities has on immigrant sense of safety and more generally on public health. As anti-immigrant rhetoric and fear of deportations are on the rise, there have been noticeable disengagements of immigrant populations from public services. I investigate the impacts of Trump's anti-immigrant platform in 2016 and reinstatement of Secure Communities in 2017 on how immigrant communities in South Central Los Angeles make use of health clinics.

Chapter 1: Introduction

A. Prologue

I have been fortunate to have taken several classes and completed three internships that have inspired my interest in the research question and have offered me access to what have become my methodologies in answering it. My first formal exposure to matters of immigration proceedings and the intense daily experiences of undocumented individuals came both from a class titled "Towards Economic Dignity in the Real World" at Scripps as well as an internship at the Koreatown Immigrant Workers Alliance. The course, instructed by Professor Tom Kim, focused on methods of organizing and immigrant-worker struggles throughout Los Angeles recent history. In addition to weekly readings and class discussions, the five students in the course spent every Friday volunteering at the Koreatown Immigrant Workers Alliance (KIWA) in Los Angeles. While much of the class material and work at the center focused on worker rights and justice for low-income families in the area, I quickly became familiar with the intersection of these issues with those of immigrant rights and contemporary struggles faced by undocumented populations in Southern California.

I was able to continue my time with KIWA the following summer and the next school year as a public health intern for the organization. In addition to my work on a number of different projects, I spent significant time canvassing for DACA and for a toxic lead eradication program through the County Public Health Department. I became close with many of the members of the center and had seemingly endless opportunities to hear about their experiences with workplace injustices, the relentless fear many lived with in response to intensifying immigration enforcement, and their challenges in accessing basic health services. My visits to hundreds of homes and other dwellings across Los Angeles offered a glimpse into the inhumane

conditions under which many low-income immigrants live in the United States, and as a student interested in public health, I constantly thought about health implications of these situations. This internship was crucial in my early understandings of the barriers to increasing access to health care as well as the immediate need for direct public services for marginalized people.

My participation in a Medical Anthropology class during the spring of my sophomore year greatly contributed to my academic and theoretical knowledge of the fundamental causes of health disparities and the impacts of institutionalized structures that prevent access to adequate medical care from case studies around the world. Professor Mahdavi helped inspire an interest in taking on the root causes to reduce these problems. During the spring of my junior year, I took a class called The Power Elite with Professor Nancy Neiman Auerbach. While the course did not directly focus on medicine or immigration, I was able to focus my final research project on the intersection of health outcomes and worker/immigrant rights through an analysis of the policies around and incidents of lead poisoning in Los Angeles. This was my first thorough look into the impacts of particular legislation on marginalized communities. My research findings indicated strong correlations between immigrant status and rates of lead poisoning for a variety of reasons, some of which had to do with particular policies that systematically denied access to health care for undocumented individuals and others that privileged wealthy white communities in eradication programs. Overall, the thorough investigation into conditions faced by certain immigrant populations and implications on health outcomes built on understandings from prior experiences and continued to motivate me to pursue a career in combatting these far-reaching public health challenges.

I spent the summer of 2017 in Boston as a Political Organizing intern for the Service Employees International Union (SEIU), specifically Local 32BJ. SEIU is the second largest labor

union in the country with significant political clout in local elections and policy measures and with a significant immigration population comprising its membership. One of my principal responsibilities with the union was in representing the union on a Safe Communities campaign in Everett, Massachusetts; a city just north of Boston. The campaign centered on passing a Safe Communities ordinance for the city that would prohibit direct collaboration between local law enforcement and federal Immigration and Customs Enforcement agents, in addition to a few other immigration-related provisions. The impetus for the ordinance came from the considerable immigrant population in Everett (over 40% and quickly rising), Trump's reinstatement of Secure Communities in January of 2017, and the deportation of a high school senior in March who had been stopped by police on the way home from school and asked for his papers.[1] I was soon able to take on a leadership role in the campaign and spent much of the summer working on the draft of the ordinance, speaking with 32BJ worker members and various people in the Everett community about issues of immigrant rights and public safety, organizing meetings with City Council members to request their support, and conducting extensive research on the effects of Secure Communities on immigrant populations.

What became most important for me in my internship with 32BJ SEIU was in speaking with Dr. Elisabeth Poorman of the Community Health Alliance in Everett. Dr. Poorman became a critical member of the campaign whose advocacy for a sanctuary policy to counter the ICE-local partnerships forged under Secure Communities was crucial in advancing the ordinance and organizing elected officials to our side. My conversations with Dr. Poorman were some of the first that helped me see the implications of strict immigration enforcement on public health. Her article on the importance of the Massachusetts Safe Communities Act was published in WBUR,

[1] "Safe Communities Ordinance," Everett Safe Communities Coalition.

Boston's NPR station, shortly after we were introduced for the first time. The article describes not only the decrease in number of Latino immigrants who have come to her health clinic over the past several years, but also of the countless instances in which those who do dare make use of the health center then refuse to report incidents of domestic assault or rape for fear of having their immigration status reported to government officials.[2] Dr. Poorman strongly advocates for the Safe Communities Act to counter legislation such as Secure Communities because of the fear she sees in her immigrant patients, whose health is declining, and whose options seem limited when she herself does not know who they can trust in their search for public assistance. I have spoken with Dr. Poorman about my thesis topic since my internship this past summer and continued my conversations with her throughout the fall and spring to build on my research and direct my findings.

Upon returning to college during the fall of 2017, I became involved with a similar sanctuary ordinance in the City of Pomona. This campaign offered me opportunities to speak with immigrants in Pomona, police officers, government officials, and other public service providers, all about the need for a citywide sanctuary ordinance. While I will not be able to include these conversations from undocumented immigrants about their experiences with access to health care in my thesis due to Institutional Review Board (IRB) restrictions, I was able to obtain information and anecdotes about fears of deportations and decreased usage of health centers amongst Latino immigrants from my work in the campaign. This involvement also granted me access to health providers from various clinics across Los Angeles County who similarly became supporters of the campaign. I built on these connections and findings

[2] Elisabeth Poorman, "Gov. Baker, If You Met My Immigrant Patients, You'd Support 'Safe Communities Act.'"

throughout the research stage of my thesis and incorporated interviews I had with these health providers later on in my findings.

B. Introduction to the Problem

The politics of health care and immigration have converged over the last several decades to emerge as some of the most pressing issues in United States public policy. Despite the growing interconnectedness of immigration and health, there exist significant disputes about how to address such large-scale challenges. While many concur that the immigrant population in the U.S. as a whole, particularly those who are undocumented, suffer from worse health outcomes than do U.S.-born residents, the root causes behind these inequities and their proposed resolutions have become increasingly contentious matters on the local, state, and national scale.[3]

One common objective amongst those who believe that immigrants should have the basic human right to health care, even when living in the country without legal documentation, is to expand general access to public health services across communities. For undocumented immigrants, however, these services can persist as unobtainable for a variety of reasons, primarily due to the fear that medical care providers and others in city government will report immigrant status of patients to federal authorities.[4] Others worry that they will be stopped on the way to a clinic and are less likely to leave their place of residence for any reason, further disengaging from the polity. These are legitimate concerns that undocumented immigrants have harbored for decades and have only increased over recent years in response to national

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[3] James Quesada, "Special Issue Part II: Illegalization and Embodied Vulnerability in Health," *Social Science & Medicine*, Part Special Issue: Migration, "illegality", and health: Mapping embodied vulnerability and debating health-related deservingness, 74, no. 6 (March 1, 2012): 894–96.

[4] Karen Hacker et al., "The Impact of Immigration and Customs Enforcement on Immigrant Health: Perceptions of Immigrants in Everett, Massachusetts, USA," 588.

legislation that has strengthened relationships between local law enforcement officers and federal Immigration and Custom Enforcement (ICE) agents.

One law in particular, Secure Communities, has expanded Immigration and Custom Enforcement's (ICE) workforce, forged new partnerships between city and state law enforcement and federal immigration agents, and systematically reported the digital fingerprint scans of prisoners to ICE.[5] It also allows ICE to detain suspected undocumented immigrants for extended periods of time, beyond what is mandated for petty crimes, for the purposes of federal agents being able to investigate people further and increase the deportation rates of undocumented immigrants. This program clearly created cultures of fear and isolation within immigrant populations, not only for those who are undocumented, but also for anyone with close friends or family at risk of being deported. These fears have only increased under Trump's presidency, as his rhetoric and reinstatement of tough customs enforcement policies have pushed immigrant families further into the shadows to avoid contact with governmental agencies. I am interested in how Secure Communities has impacted the usage of community health services, primarily amongst Latino immigrants in South Central Los Angeles.

C. Recent History of Immigration, Deportation Legislation, and Health Care for Immigrants in the U.S.

The number of immigrant detentions and deportations has peaked over the past ten years under President Barack Obama and now President Donald Trump (Figure 1). While these rates have followed an upward trend for decades, high levels of immigrant detentions and deportations by federal immigration enforcement agents is certainly not a new phenomenon. It has become increasingly clear that these rates do not necessarily fluctuate under changes in Presidential

[5] "Secure Communities: A Fact Sheet," American Immigration Council.

administrations, as Republican and Democratic administrations alike have perpetuated the upward trend and have passed legislation legitimizing and streamlining deportation procedures.[6]

Many of the initial immigration enforcement policies born out of the early 1980s came in response to a number of international and domestic events, namely the intensifying conflict in several Latin American countries; a wave of asylum-seekers from these nations; and various federated policies implemented in attempt to curb the influx of undocumented migrants.[7] A few pro-immigrant policies and the Sanctuary Movement attempted to fill gaps left by the Refugee Act of 1980, when 97% of Salvadorans and 98% of Guatemalans were denied asylum by the Immigration and Naturalization Service (INS).[8] These were countered by much stronger and institutionalized legislation such as the Immigration Reform and Control Act (IRCA) signed into law by President Ronald Reagan in 1986. While the act did grant asylum for approximately three million undocumented people living in the United States at the time, IRCA, and particularly the MacKay Amendment of the act, intended to "increase border securities and establish penalties for employers who hired unauthorized immigrants."[9] This was one of the first of many laws that have since strengthened the power and jurisdiction of federal immigration enforcement agents and have created additional barriers for judges to use discretion to block deportation procedures.[10]

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[6] "The Growth of the U.S. Deportation Machine: More Immigrants Are Being 'Removed' from the United States than Ever Before."
[7] Scott D. Rhodes et al., "The Impact of Local Immigration Enforcement Policies on the Health of Immigrant Hispanics/Latinos in the United States," 105.
[8] Corrie Bilke, "Divided We Stand, United We Fall: A Public Policy Analysis of Sanctuary Cities' Role in the Illegal Immigration Debate," 179.
[9] Muzaffar Chishti, Doris Meissner, and Claire Bergeron, "At Its 25th Anniversary, IRCA's Legacy Lives On."
[10] "The Growth of the U.S. Deportation Machine."

The next corresponding and impactful piece of legislation was Section 287(g) of the 1996 Immigration and Nationality Act, which further removed securities for immigrants living without documentation in the United States by allowing INS to establish agreements with local law enforcement agents. Jurisdictions across the country suddenly permitted INS and then ICE to open offices in county and state jails, providing direct contact for immigration enforcement procedures in prisons.[11] That same year, Section 632 of the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) reduced protections of immigrant status by mandating that medical officials report documentation status to federal authorities upon request, and Section 434 of the 1996 Welfare Reform Act removed federal funding for preventative health services for all undocumented immigrants.[12] This left those without legal documentation to rely on emergency services for their primary source of health care.[13] These policies, in coordination with related pieces of legislation and the continued increase in the number of undocumented immigrants entering the U.S. every year, resulted in a large percentage of uninsured people without access to preventative health services.

Rates of detentions and deportations continued to increase sharply after 1996 and the establishment of Immigration and Customs Enforcement (ICE) by the U.S. Department of Homeland Security in 2003, an agency that would soon become the second largest organization dedicated to the enforcement of criminal arrests and removals in the United States.[14] While

[11] Rhodes et al., "The Impact of Local Immigration Enforcement Policies on the Health of Immigrant Hispanics/Latinos in the United States." 329.
[12] "Illegal Immigration Reform and Immigrant Responsibility Act of 1996," House of Representatives.
[13] Park, "Substantial Barriers in Illegal Immigrant Access to Publicly-Funded Health Care: Reasons and Recommendations for Change," 570.
[14] "History of ICE," Immigration and Customs Enforcement.

annual "removals," or deportations, remained under 100,000 every year prior to 1996, by 1997 there were over 144,000 and by 2004, 241,000 immigrants were deported.[15]

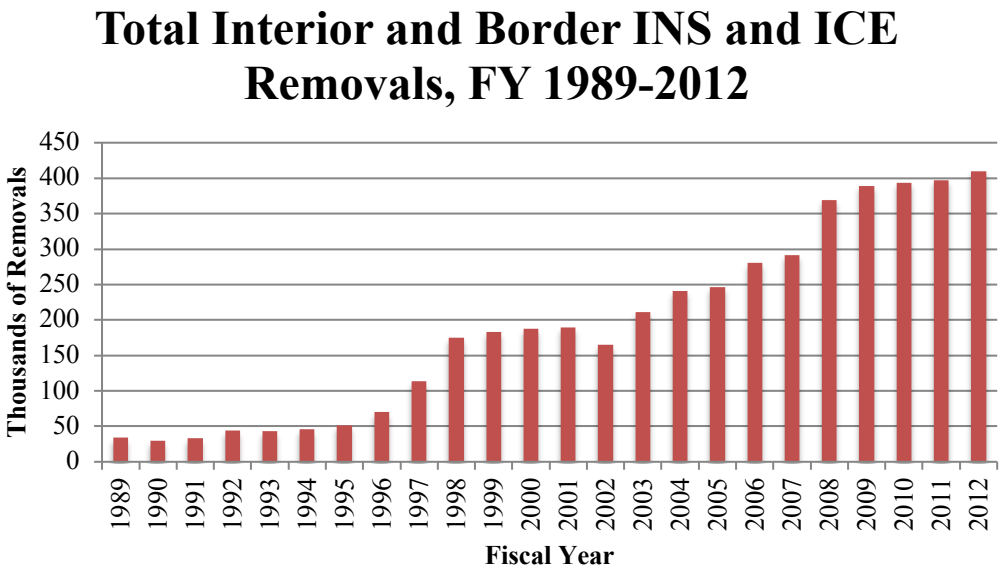

Figure 1. Number of total Immigration and Custom Enforcement removals from both the interior as well as the border, as measured from fiscal years 1989 through 2012.[16]

As depicted in Figure 1, there were a few periods of major increases in the removals of undocumented immigrants. The first was immediately following the 1996 Welfare Reform Act, when Immigration and Naturalization Service (INS) took on a more active role in identifying and deporting individuals. Between 1996 and 1998, there was a 250% increase in the number of total deportations. The next notable increase was in 2008, when Secure Communities was launched. There was a 130% increase in removals between 2007 and 2008, and these numbers continued to rise throughout the rest of Barack Obama's presidency.[17]

[15] "Interior Immigration Enforcement by the Numbers," Bipartisan Policy Publisher.
[16] "Interior Immigration Enforcement by the Numbers."
[17] Ibid.

D. Secure Communities and the Priority Enforcement Program

Secure Communities (in effect 2008-2014; replaced by the Priority Enforcement Program, or PEP, from 2014-2017; and reinstated January 2017) establishes and centralizes a "federal information-sharing partnership between the Department of Homeland Security (DHS) and the Federal Bureau of Investigation (FBI)." This partnership takes a variety of forms, but its principal procedural method as publicized on the Department of Homeland Security ICE website creates a biometric database that relies on fingerprint scans taken at local law enforcement agencies (LEAs) that are then sent to the DHS.[18] These fingerprints are next run through DHS records in search of matches with those of individuals known to be living in the United States illegally or are "otherwise removable." ICE's online description of the Secure Communities policy does not detail what other factors would make an individual "otherwise removable," only that the act prioritizes the detention and deportation of those who threaten public safety and those who have "violated the nation's immigration laws."[19] Once these individuals have been identified, ICE can call on local law enforcement to place detainers on targeted suspects for up to forty-eight hours beyond the original detention date. According to ICE, "The highest priority of any law enforcement agency is to protect the safety and security of the communities it serves."[20] The program's stated focus on public security and safety helped grow support in 2008 and has continued to give Secure Communities credibility amongst anti-immigrant advocates.

Since the initial enactment of Secure Communities in 2008, the U.S. Department of Homeland Security has expanded the ICE budget from $4,696,932,000 in 2007[21] to

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[18] "Secure Communities - ICE Overview," US Immigration and Customs Enforcement.
[19] "Secure Communities - ICE Overview."
[20] Ibid.
[21] "U.S. Department of Homeland Security FY 2007 Budget-In-Brief," US Dept. of Homeland Security.

$6,230,206,000 in 2017.[22] It is unclear what percentage of that budget went to the implementation and enforcement of Secure Communities, but as a program operating under ICE, funding for the program likely grew from 2008 through 2017 alongside the 32.6% increase in the Immigration and Customs Enforcement budget in that time period. The number of ICE employees now exceeds 20,000 in all fifty states.[23] Since its enactment nine years ago, Secure Communities has expanded from its original fourteen jurisdictions (local, county, and state prisons) in 2008, to 1,210 jurisdictions in 2011, and reached all 3,141 jurisdictions in the United States by January 22 of 2013 (Figure 2).[24] ICE deported over 1.5 million individuals from the interior as well as the border from 2008 to 2011. By the end of 2013, that number grew to over 2.3 million total interior and border deportations through tightened border security, drastic increases in employed agents, and other measures implemented by Secure Communities.[25]

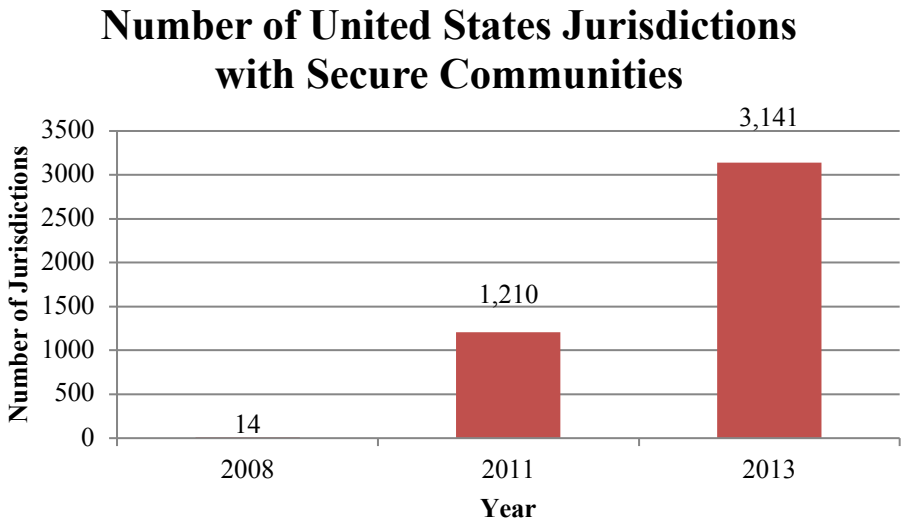

Figure 2. Number of total jurisdictions (local, state, and county prisons) in the United States that have implemented Secure Communities, as recorded in 2008, 2011, and 2013. By 2013, all 3,141 jurisdictions in the United States took part in Secure Communities.[26]

[22] Jeh Johnson, "U.S. Department of Homeland Security FY 2017 Budget-In-Brief."
[23] "History of ICE."
[24] "Secure Communities."
[25] "Secure Communities."
[26] "Secure Communities - ICE Overview."

Secure Communities was terminated in early 2014 by then Secretary of Homeland Security Jeh Johnson and replaced on the same day with the Priority Enforcement Program (PEP or PEP-Comm), a nearly identical policy that continued to detain and deport record numbers of undocumented immigrants through ICE-local partnerships under the U.S. Department of Homeland Security's auspices of a "fresh start and new program."[27] PEP remained in place until Donald Trump's inauguration in January of 2017, at which time he immediately reinstated Secure Communities with the same following priorities:

Priority 1 (prioritized for removal) includes noncitizens that meet one or more of the following criteria:

- **1(a):** national security threat
- **1(b):** apprehended immediately at the border
- **1(c):** gang member
- **1(d):** convicted of an offense classified as a felony in the state or local jurisdiction, other than one related to immigration status
- **1(e):** convicted of a felony or aggravated felony as defined by immigration law.

Priority 2 (subject to removal) includes noncitizens that meet one or more of the following criteria:

- **2(a):** convicted of three or more misdemeanors
- **2(b):** convicted of a serious misdemeanor. Serious misdemeanors are defined as offenses involving domestic violence, sexual abuse or exploitation, burglary, unlawful possession or use of a firearm, drug distribution or trafficking, driving under the influence, and other crimes in which a defendant was sentenced to actual custody of 90 days or more.
- **2(c):** entered the United States unlawfully after July 1, 2014
- **2(d):** significantly abused visas or visa waiver programs

Priority 3 (generally subject to removal) includes noncitizens subject to a final order of removal issued on or after January 1, 2014.

As of April 2018, the second iteration of Secure Communities has deported over 363,400 immigrants from the interior and border since its re-enactment on January 25, 2017.[28] The number of interior arrests and deportations alone continues to rise as well. According to ICE's website:

> The FY2017 statistics clearly demonstrate ICE's continued commitment to identifying, arresting, and removing aliens who are in violation of U.S. law, particularly those posing a public safety or national security threat, while restoring fidelity to the rule of law. In FY2017, ICE conducted 143,470 interior administrative arrests, which is the highest number of administrative arrests over the past three fiscal years.[29]

Figure 3 demonstrates the number of interior removals for fiscal years 2015, 2016, and 2017. Rather than the total removals, these are the removals that are made following arrests of "illegal aliens" identified by ICE, not including those stopped and deported at the border. As described on ICE's federal website, "the proportion of removals resulting from [interior] ICE arrests increased from 65,332, or 27 percent of total removals in FY2016 to 81,603, or 36 percent of total removals, in FY2017."[30]

[28] "Secure Communities - ICE Overview."
[29] "Fiscal Year 2017 ICE Enforcement and Removal Operations Report," U.S. Immigrations and Customs Enforcement.
[30] "Fiscal Year 2017 ICE Enforcement and Removal Operations Report."

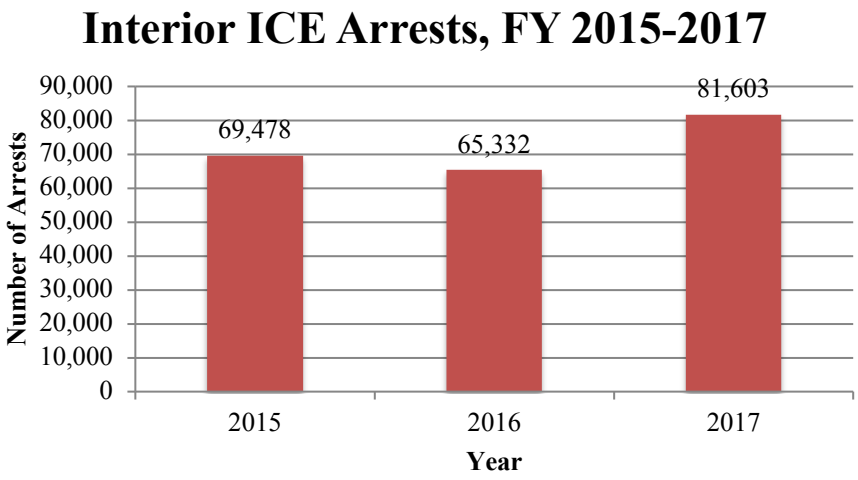

Figure 3. Number of total interior arrests made by ICE from fiscal years 2015 to 2017.[31]

E. Research Question

The implementation of Secure Communities under Barack Obama's presidential administration preceded significant expansions in the number of employed Immigration and Custom Enforcement officers, stronger connections between local law enforcement and federal immigration agencies, and an overall intensification of the surveillance of immigrant communities. Despite the revocation of Secure Communities by Secretary Jeh Johnson in 2014, little changed under the Priority Enforcement Program (PEP) that succeeded it. Immigrant populations have been weathering the observable affects of the two nearly-identical programs for almost a decade now, but based on both quantitative and qualitative data on the issue, some of the most dramatic impacts were felt in November of 2016 when Trump was elected and in January of 2017 when he declared the immediate reinstatement of Secure Communities. Trump's explicitly anti-immigrant campaign platform and his Executive Orders early on in his presidency illustrate his intentions in bringing back the program. Unlike the ways in which Secretary Jeh

[31] "Fiscal Year 2017 ICE Enforcement and Removal Operations Report."

Johnson implemented the program, Trump reestablished Secure Communities and other strict immigration policies that accompanied it alongside relentless anti-immigrant rhetoric, stated commitments to deport those who do not belong, a shift away from focusing only on undocumented criminals, and the promise to build a wall. As stated by then director of Immigration and Customs Enforcement, Thomas Homan, on December 5, 2017, "if you're in this country illegally, we're looking for you and we're going to look to apprehend you." When asked about that statement a month later, Homan replied, "I will never back down on those words."[32] In a speech to supporters weeks before his election in November of 2016, Trump emphasized his commitment to conservative immigration policies and told the crowd his top priorities if (and when) elected President. "Number one. Are you ready? Are you ready. We will build a great wall along the Southern Border. *Pause for overwhelming applause and chants of "Build the wall!"* And Mexico will pay for the wall. 100 percent. They don't know it yet, but they're going to pay for the wall." He continued to detail the aspects of the wall that he is most proud of, including use of "the best technology, above and below ground sensors," to "find and dislocate criminals."

> We will end catch and release. You catch them, you release them. You catch them, ok you release them. I will put an end to that. Under my administration, anyone who illegally crosses the border will be detained until they are removed out of our country and back to the country from which they came.[33]

These promises and others made by the President and others in his Administration have made the threat of deportation under Secure Communities far more dire for vulnerable populations. I spoke with health providers about trends they observed during the first few years

[32] Roque Planas, "ICE Chief Will 'Never Back Down' From Telling Undocumented Immigrants To Be Afraid," *Huffington Post*, February 1, 2018.
[33] Stephen Collinson and Jeremy Diamond, "Trump on Immigration: No Amnesty, No Pivot," CNN, September 1, 2016.

of Secure Communities and consulted data for this time period, but I chose to analyze more specifically the impacts of the program following Trump's election in November of 2016, when he made clear his position on immigration, as well as the months following the program's reinstatement in January of 2017. Not only are the statistics on deportations and increases in detention rates under the program important for understanding trends I observed, but similarly impactful is the perceived threat of deportation that has become so pervasive in various immigrant communities. So long as undocumented individuals and their friends and families believe they are being surveyed and are increasingly vulnerable, the policy accomplishes Trump's and ICE's intentions and can influence how these populations interact with the polity. I investigate these impacts with a particular focus on how augmented fears have affected immigrant use of public health clinics following Trump's election and the reinstatement of Secure Communities.

The next section of this thesis includes a Literature Review of prominent authors and theorists of immigration policy and trends in usage of social services. I introduce scholars on opposing sides of the issue and flesh out their arguments for and against Secure Communities to provide more context for my research question and findings. I also include a brief review of questions of legality and citizenship to frame the impacts stricter immigration policies have on how immigrant communities relate to their surroundings and conceptualize perceived risks. I then use these theories in my discussion of my research methods, which rely on qualitative data through interviews with health providers at seven community clinics in Los Angeles, as well as quantitative data from a national report on all Federally Qualified Health Clinics in the United States. My analysis is based largely on a case study of patterns of immigrant usage of health clinics in and around South Central, a region of Los Angeles home to a higher percentage of

foreign-born residents than many other parts of the city. After tying together my findings from both the interviews as well as the statistical data, I make conclusions about the overall effects Secure Communities has had on how immigrants use medical services and I end with a policy proposal to revoke the program in the interest of improving the quality of and expanding access to public health for all.

Chapter 2: Literature Review

Two major theories exist regarding the effectiveness of increased immigration enforcement and the rise in deportation rates, particularly in respect to their impacts on safety and on public health. One is generally perceived as the more progressive pro-immigrant perspective, and is comprised of those who disparage Secure Communities not only because of the hundreds of thousands of individuals deported through the program but also because of the fear it instills in the millions of undocumented immigrants living in the United States. Many categorize these perspectives as those that describe the "chilling" effect anti-immigrant rhetoric has on how immigrants make use of public resources, with a focus on health services. Particular scholarly work addressing the implications of this fear has focused on its negative effect on immigrant use of public services and access to health care.

The second theory is primarily contextualized as the more conservative anti-immigrant response from those who argue "illegal aliens" pose threats to the safety of our communities and act as drains on public resources.[34] This perspective counters my hypothesis: that Secure Communities has resulted in an increase both in deportations as well as in fear of deportations to

[34] Bilke, "Divided We Stand, United We Fall: A Public Policy Analysis of Sanctuary Cities' Role in the Illegal Immigration Debate," 178.

the extent that immigrants stop using public services to avoid contact with government officials and to limit opportunities in which they might expose immigration status. On the contrary, advocates of stricter immigration enforcement argue that the resources undocumented immigrants use draw from those of tax-paying citizens, despite the fact that even those who are undocumented pay income, sales, property, and other taxes.

There exist other prominent theories on immigration reform and the psychological impact of rising deportation rates, but I choose to review those that specifically had a focus on the impacts these fears have on health and access to medical care. While issues of immigrant rights and health care intersect, many authors differ in prioritizing the analysis of one over another. It is also worth noting that since Secure Communities was enacted in 2008 and formally launched in 2009, comparisons of Latino participation in local health clinics from before the act and now are at times challenging to access, as I draw from records and observations of health professionals over the past decade. Additionally, due to the relative newness of these policies and the frequent changes they undergo, I have yet to come across one or two highly prevalent authors who operate under an agreed upon school of thought about the impacts specifically of Secure Communities on health clinic usage. Instead, I introduce journal articles that I perceived as the most relevant to my research question, assessed the common methods and ideologies woven throughout, and finally categorized the contributions of each author into distinct theoretical approaches that pertain to how sanctuary policies influence participation of undocumented immigrants in local health services.

Finally, I draw from authors Aviva Chomsky and Monica Varsanyi to challenge how citizenship and legality are conceptualized in the United States with a particular critique of the prejudicial treatment endured by certain immigrant groups and not others. Chomsky and

Varsanyi contribute to an understanding of the complex history of immigration in the U.S., tying together the dominant social attitudes and policies of the past to explain patterns of migration and the current legal structure surrounding the issue that we see today. My review of these two scholars concludes with a discussion of how constructions of legality influences how various immigrant populations make use of health and social services.

A. The "chilling" effect on immigrant use of public services

Many authors speak of the "chilling" effect, or the phenomenon in which immigrants (particularly those without documentation or who have close family members without legal status) stop using public assistance programs for fear of their status being reported to federal enforcement authorities.[35] Scholars operating under this theory argue against partnerships between local law enforcement and federal immigration agencies, such as those codified under Secure Communities, in order to assuage fears undocumented patients might have about using public health services.

A number of studies support this trend and are used by social and political scientists such as Jacob Beniflah and Leo Chavez. Beniflah reviewed three independent variables to assess the utilization of the pediatric emergency department (PED) by immigrants before and after the Georgia House Bill 87 (HB87) was passed in 2011, and reported his investigation in "The Effects of Immigration Enforcement Legislation on Hispanic Pediatric Patient Visits to the Pediatric Emergency Department." These three variables measured over a two-year period included the number of Latino patients who visited the PED in a two-year period, the percentage of cases of these patients who were high acuity, and the number of these patients admitted to

[35] Anahí Viladrich, "Beyond Welfare Reform: Reframing Undocumented Immigrants' Entitlement to Health Care in the United States, a Critical Review," 822.

hospitals in and around the Atlanta area.[36] The study found that of all ethnic groups analyzed for these three independent variables before and after implementation of HB87 in 2011, Latinos were the only ones to report an overall decrease in number of visits to the PED and an overall increase in the percentage of high acuity cases.[37] Beniflah acknowledged that his assumptions relied on Latino patients representing the experiences of immigrants, which is not a fair or accurate conflation, but he also explains his methodology by contending it is the closest way to conduct studies because of the high degree of sensitivity required when investigating undocumented populations. Ultimately, he concludes that tighter immigration enforcement and recent legislation allowing for ICE expansion into local jurisdictions has led to fewer visits to doctors by immigrants and generally adverse health effects.[38]

Leo Chavez echoes this sentiment in discussing the results of his 2011 study on "Undocumented immigrants and their use of medical services in Orange County, California." Similar to Beniflah, Chavez assesses the use of public health programs by the immigrant population following influential anti-immigrant legislation. Chavez conducted a survey of 805 Latinos and 396 white people for four weeks in 2006, and then used a logistic regression model and binary to analyze immigrant use of medical services.[39] According to Chavez' findings, undocumented immigrants had lower incomes, were less likely to possess medical insurance, and had decreased rates of visits to medical services as compared to naturalized immigrants or U.S.-born individuals. Latinos (68.8%) were significantly less likely to have used public medical services over the past twelve months when compared to white people (89.3%) ($P<0.001$). More

[36] Jacob D. Beniflah et al., "Effects of Immigration Enforcement Legislation on Hispanic Pediatric Patient Visits to the Pediatric Emergency Department," 1122.
[37] Beniflah et al., 1125.
[38] Ibid, 1120.
[39] Leo R. Chavez, "Undocumented Immigrants and Their Use of Medical Services in Orange County, California," 890.

specifically, undocumented Latinos (54.8%) had significantly fewer trips to health services than other groups of Latinos (79.3%) ($P<0.001$).[40] Overall, citizens and legal immigrants were significantly more likely (72%) to make use of public medical care services than undocumented Latinos ($p<0.001$).[41] These results align with those of Beniflah and ultimately corroborate the proposed theory of the "chilling" effect that the fear of deportations and immigration enforcement legislation have on limiting undocumented immigrant participation in public health services.

Anahí Viladrich holistically addresses how the "chilling effect" impacts immigrant participation in health programs in "Beyond welfare reform: Reframing undocumented immigrants' entitlement to health care in the United States, a critical review." The author uses it to introduce a series of frames of advocacy against Secure Communities. She describes the "cost-saving" and "effortful immigrant" frames that pro-immigrant theorists use to highlight immigrant contribution to the United States, the first claiming that the economic consequences of poor health amongst immigrants will end up costing taxpayers more when they cannot make us of preventative medicine, and the second characterizing undocumented immigrants as "the ones that contribute the most but receive the least although they pay taxes, earn below-poverty incomes, and endure insalubrious working and living conditions."[42] Viladrich then discusses the "surveillance" frame that contends that sanctuary policies and greater access to health services will prevent the spread of communicable diseases and ensure a healthy future generation of

[40] Chavez, 891.
[41] Chavez, 892.
[42] Viladrich, "Beyond Welfare Reform," 824.

Americans.[43] I will review the remaining pro-immigrant articles using Viladrich's explanation of the chilling effect and her four frames of health care advocacy.

a) Cost-Saving Frame

As defined by Anahí Viladrich in "Beyond welfare reform," the cost-saving frame is used to advocate against Secure Communities by:

> …Stressing the fact that undocumented immigrants' poor health, in the medium and long-run, will have a negative spillover effect on the larger society with their ultimate need for emergency services mostly paid by tax dollars and non-reimbursable services.[44]

The solution to this ineffective distribution of resources, then, is to provide more preventive care options for undocumented who otherwise rely on emergency services. Jacob Beniflah provides statistical evidence regarding the intensification of high acuity cases amongst Latino patients in his study that expose the rising costs that will occur as strict immigration enforcement legislation deter undocumented members from making use of basic health programs. He found a significantly higher percentage of Latino patients categorized as high acuity (18.3% from 17.1%, $P<.01$) upon arriving at hospitals from the pre-HB87 to post-HB87 periods, as well as an increase in the number of Latino patients that were admitted to the intensive care unit or operating room across those same periods (10.2% from 8.7%, $P<.01$).[45] Beniflah measured these results against the same measurements from other marginalized ethnic groups and found that Latinos were the only ethnicity to have seen a decrease in either category from the pre-HB87 to post-HB87 periods.[46] Beniflah argues that this is clear evidence operating under the "cost-

[43] Viladrich, 824.
[44] Viladrich, 824.
[45] Beniflah et al., 1124.
[46] Beniflah et al., 1125.

saving" frame of the effect that under-utilization of preventative health services has on the U.S. economy as a whole, regardless of the ethical considerations.

Leo Chavez again confirms Beniflah's findings with his own study in Orange County, California, making use of the "cost-saving" frame of advocacy when he concludes that the per capita health expenditures from 1998-2005 were 55% lower amongst immigrants when compared to U.S.-born individuals.[47] Arguably more astounding was the fact that immigrants under the age of 18 had per capita expenditures that were 74% lower than those of U.S.-born minors.[48] These measurements occurred in the time period following the passage of some of the most significant legislation to affect immigrants in the United States, namely Section 434 of the Welfare Reform Act, Section 632 of the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA), and Section 287 of the Immigration and Nationality Act. All three of these were written into law in 1996. Chavez uses this evidence to nullify the stigmatization of undocumented immigrants as "'drains' on the health care system in public discourse."[49]

Finally, Seam Park echoes the economic accountability arguments made Beniflah and Chavez in his piece "Substantial Barriers in Illegal Immigrant Access to Publicly-Funded Health Care: Reasons and Recommendations for Change." This article offers a comprehensive overview of the impacts of recent anti-immigrant policies and deportations on the U.S. health care system, primarily employing the cost-saving, effortful, and surveillance frameworks to support his claims.[50] Without conducting a study of his own, Park reviews the findings of other prevalent experts in the field of immigration and public health to ultimately argue that terminating Secure

[47] Chavez, 888.
[48] Chavez, 888.
[49] Ibid, 892.
[50] Park, "Substantial Barriers in Illegal Immigrant Access to Publicly-Funded Health Care: Reasons and Recommendations for Change," 584.

Communities would be a step in alleviating the fears undocumented immigrants have of being detained and deported.[51]

b) Effortful Immigrant Frame

The framework of the "effortful immigrant" in Anahí Viladrich's critical review is one who has immigrated to the United States in search of work and freedom, toils away at low-wage hard labor, and ends up suffering far worse health outcomes due to inadequate living conditions, psychological oppression, and the lack of medical access.[52] Taking on a more anthropological rather than economic interpretation of the cost-saving argument, the effortful-immigrant frame describes the sociopolitical causes and effects of immigrants being portrayed as "drains" on public resources when they in fact under-utilize social services. While almost every author that I reviewed included this argument in some form, five in particular focused their inquiries around Viladrich's framework of the effortful immigrant and offered case studies with evidence to ultimately make recommendations based on this theory.

Carolyn Sargent contextualizes the forces that affect immigrant access to health care by describing it as a political matter that categorizes those who are included and those who are excluded from care, creating concepts of deservingness and entitlement amongst privileged populations and simultaneous internalized illegality across immigrant groups. According to Sargent in "'Deservingness' and the Politics of Health Care," these concepts and internalizations determine health risks and outcomes. The lived experiences of immigrants, particularly those who are undocumented, result in visceral understandings of deservingness and entitlement and

[51] Park, 588.
[52] Viladrich, 824.

can be used to distinguish the *de jure* from the *de facto* availability of resources.[53] Effectively summing up some of the arguments made by Beniflah, Chavez, and Park, Sargent describes how representations of immigrants as a drain on public services, in coordination with the "chilling" effect, result in recorded under-utilization of health services by immigrants. She operates under Viladrich's effortful immigrant frame to advocate for an anthropological perspective into the systems and structures of health care in the United States that "exclude, constrain, or facilitate access" for immigrants.[54] James Quesada contributes to this analysis by also using the term "deservingness" to describe how its socially produced implications force a sense of vulnerability upon immigrants that has widespread consequences. In "Illegalization and Embodied Vulnerability in Health," Quesada argues that this vulnerability inevitably experienced by immigrants manifests in how they are positioned in U.S. society, determining how they make decisions, interact with authorities, and ultimately participate in public programs. The intersection of other hazards and vulnerabilities that negatively affect immigrant health outcomes ingrain and perpetuate a subordinated status that imposes limited access to public services.[55]

Contributing to the various studies that provide concrete evidence of the effect enforcement legislation has on immigrant perceptions of risk and resulting under-utilization of health services are Scott Rhodes and Alexander Ortega, who used quantitative measurements of visits to doctor offices to evaluate impact of these policies. Rhodes investigated records of contact between Latinos and prenatal care facilities following the implementation of the Secure Communities act in 2011. Using interviews, hospital records, and conversations from six focus groups, Rhodes found that Latina women in six counties across North Carolina sought prenatal

[53] Carolyn Sargent, "Special Issue Part I: 'Deservingness' and the Politics of Health Care," 855.
[54] Viladrich, 857.
[55] Quesada, 895.

care later than did non-Latina women. The focus groups of Latina women he constructed to complement his research reported feeling distrustful of health care providers, and Rhodes concludes by suggesting intervention to build trust and ensure that medical providers do not compromise immigrant safety.[56]

Alexander Ortega's findings built upon those of Rhodes by offering another case study that measured the percentage of Mexican and other Latino immigrants who reported having consistent sources of care, the challenges in obtaining medical resources, and the number of visits to physicians over 2003 as a twelve-month period.[57] The study relied on responses from 42,044 participants in the 2003 California Health Interview Survey, broken down by ethnic groups and other factors such as income level, age, gender, etc. Ortega's results and conclusions operated under the effortful immigrant framework because they demonstrated that undocumented immigrants were less likely to have a reliable source of care (62.0%) as compared to other naturalized or Green Card-holding immigrants (90.5% and 84.1%, respectively), and far significantly less likely when compared to U.S.-born whites (92.5%).[58] His interviews also illuminated the greater challenges immigrants (particularly those without documentation) face in accessing health care. Finally, Ortega's results showed the significant difference in the average number of visits to physicians in the past year between undocumented Latinos (2.27) and whites (4.75)($P<.01$).[59] Ortega's comparison not only of undocumented Latinos to white people, but also of naturalized and U.S.-born Latinos, demonstrates that differences in status determine one's ability to access reliable and adequate health care. While Ortega did not explicitly recommend a

[56] Rhodes et al., "The Impact of Local Immigration Enforcement Policies on the Health of Immigrant Hispanics/Latinos in the United States." 332.
[57] Alexander N. Ortega et al., "Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos," 2354.
[58] Ortega et al., 2357.
[59] Ortega et al, 2357.

sanctuary policy to alleviate these disparities, he did conclude that the stigmatization of immigrants over-utilizing public resources is wholly inaccurate, arguing instead that their under-participation in health services has led to far worse outcomes.[60]

The fifth article I reviewed that fell under Viladrich's effortful immigrant theory was a comprehensive case study of "The impact of Immigration and Customs Enforcement on immigrant health: perceptions of immigrants in Everett, Massachusetts, USA," by Karen Hacker. The author used six focus groups made up of community members and organizations in Everett, Massachusetts that were involved in immigrant rights work. These groups engaged in conversations, completed surveys, and conducted interviews from February 2009 to February 2010. According to Hacker's research, four themes presented themselves as repeating concerns amongst the immigrants, clergy, medical professionals, and other community members that made up the six focus groups:[61]

	Four Themes Observed Amongst Everett Focus Groups
1	Fear of deportation
2	Perceptions of collaboration between local law enforcement and ICE, especially in regards to documentation required for insurance and health care
3	Concerns about documentation required for insurance and health care
4	Fear of deportation and its relationship to emotional well-being and health care compliance

In summarizing her findings, Hacker concluded that the City of Everett and other similar municipalities would need to re-establish the trust between the immigrant community and police to effect improved health outcomes. As argued by Hacker, the "police must clarify and possiby adjust their relationships with ICE in order to develop and maintain trust with immigrant

[60] Ortega et al., 2359.
[61] Hacker et al., "The Impact of Immigration and Customs Enforcement on Immigrant Health," 589.

communities."[62] Secure Communities was the primary piece of legislation that compromised the confidence in these relationships through the ICE-local partnerships.

Through case studies, observations, conversations, surveys, and other sources of data, similar theories put forth by five authors coincide with Viladrich's designation of the effortful immigrant as one frame of advocacy for immigrant rights to health care each came to some variation of the same conclusion. Sargent, Quesada, Rhodes, Ortega, and Hacker each suggested the implementation of local policies to clarify and at times establish non-collaboration between the police and ICE, using evidence of the "chilling" effect and immigrant contributions to the U.S. economy to defend their positions. Non-collaboration and sanctuary policies are only feasible with the termination of Secure Communities. This framework disproves the misconception that immigrants use more than their fair share of public resources, demonstrating instead how the immigrant population in the U.S. as a whole has been found to under-utilize these services.

c) Surveillance Frame

Grounded in an arguably racist philosophy, Anahí Viladrich's designation of the "surveillance" frame describes how some policymakers and other groups will advocate for improved health access for immigrants to prevent the spread of communicable diseases. She presents this as a concern of national security, or "a policing frame aimed at shielding insiders (meaning the U.S. native population) from foreign dangers."[63] Seam Park, amongst others, uses this frame to discuss the threat of foreign pathogens brought into the U.S. He invokes the argument that the majority of undocumented immigrants living in the United States have come

[62] Hacker et al., 593.
[63] Viladrich, 825.

from nations with high disease rates, so a lack of access to preventative care only increases the risk of the spread of communicable diseases for the greater U.S. society. He contends that these foreign pathogens, alongside other risk factors caused by poverty and inadequate living conditions, put the entire U.S. population at risk.[64] Paul Apostolidis speaks against these contentions in *Breaks in the Chain: What Immigrant Workers Can Teach America About Democracy*. He describes the stereotypical "dirty immigrant" images that are flashed across mainstream media in a misguided interest to "protect natural security."[65]

> Reports on rising pollution in the border region, in turn, complement these aspects of immigrant demonology in public discourse. They update historically entrenched concerns that Mexicans, riddled with diseases and lacking 'an essential aversion to thir own wastes,' are choking off the life-support system for the American nation by fouling its environment as they inundate the borderlands.[66]

Apostolidis continues to engage in counter arguments to dispel these harsh depictions of Mexican immigrants "riddled with diseases" and violence. These images, which dominate the political landscape around election season and other influential periods, play a role in the decisions lawmakers and the public make around immigration policy and border protection.

Finally, Jacob Beniflah raises a similar concern, noting that if we are already seeing an intensification of acuity amongst undocumented patients who now must rely on emergency treatment as their primary form of care, there must be a simultaneous rise in opportunity for communicable diseases to spread as well.[67] Importantly, as he indicates, this transmission would largely occur unregulated and outside of the traceable records of doctors' offices if

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[64] Park, 579.
[65] Paul Apostolidis, *Breaks in the Chain: What Immigrant Workers Can Teach America About Democracy* (Minneapolis: University of Minnesota Press, 2010), 68.
[66] Paul Apostolidis, 65.
[67] Park, 579.

undocumented immigrants have significantly lower participation rates in the public health care system.[68]

B. Ability of Secure Communities to Restrict Public Services to Documented Citizens

The opposing perspective that supports Secure Communities, when contextualized in public health, is primarily the argument that undocumented immigrants divert resources away from "American born" taxpayers and that the legislation makes it harder for police to do their job. While authors I have previously reviewed who argue against Secure Communities by offering evidence suggesting undocumented immigrants under-ulitilize available public resources, others such as Rose Villazor and Corrie Bilke counter the evidence with other statistics about immigrant expenditures. Villazor cites data from the U.S. Congressional Budget Office (CBO) that in "areas along the U.S.-Mexico border, state and local governments incurred nearly $190 million in healthcare costs in 2000 as a result of providing uncompensated medical care to undocumented migrants."[69] While this may be true, my research will explain how these costs are particular to a high-risk area in which immigrants risk their lives to cross a nation's border. The data drawn from this region skews other evidence of the total per capita expenditures of undocumented immigrants in the U.S. health care system being less than that of U.S.-born citizens.

Interestingly, those on both sides of the debate about Secure Communities reference issues of public safety and immigration reform. Authors such as Corrie Bilke contend that policies that allow local law enforcement to enter into agreements with ICE are necessary for

[68] Park, 584.
[69] Rose Cuison Villazor, "What Is a Sanctuary," 142.

police to effectively seek out criminals and keep communities safe.[70] This is the basis of the Secure Communities. However, as Bilke proposes, the solution is not in allowing local police to work freely with federal immigration authorities. He argues that additional funding should be allocated to ICE and to "invest additional resources in the federal immigration enforcement efforts currently in place."[71] He advocates for an expansion of the ICE labor force and an abolishment of the sanctuary policies that prevent enforcement agents from tracking indivduals who may be public menaces.

Bilke also offers evidence of the proposed withholdings of federal funds against jurisdictions that have claimed sanctuary status as a response to Secure Communities. He argues that these sanctions will hurt public programs, particularly health services, and will negatively impact the entire community. Bilke asserts that the marginal protections to immigrants that sanctuary jurisdictions offer are not worth the potential loss of funds.[72]

C. Citizenship and Legality

> The idea of citizenship is commonly invoked to convey a state of democratic belonging or inclusion, yet this inclusion is bounded and premised on a conception of a community that is bounded and exclusive. Citizenship as an ideal is understood to embody a commitment against subordination, but citizenship can also represent an axis of subordination itself (Bosniak 2006).[73]

Contemporary political discussions surrounding legality and immigration stem from historically produced social conceptions of who is legal and who is not. Citizenship, the classification given to those who were either born in the United States or who emigrated to the country and have in one way or another become legal members, functions as a system of

[70] Bilke, 190.
[71] Bilke, 192.
[72] Ibid, 178.
[73] Linda Bosniak, "Citizenship Denationalized," 478.

granting or denying rights. While citizens enjoy full rights in the United States, with exception to those currently or previously incarcerated, non-citizens do not. For those who have immigrated to the United States, being "legal" comes in a variety of forms, with some living in slightly more secure positions with permission to remain in the country as legal residents on their way to becoming citizens, others on the recently rescinded Deferred Action for Childhood Arrivals (DACA) or Temporary Protected Status (TPS) programs, and still more fear everyday that they may be deported back to their home country if they are caught without sufficient documents. Debate persists about the terms designated for groups of immigrants, and while many immigrant groups use "undocumented" to describe those here without full citizenship, some argue that "unauthorized" is more accurate, as it is often the case that immigrants will possess some documents to obtain jobs or receive government assistance, but that these documents are not always authorized.[74]

Historically, debates around citizenship have not always pertained to questions of who was born here and who was not, however. Issues of race and ethnic origins determined one's designation as either a citizen or non-citizen for much of the nation's founding, as those who were white were generally granted full rights and therefore citizenship, and those who were not, often African slaves or slaves of African descent, were denied these same rights and subsequently were not considered citizens.[75] However, once slavery was abolished, new waves of immigrant groups began entering the United States, and racial consciousness evolved, the white nationalists who had once argued that only whites could enjoy full rights soon shifted their

[74] Aviva Chomsky, *"They Take Our Jobs!" And 20 Other Myths About Immigration* (Beacon Press, 2007).
[75] Aviva Chomsky, *"They Take Our Jobs!" And 20 Other Myths About Immigration*, xiv.

focus to the restriction of immigration "when they were no longer able to legally discriminate based on race."[76]

> The Fourteenth Amendment of 1868 was the first to shift qualifications of citizenship from race to national origin. Beginning at this time, rights were ostensibly granted to "all persons born or naturalized in the United States," not including Native Americans, but broadening the former classification to include Blacks for the first time in the subsequent Naturalization Act of 1870.[77] Asians, on the other hand, were systematically denied citizenship for far longer, extending well into the twentieth century. From 1917 to 1952, the Immigration Act that colloquially became known as the "Asiatic Barred Zone" restricted immigration to certain countries and prohibited Asians from coming to the United States.[78]

The explicit link during the late nineteenth- and early twentieth-centuries between origin-based designations of citizenship and race is just as obvious today. The rights granted to citizens living in the United States are systematically and disproportionately denied from those emigrating from nations predominantly comprised of people of color, while those seeking to emigrate from white nations in Europe are far more likely to do so successfully, particularly under the proposed "merit-based" immigration plan backed by Mitt Romney and other high-profile GOP members.[79]

Aviva Chomsky, daughter of renowned political scientist and scholar Noam Chomsky, has dedicated significant scholarly work to questions of legality and immigration. Her book *Undocumented: How Immigration Became Illegal* discusses in depth the ways in which these designations of legal versus illegal immigrants have become subjective methods of maintaining the supremacy of light-skinned ethnic groups in the United States. Country quotas, the restriction of Mexican migrant workers to seasonal entry permits, and the explicit statements made against immigrants of color still today are described in juxtaposition to the pathways to citizenship

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[76] Grace Reckers, "Immigration, Labor Unions, and Political Campaigns: A Look Into SEIU's Involvement in the Immigrant Rights Movement."
[77] "14th Amendment to the U.S. Constitution," The Library of Congress.
[78] Reckers, 3.
[79] Lee Davidson, "Romney's Public Immigration Stand Calls for a New 'Merit-Based' System Favoring Those with Skills and Money," The Salt Lake Tribune, March 28, 2018.

offered to immigrants of European countries, demonstrate the ways in which particular ethnic groups are granted smooth entry, and therefore legality, while others are not. She challenges the false dichotomy that this nation is built on immigrants, with European immigrants entering the country "legally" and others more recently failing to abide by the rules. Chomsky counters the all too common defense that ancestor immigrants entered 'the right way,' unlike the large populations of Central American immigrants who have entered or attempted to enter the country, seeking asylum in the United States in just the same ways waves of European immigrants did a century ago.[80]

I had the opportunity to interview Aviva Chomsky and spoke with her about her work with immigrant workers and her scholarly texts that focus on legality and citizenship. Chomsky argues that the strategic and systematic creation of illegal groups of people and the disproportionate deportations of immigrants of color, predominantly Latinx immigrants, is a "highly racialized crime."[81] She believes that the United States has been complicit in constructing ideas of legality and citizenship based on race since the close of the Civil War, when the country began importing large quantities of low-wage workers from overseas to compensate for the labor vacuum created by the slave economy. Chomsky explained how the relationship between the U.S. and Mexico has long depended on a combination of strict immigration policies alongside temporary worker programs, such as that of the braceros, which systematically brought in millions of cheap Mexican migrant workers over a period of twenty-two years. These structures remain in place, as immigrants of color are routinely denied access,

[80] Aviva Chomsky, *Undocumented: How Immigration Became Illegal*.
[81] Aviva Chomsky, Interview with Aviva Chomsky, February 12, 2018.

yet their labor remains crucial in both the informal and formal aspects of our capitalist economy.[82,83]

Monica Varsanyi also speaks to the impacts these processes of legalization and citizenship have on how various immigrant groups interact with systems of governance, public programs, and their own immediate communities. Her book *The Paradox of Contemporary Immigrant Mobilization* delves into issues of belonging and exclusion, which she argues determine the ability of immigrant groups to become civically engaged members of society.[84] When people are deemed "illegal" and begin to conceptualize themselves that way, they are less likely to participate in the polity, often withdrawing from the public in certain ways both out of fear as well as out of feelings of "undeservingness," as characterized by Carolyn Sargent. It then becomes a matter of both anti-immigrant legislation as well as their corresponding actions that act as barriers to more social and political involvement. According to Varsanyi, immigrants can at times combat these pressures to disengage by proving themselves valuable aspects of their communities, taking part in local systems of governance and filling leadership roles, such as on school committees, community boards, and in town hall meetings. As I describe in my paper "Immigration, Labor Unions, and Political Campaigns," "undocumented immigrants have at times in history attempted to gain citizenship by first becoming active members of their communities and defining themselves as political and economic drivers."[85] As the process of citizenship and the vetting out of "unqualified" applicants partially depends on perceptions of how much immigrants will contribute to society, it can be advantageous for prospective citizens

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[82] "The Bracero Program," *UCLA Labor Center*.
[83] Chomsky, Interview with Aviva Chomsky.
[84] Monica W. Varsanyi, "The Paradox of Contemporary Immigrant Political Mobilization: Organized Labor, Undocumented Migrants, and Electoral Participation in Los Angeles."
[85] Reckers, "Immigration, Labor Unions, and Political Campaigns: A Look Into SEIU's Involvement in the Immigrant Rights Movement.""

to participate as much as they can in their local communities to prove that they will benefit the economy and will act as positive presences.

However, herein lies the problem when these same immigrants who are trying to become legal citizens harbor legitimate fears that their participation in society will expose their illegal status. As described by Varsanyi, "the simple act of taking up space in the public and the polity was, in and of itself, an act of legitimacy and belonging, and as such, an important step toward demanding recognition as full members in society."[86] They must operate under the structures of legality defined by local, state, and national governments, but they themselves often cannot fully participate in how those laws are made, and the strategic inclination to resign from institutions out of self-protection makes it harder later on to gain citizenship.

D. Application of Literature to My Own Research

Ahadí's framework of the effortful immigrant as a synechdoche for the immigrant who contributes to society but under-utilizes public resources is one that most aligns with my research inquiry. In investigating the effects of Secure Communities on undocumented immigrant participation in health services in South Central Los Angeles, I build upon the theories put forth by authors such as Sargent, Ortega, Chavez, and others who each demonstrate how increasing fears around detention and deportation cause a "chilling" effect, deterring undocumented community members from making use of preventative care. I also rely on the concepts of citizenship and legality put forth by Aviva Chomsky and Monica Varsanyi to illustrate the impacts of categories of immigration status on interactions with society. Following the trajectories of theories put forth by these authors, I hypothesize that the effects of Secure

[86] Varsanyi, "The Paradox of Contemporary Immigrant Political Mobilization."

Communities on clinics in my case study will lead to descreasing participation in health services by immigrant populations. I foresee the challenge being to disseminate information about the greater public health implications of Secure Communities to the wider community in an effective way that will offer evidence for the need to end ICE-local partnernships to protect immigrant rights, assuage legitimate fears, and re-establish trust between undocumented immigrants and the medical providers who serve them.

Chapter 3: Research Methods

A. Two Metrics to Test Hypothesis in South Central Case Study

I employ two methods of evaluating the effects of the reinstatement of Secure Communities on immigrant participation in my case study of South Central health clinics. The first is based on qualitative information gained through interviews with nine doctors, health providers, and others qualified to speak to how immigrant populations make use of health services in the South Central region. The second method of evaluation is through analysis of data offered by the Uniform Data System (UDS), an annual and publically accessible report summarizing hundreds of variables from every health center in the country. Since Secure Communities has a complicated and layered history; having been launched in 2009, replaced by the Priority Enforcement Program from 2014-2016, and re-instated in January of 2017; findings I draw from both the qualitative interviews as well as Uniform Data System attempt to take into account the fluctuations during this time period.

B. Methodology Caveats

As I was devising a way to research my topic, I initially hoped to interview immigrants of varying legal statuses about their use of health clinics and the factors that may affect their participation in them. In speaking with professors, mentors, and others familiar with the Institutional Review Board standards, however, it became clear that I would have to use a different research approach to come to my findings. I would not be able to interview the affected populations as I had originally planned, as it would put people at risk. I would not be allowed to know my interviewees' legal statuses, and even if I were to guarantee that the people I spoke with were not themselves at risk of deportation, there would be no way to ensure that their family members or friends would not face repercussions might immigration agents gain access to my research and request the names of those I interviewed. I was becoming, as Professor David Menefee-Libey in the Pomona College Public Policy department would put it, a subject of my own investigation.[87] Just as my research was demonstrating that immigrant populations were using health services less and less out of fear of having their names recorded on government documents, I would not be able to speak with these members directly for the same reasons.

C. Interviews and IRB Process

In lieu of interviews with the vulnerable population, the qualitative information I obtained came from conversations with health providers from clinics in and around South Central Los Angeles, which became the focus of my case study and my region of interest. I was able to access the bulk of my research from interviews with doctors connected to Uncommon Good, a community organization in Claremont at which I interned during the fall of 2017 and

[87] David Menefee-Libey.

spring of 2018. Uncommon Good's Medicine for the Economically Disadvantaged (MED) program relieves emerging doctors of intense student debt through loan repayment of practitioners who serve low-income areas. The program also matches these recipients with mentors who have extensive experience working with underserved communities.[88] Through my internship with Uncommon Good, I was able to talk with four community clinic doctors in and around South Central Los Angeles about their experiences working with immigrant populations and the trends they observed in who use medical services and community health clinics during periods of strict immigration enforcement and pervasive anti-immigrant rhetoric. These doctors then put me in touch with three more from the area, as well as two health administrators, totaling nine interviews with regional medical providers. These doctors and administrators not only provided me anecdotal information about the ways they have seen Trump's recent re-enactment of Secure Communities affect their health clinics in South Central, but they also offered data and sent me reports on national- and state-level usage of community health clinics, broken down by categorical qualifiers that contributed to my overall conclusions. Finally, I also spoke with a social services officer from Pomona, California, who shared her own experiences working with immigrants who come into her office, as well as Professor Aviva Chomsky from Salem State University in Massachusetts.

After introducing my thesis research and my background as a senior at Scripps College in the Public Policy Analysis department of Pomona College and getting informed consent, I asked each of my interviewees to describe their own work, observations of trends in usage amongst different patient constituent groups, and to offer any relevant statistics they might have access to. I profile three of the doctors and two of the health administrators I spoke with from three of the

[88] "Medicine for the Economically Disadvantaged (MED)," Uncommon Good.

clinics in my findings, choosing these because they provided the most relevant and important information pertaining to my research question.

I made sure to recruit interview participants and assess quantitative data while abiding by my Institutional Review Board (IRB) proposal, which was approved in December of 2017 before I began speaking with health providers or accessing any statistics. As stated in my proposal, I did not select participants of any particular gender or ethnicity—I sought out an equitable representation of gender and ethnicity when recruiting health care professionals for my study. Each interviewee was over eighteen years old, and none were of a vulnerable population by IRB's standards. My interviews were a combination of phone conversations and in-person meetings, and I made sure to read aloud the consent statement prior to each one, which is listed in Appendix 1. My research involved minimal risk to participants. The questions I asked during interviews were not significantly different from questions participants might experience in their daily work, and while the issues raised in my questions should not stray far from issues they encounter has health providers, they may inevitably evoke emotional discomfort. This distress was minimal, and the interview should not have caused any significant or overbearing psychological or physical stress.

Finally, I removed the names of ten of my eleven interviewees and labeled them Participants 1 through 7, with Participants 3a and 3b being two administrative assistants from the same clinic as the doctor labeled Participant 3 from Clinic C. I retain the name of the eleventh, Aviva Chomsky, as she is a professor from Massachusetts who is far removed from the Los Angeles case study and granted me permission to include her name. I remove the names of the clinics as well to abide by IRB protocol and to protect the confidentiality of their statements.

D. Case Study: Health Clinics In and Around South Central Los Angeles

While issues of immigration and access to health care are pervasive countrywide, and recognizing trends of increasing or decreasing health clinic usage may vary across regions, I chose to focus my research on trends in and around the South Central region of Los Angeles. South Central, which is now officially referred to simply as "South Los Angeles" under recent redevelopment and rebranding initiatives, is recorded as a 51 square-mile region just south of downtown that has historically been home to large populations of Black residents.[89] The term colloquially encompasses a much larger geography, however, as Sonsken describes that it has "become an umbrella term for Black Los Angeles…stretching all the way to Watts and Compton on the south and west across the 110 freeway into Inglewood and the Crenshaw district."[90] While the City of Los Angeles now defines the region as South Los Angeles after a unanimous 2003 vote by City Council, I will use its historical name because that is what it is typically referred to as by the people who call it home. In an effort to resist the recent luxury developments and impacts of gentrification that have displaced low-income communities, there is movement to maintain the name South Central. Push from city planners to rename it South Los Angeles have largely been in response to developers who fear that its historic name evokes negative connotations from its days of widespread gang violence, associations with the 1965 Watts Riots, and general reputation as a low-income and unsafe region.[91] I further discuss the demographics and other important contextualizing information about South Central in my findings.

[89] Mike Sonksen, "The History of South Central Los Angeles and Its Struggle with Gentrification."
[90] Sonksen.
[91] Sonksen.

D. Uniform Data System (UDS)

The second portion of my case study draws from annual statistics published by the Uniform Data System, or UDS. The United States Health Resources and Services Administration (HRSA) gathers data from all health centers and "look-alikes" each year. Every health center or similar organization in the United States must submit extensive data on patient visits, staff pay information, health outcomes, and more to the U.S. HRSA, which is then incorporated into a comprehensive Uniform Data System (UDS) that standardizes the information and sorts it into various categories. In 2017 alone, 1,367 health centers, with over 11,000 service sites, reported data for a total of 25,860,296 patients served.[92] The results of the UDS are published online annually and accessible to the general public via the U.S. Health Resources and Services Administration website, where one can choose to examine data collected from previous years or the present.

I conducted a series of statistical tests on reports published every year for the last decade in attempt to compare trends of how constituent groups made use of health clinics, particularly focusing on the years following the implementation of Secure Communities. However, as previously described, Secure Communities has a complex history, as it is exists entangled amongst other local and national immigration policies and has evolved with transitions in Presidential Administrations and shifts in the political landscape. These contextual factors undoubtedly impact the statistics reported in the UDS, and I try to account for them in what I gain from the interviews. Statistics from the 2016 and 2017 UDS are relevant because they include data from the time period immediately following Trump's election as well as the period after his reinstatement of Secure Communities, but the reports publishes all data from the entire

[92] "Health Center Data & Reporting," Human Resources and Services Administration.

year instead of breaking it down by the month. Thus, the annual data may not always be an accurate representation of the effects seasonal changes in policies and political leadership have on my findings. The trends observed in my analysis of the UDS reports show general trends in how many people from different ethnic groups and languages use health services across several years, but it does not show how those trends fluctuate following more sudden changes, i.e. when Trump was elected in 2016, or when a major ICE raid occurred in Los Angeles in February of 2017. I take these limitations into account while conducting my statistical analyses and incorporate them into my findings and conclusions about how well my hypothesis was met.

After hearing from various doctors, health administrators, and other medical providers for the first portion of my case study, I decided to compare the qualitative findings with the quantitative information gained from the UDS report. While the database contains extensive information for each health clinic in the country, I particularly focused on the seven that I used in my interviews. After attempting a series of statistical tests and models on various combinations of data points, I chose to compare the percentage of patients best served in another language, the racial and ethnic breakdown of patients served, and the types of medical conditions treated at each clinic in my final analysis, which are described in greater detail in my findings.

Chapter 4: Findings

A. Contextualizing the Case Study Region of Interest, South Central Los Angeles

As described in Research Methods, I focused my research and relied on qualitative and quantitative data drawn from the South Central region of Los Angeles, geographically depicted in Figure 4. I chose South Central because of its disproportionately high population of

immigrants and diversity of health centers in the area, each of which reports annual statistics to the Uniform Data System.

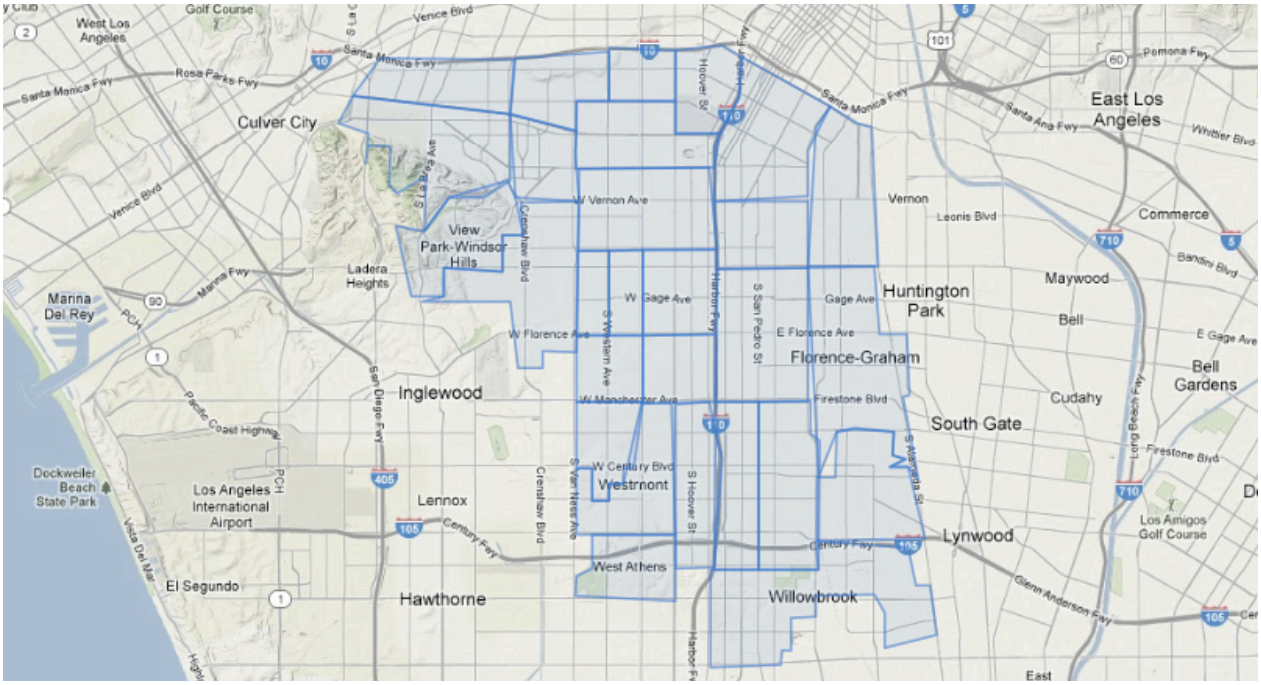


Figure 4. Map of South Los Angeles (formerly South Central), courtesy of *Los Angeles Times*.[93]

The 1980s brought a demographic shift to the predominantly Black South Central, as waves of asylum-seekers from Latin American countries affected the racial and ethnic landscape of Los Angeles as a whole. The decade began with over 80% Black residents in South Central in 1980, but by the 2000 Census, the Latinx population officially outnumbered the Black population 58% compared to 40%.[94] The rise in Latinx immigrants was not the only reason for the shift in proportions, however. Black residents were leaving their homes in record numbers, no longer able to afford the rising costs of the city. While the region is still known for its Black history, it is currently regarded as a heavily Latinx community home to immigrants from across Central and South America. As of the 2010 Census, 56.3% of the population was foreign-born,

[93] "Mapping L.A. - South L.A.," *Los Angeles Times*.
[94] "Historic South-Central," Mapping L.A.

with 82.1% from Mexico and 8.4% from El Salvador, the two most common countries of origin. Black people comprise 10.1%, non-Hispanic whites are 1.2%, and Asians are 1.0% of the South Central population. Latinxs are the greatest umbrella ethnicity, making up 87.2%.[95] According to a 2012 study by San Diego State University and the University of Southern California, approximately 9% of South Central residents are immigrants are immigrants who have become fully naturalized citizens (8,185 out of a total population of 89,787 people in South Central); 13% are authorized immigrants, but are non-citizens; and 19% are undocumented, non-U.S. citizens.[96]

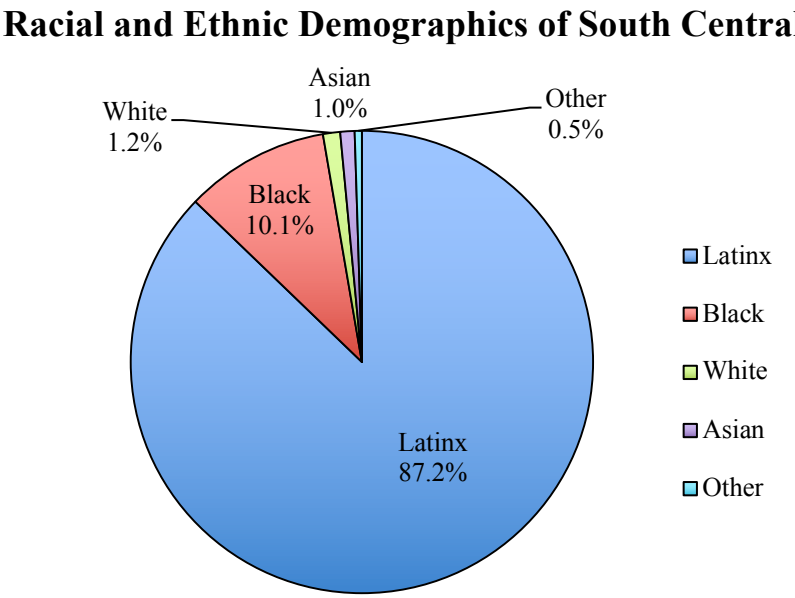


Figure 5. Breakdown of 2010 South Central racial and ethnic demographics.[97]

[95] "Historic South-Central."
[96] Enrico Marcelli and Manuel Pastor, "Unauthorized and Uninsured," San Diego State University, University of Southern California.
[97] "Historic South-Central."

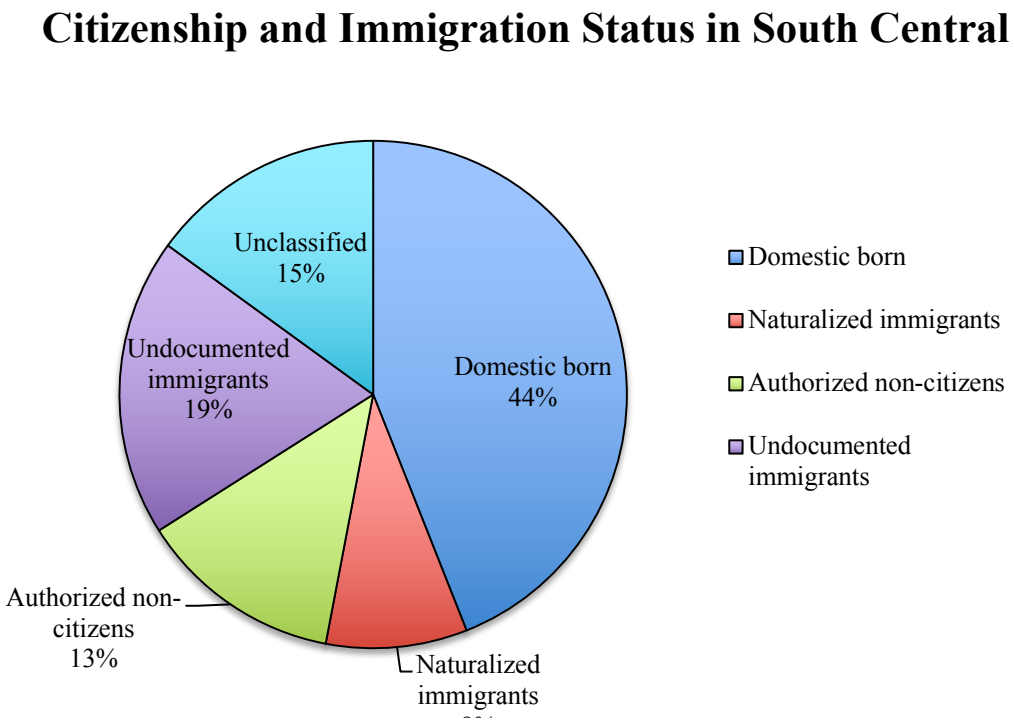


Figure 6. Breakdown of the ranges of citizenship designations and immigration statuses in South Central in 2012.[98]

The average household size in South Central is greater than that of the rest of the city at 4.1 people per household, as is the number of households headed by single parents (2,290), which make up 24.9% of households. In 2012, 49,064 South Central residents, or 55% of the total 89,787, had household incomes falling less than 150% of the Federal Poverty Level.[99] These numbers, along with only 3.2% of the population having a four-year degree and a $30,882 median household income, describe the high poverty rates in South Central.[100] The community clinics that service the region have become increasingly important for these reasons. Many residents rely on Medical and Medicare for health care, as well as My Health LA, a health

[98] Enrico Marcelli and Manuel Pastor.
[99] Enrico Marcelli and Manuel Pastor.
[100] "Historic South-Central."

program that allows undocumented residents to access care without legal status. Run through the Los Angeles County Health Services department, those eligible for My Health LA must be aged 19 and older, live in the county, otherwise do not have health insurance, and have incomes at or below 138% of the Federal Poverty Level. The program is entirely free for members and includes ongoing care, health advice, screenings, access to specialty clinics, emergency care, prescriptions, lab tests, and other services. Those who qualify must re-enroll every year through one of the 210 Community Partner clinics in Los Angeles County.[101] While My Health LA is not explicitly designed for undocumented residents, it is widely known as a program heavily used by those without full legal status.

South Central Los Angeles has higher rates of uninsured and undocumented working adults than Los Angeles County as a whole. According to the joint SDSU and USC study in 2012, while 63% of undocumented immigrants in Los Angeles County aged 25-64 did not have health insurance, 75% of undocumented immigrants in South Central were uninsured.[102] These uninsured residents generally qualify for and use My Health Los Angeles to receive subsidized and no-cost health care. This is also the population that primarily relies on community clinics for qualified care.

B. Use of Health Clinics in South Central Case Study

The shifts in both the components as well as the implementation of Secure Communities coincided with a major change in Presidential Administration. Despite Secure Communities having been enacted under President Obama's Administration, and recognizing the undeniable impacts of unprecedented deportation rates under Obama, many of my interviewees indicated

[101] "My Health LA," Los Angeles County Health Services.
[102] Marcelli and Pastor, "Unauthorized and Uninsured."

that they had observed the most dramatic changes in how immigrants use health services in the weeks and months immediately following Trump's election in November of 2016 and his inauguration in January of 2017. During this time period, Trump made clear his goals to build a wall and to reinstate the Secure Communities program that then-Secretary of the Department of Homeland Security, Jeh Johnson, rescinded in 2014. The drastic effects of Trump's anti-immigrant rhetoric and promise to bring back Secure Communities, not only on immigrant usage of health services but on social services in general, became particularly apparent as I conducted my interviews. Speaking with doctors and other health providers illuminated these particular trends more then data received by the UDS because statistics from the annual report only go through 2017 and are not broken down by month. I still report on conclusions I came to from the UDS statistics, recognizing the timeline limitations, because they offer insight into trends in how health clinics in South Central are used as well as the complex factors at play, particularly in the year following Trump's reinstatement of Secure Communities in January of 2017. The UDS does provide enough information through 2017 to illustrate several trends relevant to my research question, both challenging and supporting some of my findings from my interviews. Many of my interviewees had been working in health care longer than Secure Communities had been in place, but in recognizing the limitations of memory and not wanting to bias my interviewees, I chose to ask more specifically about trends they recognized over the past few years in particular. Both methodologies focus on seven health clinics in and around the South Central region of Los Angeles. Here I summarize interviews with three doctors and two administrative health professionals from Clinics B, C, and E.

I first spoke with Participant 5 on February 2, 2018. Participant 5 runs Clinic E in Skid Row, a 50-block neighborhood in downtown Los Angeles known for its large homeless

population. 1,800 of the 50,000 people in Los Angeles sleep on the streets of Skid Row every night, and those who do have more secure places of residence still face disproportionately high rates of poverty.[103] Clinic E is a Federally Qualified Health Center (FQHC) that receives federal grants as well as private gifts. Under the FQHC rules, anyone who enters the clinic must be served, regardless of their ability to pay and regardless of immigration status.[104] Participant 5 now primarily works in Clinic E's dental clinic, which sees different trends in usage because it is a more specialized form of care, but his experiences in the overall operations of the clinic allowed him to provide useful anecdotal information for my thesis research.

Since Participant 5 primarily works with the dental program, he began our conversation by disclosing that he may not have a fully accurate impression of how trends in clinic usage have changed for health services in general. However, he was still able to offer information about the fluctuations in patient participation that he has observed for the dental clinic. "People move around, they lose their homes, they use other health clinics, they drop out of care. There are a number of reasons why people don't consistently visit the same clinic."[105] Participant 5, along with other doctors I interviewed, spoke about the challenges of retaining patients when their living and housing conditions are at times unstable, particularly when the tough job market requires people to move around in search of work. There can also be a lack of understanding of the importance of having a consistent doctor for those who did not grow up with continuous care. The challenge is in distinguishing between the pre-existing fluctuations in patient visits with more recent trends that result from Secure Communities and other anti-immigrant legislation.

[103] "Medicine for the Economically Disadvantaged (MED)."
[104] Participant 5.
[105] Participant 5.

One of the greatest changes that Participant 5 reported noticing in regards to the rates of immigrant patients visiting Clinic E had to do with an observed increase in the number of patients coming to the clinic "at the last minute." He described how he has seen more people push off medical treatments longer than usual, presumably to avoid using health services until absolutely necessary to reduce risk of exposing status.[106] This is a trend also observed by authors Leo Chavez and Seam Park that I discussed in the Literature Review. Previous studies have seen a decrease in the number of patients using preventative services and a corresponding increase in the usage of emergency services.[107] According to Participant 5, the rise in the number of people using Clinic E "last minute" as more of an emergency clinic rather than a source of continued care may speak to some of the impacts current immigration policies have on how undocumented immigrants participate in health clinics. While I do not include data about changes in the use of emergency medical services in my quantitative findings, I took this anecdotal information into account when formulating my conclusions.

My second interview was with Participant 2, the Chief Medical Officer and Chief Executive Officer at Clinic B in South Central. Participant 2 started the clinic in 2007, initially as a for-profit clinic with the hopes of subsidizing care for the people who need it most. In 2010, Participant 2 converted the clinic to a federally funded care center, similar to that of Participant 5. Not only is the clinic known for its excellent affordable care, but it also has a high-quality mental health program created by Participant 2 in response to his observations of the lack of sufficient options for patients seeking mental health services in South Central, particularly for

[106] Participant 5.
[107] Chavez, "Undocumented Immigrants and Their Use of Medical Services in Orange County, California."

People of Color and those coming from low-income backgrounds. He has consistently advocated for and obtained major grants to better serve those seeking mental health resources.[108]

My interview with Participant 2 from Clinic B was crucial to my research, not only due to his responses to my questions about trends he has observed, but also because of his guidance with the Uniform Data System (UDS) that I relied so heavily on in my quantitative analysis. Participant 2 broke down each of the relevant sections of the report for me and made suggestions about which parameters I should focus on to draw more conclusions about the ways Secure Communities has affected health clinic usage. He also spoke about interactions he has had with DACA recipients who have expressed fears of the impending revocation and what their futures might look like. These patients are at times even more fearful of what will happen when their protected status is taken away because their names are already in federal databases, and the government can presumably track when they no longer are registered as a DACA recipient. Along with his work at Clinic B, Participant 2 is also a civil surgeon, meaning he conducts many of the medical background checks for those in Los Angeles in the process of gaining citizenship status. He described to me the stories patients have shared about their withdrawal from many health services as undocumented individuals, both because they worry the clinics will record and report their private information, but also because they more generally have stopped leaving their homes out of fear of being stopped on the street. Participant 2 also indicated that he saw an increase in the number of people trying to become citizens in the beginning of 2017, at the onset of Trump's presidency, and believes that it was a result of augmented fears of deportation of those not "legalized."[109]

[108] Participant 2.
[109] Participant 2.

These observations were similarly noted by Participant 3 of Clinic C, who not only began hearing from more immigrant patients about their increased fears under the Trump administration, but she also had a considerable number of patients call to cancel appointments during the fall of 2016 and the early months of 2017. She explained that there were more people failing to show up for appointments that were already made immediately following Trump's election; according to Participant 3, in the first week after his election, the organization had more no-shows than they had ever seen. This sparked a rapid response by the clinic staff, who organized meetings and released memos to staff and patients about their commitment to preserving patient privacy. Participant 3 also described how immigrant patients who did continue to come to the clinic would at times refuse to fill out the intake paperwork, which posed greater problems for the administrators who were simultaneously trying to offer quality care and abide by federal rules. Clinic C began stationing nurses and administrators in the waiting rooms to assist with the paperwork and to assure patients that they would not be asked about immigration status, and that their names would not be reported with information filled out on the surveys.[110]

The larger organization of Clinic C has six locations across Los Angeles County. Participant 3 was at one of the sites in Carson from 2014-2016 before transitioning to Inglewood, the site that primarily services Inglewood, South Central, Hawthorne, and portions of other regions in Los Angeles County. Like the other clinics I surveyed in my research, Clinic C offers low- and no-cost health care to anyone who walks through their doors, with a focus on "economically disadvantaged and uninsured populations" in Los Angeles.[111] Known for their comprehensive care and quality services, Clinic C offers primary medical care, pediatric care, and dental care to its diverse patient constituents. Participant 3's everyday interactions with

[110] Interview with Participant 3.
[111] Clinic C.

people of a range of legal statuses allowed her to provide me with information about the kinds of concerns some of her immigrant patients bring up in regular appointments, the sudden increase in canceled appointments that occurred immediately after Trump's election in November of 2016, and her anecdotal observations of the drop in number of people who to re-enroll in My Health LA this year. She also explained some of the efforts Clinic C as an organization has made in mitigating the effects of rising fears of deportations and the statements her clinic has published that reiterate their commitment to protecting and serving all patient, regardless of status.

Participant 3 kindly put me in touch with two health administrators from Clinic C. Participant 3a, the Director of Patient Enrollment at Clinic C, and Participant 3b, a Patient Enrollment Specialist, spoke with me about the changing demographics in patient enrollment at the five Clinic C sites. They also provided me with a 2015-2016 report on the numbers of Medi-Cal and My Health LA (MHLA) patients enrolled at three of their clinics, broken down by gender (male or female), race, age bracket, and type of insurance (Medi-Cal or MHLA). I used these statistics in conjunction with the information from the interviews as well as data from the national report in my findings (Figures 7-8, Appendices 2-4).

These two administrators from Clinic C also echoed Participant 3's explanation of the events following Trump's election and the increase in calls received by the clinic from concerned immigrant patients. According to Participants 3a and 3b, patients frequently called asking if they would still have coverage under My Health LA (MHLA), the health program used by many undocumented residents because it does not require disclosure of status to enroll. Clinic C is one of the MHLA enrollment sites in Los Angeles County, and Participants 3a and 3b take part in the enrollment process. Participant 3a recalled the following when I spoke with her about the issue in early March of 2018.

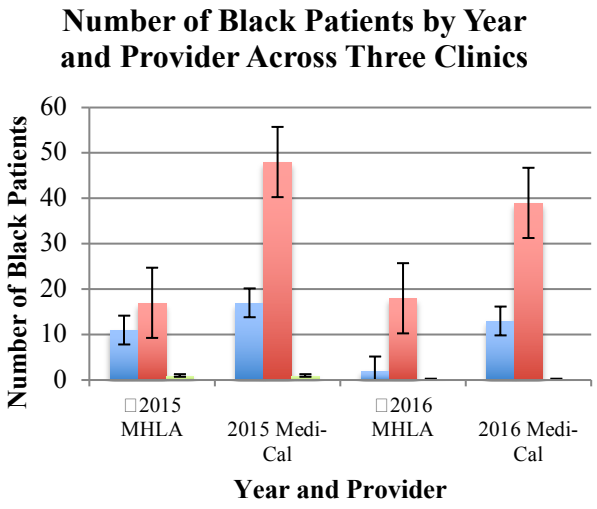
> It felt like the same questions were being brought up over and over again, ones we had not heard before. They just kept asking about what would happen with My Health LA once Trump was in power and for some, it was like they doubted that they should re-enroll. I say that because we actually had issues with re-enrollment. We had to call people to get them to re-enroll for MHLA last year because people thought that it either did not exist anymore or they were scared that if they used it, they would be recorded.[112]

Most Clinic C patients rely on either Medi-Cal or My Health LA (MHLA) for service coverage, while the marginal number of remaining patients have other forms of insurance or no insurance at all. As reflected in the quote, Participants 3a, 3b, and others in Clinic C staff grew worried that MHLA recipients were no longer getting the care they needed and actively tried to bring enrollment up again. They both said that these trends occurred as a result of Trump's election and following his inauguration in January of 2017, when his anti-immigrant rhetoric transitioned from an encroaching threat to a more pressing reality. "If there are already patients no longer using My Health LA," Participant 3b told me, "it would also think that there are fewer undocumented patients using health services in general."[113]

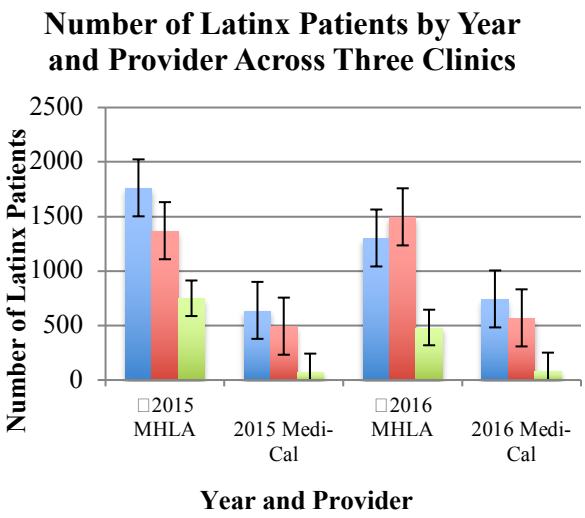
The two administrators I spoke with at Clinic C also provided me with information on the numbers of patients that visit three of their five clinics, broken down by race, age, gender, and insurance provider. I received this data for their Gardena, Inglewood, and Redondo clinics for 2015 and 2016. While these statistics cannot speak to the immediate impacts of the reinstatement of Secure Communities or Trump's election because they do not give a monthly breakdown of patient usage, and the data only goes through 2016, I found it still to be helpful to visualize the number of patients that use Medi-Cal versus My Health LA for coverage. I sorted the raw data provided by Participants 3a and 3b by race/ethnicity and cost provider for each clinic, graphed in Figure 7 below.

[112] Interview with Participant 3a.
[113] Interview with Participant 3b.

A



B



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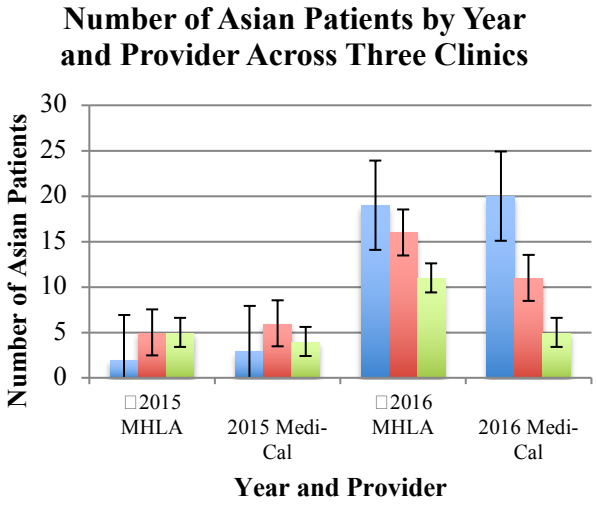

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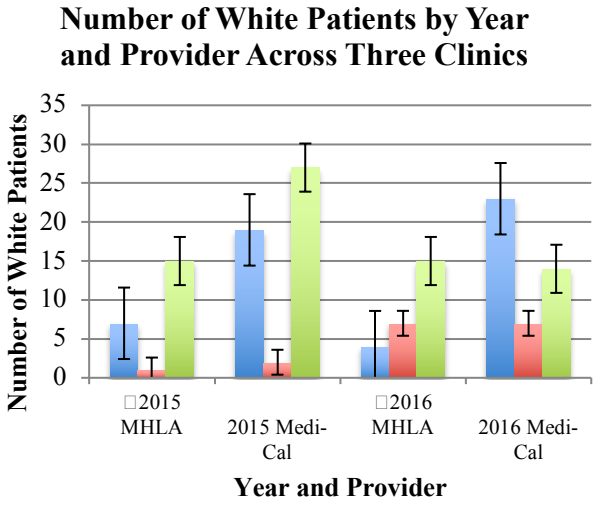


Figure 7. Numbers of patients visiting three Clinic C sites, broken down by race/ethnicity, year, and cost provider. **A.** Number of Black patients, **B.** Number of Latinx patients, **C.** Number of Asian patients, and **D.** Number of White patients. Blue blocks represents patients at the Gardena clinic, red represents Inglewood, and green represents Redondo.[114]

[114] "Clinic C Patient Demographics, 2015-2016" (Clinic C).

As evidenced in the graphs and in Appendix 2, Latinx patients recorded the highest proportion of My Health LA visits. White, Asian, and Black patients all had more visits from those covered by Medi-Cal than by MHLA. Recognizing the significant existences of undocumented immigrants from other races, but operating under the assumption that most undocumented individuals in Los Angeles are from Latin America, this finding corroborated statements made by the health administrators at Clinic C and others I spoke with that analyzing visit rates from those using My Health LA can be used as a proxy to understand rates of visits by undocumented immigrants. Keeping in mind the limitations of observing data from only two years, and the fact that this data is from the year prior to Trump's reinstatement of Secure Communities, I used this proxy to get a sense of how rates of MHLA patient visits can an indication of how many undocumented residents make use of health clinics.

Based on the statistics provided in Clinic C's patient demographics report (Appendix 5), all three clinics saw increases in the number of visits from Latinx patients with Medi-Cal from 2015-2016, but Gardena and Redondo saw decreases in the number of Latinx patients using My Health LA (Gardena: 1,763 in 2015 to 1,303 in 2016; Redondo: 750 in 2015 to 482 in 2016). When I ran a two-tailed t-test on the complete data set by age brackets, I found that there were no statistically significant changes in number of visits for Latinx patients at any of the sites. The only statistically significant change in visit rates came from Asian patients at each of the clinics. When totalling the number of visits by Asian patients for all three Clinic C sites, there was a significant increase in the number of Asian patients when broken down by age brackets both on My Health LA ($p=0.043$) as well as Medi-Cal ($p=0.023$).[115] However, this occurred with a

[115] "Clinic C Patient Demographics, 2015-2016."

smaller number of Asian patients, and is likely due to the overall significant increase in number of Asian patients visiting Clinic C sites from 2015 to 2016.

I then totalled the number of patient visits across races/ethnicities as well as age brackets and included all patient information in one graph, broken down by year, provider, and clinic site (Figure 8).

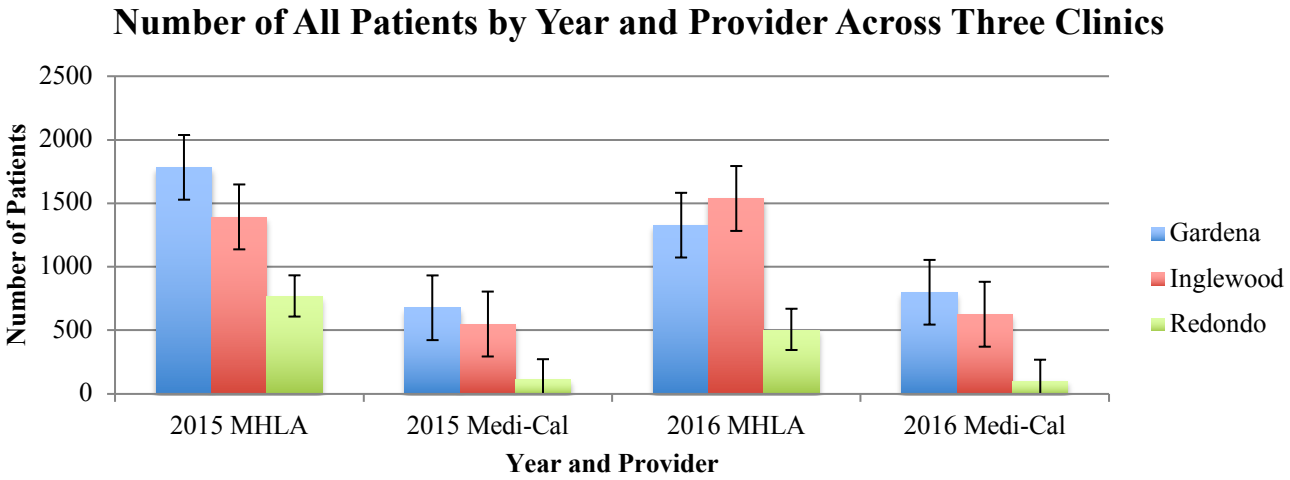


Figure 8. Total number of patients who visited three Clinic C sites from 2015 to 2016, broken down by year and cost provider. All races and ethnicities are summed. Blue blocks represent patients from Gardena, red represents patients from Inglewood, and green represents the Redondo clinic.[116]

More patients visited Clinic C with My Health LA coverage than Medi-Cal for all three clinics. This is likely due significantly higher percentage of Latinx patient enrollments: for all five Clinic C sites, 56.10% of patients were Latinx in 2016. The next highest percentage of patients were Black patients, comprising 22.06%.[117] Overall, there was a 14.5% decrease in all MHLA patient visits from 2015 to 2016 for Gardena, Inglewood, and Redondo (3,947 in 2015 to 3,374 in 2016). Meanwhile, the number of patients visiting all three clinics with Medi-Cal

[116] "Clinic C Patient Demographics, 2015-2016.""
[117] "Health Center Program Grantee Profiles," Health Resources and Services Administration, Uniform Data Systems.

increased by 14.6% (1,339 in 2015 to 1,534 in 2016). While this data captures 2016 as a whole rather than the last few months following Trump's election, there may be some indication of the intensifying anti-immigrant rhetoric and policy advancements that occurred in the months leading up to the election. The fact that the number of MHLA visits declined across all three clinics, alongside the stories I heard about appointment cancelations and no-shows from the medical providers I spoke with at Clinic C, demonstrate a fluctuation in usage of health clinics that may reveal how recent legislation and corresponding fears influence immigrant participation in health clinics. I take these trends into consideration when evaluating the rest of the data from the annual Uniform Data System report.

Each of the doctors I interviewed spoke about the vast challenges in treating patients who face so many intersectional forms of oppression that act as significant obstacles in accessing quality and consistent health care. While the racial and ethnic compositions of health clinics across South Central vary greatly, residents generally fall into lower income brackets, and high rates of poverty persist across the population. Community health clinics have become fixtures in the region to provide the residents with quality care for low costs. These clinics deal with a variety of insurance levels, from those with consistent insurance, to those using non-insurance programs such as My Health Los Angeles, to those without any form of coverage. Some patients are regulars who benefit from the wide range of services offered by the clinics, but others struggle to obtain consistent care due to long work hours, unstable living conditions, lack of knowledge about services provided by health centers, and fears of having private information shared.

I asked several of the medical providers that I interviewed what the process of intake at their clinics looks like. Each described an initial survey given to each new patient that walks

through their doors, generally asking basic questions of name, gender, age, pre-existing conditions, income level, insurance status, and residential address. These forms are generally offered in at least three to four languages, matching the dominant languages of the region. Frequent returners on occasion receive shorter forms asking more specifically about reasons for visit in lieu of the initial survey, but most doctors indicated that every patient is asked the same general questions each time they arrive. I asked if any of these forms, or if at any point in one's visit to a clinic, would a patient be asked about immigration status. Everyone I spoke with and all literature I reviewed made clear that people should never be asked about immigration status when seeking social services. However, many undocumented patients are not aware of this or are otherwise still concerned that their names will be recorded on government documents. Participant 2 stressed that he often has to remind patients that their status is not known by medical personnel, and that even if it were, the clinic would not report it to federal authorities. In fact, several of the doctors I spoke with indicated that their clinics had either already declared or were in the process of declaring themselves sanctuary sites that would refuse cooperation with Immigration and Customs Enforcement.[118]

Participant 5, along with others, expressed concern that these intake forms may act as deterrents to undocumented immigrants who harbor legitimate fears that the information they disclose will be used against them. However, he also explained that he could not imagine an alternative intake process, as the questions asked on the survey are used to vet out unqualified patients and to keep track of important trends in usage for accountability and funding purposes. Patients must be residents of Los Angeles County to receive the free and reduced-price services for many of the clinics, and they must fall under a certain low-income bracket as well.

[118] Interview with Participant 2.

Participant 5 explained that the form is used to prevent abuse of the subsidized health care system and to ensure that patients are receiving consistent and quality care.[119]

As a result of these necessary restrictions against inquiring about immigration status, one of the challenges in conducting interviews was in gathering information about immigrant usage of health clinics with the recognition that the doctors presumably do not know which patients are documented and which are not. As discussed by Beniflah and Viladrich, even those who are fully authorized may be hesitant to use public services if their friends or family are in vulnerable positions, but there remained the issue of identifying which trends were due to immigration policies rather than other factors. Each doctor had different ways of commenting on these patterns, be it on type of insurance used by patients, English-speaking ability, general fears expressed while visiting the clinic, or other discernible metrics.

C. Analysis of Statistics from UDS Annual Report on Community Clinics

I was first introduced to the Uniform Data System annual report through an interview with Participant 2, the Chief Medical Officer and Chief Financial Officer at Clinic B in South Central. Under the direction of Participant 2, I began exploring the extensive database on my own and followed his suggestions to look at data on poverty levels, racial and ethnic breakdowns, intake from migratory and seasonal patients, information on cost providers, and other variables across several years. The website allows public users to compare reports from state to state, from state to national, and between years. I chose to filter the data based on a few selected variables recorded by the seven clinics in Los Angeles that I included in my case study, which I label Clinics A through G throughout the paper to protect confidentiality.

[119] Interview with Participant 5.

The 2017 UDS annual report from all 1,367 health centers nationwide includes statistics from the tables below. The Health Resources and Services Association (HRSA) publishes a yearly manual instructing health centers on how to report their statistics, describing in detail the parameters of each table.[120]

Uniform Data System Annual Report Parameters

Table	Criteria
3A	Patients by Age and Gender
3B	Patients by Hispanic or Latino Ethnicity/Race/Language
4	Selected Patient Characteristics
5	Staffing and Utilization
5A	Tenure for Health Center Staff
6A	Selected Diagnoses and Services Rendered
6B	Quality of Care Indicators
7	Health Outcomes and Disparities
8A	Financial Costs
9D	Patient Related Revenue
9E	Other Revenues
EHR	Electronic Health Record

After sorting through thousands of rows of data from each yearly published report, I narrowed down the variables that I saw as the most accurate indicators of trends of trends relevant to my research question. I compared the trends for each parameter across four years, from 2014-2017, choosing to focus on a smaller time range to limit the effects of larger immigration patterns occurring in the area. The number of foreign-born residents in Los Angeles County grew by 22,301 from 2010 to 2014, and by 11,110 for the City of Los Angeles alone.[121] This accounted

[120] "Uniform Data System: Reporting Instructions for 2017 Health Center Data," HRSA Health Center Program.
[121] "New Americans in Los Angeles" (New American Economy, 2015).

for 7.7% of the total population growth in the county during the same time period and an 8% increase in the city. However, the overall populations of Los Angeles County and the City of Los Angeles were expanding at a much faster rate: while foreign-born residents made up 39.6% of the county in 2010, they only comprised 37.8% in 2014.[122] Since the years leading up to 2014 saw major increases in immigrants moving to the Los Angeles area, so much so that the rise in immigrant populations skewed changes I measured in trends of immigrant participation in health clinics, I omit these early comparisons from my final analysis. Instead, I narrowed down my statistical tests to 2014-2017 because the influx of immigrants to the Los Angeles area remained more stable. This period gives sufficient time to observe trends across the years before Trump's election, during which he campaigned heavily on an anti-immigrant platform with promises to build a wall and deport higher rates of immigrants, and to compare these trends with data following the reinstatement of Secure Communities in January of 2017.

i. Patients by Race & Ethnicity

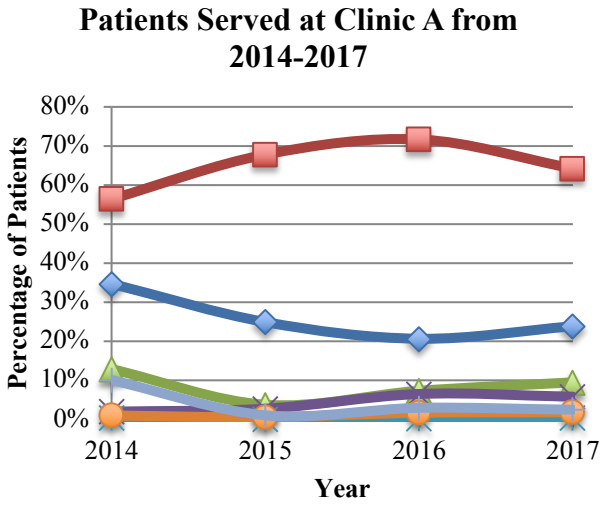
I first looked at the racial breakdown at each of the seven clinics from the self-declared racial classification question on walk-in and appointment intake forms. The annual Uniform Data System report categorizes race by Non-Hispanic Whites, Hispanic/Latino Ethnicity, Black/African American, Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, and More Than One Race (Appendix 6). I recognized from the start the challenge of retaining one category for those who qualify for "More Than One Race," as patients might get confused and choose to check this box rather than another race that they fall under, thereby

[122] "New Americans in Los Angeles."

resulting in inaccurate reporting. However, the percentage of those in this category generally ranged from 0.5-3% for each of the clinics I analyzed, so I considered its effects marginal.

Hispanic/Latino Ethnicity patients comprised the greatest percentage of visits to all but one clinic, Clinic F, where Blacks/African Americans recorded the highest visit rates from 2014-2017. Rates of patients served at each clinic across the three years are graphically depicted in Figure 9.

A.



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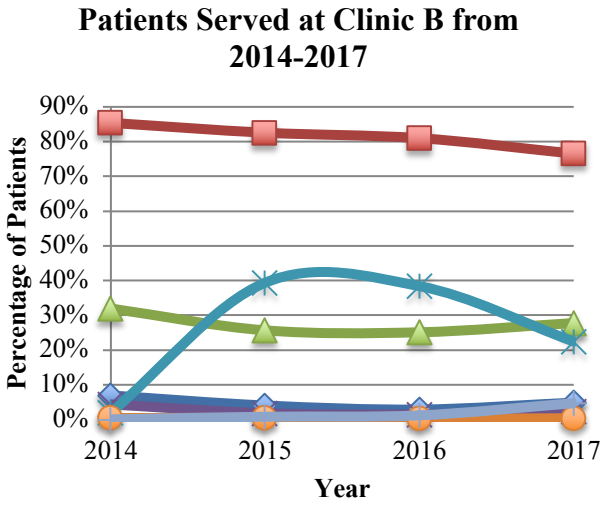

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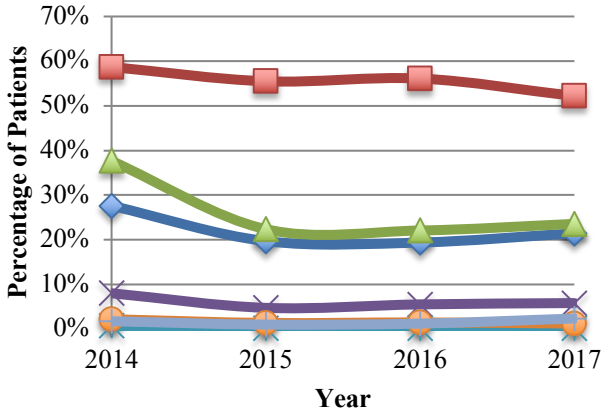

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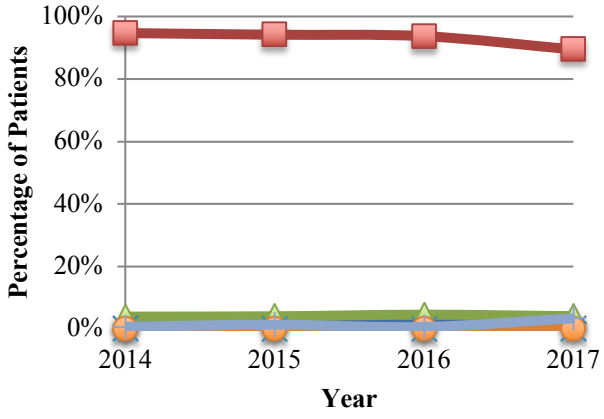

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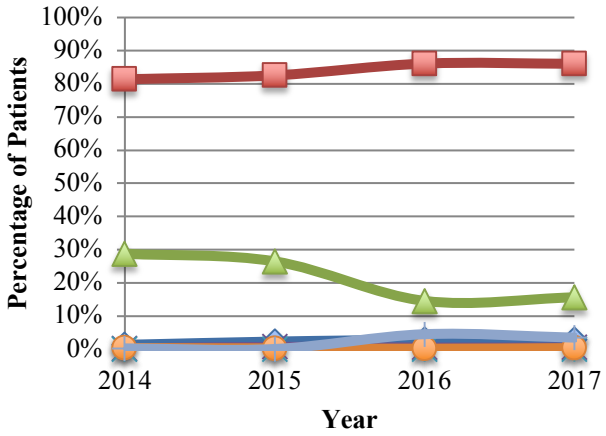

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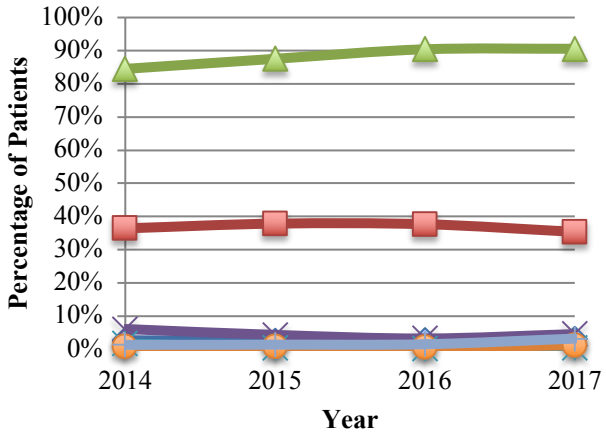

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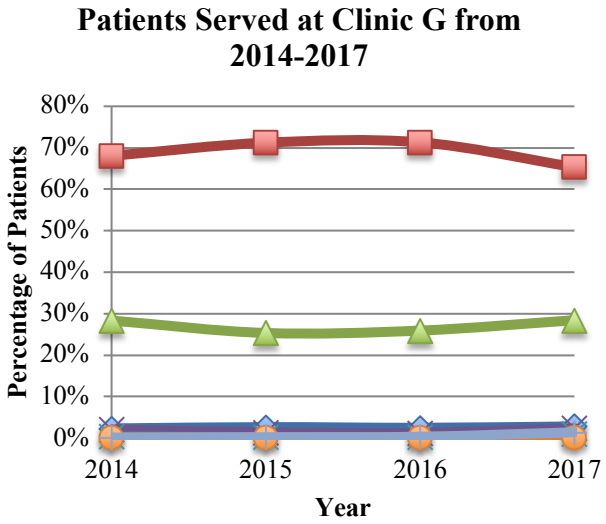


Figure 9. Rates of patient visits at seven clinics, broken down by year and race/ethnicity, from 2014-2017. **A.** Patient visits at Clinic A, **B.** Clinic B, **C.** Clinic C, **D.** Clinic D, **E.** Clinic E, **F.** Clinic F, and **G.** Clinic G. Red with squares represent Latinx patients, green with triangles represent Black patients, navy blue with diamonds represent non-Hispanic white patients, purple with bowtie shapes represent Asian patients, light blue with three lines represent American Indian/Alaska Native, orange with circles represent Native Hawaiian/other Pacific Islander, and periwinkle with one line represent more than one race.[123]

[123] "Health Center Program Grantee Profiles."

I was most interested in the trends of Latinx patients across the three years. As previously mentioned, there are large undocumented immigrant populations from Korea, Haiti, the Philippines, etc. living in Los Angeles; however, most unauthorized individuals living in Los Angeles are Latinx.[124] The percentage of visits from Latinx patients steadily increased at four clinics from 2014-2016, but then dropped from 2016-2017: Clinic A, E, F, and G (Table 1).

Table 1. Patients by race and ethnicity at the five clinics whose rates of Latinx visits increased from 2014-2016 and then decreased from 2016-2017. **A.** Clinic A, **B.** Clinic E, **C.** Clinic F., and **D.** Clinic G. Rates of Hispanic/Latino Ethnicity visits are in bold because they represent the trend of interest.[125]

A.
Clinic A

Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	34.71%	24.91%	20.64%	23.84%
Hispanic/Latino Ethnicity	**56.42%**	**67.79%**	**71.67%**	**64.22%**
Black/African American	12.87%	3.74%	7.31%	9.48%
Asian	1.98%	2.73%	6.50%	5.80%
American Indian/Alaska Native	0.34%	0.06%	0.32%	0.40%
Native Hawaiian/Other Pacific Islander	1.00%	0.57%	1.72%	1.82%
More than one race	10.07%	1.04%	2.95%	2.47%

B.
Clinic E

Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	1.32%	2.31%	2.87%	2.94%
Hispanic/Latino Ethnicity	**81.38%**	**82.56%**	**86.11%**	**86.05%**
Black/African American	28.79%	26.48%	14.57%	15.64%
Asian	0.23%	0.72%	0.52%	0.55%
American Indian/Alaska Native	0.09%	0.08%	0.05%	0.08%
Native Hawaiian/Other Pacific Islander	0.36%	0.27%	0.16%	0.34%
More than one race	0.25%	0.07%	4.53%	3.49%

[124] Brittany Mejia, Cindy Carcamo, and Corina Knoll, "L.A., Orange Counties Are Home to 1 Million Immigrants Who Are in the Country Illegally, Analysis Shows," Los Angeles Times.
[125] "Health Center Program Grantee Profiles."

C.
Clinic F

Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	2.71%	2.53%	2.73%	3.20%
Hispanic/Latino Ethnicity	**36.43%**	**37.68%**	**37.86%**	**35.38%**
Black/African American	84.51%	87.55%	90.42%	90.58%
Asian	6.09%	4.32%	3.24%	4.56%
American Indian/Alaska Native	1.76%	0.48%	0.23%	0.32%
Native Hawaiian/Other Pacific Islander	0.88%	0.82%	0.51%	1.21%
More than one race	1.31%	1.38%	1.50%	3.20%

D.
Clinic G

Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	2.31%	2.63%	2.47%	2.80%
Hispanic/Latino Ethnicity	**68.06%**	**71.23%**	**71.31%**	**65.32%**
Black/African American	28.33%	25.33%	25.91%	28.41%
Asian	2.05%	1.35%	1.23%	2.34%
American Indian/Alaska Native	0.33%	0.23%	0.27%	0.94%
Native Hawaiian/Other Pacific Islander	0.15%	0.07%	0.09%	0.04%
More than one race	0.11%	0.20%	0.31%	1.38%

While visit rates of other ethnic/racial groups fluctuated as well across the three years, the increase in visits by Latinx patients and subsequent fall in 2017 for four of the seven clinics indicates the effect Secure Communities and other anti-immigrant policies have had on the ability of undocumented individuals to participate in health clinics. Rates of visits for Latinx patients also saw an overall decrease from 2014-2017 at the remaining three clinics, Clinic B, C, and D (Table 2).

Table 1. Patients by race and ethnicity at the three clinics whose rates of Latinx visits had an overall decrease from 2014-2017. **A.** Clinic B, **B.** Clinic C, and **C.** Clinic D. Rates of Hispanic/Latino Ethnicity visits are in bold because they represent the trend of interest.[126]

A.
Clinic B

Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	6.88%	4.00%	2.84%	4.82%
Hispanic/Latino Ethnicity	**85.39%**	**82.56%**	**80.99%**	**76.53%**
Black/African American	31.92%	25.64%	25.08%	27.74%
Asian	4.31%	1.78%	1.43%	2.39%
American Indian/Alaska Native	1.97%	39.36%	38.37%	22.42%
Native Hawaiian/Other Pacific Islander	0.38%	0.43%	0.24%	0.32%
More than one race	0.00%	0.76%	1.16%	4.66%

B.
Clinic C

Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	27.59%	19.68%	19.37%	21.43%
Hispanic/Latino Ethnicity	**58.68%**	**55.48%**	**56.10%**	**52.18%**
Black/African American	37.64%	22.35%	22.06%	23.54%
Asian	8.00%	4.73%	5.51%	5.80%
American Indian/Alaska Native	0.65%	0.14%	0.18%	0.14%
Native Hawaiian/Other Pacific Islander	2.18%	1.35%	1.47%	1.21%
More than one race	1.73%	0.98%	1.20%	2.34%

C.
Clinic D

Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	1.07%	1.68%	1.65%	1.88%
Hispanic/Latino Ethnicity	**94.69%**	**94.16%**	**93.69%**	**89.44%**
Black/African American	3.96%	4.06%	4.57%	4.10%
Asian	0.13%	0.09%	0.10%	0.24%
American Indian/Alaska Native	0.04%	0.02%	0.02%	0.03%
Native Hawaiian/Other Pacific Islander	0.03%	0.07%	0.05%	0.10%
More than one race	0.72%	1.35%	0.64%	3.40%

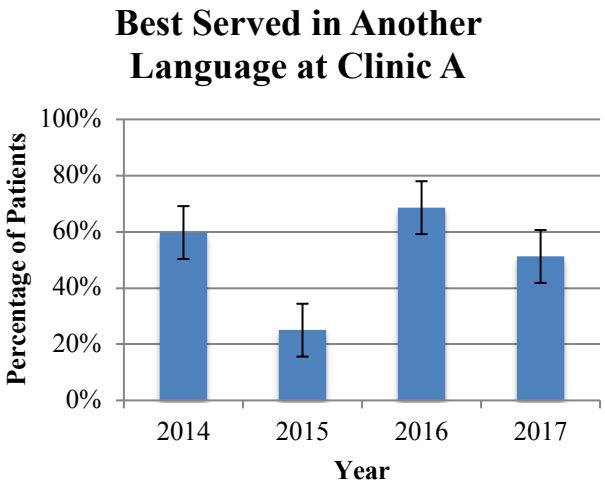
[126] "Health Center Program Grantee Profiles."

In summary, the breakdown of visits from patients based on race/ethnicity demonstrated a clear decrease in the number of Latinx patients either consistently throughout the four-year time period or from 2016-2017 (Tables 1 and 2). When using Latinx patients as a proxy for undocumented individuals, while fully recognizing the errors in conflating the two groups, these findings indicate a decrease in the number of undocumented patients participating in health services by 2017, the year Secure Communities was reinstated.

ii. Patients Best Served in Another Language

I next chose to analyze the rates of patient visits from those who were best served in a language other than English, one of the data points given by the Uniform Data System annual report (Appendix 7). Results are graphically depicted in the bar graphs of Figure 10.

A.



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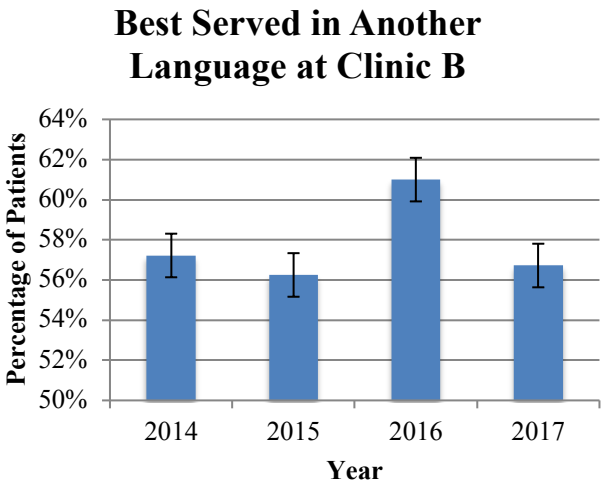

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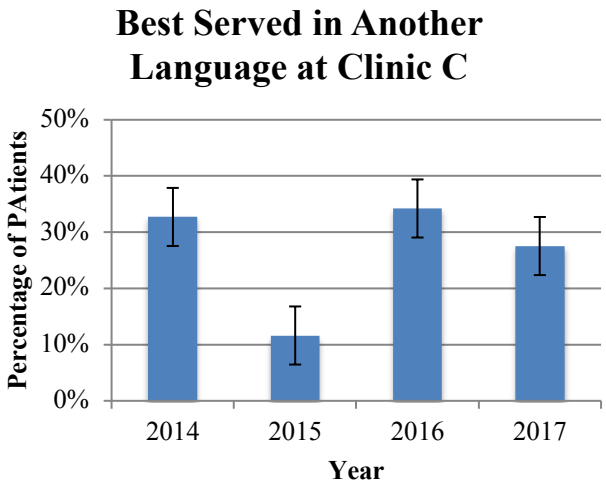

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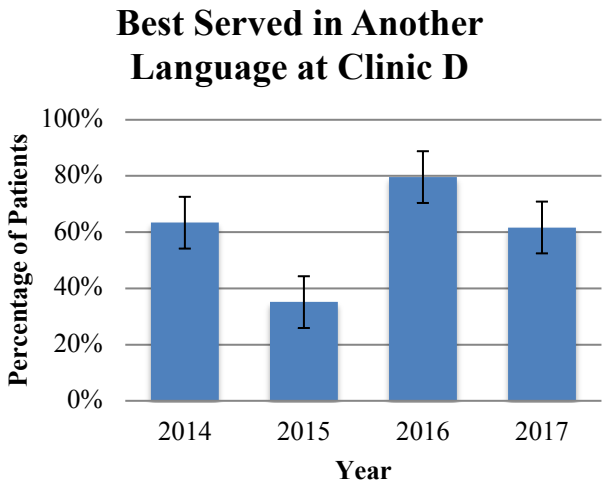

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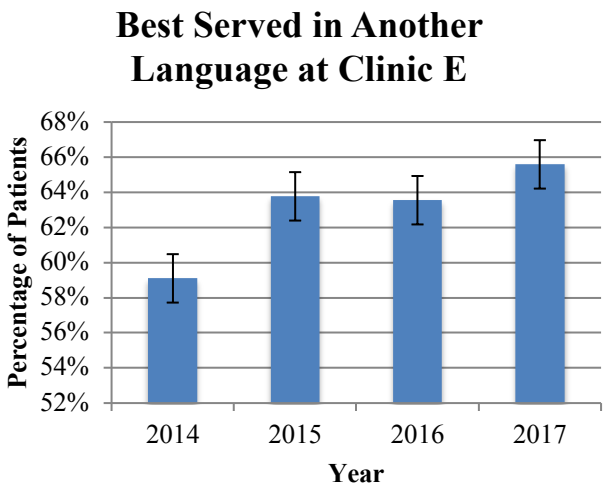

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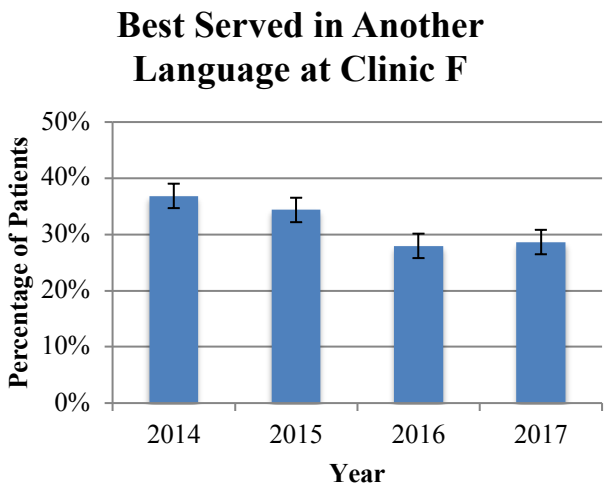

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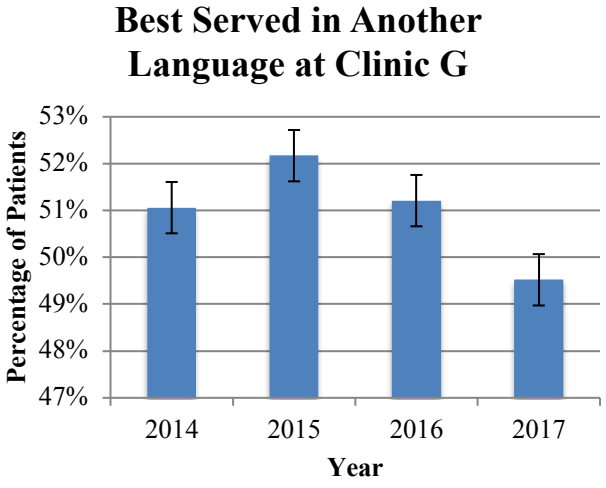


Figure 10. Rates of patient visits at seven clinics, broken down by those best served in a language other than English, from 2014-2017. **A.** Clinic A, **B.** Clinic B, **C.** Clinic C, **D.** Clinic D, **E.** Clinic E, **F.** Clinic F, and **G.** Clinic G.[127]

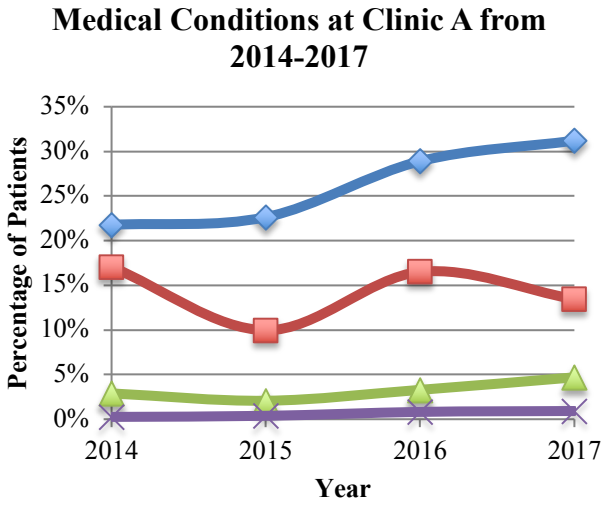
As illustrated by the charts, the proportion of patients best served in a language other than English declined from 2016-2017 for five out of the seven clinics all but Clinics E and F. Like the data from patient visits down by race/ethnicity, the decrease for the majority of the sites from 2016 to 2017 as measured by visits by patients best served in another language demonstrates a decline in immigrants using clinics.

iii. Rates of Medical Conditions Treated

The last metric I measured from the annual health center report was of the rates of various medical conditions treated at each clinic. Literature I reviewed, as well as doctors I interviewed, suggested I focus on rates of treatments for conditions commonly associated with the Latinx community. Diabetes disproportionately affects Latinx patients both nation- and statewide, more than any of the other ailment I researched.[128] I sorted data from the annual report to determine rates of diabetes at each clinic and compare it to trends of treatments of other illnesses (Appendix 8). Figure 11 graphically depicts the rates of medical conditions treated across all seven clinics.

[128] "America's Health Rankings: Diabetes" (United Health Foundation).

A.



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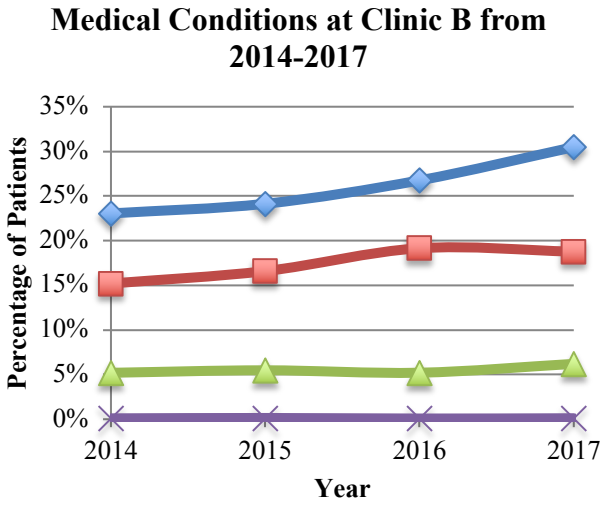

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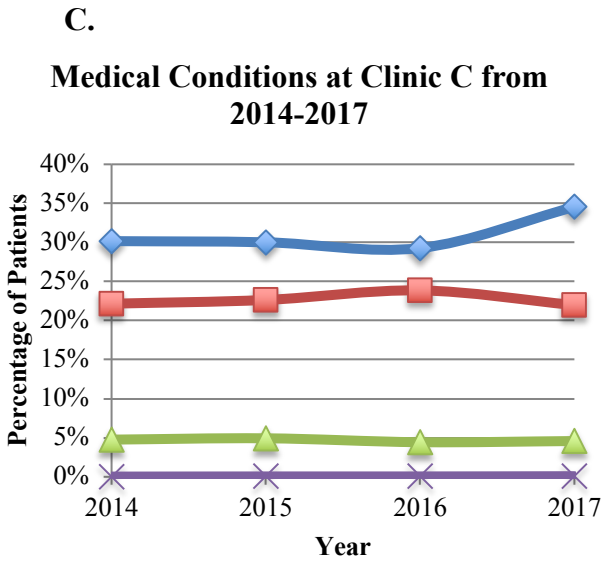

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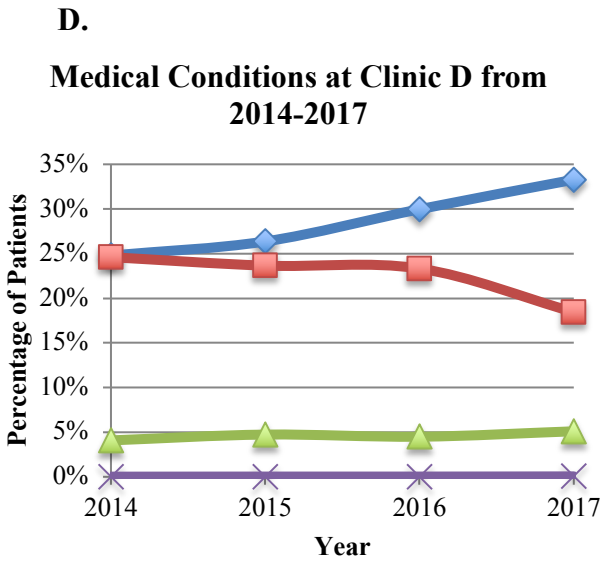

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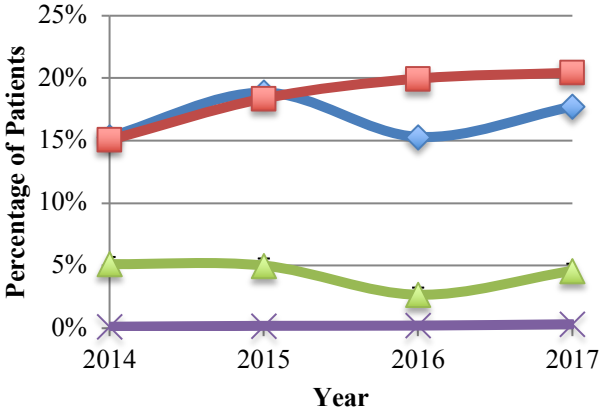

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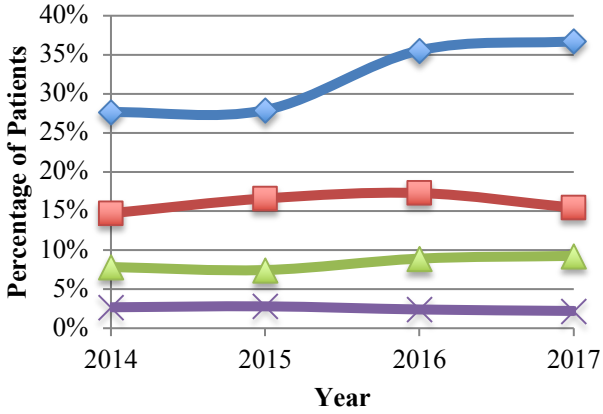

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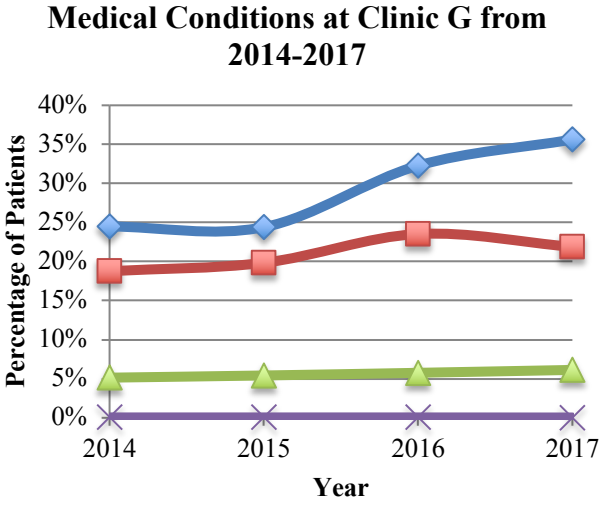

Figure 11. Rates of medical conditions from 2014-2017. **A.** Clinic A, **B.** Clinic B, **C.** Clinic C, **D.** Clinic D, **E.** Clinic E, **F.** Clinic F, and **G.** Clinic G.[129] Red with squares represent rates of diabetes, green with triangles represent asthma, navy blue with diamonds represent hypertension, and purple x's represent HIV.[130]

According to the data from the annual report (Appendix 4) graphically represented in Figure 11, hypertension and diabetes comprised the most common medical conditions treated at the seven clinics, while asthma and HIV were less common. Each fluctuated across the years.

[129] "Health Center Program Grantee Profiles."
[130] "Health Center Program Grantee Profiles."

Most striking was the fact that diabetes treatments decreased for all but one clinic from 2016-2017.[131] Just as percentages of patients best served in another language and rates of Latinx patients were used to indicate patterns of usage of health clinics by undocumented individuals, trends of diabetes treatments can similarly be evidence of these same patterns because diabetes has a higher prevalence in the Latinx community more than any other race or ethnicity, and most of the undocumented immigrants in Los Angeles are Latinx. While rates of diabetes generally increased from 2014-2016 for most of the sites, the drop from 2016-2017 could be an indication of the declining undocumented population making use of health services in the year following Trump's election and the corresponding reinstatement of Secure Communities. I summed all medical conditions data across each clinic to incorporate the findings from this third metric in one graph, which I then compared to rates of those same medical conditions to their prevalence in California as a whole to look at differences in trend (Figure 12).

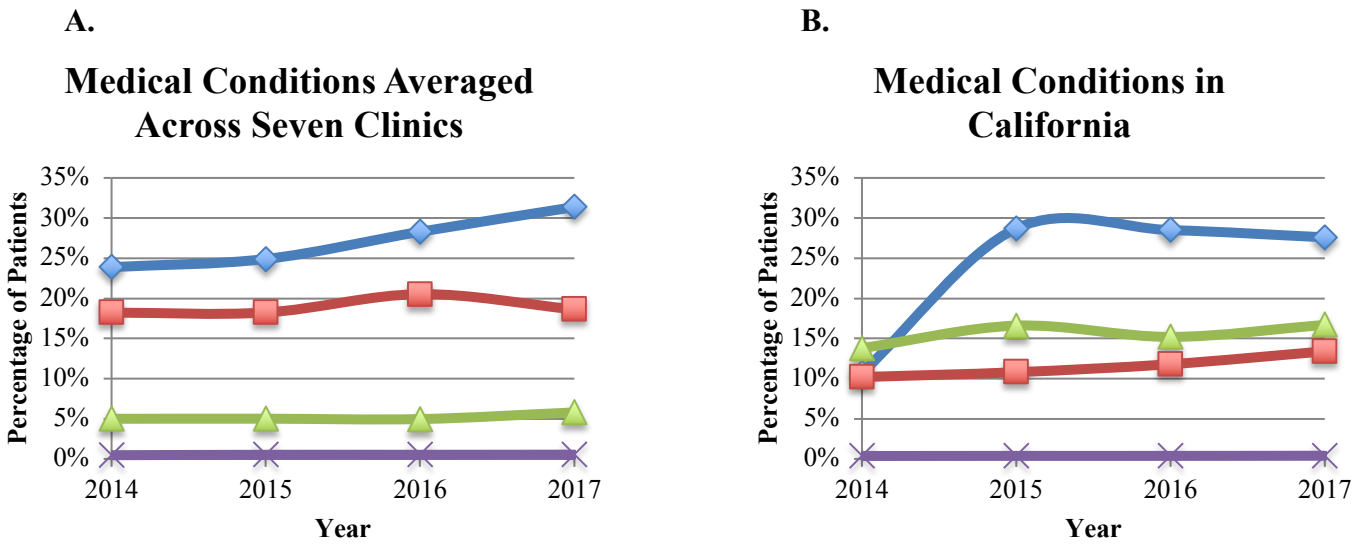

Figure 12. Rates of medical conditions in **A.** all seven case study clinics totaled and **B.** California as a whole, from 2014-2017.[132]

[131] "Health Center Program Grantee Profiles."
[132] "Health Center Program Grantee Profiles."

While rates of diabetes increased from 2014 to 2016 and then decreased from 2016 to 2017 for all clinics combined, rates of diabetes rose consistently across all four years in California as a whole. The state-level statistics also demonstrated higher incidences of asthma than diabetes, a trend not reflected in the seven clinics in and around South Central. The comparison between the community health clinic trends with those of the state suggest that the decline in diabetes treatments from 2016-2017 in the Los Angeles clinics is not symptomatic of an overall reduction in diabetes. Since rates increased in California from 2014-2017, but not in the health centers that serve a greater percentage of immigrants, the rates observed in the case study data could be illustrative of the decline in immigrant usage of health services.

The three metrics I examined in my investigation of the quantitative data provided by the Uniform Data System each suggested a dropoff in visits to health clinics by immigrants in South Central, when operating under a few assumptions proposed by prominent immigration and health scholars. In examining trends of patient visits broken down by race and ethnicity, every one of the seven clinics in the South Central case study observed a decrease in Latinx patient visits from 2016 to 2017 (Figure 9). Four of these clinics saw an increase in visits by this population for three years prior to 2017, and then a decline in the year Secure Communities was reinstated (Table 2). Since Latinx individuals comprise the highest proportion of undocumented immigrants in Los Angeles, this data indicates that fewer immigrants used health services in 2017 than did in 2016. This finding was corroborated by an examination of patient visits by those best served in another language, a percentage that declined for five of the seven clinics from 2016 to 2017 (Figure 10). Similarly, when operating under the assumption that those patients best served in another language are more likely to be undocumented immigrants than are those who speak

perfect English, this decreasing trend between the last two years suggests Secure Communities, or other related anti-immigration policy and rhetoric, has played a role.

Observations of the medical conditions treated at each clinic in the South Central case study further substantiated these conclusions, as rates of treatment for diabetes declined from 2016 to 2017 when averaged across all seven clinics, despite statewide diabetes rates increasing during that same time period (Figure 12). Since diabetes disproportionately affects Latinx individuals, and the majority of undocumented immigrants in Los Angeles come from Latin American countries, this trend in medical treatments suggests a dropoff in number of Latinx patients, and perhaps of undocumented patients, between 2016 and 2017.

Finally, data on patient visits at three sites from Clinic C also contributed to my findings about the impacts of Secure Communities. These statistics provided by Participants 3, 3a, and 3b from Clinic C give an indication of the decreasing rates of patients with My Health LA from 2015 to 2016 (Appendix 2). Rates of visits by patients with Medi-Cal generally increased from 2015 to 2016, so the decline in usage of My Health LA (MHLA) by Latinx individuals over that same period, when acknowledging the disproportionate number of unauthorized individuals with MHLA, could suggest that fewer undocumented immigrants are making use of these health clinics in recent years (Figures 7 and 8). This specific data from Clinic C on patient visits broken down by provider, when analyzed in coordination with the aforementioned trends I observed from the larger Uniform Data System, support my hypothesis that Trump's election and his subsequent reinstatement of Secure Communities in January of 2017 have had negative impacts on the participation of immigrants in health clinics.

Chapter 5: Assessment of Secure Communities and Policy Recommendation

In an era of such contentious debates around immigration, health care reform, and national security, the implementation of policies regarding any one of these subjects cannot be evaluated in a vacuum. Each plays a role in another, with impacts felt across industries and communities in ways that the original policymakers might not always predict. In the case of Secure Communities, not only has the program resulted in record numbers of detentions and deportations, but it has also had implications on perceptions of safety and belonging by immigrants themselves. These psychological effects continue to influence human behavior, access to resources, and ultimately public health. As fears of deportations drastically rise, we have seen disengagement of immigrant populations from certain public services and local communities. This thesis has demonstrated a consequential decline in immigrant use of health clinics as well, suggesting a much more severe affront to public health and safety of society as a whole. In analyzing the qualitative information gained by participant interviewees, quantitative data from a national report on community clinics, and relevant case studies from reputable immigration and health scholars, my research illuminates a concerning trend: recent anti-immigrant rhetoric and policies, such as that of Donald Trump and his reinstatement of Secure Communities, has resulted in a decrease in immigrant participation in South Central health clinics. Various data included in this thesis support this hypothesis.

My conversation with Participant 2 from Clinic B on February 4 introduced a response to these policy impacts that I had not anticipated. The Community Clinic Association of Los Angeles County, in recognizing the immediate threats posed by policies and rhetoric of the new presidential administration, held a series of meetings in the fall of 2016 and early months of 2017 to set new standards to keep their patients safe and secure, particularly for those of vulnerable

status. Participant 2's Clinic B participates in the Community Clinic Association (CCA), where he shares best practices and engages in advocacy work with the state and federal government on the issue of immigrant rights and health care. He has worked with the CCA to fight for sanctuary policies for clinics like his so that ICE agents are prohibited from entering and using reported information, and he has begun pushing other clinics to do the same. However, one of his primary concerns is in the size and capacity of the Clinic B. While he can publish statements regarding the clinic's stance on immigration and emphasize their commitment to the privacy and protection of their patients, Clinic B is too small of a clinic to have full-time staff physically preventing federal immigration agents from entering.[133]

Participant 2 was not the only one of my interviewees to speak about the proactive steps he and his coworkers have taken to safeguard patient safety, especially amidst such pervasive anti-immigrant rhetoric and legislation. Participant 1 of the Clinic A also spoke to practices recently implemented to make sure the site's undocumented patients feel safe and comfortable coming in for necessary appointments. His clinic is one of the many in Los Angeles that enrolls patients for My Health LA, and like Participant 3, he began seeing a major decline in the number of patients enrolled in the program and visiting the clinic after Trump's election. Participant 1 took it upon himself to call as many patients as he could to personally encourage them to sign up, and to assure them that doing so would not compromise their ability to remain in the United States. Just as the Patient Enrollment administrators at Clinic C reported, many immigrant patients opted not to complete the annual re-enrollment of My Health LA. Some stated they thought it was terminated under Trump. Others simply feared to put down their name on any

[133] Interview with Participant 2.

government records, particularly for a program commonly associated with undocumented individuals.[134]

Participant 3 did give me some hope by the end of our conversation. While she all too clearly saw the effects of the statements that have been made against immigrants on the local, state, and national level over the past few years and dreads the increased presence of Immigration and Custom Enforcement in Los Angeles under Secure Communities, she explained that she and several coworkers had hosted a series of communications and trainings about how to talk with patients for staff members at Clinic C. She has gradually seen patients return over the past few months, and she told me about a statement the clinic sent out to all patients and the wider community clarifying their position on issues of immigration. They promise to not inquire about immigration status, refrain from releasing patient information to ICE to the extent that is legally possible, and to remain committed to serving and protecting everyone who walks through their doors.[135] Participant 3, along with each of the other doctors, health administrators, the social worker, and the professor I spoke with each made one thing clear: the medical services provided by the health clinics not only in South Central, but also in Los Angeles and in cities across the nation, are necessary institutions that see some of the neediest patients in the country. Any piece of legislation, Executive Order, or other government program that might compromise access to these centers for any patient poses a far greater problem for public health than is currently recognized by those implementing such policies. A revocation of Secure Communities and prioritization of quality health care for those who need it most is paramount in a time of such fear, xenophobia, and dramatic disparities in health outcomes.

[134] Interview with Participant 1.
[135] Interview with Participant 3.

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Appendix

Appendix 1. Components of IRB proposal, including the Consent Form (A) and Debriefing Form (B), which was approved in December of 2017.

(A) Consent Form

Project Title: Impacts of Secure Communities on Immigrant Participation in Health Clinics

Principal Investigator (the head researcher):
This research is being conducted by Grace Reckers, a student at Scripps College, as part of the senior thesis requirement under the supervision of Nancy Neiman Auerbach, a Professor in the Department of Politics at Scripps College.

Project Description:
You are invited to participate in this research study about the usage of health services by immigrant populations. The following information is provided in order to help you to make an informed decision about whether or not to participate. If you have any questions please do not hesitate to ask. The purpose of this research study is to investigate how the usage of health services has changed after the passage of strict immigration policies over the past five years. In particular, I am interested in whether or not there has been a change participation rates of Latino patients in terms of visits to the health clinic. I am hoping this information will indicate whether or not increasing fears of deportation influence how public health services are used by Latino immigrants.

Who Can Participate:
You are qualified to participate in this research because you are a health care provider for people in Pomona. This means you are 18 years or older, you are a U.S. citizen, you have never been convicted of a felony, and you can understand spoken English.

What Participating Involves:
Participation in this study will require approximately half an hour to one hour of your time. I have a series of questions to ask you for the interview/survey/focus group. The questions I will ask you are about what you know about Secure Communities; whether or not you have seen an increase, decrease, or no change in the number of Latino residents coming to the health clinic over the past five years; and what effects you think recent immigration policies have had on the usage of public health services by Latinos at your clinic. The information I gather from interviews and other research will culminate in my senior thesis, which will be available for online public view starting April of 2018 as part of the Scripps College senior thesis requirement.

Possible Benefits of Participating:
You are likely to experience no direct benefits to your participation in this research.

Possible Risks of Participating:

Participation in this study will likely involve minimal risk to you. The questions you will be asked will be similar to what you encounter in your daily life. You are not likely to experience any physical discomfort, and any emotional discomfort should be minimal. In the event of any problems resulting from participation in the study, information about psychological treatment is available through the American Psychological Association at locator.apa.org.

Agreeing to Participate:

You are voluntarily making a decision whether or not to participate in this research study. Your signature certifies that you have decided to participate having read and understood the information presented and that you are 18 years old or older. You will be given a copy of this consent form to keep.

_____	_____	_____
Signature of Research Participant	Printed Name	Date
_____	_____	_____
Signature of Researcher	Printed Name	Date

Grace Reckers, Principal Investigator

(B) Debriefing

Impacts of Secure Communities on Immigrant Participation in Health Clinics

Thank you for your participation in this study. This debriefing is given as an opportunity for you to learn more about this research project, how your participation plays a part in this research, and why this research may be important to society. Please do not discuss this study with anyone else who might also participate in the future. Knowledge about the study may influence their responses and, essentially, invalidate the information obtained from them.

Recent immigration policies and expansion of the federal Immigration Custom Enforcement (ICE) agents has been a major topic of conversation throughout the United States. As the rates of deportations of undocumented immigrants rise, so do fears of detentions and deportations, particularly amongst immigrant Latino families who either are themselves undocumented or who have close family and friends who are in this country without papers. Some have observed that alongside these increasing fears of deportation has been a decrease in usage of public services by Latino immigrants. Once such policy that has had an observable influence on rising fears amongst immigrants is the Secure Communities Act, which was reinstated by President Trump in January of 2017. This Act expanded the number of ICE agents involved in immigration enforcement and has created partnerships between local and state law enforcement and federal ICE agents. Many have argued that this sharing of information between local government officials and ICE has created a "chilling effect" amongst undocumented Latino immigrants, who are now less likely to use public assistance and health services for fear of reporting immigration status. This study is concerned with determining whether or not the use of health clinics by Latinos in Pomona has changed in response to the Secure Communities Act.

This study is designed to gain information from health care providers about their own observations of what effect the Secure Communities Act has had on Latino families and their use of health clinics. The questions I have asked in my interviews with health care providers in Pomona have attempted to expose what changes they might have seen in terms of the number of Latinos who visit the health clinic. I hypothesized that due to recent strict immigration policies, particularly as a consequence of the Secure Communities Act, the number of visits to health clinics by Latinos has decreased. This research is important because it exposes greater implications of the Secure Communities Act, beyond its stated purpose of keeping communities safe. Demonstrating a relationship between increasing fears of deportation and a drop in the use of health services would be significant because this would indicate a public health issue facing the larger community. Lesser participation in medical clinics by a considerable proportion of the population would be a major problem and one that would tie together issues of immigration and public health.

It is likely that the results of this research will be presented at an academic conference in April of 2018. Again, your individual responses will be kept anonymous during this process. If you are interested in the results of this study or if you have any additional questions or comments, please contact Grace Reckers by phone at (xxx) xxx-xxxx or by mail at Scripps College, 345 E. 9th St., Box #xxx, Claremont, CA 91711. If you have any questions about your rights as a research participant, please contact the Scripps College Institutional Review Board at irb@scrippscollege.edu.

Thank you again for your participation!
Grace Reckers

Appendix 2. Patients at three Clinic C sites, broken down by ethnicity/race, age bracket, and cost provider, from 2015-2016 (Clinic C Patient Demographics, 2015-2016).

2.A. Latinx patients at Gardena, Inglewood, and Redondo.

Gardena	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	698	32	204	270
19-30 yrs	101	102	101	99
31-45 yrs	491	613	134	147
46-60 yrs	348	427	154	156
60 Yrs and over	125	129	46	72
TOTALS	1763	1303	639	744

Inglewood	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	89	29	166	209
19-30 yrs	107	102	79	89
31-45 yrs	636	726	63	102
46-60 yrs	447	526	134	129
60 Yrs and over	91	114	52	41
	1370	1497	494	570

Redondo	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	51	28	16	19
19-30 yrs	60	23	21	16
31-45 yrs	346	214	9	13
46-60 yrs	234	170	22	17
60 Yrs and over	59	47	11	23
	750	482	79	88

2.B. Latinx patients totaled for all three Clinic C sites (Gardena, Inglewood, and Redondo), broken down by age bracket, race/ethnicity, and cost provider (Clinic C Patient Demographics, 2015-2016).

All Latinx patients	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	838	89	386	498
19-30 yrs	268	227	201	204
31-45 yrs	1473	1553	206	262
46-60 yrs	1029	1123	310	302
60 Yrs and over	275	290	109	136
	3883	3282	1212	1402

2.C. Black patients at Gardena, Inglewood, and Redondo.

Gardena	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	1	0	6	6
19-30 yrs	9	0	3	1
31-45 yrs	0	1	5	3
46-60 yrs	0	0	3	2
60 Yrs and over	1	1	0	1
TOTALS	11	2	17	13

Inglewood	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	4	1	15	6
19-30 yrs	0	0	12	8
31-45 yrs	4	7	6	7
46-60 yrs	4	6	10	13
60 Yrs and over	5	4	5	5
	17	18	48	39

Redondo	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	0	0	0	0
19-30 yrs	0	0	0	0
31-45 yrs	1	0	1	0
46-60 yrs	0	0	0	0
60 Yrs and over	0	0	0	0
	1	0	1	0

2.C. Black patients totaled for all three Clinic C sites (Gardena, Inglewood, and Redondo), broken down by age bracket, race/ethnicity, and cost provider (Clinic C Patient Demographics, 2015-2016).

All Black patients	2015 MHLA	2015 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	5	1	21	12
19-30 yrs	9	0	15	9
31-45 yrs	5	8	12	10
46-60 yrs	4	6	13	15
60 Yrs and over	6	5	5	6
	29	20	66	52

2.D. Asian patients at Gardena, Inglewood, and Redondo.

Gardena	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	0	0	1	6
19-30 yrs	0	0	0	4
31-45 yrs	0	5	0	0
46-60 yrs	2	6	2	9
60 Yrs and over	0	8	0	1
	2	19	3	20

Inglewood	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	1	0	1	1
19-30 yrs	0	1	0	3
31-45 yrs	1	3	3	2
46-60 yrs	1	8	0	3
60 Yrs and over	2	4	2	2
	5	16	6	11

Redondo	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	0	1	0	1
19-30 yrs	0	0	0	1
31-45 yrs	3	6	0	3
46-60 yrs	0	0	1	0
60 Yrs and over	2	4	3	0
	5	11	4	5

2.E. Asian patients totaled for all three Clinic C sites (Gardena, Inglewood, and Redondo), broken down by age bracket, race/ethnicity, and cost provider (Clinic C Patient Demographics, 2015-2016).

All Asian patients	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	1	1	2	8
19-30 yrs	0	1	0	8
31-45 yrs	4	14	3	5
46-60 yrs	3	14	3	12
60 Yrs and over	4	16	5	3
	12	46	13	36

2.F. White patients at Gardena, Inglewood, and Redondo.

Gardena	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	1	0	2	4
19-30 yrs	2	0	4	4
31-45 yrs	1	2	8	6
46-60 yrs	0	1	5	7
60 Yrs and over	3	1	0	2
	7	4	19	23

Inglewood	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	0	0	0	0
19-30 yrs	1	1	1	1
31-45 yrs	0	2	1	2
46-60 yrs	0	4	0	4
60 Yrs and over	0	0	0	0
	1	7	2	7

Redondo	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	1	2	2	4
19-30 yrs	1	1	8	1
31-45 yrs	3	3	5	3
46-60 yrs	7	7	8	4
60 Yrs and over	3	2	4	2
	15	15	27	14

2.G. White patients totaled for all three Clinic C sites (Gardena, Inglewood, and Redondo), broken down by age bracket, race/ethnicity, and cost provider (Clinic C Patient Demographics, 2015-2016).

All White patients	2015 MHLA	2016 MHLA	2015 Medi-Cal	2016 Medi-Cal
0-18yrs	2	2	4	8
19-30 yrs	4	2	13	6
31-45 yrs	4	7	14	11
46-60 yrs	7	12	13	15
60 Yrs and over	6	3	4	4
	23	26	48	44

Appendix 3. Patients totaled for all age brackets of Clinic C patients, broken down by cost provider, clinic site, and race/ethnicity for 2015-2016 (Clinic C Patient Demographics, 2015-2016).

Latinx patients, summed across age brackets

	2015 MHLA	2015 Medi-Cal	2016 MHLA	2016 Medi-Cal
Gardena	1763	639	1303	744
Inglewood	1370	494	1497	570
Redondo	750	79	482	88

Black patients, summed across age brackets

	2015 MHLA	2015 Medi-Cal	2016 MHLA	2016 Medi-Cal
Gardena	11	17	2	13
Inglewood	17	48	18	39
Redondo	1	1	0	0

Asian patients, summed across age brackets

	2015 MHLA	2015 Medi-Cal	2016 MHLA	2016 Medi-Cal
Gardena	2	3	19	20
Inglewood	5	6	16	11
Redondo	5	4	11	5

White patients, summed across age brackets

	2015 MHLA	2015 Medi-Cal	2016 MHLA	2016 Medi-Cal
Gardena	7	19	4	23
Inglewood	1	2	7	7
Redondo	15	27	15	14

Appendix 4. Patients of all age brackets and races/ethnicities, broken down by cost provider and clinic site for 2015-2016 (Clinic C Patient Demographics, 2015-2016).

All Medi-Cal/MHLA patients summed across race/ethnicity and age bracket

	2015 MHLA	2015 Medi-Cal	2016 MHLA	2016 Medi-Cal
Gardena	1783	678	1328	800
Inglewood	1393	550	1538	627
Redondo	771	111	508	107
TOTALS	3947	1339	3374	1534

Appendix 5. Profiling seven clinics in the case study (Health Center Program Grantee Profiles, Human Resources and Services Administration).

Clinic A

Age (% of total patients)	2014	2015	2016	2017
Children (< 18 years old)	35.30%	32.96%	23.44%	27.34%
Adult (18 - 64)	59.87%	58.12%	65.54%	63.23%
Older Adults (age 65 and over)	4.83%	8.92%	11.02%	9.43%
Racial and/or Ethnic Minority				
	70.57%	75.45%	85.00%	81.22%
Patients By Race & Ethnicity				
Non-Hispanic White	34.71%	24.91%	20.64%	23.84%
Hispanic/Latino Ethnicity	56.42%	67.79%	71.67%	64.22%
Black/African American	12.87%	3.74%	7.31%	9.48%
Asian	1.98%	2.73%	6.50%	5.80%
American Indian/Alaska Native	0.34%	0.06%	0.32%	0.40%
Native Hawaiian/Other Pacific Islander	1.00%	0.57%	1.72%	1.82%
More than one race	10.07%	1.04%	2.95%	2.47%
Best Served in another language				
	59.72%	24.99%	68.59%	51.22%
Medical Conditions				
Hypertension	21.77%	22.63%	28.90%	31.20%
Diabetes	17.06%	9.97%	16.50%	13.44%
Asthma	2.89%	2.07%	3.29%	4.69%
HIV	0.26%	0.38%	0.82%	0.92%
Prenatal Patients	834	770	996	1,023
Prenatal Patients who Delivered	507	273	663	856

Clinic B

Age (% of total patients)	2014	2015	2016	2017
Children (< 18 years old)	46.33%	46.85%	46.65%	48.54%
Adult (18 - 64)	49.90%	48.99%	49.27%	49.11%
Older Adults (age 65 and over)	3.77%	4.16%	4.08%	2.35%
Racial and/or Ethnic Minority				
	98.94%	97.85%	98.23%	96.55%
Patients By Race & Ethnicity				
Non-Hispanic White	6.88%	4.00%	2.84%	4.82%
Hispanic/Latino Ethnicity	85.39%	82.56%	80.99%	76.53%
Black/African American	31.92%	25.64%	25.08%	27.74%
Asian	4.31%	1.78%	1.43%	2.39%
American Indian/Alaska Native	1.97%	39.36%	38.37%	22.42%
Native Hawaiian/Other Pacific Islander	0.38%	0.43%	0.24%	0.32%
More than one race	0.00%	0.76%	1.16%	4.66%
Best Served in another language				
	57.22%	56.25%	61.00%	56.72%
Medical Conditions				
Hypertension	23.05%	24.13%	26.75%	30.48%
Diabetes	15.20%	16.59%	19.15%	18.77%
Asthma	5.20%	5.48%	5.21%	6.20%
HIV	0.10%	0.14%	0.08%	0.11%
Prenatal Patients	659	584	551	573
Prenatal Patients who Delivered	351	277	290	228

Clinic C

Age (% of total patients)	2014	2015	2016	2017
Children (< 18 years old)	24.52%	27.16%	27.06%	25.37%
Adult (18 - 64)	70.48%	68.30%	67.93%	70.83%
Older Adults (age 65 and over)	5.00%	4.55%	5.02%	3.80%
Racial and/or Ethnic Minority				
	85.62%	83.48%	84.53%	82.84%
Patients By Race & Ethnicity				
Non-Hispanic White	27.59%	19.68%	19.37%	21.43%
Hispanic/Latino Ethnicity	58.68%	55.48%	56.10%	52.18%
Black/African American	37.64%	22.35%	22.06%	23.54%
Asian	8.00%	4.73%	5.51%	5.80%

American Indian/Alaska Native	0.65%	0.14%	0.18%	0.14%
Native Hawaiian/Other Pacific Islander	2.18%	1.35%	1.47%	1.21%
More than one race	1.73%	0.98%	1.20%	2.34%
Best Served in another language				
	32.71%	11.62%	34.22%	27.54%
Medical Conditions				
Hypertension	30.17%	30.02%	29.28%	34.55%
Diabetes	22.16%	22.64%	23.86%	21.98%
Asthma	4.76%	4.93%	4.43%	4.58%
HIV	0.03%	0.05%	0.05%	0.08%
Prenatal Patients	735	434	415	568
Prenatal Patients who Delivered	430	233	199	245

Clinic D

Age (% of total patients)	2014	2015	2016	2017
Children (< 18 years old)	29.45%	30.89%	31.89%	32.42%
Adult (18 - 64)	65.84%	64.19%	62.38%	60.88%
Older Adults (age 65 and over)	4.71%	4.92%	5.72%	6.70%
Racial and/or Ethnic Minority				
	98.98%	98.38%	98.41%	98.23%
Patients By Race & Ethnicity				
Non-Hispanic White	1.07%	1.68%	1.65%	1.88%
Hispanic/Latino Ethnicity	94.69%	94.16%	93.69%	89.44%
Black/African American	3.96%	4.06%	4.57%	4.10%
Asian	0.13%	0.09%	0.10%	0.24%
American Indian/Alaska Native	0.04%	0.02%	0.02%	0.03%
Native Hawaiian/Other Pacific Islander	0.03%	0.07%	0.05%	0.10%
More than one race	0.72%	1.35%	0.64%	3.40%
Best Served in another language				
	63.38%	35.12%	79.61%	61.68%
Medical Conditions				
Hypertension	24.79%	26.36%	29.97%	33.28%
Diabetes	24.60%	23.65%	23.33%	18.45%
Asthma	4.08%	4.73%	4.49%	5.10%
HIV	0.02%	0.03%	0.03%	0.05%
Prenatal Patients	492	478	617	556
Prenatal Patients who Delivered	282	284	355	295

Clinic E

Age (% of total patients)	2014	2015	2016	2017
Children (< 18 years old)	30.32%	32.32%	30.29%	31.53%
Adult (18 - 64)	66.95%	64.49%	66.21%	65.23%
Older Adults (age 65 and over)	2.74%	3.20%	3.50%	3.24%
Racial and/or Ethnic Minority				
	99.20%	98.59%	97.14%	98.34%
Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	1.32%	2.31%	2.87%	2.94%
Hispanic/Latino Ethnicity	81.38%	82.56%	86.11%	86.05%
Black/African American	28.79%	26.48%	14.57%	15.64%
Asian	0.23%	0.72%	0.52%	0.55%
American Indian/Alaska Native	0.09%	0.08%	0.05%	0.08%
Native Hawaiian/Other Pacific Islander	0.36%	0.27%	0.16%	0.34%
More than one race	0.25%	0.07%	4.53%	3.49%
Best Served in another language	2014	2015	2016	2017
	59.10%	63.77%	63.55%	65.59%
Medical Conditions	2014	2015	2016	2017
Hypertension	15.31%	18.85%	15.31%	17.73%
Diabetes	15.06%	18.38%	19.97%	20.44%
Asthma	5.13%	5.01%	2.68%	4.59%
HIV	0.12%	0.19%	0.21%	0.32%
Prenatal Patients	840	1,346	1,225	1,334
Prenatal Patients who Delivered	528	718	809	963

Clinic F

Age (% of total patients)	2014	2015	2016	2017
Children (< 18 years old)	23.19%	23.57%	33.20%	28.49%
Adult (18 - 64)	71.95%	71.19%	61.79%	64.95%
Older Adults (age 65 and over)	4.86%	5.24%	5.02%	6.56%
Racial and/or Ethnic Minority				
	98.20%	98.38%	98.36%	98.90%
Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	2.71%	2.53%	2.73%	3.20%
Hispanic/Latino Ethnicity	36.43%	37.86%	37.68%	35.38%
Black/African American	84.51%	87.55%	90.42%	90.58%
Asian	6.09%	4.32%	3.24%	4.56%
American Indian/Alaska Native	1.76%	0.48%	0.23%	0.32%

Native Hawaiian/Other Pacific Islander	0.88%	0.82%	0.51%	1.21%
More than one race	1.31%	1.38%	1.50%	3.20%
Best Served in another language	2014	2015	2016	2017
	36.86%	34.36%	27.97%	28.65%
Medical Conditions	2014	2015	2016	2017
Hypertension	27.66%	27.92%	35.56%	36.73%
Diabetes	14.71%	16.61%	17.30%	15.42%
Asthma	7.83%	7.45%	8.91%	9.26%
HIV	2.68%	2.80%	2.40%	2.21%
Prenatal Patients	237	275	309	305
Prenatal Patients who Delivered	119	106	183	195

Clinic G

Age (% of total patients)	2014	2015	2016	2017
Children (< 18 years old)	20.26%	25.29%	26.94%	27.21%
Adult (18 - 64)	75.20%	69.48%	67.32%	65.38%
Older Adults (age 65 and over)	4.55%	5.23%	5.74%	7.41%
Racial and/or Ethnic Minority				
	97.83%	97.49%	97.71%	98.45%
Patients By Race & Ethnicity	2014	2015	2016	2017
Non-Hispanic White	2.31%	2.63%	2.47%	2.80%
Hispanic/Latino Ethnicity	68.06%	71.23%	71.31%	65.32%
Black/African American	28.33%	25.33%	25.91%	28.41%
Asian	2.05%	1.35%	1.23%	2.34%
American Indian/Alaska Native	0.33%	0.23%	0.27%	0.94%
Native Hawaiian/Other Pacific Islander	0.15%	0.07%	0.09%	0.04%
More than one race	0.11%	0.20%	0.31%	1.38%
Best Served in another language	2014	2015	2016	2017
	51.06%	52.17%	51.21%	49.52%
Medical Conditions	2014	2015	2016	2017
Hypertension	24.49%	24.40%	32.28%	35.62%
Diabetes	18.77%	19.84%	23.53%	21.88%
Asthma	5.14%	5.42%	5.76%	6.13%
HIV	0.05%	0.05%	0.05%	0.04%
Prenatal Patients	131	87	18	86
Prenatal Patients who Delivered	19	33	6	24

Appendix 6. Percent of patients served by race, broken down by clinic and year, and averaged for all clinics (Health Center Program Grantee Profiles, Human Resources and Services Administration).

Percent of Patients Served by Race

	Clinic A	Clinic B	Clinic C	Clinic D	Clinic E	Clinic F	Clinic G	AVERAGE
2014	0.3471	0.0688	0.2759	0.0107	0.0132	0.0271	0.0231	0.1094
	0.5642	0.8539	0.5868	0.9469	0.8138	0.3643	0.6806	0.6872
	0.1287	0.8192	0.3764	0.0396	0.2879	0.8451	0.2833	0.3972
	0.0198	0.0431	0.0800	0.0013	0.0023	0.0609	0.0205	0.0326
	0.0034	0.0197	0.0065	0.0004	0.0009	0.0176	0.0033	0.0074
	0.0100	0.0038	0.0218	0.0003	0.0036	0.0088	0.0015	0.0071
	0.1007	0.0000	0.0173	0.0072	0.0025	0.0131	0.0011	0.0203
2015	0.2491	0.0400	0.1968	0.0168	0.0231	0.0253	0.0263	0.0825
	0.6779	0.8256	0.5548	0.9416	0.8256	0.3786	0.7123	0.7023
	0.0374	0.2564	0.2235	0.0406	0.2648	0.8755	0.2533	0.2788
	0.0273	0.0178	0.0473	0.0009	0.0072	0.0432	0.0135	0.0225
	0.0006	0.3936	0.0014	0.0002	0.0008	0.0048	0.0023	0.0577
	0.0057	0.0043	0.0135	0.0007	0.0027	0.0082	0.0007	0.0051
	0.0104	0.0076	0.0098	0.0135	0.0007	0.0138	0.0020	0.0083
2016	0.2064	0.0284	0.1937	0.0165	0.0287	0.0273	0.0247	0.0751
	0.7167	0.8099	0.5610	0.9369	0.8611	0.3768	0.7131	0.7108
	0.0731	0.2508	0.2206	0.0457	0.1457	0.9042	0.2591	0.2713
	0.0650	0.0143	0.0551	0.0010	0.0052	0.0324	0.0123	0.0265
	0.0032	0.3837	0.0018	0.0002	0.0005	0.0023	0.0027	0.0563
	0.0172	0.0024	0.0147	0.0005	0.0016	0.0051	0.0009	0.0061
	0.0295	0.0116	0.0120	0.0064	0.0453	0.0150	0.0031	0.0176
2017	0.2384	0.0482	0.2143	0.0188	0.0294	0.032	0.028	0.0870
	0.6422	0.7653	0.5218	0.8944	0.8605	0.3538	0.6532	0.6702
	0.0948	0.2774	0.2354	0.041	0.1564	0.9058	0.2841	0.2850
	0.0580	0.0239	0.058	0.0024	0.0055	0.0456	0.0234	0.0310
	0.0040	0.2242	0.0014	0.0003	0.0008	0.0032	0.0094	0.0348
	0.0182	0.0032	0.0121	0.001	0.0034	0.0121	0.0004	0.0072
	0.0247	0.0466	0.0234	0.034	0.0349	0.032	0.0138	0.0299

Appendix 7. Percentage of patients best served in another language, broken down by year and clinic (Health Center Program Grantee Profiles, Human Resources and Services Administration).

Percentage of Patients Best Served in Another Language

	2014	2015	2016	2017
Clinic A	59.72%	24.99%	68.59%	51.22%
Clinic B	57.22%	56.25%	61.00%	56.72%
Clinic C	32.71%	11.62%	34.22%	27.54%
Clinic D	63.38%	35.12%	79.61%	61.68%
Clinic E	59.10%	63.77%	63.55%	65.59%
Clinic F	59.10%	63.77%	63.55%	28.65%
Clinic G	51.06%	52.17%	51.21%	49.52%

Appendix 8. Yearly rates of medical conditions across all seven clinics, and averaged for each (Health Center Program Grantee Profiles, Human Resources and Services Administration).

Medical Conditions

		Clinic A	Clinic B	Clinic C	Clinic D	Clinic E	Clinic F	Clinic G	AVERAGE
2014	Hypertension	0.2177	0.2305	0.3017	0.2479	0.1531	0.2766	0.2449	0.2389
	Diabetes	0.1706	0.1520	0.2216	0.2460	0.1506	0.1471	0.1877	0.1822
	Asthma	0.0289	0.0520	0.0476	0.0408	0.0513	0.0783	0.0514	0.0500
	HIV	0.0026	0.0010	0.0003	0.0002	0.0012	0.0268	0.0005	0.0047
2015	Hypertension	0.2263	0.2413	0.3002	0.2636	0.1885	0.2792	0.2440	0.2490
	Diabetes	0.0997	0.1659	0.2264	0.2365	0.1838	0.1661	0.1984	0.1824
	Asthma	0.0207	0.0548	0.0493	0.0473	0.0501	0.0745	0.0542	0.0501
	HIV	0.0038	0.0014	0.0005	0.0003	0.0019	0.0280	0.0005	0.0052
2016	Hypertension	0.2890	0.2675	0.2928	0.2997	0.1531	0.3556	0.3228	0.2829
	Diabetes	0.1650	0.1915	0.2386	0.2333	0.1997	0.1730	0.2353	0.2052
	Asthma	0.0329	0.0521	0.0443	0.0449	0.0268	0.0891	0.0576	0.0497
	HIV	0.0082	0.0008	0.0005	0.0003	0.0021	0.0240	0.0005	0.0052
2017	Hypertension	0.312	0.3048	0.3455	0.3328	0.1773	0.3673	0.3562	0.314
	Diabetes	0.1344	0.1877	0.2198	0.1845	0.2044	0.1542	0.2188	0.186
	Asthma	0.0469	0.062	0.0458	0.051	0.0459	0.0926	0.0613	0.058
	HIV	0.0092	0.0011	0.0008	0.0005	0.0032	0.0221	0.0004	0.005