FRAMING HEALTH DESERVINGNESS OF UNDOCUMENTED IMMIGRANTS:

PERSPECTIVES FROM HEALTH WORKERS

AT TWO ALABAMA CLINICS

by

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ABSTRACT

This study seeks to answer the call of medical anthropologists to study the moral issue of health deservingness through social scientific analysis. Specifically, this research attempts to find ways in which notions of health care deservingness for undocumented immigrants are framed by health workers in the southeastern United States. Interviews were conducted with health workers at all levels (n=31) in two safety-net clinics in Alabama to test two hypotheses. Based on clinic characteristics, it was hypothesized that a medical humanitarianism frame would be more frequently used among health workers at the community health center than at the public health department clinic. Based on the interests of public health in infectious disease control and surveillance, it was hypothesized that an infectious disease frame would be more frequently used among health workers at the public health department clinic than at the community health center. Content analysis was used to examine arguments, and chi-squares were used to test hypotheses. Health workers at both clinics stressed medical humanitarianism more than any other frame to argue for the health deservingness of undocumented immigrants in the United States. Furthermore, participants relied on the articulation of several frames. Conclusions demonstrate the salience of humanitarian ideals and reveal the ways in which frames are used to argue for or against deservingness.
DEDICATION

This thesis is dedicated to the memory of my grandmother, Jean Bianchi.
LIST OF ABBREVIATIONS AND SYMBOLS

CHC  Community Health Center

PHD  Public Health Department

N    Study sample

\( p \)  Probability associated with the occurrence under the null hypothesis of a value as as or more extreme than the observed value

\( \alpha \)  Level of significance and probability of rejecting a true null hypothesis

\( t \)    T-statistic

\( r \)    Pearson correlation
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CHAPTER ONE
INTRODUCTION

Debates around the world currently focus on who is and is not deserving of health-related investment and care (Willen 2012). These debates are especially important for the estimated 20-30 million undocumented, or unauthorized, migrants worldwide (Ruiz-Casares, Rousseau, Derluyn, Watters, and Crepeau 2010). Ethnographic studies have focused on the construction of health deservingness, or lack thereof, for migrants in places like Israel (Willen 2012), France (Larchanche 2012), California (Marrow 2012), Canada (Vanthuyne et al. 2013), Germany (Castañeda 2009; Hushke 2014), and Costa Rica (Dos Santos 2015). In this thesis, I critically explore the health deservingness of undocumented immigrants in the state of Alabama, located in the southeastern United States. My research builds on the literature base of the health deservingness of migrants, which Castañeda (2012:830) defines as “‘migrants’ shifting and historically produced experiences of socio-political exclusion from their countries of residence, often leading them to be portrayed as unwanted, undesirable, and unworthy of services.”

The exclusion faced by undocumented immigrants is in many ways distinct from other forms of social exclusion rooted in socioeconomic status, racial-ethnic background, lack of permanent residence, history of incarceration, dependence on addictive substances, or mental health status, among other factors (Willen 2012). As non-citizens without formal rights to membership or belonging, undocumented immigrants are excluded from participating in the political sphere (Willen 2012). They not only lack rights but lack the right to have rights in the first place (Arendt 1973). Thus, they are excluded from the political community and the moral
community of people whose injuries, illnesses, and lives are considered worthy of concern, attention, or investment (Willen 2011; Willen 2013). Both forms of exclusion carry ethical, experiential, and epidemiological consequences (Willen 2012).

While deservingness has been extensively explored in the welfare literature, much less is known about health-related deservingness (Willen 2012). Health deservingness is different from formal entitlements to health, with legal stipulations that comprise the right to health care. Instead, deservingness is rendered from ethical decisions and moral assessments. These assessments are often conditional, relying on perceived or actual characteristics of an individual or group (Willen 2012). These constructions are also influenced by social, cultural, political, and economic contexts (Willen 2012).

Health deservingness of immigrants has been “framed” in different ways by various stakeholders and by immigrants themselves (Willen 2011; Viladrich 2012). Framing has been used by cognitive and linguistic anthropologists, along with other social scientists, as an analytical tool (Sargent 2012). Frames are those language structures that organize schemas and cultural models for verbal expression, and as the term implies, focus the attention on certain elements and not on others (Casson 1983). Readers will recognize frames that cast undocumented immigrants as “illegal aliens,” which suggest unlawful behavior and violation of rules, along with frames that posit that health care is fundamentally a human right (Viladrich 2012). These frames help to extend or limit the deservingness of undocumented immigrants. In this thesis, I critically investigate frames utilized by health workers in two safety-net clinics.

The 2011 Alabama law House Bill 56 was described at the time as the strictest immigration law in the nation (Robertson 2011). This bill required proof of lawful U.S. residence to receive state and local public benefits, except those protected by federal laws, including
prenatal and emergency care, child and adult protective services, and other services (i.e., immunizations; the Special Supplemental Nutritional Program for Women, Infants, and Children; and short-term disaster relief) (Preston 2011; White et al. 2014). This bill casts undocumented immigrants as “illegal aliens” undeserving of governmental health benefits (HB 56 2011; White et al. 2014). HB56 bill, coupled with the 2010 Patient Protection and Affordable Care Act (ACA), which explicitly excludes undocumented immigrants from participation, creates symbolic, social, and empirical exclusions for this population (Marrow and Joseph 2015).

Previous research has demonstrated that laws aimed exclusively at restricting immigrants’ access to public benefits actually reduces immigrants’ use of health services, including those that are protected under federal law (White et al. 2014). White et al (2014) found that Latina immigrants reported reduced access to care following the implementation of HB56 in Alabama. Latinas gave many reasons for this reduced access, including perceiving themselves to be ineligible for publicly-funded health services and describing experiences of being denied services by staff unaware of exemptions protected by federal law (White et al. 2014).

This research examines views of health providers and staff at two safety-net clinics, both of which are embedded in the state and federal policies that in many ways restrict access to care for unauthorized immigrants. As such, these health workers are considered to be the main frontline or “street-level bureaucratic arms” of local governments (Marrow 2012: 848). Even while being influenced by bureaucratic processes and rules, they have some discretion in interpreting, enacting, and enforcing government policies in their work (Lipsky 1980; Maynard-Moody and Musheno 2003; Marrow 2012). Thus, this research seeks to explore how health deservingness is reckoned by street-level bureaucrats embedded in restrictive state and federal health policies that
deny undocumented immigrants’ “biolegitimacy” (Fassin 2009), or the legitimacy of their suffering bodies (Vanthuyne et al. 2013).

Thus, using a cognitive anthropological approach, I unite the literatures of framing, health deservingness, and street-level bureaucracy to investigate how health workers in Alabama construct undocumented immigrants’ health deservingness against the backdrop of HB 56 and the Affordable Care Act. Specifically, I compare frame use between health workers at two safety-net clinics, a community health center and county public health department, both of which provide medical care to un- and under-insured persons at sliding scale fees.

In the second chapter, I expand on immigrant health in the United States. This includes a brief introduction to health policies affecting immigrants without legal status. I also describe the roles of safety-net clinics and street-level bureaucrats in this system.

In the third chapter, I define health deservingness. As mentioned above, this topic, once relatively previously unexplored by anthropologists, has received greater attention in light of increasing health care costs, neoliberal pressures that drive the privatization and commoditization of health care, and growing health disparities within and between countries. Notions of health deservingness, while important, are often implicit parts in the political process.

In the fourth chapter, I detail “framing” and its relation to anthropology, specifically cognitive anthropology. Contemporary research methods in cognitive anthropology utilize a cognitive theory of culture, described by Ward Goodenough (1957:167) as “whatever it is one must know in order to behave appropriately in the any of the roles assumed by any member of society.” Frames are essentially those language structures that organize cultural knowledge for verbal expression, and as the term implies, focus the attention on certain elements and not on others (Casson 1983).
In the fifth chapter, I describe the mixed-methods used in this study. These methods include semi-structured interviews with health workers (n=31) at two clinics and observations in clinic waiting rooms. Content analysis was employed to analyze frames used by health workers. Statistical procedures, including chi-squares, were used for hypothesis testing.

In the sixth chapter, I present the results. This includes demographic information and hypothesis testing. This also includes a presentation of emergent themes from semi-structured interviews and statistically analysis. In the seventh chapter, I discuss these results in light of existing literature on health deservingness. Last, in chapter eight, I offer conclusions and future directions for this research.
CHAPTER TWO

UNDOCUMENTED IN THE UNITED STATES

An estimated 11.1 million undocumented immigrants lived in the United States in 2014 (Passel and Cohn 2016). Most of these unauthorized immigrants entered the country without documents or had valid visas but stayed past their visa expiration date or in some way violated the terms of admission into the country (Passel and Cohn 2016). Undocumented immigrants are not eligible for public benefit programs, including Medicaid, as program applicants are required to prove lawful residency (White, Blackburn, Manzella, Welty, and Menachemi 2014). Exceptions are made for medical emergencies and certain public health programs (e.g., immunizations), and health care subsidies for federal services for the uninsured, no matter immigrant status, are offered in certain states and localities (White et al. 2014). These restrictions are not just aimed at immigrants without legal status. Even some legal immigrants do not qualify for Medicaid or the State Children’s Health Insurance Program (SCHIP) since the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) which requires that legal immigrants wait five years after receiving permanent resident status before applying for these programs (Newton and Adams 2009). Taken all together, it is not surprising that federal health care policy in the United States has been described as “decidedly hostile” towards immigrants (Newton and Adams 2009: 422).

At least since the passage of the PRWORA in 1996, there have been two groups of immigrants in the United States: those qualified for health and social entitlements and those unqualified (Viladrich 2012). As such, immigrant health in the United States reflects exclusion-
and entitlement-based policies that influence health risks and access to care (Sargent 2012). Such restrictions, coupled with the fact that unauthorized immigrants are concentrated in low-wage and informal jobs not likely to provide private insurance, help explain why unauthorized immigrants have some of the highest rates of lacking a usual source of care, highest rates of uninsurance and chronic uninsurance, lowest rates of per capita health spending, highest out-of-pocket costs for care, and least frequent rates of visiting a physician (Marrow 2012).

The 2010 Patient Protection and Affordable Care Act (ACA)—the first major health care reform in 45 years—moved the US paradigm for insurance from one based on exclusionary welfare-models towards a broader, more inclusive paradigm designed to ensure that almost all Americans can obtain health insurance (Marrow and Joseph 2015; Martinez et al. 2015). However, unauthorized immigrants are the only group explicitly excluded from participation (Marrow and Joseph 2015). Thus, the ACA may actually reduce access to care for many undocumented immigrants by isolating them from the previously uninsured population (Martinez et al. 2015).

A. *Biocultural Impacts of Immigrant Health Policy*

Restrictive access to healthcare is an effect of exclusion arising from the state’s attempts at criminalization and legalization (Castañeda 2012). As Willen et al. (2011:338) writes, “There is nothing natural or automatic about ‘illegal’ migration statuses or migrant ‘illegalities.’” Instead, these are social, economic, ideological, political, and juridical constructions that are designed and deployed for particular reasons in specific contexts. For example, along the U.S.-Mexico border, the notions of “immigrant,” “legality,” and “illegality” were selectively applied and regularly reformulated in the 19th and 20th centuries in light of changing U.S. employer demands and policies (Ngai 2004).
Willen (2007) argues that there are three dimensions of migrant “illegality”: as a configuration of juridical status, a sociopolitical condition, and a way of being-in-the-world. The independent embodied and experiential ramifications of “illegality” intersect with other dimensions of subjectivity (i.e., class, race/ethnicity, gender, and individual experiences) (Willen et al. 2011). Past research has demonstrated how being classified as “illegal” can engender feelings of fear, humiliation, disrespect, and ridicule; these feelings can occur concomitantly with other forms of exclusion, including stigma, denial of services, and discrimination (Fassin 2004; Sargent 2006; Willen et al. 2011). In many ways, then, the condition of “illegality” is a risk factor for immigrants’ health, their children’s health, social vulnerability and abuse across contexts (Castañeda 2009; Larchanche 2012; Simich et al. 2007).

Previous research has demonstrated associations between immigration policies and mental health among undocumented immigrants (Martinez et al. 2015). These experientially-grounded health consequences may also affect those not classified as “illegal” (Willen et al. 2011). For example, these may be familiar to people in “status limbo,” like those with Temporary Protected Status (Coutin 2003; Foxen 2008), or to members of mixed-status families (i.e., families with undocumented parents and citizen children) (Yoshikawa 2011).

Furthermore, structural inequalities become embodied in both epidemiological and phenomenological senses when undocumented immigrants avoid seeking care for fear of deportation (Quesada 2011) or internalize arguments that they do not deserve health care (Larchanche 2012; Willen 2012). Allostatic load, or the systemic somatic damage and loss of resilience resulting from persistent adaptation to stressors, may help explain differential health outcomes (Gersten 2008; Kaestner, Pearson, Keene, and Geronimus 2009; Edes and Crews 2017) in addition to more observable consequences, such as late-stage cancers or advanced
stages of treatable infectious disease (Willen 2012). They are also at perpetual risk of arrest and deportation, although health care institutions are not mandated to turn them in to federal immigration authorities (Heyman et al. 2009). Even as health care workers are not required to report to immigration authorities, undocumented immigrants may still face prejudice and discrimination when seeking medical care (Martinez et al. 2015). These issues are especially salient for undocumented pregnant women, who face numerous barriers when accessing prenatal care due to their marginalized status in the host country (Korinek and Smith 2011). Lack of insurance and unfamiliarity with the U.S. health system are among these barriers (Fleuriet 2009).

B. Safety Net Clinics

Health safety net hospitals and clinics are the major providers of health care for undocumented immigrants (Martinez et al. 2015). This research relies on perspectives from health workers at two types of safety-net clinics that provide health care for undocumented immigrants in Alabama: a county health department and a federally-qualified health center. Local public health departments operate as safety-net clinics for low-income, uninsured, and underinsured county residents. These are supported by a combination of local, state, and federal funds and offer a number of services that are protected (i.e. immunizations) and unprotected (i.e., primary care) under federal law (White et al. 2014). Thus, undocumented immigrants are generally eligible for some, but not all, health services offered at county health departments. Importantly, undocumented immigrants’ eligibility for services at public health departments vary by region. For example, California covers prenatal care for undocumented pregnant women who meet certain income requirements through its Medi-Cal program (MCAP 2017). Alabama, on the other hand, does not cover prenatal care for this population, meaning that uninsured,
undocumented pregnant immigrant pay out-of-pocket for pregnancy-related care (White et al. 2014).

Since the 1960s, the national system of federally qualified health centers (FQHCs), also called community health centers, has represented the main source of primary care for the nation’s designated ‘medically underserved populations’ (Marrow and Joseph 2015). These non-profit centers are open to all residents, regardless of citizenship status, insurance status, or ability to pay; are located in high-need areas where few physicians practice, with high rates of poverty, and high infant mortality rates; and provide comprehensive primary care services, including services that improve access to care, such as interpretation, case management, and transportation services (NACHC, 2016a). As such, community health centers have become important providers of health care for immigrants in the United States and have contributed to reducing ethno-racial health disparities (Mickey 2012; Searles 2012). In 2014, Alabama had fourteen federally-funded community health centers which received over 52 million dollars in federal funds to serve over 330,000 patients, nearly half of which were uninsured (NACHC 2016b).

As nonprofits become institutionalized and begin to provide services that were formerly provided by the state, nonprofit health organizations remove the state’s responsibility to address the needs of marginalized communities (Kamat 2003) by relying on low-cost local labor, while de-politicizing the issues (White 1999). This is a similar trend in other countries, including France, where Fassin (2004: 212) notes that the “state, rather than allowing itself the means to address problems specific to immigrants, started to withdraw by financing nongovernmental organizations responsible for implementing its health and social policies.” Thus, these non-profit health centers may unintentionally strengthen the legitimacy of the states’ withdrawal from
responsibility for exclusionary policies and social services, since their discourse is one of charity, not entitlement (Ticktin 2006; Gottlieb et al. 2012).

C. Why Alabama?

Studies have examined responses of states towards migrant populations, looking at how policies and practices affect bodies, notions of citizenship, and what it means to be human (Ticktin 2006). These include immigration policies. The United States has a long history of recruiting foreign workers and encouraging immigrants to settle throughout the county. At the same time, the federal government and individual states have made efforts to exclude migrants who are deemed undesirable (Gerken 2013). Over time, the criteria used to differentiate between desirable and undesirable immigrants has changed, revealing ways that immigration policies are affected by larger social, political, and economic forces (Gerken 2013). These include national security concerns, ideas about national identity, economic interests, and anxieties of immigrants’ ethnicity, gender, and sexuality (Gerken 2013).

Since the 1990s, there has been an increase in state and local immigration laws in the United States (Newton and Adams 2009). Some states have chosen to extend benefits to some immigrants, including children, the elderly, or students (Newton and Adams 2009). Other states have chosen to pass legislation that extends restrictions (Newton and Adams 2009). In 2011, Alabama joined several other states, including South Carolina, Georgia, and Arizona, in attempting to implement statewide immigration laws that restrict undocumented immigrants’ access to publicly funded health benefits (White et al. 2014). The Beason-Hammon Alabama Taxpayer and Citizen Protection Act (HB56 2011) was described at the time as the strictest immigration law in the nation, resembling a similar bill put forth by Arizona lawmakers, many parts of which were eventually suspended by the U.S. Supreme Court (Robertson 2011). HB56
was written in response to what Alabama lawmakers described as “economic hardship and lawlessness” caused by “illegal immigration” and “encouraged when public agencies within this state provide public benefits without verifying immigration status” (HB56 2011).

This bill required proof of lawful U.S. residence to receive state and local public benefits, except those protected by federal laws, including prenatal and emergency care, child and adult protective services, and other services (i.e., immunizations; the Special Supplemental Nutritional Program for Women, Infants, and Children; and short-term disaster relief) (Preston 2011; White et al. 2014). It further required public schools to report the immigration status of all students to ascertain any costs associated with the education of immigrant children without legal status (HB56 2011). It included provisions that authorized state and local police officers to inquire about the immigration status of anyone they stopped based on “reasonable suspicion” that the person does not have legal status (HB56 2011). The bill also required all Alabama employers to use a federal system, E-Verify, to confirm the legal status of workers, made it a crime for anyone to transport an immigrant without legal status, and made it a state crime for an immigrant not carrying a document proving legal status (Preston 2011).

After many of the most contentious parts of the bill were initially upheld by a federal judge, including the requirement of public schools to acquire the immigration status of students during registration, news reports described “the exodus of Hispanic immigrants” in the state, with parents pulling children from schools, even as some school superintendents reassured parents that children who were already enrolled would not be affected (Robertson 2011). Contractors, home builders, and farmers criticized the bill as causing critical shortages of labor, as undocumented and documented workers alike left the state (Robertson 2011). Proponents of
the bill, including Representative Mo Brooks, argued that these were precisely the “intended consequences” of the bill (Trowbridge and Weinger 2011).

In 2013, several parts of HB56 were permanently blocked after two separate lawsuits were brought against the state. One lawsuit was filed by several civil rights groups, including the Alabama-based Southern Poverty Law Center, and the other was filed by the U.S. Department of Justice. The blocked parts of the law included provisions that required schools to verify the immigration status of newly enrolled K-12 students and criminalized the transport of undocumented immigrants (SPLC 2013). Other parts of the bill are still in place, including a provision that during “any lawful stop, detention or arrest made by a law enforcement officer (state, county, or municipal) and reasonable suspicion exists that a person is an alien, unlawfully present, a reasonable attempt shall be made, when practical, to determine immigration status” (HB56 2011; Sheets 2017).

Previous research has demonstrated that laws aimed exclusively at restricting immigrants’ access to public benefits reduce immigrants’ use of health services (White et al. 2014). For example, immigrants were unable to receive or postponed medical care out of fear of deportation after California’s Proposition 187 was passed in 1994 (Asch et al. 1994; Berk and Schur 2001). In the wake of HB56 in Alabama, White et al. (2014) found that immigrants’ access to protected benefits – including communicable disease (e.g., sexually transmitted infections, tuberculosis) and family planning— was reduced. In a separate study, White et al (2014) found that Latina immigrants reported reduced access to care following the implementation of HB56. Latinas gave many reasons for this reduced access, including perceiving themselves to be ineligible for publicly-funded health services and describing experiences of being denied services by staff unaware of exemptions protected by federal law.
Latina immigrants also recounted experiences of mistreatment by staff at local clinics, including registration, billing, and clinical health workers (White et al. 2014). They attributed these incidents of mistreatments to the law (White et al. 2014). As White et al. (2014) argues, prior to HB56, undocumented immigrants faced many barriers to care, including lack of transportation, English proficiency, or health insurance; following HB56, these barriers were exacerbated.

D. Street-level Bureaucracy

This research examines views of providers and staff at two safety-net clinics, both of which are embedded in the state and federal policies that in many ways restrict access to care for unauthorized immigrants. As such, these health workers are considered the main front-line or “street-level bureaucratic arms” of local governments (Marrow 2012: 848). Even while being influenced by bureaucratic processes and rules, they have some discretion in interpreting, enacting, and enforcing government policies in their work (Lipsky 1980; Maynard-Moody and Musheno 2003; Marrow 2012). In immigration policy, some of the more obvious street-level bureaucrats include immigration enforcement officers and personnel. Some of the more recent immigration policies use subjective standards for enforcement, making it easier for immigration personnel and officers to enforce the policies, but also leaving more room for discretionary behavior, including discrimination and profiling (Martinez et al. 2015). Outside of immigration enforcement, recent research in political sociology has demonstrated that a variety of street-level bureaucrats are involved in the everyday processes of immigrant inclusion and exclusion (Marrow 2012). These include medical and social service providers, public teachers, and even librarians (Van der Leun 2006; Marrow 2009).
Since resource scarcity tends to result in what Lopez (2006:26) calls “de facto disentanglement” by a range of street-level bureaucrats, inclusion seems to be strongest when financial resources are greatest (Marrow 2012). Furthermore, Marrow (2009) argues that inclusion appears strongest in institutions where service-oriented professional missions and inclusive government policies intersect. On the contrary, inclusion is least apparent in institutions where regulatory-oriented professional missions intersect with restrictive government policies (Marrow 2009). Of course, street-level bureaucrats may exhibit both of these orientations, service and regulatory, but their positions exist along a continuum (Marrow 2012). For example, previous work has distinguished between the less powerful and more regulatory-oriented roles of workers in social welfare service agencies and the more powerful and service-oriented roles of physicians in healthcare institutions (Horton 2006; Van der Leun 2006). Even within healthcare institutions, some distinguish between more regulatory-oriented roles of higher-level administrators and managers with responsibilities of maintaining their organizations’ fiscal resources, from more service-oriented roles of direct health providers, or “insulated caregivers” (Walter and Schillinger 2004:304) and “front-line clerical personnel” (Weiner et al. 2004:306) who have repeated and continued interactions with patients (Marrow 2012). For example, neither “insulated caregivers” nor administrators handle proofs of residence or income or insurance eligibility information (Portes et al. 2012). This task belongs to the clerical personnel who must transform those persons seeking care into ‘paying patients’, either directly or through some type of aid program (Portes et al. 2012). Thus, the clerk acts as a gate-keeper to not only protect the fiscal viability of the institution, but to insulate direct health providers from interaction with ineligible patients (Portes et al. 2012).
CHAPTER THREE
HEALTH DESERVIGNESS

Debates around the world focus on undocumented immigrants deservingness, or lack thereof. These debates occur in popular, policy, and non-profit discussions of undocumented immigrants and health (Willen et al. 2011). These constructions of health deservingness have received greater attention by many social scientists, including anthropologists, in light of increasing health care costs, growing health disparities within and between countries, and neoliberal pressures that drive privatization and commoditization of health care (Willen 2012).

Questions of “who deserves what” are important, even though often implicit, in the political process (Willen 2012). Notions of deservingness often serve as “symbolic props” (Farmer 2004: 307) that pattern structural inequalities and health-related vulnerabilities (Willen 2012). These notions are frequently informed by claims that contradict evidence from epidemiological and economic research (Berk, Schur, Chavez, and Frankel 2000; Chavez 2012; Goldman, Smith, and Sood 2006; Willen 2012). These questions have shaped the practice and discourse of health care institutions (Horton 2004), citizens (Schneider and Ingram 2005), policymakers and legislators (Guetzkow 2010; Heyman 2009). For example, “moral hazard,” a term coined by economists, is the idea that if care were free and universal, people would take undue advantage of it, which would ultimately lead to its breakdown. According to this logic, the costs of healthcare in the U.S. are necessary to maintain this discipline and prevent the system from being overwhelmed. As a framing device, moral hazard was one of the most effective
ideological weapons used against efforts to implement a universal health care system in the U.S. during the Clinton Administration in the 1990s (Portes et al. 2009).

While deservingness of welfare has been extensively explored, much less is known about health deservingness (Willen 2012). Health deservingness is related but distinct from juridical arguments of health rights (Willen 2012). Juridical arguments center on formal entitlements to health-related rights, while notions of health deservingness create the moral judgments of entitlements and access (Willen 2011). Furthermore, juridical arguments posit universality and equality under the law, while moral reckonings of deservingness are usually relational and conditional (Willen 2012). These are based on one’s own sense of deservingness, assessments of one’s connection to those with precarious deservingness, and evaluations of real or perceived individual or group characteristics (Willen 2012). Importantly, conceptions of deservingness and undeservingness do not exist in a vacuum, but rather are shaped by social, cultural, political, and economic forces alongside personal values and commitments (Vanthuyne et al. 2013). As Horton has written, “Conceptions about patients’ deservingness do not always originate in the health care context alone…but must be further contextualized within the national and local political-economic contexts within which they are formulated” (2004: 473). Thus, constructions of deservingness do not exist independently but are negotiated through economic, political, social, and cultural processes alongside personal values, reinforcing notions of citizenship, race, nation, and belonging (Willen 2012).

In light of the power of discursive frames in shaping policy, ideologies, practices and local biologies, medical anthropologists and sociologists have called for a greater emphasis on how frames of health deservingness are conceptualized, utilized, and discussed by different
people, including health workers (Chavez 2012; Larchanche 2012; Marrow 2012; Viladrich 2012; Willen 2012).

A. Health Deservingness of Immigrants

Immigrants are described in variable terms, such as illegal, undocumented, unqualified, irregular, or unauthorized (Willen 2012). Anthropology recognizes that these categories are socially constructed and reflect systems of power (Yarris and Castañeda 2015). Notions of health care deservingness, in which certain groups are deemed worthy of care, attention, and investment over others, are also socially reproduced (Yarris and Castañeda 2015). According to Castañeda (2012), health-related deservingness contributes to “migrants’ shifting and historically produced experiences of socio-political exclusion from their countries of residence, often leading them to be portrayed as unwanted, undesirable, and unworthy of services” (830).

The idea that migrants are underserving of healthcare is present around the world (Willen, 2012). As non-citizens, they are described as “uninvited guests” (Grove and Zwi 2006: 1934), “criminal aliens” and “freeloaders” (Newton 2005:151-3), and as deviants who immigrate solely to gain access to social welfare benefits or to deliver “anchor babies” who might establish entitlements to residency (Chavez 2008:88; Willen 2012). These constructions, coupled with categorical exclusion from health systems, diminish the moral worth of unauthorized immigrants (Willen 2012). Thus, powerful voices have often declared unauthorized immigrants as underserving of health care and investment (Willen 2012). Other voices, including those of migrant advocates, social scientists, and clinicians have used arguments to the contrary, often drawing from human rights, humanitarianism, or public good discourse (Willen 2012). However, not much is known about how these ethical theories and forms of moral reasoning are negotiated or put into practice (Goodale 2006; Willen 2011).
CHAPTER FOUR
FRAMING AND COGNITIVE ANTHROPOLOGY

Within the field of cognitive anthropology, some anthropologists use the cognitive theory of culture famously proposed by Ward Goodenough (1957: 167) as “whatever it is one must know in order to behave appropriately in any of the roles assumed by any member of a society.” Culture, then, is understood as the knowledge that enables individuals to act within the social world while predicting, interpreting, and understanding the thoughts, values, behaviors, goals, and actions of others and the self (Kronenfeld 2011; Dengah 2013). These understandings are structured by schemas and cultural models found in individual minds (Dressler 2009).

Importantly, within this theory, culture is a differentially learned, shared, and enacted knowledge system. As Dressler (2015: 5) writes, “There must be cultural variability within a society, and a cognitive approach accounts for this variability.” There are many different ways that intracultural variation can exist within culture. Culture within a social group may be variable due to the presence of many cultural models in the aggregate (Dressler 2015). Culture may be variable due to varying degrees of personal influences on the construction and interpretation of the models (Dressler 2015). In other words, some people may be able to approximate the model better than others (Dressler 2015).

Another aspect of this theory is that knowledge is stored both in the individual mind and in the aggregate. While shared meaning may seems to be in some sense external (Kessing 1974), cognitive anthropologists have long advocated for a cognitive theory of culture; in other words, culture is located in the head (de Munck 2000). From this perspective, culture is viewed as
systems of knowledge (Keesing 1974). D’Andrade’s (1984) theory of cultural meaning systems is an important variant of this cognitive theory of culture. This theory posits that while culture is a system of shared knowledge that gives social acts their meaning, some of that shared meaning and knowledge is found in individual minds (Dressler et al. 1997). This theory thus suggests that culture is found in individual minds, but that a whole understanding of the system would require a level of knowledge or perception outside of what individuals may know and be able to communicate (Dressler et al. 1997).

Contemporary research methods in cognitive anthropology investigate the ways shared cultural knowledge is “constructed, organized, and distributed among members” (Dengah 2013: 347). Some cognitive anthropologists focus on cultural models in order to investigate just how cultural knowledge is constructed, organized, and distributed across individuals. There are many components to a definition of a cultural model. D’Andrade (1995) proposes three distinctive psychological criteria of cultural models: they are mostly implicit rather than explicit; they take a relatively long time to learn or alter, which suggests they rely on connectionist learning; and they are composed of many schemas, far too many to fit into short-term memory at a single point in time. Gatewood (2012) expands upon these criteria to include at least two more: individuals are active agents in the use and interpretation of these models while only shared mental models can be called cultural models. Furthermore, no two individuals can hold identical models for a given domain (Dengah 2013). The articulation of life histories with the heterogeneous distribution of knowledge means that it is “physically impossible for any two people to hold identical cultural configurations (Handwerker 2002: 109; Dengah 2013). Dengah (2013) also proposes that cultural models are subject to change because cognition changes. Dressler (2009)
might add that cultural models are not things but are organized knowledge systems used to solve problems.

While there are more attributes of the cultural model, it is clear that cultural models relate to schema. Quinn (2005) describes schemas as general outlines of the world, or some part of it, composed of experience and stored in memory (Quinn 2005). Furthermore, they are based on repeated experiences (Quinn 2005). As such, they tend to be somewhat stable, with influence over interpretations of future experiences (Quinn 2005). People share schemas based on common experience. Quinn (2005) argues that these shared experiences and schemas result in a common culture or subculture. These cultural schemas, created from shared experience, are not limited to words or labels (Quinn 2005). As Quinn (2005: 38) writes, “They can include experience of all kinds—unlabeled as well as labeled, inarticulate as well as well-theorized, felt as well as cognized. Schemas, in short, can be various and complex as the experience from which they are derived.”

Casson (1983) also details schemata in cognitive anthropology. In the time of his writing, schema was the most common term used to refer to the “building blocks of cognition” (Casson 1983: 429). Bartlett is usually credited to have first used the term schema in its present-day sense, in which schemata are used to give “a general impression of the whole” and to construct “probable details” (Bartlett 1932: 206). Furthermore, schemata are “autonomous and automatic—once set in motion they proceed to their conclusion—and they are generally unconscious, nonpurposive, and irreflexive” (Casson 1983: 431). Schemata and frames are thought to activate each other, or as Casson writes, “linguistic forms bring schemata to mind and schemata are expressed in “linguistic reflexes” (Casson 1983: 433). In other words, lexical or grammatical forms are the ways schemata are organized and expressed (Casson 1983). Frames
are essentially language structures that organize schemata for verbal expression, and as the term implies, focus the attention on certain elements and not on others (Casson 1983).

Frake (1977) described the frame as one of cognitive anthropology’s best known methodological devices in the late 1970s. Goffman (1974) defined framing as those conceptual structures that shape discourses and construct narratives within patterns of valuation and selection (Viladrich 2012). Frames were thought to be a powerful tool, providing a useful way to organize data (Frake 1977). However, critics of this methodological tool pointed out that not all data are easily captured by a frame; furthermore, data that was obtained was often not all that interesting or important (Frake 1977). Overall, the criticism was that cognitive anthropology should go beyond these snippets of cognitive maps to offer a broader view of cultural meaning (Frake 1977). Frake (1977) surmised that these methodological difficulties, particularly regarding the “snippets” of cognitive maps, resulted from a failure of the frame model to be adequately situated in an interacting context of meaning. Instead, phrases received the focus of analysis, which obscures the context of meaning in which frames meaningfully exist (Frake 1977). In short, Frake (1977) argued to situate frames within the larger social context.

According to Frake (1977), another problem with the frame method was getting people to talk about cultural domains of interest to the researcher and relevant to the participants (Frake 1977). This led to an obsession with finding the “right questions” (Frake 1977). However, Frake (1977) suggests an alternative approach, one which resonates with the ethnography of communication approach put forth by Dell Hymes (1974). Frake writes,

Perhaps instead of trying to devise provocative questions and other instruments to persuade people to talk about things they do not ordinarily talk about in that way, we should take as a serious topic of investigation what people in fact talk about, or, better, what they are in fact doing when they talk. When we look at talk, we find that people do not so much ask and answer inquiries; they propose, defend, and negotiate interpretations
of what is happening. Because what is happening is what we are interested in explicating, these interpretations provide the key to understanding. Viewing informants not just as question-answerers, but also as interpreters of their lives, provides not only a sounder perspective for handling problems of informant variability and reticence, but also a more realistic notion of the relation of cognitive systems to behavior. (Frake 1977: 3)

The issue of getting participants to talk about frames may relate to the often implicit nature of cultural knowledge. As Strauss (2005: 204) writes, “What is tricky about finding shared cultural assumptions in talk is that ordinarily these deep assumptions are left unsaid.”

Frames also seem to relate to conventional discourse. Strauss (2013) describes conventional discourses as repeated, formulaic schema. These are different from Foucauldian discursive frameworks (Strauss 2013). Instead conventional discourses serve as “stock rhetorical-interpretive frameworks” (Strauss 2013:262). They “provide readily grasped, simplified mental and verbal representations that are easy to think and say. They are mental shortcuts and verbal signaling devices. Repeating them helps determine what will be taken to be the conventional wisdom in an opinion community” (Strauss 2013: 268). Furthermore, conventional discourse acts as cognitive and rhetorical scaffolds (Clark 1998, Strauss 2013). They allow speakers to talk without a great deal of thinking through their stance from scratch (Strauss 2013). Strauss (2013) argues that the formulaic aspects (in form and content) of conventional discourse suggest that they are learned from others and are therefore shared.

In short, it appears that frames and schemata are mutually activating, while schemata comprise cultural models. While schema underlies conventional discourse, frames organize and express underlying schemata (Casson 1983, Strauss 2013). Frames also seem to be highly related to conventional discourses, sharing qualities of being simplified, formulaic verbal representations that simultaneously work as signals, shortcuts, and scaffolds. Thus, these terms are highly related. Another important aspect of this relation is the cognitive theory of culture, in which
knowledge (i.e., culture) is found in individual minds in the forms of cultural models and schema that structure understanding (Dressler 2009). Frames and conventional discourse appear to be the expressions of this cultural knowledge.

A. Framing Health Deservingness

Immigrants who are described in variable terms, such as illegal, undocumented, unqualified, irregular, or unauthorized, currently have their health care deservingness in question (Willen 2012). Frames that do not support health deservingness of immigrants include “illegal immigrant” and “illegal alien” (Viladrich 2012). These index a violation of rules and laws and cast unauthorized immigrants as lawbreakers in both a judicial and moral sense (Viladrich 2012). Another framing device used to argue against the health deservingness of undocumented immigrants is to claim that a problem does not really exist (Portes, Light, and Fernandez-Kelly 2009). Other frames include those that emphasize health care as a privilege. For example, previous research on discursive frameworks suggests the health care of undocumented immigrants is seen as a privilege, not a right, by health care workers in Canada (Vanthuyne et al. 2013).

The invocation of human rights and medical humanitarianism frames, on the other hand, call for the inclusion of undocumented immigrants into the larger health care system. While at first glance these may appear synonymous, they entail different practices, and implications. The human rights frame focuses on individual entitlement to health; under this approach, the state is obligated to provide the infrastructure, services, and social goods necessary to ensure health as a human right (Castañeda, 2011). The human right to health has been preserved in the United Nation’s Universal Declaration of Human Rights and in many state constitutions (Horton et al. 2014).
The medical humanitarianism frame advocates for alleviating suffering based on ideas of compassion and charity that call for the moral recognition of patients’ “biolegitimacy” (Fassin 2009), or the legitimacy of their suffering bodies (Vanthuyne et al. 2013). This understanding of medical humanitarianism has been canonized by the International Red Cross (IRC) in four principles: humanity (assisting the suffering based on common humanity, without discrimination); impartiality (establishment of priorities only by urgency and need); neutrality (helping victims without taking sides); and universalism (using the same approach no matter the location) (Chandler 2001). According to various scholars (Castañeda 2011; Willen 2011; Viladrich 2012; Vanthuyne et al. 2013), the humanitarianism frame has become dominant within scholarly and public discourse regarding undocumented immigrants’ health-related deservingness.

Discourse within public health is often used to support the inclusion of immigrants into the health system. Frames include “effortful immigrant,” which describe immigrants as deserving contributors to American society based on their hard work ethic and payment of taxes (Viladrich 2012). The “cost saving” discourse emphasizes immigrants’ benefits to society and their low use of health services (Viladrich 2012).

Other public health discourse that supports immigrants’ inclusion into the health system includes the “national security” frame, which is based on the idea that immigrants are a public hazard to others because immigrants carry a “disproportionate burden of undiagnosed illness—including communicable diseases such as tuberculosis and HIV, and that they frequently lack basic preventive care and immunizations” (Kullgren 2003:1630). The characterization of immigrants as vectors of disease is not new. What is new here is that the health science literature in particular has taken this frame and used it to defend immigrants’ access to care in the U.S.
In this thesis, I use the “infectious disease” and “national security frame” as synonyms.

The “maternalistic” frame is used to endorse the inclusion of families, specifically immigrant mothers, into the health system as caretakers of American children (Viladrich 2012). As Viladrich (2012:825) writes, “If the children of immigrants are the nation’s future, supporting their mothers (even undocumented ones) becomes an imperative.” Anthropological contributions to discursive frames include the “chilling effect” frame, which examines voluntary withdrawal of persons/immigrants from health benefits as a result of their embodiment of health care undeservingness (Viladrich 2012). Another anthropological contribution includes the “injustice” frame, which emphasizes both strengths and limitations of a social justice framework (Viladrich 2012). While strengths include advocacy for vulnerable immigrant groups, such as immigrants with disabilities and the poor elderly, this becomes paradoxical as this discourse selectively includes some immigrants as health-deserving while excluding others (i.e., single mothers) (Viladrich 2012).

The main goal of this research is to explore those frames that street-level bureaucrats use to describe the deservingness or undeservingness of undocumented immigrants. Not much is known about the social production of discursive frames that support, wholly or selectively, the deservingness of undocumented immigrants (Viladrich 2012), especially in Alabama.

**B. Hypotheses**

In this research, I hypothesize that frames of health deservingness of undocumented immigrants utilized by health workers will vary based upon clinic locale, that perhaps being immersed in a certain clinic culture will affect health workers’ perceptions of their own work and the people who seek their knowledge, expertise, and resources. I also suspect that individual
variance influences these perspectives. These assumptions directly relate to a cognitive theory of culture in which knowledge is both stored in the individual human brain, but it is also shared and thus is a property of the aggregate (Dressler 2015). Thus, when talking to an individual, researchers are not observing either a purely cultural model or a purely idiosyncratic model. In other words, the individual model is comprised of both the cultural model and the personal model (Dressler 2015). Thus, a cognitive theory of culture proposes that the mind should be viewed in a context that is larger than the individual (Dressler et al. 1997); by focusing on frames as cognitive and cultural scaffolds, this research attempts to do just that. Based on these assumptions, I hypothesize that: (1) health workers at the public health clinic will more likely employ an infectious disease, or national security, frame in their reasoning for the inclusion of undocumented immigrants in the health safety net, since public health efforts often focus on control of communicable disease; and (2) health workers at a community health clinic will more likely employ a medical humanitarianism frame, due to their practices in providing medical care to low-income, medically uninsured individuals.
CHAPTER FIVE

METHODS

The findings presented below are from a mixed-methods study conducted in Alabama over ten consecutive months between 2016 and 2017. The study protocol was approved by each clinic administration, the Alabama Department of Public Health, and the University of Alabama Institutional Review Board. All participants gave individual informed written consent and were compensated for their time with a monetary award of ten dollars. Participants in this study were recruited from two clinics in Alabama. Participants were health workers at both a FQHC, hereafter called the Community Health Center (CHC) (a pseudonym), and a county public health center, hereafter called the Public Health Department (PHD) (a pseudonym). CHC provides comprehensive primary care services, including dental care and HIV/AIDS care. CHC houses governmental health organization offices, including Medicaid and Special Supplemental Nutritional Program Services for Women, Infants, and Children (WIC) offices. CHC serves a diverse patient population of low-income, uninsured, and racial/ethnic minority patients. PHD provides select services, including family planning, children’s dental care, and infectious disease treatment. It also houses governmental health agency offices, including Medicaid and WIC offices.

A. Participants

Participants in this study included 31 health workers from a community health center and county public health department in Alabama. There were 16 total participants recruited from CHC and 15 total participants from PHD. Participants included a range of staff and professional
health workers. The interview data analyzed below were collected between November 2016 and January 2017 using a semi-structured interview guide (see Appendix D). A preliminary interview guide was pre-tested on seven health care workers from a public hospital and private clinic who were compensated with a gift card for their help. The interview guide was revised following this pre-test based on feedback offered from these participants.

Gatekeepers first introduced me to health workers at each clinic. Recruitment began during these initial clinic walk-throughs when I was given the chance to explain the study and the interview process. During these initial walk-throughs, I scheduled several interviews according to health worker preferences. After this initial walk through the clinics, I conducted recruitment as needed. Snowball sampling carried most of the recruitment. Interview times were generally arranged in advance, although several interviews did occur right after recruitment, depending on health worker availability. At CHC, interviews were conducted throughout the day according to health worker preferences. At PHD, interviews were generally conducted during lunch breaks.

The interview process began with an explanation of the interview process and informed consent, including asking for permission to audio-record. Several informants (n=5) declined for their interview to be audio-recorded. Audio-recording began as soon as the interview started for participants who gave permission. These recordings were conducted using the iPhone Voice Memo application and were transferred to the investigator’s computer at the end of the day.

Duration of interviews ranged from approximately 26 to 90 minutes. The investigator took extensive notes during all interviews. Data collected included general demographic information (i.e., age, ethnicity, gender); occupation within the clinic; level of health policy interest; and perceptions of health deservingness of undocumented immigrants in general and
undocumented pregnant immigrants specifically. The term “undocumented” was used in interviews to refer to individuals who live in the United States without legal status. While other terms, like “unauthorized,” are used to refer to this immigration status, “undocumented” was selected because of its perceived clarity and common use. At the end of each interview, the participant was thanked for their time and given ten dollars.

In addition to semi-structured interviews, the investigator conducted unobtrusive observations at each clinic site. Observational data included interactions between people in the waiting room, including those between patients and clerical workers. The investigator also noted the space of each clinic. No identifying information was recorded that might possibly jeopardize the identity or privacy of those in the waiting room. While it was not possible to triangulate these observations with participant responses, they did serve to add insight into clinic procedures and overall affect.

B. Data Analysis

All names and identifying characteristics of individual participants were changed to ensure anonymity. Pseudonyms were selected from a list of most common names in the United States. All audio-recorded interviews were transcribed and coded for discursive frames according to content analysis. These frames were classified as either “frames of deservingness” or “frames of undeservingness.” Frames of deservingness were classified as such if they described immigrants as deserving of health care in some way, while frames of undeservingness explicitly placed limits that deservingness. Notes from interviews not audio-recorded were also coded for frames.

After transcription and coding, frame use by health worker was quantified in IBM SPSS Statistics (Version 24). SPSS was used to run descriptive statistics and quantitative analysis of
frame use, including chi-squares. One-tailed Fisher’s Exact Tests were used to test hypotheses at alpha-level .10. Although this alpha-level increases the likelihood of Type I error, it also increases the power of the test, thereby reducing the likelihood of a Type II error. Thus, this alpha-level balanced Type I and II errors. The small sample size and the low-risk nature of the research further contributed to the selection of the alpha-level.
CHAPTER SIX

RESULTS

A. Demographics

Thirty-one health workers were interviewed, with 51.6 percent (n=16) of health workers participating from the community health center and 48.4 percent (n=15) from the public health clinic. Regarding gender, 90.3 percent (n=28) of health workers were women, while the remaining 9.7 percent (n=3) were men. All three men were recruited from the community health center. All participants from the public health clinic were women. Regarding ethnicity, 61.3 percent of health workers (n=19) self-identified as African American or Black; 19.4 percent identified as Caucasian or White (n=6); 9.7 percent (n=3) identified as Hispanic; 3.2 percent (n=1) identified as African American and Cherokee; 3.2 percent (n=1) identified as Black, Creole, and Indian; and 3.2 percent (n=1) stated that she did not know. Thus, approximately 61 percent of health workers (n=19) self-identified as black, while the remaining 39 percent (n=12) self-identified as another ethnicity (See Table 1).

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>CHC</th>
<th>PHD</th>
<th>n (% of n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>10</td>
<td>9</td>
<td>19 (61.3)</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>6</td>
<td>12 (38.7)</td>
</tr>
<tr>
<td>n (% of n)</td>
<td>16 (51.6)</td>
<td>15 (48.4)</td>
<td>31</td>
</tr>
</tbody>
</table>

Participants occupied a range of positions for a total of eighteen different job titles. These were collapsed into five categories: clerk, clinical assistants, clinicians, social service coordinators, and institutional resource managers. Approximately 23 percent (n=7) worked in
clerical positions. Nearly 36 percent (n=11) worked as clinical assistants, which included nursing assistants, medical assistants, phlebotomists, and interpreters. About seven percent (n=2) were clinicians; this included one nurse and one doctor. Approximately 29 percent (n=9) worked in social services, which included social workers, immunization coordinators, patient assistance coordinators, and a disease intervention specialist. Nearly 7 percent (n=2) managed institutional resources. Women who participated (n=28) held positions in these five categories, while the three men who participated (n=3) held positions in only three categories: clinical assistant, clinician, and institutional resource manager. Categories were collapsed further into a dichotomy of staff (n=18; 58.1%) and professional (n=13; 41.9%). Staff included clerks and clinical assistants, while professionals included clinicians, social service coordinators, and institutional resource managers (see Table 2).

<table>
<thead>
<tr>
<th>Occupation</th>
<th>CHC</th>
<th>PHD</th>
<th>n ( % of n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerk</td>
<td>2</td>
<td>5</td>
<td>7 (22.6%)</td>
</tr>
<tr>
<td>Clinical assistant</td>
<td>10</td>
<td>1</td>
<td>11 (35.5%)</td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>1</td>
<td>1</td>
<td>2 (6.45)</td>
</tr>
<tr>
<td>Social service coordinators</td>
<td>1</td>
<td>8</td>
<td>9 (29.0%)</td>
</tr>
<tr>
<td>Institutional resource managers</td>
<td>2</td>
<td>0</td>
<td>2 (6.45)</td>
</tr>
<tr>
<td>n (% of n)</td>
<td></td>
<td></td>
<td>31</td>
</tr>
</tbody>
</table>

Age of participants was a normally distributed, with a mean of 41 years, ranging from 26 and 60 years. The mean age of participants at the community health center was 39.5 years compared to 42.7 at the health department. Staff were on average younger than professionals. The mean age of staff was 38.5 years, while the mean age of professionals was 44.6. This difference was significant at alpha level .10 (t-statistic= -1.787; p= .084).
Participants had worked at their respective clinic sites ranging from 0.75 to 324 months (27 years). The mean employment time was 88.5 months (approximately 7.4 years). The mean amount of time that participants had worked at the community health center was 29 months (approximately 2.4 years). The mean amount of time participants had worked at the public health clinic was about 152 months (approximately 12.7 years). Time worked at the clinic was dichotomized into those working less than 45 months (n=15; 48%) and those working 45 months or longer (n=16; 52%). The majority of health workers sampled at CHC (n=12; 75%) had worked less than 45 months, while the majority of health workers sampled at PHD (n=12; 80%) had worked 45 months or longer. This difference was significant at alpha level .10 (two-tailed Fisher’s Exact Test, $p = .004$). The majority of staff sampled (12; 67%) had worked for less than 45 months, while the majority of professionals sampled had worked 45 months or longer (n=10; 77%). This difference was significant at alpha level .10 (two-tailed Fisher’s Exact Test, $p = .029$). The majority of health workers self-identifying as African American/ Black had worked 45 months or longer (n=12; 63%). The majority of health workers self-identifying as ethnicities other than African American/ Black had worked less than 45 months (n=8; 67%). This difference was not significant at alpha level .10 (two-tailed Fisher’s Exact Test, $p= .149$).

B. Unobtrusive observations

Waiting room unobtrusive observations were conducted in each clinic. While these were originally intended to capture interactions between clerical workers and patients, each clinic presented its own challenge to this goal. At CHC, the front desk is protected by walls, such that views of the front desk are obscured from the waiting areas. Thus observations at CHC revealed little information aside from many people waiting, with a single comment between people about
the wait being long. At PHD, each clinic space has a separate waiting room, each of which is small and affords little opportunity for the researcher to be unobtrusive.

C. Frames

i. Hypothesis One

The infectious disease frame, which emphasizes the threat of untreated communicable diseases, was used by 16 percent (n=5) of health workers overall. Six percent (n=1) of health workers from the community health center used an infectious disease frame, while 27 percent (n=4) health workers from the health department used this frame. Health workers who emphasized infectious disease included three workers in social services, one in administrative work, and one clinic professional. For example, Betty, a resource manager at the community health center said, “I think everybody needs to be treated the same, they should have the same availability to care if we’re gonna affect our outcomes and you know, have preventive things even with things like immunizations because there’s other diseases and things that we can prevent and a lot of ‘em may not be aware of that.” A one-tailed Fisher’s Exact Test was used to assess the second hypothesis, which stated that public health workers would emphasize infectious disease frames more often than community health center workers. Although there was a distinct trend, no statistically significant differences were found at alpha-level .10 (p=.146).

Logistic regressions were conducted to test relationships between infectious disease frame use and age, gender, and dichotomized variables job and time worked. No significant differences were noted.

ii. Hypothesis Two

The medical humanitarianism frame, which stresses human equality and help, was used by 84 percent (n=26) of health workers overall. Eight-one percent (n=13) of health workers at the community health center used this frame. Likewise, 87 percent (n=13) of health workers at
the health department clinic invoked humanitarianism when discussing the health deservingness of undocumented immigrants.

For example, Karen, a clerical worker at the community health center utilized the humanitarianism frame by stating, “Give them the opportunity to come and be seen and be treated as human. And not as you know, the other or something, you know what I mean?”

Likewise, Sharon, a public health educator, said:

I mean people should be human regardless of where you come from, if you need medical care you just need medical care. I don’t think a person should be turned down for medical care based on where they come from. To me that’s just cold cruel-hearted. Regardless of where they come from, how they got here, if you can help ‘em with whatever illness it is or help them prevent them from getting a certain illness or disease, not the fact that well you ain’t from the US so we don’t need to help you, tough luck you see what I’m saying. If it was left up to me, I would try to help you know everybody.

A one-tailed Fisher’s Exact Test was used to assess the first hypothesis, which posited that community health center participants would utilize medical humanitarianism frames more often than public health workers to invoke the deservingness of undocumented immigrants. No statistically significant differences were found at alpha-level .10 (p=.532).

Logistic regressions were conducted to test relationships between medical humanitarianism frame use and age, gender, and dichotomized variables job and time worked. No significant differences were noted.

iii. Multiple Frames

Noteworthy from Betty’s excerpt above is the emphasis placed not only on infectious disease, but also on equal treatment and access to care, which was coded as both humanitarianism and equality. All five participants using infectious disease frameworks also used medical humanitarianism and equality frames, such as this one, to express their views on the deservingness of undocumented immigrants. This excerpt also points to a larger pattern in
these interviews, which is that most participants (n=27) utilized more than one frame when explaining why undocumented immigrants were deserving or not deserving of health care. This continuous variable was normally distributed, with a mean number of frames used by a single participant equal to 3.8. Independent samples t-tests were conducted to determine whether the number of frames utilized by a single participant differed by dichotomized variables clinic locale, ethnicity, job, and time worked at the clinic. The number of frames used by health workers did not differ significantly by clinic locale ($t = .390; p=.699$), ethnicity ($t= .129; p=.898$), or time worked ($t=-.578; p=.568$). The number of frames utilized by a single participant differed significantly by type of job (staff or professional). The mean number of frames staff used was 3.2; professionals used a mean number of 4.6 frames. This difference was significant at alpha level .10 ($t = -2.124; p=.042$). The mean number of frames used to frame deservingness was 3.6. The mean number of frames used in expressing both deservingness and undeservingness was 4.4. This difference was not significant at alpha level .10 ($t = -.979; p = .353$). A bivariate correlation was conducted to test the relationship between age and number of frames utilized, which are both parametric variables in this study. No relationship was noted ($r = -.005; p = .980$).

Overall, a total of 27 frames were used by health workers (See Table 3). Eighteen frames were used to describe deservingness or undeservingness of undocumented immigrants in general. Twenty-two frames were used to describe deservingness of undocumented pregnant immigrants. There were 13 overlapping frames used. Five frames were used to describe the deservingness of undocumented immigrants that were not used to describe the deservingness or undeservingness of undocumented pregnant immigrants. Nine frames were uniquely used to describe the deservingness or undeservingness of undocumented pregnant immigrants.
Table 3. Frames used by health workers to discuss undocumented immigrant deservingness, with n (number of cases utilizing frame) and a representative participant quotation. Frames described undocumented immigrants, in general. Frames also described immigrants who were undocumented and pregnant. Shared frames were those used to describe both undocumented immigrants in general and pregnant undocumented immigrants.

<table>
<thead>
<tr>
<th>Frames</th>
<th>n</th>
<th>Representative Participant Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undocumented immigrants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paying or contributing to system</td>
<td>4</td>
<td>But they'll pay you, it's like I have money, here, it's not that many that really come in with no money and no intent of paying.</td>
</tr>
<tr>
<td>Contributing member of society</td>
<td>1</td>
<td>I mean, health care is, you know, maintaining good health. It’s kinda critical to bein’ a contributing member of society, I mean if you’re not, you know, feel good, you are sick whatever, you can’t be productive. It creates other issues, you know. If you’re a mother, you can’t take care of your children. If you’re head of the household, you’re not working.</td>
</tr>
<tr>
<td>Emphasizes children</td>
<td>1</td>
<td>They should definitely take care of the children.</td>
</tr>
<tr>
<td>Not to police borders</td>
<td>1</td>
<td>Our jobs as physicians is not, or as a healthcare place, is not to police the borders</td>
</tr>
<tr>
<td>Emergency services</td>
<td>1</td>
<td>If an emergency, they need to see a doctor. You know, somebody have to take those patients.</td>
</tr>
<tr>
<td><strong>Undocumented and pregnant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risks of pregnancy</td>
<td>6</td>
<td>While they pregnant, it should be some different diseases that can come along, possibly while they’re pregnant, like gestational diabetes, something going wrong with the baby.</td>
</tr>
<tr>
<td>Infant as human</td>
<td>3</td>
<td>Yeah because regardless whether the fact whether the person is documented or not documented, that’s a human life that they’re carrying.</td>
</tr>
<tr>
<td>Evaluation of pregnant women</td>
<td>2</td>
<td>They come in, some are pregnant with one, they have one or two walking then they totin one. I don’t understand why they want to have multiple babies like that, it’s just so many. And I mean, you already strugglin’.</td>
</tr>
<tr>
<td>Maternalistic frame</td>
<td>2</td>
<td>You should be about the unborn baby that the person is carrying because the pregnant mom herself maybe undocumented but once she gives birth to the baby, it’s in Alabama. That makes that baby a citizen here.</td>
</tr>
<tr>
<td>Two lives</td>
<td>1</td>
<td>It’s two lives there, at least. Two lives.</td>
</tr>
<tr>
<td>Anchor babies</td>
<td>1</td>
<td>So all I’m sayin is why you havin’ multiple births if you ain’t legal. Now if you have to go back, you are, you thinkin’ you can say because you got all these babies and they are citizens, they born citizens. But you’re not. It just ain’t right.</td>
</tr>
<tr>
<td>Importance of prenatal care</td>
<td>1</td>
<td>That they receive full prenatal care because it’s so important for the life of the child, for the life of the mother, for the quality of life. But there should be, there should be prenatal care.</td>
</tr>
<tr>
<td>Education</td>
<td>1</td>
<td>Because sometimes they don’t know how to really take care of their baby or theirself to prepare the body for a new baby</td>
</tr>
<tr>
<td>Public health mission</td>
<td>1</td>
<td>We are here for people, supposed to be for people.</td>
</tr>
</tbody>
</table>
### Table 3 – Continued

<table>
<thead>
<tr>
<th>Shared Frames</th>
<th>Frequency</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical humanitarianism</td>
<td>26</td>
<td>It's the job of the health worker to care for people who need care.</td>
</tr>
<tr>
<td>Equality</td>
<td>21</td>
<td>Because they’re humans. We’re all human.</td>
</tr>
<tr>
<td>Preventive care</td>
<td>8</td>
<td>Regardless of where they come from how they got here if you can help em with whatever illness it is or help them prevent them from getting a certain illness or disease not the fact that well you ain’t from the US so we don’t need to help you…</td>
</tr>
<tr>
<td>Golden rule</td>
<td>7</td>
<td>I try to do extra for them because I think if I was in their situation in their country and I’m getting something done, I would want someone to be nice and help me, you know?</td>
</tr>
<tr>
<td>Illegality</td>
<td>5</td>
<td>…see when you’re undocumented, you can’t be on the same level, cuz you, you workin-it’s illegal. It’s just illegal all the way around. There ain’t no way, even if you got good work ethic, you ain’t got the proper documentation to work honestly in the United States.</td>
</tr>
<tr>
<td>Health as right</td>
<td>5</td>
<td>Even though they’re undocumented I feel like they still need help and they should have rights even though they’re not citizens....</td>
</tr>
<tr>
<td>Infectious disease</td>
<td>5</td>
<td>I know that it’s a high case of tuberculosis in Hispanics so if they’re not seeking any type of health care then that just makes things worse.</td>
</tr>
<tr>
<td>Not the child’s fault</td>
<td>4</td>
<td>The children didn’t ask to be here, they’re brought here because of an adult of course.</td>
</tr>
<tr>
<td>Category</td>
<td>Score</td>
<td>Comment</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Establishment</td>
<td>3</td>
<td>Yup to feel more comfortable and to just know that they have like a hopefully a safe haven and maybe some way that they can establish some type of support you know networks and support systems and then who knows from there what it could evolve into…</td>
</tr>
<tr>
<td>Health as commodity</td>
<td>3</td>
<td>I’m one of those people that healthcare’s not a right. But it should be available but then people need to be accountable as well. And it goes both ways you know, it’s one of those if you’re needing access and you should be able to come in and be provided the care you need but then you also need to pay for it.</td>
</tr>
<tr>
<td>Cost effectiveness</td>
<td>3</td>
<td>From a cost-effective standpoint for medical resources, earlier access to care will prevent expenses down the line.</td>
</tr>
<tr>
<td>Taking advantage/Or not contributing</td>
<td>3</td>
<td>Because in the type of field we’re in and like this clinic it is based on income and based on what you pay but who pay for the services? The taxpayers. They have to come out of pocket and do that… because if they’re not documented, it’s like, we’re payin for em and they’re payin nothing.</td>
</tr>
<tr>
<td>Compliance</td>
<td>1</td>
<td>You know it, undocumented versus documented is, there’s still um like I said an accountability factor that needs to be brought into play. I mean if you’ve got somebody that comes in, they’re on Medicaid, they weigh 400 pounds, they’re hypertensive… and they’re diabetic, and their doctor says well you need to check your blood sugar three times a day, you’re diabetic, you need to lose 200 pounds, blah blah blah, and they say we’re not gonna do it, and the next thing you know they end up in the hospital, they’ve had a stroke…and what do you do? And so it ends up being a big drain because of their choice not to be compliant.</td>
</tr>
</tbody>
</table>
iv. Frames of deservingness

For most health workers, multiple frames were used to argue for the health-related deservingness of undocumented immigrants (n=23). For example, Elizabeth, a staff member at CHC, utilized three different frames in expressing deservingness. First, she utilized the equality frame, stating:

Treat them the same. Although we do know they’re illegally here, but still, why treat them different? They just over here to make a life and a living just like we are…Why, you know, make it difficult to them when they still, they over here, they need healthcare.

She later framed the issue as a matter of the golden rule, stating, “So why treat them different? When we could be in the same situation. Without healthcare. You wouldn't want anybody to treat you that way.” She also utilized the medical humanitarianism framework by stating, “Every situation is going to be different, but still you handle each situation the same. I mean, you just you’re there to help, no matter what. So, that’s just how I look at it. This is my job, I’m here to help you. So let’s figure this out.”

Elizabeth was not alone in using these three frames in particular. In fact, the most commonly used frames at both clinics to support the deservingness of undocumented immigrants were medical humanitarianism (n=26) and equality (n=21). As previously mentioned, there was significant overlap between these frames, in part because notions of equality comprise the humanitarianism vision to help all people. Unsurprisingly then, all participants who utilized an equality frame also used medical humanitarianism; five participants who used medical humanitarianism did not invoke an equality frame. There were no significant relationships between medical humanitarianism and dichotomized variables ethnicity, job, and time worked. Similarly, there were no significant relationships between equality and dichotomized variables ethnicity, job, and time worked.
Aside from equality and medical humanitarianism, five frames were used by more than five health workers to assert the health deservingness of undocumented immigrants. These included the golden rule frame, infectious disease, health as a human right, preventive care, and risks associated with pregnancy. All of these frames are used in conjunction with medical humanitarianism and equality.

The golden rule frame – which stressed a reversal of roles – was used by seven health workers in total. In all seven cases, the golden rule was used in conjunction with medical humanitarianism. There were no significant relationships between golden rule frame use and dichotomized variables ethnicity, job, and time worked. Interestingly, the golden rule was used more by staff (n=6) than professionals (n=1), although this difference was not significant at alpha level .10 (two-tailed Fisher’s Exact Test, p=.191).

Infectious disease, as reported above, was utilized by five participants. There were no significant relationships between infectious disease and dichotomized variables clinic locale, ethnicity, and time worked. There was a significant relationship between infectious disease frame and job in that all five health workers stressing infectious disease were professionals. This difference was significant at alpha level .10 (two-tailed Fisher’s Exact Test, p = .008). These five health workers simultaneously stressed infectious disease, medical humanitarianism, and equality.

Health was described as a human right by five participants, four of whom used medical humanitarianism and equality frames as well. There were no significant relationships between human rights and dichotomized variables clinic locale, ethnicity, job, and time worked. Interestingly, health as a human right was used more by health workers at PHD (n=4) than at
CHC (n=1), although this difference was not significant at alpha level .10 (two-tailed Fisher’s Exact Test, \( p = .172 \)).

Eight participants discussed the importance of preventive care, seven of which simultaneously emphasized equality and medical humanitarianism as well. While prevention has conceptual overlap with infectious disease, only two of participants who emphasized preventive care also emphasized infectious disease surveillance and control. Thus, six participants discussed preventive care without invoking infectious disease frames. There were no significant relationships between preventive care frame and dichotomized variables clinic locale, ethnicity, and time worked. Interestingly, there was a significant difference at alpha level .10 between whether staff (n=2) or professional (n=6) health worker employed this frame (two-tailed Fisher’s Exact Test; \( p = .043 \)). Ashley, a health professional at PHD, used the prevention frame when she stated:

There certainly should be a way that maternity care is paid for. Because like I said… it’s about babies that are gonna grow up with these terrible birth defects that had the mom been given folic acid, could have been prevents.

Ashley’s statement points to another frame that was used when discussing the health-related deservingness of undocumented pregnant women: that of perceived health risks associated with pregnancy. Six participants emphasized deservingness based on such perceived risks of pregnancy. This frame was used equally between clinics, more by black health workers (n=4) than workers of other ethnicities (n=2), more by professionals (n=4) than staff (n=2), and more by those who had worked 45 months or longer (n=5) than those who had worked less than 45 months. None of these differences were statistically significant at alpha level .10. Kim, a health professional at PHD, described pregnancy as an exceptional condition based on perceived risks.

If they have a cold maybe they can figure it out, just because there’s other people whether they’re documented or not documented that don’t have insurance that
have to deal with the same kinds of issues. But I just think pregnancy there’s just too many things that can happen and go wrong that can cause so many health problems for both the mother and the child.

Thus, pregnant women were seen by some health workers as deserving of health services based on pregnancy-associated risks that may affect the mother and child. All health workers who emphasized these risks used frames of equality and medical humanitarianism as well. Risks associated with pregnancy was just one frame among many that health workers used to argue for pregnancy-health related deservingness. Other frames used included emphasizing that infants are humans too (n=3), stressing the importance of prenatal care to the quality of life for the mother and child (n=1), highlighting that there are two lives at stake (n=1), and describing the mother as the caretaker of a future citizen (n=2) (i.e., the maternalistic frame) (See Table 3).

v. Conflicting Frames

The majority of health workers in this study used frames of deservingness to argue for the inclusion of undocumented immigrants into the U.S. health system. Some health workers also described immigrants using frames that call that deservingness into question. Eight health workers, including five professional and three staff, expressed conflict when discussing deservingness, such that they seemed to argue for the deservingness of undocumented immigrants with limitation. Five of these eight health workers worked at CHC. Likewise, five of these eight health workers self-identified as black. Five had worked less than 45 months. None of these differences were statistically significant at alpha level .10.

For instance, when asked if health services for undocumented immigrants in Alabama should be changed, Robert, a clinician at the community health center stated:

We have a large Hispanic population and that’s largely where our undocumented immigrants come from, and we need to be as a healthcare system prepared to deal with that. So yes access needs to be explained…we need to be set up to deal with navigating undocumented immigrants… through the system um or finding, you
know, ways in which they can pay for care or get the specialty services that they need if they need them… The other part is you know, it’s one of those double-edged swords because our jobs… as a healthcare place is not to police the borders...

In the same token…our health care system isn’t set up to treat everybody because there is a finite amount of money and if you’re not contributing into that system at some point the system will break down, and as it is we’re already overtaxed as a medical community. There’s not enough physicians, there’s not enough nurse practitioners, there’s just not enough resources to… simply to just give out. And so it’s difficult from a state standpoint versus a personal kind of standpoint. There are two different issues so I can understand the dilemma.

Concerns over the costs of healthcare—and who pays for whom—factored into these ambivalent arguments. Robert focuses on the financial and social constraints on the health system, which are at odds with his personal views of treating everyone. When asked later in the interview about his ideal health system, he answers that, “The same health care system should be one that respects people of all cultures and ethnicities, where again their job isn’t to say who can be treated but to treat whoever presents for treatment.”

Some health workers focused on the perceived financial resources and behaviors of undocumented individuals themselves. These included perceptions of immigrants as taking advantage of taxpayers, which seemed to undermine frames of deservingness. For example, Susan, a staff worker at CHC stated:

Because in the type of field we’re in and like this clinic it is based on income and based on what you pay but who pay for the services, the taxpayers, they have to come out of pocket and… if they’re not documented, it’s like, we’re payin’ for ‘em and they’re payin’ nothing.

Susan’s sentiment was shared by only one other health worker in this study, also a staff worker at CHC. Susan later expressed humanitarianism when she said, “I think everybody deserve help though. I don’t think they should get turned away.”
James, an institutional resource manager at CHC, also expressed conflicting frames of the health-related deservingness of undocumented immigrants. Early in the interview, James stressed that health and healthcare were necessary for being productive, contributing members of families and societies. He talked about the importance of preventive care. Still, as in the other cases of ambivalence, he stressed that health care was a commodity, stating: “I’m one of those people that healthcare’s not a right…it should be available but then people need to be accountable as well…You should be able to come in and…be provided the care you need but then you also need to pay for it.”

James also drew from discourses of patient fiscal accountability and compliance with biomedical standards. At the start of the interview, James noted that the undocumented immigrants he interacted with were “very accountable, self-reliant” people who will “pay you…it's like I have money, here, it's not that many that really come in with no money and no intent of paying.” He joins three other health workers, all at CHC, in positively evaluating undocumented as paying patients who contribute, in one way or another, to the health system. Yet, in the following excerpt, he provides a narrative for what might happen in the instance of a “proverbial time bomb” ticking in the absence of patient responsibility:

Well, in some cases it’s like everything else…health care’s not cheap, but it’s necessary. So you have multiple visits during a pregnancy, or should have multiple visits. You may end up having even more visits if you have any sort of complications. So like I said, it’s one of those things you probably, probably the biggest issue is with people that show up that are pregnant ready to deliver, no prenatal care, talk about proverbial time bomb. You have no idea and it may turn out everything’s great and wonderful but then what if it doesn’t? And our society automatically says well, what did the provider do wrong? Maybe it wasn’t the provider, maybe it was the patient. You’ve got people who are pregnant that are still drinking and smoking and doing a lot of unhealthy lifestyle things and they’re not willing to change. They may end up with a child
that has some sort of issues. Whose fault is that? It’s not the system.

James was not alone in his evaluation of the compliance of pregnant women. In his example, not all pregnant women are compliant with standards of pregnancy care, including seeking regular prenatal care. According to this participant, seeking prenatal care is an act of accountability and compliance based on personal behavior. When pregnancies are met with complications, and a woman has not been a compliant agent in seeking prenatal care, then the health care system is not to blame: the woman is.

While not explicitly referring to immigrant pregnant women here, James demonstrates one way in which a pregnant woman’s health deservingness could be called into question. Other evaluations of pregnant women factored into how health workers constructed their arguments of deservingness of pregnancy-related care. This includes the aforementioned evaluation of compliance with standards of prenatal care. Furthermore, two participants evaluated the deservingness of pregnant women based on perceptions of excess fertility of immigrant women.

Barbara, a staff worker at CHC stated:

I know we got amendments and rights, and I’m not tryin to say nothing against, like going against what our rights are, cuz everybody have a right. But what I’m sayin is…it should be a limit on how many times you can, we gon’ pay for you to have a birth, and if you start makin’ ‘em pay it out the pocket then I think you’ll see a big difference. But if you allow ‘em to keep havin’ ‘em and we, tax-payin’ hard-workin’ middle cla - ugh not middle class, cuz I’m just as poor as a church mouse, uh there I think we’ll see a big drop in it. It is. It’s somethin’. That’s for anybody. But if you, you’re havin’ ‘em for free. You know, you have one this year, this nine months, and three four months later you’re pregnant again. That’s just, come on now. And they need, and you should be, the stipulations to get these benefits, I’m not tryin’ to control you, it’s your choice, but in order for you to get, this the birth control you have to have. You know. You have to stop with some kind of way.

This sentiment – of regulating immigrant women’s fertility – was echoed by only one other participant, also a staff worker at CHC, who suggested that there be a limit to the “regular help”
a pregnant immigrant may receive, until she can become legally documented. Barbara also described undocumented pregnant women as having “anchor babies.” She stated, “Why you havin’ multiple births if you ain’t legal? Now if they if they if you have to go back, are you thinkin’ you can stay because you got all these babies and they are citizens they born citizens. But you’re not. It just ain’t right.” This focus on the “illegality” of undocumented immigrants was shared among five of the health workers who expressed conflicting frames.

vi. Emergent Themes

i. Challenges to Care

The “language barrier” was perceived to be a challenge to providing care for undocumented immigrants. For instance, CHC staffs several interpreters who speak at least English and Spanish. John explained that while he works with many Spanish-speaking patients at CHC, he does receive calls to interpret for patients speaking other languages, including what he described as a Guatemalan dialect. He recommended that CHC staff an interpreter who speaks this language, so that CHC could do more for those patients. Another staff member at CHC, Barbara, was not as sympathetic in recognizing the challenges of a language barrier for the patient. When asked if she had any experience working with undocumented patients, she described the following situation:

Yeah I had one the other day, it wasn’t a – it’s not a bad experience but I think when you go in and you, you know you, call the patient back, you have the translator to ask the patient the reason for the visit whether it’s follow up, hospital follow-up or whatever it may be, then they’ll tell me what they’re saying you know and I write it down but when the doctor gets in the room, it’s a whole ‘nother story but it’s like, you’re telling me what the translator has said but when the doctor get in the room it ain’t even close to what you told me…I mean it really upset me.

Barbara was one health worker who expressed conflicting frames of deservingness, which suggests that she views undocumented immigrants as deserving but with limitation.
At PHD, there were no interpreters on staff. Instead, health workers used the “language line” when necessary. Many health workers spoke highly of this tool, like staff member Emily who described it as “fantastic.” Others spoke of its limitations, as when a Spanish-speaking patient might call to schedule an appointment and be received by an English-only speaking staff. Apart from language, “culture” or knowledge was also perceived by some health workers to be a possible challenge to providing care. Robert, a health professional at CHC, expressed that what other “cultures” do, like using home remedies or medicines without labels, can be barriers to biomedical care. Donna, a staff worker at PHD, explained that undocumented pregnant women need public health services because they may not know how to take care of their baby or themselves, especially in “preparing the body for a new baby.”

Health workers discussed possible difficulties that undocumented immigrants may face when seeking care outside of their clinics. Nancy, who worked as a liaison between pharmaceutical companies and patients needing assistance to pay for medications, explained that undocumented immigrants are not eligible for this assistance. She stated,

I’ve had several to come in and want assistance but if I can’t prove their legal residency, the company are gonna deny ‘em, so I’ve had to tell several that, I’m sorry I can’t assist you because you have to have legal residence, you know something proving that you are here, you have to have a green card, you have to have a social, you have to have your paperwork. And if you don’t, then there’s nothing I can do.

Local private clinics and hospitals, especially emergency rooms, were described as being particularly unwelcoming to patients without legal or insurance status. Health workers shared experiences of witnessing perceived ethnic- and insurance-based bias, both personally and professionally. Sarah, a clerical worker in the pediatrics clinic of CHC, described how undocumented immigrants – or those who are perceived to be undocumented— might face difficulties, particularly from health workers in the government health agency office down the
hall from her office. She explained that these health workers were rumored among CHC clinic staff to be “very mean to the Hispanic people and that’s not right. Is it because they do not speak English? Well you know they might look at you like, you don’t speak Spanish, okay?” Sarah was bothered by this behavior in part because it might directly affect the health of children. She shared that she had seen an infant die from malnutrition, so when a Spanish-speaking woman with an infant was left in the waiting room of a government agency office down the hall from Sarah, which unbeknownst to the woman, had closed early for a two-day holiday break, Sarah and other CHC staff intervened to provide the woman and her infant formula from their clinic to last the length of the holiday.

   ii. Citizen-making in the Clinic

   Another emergent theme in this research was the questioning of who is undocumented. Both clinics require patients to present identification, although this does not have to be U.S.-government issued. Thus, it was not always evident to participants who was an undocumented immigrant. There were a few different explanations given on how to identify an undocumented immigrant. One health worker at CHC explained that a patient lacking a social security number in the electronic health record was likely an undocumented immigrants. Another CHC staff worker disputed this, arguing that a patient without a social security number on file does not mean that patient does not have a social security number. Other health workers at CHC were not sure that they had ever interacted with an undocumented immigrant. Thus, some health workers expressed ambiguity about who is undocumented. However, most health workers did not seem to question their identification of someone as undocumented. Speaking a different language, primarily Spanish or what health workers described as a Guatemalan dialect, being perceived as
Hispanic, not having insurance, using alias names, and having many children were a few characteristics that seemed to index an undocumented status.
CHAPTER SEVEN
DISCUSSION

A. Infectious Disease

While there was no significant difference in infectious disease frame use between clinics, more health workers from PHD used this frame than health workers from CHC. This is a trend that suggests that infectious disease is more salient to health workers at PHD, although a larger sample size is needed to confirm a meaningful relationship. As mentioned previously, describing undocumented immigrants as vectors of communicable disease who might infect others is not a new concept. Migrants have often been described as “at-risk” for various infectious diseases (Casteneda 2011). These have contributed to stereotypes, stigma, and racism directed as immigrants (Marks and Worboys 1977). These same representations have been used by these health workers to support the inclusion of immigrants into the health system (Viladrich 2012). This is not necessarily novel, either. Access to care for communicable disease is one of the few federal protections that undocumented immigrants have in the U.S. Even Alabama’s anti-immigration law H.B. 56, parts of which were eventually ruled unconstitutional based on its discriminatory nature, protected this access to infectious disease care.

In other words, this frame does support health deservingness, but it still characterizes undocumented immigrants as vectors of disease. This begs the question: do these health workers extend health deservingness beyond infectious disease control? In other words, do they only conceptualize immigrants as vectors of disease?
Analysis reveals that all five health workers using infectious disease simultaneously stressed notions of equality and medical humanitarianism. These results suggest that these health workers do extend health deservingness beyond infectious disease to undocumented immigrants because, according to these health workers, undocumented immigrants deserve help and are humans too. This is clear when Amanda, a clinician at PHD, explained:

I feel like any person, any human being deserves health care, and so when you don’t offer it to someone because they may not be documented, that person could be with someone that is documented. It could be someone that is a U.S. citizen, that’s born here, so it’s going to affect our community overall. It could end up being something like say TB that’s contagious and we’ll say, oh we’re not going to treat you because you don’t have papers, you’re not official, and that person goes to work and works around other people you could have an epidemic in just a matter of days or weeks or months so I don’t think that person should be isolated because they’re undocumented.

Even when Amanda presents a hypothetical situation in which an undocumented immigrant has tuberculosis, an infectious disease, she stresses that this person should not be isolated.

B. Medical Humanitarianism, Rights, and Equality

No significant differences were found in medical humanitarianism frame use between health workers at these two safety net clinics in Alabama. Given that the two clinics share institutional missions to provide medical care for un- and underinsured populations, this result is not surprising. In fact, medical humanitarianism was the most commonly used frame by health workers in this study to describe the health deservingness of undocumented immigrants. This result corresponds with research from various other scholars (Castañeda 2011; Willen 2011; Viladrich 2012; Vanthuyne et al. 2013) who describe the humanitarianism frame as one that has become dominant in scholarly and public discourse.

However, anthropologists (Ticktin 2006, Fassin 2011, Ticktin 2011) have challenged the institutional and ethical bases of humanitarianism. One criticism of humanitarianism is that it can only go so far in an exclusionary health system. As Marrow (2012) documents in her research on
deservingness of unauthorized immigrants, the local policy environment of San Francisco works to reinforce and encourage public safety-net providers’ views of unauthorized immigrants as deserving of equal care, partly by providing increased financial resources for providers to translate their views into behavior. However, this local policy climate is embedded within restrictive state and federal health policies. Thus, these “hidden bureaucratic barriers to care” continue to exist, ultimately limiting public safety-net providers’ abilities to offer equal care to unauthorized immigrants (Marrow 2012: 847). Likewise, in this study, several health workers spoke of similar hidden bureaucratic barriers to care, such as when they attempted to refer patients to specialty clinics, which can be costly without insurance.

A second criticism leveled against humanitarianism action is that it is discretionary compassion. As Ticktin (2006:43-4) writes: “Compassion depends on circulating narratives, images, and histories and often on maintaining an unequal power relation between nurse and patient and citizen and foreigner—distinctions that are already heavily gendered and racialized.” Since this compassion is discretionary, it is highly variable between clinics, but also between actors in the same clinic. This has been described as being a sort of lottery: “a chance encounter with a motivated advocate or a compassionate professional” (Portes et al. 2009: 490).

Health workers recognized the limits of humanitarianism when emphasizing possible challenges that undocumented immigrants might face when interacting with different health workers, either outside or within their own clinic spaces. These challenges were described as being bureaucratic, such as insurance-based bias directed at patients without insurance or with Medicaid, or as being discretionary, such as discrimination based on ethnicity or perceived immigration status. This reveals that a single clinic has dimensions of health deservingness,
varying by space and agent. As Smith (2016:55) writes, “Each space and worker in the clinic is shaped by larger community narratives of power, belonging, and deservingness.”

Most health workers simultaneously stressed medical humanitarianism and equality. This is likely because notions of equality comprise the humanitarianism vision to help all people, regardless of perceived differences. Interestingly, notions of medical humanitarianism equality were invoked far more often than notions of human rights. While twenty-one participants discussed human equality, only five health workers spoke of health being a human right.

The formulation of a human right to health has been transformed over the past 20 years, such that it has taken on different meanings in different parts of the world. For example, in Colombia, citizens have utilized the concept of a right to health to oppose reforms that limit access and quality (Abadia-Barrero 2012). In the U.S., the right to health has been adapted to mean a right to consumer choice – of pharmaceuticals, physicians, and health insurance plans (Horton et al. 2014). Castañeda (2011) argues that the right to health care is not generally acknowledged in the U.S. system, which is characterized by inequalities. Instead, she states, “charity and humanitarianism are necessary features that directly result from this system” (Castañeda 2011:12). The results from this research echo Castañeda’s (2011) argument, since few health workers framed health-related deservingness in terms of human rights; instead, they emphasized humanitarianism.

C. Framing Deservingness and Cognitive Anthropology

These results demonstrate the ways that frames, as mental shortcuts, map across individuals working at two safety-net clinics. This map provides a view of the cultural knowledge of health-related deservingness. This provides answers to research questions (i.e., hypotheses) described above, but it also provides a view of the frequency of each frame across
the sample. For example, as mentioned above, medical humanitarianism and equality frames were most commonly used to justify deservingness. That this sample of health workers constructed health deservingness based on ideals of help, generosity, and human quality is not a surprising result, given that they work to provide care for the medical underserved, many of whom may face obstacles when seeking medical care. In fact, many health workers not only framed health deservingness in these terms, but they also constructed their personal and clinical identities on these ideals. In several cases, these personal and/or clinic characteristics were described in contrast to the practices of other clinics, hospitals, or even offices within the same building. For example, Sarah, who is introduced in the previous chapter, stresses that people working in a governmental office down the hall from her are “mean to Hispanic people.” In contrast, she describes a scenario in which workers in the CHC clinic go out of their way to ensure that a patient, who she suspects is undocumented, receives care. These results suggest that not only are ideals of charity and help important in framing health deservingness, but they are also important in shaping health workers’ identities as compassionate caregivers.

While this analysis reveals the shared cultural knowledge of health deservingness as evidenced by frequent frame use, it also sheds light on how frames exist as unevenly distributed cultural knowledge. For example, the evaluation of immigrant women as excess reproducers were used by only two participants, suggesting that this opinion is not shared among participants. However, this frame is not idiosyncratic. Marchesi (2012) documents how migrant women are scrutinized for fertility rates in Italy, where some discourses emphasize the reproductive practices of immigrant women as irrational, irresponsible, and immoral. Furthermore, the children of immigrants are described to be threats, rather than contributions, to the reproduction of the nation (Marchesi 2012). For two participants in this study, the reproduction of
undocumented immigrants is similarly perceived. Both health workers suggest that the reproductive practices of immigrant women are in need of disciplining. Such discourses of responsible reproduction underscore the planned and intentional reproductive behavior that is expected of “modern” subjects (Marchesi 2012).

As in the case of Dos Santos’ (2015) work on pregnancy health deservingness in Costa Rica, one health care professional in this study blamed immigrant women for not seeking prenatal care and potentially putting their unborn child at risk in the process. Dos Santos (2015) has argued that most who share this perspective do not consider possible barriers the mother might encounter in attaining prenatal care in the first place. This is the case here as well. While undocumented pregnant immigrants can access prenatal care at places like CHC, since CHC does not require legal documentation to be treated, they are not eligible to receive pregnancy-related care at PHD. PHD, which offered pregnancy-related care in the past, was no longer offering these services at the time of this study. Instead, PHD referred pregnant patients to a non-governmental organization (NGO) which attempts to connect Medicaid patients to obstetrical care. This NGO is funded through the Alabama Medicaid Agency. As such, eligibility for prenatal care is determined by the same criteria used to determine eligibility for Medicaid. Since undocumented women are not eligible to receive Medicaid during pregnancy, CHC is essentially their only option in the area for prenatal care, if they are uninsured. This gap in prenatal care coverage stands in direct odds with the evocation of pregnancy-care health deservingness expressed by the majority of health workers in this study.

This analysis further reveals the frequency of frame use by participant. Health professionals (i.e., social workers, clinicians, public health workers, and institutional resource managers) used, on average, more frames than health workers employed in staff positions (i.e.,
clinical aids, interpreters, and clerical workers) to talk about deservingness of undocumented immigrants. This suggests that health professionals drew from more cultural models, including those of health, immigration, and society, than staff when discussing health deservingness of immigrant populations. This heteroglossia has been described by anthropologist Claudia Strauss (2012), who suggests that people internalize a variety of frames they encounter in their differing communities. While these frames may be somewhat standardized—revealing the ways in which frames are a type of cultural knowledge distributed across members— the ways they are used in combination are unique (Strauss 2012).

One emergent finding of this research is that eight health workers used a combination of frames that, in different parts of the interview, extended and limited deservingness for undocumented immigrants. That is, while most health workers supported the inclusion of undocumented immigrants into the health system, others presented ambivalent arguments that framed both deservingness and undeservingness. Four of these conflicted individuals were involved in providing medical care to patients, whether as health care professionals or medical assistants. The remaining four worked in positions outside the exam room. This included an administrative assistant, two public health coordinators, and a financial manager. Thus, undocumented immigrants were described in various deserving and undeserving terms both within the clinic exam room and outside of it.

In other words, undocumented immigrants inspired “both compassion and repression” for these eight health workers (Fassin 2005). For example, in addition to those reproduction-based evaluations mentioned above, repression of health deservingness was based on perceived behaviors of taking advantage of tax-payers, being lawbreakers, or not paying into the healthcare system. These findings build upon previous research that has investigated the ways that migrant
“illegality” denies immigrant “biolegitimacy” (Fassin 2009), as they are excluded from the community of people whose health is worth concern (Willen 2011; Willen 2012). According to these same participants, however, undocumented immigrants were deserving of health because they will pay their bill, have rights to care, and should not be turned away. That frames were used to either extend or limit deservingness at different parts of the interview highlights how frames act as mental shortcuts that allow individuals to talk without thinking about their stance from scratch (Strauss 2013).

Ultimately, the diversity of frames used across health workers in a range of positions reveals a geography of deservingness that undocumented immigrants must face when seeking and receiving care at safety-net clinics. At each step of process, from information-seeking to appointment scheduling, from clinical encounters to billing and follow-up, a patient may encounter a health worker who views them as either deserving of their time, attention, and care, or not. While there are rules and regulations that health workers must follow, they are also the front-lines or “street-level” bureaucratic arms of the local government (Marrow 2012). As such, they have some discretion to interpret and enact government policies, even while being influenced by rules and bureaucratic processes (Marrow 2012). This research suggests that at safety-net clinics, even in places where frames of undeservingness are codified in state law, health workers view undocumented immigrants as deserving of health care, attention, and investment. Thus, these results reveal discrepancies between the views of deservingness in clinics and those expressed by state-level bureaucrats.

D. Limitations

There are several limitations in the methodology of this study. First, content analysis is not able to demonstrate the extent to which understandings of health deservingness are acted
upon in health workers’ lives. This research leaves unanswered the question of how frames relate to behavior. A second limitation concerns the sampling methods. Sample size was small (n=31), and a larger, random sample would have yielded greater statistical strength. Snowball sampling was used, and thus a random sample was not achieved, as the sample was based on the choices of participants first interviewed. Furthermore, snowball samples may be biased towards including individuals in social networks, which may have overestimated the similarity of frames.

Impression management is a third limitation (Goffman 1959). According to Goffman, individuals present themselves with certain “fronts” during performances, such as interview encounters, that are shaped by audiences and environments (1959: 17). During interactions, actors construct these fronts as part of the process of establishing a social identity. According to Goffman, these fronts are based more on desired impressions consistent with “characteristics that are socially sanctioned” (67) than on the actual behavior of the unobserved individual. However, conflicted responses suggest that for many health workers, impression management was not the primary task, unless the intended impression was one of conflict. Overall, impression management is almost always part of the interview process on behalf of both the participant and investigator. Future research in this area might triangulate interview responses with observational data to connect the dots between impression management and actual behavior.

Lastly, this research relies on interviews and observations at two clinics at one end of the health care spectrum. That is, these clinics have reputations for providing care to the medically underserved (i.e., uninsured and undocumented). As such, this research only goes so far in capturing the full spectrum of views of health workers in Alabama.
CHAPTER EIGHT

CONCLUSIONS

This research demonstrates how frames of deservingness and undeservingness are used by health workers at two safety-net clinics in Alabama. Health workers at the public health department were more likely than health workers at the community health center to emphasize infectious disease, although this was not a statistically significant difference. No significant differences were found in medical humanitarianism frame use between health workers at these two safety net clinics in Alabama. In fact, what unites health workers at these two safety net clinics is their commitment to medical humanitarian principles of help and compassion. Various scholars (Castañeda 2011; Willen 2011; Viladrich 2012; Vanthuyne et al. 2013) have documented the humanitarianism frame as one that is dominant within scholarly and public discourse regarding undocumented immigrants’ health-related deservingness. There are limits to humanitarianism, with principles based on generosity and exceptions, rather than rules and entitlements (Ticktin 2006). Yet by arguing for the health deservingness of undocumented immigrants, health workers align themselves against current government policies and political discourse that denies the bio-legitimacy of undocumented immigrants (Willen 2011). In so doing, health workers challenge the “unspoken—but nearly ubiquitous—assumption that unauthorized im/migrants can and should be categorically excluded from the moral community in which the rest of us live, work, and vote” (Willen et al. 2011).
These results also draw attention to those institutional contradictions that may frustrate street-level providers’ intentions to provide help for patients regardless of legal status. Despite their good intentions, and abilities to act on these good intentions as street-level bureaucrats, these Alabama health workers still operate within the larger federal and moral environments that restrict unauthorized immigrants’ access to a range of health services. Thus, their rendering of undocumented immigrants’ deservingness of health, largely through frames of medical humanitarianism and notions of equality, has limited relevance for immigrants seeking services outside of safety-net clinics, where they may be confronted by health workers viewing them as undeserving of health related concern and care.

Analysis demonstrated that health professionals employed, on average, more frames in their interviews than health workers in staff positions. The majority of health workers in this study used frames of deservingness to argue for the inclusion of undocumented immigrants into the U.S. health system. Some health workers also described immigrants using frames that call that deservingness into question. Eight health workers, including five professional and three staff, expressed conflict when discussing deservingness, such that they seemed to argue for the deservingness of undocumented immigrants with limitation. Overall, a total of 27 frames were used to describe the health deservingness and undeservingness of undocumented immigrants.

Ultimately, these results demonstrate the ways that frames, as mental shortcuts, map across individuals working at two safety-net clinics. This map provides a view of the cultural knowledge of health-related deservingness, including the ways this knowledge is shared across health workers. Future research on how health deservingness is understood outside of safety-net clinics is needed in Alabama in order to further understand the geography of deservingness.
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APPENDIX A: Institutional Review Board, University of Alabama

October 26, 2016

Anna Bianchi
Department of Anthropology
The University of Alabama
Box 870210

Re: IRB # 16-OR-366-ME: “Health Deservingness Frames of Pregnant Immigrant Women by Health Care Workers in Alabama”

Dear Ms. Bianchi,

The University of Alabama Institutional Review Board has granted approval for your proposed research. Your application has been given expedited approval according to 45 CFR part 46. You have also been granted a waiver of informed consent for the observation phase of the study. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your approval will expire on October 25, 2017. If the study continues beyond that date, you must complete and submit the Renewal Form within e-Protocol. If you modify the application, please submit the Revision Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, please complete the Final Report Form. Please use the IRB-stamped consent form.

NOTE: The UA IRB approval is contingent upon receipt of final IRB approval from the Alabama Department of Public Health. Please submit documentation of ADPH IRB approval to the Office for Research Compliance.

Should you need to submit any further correspondence regarding this application, please include the assigned IRB approval number. Good luck with your research.

Sincerely,

[Signature]
Director & Research Compliance Officer
Office for Research Compliance

cc: Dr. Kathryn Oths

358 Rose Administration Building | Box 870127 | Tuscaloosa, AL 35487-0127
205-348-8461 | Fax 205-348-7189 | Toll Free 1-877-820-3066
APPENDIX B: Approval from the Alabama Department of Public Health

MEMORANDUM

TO: Anna E. Bianchi
FROM: Jameson C. Durham, M.B.A., Director
       Bureau of Professional and Support Services
       DOAR/IRB Chair

SUBJECT: IRB approval of the “Health Desirability Frames of Pregnant Immigrant Women By Health Care Workers in Alabama”

ADPH’s DOAR has reviewed your proposal and has determined that it is exempt from IRB approval based on the fact that the information you are collecting on the subjects cannot be identified, directly or through identifiers linked to the subjects. Additionally, any disclosure of the human subjects’ responses outside the research would not place the subjects at risk of criminal or civil liability, or be damaging to the subjects’ financial standing, employability, or reputation.

Any changes to the reviewed application must be submitted, as an amendment, to ADPH’s DOAR/IRB for approval prior to implementation. Please keep this letter in your application file as proof of DOAR review.

cc: Dr. Mary McIntyre
    Brian Hake
APPENDIX C: Copy of Informed Consent

Informed Consent for a Non-Medical Study

TITLE OF RESEARCH: Health Deservingness Frames of Pregnant Immigrant Women By Health Care Workers in Alabama

IRB PROTOCOL:

INVESTIGATOR: Anna Elizabeth Bianchi, MPH and Kahlryna Oths, PhD

SPONSOR: UA Department of Anthropology

You are being asked to take part in a research study. This study is called “Health Deservingness Frames of Pregnant Immigrant Women By Health Care Workers in Alabama.” The study is being done by Anna E. Bianchi, who is a graduate student at the University of Alabama. Ms. Bianchi is being supervised by Dr. Kathryn Oths who is a professor of anthropology at the University of Alabama.

Purpose of the Research
The main purpose of this study is to explore approaches to care for immigrants in the United States.

What is the study about?
This study investigates how health workers approach the ethics and rights of health care. Specifically, this study seeks to understand how health workers approach care for immigrants.

Why is this study useful?
This research is important because it gives health workers a chance to share their experiences of working in health care, and their views of what they think health care should ideally be, and how it should ideally work.

Why have I been asked to be in this study?
You have been asked to be in this study because you are a health worker and have responded to our advertisement and expressed interest in the study.

How many people will be in the study?
About 30 people will be in this study.

What will I be asked to do in this study?
If you decide to participate in the study, you will be asked to participate in an interview on your perceptions of care for immigrants in the United States. This will take no more than 90 minutes. This interview will be audio-recorded and kept in the investigator’s office.

Will being in this study cost me anything?
The only cost to you from this study is your time.
**Will I be compensated for being in this study?**
In appreciation of your time, you will be given $10. If you start the study but decide not to finish, you will still be given $10.

**What are the risks (dangers or harms) to me if I am in the study?**
Little or no risk is foreseen. Data will be coded to maintain confidentiality; thus, no data will be personally identified with you. Your name will not appear in any materials coming from this research. Any information you share is confidential and no information will be available to the Clinic Staff that could in any way be traced to you. Audio-recordings of your interview will be deleted after two years.

**What are the benefits (good things) that may happen if I am in this study?**
There are no direct benefits to you. However, this research gives health workers a chance to share their experiences of working in health care, and their views of what they think health care should ideally be and how it should ideally work.

**What are the benefits to science or society?**
This research will add to our understanding of the practiced ethics of health care in the United States. This research will increase the awareness of how care is sought and received in clinics. It also seeks to add to our understanding of how the broader community’s historical, social, and political-economic contexts affect clinic access.

**How will my privacy be protected?**
You will be interviewed in a site of your choosing. You do not have to answer any questions that you do not want to.

**How will my confidentiality be protected?**
By participating in the interview, you are giving your consent to participate in this study. Data will be coded to maintain confidentiality; thus, no data will be personally identified with you. Your name will not appear in any materials coming from this research. Any information you share is confidential and no information will be available to the Clinic Staff that could in any way be traced to you. Audio-recordings of your interview will be deleted after two years.

**What are the alternatives to being in this study? Do I have any other choices?**
The alternative to being in this study is not to participate.

**What are my rights as a participant in this study?**
Taking part in this study is voluntary. It is your free choice. You can refuse to be in it at all. If you start the study, you can stop at any time. Your participation in this study (or lack of participation) will have no effect on your relations with your employer or The University of Alabama.

The University of Alabama Institutional Review Board (“the IRB”) is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.
Who do I call if I have questions or concerns?
If you have any questions about the study right now, please ask them. If you have questions about the study later on, please contact the Principal Investigator, Anna Bianchi, at 334-202-1487, or at abianchi@crimson.ua.edu, or the faculty supervisor, Dr. Kathryn Oths at 205-348-5947 or via email at koths@ua.edu.

If you have questions, concerns, or complaints about your rights as a person in a research study, you may contact Ms. Tanta Myles, the Research Compliance Officer at The University of Alabama, at 205-348-8461 or toll-free at 1-877-820-3066.

You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email the Research Compliance office at participantoutreach@bama.ua.edu.

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the co-investigator for a copy of it and mail it to the University Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

Audio-recording

Does the researcher have your permission to audio record the interview? __ Yes __ No

I have read this consent form. I have had a chance to ask questions. I agree to take part in it. I will receive a copy of this consent form to keep.

Signature of Research Participant ____________________ Date ______

Signature of Investigator ____________________ Date ______
APPENDIX D: Interview Schedule

Case ID:
Date:
Time:
Location:

Part I - Demographic/biographic data: These first questions will ask for some information about yourself.

1. Gender: ___Male   ___Female
2. How do you identify your ethnicity or race:
3. How old are you?
4. What is your job at the clinic?
5. How long have you worked here?
6. Can you tell me the story of how you decided to work healthcare?
7. What do you think motivates you to work at this clinic? (i.e., why do you work at this clinic?)

Part II - These questions are about immigrant health care in Tuscaloosa. There are no right or wrong answers to these questions. I'm just interested in your opinion.

8. Where do you think undocumented immigrants might access health care in Tuscaloosa?
9. In your opinion, what are some of the problems undocumented immigrants might face when trying to get health care in Tuscaloosa?
10. In your opinion, does the clinic see many undocumented patients?
11. What types of documents do they need to present to qualify?
12. What do patients have to pay?
13. What is your experience working with undocumented patients?
    a. What are some stories you have that illustrate this experience?
14. Do you think health care services should be made available to undocumented individuals living in Tuscaloosa in a different way from what they are now?
15. What are the reasons you feel this way?
16. What do you think an ideal health care system looks like for undocumented patients?
17. What are the reasons you feel this way?

Part III: These next questions will ask for your thoughts specifically about pregnancy care.
18. Where do you think undocumented pregnant immigrants access health care in Tuscaloosa?

19. What are some of the types of health services sought by pregnant immigrant women in Tuscaloosa?

20. What are some problems that undocumented pregnant immigrants might face when accessing care in Tuscaloosa?

21. In your opinion, does the clinic see many undocumented pregnant patients?

22. What types of documents do they need to present to qualify?

23. What do patients have to pay?

24. What has been your experience working with undocumented pregnant patients?
   a. Do you have any stories that illustrate this experience?

25. Do you think health care services should be made available to undocumented pregnant immigrants living in Tuscaloosa in a different way from what they are now?

26. What are the reasons you feel this way?

27. What do you think an ideal health care system is for undocumented pregnant immigrants?

28. What are the reasons you feel this way?

Part IV: These last few questions will ask about your own experiences and opinions about the health care system. Again, there are no right or wrong answers. I’m just interested in your opinion.

29. What are some reasons you think free or sliding scale clinics exist in:
   a. Tuscaloosa?
   b. In the U.S.?

30. What are some ways you feel services at free or sliding scale clinics in Tuscaloosa could be changed in any way?
   a. For undocumented immigrants?
   b. For pregnant undocumented immigrants?

31. What are some reasons you feel this way?

32. What are some ways you feel access to care at free or sliding scale clinics in Tuscaloosa could be changed in any way?
   a. For undocumented immigrants?
   b. For pregnant undocumented immigrants?

33. What are some reasons you feel this way?
34. What are some reasons why public health clinics exist in:
   
a. Tuscaloosa?
b. In the U.S.?

35. What are some ways you feel services at the public health clinic in Tuscaloosa could be changed in any way?
   
a. For undocumented immigrants?b. For pregnant undocumented immigrants?

36. Why do you feel this way?

37. What are some ways you feel access to care at the public health clinic in Tuscaloosa could be changed in any way?
   
a. For undocumented immigrants?b. For pregnant undocumented immigrants?

38. What do you know about current state policy regarding undocumented immigrants’ access to health care?

39. What do you know about current state policy regarding undocumented immigrants’ access to coverage options?

40. In what ways could current state policy regarding undocumented immigrants’ access to care or insurance be changed?

41. What are some reasons you feel this way?

42. Would you say you that you are interested or uninterested in immigrant health policy?
   
a. If interested: Are you a little or a lot interested in immigrant health policy?
      __Little interest
      __A lot of interest

   b. If not interested: Are you a little uninterested or a lot uninterested in immigrant health policy?
      __Little uninterest
      __A lot of uninterest

43. About how many times have you traveled to a different country outside your country of residence?
   
   Number: ____

44. Do you have any questions, or is there anything you’d like to add?