

Undocumented Immigrants and the Inclusive Health Policies of Sanctuary Cities

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Abstract

Undocumented immigration remains the subject of contentious debate in the United States. While this debate has increasingly focused on the cultural, economic, and national security concerns raised by undocumented immigration, the work of several cities has highlighted the human side to this debate. Drawing from three months of field work and 21 semi-structured interviews at an emergency shelter in Central Texas, this paper discusses the inclusive health policies of so-called “sanctuary cities.” The inclusive health policies of sanctuary cities, including the establishment of city health insurance and healthcare programs, has the potential to bridge a widening gap in health outcomes between undocumented individuals and their native-born or authorized counterparts. These local policies extend a form of membership to undocumented immigrants and inform new directions for federal immigration enforcement policies, including an enhanced focus on the specific health needs of undocumented immigrants alongside the securitization of national borders. To ensure adequate care of undocumented immigrants, inclusive health policies should be

increasingly pursued by local and federal levels of government in tandem.

Introduction

Undocumented immigration remains the subject of contentious debate in the United States. Cultural, economic, and—in more recent times—national security concerns have sustained an intense focus on our borders. But, there is also a very human side to the undocumented immigration debate; those who choose to cross our borders are considerably impacted by the policies regulating entry and exit.

Established in 2008, Secure Communities was an immigration enforcement program designed to strengthen the federal information-sharing partnership between the Federal Bureau of Investigation, U.S. Department of Homeland Security, and local law enforcement. The program aimed to streamline the enforcement of federal immigration law by simplifying the identification of undocumented persons in custody. Local law enforcement personnel were directed to collect biometric data, such as fingerprints, from all arrested

individuals. Fingerprints collected by a local police officer were then automatically transmitted to the Federal Bureau of Investigation; the Bureau, in turn, forwarded queries onto U.S. Immigration and Customs Enforcement—a Component of the Department of Homeland Security—which then initiated and adjudicated deportation proceedings. While Secure Communities did not grant local police officers the ability to directly enforce federal immigration law, the program effectively recruited police officers to aid in the holding of persons suspected of illegal entry. This temporary detention then allowed federal immigration officers to interview and assess an individual's deportability.¹ In Fiscal Year 2012, removal numbers peaked at over 400,000 individuals.² However, by Fiscal Year 2015, this figure had dropped substantially to a little more than 200,000 individuals.¹ This drop was, in part, attributable to growing local noncompliance.³ Increasingly, city officials recognized the pronounced, chilling effect of the program on their communities and sought to curb its influence.⁴

Undocumented families stopped sending their children to school for fear of deportation. Some avoided community events, widely-attended gatherings, or even contacting local law enforcement, whether they were a witness to or victim of a crime.

Others avoided visiting their doctors or seeking care at hospitals. The Secure Communities Program effectively stifled whole segments of local populations. Recognizing the need to reengage these portions of the community, cities increasingly self-identified as “sanctuary cities.”⁴ These cities established informal noncompliance protocols with federal immigration enforcement, curtailing local police officers from collecting legal statuses of victims or suspects and limiting the aggregation of legal status information for the delivery of social and medical benefits.

The association of the sanctuary city label with noncompliance protocols is a relatively recent phenomenon. Sanctuary cities originally developed out of the faith-based response to the mass migration of Central American refugees in the 1980s, a phenomenon known as the Central American Refugee Sanctuary Movement (CSM). Central American refugees were fleeing social instability and rampant political violence.^{5 6 7} Congregations and other faith-based actors rallied to provide resources and social services to these newcomers. Notably, the CSM placed a premium on combining diffuse local resources for the concentrated

¹ S. Immigration and Customs Enforcement. (2015a). Secure Communities (Archived Fact Sheet.) Retrieved from <https://www.ice.gov/secure-communities>.

² S. Immigration and Customs Enforcement. (2015b). FY 2015 ICE Immigration Removals (Online Report). Retrieved from <https://www.ice.gov/removal-statistics>.

³ S. Department of Homeland Security. (2015). DHS Releases End of Fiscal Year 2015 Statistics (Press Release). Retrieved from

<http://www.dhs.gov/news/2015/12/22/dhs-releases-end-fiscal-year-2015-statistics>

⁴ Villazor, R. C. (2008). What Is A ‘Sanctuary City’?. *SMU Law Review*, 61:133-158.

⁵ Bau, I. (1985). *This Ground is holy: Church sanctuary and Central American refugees*. New York, NY: Paulist Press

⁶ Golden, R. & McConnell, M. (1986). *Sanctuary: The New Underground Railroad*. Maryknoll, NY: Orbis Books.

⁷ Tomsho, R. (1987). *The American Sanctuary Movement*. Austin, TX: TexasMonthly Press.

care and humane treatment of undocumented persons⁸

The CSM officially began in 1982 when the Southside United Presbyterian Church Congregation in Tucson, Arizona, declared their house of worship a sanctuary.⁹ This first declaration of sanctuary soon encouraged other congregations to follow suit.⁵ At the zenith of the movement, approximately 20,000 to 30,000 church members and over 100 churches and synagogues joined the cause.⁴ Sanctuary sites spread across all major geographic areas of the United States, and many of these sites developed strong ties with sanctuaries in Canada.^{10,11}

The network of faith-based actors that emerged from this first effort made several resources available to the undocumented population including money for bail, legal representation at deportation hearings, support for asylum applications, food, shelter, transportation, resettlement, and medical aid.⁵

Public actors were also involved in the CSM. By the summer of 1987, 22 city councils and one governor had declared sanctuary.¹⁰ Decisions affecting public spaces were often prompted by the same underlying political motivations that encouraged the development of faith-based sanctuary spaces, including opposition to

federal immigration policies and practices and a concern for the well-being of undocumented persons.

The Los Angeles Police Department (LAPD) issued a memorandum in November 1979, constituting the first local sanctuary policy initiative for undocumented immigrants in the United States.⁴ This internal document, also known as Special Order 40, prohibits LAPD officers from initiating “police action with the objective of discovering the alien status of persons.”¹² The order also stipulates that officers avoid making arrests for illegal entry into the United States.¹²

Though the discussion on sanctuary cities has become increasingly polarized due to an association with the negative implications of noncompliance, including the release of repeat offenders back into communities, they have not strayed far from their CSM origins. Sanctuary cities continue to provide a number of key resources and support to an otherwise underserved, undocumented population. Aside from noncompliance protocols, sanctuary cities have provided local benefits and resource networks, including city-wide minimum wage laws, anti-discrimination employment statutes, extension of the local franchise to all residents, and city health insurance and healthcare programs.^{13,14} Still other initiatives

⁸ Phelps, T. G. (1991). No Place to Go, No Story to Tell: The Missing Narratives of the Sanctuary *Washington and Lee Law Review*, 48:123-137.

⁹ Davidson, M. (1988). *Convictions of the Heart: Jim Corbett and the Sanctuary Movement*. Tucson, AZ: The University of Arizona Press

¹⁰ Cunningham, H. (1995). *God and Caesar at the Rio Grande: Sanctuary and the Politics of Minneapolis*, MN: University of Minnesota Press

¹¹ Canada-US border. In R. K. Lippert & S. Rehaag (Eds.), *Sanctuary Practices in International*

Perspectives: Migration, citizenship and social movements, (pp. 233-244). New York, NY: Routledge

¹² Maya, T. W. (2002). To Serve and Protect or to Betray and Neglect?: The LAPD and Undocumented Immigrants. *UCLA Law Review*, 49:1611-1653.

¹³ Mitnik, P.A., and Halpern-Finnerty, J. (2010). Immigration and Local Governments: Inclusionary Local Policies in the Era of State Rescaling. In M. W. Varsanyi (Ed.), *Taking Local Control: Immigration Policy Activism in U.S. Cities and States* (pp. 51-72), Stanford, CA: Stanford University Press.

support immigrant workers' right to organize; the creation of day laborer centers; the establishment of multipurpose agencies or boards in local government to address immigrant concerns; the recognition of foreign consular identification cards; and the distribution of municipal identification cards.¹³

The healthcare resources sanctuary cities provide to undocumented immigrants are an instance of local action in response to recognized disparities. Granting access to healthcare resources and critical support systems is both a concrete and symbolic gesture. On the one hand, such action ensures that vulnerable populations—such as the undocumented—may seek out primary care providers, put food on the table, and overcome prejudices in the workplace. On the other hand, this action embodies a certain degree of recognition; undocumented immigrants in receipt of these services are recognized as community members. They are members in so far as they occupy the same physical space as their cohabitants and live in close proximity to those native-born, naturalized, and lawfully-present residents who bear witness to the inequalities characterizing a life in the shadows;¹⁴ they are recognized as members in need of services. Finally, sanctuary cities provide a useful model for how we might improve undocumented persons' access to healthcare resources through case management and focused nodes of support; the development of

federal policy has benefited and may continue to benefit from these local instances of inclusive health policies. To ensure undocumented immigrants receive quality care in the future, inclusive health policies should be increasingly pursued at both local and federal levels of government.

Methods Section

Three months of field work were conducted in Central Texas. In the summer of 2013, 21 semi-structured interviews were held at an emergency shelter for immigrants with residents, staff, and other community leaders. This shelter was located in a recognized sanctuary city. Given the ever-changing legal landscape and controversial nature of the immigration debate, respondents

Living Tentatively

Undocumented immigrants lead tentative, vulnerable lives. Resource scarcity is a primary barrier to undocumented immigrants' healthcare access. Undocumented immigrants are less likely to be insured and often do not have the financial means to afford care on their own.^{15 16} This has a direct impact on access to preventative care and immunizations, and contributes to undocumented immigrants' underutilization

¹⁴ Joseph, T. D. (2016). What Health Care Reform Means for Immigrants: Comparing the Affordable Care Act and Massachusetts Health Reforms. *Journal of Health Politics, Policy and Law*, 41(1):101-116

¹⁵ Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented

immigrants: a literature review. *Risk Management and Healthcare Policy*, 8:175-183

¹⁶ Kullgren, J.T. (2003). Restrictions on Undocumented Immigrants' Access to Health Services: The Public Health Implications of Welfare Reform. *American Journal of Public Health*, 94(10):1630-1633

of healthcare resources.^{161718 1920212223} Few undocumented immigrants have a primary care physician or first point-of-contact in the healthcare system aside from the Emergency Room; and although the Emergency Room remains an option, undocumented immigrants still make fewer visits than their U.S.-born or naturalized counterparts.¹⁹²⁴ As a secondary barrier, the threat of deportation curtails undocumented immigrants' access to and utilization of healthcare resources.²⁵ Arizona's *Support our Law Enforcement and Safe Neighborhoods Act of 2010*, otherwise known as SB 1070, provides an illustrative example. This law enhanced the ability of the police to detain persons suspected of unauthorized status and criminalized the failure to possess sufficient documentation.²⁶ Healthcare providers living in communities directly affected by the passage of this law, noted a drop in patient visits, diabetes and HIV consultation attendance, vaccinations, prenatal care, and

filled prescriptions.²⁶²⁷ Further research suggests that the fear of deportation, often prompted by requirements to provide documentation for medical services, contributes to avoidance of care.¹⁹

A natural consequence of these barriers to healthcare resources is an exacerbation of preexisting health conditions. Circumstances of departure are often unplanned and precarious²⁸ Fleeing impending violence and/or poor living conditions, undocumented immigrants arrive burdened by the lingering effects of psychological trauma and depression; communicable disease; and chronic illness.^{16 19} Further compounding these realities, federal efforts to overhaul the U.S. healthcare system have left undocumented immigrants behind. While healthcare reform has improved access to healthcare resources for many U.S. citizens, undocumented immigrants have reaped few, if any, benefits from these advances.

¹⁷ Derose, K., Escarce, J., & Lurie, N. (2007). Immigrants and health care: Sources of vulnerability. *Health Affairs*, 26(5):1258-1268.

¹⁸ Dubard, C. A., & Massing, M. W. (2007). Trends in emergency Medicaid expenditures for recent and undocumented immigrants. *Journal of the American Medical Association*, 297(10):1085-1092.

¹⁹ Messias, A.K.H., McEwen, M., & Clark, L. (2015). The impact and implications of undocumented immigration on individual and collective health in the United States. *Nursing Outlook*, 63:86-94

²⁰ Rodriguez M. A., Bustamante A.V. & Ang A. (2009). Perceived quality of care, receipt of preventive care, and usual source of health care among undocumented and other Latinos. *Journal of General Internal Medicine*, 24(3):508.

²¹ Stimpson, J. P., Wilson, F. A., & Eschbach, K. (2010). Trends in health care spending for immigrants in the United States. *Health Affairs*, 29(3):544-550.

²² Stimpson J. P., Wilson F. A., & Su D. (2013). Unauthorized immigrants spend less than other immigrants and US natives on health care. *Health Affairs*, 32(7):1313.

²³ Stimpson J. P., Wilson F. A., & Zallman L. (2014). ED visits and spending by unauthorized immigrants compared with legal immigrants and US natives. *American Journal of Emergency Medicine*, 32(6):679.

²⁴ Ortega, N. et al. (2007). Health care access, use of services, and experiences among undocumented Mexicans and other Latinos. *Archives of Internal Medicine*, 167(21): 2354-2360.

²⁵ Nandi, Arijit et al. (2008). Access to and Use of Health Services Among Undocumented Mexican Immigrants in a US Urban Area. *American Journal of Public Health*, 98(11):2011-2020.

²⁶ Hardy, L. J. et al. (2012). A Call for Further Research on the Impact of State-Level Immigration Policies on Public Health. *American Journal of Public Health*, 102(7):1250-1254.

²⁷ Toomey, R. B. et al. (2014). Impact of Arizona's SB 1070 Immigration Law on Utilization of Health Care and Public Assistance Among Mexican-Origin Adolescent Mothers and Their Mother Figures. *American Journal of Public Health*, 104:S28-S34

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The Patient Protection and Affordable Care Act of 2010 developed a number of innovative measures—such as the high-risk persons’ insurance pool, state health exchanges, or federal tax credits to help meet the burden of healthcare costs—but, undocumented immigrants do not qualify for many of these options²⁹ These exclusions are a legacy of the push for welfare reform in the 1990s. Lawmakers then endeavored to stymie unauthorized immigration by reducing access to publicly-funded resources and benefits. This effort was marked by the passage of two pieces of legislation in 1996—the *Personal Responsibility and Work Opportunity Reconciliation Act* and the *Illegal Immigration Reform and Immigrant Responsibility Act*.¹⁴ These two laws effectively disqualified undocumented immigrants from the Child Health Insurance Program, Medicaid, and Medicare.¹⁴ ¹⁵³⁰ Retrieved From: [http://www.undocumentedpatients.org/issue-brief/health-policy-and-access-to-care/.](http://www.undocumentedpatients.org/issue-brief/health-policy-and-access-to-care/)]

The exclusion of undocumented immigrants from welfare and healthcare reform has furthered a widening gap in healthcare outcomes.¹⁴ Often of limited financial means, undocumented immigrants are, thus, left with the only option of purchasing expensive, unsubsidized coverage from private

insurance carriers.¹⁴ This has made local intervention on the part of sanctuary cities all the more critical in bridging a widening gap between the health outcomes of undocumented immigrants and the remainder of the populace.

Inclusive Health Policies

In many ways, the self-understanding of undocumented immigrants is impacted by the tone of public policy and rhetoric addressing their presence.³¹ ³²³³ Whether they view themselves to be members; to be worthy of due consideration; to have a claim to the community or its resources; or to have a say regarding their own health and well-being is influenced by the character of their surroundings.

Sanctuary cities are largely inclusive settings. They are local communities that recognize undocumented immigrants as contributors to and benefactors of shared resources. In the case of healthcare, the provision of resources and support to an undocumented populace puts forth something more than vaccinations, continued care, or affordable medications; such action communicates a willingness to enter into a dialogue with those who may otherwise prove to be unfamiliar.³⁴

During my time at the emergency shelter for immigrants, I encountered several residents

²⁹ Torres, J.M. & Wallace, S.P. (2013). Migration Circumstances, Psychological Distress, and Self-Rated Physical Health for Latino Immigrants in the United States. *American Journal of Public Health*, 9:1619-1627.

³⁰ Marrow, H. B. & Joseph, T. D. (2015). Excluded and Frozen Out: Unauthorised Immigrants’ (Non)Access to Care after US Health Care Reform. *Journal of Ethnic and Migration Studies*, 41(14):2253-2273

³¹ Gusmano, M. K. (2012). Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care [Online Article

³² Bloemraad, I. (2006). Becoming a Citizen in the United States and Canada: Structured Mobilization and Immigrant Political Incorporation. *Social Forces*, 2:667-695.

³³ Bosniak, L. (2006). *The Citizen and the Alien: Dilemmas of Contemporary Membership*. Princeton, NJ: Princeton University Press

³⁴ Benhabib, S. (2004). *The Rights of Others: Aliens, Residents, and Citizens*. Cambridge, UK: Cambridge University Press

and staff members who highlighted the benefits of inclusive health policies toward undocumented immigrants. In particular, the inclusive health policies of the city—which enabled the shelter’s work—afforded a holistic case management approach and provided undocumented immigrants with strong system navigators who could advocate on their behalf.

Joe was a resident who had lived at the shelter for about three months. I met him early on during my time there. He was a Zimbabwean refugee fleeing prejudice towards his sexual orientation, grappling with the lingering effects of severe depression, and coping with the immediacy of homelessness. He had overstayed a visitor visa and subsequently sought assistance in navigating the complex immigration legal system. While he had received training as a nurse, he was no longer practicing. He spent most of his days at the shelter, sitting around the picnic table that served as the dining area, keeping up with old acquaintances online, and attending counseling sessions. What was striking about Joe’s case were the number of significant overlapping factors affecting his physical and psychological health.

The shelter had a modest staff but maintained a number of key, strong relationships with community organizations that could connect residents to critical resources. In many ways, the shelter served as an important node within the network of resources provided via the sanctuary city’s inclusive health policies. Joe benefited from the shelter’s holistic case management approach. The shelter gave Joe access to legal counsel; housing options; food and basic necessities; medical care and psychological counseling; and the company

of others who had withstood similar difficulties in migrating to the United States.

The impact of this concentration of resources was a reaffirmation of Joe’s value and role as a member of the community. At the shelter, Joe acquired a sense of self-agency:

I feel actually really loved here at the shelter. And, it’s a feeling that is new to me because in the different places that I’ve lived, I think I have had difficulty building good and healthy interpersonal relationships ... I definitely feel a sense of ‘Here you are. You are welcome here.’ You know. ‘We want to hear your ideas, and we will take them up into consideration. And, we will actually *do* something about it.

While Joe no longer possessed authorization to work and was consequently unemployed, he felt that he served a purpose within the shelter:

I feel connected to ... Daniel who is an older guy ... and he’s sick. And, I feel connected to him because I am an RN by trade, and I’m able to provide him with services that I have. Like, when he needs medical attention. When people are unsure of how he’s doing, I can go in and assess him and check his vital signs. You know. And, I feel like that’s what I bring to the table.

Not only did the shelter provide Joe with tangible health resources and support, but the shelter also provided Joe with an opportunity to feel like he belonged. At the shelter, Joe was able to take ownership of his own well-being as well as that of his co-residents.

Daniel, who Joe often cared for, was an elderly undocumented immigrant from Mexico. He had worked as a day-laborer for more than two decades. He was a Spanish-

only speaker, separated from his family by the border and the increasing danger involved in crossing it. He had no access to traditional retirement or resources for elderly care. As one of the oldest residents, he had the reputation of being the shelter's patriarch and had garnered the respect of his younger fellows. With multiple co-morbidities, Daniel's health was on the decline; staff ensured that he received qualified hospice care at the shelter. For much of the time, he rested on a single bunk bed in the men's quarter of the shelter.

Julie served as a staff member. As Daniel's case manager, Julie helped transport Daniel to medical appointments at free clinics run by the city. When Daniel's health declined, Julie then helped connect Daniel to hospice care providers. Julie worked alongside other staff members who cared for Daniel, including a practitioner of alternative medicine staffing the small, on-site clinic. During our interview, she reflected on her responsibilities as a medical advocate and the sense of community she felt alongside the undocumented immigrants at the shelter:

Here at the shelter, it's the residents. In a way, it is a community even though I *do* work here, you know, it becomes a little blurry sometimes ... being in charge of case management and making sure that the shelter runs but still [being] a part of the shelter's community. So, my coworkers the population who I serve ... some residents require more time and medical case management—it's a lot of advocacy and taking them to appointments and waiting and being patient and being patient again ...

In many ways, Julie and her fellow staff members were system navigators. They connected residents at the shelter with

community resources far and wide. Shelter staff maintained an updated list of organizations providing pro bono care, and they made regular use of it. This model proved very successful. Notably, staff members were also able to extend their case management services to members of the larger immigrant population in the city, including those who did not physically reside at the shelter.

The working relationship between the city and emergency shelter was symbiotic in nature: the inclusive health policies of the sanctuary city enabled the emergency shelter to find the support and resources upon which its residents and larger, immigrant community relied. In return, the work of the shelter helped city officials connect with and serve the undocumented portion of their constituency. Working closely with undocumented immigrants and their extended families, the shelter fostered trust between city officials and those they were tasked to serve. This functional understanding between city and shelter was exemplified by the location of a satellite police station; although the satellite was just across the street from the shelter, residents and staff did not report significant law enforcement incursion.

These inclusive health policies of sanctuary cities and the case management model of care for undocumented immigrants have influenced policy at the federal level. Federal policy has shifted away from the problematic Secure Communities Program which sparked the rise of sanctuary city noncompliance protocols. Increasingly, federal immigration enforcement has recognized the health needs of undocumented immigrants alongside a requirement to secure national borders.

Discussion: Learning From Local Experiences

While recent events have cast the noncompliance protocols of sanctuary cities into question, the inclusive health policies adopted by sanctuary cities have conversely influenced federal policy making.³⁵ Significantly, there has been a greater recognition of undocumented immigrants' physical and mental health needs. This greater recognition has been marked by a shift towards alternative detention methods including family case management, and an attempt to prioritize enforcement of immigration laws to spare from deportation those undocumented persons who have not committed a serious crime, have resided in the United States for a considerable length of time, or who otherwise have a credible or reasonable fear of persecution upon return to their country of origin.

At the shelter, a recently-arrived resident benefited from these developments. Sarah was a Honduran refugee and victim of domestic violence. Previously in the custody of Immigration and Customs Enforcement, Sarah participated in the Community Support Network (CSN) pilot program. The CSN pilot was launched to assess the efficiency and benefit of community-based services in lieu of immigrant detention at large, off-site facilities.³⁶ The CSN pilot enabled Sarah to reside at the shelter where she could access

counseling, health services, and benefit from the presence of others. The shelter, unlike an off-site detention facility, could adequately address Sarah's psychological needs while also ensuring compliance with court appearances and the asylum application process.

The CSN pilot is a concrete example of how local understandings and experiences are influencing federal directions. While the local resources provided via inclusive health care policies in sanctuary cities are certainly limited, they may provide the foundations for action on a larger scale. Although of smaller means, cities that adopt inclusive health policies can have an impact on the federal policies that influence the treatment of undocumented persons. The changing landscape of federal immigration enforcement illustrates this impact.

On November 20, 2014, the Department of Homeland Security discontinued the controversial Secure Communities Program and launched the Priority Enforcement Program or PEP.³⁷ Washington, DC: U.S. Department of Homeland Security.]³⁸ PEP builds directly off of a June 15, 2015 memorandum issued by the Department. This memorandum designates a "low priority" of persons for which Immigration and Customs Enforcement personnel "should immediately exercise their discretion...in order to prevent [them] from being placed into removal

³⁵ Abizadeh, A. (2008). Democratic Theory and Border Coercion: No Right to Unilaterally Control Your Own Borders. *Political Theory*, 36(1):37-65

³⁶ Littlefield, C. (2015, July 24). Sanctuary Cities: How Kathryn Steinle's death intensified the immigration debate. *Los Angeles Times*. Retrieved from <http://www.latimes.com/local/california/la-me-immigration-sanctuary-kathryn-steinle-20150723-htmllstory.html>.

³⁷ Lutheran Immigration and Refugee Service. (2015). Community Support Network. Retrieved from <http://lirs.org/our-work/partnership/service-partners/access-to-justice-partners/community-support-network/>.

³⁸ Johnson, J.C. (2014a). *Secure Communities* [Memorandum

proceedings or removed from the United States.”³⁹This low priority category included minors, persons who continuously resided in the United States for at least five years, and those who have not been convicted of a felony offense, significant misdemeanor offense, or multiple misdemeanor offenses.³⁹

Along a similar vein, PEP advises immigration enforcement personnel to consider additional factors such as “family or community ties in the United States; status as a victim, witness or plaintiff in civil or criminal proceedings; or compelling humanitarian factors such as poor health, age, pregnancy, a young child, or a seriously ill relative.”⁴⁰The November 20, 2014 memorandum outlining PEP further mentions that detention resources should not be expended on persons “suffering from serious physical or mental illness, who are disabled, elderly, pregnant, or nursing, who demonstrate that they are primary caretakers of children or an infirm person, or whose detention is otherwise not in the public interest.”⁴⁰

While the immigration debate certainly continues, it is clear that local communities have something to add to the discussion. Sanctuary cities’ consideration of the health needs of undocumented persons’ have shaped the future direction of federal immigration enforcement programs; federal apprehension and detention programs are increasingly recognizing the particular health vulnerabilities of the undocumented population. And, while we might not yet have

found a perfect balance between the securitization of our borders and the care of undocumented persons, a precedence for continued dialogue between localities and the Federal Government has already been set.

Sanctuary cities have close-range interactions with undocumented immigrants and thus have a unique ability to minimize a growing gap in health outcomes. By leveraging local resources through inclusive health policies, sanctuary cities also extend a form of membership; they recognize undocumented immigrants as persons who are deserving of access to shared resources and benefits. The Federal Government should increasingly work alongside these cities to foster a view of undocumented immigrants as persons belonging to communities rather than strangers; such a view is in the public interest as it has the potential to reaffirm the essential, human character of undocumented immigration.

³⁹ S. Immigration and Customs Enforcement. (2015c). Priority Enforcement Program (Online Article). Retrieved from <https://www.ice.gov/pep>.

⁴⁰ Morton, J. (2012). *Secretary Napolitano’s Memorandum Concerning the Exercise of*

Prosecutorial Discretion for Certain Removable Individuals Who Entered the United States as a Child (Memorandum). Washington, DC: U.S. Department of Homeland