THE HEALTH OF UNDOCUMENTED MEXICANS IN NEW YORK CITY

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In partnership with the Center for Urban Epidemiologic Studies, and in collaboration with diverse institutions and individuals, the Center for Community Problem Solving completed a study of the health of 431 undocumented Mexicans in New York City. Informed by a robustly democratic rebellious vision of problem solving and by a decidedly unorthodox rival theory of undocumented Mexican migration, the study reveals patterns that, if fortified by further investigation, might well change how we think about the health of undocumented Mexicans, how we allocate resources, and how we target interventions. In this Article, Professor Gerald P. López analyzes how this study – more accurately, the effort of which the study is a part – aims at once to close two gaps: the gap between what we now know and what we might learn about the health of undocumented Mexicans in New York City, and the gap between what we typically do now through our practices and what we might do through a rebellious vision of problem solving.

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Table of Contents

INTRODUCTION

Already by 2003, the migration of undocumented and documented Mexicans to the United States was "in the midst of a fundamental transformation."[1] The 1990s began to reveal changes that perhaps first took hold in the mid-1980s, especially pivoting around the passage of the Immigration Reform and Control Act of 1986 (IRCA) and soon extending themselves as a result of the ensuing policies pursued by the Clinton and Bush Administrations.[2] In particular, the post-IRCA era saw the rise of new destinations and new origins. Scholars spoke of the "new geography of Mexican migration,"[3] and reports began to appear of undocumented and documented Mexican immigrants living in such places as Dalton, Georgia; Marshalltown, Iowa; Lexington, Nebraska; Belhaven, North Carolina; Morgan City, Louisiana; Kennet Square, Pennsylvania; and New York, New York.[4]

According to the United States Census, the number of Mexicans in New York City grew from 7,893 in 1970, to 25,577 in 1980, to 61,722 in 1990, and finally, to 186,872 in the year 2000. Most experts believed these census figures considerably undercounted undocumented Mexicans.[5] Researchers estimated that 350,000-450,000 Mexican immigrants

[1] Víctor Zúñiga & Rubén Hernández-León, *Introduction* to NEW DESTINATIONS – MEXICAN IMMIGRATION IN THE UNITED STATES xi, xi (Víctor Zúñiga & Rubén Hernández-León eds., 2005).

[2] For an extended analysis of the impact of these policies and practices by the nation's preeminent immigration scholar and lawyer, see BILL ONG HING, DEPORTING OUR SOULS: VALUES, MORALITY, AND IMMIGRATION POLICY (2006).

[3] Jorge Durand, Douglas S. Massey, and Chiara Capoferro coined the term, and their research appears in *The New Geography of Mexican Immigration*, *in* NEW DESTINATIONS – MEXICAN IMMIGRATION IN THE UNITED STATES 1 (Víctor Zúñiga & Rubén Hernández-León eds., 2005).

[4] For reports on these and other destinations, see NEW DESTINATIONS – MEXICAN IMMIGRATION IN THE UNITED STATES (Víctor Zúñiga & Rubén Hernández-León eds., 2005); *supra* note 2. For other descriptions and analyses of the new migration patterns, see e.g., CON. BUDGET OFF., A DESCRIPTION OF THE IMMIGRANT POPULATION (2004); RANDY CAPPS ET AL., THE NEW NEIGHBORS: A USER'S GUIDE TO DATA ON IMMIGRANTS IN U.S. COMMUNITIES (2003).

[5] Infoshare, New York, Place of Birth of Foreign-born Population in New York City - 2000

fanned out across the five boroughs[6] of New York City, and each year undocumented arrivals made up perhaps as high as 80 to 85 percent of the total – and certainly exceeded the number of – overall legal immigrants.[7]

You might think that large and growing numbers of undocumented Mexicans who made New York City their destination would have triggered considerable curiosity – not least about their health access and health status. Some feared immigrants brought with them infectious diseases.[8] Others stressed that, having arrived, undocumented immigrants may not have sought medical treatment for fear of apprehension.[9] Even if fear could have been overcome, attention focused upon language barriers that may have impeded comfortable access and quality care.[10] High odds of health risks and low odds of health access would alone have called for well-designed and well-funded research.[11]

Census Long Form, http://www.infoshare.org (last visited on Apr. 27, 2004); Francisco L. Rivera-Batiz, *The State of New York Titlan: A Socioeconomic Profile of Mexican New Yorkers* (Sep. 15, 2003), *available at* http://www.columbia.edu/~flr9/.

[6] Abel Valenzuela Jr., Nik Theodore, Edwin Meléndez & Ana Luz Gonzalez, *On the Corner: Day Labor in the United State* (UCLA's Center for the Study of Urban Poverty; 2006), *available at* http://www.uic.edu/cuppa/uicued/; Sam Roberts, *Immigrants Swell Numbers In and Near City*, N.Y. Times; Aug. 15, 2006, at B1.

[7] Jeffrey S. Passel, The Size and Characteristics of the Unauthorized Migrant Population in the U.S. 4 (Pew Hispanic Center, Mar. 7, 2006), *available at*: http://pewhispanic.org/reports/report.php?ReportID=61; Rivera-Batiz, *supra* note 4. That would rank New York's Mexican immigrant population – both documented and undocumented – as roughly as large as San Diego and San Jose, cities with longstanding immigrant populations, in geographical areas once part of Mexico and long the destination of Mexican immigrants.

[8] For a scholarly exploration of such concerns by researchers, see Elena Zúñiga et al., *Mexico-United States Migration: Health Issues* (UCLA Center for Health Policy Research, 2005). For important work illuminating policies and practices aimed at Mexicans and Pilipínos and the infectious diseases they presumably carried, see Emily K. Abel, "*Only the Best Class of Immigration": Public Health Policy Toward Mexicans and Filipinos in Los Angeles, 1910–1940,* 94 Am. J. Pub. Health 932, 932-35 (2004). Abel's later work extends this proves every bit as rewarding analysis. *See, e.g.*, Emily K. Abel, Tuberculosis & The Politics of Exclusion — A History of Public Health and Migration to Los Angeles (2007). For another important contribution to understanding how Los Angeles received, regarded, and treated immigrants, see, for example, Natalia Molina, Fit to Be Citizens? Public Health and Race in Los Angeles, 1879–1939 (2006).

[9] Marc L. Berk & Claudia L Schur, *The Effect of Fear on Access to Care Among Undocumented Latino Immigrants*, 3 J. Immigrant Health 151 (2001).

[10] Margaret W. Vitullo & Amy K. Taylor, *Latino Adults' Health Insurance Coverage: An Examination of Mexican and Puerto Rican Subgroup Differences*, 13 J. Health Care Poor Underserved 504 (2002).

[11] For a knowledgeable identification of relevant concerns, see Elena Zúñiga et al., *supra* note 7. For a representative view of how these concerns may well be exacerbated by restrictions on access, see e.g., Jeffrey T. Kullgren, *Restrictions on Undocumented Immigrants' Access to Health Services: The Public Health Implications of Welfare Reform*, 93 Am. J. Pub. Health

If these were not reasons enough to expect to see considerable curiosity at work on the research front, the very approach to knowledge that characterized health care by 2003 would presumably have propelled such learning. Prominent scholars and practitioners stressed the relationship between empirical inquisitiveness and well-structured systems.[12] Others interested in what has come to be known as "evidence-based" practice – across public, private, and civic spheres – praised medicine as leading the way toward accountable and effective approaches.[13]

Searching for ways to improve, those in health care outspokenly demanded much of themselves and others. A blue-ribbon panel of the National Research Council Panel, charged by Congress with assessing the adequacy of the Department of Health and Human Services (DHHS) data collection systems for illuminating the reasons for disparities in health and health care across racial, ethnic, and socio-economic boundaries, concluded in 2004 that current evidence is "severely limited." As a solution, the Panel proposed a comprehensive plan of action, and urged DHSS to adopt and implement and monitor the plan immediately.[14]

Even more particularly, leaders of evidence-based public health practice urged the development of an urban epidemiology. They emphasized attitudes and methods that reached beyond contrasting urban and rural areas to focus upon "intra-urban variability and its association with health and behavior."[15] In parallel with plans for improved national

1630 (2003).

[12] *See e.g.,* Jonathan E. Fielding & Peter A. Briss, *Promoting Evidence-Based Public Health Policy: Can We Have Better Evidence and More Action?,* 25 HEALTH AFFAIRS 969 (2006).

[13] For a sample of the rich literature, scholarly and professional, that had developed around the rubric "evidence-based," singling out medicine and public health as leaders in programmatic and systematic approaches, see, e.g., MATTHEW CHINMAN, PAMELA IMM & ABRAHAM WANDERSMAN, GETTING TO OUTCOMES 2004: PROMOTING ACCOUNTABILITY THROUGH METHODS AND TOOLS FOR PLANNING, IMPLEMENTATION, AND EVALUATION (2004); For government websites, see the Center for Substance Abuse and Prevention at http://www.modelprograms.samhsa.gov (last visited on May 22, 2012); the U.S. Department of Education's Office of Safe and Drug-Free Schools at http://www.ed.gov/about/offices/list/osdfs/resources.html (last visited on May 22, 2012); the Office of Juvenile Justice and Delinquency Prevention at http://ojjdp.ncjrs.org/index.html (November 20, 2013).

[14] In carrying out the charge, the Panel comprehensively reviewed available data collection systems (across federal and state boundaries, public and private divides). *See* NAT'L RES. COUNCIL, ELIMINATING HEALTH DISPARITIES: MEASUREMENT AND DATA NEEDS (2004).

[15] Sandro Galea, Sasga Rudenstine & David Vlahov, *Drug Use, Misuse, and the Urban Environment.* 24 DRUG & ALCOHOL REV. 127 (2005). *See generally*, Freudenberg et al., *infra* note 17; Sandro Galea & David Vlahov, *Urban Health: Evidence, Challenges, and Directions*, 26 ANN. REV PUB. HEALTH 341 (2005; Sana Loue & Nancy Mendez, *Health and Health Access Among Urban Immigrants*, *in* HANDBOOK OF URBAN HEALTH: POPULATIONS, METHODS, AND

data, these leaders have upgraded efforts to search for and understand disparities in access and outcomes implicating racial, gender, and class dynamics. And, as part of this push, they aimed to remedy conspicuous deficiencies in probative information about immigrant populations, especially those living without authorization in the United States.[16]

Yet, to this day, knowledge of the health of undocumented Mexicans living in New York City – or other urban and metropolitan areas – remains relatively scant.[17] Most studies use heterogeneous samples of immigrants of diverse nativities and varying immigration statuses permitting them to assert that – but precluding them from analyzing how exactly – legal status operates as an important and complex variable in accessing health outcomes and health access. In recent years, quite remarkable research regularly gathers data from Mexicans – on one or both sides of the border – in order to illuminate the characteristics, nature, and evolution of the migratory cycle.[18] Still, despite extraordinary efforts of some centers and scholars, we know less than we should about the health of undocumented Mexicans and, to my knowledge, precious little about those who live in New York City.[19]

Practice 103 (Sandro Galea & David Vlahov eds., 2005); Khiya J. Marshall et al., *Health Status and Access to Health Care of Documented and Undocumented Immigrant Latino Women,* 26 Health Care for Women Int'l 916 (2005); Jeffrey T. Kullgren, *Restrictions on Undocumented Immigrants' Access to Health Services: The Public Health Implications of Welfare Reform,* 93 Am. J. Pub. Health 1630 (2003); Elena Zúñiga et al., *supra* note 7; Victoria D. Ojeda & E. Richard Brown, *Mind the Gap: Parents' Citizenship as Predictor of Latino Children's Health Insurance*, 16 J. Health Care Poor & Underserved 555 (2005).

[16] Nicholas Freudenberg, Sandro Galea & David Vlahov, Cities and the Health of the Public (2006); Nat'l Res. Council, *supra* note 13. For perhaps the most comprehensive and sustained effort in this regard, see the work of the UCLA Center for Health Policy Research at http://www.healthpolicy.ucla.edu/.

[17] For a valuable 2006 research report of documented immigrant immigrants in New York City, one of a slate of important reports routinely produced by the Department of Health and Hygiene , see M. Kim, Gretchen Van Wye, Bonnie Kerker, Lorna Thorpe, Thomas R. Frieden, The Health of Immigrants in New York City – A Report from New York City Department of Health and Mental Hygiene (2006).

[18] For a compilation of efforts, both by investigators at Princeton University and the University of Guadalajara, see multi-disciplinary research at the Mexican Migration Project, *available at* http://mmp.opr.princeton.edu/.

[19] The small number of notable exceptions examining the health of urban undocumented immigrants includes the prominent work undertaken by the Center for Health Policy Research at UCLA, initiated by the late E. Richard Brown. *See e.g.*, Veronica F. Gutierrez, Stephen P. Wallace & Xochitl Castaneda, *Demographic Profile of Mexican Immigrants in the United States* (UCLA Center for Health Policy Research, 2004); Steven P. Wallace, Veronica Gutierrez & E. Richard Brown, *Mexican Immigrants are Generally Healthier, but Have Less Access to Needed Health Care* (UCLA Center for Health Policy Research, 2003); Steven P.

In this article, I shall report on one effort to begin filling this void. Upon arriving in New York in 1999, through various informal collaborations, then formally through the Center For Community Problem Solving (the Center), which I founded, and finally in partnership with the Center for Urban Epidemiologic Research (CUES), we tried to learn as much as possible about low-income, of color, and immigrant communities in New York City.[20] We did so as a reflection of and in order to put into operation a rebellious vision of problem-solving that, along with others, I have championed for some time.[21] In full appreciation that

Wallace, Veronica F. Gutierrez & Xochitl Castaneda, *Health Service Disparities Among Mexican Immigrants* (UCLA Center for Health Policy Research, 2005); Nadereh Pourat et al., *Demographics, Health, and Access to Care of Immigrant Children in California: Identifying Barriers to Staying Healthy* (Center for Health Policy Research, 2003); Jennifer Aguayo et al., *Important Health Care Issues for California Latinos: Health Insurance and Health Status* (UCLA Center for Health Policy Research, 2003); E. Richard Brown et al., *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* (UCLA Center for Health Policy Research, 2000); E. Richard Brown et al., *The State of Health Insurance in California: Long-Term and Intermittent Lack of Health Insurance Coverage* (UCLA Center for Health Policy Research, 2003). For examples of other valuable research, see Paula Worby et al., *Occupational health and Latino migrant day laborers: a preliminary exploration* (ILE Conference UC Santa Cruz, 2002); Randy Capps et al., *The Health and Well-Being of Young Children of Immigrants* (Urban Institute, 2004); Mark S. Kaplan et al., *The association between length of residence and obesity among Hispanic immigrants*, 27 AM. J. PREVENTIVE MED. 323 (2004); Jennifer Kasper et al., *Hunger in legal immigrants in California, Texas, and Illinois*, 90 AM. J. PUB. HEALTH 1629 (2000); Namratha R. Kandula, Margaret Kersey & Nicole Lurie, *Assuring the Health of Immigrants: What the Leading Health Indicators Tell Us*, 25 ANN. REV. PUB. HEALTH 357 (2004); California Food Policy Advocates, *Impact of Legal Immigrant Food Stamp cuts in Los Angeles and San Francisco* (California Food Policy Advocates, 1998); Dana P. Goldman, James P. Smith & Neeraj Sood, *Legal Status and Health Insurance Among Immigrants*, 24 HEALTH AFFAIRS 1640 (2005).

[20] Our efforts to elicit and gather and share knowledge about these communities have been, in part, reported and analyzed in various publications, including Gerald P. López, *Shaping Community Problem Solving Around Community Knowledge,* 79 N.Y.U. L. REV. 59 (2004); Michelle Tseching Fei & Gerald P. López,. *Learning How Regularly to Improve Our Capacity to Meet the Challenges of Asian and Pacific Islander Re-Entry*, 31 AMERASIA JOURNAL 61 (2005).

[21] For my own elaboration of this view of theory and problem solving, see generally GERALD P. LÓPEZ, REBELLIOUS LAWYERING: ONE CHICANO'S VISION OF PROGRESSIVE LAW PRACTICE (1992); Gerald P. López, *Shaping Community Problem Solving Around Community Knowledge*, 79 N.Y.U. L. REV. 59 (2004). For kindred expressions of the rebellious vision, see, for example, Muneer I. Ahmad, *Interpreting Communities: Lawyering Across Language Difference*, 54 UCLA L. REV. 999 (2007); Sameer M. Ashar, *Law Clinics and Collective Mobilization*, 14 CLINICAL L. REV. 355 (2008); Gary Bellow, *Steady Work: A Practitioner's Reflections on Political Lawyering*, 31 HARV. C.R.-C.L. L. REV. 297 (1996); Luke W. Cole, *Empowerment as the Key to Environmental Protection: The Need for Environmental Poverty Law*, 19 ECOLOGY L.Q. 619 (1992); Christine Zuni Cruz, *[On The] Road Back In: Community Lawyering in Indigenous Communities*, 5 CLINICAL L. REV. 557 (1999); Bill Ong Hing**,** *Coolies, James Yen, and Rebellious Advocacy*, 14 ASIAN AM. L.J. 1 (2007); Bill Ong Hing, *Nonelectoral Activism in*

researchers knew practically nothing about the health of undocumented Mexicans in New York City, the Center and CUES tried unsuccessfully to raise dollars to fund an ambitious longitudinal study. Having failed, we decided to design a more modest research project that we perhaps could complete through largely in-kind resources and trained volunteers, and to use what we might learn to enhance our knowledge, the quality of current policies and practices, and the likelihood of persuading funders to support much needed research in future years.

In the fall of 2004, in partnership with the Center for Urban Epidemiologic Research (CUES), and working in collaboration with a wide range of institutions and individuals, the Center for Community Problem Solving (the Center) undertook without targeted funding a small-scale study of the health of undocumented Mexicans in New York City. This was not an instance of an experiment specifically designed to test strong hypotheses about health outcomes and health access. Instead, those collaborating aimed to gather evidence in order to see what details and

Asian Pacific American Communities and the Implications for Community Lawyering, 8 Asian Pac. Am. L.J. 246 (2002); Bill Ong Hing, *Raising Personal Identification Issues of Class, Race, Ethnicity, Gender, Sexual Orientation, Physical Disability, and Age in Lawyering Courses*, 45 Stan. L. Rev. 1807 (1993); Dale Minami, *Asian Law Caucus: Experiment in an Alternative,* 3 Amerasia Journal 28 (1975); Dale Minami, *Guerrila War at UCLA: Political and Legal Dimensions of the Tenure Battle*, 16 Amerasia 81 (1990); Shauna I. Marshall, *Mission Impossible?: Ethical Community Lawyering*, 7 Clinical L. Rev. 147 (2000); Ascanio Piomelli, *Appreciating Collaborative Lawyering*, 6 Clinical L. Rev. 427 (2000); Ascanio Piomelli, *The Democratic Roots of Collaborative Lawyering*, 12 Clinical L. Rev. 541 (2006); Ascanio Piomelli, *Foucault's Approach to Power: Its Allure and Limits for Collaborative Lawyering*, 2004 Utah L. Rev. 395; William P. Quigley, *Reflections of Community Organizers: Lawyering for Empowerment of Community Organizations*, 21 Ohio N.U. L. Rev. 455 (1994); Dean Hill Rivkin, *Lawyering, Power, and Reform: The Legal Campaign to Abolish the Broad Form Mineral Deed*, 66 Tenn. L. Rev. 467 (1999); Ann Shalleck, *Constructions of the Client Within Legal Education*, 45 Stan. L. Rev. 1731 (1993); Clyde Spillenger, *Elusive Advocate: Reconsidering Brandeis as People's Lawyer,* 105 Yale L.J. 1445 (1996); Julie A. Su, *Making the Invisible Visible: The Garment Industry's Dirty Laundry*, 1 J. Gender Race & Just. 405 (1998); Lucie E. White, *Collaborative Lawyering in the Field? On Mapping the Paths from Rhetoric to Practice*, 1 Clinical L. Rev. 157 (1994); Lucie E. White, *Mobilization on the Margins of the Lawsuit: Making Space for Clients to Speak*, 16 N.Y.U. Rev. L. & Soc. Change 535 (1987–88); Lucie White, *Representing "The Real Deal,"* 45 U. Miami L. Rev. 271 (1990–1991). For discussion of progressive law practice in the context of public defender work, see Cmty. Justice Inst., Brennan Ctr. for Justice, Taking Public Defense to the Streets, *available at* http://www.brennancenter.org/page/-/d/download_file_34975.pdf; Kim Taylor-Thompson, *Effective Assistance: Reconceiving the Role of the Chief Public Defender*, 2 J. Inst. for Study Legal Ethics 199 (1999); Kim Taylor-Thompson, *Individual Actor v. Institutional Player: Alternating Visions of the Public Defender*, 84 Geo. L.J. 2419, 2421-23 (1996); Kim Taylor-Thompson, *The Politics of Common Ground*, 111 Harv. L. Rev. 1306 (1998) (reviewing Randall Kennedy, Race, Crime, and the Law (1997)).

patterns would emerge.[22] Those details and patterns hopefully would provide, in turn, a newly formulated starting point for understanding – and acting on our understanding of – the health and health access of undocumented Mexicans in New York City.

To gather evidence, however, the study necessarily reflects notably significant standpoints. Even the most decidedly exploratory research frames some questions and not others; elects some methods and not others; employs some interpretative strategies and not others. I shall make explicit the most prominent of those standpoints. What common vision of problem solving molded the respective practices of the Center and CUES and informed the choice to undertake unfunded research of the health of undocumented Mexicans? What theory of undocumented Mexican migration guided the decisions we made, explained the arrival in significant numbers of undocumented Mexicans to New York City, and influenced our decisions in trying to understand their health?

This article, then, is meant to not simply report certain survey findings and analyze their tentative implications; I aim as well to describe the ways in which the decision to engage in the survey research is itself part of a larger project to implement on the ground in New York City a particular, progressive vision of problem solving shared by practitioners ranging from public health specialists to lawyers to neighborhood activists. And I aim to suggest that the rival theory of undocumented Mexican migration that oriented our design of the pilot study, and the conditional interpretations I offer, is superior to the prevailing theory that has for too long has driven immigration policies and practices in the United States.

Just as this study is but one part of an overarching effort, this article is but one of many reports on this study and this larger effort of which it is a part. Already CUES and the Center have shared some of what together we have learned with others in New York City and beyond. Through community meetings, campaign workshops, professional conferences, media coverage, and other forums, we have targeted diverse audiences that include undocumented Mexicans themselves, those who work directly with them, and those who make policies about them.

[22] For an account about science that parallels the Center's and CUES' conception of these two intimately related activities see Herbert A. Simon, *Science Seeks Parsimony, Not Simplicity: Searching for Pattern in Phenomena*, in SIMPLICITY, INFERENCE, AND MODELING: KEEPING IT SOPHISTICATEDLY SIMPLE (Arnold Zellner, Hugo A. Keuzenkamp & Michael McAleer eds., 2002).

And we have shared analyses with those who read public health journals and with those who consume information circulated through such publications.[23]

In this article, I aim to identify and illustrate how the Center, CUES, and all with whom we work, hope to begin closing two related gaps: the gap between what we know and what we might learn in the future about the health of undocumented Mexicans in New York City, and the gap between what we do now in our diverse practices and what we might do through a rebellious vision of problem solving. The last thing I intend is to overstate what we know or what we have learned. For all the extraordinary work at the heart of this collaboration, our study should be regarded as relatively modest and our findings to date as at most suggestive. Perhaps in time elegant testable hypotheses will emerge. In any event, small contributions of this sort hopefully can help accelerate and extend the very transformation we need in learning about the health of undocumented Mexicans and in learning how we might work together, particularly in helping to improve the daily lives and future prospects of so many who help shoulder the burdens of keeping our communities together.

I.
Rebellious Health Practice

Understanding the vision of problem solving shared by the Center and CUES – an orientation that I call "rebellious health practice" – helps explain our search for all we know about undocumented Mexicans and our decision to go forward with an unfunded study.

A. *A Common Vision of Problem Solving*

The Center and CUES share much in their respective approaches to problem solving. In the language of public health, CUES believes in and implements a community-based participatory approach to public health. In the language of lawyering, the Center aims to put into operation a rebellious vision of problem solving. Even if the idioms vary, community-based participatory research and rebellious problem solving

[23] For illustrations of the health scholarship we have produced, see for example, Arijit Nandi, Sandro Galea, Gerald López, Vijay Nandi, Stacey Strongarone & Danielle C. Ompad, *Access to and Use of Health Services Among Undocumented Mexican Immigrants in a U.S. Urban Area*, 98 Am. J. Public Health 2011 (2008); Craig Hadley, Sandro Galea, Vijay Nandi, Arijit Nandi, Gerald López, Stacey Strongarone & Danielle Ompad, *Hunger and Health Among Undocumented Mexican Migrants in a U.S. Urban Area*, 11 Public Health Nutr. 151 (2008).

revolve around working collaboratively and effectively with others. And that way of working led naturally to investigating what we already knew about the health of undocumented Mexicans in New York City and concluding that we would undertake an unfunded study as part of a more encompassing effort to learn considerably more over time.

Our interest in understanding as much as possible about undocumented Mexican health traces back beyond our formal alliance. Some of us who work at the Center and CUES had worked on other projects concerning undocumented Mexicans in New York City.[24] And we continued over time to track down, through a variety of networks, all we could learn qualitatively and quantitatively. Some time after the launches of our respective and joint investigations, a large survey conducted by the Center (with statistical support from CUES) produced a huge body of data, including extremely interesting (ialbeit necessarily limited and preliminary) findings about the health of Mexican immigrants in New York City.

That sizeable survey served as part of my initiation to living in New York City. In order to ground both my own work with clinical students and the Center's launch, I led a multi-disciplinary team in conducting the Neighborhood Legal Needs and Resources Project (NLN&RP). The NLN&RP is a sweeping study in English, Spanish, Mandarin, and Cantonese, of problems (by no means restricted to health issues) and resources available in the New York City communities of Harlem, East Harlem, Chinatown, the Lower East Side, Bushwick, and Bedford-Stuyvesant ("Bed-Stuy").[25] The NLN&RP comprised two principal information-gathering mechanisms: a sophisticated telephone survey of 2,000 residents, as well as comprehensive research and intensive in-person interviews of almost 1,700 public, private, and civic service providers. My research team aimed to gather information about problems and resources that would provide evidence to shape, and later evaluate, the targeting of resources and interventions.

[24] Before moving to New York City, I learned a great deal from many diverse sources and New Yorkers, not least in my brainstorming conversations with Cara Cherry about the lives of undocumented and documented Mexicans, including the successful challenge by Latino workers of Mt. Kisco's discriminatory policies and practices. *See generally* The Mount Kisco Workers' Project v. the Village/Town of Mount Kisco *available at* http://www.clearinghouse.net/chDocs/public/IM-NY-0039-9000.pdf (docket of litigation),.

[25] For an account of the origins, challenges, and promise of studies like the Neighborhood Legal Needs & Resources Project in rebellious problem solving, see López, *supra* note 20.

By June 2003, we had completed the telephone survey and learned that 58 of the 2,000 telephone respondents were Mexican immigrants. Though the survey instrument did not inquire about legal status, the small population's answers did attract our attention. Initial analyses suggested no significant differences between Mexican immigrants and others interviewed in responding to questions about such matters as housing and social services, for example. Data suggested, however, striking disparities in access to health care and notable differences in health outcomes between Mexicans and non-Mexicans.

We had included a wide range of health-related questions partly to document disparities of this sort on top of general expected differences between residents of Harlem, East Harlem, Chinatown, the Lower East Side, Bushwick, and Bed Stuy. Our results showed that non-Mexicans were more than twice as likely as Mexicans to have a doctor or regular source of health care (respectively, 77.4% vs. 35.1%; p-value=0).[26] Non -Mexicans were more likely than Mexicans to have been tested for HIV (63% vs. 47%; p-value<0.05). A startlingly greater percentage of non -Mexicans than Mexicans had private health insurance (40.0% vs. 5.0%), and a substantially greater percentage of Mexicans than non-Mexicans had no insurance at all (70% vs. 21.2%). Non-Mexicans were also nearly three times more likely than Mexicans to have coverage for prescription drugs (66.4% vs. 23.9%; p-value=0). And non-Mexicans were much more likely than Mexicans to report being able to get health care to meet all their needs (82.2% vs. 65.4%, p-value<0.01). In a grand sense, Mexicans were several times more likely than non-Mexicans to report that the reason they couldn't access adequate health care was poor facilities (3.5% vs. 0.7%, p-value<0.05).

While access to health care was significantly more restricted for Mexicans than non-Mexicans, Mexicans' health was not necessarily worse off. Mexicans did not report increased prevalence of many of the conditions we asked about (high blood pressure, angina, heart attack, congestive heart failure, diabetes, ulcers, arthritis, rheumatism, stroke, kidney disease, cancer (non-skin), liver disease, asthma, and HIV). Instead, non-Mexicans were more likely to report high blood pressure

[26] To develop these and other preliminary findings, the CUES statistical team with whom we at the Center worked employed bivariate analyses, multivariable analyses, and stepwise and multivariable logistic regression models.

(22.4% vs. 5.1%; p-value<0.01), asthma (16.1% vs. 4.5%; p-value<0.05), and "other" medical conditions (9.5% vs. 2.0%; p-value<0.05).

However small the sample, the data piqued curiosity – at least our own. We realized, of course, that reports by Mexicans might well reflect their lack of awareness of certain health problems, generated in part by their lack of access to regular health care. Yet such apparent "paradoxes" reinforced what we had already concluded. The importance of what we had begun to learn emphasized how much more we still needed to know simply to develop familiar baseline information essential to our problem solving practices.

1. *CENTER FOR URBAN EPIDEMIOLOGIC STUDIES*[27]

Originally established as a research consortium by The New York Academy of Medicine and the New York City Department of Health, and emboldened by the later appointment of David Vlahov as its Director, the Center for Urban Epidemiologic Studies (CUES) aspires to improve health and create new understandings of factors that influence the well-being of urban populations. In order to address the complex set of relationships between the health of urban residents and social, physical and economic determinants, researchers, public health practitioners, and community members draw their guidance from the community -based participatory approach to public health. Involving a partnership between community members, academic researchers, and representatives from community-based organizations and health and social service agencies, this approach equitably involves all members in all aspects of the public health practice, with everyone contributing their expertise

[27] For examples of many diverse sources from which the CUES philosophy of practice can be assembled and the community-based participatory approach to public health carefully examined, see Barbara A. Israel et al., *Challenges and Facilitating Factors in Sustaining Community-Based Participatory Research Partnerships: Lessons Learned from the Detroit, New York City and Seattle Urban Research Centers,* 83 J. URB. HEALTH 1099 (2006); Nicholas Freudenberg, *Case History of the Center for Urban Epidemiologic Studies in New York City,* 78 J. URB. HEALTH 508 (2001); Sandro Galea et al., *Collaboration Among Community Members, Local Health Service Providers, and Researchers in an Urban Research Center in Harlem, New York,* 116 PUB. HEALTH REP. 530 (2001); Donna L. Higgins et al., *CDC Urban Research Centers: Community-Based Participatory Research to Improve the Health of Urban Communities,* 10 J. WOMEN'S HEALTH & GENDER BASED MED. 9 (2001); Donna L. Higgins & Marilyn Metzler, *Implementing Community-Based Participatory Research Centers in Diverse Urban Settings,* 78 J. URB. HEALTH 488 (2001). *See also* The Center for Urban Epidemiologic Studies at http://www.nyam.org/initiatives.cues.shtml (last visited November 20, 2013); Harlem Resource Guide at http://www.harlemresourceguide.org/

last visited November 20, 2013).

and decision-making, and taking ownership in projects aimed at both enhancing knowledge and improving the health of community members through interventions and policy and social change.

Consistent with this community-based participatory model, CUES works to promote and advance cooperative efforts to understand the social, environmental, and biological influences on health. With the benefit of considerable and varied funding, CUES developed partnerships with universities, community-based organizations, professional organizations, the New York City and New York State Health Departments, and varied public agencies. CUES conducts a wide range of studies geared at disease prevention and educating communities on health risks. These studies demonstrate new and innovative approaches to research as they address many of the health problems present in today's society.

In particular, and through the efforts of the Harlem Urban Research Council and its successor cooperative, CUES conducted collaborative, multi-disciplinary, population-based participatory research, with a special focus on low-income, disadvantaged populations. Community residents and organizations helped to identify vital research needs. Through an array of interventions and studies, CUES worked with its partners to bring about a better understanding of diseases and other threats to health concentrated in urban areas (including – but not limited to – HIV and other infectious diseases; substance abuse; asthma; the role of social determinants of health, particularly among minority populations; and acute cardiac arrest).

2. *Center For Community Problem Solving*[28]

During its short run (2003 – 2008), The Center for Community Problem Solving at New York University (the "Center") focused broadly on a wide array of legal, social, economic, health, and political problems. Our central mission was to team up with low-income, of color, and immigrant communities to solve problems and to improve our future capacity to solve such problems. Along the way, the Center aimed to realize our dream of an accountable and equitable democracy – one where equal citizenship was a concrete everyday reality, not just a vague constitutional promise.

[28] For one principal source of this description, see The Center for Community Problem Solving, About the Center, http://www.communityproblemsolving.org/about.html (last visited November 20, 2013).

To meet these aspirations, the Center put into action a rebellious vision of problem solving. Problem solving, in this approach, demands robustly democratic collaboration with problem solvers of all sorts and to meld street savvy, technical sophistication, and collective ingenuity into a compelling practical force. As an on-the-ground effort to implement the rebellious approach, the Center served, in part, as an institution through which my clinical students could participate intimately in projects to learn directly how lawyers can work with others in an alternative vision of problem solving.

The Center's vision of community problem solving united certain key fundamentals. The Center collaborated with those who lived and worked in low-income, of color, and immigrant communities, seeking out and sharing knowledge about existing problems, available resources, and useful strategies. The NLN&RP survey was conducted as part of this vision to learn more detailed information not only about the demographics of the boroughs in which the Center worked but also to determine how residents of these communities viewed the day-to-day issues in their lives and how those who deliver legal, social, and health services to communities defined and addressed those issues.

Based on what we had learned through the NLN&RP and other important experiences, the Center connected those who faced problems with those in public, private, and civic realms who helped address them, building networks of valuable know-how among diverse problem solvers and helping shape and meet common goals. Whenever problems remained unaddressed even after making such connections, the Center attempted to fill those voids by scavenging around for resources (in NYC, across the U.S., across the globe), leveraging what was available with what may never have been tried, assembling as-needed one-time trouble-shooting squads to more-permanent full-fledged partnerships. Deeply committed to monitoring the implementation and evaluating the success of particular strategies, the Center sought with others to create feedback loops in order to constantly learn from one another and from our experiences.

3. *A Shared Way Of Working With Others*[29]

The literatures on community-based participatory practice and the rebellious vision of problem solving reveal what the two approaches have

[29] For a sample of literature describing and analyzing community-based participatory research, see *supra* note 27. For a thoughtfully developed account of how a community-based

in common. This way of working, at once, aims to produce – and depends upon – networks of co-eminent institutions and individuals collaborating with one another. Such collaborators routinely engage and learn from one another (no, not ideally from either bottom-up or top-down, but every which way at once).[30] They demonstrate a profound commitment to revising time and again provisional goals and methods for achieving them; to searching constantly for how to better realize institutional, network, and individual aspirations; and to monitoring and evaluating, from diverse perspectives and reporting "warts and all" what's working and what's not, and what such feedback may reveal about both future possibilities and current practices.

In this way of working, we collaborate as equals both in response to our known limitations (most centrally, bounded rationality)[31] and in pursuit of articulated aspirations (most centrally, radically democratic and egalitarian life).[32] Problem solving so conceived does not presume

participatory approach to research informed the important and influential California Health Interview Survey, see E. Richard Brown et al., *Community-based Participatory Research in the California Health Interview Survey,* Preventing Chronic Disease (Oct. 2005), http://www.cdc.gov/pcd/issues/2005/oct/05_0046.htm. For literature regarded as significant by many in public health and health care, see e.g., Community-based participatory research for health (Meredith Minkler & Nina Wallerstien eds., 2003); Barbara A. Israel et al., *Review of Community-based Research: Assessing Partnership Approaches to Improve Public Health*, 19 Ann. Rev. Pub. Health 173 (1998); Margaret W. Leung, Irene H. Yen & Meredith Minkler, *Community-based Participatory Research: A Promising Approach for Increasing Epidemiology's Relevance in the 21st Century*, 33 Int'l J. Epidemiology 499 (2004); Meera Viswanathan et al., *Community-based Participatory Research: Assessing the Evidence,* Evidence Rep./Tech. Assessment No. 99 (Agency for Healthcare Res. and Quality Pub. No. 04-E022-2, Rockville, Md.,), July 6, 2004 Jul. 6; Fernando I. Soriano, Conducting Needs Assessments: A Multidisciplinary Approach (1995). For a sample of legal scholarship self-consciously developing the rebellious vision of problem solving, see *supra* note 21.

[30] Caricatures of the rebellious vision of problem solving include, prominently, that those of us who pursue such a way of working and living imagine "the oppressed" or "subordinated" as the "only" source of transformative insights. Like others, I have tried systematically to anticipate and preempt such cartoon-like critiques and, now and then, elaborated what I regarded as already explicit and transparent in practice itself and in scholarly analyses, see, e.g., Gerald P. López, *An Aversion to Clients: Loving Humanity and Hating Human Beings*, 31 Harv. C.R.-C.L. L. Rev. 315 (1996). Others, especially Ascanio Piomelli, have done extraordinarily meticulous and persuasive work challenging unsupported and unsupportable claims, see, e.g., Piomelli, *supra* note 21.

[31] For the origins of bounded rationality, turn to the work of Herbert Simon., and particularly his collaborations with Allen Newell. *See, e.g.,* Herbert A. Simon, Administrative Behavior (1947); Allen Newell & Herbert A. Simon, Human Problem Solving (1972).

[32] For suggestive approaches to achieving democracy and equality radically conceived, see, e.g., Gloria Anzaldúa, Borderlands/La Frontera: The New Mestiza (1987); John Dewey, Liberalism and Social Action (1935); John Dewey, The Quest for Certainty: A Study of

that any one knows so much or sees so well as to make the calls alone about any or all problems. Nor does it presume that the unfortunately necessary response to bounded rationality often turns out to be almost mindless institutional routines and individual habits.

This highly collaborative, problem solving approach aims to support and reinforce – at its best, may even take the lead in demonstrating – how we might live together in a full-bodied democracy. But that desired relationship between work and life does not unfold automatically or necessarily. Problem solving – pragmatism itself – might just as well be interpreted as consonant with the reigning, rather than more radical, versions of democratic living.[33] But rebellious variations of working together certainly, at their best, parallel and encourage robust democracy.

Trying collectively to secure cooperation in the midst of unavoidable complexity, difference, and vulnerability – problem solving, alternatively defined – takes as its point of departure and declares as its goal engaging equals in understanding and enhancing life. The challenge entails embedding into routine, effective mechanics of learning – as much as wise methods of holding decision-makers accountable.[34] At all costs,

THE RELATION OF KNOWLEDGE AND ACTION (1929); HANNA FENICHEL PITKIN, THE CONCEPT OF REPRESENTATION (1967); RENATO ROSALDO, CULTURE AND TRUTH: THE REMAKING OF SOCIAL ANALYSIS (1989); STEVEN H. SHIFFRIN, DISSENT, INJUSTICE, AND THE MEANINGS OF AMERICA (1999); ROBERTO MANGABEIRA UNGER, FALSE NECESSITY: ANTI-NECESSITARIAN SOCIAL THEORY IN THE SERVICE OF RADICAL DEMOCRACY (1987); Andrea Cornwall & John Gaventa, *From Users and Choosers to Makers and Shapers: Repositioning Participation in Social Policy* (Inst. of Dev. Stud., Working Paper No. 127, 2001); Warren C. Haggstrom, *For a Democratic Revolution: The Grass Roots Perspective, in* TACTICS AND TECHNIQUES OF COMMUNITY PRACTICE. 220 (Jack Rothman, John L. Erlich & John E. Tropman eds., 4th ed. 1984); Hanna Fenichel Pitkin, *The Idea of a Constitution*, 37 J. LEGAL EDUC. 167 (1987); Bernice Johnson Reagon, *Coalition Politics: Turning the Century*, *in* HOME GIRLS: A BLACK FEMINIST ANTHOLOGY 356 (Barbara Smith ed., 1983).

[33] For an inspired account of how radical democratic theory parallels, informs, and reflects rebellious visions of problem solving, see Ascanio Piomelli, *The Democratic Roots of Collaborative Lawyering*, 12 CLINICAL L. REV. 541 (2006). For sample of earlier insightful analyses of lawyering and democratic theory, see, e.g., Lucie E. White, *Creating Models for Progressive Lawyering in the 21st Century*, 9 J.L. & Pol'y 297, 303 (2001) (comments of Lucie E. White); White, *"Democracy" in Development Practice, supra* note 28. For a classic and influential account of what elsewhere I call the reigning vision of democracy, see JOSEPH A. SCHUMPETER, CAPITALISM, SOCIALISM, AND DEMOCRACY (1942), and for a modern defense of Schumpeter by an influential scholar and jurist, see RICHARD A. POSNER, LAW, PRAGMATISM, AND DEMOCRACY (2003).

[34] Overlapping literatures address governance and accountability from different traditions and in varied vocabularies. For one of several lines of engaging advancements, see, e.g., JOSEPH E. STIGLITZ, GLOBALIZATION AND ITS DISCONTENTS (2003); Benedict Kingsbury, Nico Krisch & Richard.B. Stewart, *The Emergence of Global Administrative Law*, 68 LAW & CONTEMP. PROBS.

though, our common approach to problem solving is premised upon a belief that we cannot ultimately absolve ourselves of the duty, individually and collectively, to always evaluate our interventions (including our choices of lead institutions and actors).

B. *Too Little Knowledge About NYC Mexican Immigrant Health*

With these philosophies shaping our approach, and fascinated by the health differentials we had discovered in the Center's NL-N&RP survey, we set out to learn what else was known about undocumented Mexican immigrant health in New York City. We quickly uncovered what the print media had produced.[35] Knowing the history of Mexicans in the United States,[36] we then determined the

15 (2005); Anne-Marie Slaughter, *Global Government Networks, Global Information Agencies, and Disaggregated Democracy*, 24 Mich. J. Int'l L. 1041 (2003); Robert Keohane, *Governance in a Partially Globalized World*, 95 Am. Pol. Sci. Rev. 1 (2001); Daniel K. Tarullo, *Rules, Discretion, and Authority in International Financial Reform*, 4 J. Int'l Econ. L. 613 (2001); Archon Fung, Dara O'Rourke & Charles Sabel, *Ratcheting Labor Standards: Regulation for Continuous Improvement in the Global Workplace* (KSG Working Paper No. 00-101, May 2, 2000), *available at* http://ssrn.com/abstract=253833.

[35] For a mix of media coverage during these years, see Sam Roberts, *Immigrants Swell Numbers In and Near City*, N.Y. Times, Aug. 15, 2006, at B1; Nina Bernstein, *Invisible to Most, Immigrant Women Line Up for Day Labor,* N.Y. Times, Aug. 15, 2005, at A1; Anthony DePalma, *15 Years on the Bottom Run,* N.Y. Times, May 26, 2005, at A1; Debbie Nathan, *David and His 26 Roommates,* N.Y. Mag., May 16, 2005; Julie Salamon, *Celebrating Mexican Life in New York,* N.Y. Times, Dec. 8, 2004, at E1; Seth Kugal, *URBAN TACTICS; Destination, Neza York,* N.Y. Times, Feb. 15, 2004, at 14; Michael Kamber, *A Link in the Chain,* Village Voice, Apr. 17, 2001 and *Deadly Game*, Village Voice, Apr. 24, 2001; Michael Kamber, *Toil and Temptation*, Village Voice, May 1, 2001; Michael Kamber, *On the Corner,* Village Voice, July 25-31, 2001; Gisele Regatao, *Viva Poblanos,* Newsday, May 21, 2001, at C14; Susan Sachs, *Hispanic New York Shifted in 1990's*, N.Y. Times, May 22, 2001, at B8; Galia Garcia-Palafox, *Church Opens Doors to Mexican Faithful,* Daily News, Dec. 14, 2003; Ricardo Alonso-Zaldivar, *Big Apple Takes On a Flavor of Mexico,* L.A. Times, Feb. 19,1999; Michael Deiber, *The New New Yorkers*, Newsday, Sept. 15, 2004, at A28; Eric Asimov, *The True Flavors of Mexico, Hidden in New York*, N.Y. Times, July 23, 2003, at F1; Robert Dominguez, *Mexico City, USA On Display*, N.Y. Daily News, Jan. 10, 2003; Joanne Wasserman, *Determined Mexicans Movin' On Up*, N.Y. Daily News, Oct. 10, 2004; Eric Pape, *So Far From God, So Close to Ground Zero*, L.A. Times, Aug. 3, 2003; Seth Kugel, *The Bronx Discovers Its Own Inner Mexico*, N.Y. Times, Apr. 2, 2004, at E1.

[36] For a sample of a literature that, even by these years, already was huge, see, for example, Carey McWilliams, North from Mexico: The Spanish-Speaking People of the United States 103 (1949); Americo Paredes, "With His Pistol in His Hand": A Border Ballad and Its Hero (1958); Frederick Merk, Manifest Destiny And Mission In American History: A Reinterpretation (1963); Ernesto Galarza, Merchants of Labor: The Mexican Bracero Story (1964); Abraham Hoffman, Unwanted Mexican Americans in the Great Depression: Repatriation Pressures, 1929–1939 (1974); Clifford Alan Perkins, Border Patrol: With the U.S. Immigration Service on the Mexican Boundary 1910–54, (1978); Albert Camarillo, Chicanos in a Changing Society: From Mexican Pueblos to American Barrios in Santa Barbara and Southern California, 1848–1939 (1979); Mario T. Garcia, Desert Immigrants: The Mexicans

published research about Mexicans in New York City proved surprisingly limited.[37] After finding all of the published information we

OF EL PASO, 1880–1920 (1981); REGINALD HORSMAN, RACE AND MANIFEST DESTINY: THE ORIGINS OF RACIAL ANGLO-SAXONISM (1981); THOMAS R. HIETALA, MANIFEST DESIGN: ANXIOUS AGGRANDIZEMENT IN LATE JACKSONIAN AMERICA (1985); ALFREDO MIRANDÉ, GRINGO JUSTICE (1987); DAVID MONTEJANO, ANGLOS AND MEXICANS IN THE MAKING OF TEXAS, 1836–1986 (1987); DAVID LANGUM, LAW AND COMMUNITY ON THE MEXICAN CALIFORNIA FRONTIER: ANGLO-AMERICAN EXPATRIATES AND THE CLASH OF LEGAL TRADITIONS, 1821–1846 (1987); RAMÓN A. GUTIÉRREZ, WHEN JESUS CAME, THE CORN MOTHERS WENT AWAY: MARRIAGE, SEXUALITY, AND POWER IN NEW MEXICO, 1500–1846 (1991); GEORGE J. SANCHEZ, BECOMING MEXICAN AMERICAN: ETHNICITY, CULTURE, AND IDENTITY IN CHICANO LOS ANGELES, 1900–1945 (1995); ROGERS M. SMITH, CIVIC IDEALS (1997); ANDERS STEPHANSON, MANIFEST DESTINY: AMERICAN EXPANSION AND THE EMPIRE OF RIGHT (1995); IAN HANEY-LÓPEZ, RACISM ON TRIAL: THE CHICANO FIGHT FOR JUSTICE (2003); ANITA GONZALEZ, JAROCHO'S SOUL: CULTURAL IDENTITY AND AFRO-MEXICAN DANCE (2004); Gerald P. López, *Undocumented Mexican Migration: In Search of A Just Immigration Law and Policy*, 28 UCLA L. REV. 615, 674 (1981); Laura E. Gómez, *Race, Colonialism and Criminal Law: Mexicans and the American Criminal Justice System in Territorial New Mexico*, 34 LAW & SOC'Y. REV. 1129 (2000); Laura E. Gómez, *Race Mattered: Racial Formation and the Politics of Crime in Territorial New Mexico,* 49 UCLA L. REV. 1395 (2002); Laura E. Gómez, *Off White in an Age of White Supremacy: Mexican Elites and the Rights of Indians and Blacks in Nineteenth Century New Mexico,* 25 UCLA CHICANO-LATINO L. REV. 9 (2005).

[37] At about this time, scholarly works about undocumented Mexicans in New York included Robert Courtney Smith, MEXICAN NEW YORK: TRANSNATIONAL LIVES OF NEW IMMIGRANTS (2006); Robert Courtney Smith, *Racialization and Mexicans in New York City, in* NEW DESTINATIONS – MEXICAN IMMIGRATION IN THE UNITED STATES 220 (Víctor Zúñiga & Rubén Hernández-León eds., 2005); Robert Courtney. Smith, *Imagining Mexican Educational Futures in New York, in* IMMIGRANTS AND SCHOOLING: MEXICANS IN NEW YORK 93 (Regina Cortina & Mónica Gendreau eds., 2003); Gilberto Giménez & Mónica Gendreau, *Modernization, Migration and Enduring Localism in Rural Communities of Central Mexico, in* IMMIGRANTS AND SCHOOLING: MEXICANS IN NEW YORK 145 (Regina Cortina & Mónica Gendreau eds., 2003); Jocelyn Solís, *Immigration Status and Identity: Undocumented Mexicans in New York, in* MAMBO MONTAGE: THE LATINIZATION OF NEW YORK 337 (Agustín Laó-Montes & Arlene Dávila eds., 2001) (sharing stories of poverty, abuse, and exploitation of Mexican immigrants in which undocumented status makes it difficult to enforce workplace rights); Robert Smith, *"Mexicanness" in New York: Migrants seek New Place in Old Racial Order,* 35 NACLA REP. ON AM. 14 (2001); JOCELYN SOLÍS, 2002. THE (TRANS)FORMATION OF ILLEGALITY AS AN IDENTITY: A STUDY OF THE ORGANIZATION OF UNDOCUMENTED MEXICAN IMMIGRANTS AND THEIR CHILDREN IN NEW YORK CITY. Ph. D. Thesis, City University of New York. Abstract in *Dissertation Abstracts International* 63(3):1590B (2002).); Jocelyn Solís, Mexican Women's Community Response to Domestic Violence: A Sociocultural Analysis of Migration, Gender , and Violence (Nov. 7, 2002) (unpublished article, presented at Hominis Intercontinental Psychology Convention, Havana, Cuba) (on file with author); Jocelyn Solís & Liliana Rivera-Sánchez, *Recovering the Forgotten: The Effects of September 11 on Undocumented Latin American Victims and Families*, 29 CAN. J. LATIN AMERICAN & CARIBBEAN STUD. 93 (2004); Alyshia Gálvez, *"She Made Us Human": The Virgin of Guadalupe, Popular Religiosity and Activism in Mexican Devotional Organizations in New York City, in* PERFORMING RELIGION IN THE AMERICAS: MEDIA, POLITICS, AND DEVOTIONAL PRACTICES IN THE 21st CENTURY (2007); Alyshia Gálvez, *Resolviendo: The Response of a New York City Mexican Immigrant Organization to September 11th and the Formation of a Movement, in* THE TRANSFORMATION OF THE NONPROFIT SECTOR IN THE ERA OF THE DECLINING

could, the Center staff and volunteeres spoke to many of the published authors and determined that these interdisciplinary scholars did not actually know anyone studying the health of undocumented Mexicans in New York City.[38]

Disciplinary boundaries notoriously separate scholars and professions and institutions. Still, the Center's and CUES' direct involvement with undocumented Mexicans and those who work with them and those who study the health of immigrants (including, in particular, Mexican immigrants) corroborated the views of the scholars with whom the Center consulted. Through its own direct work in New York City, and especially through the rather extraordinary networks of diverse health providers and researchers with which it regularly collaborates, CUES could not name an institution or researcher studying the health of undocumented Mexicans in New York City. That fact seemed improbable to many epidemiologists at and beyond CUES. Because well-funded data collection, especially about those populations facing enhanced health risks, so defines the mission of a large set of public health institutions, experienced scholars wagered that we would surely soon uncover relevant people and studies exploring these particular categories.

In the face of public health's commitment to obtaining concrete evidence, that unruffled confidence seemed justified. But the Center's overlapping investigation cast doubt on the otherwise sensible conviction. Through a highly regarded colleague and friend, the Center reached out

Welfare State (Elisabeth Clemens & Doug Guthrie eds., forthcoming). *See also* Marcelo M. Suárez-Orozco & Mariela M. Páez, *Introduction: The Research Agenda, in* Latinos: Remaking America 1 (Marcelo M. Suárez-Orozco and Mariela M. Páez eds., 2002). For a history of Mexicans in the U.S. tracing back four centuries with a focus on developments since the 1960s, see David G. Gutiérrez, *Globalization, Labor Migration, and the Demographic Revolution: Ethnic Mexicans in the Late Twentieth Century, in* The Columbia History of Latinos in the United States Since 1960 43 (David G. Gutiérrez ed., 2004). For a look inside the lives of some undocumented and documented Mexican immigrants in New York City, see Gabriel Thompson, There's No José Here: Following The Hidden Lives of Mexican Immigrants (2007).

[38] All with whom we met and spoke proved exceedingly generous to our research teams, but Alyshia Gálvez and the late Jocelyn Solís should be regarded as first among equals. Alyshia's and Jocelyn's remarkable knowledge of vast networks of Mexicans living in New York City, their unfailing generosity in advising and connecting me to others, their willingness to review provisional plans for various projects and campaigns, all this and more aided greatly our understanding, planning, and execution. For examples of early work by Solís and more recent publications by Gálvez, see Jocelyn Solis, *Re-Thinking Illegality as a Violence Against, not by Mexican Immigrants, Children, and Youth,* 59 Journal of Social Issues, 15 (2003); Alyshia Gálvez, Guadalupe in New York: Devotion and the Struggle for Citizenship Rights among Mexican Immigrants (2009); Alyshia Gálvez, Patient Citizens, Immigrant Mothers: Mexican Women, Public Prenatal Care, and the Birth Weight Paradox (2011)..

to wide national and international networks of those who themselves undertook or at least read health research about Latinos and Mexicans in particular.[39] After many emails and phone calls and extensive literature searches, none in these networks could name a study (published or unpublished) about the health of undocumented Mexicans in New York City. Indeed, they could identify only a small number of health studies of undocumented Mexicans in any urban area in the United States. And though some showed interest in undertaking such work, they had not at all prepared to launch any type of study in this area.

C. *Deciding To Undertake An Unfunded Study*

Once we determined that no one was systematically studying undocumented Mexican immigrant health, the Center and CUES agreed we should design, fund, and implement a health study to gather baseline information and search for intriguing patterns.

Perhaps too ambitiously, the Center aimed ideally to devise a longitudinal study that regularly (every two years) gathered information from a stratified random sample of both undocumented Mexicans and health providers in all of New York City's five boroughs. The NLN&RP – its strengths and weakness – did indeed serve as a grounded lesson. But, in the 1980s, a relatively comprehensive study had been carried out in San

[39] The remarkably knowledgeable Fernando S. Mendoza, M.D., M.P.H., Professor of Pediatrics, Stanford University of School Medicine connected us to a set of overlapping national and international networks of health scholars and providers in Hispanic-Serving Health Professions Schools, UCLA Center for Health Policy Research, and the Committee on the Health and Adjustment of Immigrant Children and Families to name a few. For a series of publications identifying health challenges facing and contributions made by Latinas and Latinos, see, e.g., DAVID E. HAYES-BAUTISTA, LA NUEVA CALIFORNIA: LATINOS IN THE GOLDEN STATE (2004); DAVID E. HAYES-BAUTISTA, HEALING LATINOS: FANTASÍA Y REALIDAD (1999); DAVID E. HAYES-BAUTISTA, NO LONGER A MINORITY: LATINO SOCIAL PARTICIPATION IN CALIFORNIA (1992), DAVID E. HAYES-BAUTISTA, THE BURDEN OF SUPPORT: YOUNG LATINOS IN AN AGING SOCIETY (1988); David E. Hayes-Bautista, *The Latino Health Research Agenda for the 21st Century, in* LATINOS: REMAKING AMERICA 1 (Marcelo M. Suárez-Orozco and Mariela M. Páez eds., 2002); Fernando S. Mendoza et al., *Importance of Generational Status in Examining Access to and Utilization of Health Care Services by Mexican American Children,* 115 PEDIATRICS e322 (2005); Fernando S. Mendoza et al., *Use of the Pediatric Symptom Checklist in a Low-income, Mexican American Population,* 157 ARCHIVES PEDIATRICS & ADOLESCENT MED. 1169 (2003); Fernando S. Mendoza & Elena Fuentes-Afflick, *Latino Children's Health and the Family-Community Health Promotion Model,* 170 W. J. MED. 85 (1999); Fernando S. Mendoza & Noel Rosales, *Health Issues of Immigrant Children of Color, in* CHILDREN OF COLOR: RESEARCH, HEALTH, AND POLICY ISSUES (Hiram E. Fitzgerald, Barry M. Lester & Barry S. Zuckerman eds., 1999); Fernando S. Mendoza, *The Health of Latino Children in the United States,* 4 FUTURE CHILD 4 (1994); Fernando S. Mendoza et al., *Health Status of U.S. Hispanic Children, in* HEALTH POLICY AND THE HISPANIC (Antonio Furino ed., 1992).

Diego.[40] And, though no available evidence suggested it had fired up a different sort of public health practice in that great city, Center staff sensed both the necessity for and the potential in establishing a rich baseline and routinely updated data for our research in New York City.

In any event, CUES signaled its willingness to partner an ambitious study. Both Centers, with wildly divergent expertise and success, shopped the study to a range of funders. The expectation was that CUES would get funding and work could proceed. To everyone's surprise, the effort failed. For the Center to fall short was not unexpected.[41] But the fact that CUES, exceedingly accomplished and internationally recognized, could not interest funders proved puzzling. Some funders urged a "pilot study" to demonstrate the need for a more comprehensive and expensive research project. But they offered no financial support to back their suggestion.

A short while later, in a coffee house across the street from and following a meeting at the City of New York's Department of Health and Mental Hygiene, my co-principal investigator and I decided to proceed without any dedicated funds. Drawing upon decades of experiences working with undocumented Mexicans and upon considerable ethnographic knowledge of the lives of undocumented Mexicans in New York City and the practices of service providers working directly with them, we sketched on the back of several napkins the broad outlines of the study, its implementation, and its dissemination.

With guidance and feedback from many with whom we worked, we together would design the study. With the help of my clinical students and a team of community volunteers, and tapping into networks developed through the implementation of both the NLN&RP and other various ambitious campaigns, the Center would plan for and administer the study. If the study was completed, CUES would then provide, to the degree feasible, targeted analyses of the collected data. And both the Center and CUES would circulate findings through varied formats and to diverse audiences.

[40] For a report on the study itself, see Wayne A. Cornelius, Leo .R. Chávez & Oliver .W. Jones, Mexican Immigration and Access to Health Care (1984) [hereinafter Cornelius, Access to Health Care]. For one analysis of the research data, see Leo R. Chávez, Wayne .A. Cornelius & Oliver .W. Jones, *Mexican Immigrants and the Utilization of U.S. Health Services: The Case of San Diego*, 21 J. Soc. Sci. & Med. 93 (1985).

[41] For an account of failed fundraising efforts, doubtless attributable in significant part to my own limits, see López, *supra* note 21, at 98.

If a shared vision of public health practice led both to unearthing how little was then known about the health of undocumented Mexicans and to launching an unfunded study, a decidedly unorthodox rival theory of undocumented Mexican migration informed decisions about the survey's architecture, heuristics guiding the search for patterns in the data, and reports about what we have learned. A compressed sketch of the rival theory, and the prevailing theory it aimed to displace, will illuminate the assumptions, methods, and aspirations at work in this article, and in the larger efforts in which this and other publications play a role.

II.

THE RIVAL THEORY OF UNDOCUMENTED MEXICAN MIGRATION THAT SHAPES THIS STUDY AND THE LARGER HEALTH CAMPAIGN OF WHICH THE STUDY IS A PART

Through the late 1900s and the entire twentieth century, and at least as robustly in 2012, a prevailing theory about why large numbers of immigrants migrate to the U.S. pervades the rhetoric of a wide range of public and private actors. Borrowing from the formal degradation of the humanity of African slaves and Native peoples,[42] the prevailing theory has been most prominently used as a framework for presidential administrations and congress to discuss, debate, and defend immigration policies and practices directed against Chinese, Japanese, and Mexican immigrants.[43] I am among a small number of people who consider

[42] For valuable contributions to the examination of African slaves as forced immigrants, see Lolita K. Buckner Inniss, *Tricky Magic: Blacks as Immigrants and the Paradox of Foreignness*, 49 DEPAUL L. REV. 85 (1999); Rhonda V. Magee, *Slavery as Immigration?* 44 U.S.F. L. REV. 273 (2009). For an influential account of state and local government regulation of immigration, including the immigration of African free and slave labor, until 1875, s*ee* Gerald L. Neuman, *The Lost Century of American Immigration Law (1776-1875),* 93 COLUM. L. REV. 1833, 1865-73 (1993) (describing pre-1875 sub-federal immigration regulation of immigration). For an argument that we ought understand the intimate relationship between Black history and immigration history in the United States, see ROGER DANIELS, COMING TO AMERICA 54-55 (1990) (lamenting both the artificial divide between Black history and immigration history and the widespread refusal to interpret slave trade as a form of migration). And for a fresh perspective on the role of race in the making of the United States, MARTHA MENCHACA, RECOVERING HISTORY, CONSTRUCTING RACE: THE INDIAN, BLACK, AND WHITE ROOTS OF MEXICAN-AMERICANS (2001).

[43] For literature that taught me, in the 1970s, how Chinese and Japanese helped create the very U.S. immigration law that for generation proved so racistly harsh on them , see GUNTHER BARTH, BITTER STRENGTH: A HISTORY OF THE CHINESE IN THE UNITED STATES, 1850–1870 (1964); PING CHIU, CHINESE LABOR IN CALIFORNIA, 1850–1880: AN ECONOMIC STUDY 16 (1963); MARY COOLIDGE, CHINESE IMMIGRATION 17 (1909); ROSE H. LEE, THE CHINESE IN THE UNITED STATES

the prevailing theory of undocumented Mexicans wrong. By "wrong," I mean it is both descriptively inaccurate and morally misleading. In place of the prevailing theory, I would have us adopt a rival theory of undocumented Mexican migration. That rival theory equips us with an ethically and historically defensible vantage point from which to address the complex phenomena created by the U.S. and Mexico, in transnational and in local circumstances.[44]

A. *The Prevailing Theory*

The prevailing theory views undocumented immigration in stylishly straight terms. It sees "illegal immigration" as a social "problem," emphasizing the threatening impact of undocumented immigrants, especially undocumented Mexicans, on the economic, ecological, and cultural well-being of U.S. citizens.[45] Drawing heavily upon classical "push-pull" theory and presupposing rationally maximizing individuals, the prevailing

of America (1960); Stuart Miller, The Unwelcome Immigrant: The American Image of the Chinese, 1785–1882 (1969); Elmer Sandmeyer, The Anti-Chinese Movement in California 12 (1939); Alexander Saxton, The Indispensable Enemy: Labor and the Anti-Chinese Movement in California (1971); Roger Daniels, The Politics of Prejudice: The Anti-Japanese Movement in California and the Struggle for Japanese Exclusion 9 (2d ed. 1977); Betty Sung, Mountain of Gold: The Story of the Chinese in America (1967); William L. Tung, The Chinese in America 1820–1973, at 1, 7 (1974). For the explosion of superb recent literature, see for example, Bill Ong Hing, Making and Remaking Asian America Through Immigration Policy, 1850–1990 (1993), Lucy M. Cohen, Chinese in the Post-Civil War South: A People Without a History (1984); Bill Ong Hing, Defining America Through Immigration Policy (2003); Bill Ong Hing, The State of Asian Pacific America: Reframing the Immigration Debate (Bill Ong Hing & Ronald Lee eds., 1996); Bill Ong Hing, To Be an American: Cultural Pluralism and the Rhetoric of Assimilation (1997); Charles J McClain, In Search of Equality: The Chinese Struggle Against Discrimination in Nineteenth-Century America. (1994); Ronald Takaki, Strangers from A Different Shore (1989); Paul R. Spickard, Japanese Americans: The Formation and Transformation of an Ethnic Group 27 (1996);. Sucheng Chan, Asian Americans: An Interpretive History (1991); The Exclusion of Chinese Women, 1870-1943 (Sucheng Chan ed., 1992). For kindred history thrust forward, see Helen Zia, Asian American Dreams: The Emergence of an American People (2000) Yuji Ichioka, The Issei: The World of the First Generation Japanese Immigrants, 1885–1924 (1988); Marius B. Jansen, The Making of Modern Japan (2002).

[44] For my own full development of this rival theory of undocumented Mexican migration from which this compressed account draws, see Gerald P. López, *Don't We Like Them Illegal?* 45 UC Davis L. Rev. 1711 (2012).

[45] For the sources available in the 1970s making explicit the prevailing theory that already had become the default ideology, see these prominent examples: D. North & M. Houstoun, The Characteristics and Role of Illegal Aliens in the U.S. Labor Market: An Exploratory Study (1976); Arthur F. Corwin, Immigrants – and Immigrants: Perspectives in Mexican Labor Migration to the United States (1978);; ." Paul H. Ehrlich, Anne H. Ehrlich & Loy Bilderback, The Golden Door: Immigration, Mexico, and the United States (1979).

theory stresses the economic disparity between the U.S. and Mexico as the "but-for" causal explanation for massive undocumented migration.[46] It blames the Mexican government for failing to care for and control its own citizens, while it paints the U.S. as the unwitting and blameless recipient of emigration spurred by the U.S.' success in enhancing its own domestic well-being.[47] The prevailing theory presumes, fortunately, that well-targeted and vigorously enforced laws can control, and even ultimately solve, the undocumented immigration problem.

For at least the last one hundred years, policymakers committed to the prevailing theory have enacted a series of policies and practices that supposedly aimed at controlling migration and, instead, consistently resulted in the continuation and enhancement of undocumented and documented Mexican migration.[48] True enough, policymakers can do only their best in devising solutions to problems, and sometimes the laws do not work as expected. Yet the routine and predictable failure of immigration laws shaped by the prevailing theory suggests an altogether divergent explanation.

Much as the citizenry may demand policies and practices that seem to abide by the prevailing theory's assumptions, at least some elected officials and policymakers do not regard themselves as actually trying to solve the immigration "problem." Instead, they are acting on a different understanding of the circumstances, one that does not presuppose that such a problem exists: the U.S. always needs undocumented Mexican immigrants and must keep them in plentiful supply, and Mexican officials and elites are only too happy to accommodate this demand, taking full advantage of one principal means for managing economic, social, and political pressures within their own nation.

[46] Many trace push-pull theory to the nineteenth-century British geographer Edward G. Ravenstein. Edward G. Ravenstein, *The Laws of Migration*, 52 J. ROYAL STAT. SOC'Y 241-301 (1889).

[47] Rhetoric in 2011 imitates ways of talking about undocumented Mexicans in earlier eras, including this sample from the 1970s: "They want it and we've got it: jobs, prosperity, the Ladies' Home Journal-Playboy life-style. As a result we are being invaded by a horde of illegal immigrants from Mexico." PAUL H. EHRLICH, ANNE H. EHRLICH & LOY BILDERBACK, THE GOLDEN DOOR: IMMIGRATION, MEXICO, AND THE UNITED STATES AT VII. (1979); *see also* U.S. DOMESTIC COUNCIL COMM. ON ILLEGAL ALIENS, PRELIMINARY REPORT 42 (1976).

[48] For only one modern example, examine the literature describing the contradictions imbuing The Immigration Reform and Control Act ("IRCA") of 1986, including Kitty Calavita, *Employer Sanctions Violations: Toward a Dialectical Model of White Collar Crime*, 24 LAW & SOC'Y REV. 1041, 1056-1064 (1994). For an overarching exploration of related maneuvering, see generally PETER ANDREAS, BORDER GAMES: POLICING THE U.S.-MEXICO DIVIDE (2000).

B. *The Rival Theory*

Through my rival theory, the problem of undocumented Mexican migration is understood in a fundamentally different way: Up until very recently, and for a least the past century, the solution to the problem of undocumented Mexican immigrants has always been, initially, and perhaps drastically, reducing their numbers and, then, in dribs-and-drabs, increasing them, followed in due course by dramatically enlarging the undocumented and documented populations.[49] At some point, this solution leads once more to the demands to address the growing problem, demands that ultimately prove too politically perilous to ignore, leading political leaders and elites to respond with the solution implemented the last time around. To be able to exercise such extraordinary flexibility, time and again, the U.S. and Mexico have managed two immigration systems: one is documented ("legal"), and the other undocumented ("illegal"). Together they comprise complementary and overlapping domains of one overarching regime.

Sovereigns operate their legal regimes – and the U.S. and Mexico run their legal and illegal immigration systems – through prohibitions and permissions. Prohibitions and permissions establish the framework of ground rules through which law processes disputes, influences behavior, and distributes power.[50] Prohibitions are by far the easier to spot and to experience as law. When the U.S. enacts laws making it illegal to enter and to remain without authorization, most everyone interprets these prohibitions as lawmakers having acted. If indeed lawmakers generate lots of prohibitions, we perceive law (and government) as playing a bigger role in our lives than before. Still, the number of prohibitions

[49] For indications of the cross-section of actors in the U.S. and Mexico that long ago, I believe, acted upon something kindred to my rival theory, see the classic work Manuel Gamio, Mexican Immigration To the United States (1930); Paul S. Taylor, A Spanish-Mexican Peasant Community: Arandas in Jalisco, Mexico (1933); Paul S. Taylor, An American-Mexican Frontier: Nueces County, Texas (1934).

[50] For extraordinarily important legal scholarship developing and exploring such insights about legal systems, see the early scholarship of Wesley Hohfeld and Robert Hale and the more contemporary work by Duncan Kennedy and Joseph Singer. *See* Duncan Kennedy, *The Stakes of Law: Or Hale and Foucault!*, 15 Legal Stud. Forum 4 (1991); Joseph William Singer, *Legal Realism Now*, 40 Calif. L. Rev. 465 (1988); Joseph William Singer, *The Legal Rights Debate in Analytical Jurisprudence from Bentham to Hohfeld*, 1982 Wis. L. Rev. 975; *see, e.g.*, Robert Hale, *Force and the State: A Comparison of 'Political' and 'Economic' Compulsion*, 35 Colum. L. Rev. 149 (1935); Wesley Hohfeld, *Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 23 YALE L.J. 16 (1913); Wesley Hohfeld, *Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 26 Yale L.J. 16 (1917).

– in any period or over time – does not make legal regimes more or less central to disputes, behavior, or distribution.

Permissions prove far more elusive to pick out and to comprehend. The U.S. could prohibit employers from hiring undocumented immigrants, landlords from renting to them, and grocers from selling them food, but instead it decides to permit ("legally privilege" by not prohibiting) these relationships and transactions and huge numbers of others like them. Lawmakers appear to be doing nothing when they resist demands to prohibit these relationships and transactions, and many experience law as having nothing to do with these results. Savvy participants in – and astute observers of – the legal regime know better, however. These permissions are not inadvertent gaps but choices by lawmakers to let employers, landlords, and grocers – and, not coincidentally, undocumented immigrants – do what they must in order for illegal and legal migration to serve the mutual needs of the U.S. and Mexico. The law is no less involved when it creates ground rules of permission rather than of prohibition.

With perception counting at least as much as reality, the U.S. and Mexico combine prohibitions and permissions in order to accomplish whatever they most want while appearing to have played either no active role or a hugely central role in the outcome. When aiming to increase undocumented Mexican laborers, the U.S. typically emphasizes prohibitions and diverts attention away from permissions, including the de facto sorts signaled through conscious under-enforcement. When aiming to put a stop to all undocumented Mexican migration, the U.S. makes theatrical productions of the prohibitions being enforced, of apprehensions at the border and raids, sweeps, and mass deportations inland.[51] Mexico plays its role in this drama, emphasizing efforts to improve its own economy, to dissuade illegal emigration, and to protect Mexican citizens in the U.S.; all while steering clear of its failure both to enact many prohibitions and to enforce those few on the books. [52]

To say the U.S. and Mexico have operated two compatible systems is not to say the systems reflect equal power. Mexico aims every bit as vigorously as the U.S. to satisfy its self-interest. Yet the U.S. has always

[51] For illustrations of this pattern since at least the 1880s, see López, supra note 36.

[52] For a range of scholars expressing such views, see, for example, Arthur F. Corwin, *Mexican Policy and Ambivalence Toward Labor Emigration to the United States*, *in* IMMIGRANTS AND IMMIGRANTS: PERSPECTIVES ON MEXICAN LABOR MIGRATION TO THE UNITED STATES (Arthur F. Corwin ed., 1978); JOHN MARTÍNEZ, MEXICAN EMIGRATION TO THE U.S., 1910–1930 (1957) (1999).

been the vastly more powerful partner and Mexico the accommodating junior associate.[53] However, in creating and controlling the illegal and legal immigration systems, the U.S. and Mexico do not operate as unitary nation-states. Federal governments in both nations possess primary constitutional power to formulate practices, policies, and rhetorical justifications in the name of immigration. But state and local governments have significantly influenced documented and undocumented immigration, at times because they assert themselves when the federal government does not, at times because they share formal power at the request of the federal government, and at other times because they do what they want, occasionally with the federal government consciously averting its gaze.[54]

Shared influence sometimes leads to struggles over constitutional power. Going perhaps to the heart of the matter, state and local governments may decide to interfere with federally granted permissions. They can enact laws prohibiting hiring, housing, and feeding undocumented immigrants, pushing the U.S. to reassert that, constitutionally, only the federal government can choose how best to govern immigration – in essence, how best to mix prohibitions and permissions.[55] Since 1875, the federal government almost always wins these showdowns, with nearly absolute deference to federal power over immigration becoming linked to the very idea of sovereignty. Still, the public insistence that state and local government should have a role in granting and revoking permissions makes prominent – and far more controversial – the ground rules

[53] For a sample of other prominent accounts of Mexico, Mexican emigration, and Mexico's relationship to the U.S. see Lawrence Cardoso, Mexican Emigration to the United States, 1897–1931 (1980); Gilbert G. Gonzáles, Mexican Consuls and Labor Organizing: Imperial Politics in the American Southwest.

[54] For valuable accounts of the relationship between federal and state governments in the United States, s*ee* Gerald L. Neuman, *The Lost Century of American Immigration Law (1776-1875),* 93 Colum. L. Rev. 1833, 1865-73 (1993) (describing pre-1875 sub-federal immigration regulation of immigration). And for an ethnographically informed account of federal and sub-federal governments in Mexico, see David Fitzgerald, State and Immigration: A Century of Emigration Policy in Mexico (2005) (exploring emigration from the Mexican perspective).

[55] For an illustration of how this strategy has been deployed by the current state sovereignty and anti-undocumented Mexican alliance has forged as its principal strategy, see for example, the work of Kris Kobach, a principal leader of both movements. Kris W. Kobach, *Reinforcing the Rule of Law: What States Can and Should Do to Reduce Illegal Immigration*, 22 Geo. Immigr. L.J. 459, 463-82 (2008) ("[T]here is wide latitude for states and municipalities to act without being preempted, provided the statutes are drafted correctly.").

of permissions that citizens far more typically do not regard as law or as related to the social realities they see around them.[56]

To manage the inevitable complexities, the legal and illegal systems provide the U.S. and Mexico a catalog of stock practices, policies, and justifications – a menu of available options – for anticipating and responding to diverse circumstances. What can appear as nothing but ad hoc hodgepodge of political tradeoffs can be seen from a distance as options oscillating between two paired polar opposites.[57] Near one end there is a set of pre-scripted practices, policies, and rhetorical justifications for "once and for all" excluding and removing all undocumented Mexicans. Taking back in the direction of the other pole, there is a cluster of pre-scripted practices, policies, and rhetorical justifications for admitting some documented Mexicans and for overlooking the often much larger numbers of undocumented immigrants already living in the U.S. or migrating (often making their way back) from Mexico.

As a matter of ideological orientation (not theoretical inevitability or permanent political slant), the field of operation is heavily tilted toward the pole that excludes, detects, and deports undocumented

[56] See e.g, Peter J. Spiro, *Learning to Live with Immigration Federalism,* 29 CONN. L. REV. 1627, 1635-36 (1997) (urging the historical and practical necessity of recognizing and adapting to shared power over immigration); Howard F. Chang, *Public Benefits and Federal Authorization for Alienage Discrimination by the States*, 58 N.Y.U. ANN. SURV. AM. L. 357, 363-64 (2003) (divergent state policies could plausibly be regarded as creating laboratories of generosity toward immigrants"); Peter H. Schuck, *Some Federal-State Developments in Immigration Law*, 58 N.Y.U. ANN. SURV. AM. L. 387, 389 (2002) (taking immigration federalism to be credible and justified);

[57] For the notion of pre-scripted practices as deployed in human and professional problem solving, see Gerald P. López, *Lay Lawyering*, 32 UCLA L. REV. 1 (1984).(offering a theory of lawyering as problem solving, tracing its origins to the use of stock stories and arguments by all humans to categorize and deal with everyday circumstances). For influential work in law about paired polar opposites in the ways we make meaning, see *, e.g.*, J.M. Balkin, *The Crystalline Structure of Legal Thought*, 39 RUTGERS L. REV. 1 (1986) (proposing that and illustrating how arguments people make to advance legal doctrine share a common structure, replicated across bodies of doctrine and at successive levels of complexity); J.M. Balkin, *Nested Oppositions*, 99 YALE L.J. 1669 (1990) (illuminating how deconstruction permits a reinterpretation of law's logic of similarities and differences, permitting user and observer to see "nested oppositions," oppositions that involve a relation of dependence, similarity, and containment between the opposed concepts); DUNCAN KENNEDY, LEGAL EDUCATION AND THE REPRODUCTION OF HIERARCHY: A POLEMIC AGAINST THE SYSTEMS (15) 1983 ("[Law students] learn a list of balanced, formulaic, Pro/con policy arguments that lawyers use in arguing that a given rule should apply to a situation . . . ."); Duncan Kennedy, *Form and Substance in Private Law Adjudication*, 89 HARV. L. REV. 1685, 1713 (1976) ("My assertion is that the arguments lawyers use are relatively few in number and highly stereotyped, although they are applied in an infinite diversity of factual situations.").

Mexicans from the U.S. And the standard practices, policies, and rhetorical justifications defining both poles reflect the thoroughly racial nature of the two systems. With immediate precedents in the treatment of and thinking about Chinese and Japanese laborers, with even deeper roots in the forced immigration from Africa of Black slaves and the mandated movement of Native peoples within the U.S., the stocks of stories and arguments used to praise and vilify undocumented and documented Mexicans have always revealed racist convictions. Of course, Mexico is itself pervaded by profoundly racial and racist ideologies. Even so, Mexican immigrants know they are in the U.S. in part by experiencing how others racially perceive them. Both at the border and throughout the U.S., racial profiling of undocumented-looking Mexicans appears regarded as a political and practical necessity.[58]

The paired poles that structure the oscillating stocks of practices, policies, and rhetorical justifications contain opposing explanations of undocumented migration and contrasting moral assessments. In the prevailing explanation, the natural allure of the U.S. reflects economic advantages, political freedoms, and physical accessibility, and poor individual Mexicans cannot help but feel pushed out by their own inferior country and pulled in by possibilities immediately across the northern border. This rival theory offers an explanation that aims to challenge this

[58] For the rationalizations expressed by the Supreme Court in a series of opinions in 1970s and 1980s, see *See, e.g.*, United States v. Montoya de Hernandez, 473 U.S. 531 (1985) (strip searches at the border permissible without either probable cause or a warrant); United States v. Ramsey, 431 U.S. 606, 616 (1977) ("[S]earches made at the border, pursuant to the long-standing right of the sovereign to protect itself . . . , are reasonable simply by virtue of the fact that they occur at the border."); United States v. Martinez-Fuerte, 428 U.S. 543 (1976) (sanctioning an Immigration and Naturalization Service (INS) factory sweep and the questioning of Latino workers by declaring actions beyond the reach of the Fourth Amendment and by veiling obvious racial dimensions); United States v. Brignoni-Ponce 422 U.S. 873 (1975) (sanctioning the use of race to justify intrusive investigation of roving patrols near the border). Decades later, some criminal justice scholars focus their attention on the practices constitutionally immunized during these years. *See* Bernard Harcourt, United States v. Brignoni-Ponce *and* United States v. Martinez-Fuerte: *The Road to Racial Profiling*, *in* Criminal Procedure Stories 315 (Carol Steiker ed., 2006); Randall Kennedy, *Race, Law and Suspicion: Using Race as a Proxy for Dangerousness*, *in* Race, Crime and the Law 136-67 (1997). For a later call for "rebellious lawyering" to challenge these policies and practices, see, for example, Kevin R. Johnson, *How Racial Profiling Became the Law of the Land:* United States v. Brignoni-Ponce *and* Whren v. United States *and the Need for Truly Rebellious Lawyering,* 98 Geo. L.J. 1005 (2010). For a very recent analyses of how race-driven law enforcement-related immigration cases remain largely ignored by conventional approaches to legal scholarship and criminal procedure courses, see Devon W. Carbado & Cheryl I. Harris, *Undocumented Criminal Procedure*, 58 UCLA L. Rev. 1543 (2011).

orderly chronicle: where there is substantial economic disparity between two adjoining countries, the potential destination country promotes de jure *and* de facto access to its substantially superior minimal wage. And the potential origin country accommodates this movement, such that promotion and accommodation encourages migrant households and everyone else reasonably to rely on the continuing possibility of migration, employment, and residence until a competitive economic alternative is made available.

In the moral assessment that has long reigned supreme, the U.S. and Mexico assert — as all sovereign nations apparently should — the right to admit or exclude as a necessary extension of the right to form distinctive and stable communities. Access to the national community is a right presumptively shared only and always by those who are fully legal citizens and, especially in difficult economic times, sovereign nations should focus exclusively on the well-being of those who are full members of their national community, dealing with undocumented and even documented immigrants as they must, however harshly, one-sidedly, and unconscionably. But a competing vision immerses moral responsibility in messy reality.[59] The U.S. and Mexico together developed mass Mexican migration, using both legal and illegal systems, in order to respond to the needs and aspirations of their linked political economies, especially to build the prosperity of the U.S. Undocumented Mexicans have been integral parts of work crews, child or elderly care arrangements, kinship networks and families, neighborhoods and communities. And it is not possible to have persons live, work, and participate in shouldering daily responsibilities and affinities without creating in these individuals a sense of entitlement to benefits of community membership and a moral obligation based on their reasonable expectations. No matter how strongly our formal laws deny it, our conduct creates the obligation.

It is important to realize that both poles — and every point between them — contain both opposing explanations of undocumented migration and the contrasting moral assessments associated with each explanation. At one pole, to be sure, the prevailing theory utterly dominates thinking and exchanges. Perhaps in some other era, the opposing paired pole will reflect the authority of the rival theory, complete with the competing vision of moral responsibility. Anyway, this ideological

[59] For an earlier effort of mine to give full life to this competing vision of moral responsibility, see López, *supra* note 36.

imbalance should not divert our attention from the crucial structural feature. At the poles, and at any point between them, and at every point in time, both stocks of practices, policies, and justifications exist, even if one appears almost entirely to have disappeared.[60] The vanquished lies, waiting to surface again in yet another fight – across a kitchen table, in legislative halls, or before some court. Like all polarities in diverse forms of rhetoric, the stories and arguments hang around to be deployed by someone who can imagine how to make them intelligible again, to make them plausible, perhaps compelling.[61]

It is every bit as important to realize that the U.S.' and Mexico's largely tacit and incredibly robust systems of undocumented and documented migration have always presupposed a rough equality between the U.S.' power to exclude, detect, and deport, and its power to attract, admit, and overlook. Of course, we have typically enacted practices and policies that appear to be exclusionary, and certainly we have talked up the exclusionary effects of our approaches. However, those same practices and policies have often purposely been constructed and carried out in ways that, at the same time, encourage and overlook undocumented migration. They permit at least as much as they prohibit. In the U.S. in particular, we have always relied upon our ability – through the federal government's sovereign plenary control over immigration – to change our minds and do whatever we want, whenever we want, depending on what suits or benefits us.

[60] *See* Balkin and Kennedy, *supra,* note 56.. In my own work, and in the work of others, these polarities are cast in story/argument pairs rather than in policy maxims or argument bites — a distinction I regard as important to accurately portraying how problem solving works in everyday persuasion and in sylized legal analysis. *See, e.g.*, Gerald P. López, *Lay Lawyering*, 32 UCLA L. Rev. 1 (1984) (offering a theory of lawyering as problem solving, tracing its origins to the use of stock stories and arguments by all humans to categorize and deal with everyday circumstances). The origins of such theories — this sociology of problem solving, persuasion, analysis — can be traced to many sources, including (I would insist) everyday performers of problem solving going back to the days before Aristotle. For an idiosyncratic and valuable history of relevant sources of "the semiotics of legal argument," see Duncan Kennedy, Legal Reasoning: Collected Essays 127 (2008).

[61] Ideological dominance of this sort leads to labeling stories and arguments "off the wall," a derogatory slam, but one that reflects, at a deeper level, conventional acceptability and not soundness or past or future appeal. *See* Jack M. Balkin, *How Social Movements Change (or Fail to Change) The Constitution: The Case of the New Departure*, 39 Suffolk U. L. Rev. 27, 28 (2005) (explaining how social movements help shape the contours of constitutional reasoning, moving claims from being "off the wall" to being central examples of constitutional common sense).

Today, this presumed capacity to change our minds appears threatened as perhaps never before. So effective and unified have the Obama, Bush, and Clinton Administrations been in their unprecedented development of the exclusion, detection, and deportation power, they may well have permanently undermined our capacity to attract, admit, and turn a blind eye. Their dramatic enhancement of federal and state infrastructure, local, state, and federal personnel, and a nationalized network of combat-grade electronic surveillance technology make it difficult and perhaps impossible to back off and begin the cyclical move back toward the opposite pole, as we once so readily could.[62] To make matters even more convoluted, some states argue they should play their own sovereign role in enforcing federal prohibitions and denying federal permissions, putting constitutionally at-risk the plenary federal power pivotal to the illegal and legal systems of migration. Perhaps this revolt will fall short. Even so, the power to exclude now nearly matches the extreme rhetoric and, as modern wars demonstrate, this and future administrations may find it nearly impossible (procedurally, politically, or economically) to reverse course.[63]

III.
THE STUDY

Contemporary undocumented migration from Mexico to the United States reveals, simultaneously, major modifications to and strong continuities with migration of past decades. While the odds that post-1995 Mexican immigrants would head to newer destinations climbed markedly, the connection between traditional destinations and sending areas remained forceful.[64] The persistence of long-established migrant circuits would not surprise those who already know that evidence indicates geographic distribution at any point reflects where earlier cohorts

[62] For a full elaboration of what Obama, Bush, and Clinton have undertaken can be found in López, *supra* note 44.

[63] For imaginative expressions of how the U.S, might respond through regionally formulated immigration policy, see *See generally* Keith Aoki & John Shuford, *Welcome to Amerizona — Immigrants Out!: Assessing "Dystopian Futures" and "Useable Futures" of Immigration Reform, and Considering Whether "Immigration Regionalism" Is an Idea Whose Time Has Come*, 38 FORDHAM URB. L.J. 1 (2010–2011) (envisioning progressive U.S. immigration reform shaped by public, private, and civic assessments undertaken on a regional basis)

[64] *See* Zúñiga & Hernández-León, *supra* note 1. *See also* Martha L. Crowley, Daniel T. Lichter & Zhenchao Qian, *Beyond Gateway Cities: Economic Restructuring and Poverty Among Mexican Immigrant Families and Children* (Rural Poverty Res. Center, Working Paper No. 05-07, June 2005), *available at* http://www.rprconline.org/wp2005.htm.

of Mexican immigrants have settled.[65] Yet the mix of durable continuity and notable variance – and the relationship between the two – together mirror and contribute to considerable complexity.

Guiding our curiosity, the rival theory of undocumented Mexican migration – particularly informed by what we have begun to learn about changes and continuities between 1986 and 2004 – could have translated into a version of the longitudinal health study of immigrants and health facilities that the Center initially had contemplated. That way, health would be explored in relationship to a range of variables about both immigrants and health care providers. Even in the unfunded down-sized variation, the alternative theory suggested a survey questionnaire as rich with well-framed questions about Mexico, say, as about life in New York City. That way, we might well have enhanced our understanding of the relationship between health and the entire migration cycle.

But studies reflect constraints as much as anything. And this sidewalk study about the health of undocumented Mexicans faced particular restrictions. Many New Yorkers thought undocumented Mexicans would not cooperate. Even among the small number who thought the Center and CUES were correct in predicting a reasonable response rate, anxieties grew with the length of the questionnaire. Concern about the time to administer the study reflects hard-earned wisdom. Even most willing respondents have their limits. When undocumented Mexicans, traveling on sidewalks by foot in New York's fall and early winter weather, are the chosen population, advice strongly recommended brevity in administering the questionnaire.

Beyond the perceived virtues of brevity lie the demands of custom. Much as the Center and CUES aimed to tailor a basic health survey to the realities of undocumented life, the survey had to be perceived by health specialists and funders alike as inquiring about and yielding information readily recognizable as within the boundaries of traditional health research. Otherwise odds of drumming up later interest in the overarching effort – particularly in funding later studies, of current and alternative interventions, among other things – might well decrease. The survey we ended up designing reflects tensions and compromises between ambitiously-formed questions and familiar-looking output, all further circumscribed by appreciation of how length might well undermine any notable success.

[65] Durand, Massey & Capoferro, *supra* note 3, at 13.

A. *Sample*

Hoping to diversify our respondent experiences, we recruited a sample of adults (age 18 years or older) from all five boroughs of New York City who reported being born in Mexico. We recruited participants from venues throughout New York City in communities with large populations of undocumented Mexican immigrants. We selected venues using a three-step procedure. First, using U.S. Census data, we identified the twelve neighborhoods in New York City with the highest concentrations of Mexican immigrants: Sunset Park, East Harlem, North Corona, Elmhurst, Jackson Heights, Astoria, Bushwick, Williamsburg, the South Bronx, Chelsea, the Lower East Side, and Port Richmond). Second, drawing on our previous experiences in many of these neighborhoods and on people and institutions with considerable knowledge of these communities, we roamed particular targeted areas. Third, we conducted at least two systematic walk-throughs of all streets in each of the twelve neighborhoods – on different days and at different times of day – to identify intra-neighborhood venues with heavy volumes of foot traffic that might prove most suitable to conducting interviews.

In choosing this approach, we sacrificed certain obvious advantages of "snowball" sampling. In order to overcome identification and access problems in interviewing undocumented immigrants, snowballing employs networks to identify willing respondents who, in turn, provide a research team with the names of other willing immigrants, providing contact information and even introductions in order to enhance credibility and trust, building over time a sizeable sample of cooperative interviewees. But even those who have effectively used snowballing in interviewing undocumented Mexicans recognize the method's tendency to produce a sample of people who have been in the United States for a long time.[66] Without doubting the advantages of snowballing, we aimed through "cold calls" on neighborhood sidewalks to reduce this demonstrated bias and perhaps produce a sample more representative of New York City's and the nation's undocumented Mexican population.

B. *Design*

With several rounds of input and feedback from immigrants and service providers and survey specialists, we designed a survey to explore what together the rival theory and earlier epidemiological research

[66] *See, e.g.*, CORNELIUS, ACCESS TO HEALTH CARE, *supra* note 40, at 10-12.

indicate might be important to the health of undocumented Mexicans. We inquired about demographic characteristics, including age, gender, marital status, level of education, children, children living with them or not, size of household, where they sleep. Certainly, answers to these questions would permit us to develop a profile and to compare our profile with undocumented Mexican populations determined through census data of the nation and New York City. But undocumented Mexicans are not a homogenous group about which a single stock account applies, and the same questions that serve to build a profile would help to mark differences between those living in New York City.

We documented legal status through self-reports, specifically asking respondents whether or not they were legal residents of the United States. Because available research indicates that time spent, especially in a particular place, may influence and reflect much else, we inquired how long respondents had lived in New York City. To help assess whether any of the Clinton or Bush Administration policies (perhaps most importantly preclusion from public services) might notably matter, we asked the year respondents entered the U.S.

Significant literatures address the role and impact of undocumented Mexicans in labor markets. Perhaps unduly influenced by the prevailing theory and the limits of census data, most studies have examined participation and earnings through formal ("on the books") jobs. Instead, we inquired about sources of income – formal and informal labor markets and any other sources of income – and about how much money respondents made in each. We hoped to begin to learn how respondents made money in New York City: Do they package diverse incomes and, if so, in what ways?

Even more particularly, we asked whether or not respondents had worked as a day laborer in the last six months. For all the anecdotal and journalistic reports on day labor, for as central as day laborers have become in various parts of the United States, only in relatively recent years have scholars aimed more systematically to understand the various roles day laborers fill and the various challenges they face. With the advantage of one such study having been completed in New York City, and with the Center's extensive work directly with day laborers, we understood that discovering the extent of day labor participation and its relationship to health seemed essential to establishing baseline information.

The rival theory of undocumented Mexican migration has stressed that undocumented Mexicans work in perhaps significant part to send money back home. In making this claim, the theory traces its origins to a tiny number of careful observers who many decades earlier analyzed the importance of remittances to the unfolding dynamic and reflects a modern interdisciplinary scholarship, sharpening appreciation about the importance of analyzing remittances. We asked directly if respondents send money to family or friends in Mexico and, if so, how much every month over the past six months? Especially together with answers to questions about sources and amounts of income, data about remittances perhaps would help illuminate whether and how transnational households survive in part through work in New York City.

Following the lead of important research, we assessed respondents' access to health care through a sequence of questions. We asked where do they usually go to see a doctor, nurse, or physician's assistant for medical care – a doctor's office or clinic, Medicaid/HMO, emergency room in a hospital, drug treatment center, other location, or nowhere? We asked whether respondents see the same person. Especially given the strong claims that undocumented Mexicans often use (at great expense) emergency rooms, we inquired whether respondents had been to or received care in an emergency room during the past six months. And we asked whether the respondents were covered by any form of health insurance in the last six months.

Consistent with well-developed and reliable past research, we inquired about health in overlapping and particular ways. We asked respondents how they would rate their health overall. We asked respondents separately about physical health and mental health, which was each recorded as the number of days in the last thirty that they regarded their physical health as "not good." And we asked how many days in the last thirty did poor physical or mental health keep respondents from doing normal activities like work or recreation. Because of the perhaps publicly unappreciated prevalence and importance of "food insecurity" among those living in the U.S., especially undocumented Mexican immigrants, we asked during the past six months if they were ever hungry but didn't eat because they couldn't afford enough food.

Of the many overlapping networks undocumented migration implicates, we certainly needed to discover more about what might be described as "cultural associations" – the types of people with whom

respondents in fact hang out with or would prefer to hang out with in New York City. Across four examples (close friends, social gatherings, visits, and wishes about children), we asked respondents to choose from among five choices—at one end, all were Mexican/Latino/Hispanic and, at the other, *almost* all were not Mexican/Latino/Hispanic. A wide range of literatures, including but not limited to those addressing undocumented Mexican migration and epidemiology, indicate answers to these questions would help us understand actual and desired cultural associations and their relationship to health.

To learn about and evaluate social support, we posed a set of demonstrably revealing inquiries. We asked respondents if, in the last six months, someone was available to help them if they were confined to bed, to give them good advice about a crisis, to get together for relaxation, to confide in or talk to about their problems, to love them and make them feel wanted. And for each we asked whether the answer was "none of the time," "some of the time," most of the time," or "all of the time" for each of these questions. On its own terms, exploring social support proves often telling. And in relationship to health, especially for an undocumented Mexican far from home, the networks may well prove even more revealing.

The final questionnaire included sixty-five (65) questions (many with sub-parts) covering twenty-two (22) pages. Through simulations and test-runs, we estimated that, on average, the administration of the questionnaire would take twenty-five (25) minutes. We included an introductory paragraph explaining the purpose of the study and reminding respondents of their ability to skip questions and end the survey at any time. And we included throughout the instrument – and particularly before any more sensitive questions – reminders that the survey was completely confidential and anonymous. We indicated to respondents that on any and all questions they could answer "refuse" or "don't know" and move forward.

C. *Implementation*

Because we expected to conduct all interviews in Spanish, we translated and back-translated the structured questionnaires, scripts, and prompts that outreach workers memorized, honing the language for maximum clarity. Heading the translator team was a professional interpreter with whom the Center regularly works (herself born and raised in a region that serves as one of the principal sources of New York City's

undocumented Mexican population). The lead interpreter worked, in turn, with a range of other Mexicans and fully bi-lingual speakers, testing and re-testing product, in simulation and in a sequence of "test runs." The Institutional Review Board at the New York Academy of Medicine and the University Committee on Activities Involving Human Subjects at New York University approved the study.

Through extensive community networks carefully developed and regularly used to enlist volunteers on other Center campaigns and projects, we recruited native Spanish-speaking and Spanish-fluent outreach workers. Without any dedicated funding or available reserves, we could not pay these outreach workers. But, consistent with Center policies, we did hold them accountable to high standards of performance. Following outreach methods common to both the Center's practice and community participatory research, we trained these volunteers in data-collection ambitions, skills, and sensibilities. Through background reading materials and repeated simulations, we focused in particular on challenges implicated in recruiting undocumented Mexicans through cold-calls on public sidewalks and administering the survey in a variety of settings and climates.

Under the direct supervision of Center staff and one of the co-principal investigators, and working with four clinic students assigned to the job, the trained outreach workers began administering the survey on October 8, 2004, with each weekly shift consisting of Friday afternoon, and Saturday and Sunday mornings and afternoons. With supervisors bearing everything from folding tables and chairs to posters, surveys, consent forms, hot drinks, crayons and paper for children to draw, outreach workers positioned at targeted venues. (See Appendix A1-A4) They invited participation by distributing descriptive fliers and engaging potential participants in open-ended conversations about the objectives, the inclusion criteria, and the voluntary nature of the study. Participants qualified for the study if they reported being 18 years of age or older, born in Mexico, and current residents of NYC. All study subjects provided oral consent at the time of the interview. And in order to preserve participants' anonymity, we collected no identifying information about participants.

Because we viewed the sidewalk study as another valuable outreach, education, and mobilizing opportunity, we prepared handouts and "raps" with those aims in mind. Most prominently, perhaps, we drew on data we had gathered from the outreach side of the NLN&RP to create

a specially designed thirteen-page Referral List. This guide provided detailed information about forty (40) community-based organizations, all providing services to undocumented Mexicans across a range of important problems, all as geographically nearby to the twelve (12) neighborhoods as any in the city. We offered this Referral List to every person we contacted, totaling over 2,000 people (See Appendix B).

Initially, we had set our goal for the Pilot Study at 250 completed questionnaires. But we passed that mark sooner than almost anyone expected, and we decided to complete as many as we could by December 5, 2004. We kept careful track of per-hour productivity in different neighborhoods, temperatures, and weeks (See Appendix C). The questionnaire sometimes took an hour to complete. More typically, though, administering the survey averaged between twenty (20) to thirty (30) minutes. And by December 5, just two unfunded, highly focused, and carefully executed months after our launch, we had completed 508 surveys, with 431 undocumented respondents.

A small, select group of the outreach workers, together with the supervisors, coded all questionnaire responses for computer analyses. Because they themselves had trained and served as interviewers, they knew well potential sources of interviewer and respondent error. As they inputted, they checked and re-checked one another's work for coding and keypunch errors.

D. *Measures*

For those variables most salient to this article, here is how we defined and measured what we describe and analyze:

- **Age**. Respondents were asked their age in years. These were collapsed into three categories: 18-29, 30-39 and 40+. Respondents who were younger than 18 or who refused to provide their age were disqualified from the study.
- **Education**. Respondents were asked, "What is the highest level of education or schooling that you have completed?" If they responded "Some high school," they were prompted for whether they completed a GED. Responses were collapsed into three categories: none to 8th grade, some high school or GED, and high school graduate or more.
- **Children / Children live with you**. Respondents were asked if they have children, how many, and whether their children live with them. These responses were combined into a single variable with three

categories: no children, children but do not live with them, and children live with them.

- **Moms**. In this variable, women with children are coded "1" and all other respondents are coded "0".
- **Household size**. Respondents were asked where they live or sleep most of the time. If they answered that they live in a residence (house, apartment, rented room, etc.) they were further queried how many adults live in that house, apartment or rented room. The responses were collapsed into three categories: 1 (live alone), 2-4, and 5+.
- **Homeless**. Respondents were asked, "Have you ever been homeless?"
- **Time lived in New York**. Respondents were asked, "How long have you lived in New York?" Those who responded that they were born in New York were disqualified from the study. The rest chose from five categories: 20 years or longer, 10-19 years, 5-9 years, 1-4 years and less than 1 year. The two longest categories (10-19 years and 20 years or longer) were combined for the analysis.
- **Physical Health**. Respondents were asked, "Now thinking about your physical health, for how many days during the past 30 days was your physical health not good?" This variable is coded "1" if the response was 7 days or more, and "0" if other.
- **Mental Health**. Respondents were asked, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" This variable is coded "1" if the response was 7 days or more, and "0" if other.
- **Hunger**. Respondents were asked, "During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?"
- **Income packaging**. Respondents were asked, "During the last 6 months, did you receive any money from:" and were read a list of 8 possible sources of income. Respondents could choose multiple sources, and all responses were recorded. Responses were coded into four categories: formal employment (regular salary) only; informal employment (off the books) only; a combination of formal and informal employment; and other (street vending, public assistance, recycling, spouse's income, etc.).

- **Day Labor**. Respondents were asked, "During the past 6 months, did you work as a day laborer?"
- **Remittances**. Respondents were asked, "Do you send money to family or friends in your home country?"
- **Cultural Association (Cultural Exclusivity)**. This variable is a 5-point index constructed from answers to four questions that probed the cultural composition of "the types of people with whom you hang out." The questions they were asked are: your close friends are; you prefer going to social gatherings/parties where people are; the person you visit or who visit you are; and, if you could choose your children's friends, you would want them to be. The answers to the questions were coded "1" if the respondent answers "Almost all Mexican/Latino/Hispanic" and "0" otherwise. These were summed across all questions to create the index with a range from 0 to 4. 0 indicates a low level of Cultural Exclusivity, 4 indicates a very high level of Cultural Exclusivity.
- **Social Support**. This variable is 5-point index constructed from the answers to five questions that probed whether the respondent had one or more people available in given situations: to help you if you were confined to bed; to give you good advice about a crisis; to get together with for relaxation; to confide in or talk about your problems; to love you and make you feel wanted. The answers to these questions were coded "1" if the respondent answered "Most of the time" or "All of the Time" and "0" otherwise. These answers were summed across all questions (5 was collapsed into 4) to create the index with a range from 0 to 4. 0 indicates that the respondent has a low level of social support, 4 indicates a very high level of social support.
- **Social Support Network and Cultural Insularity combined**. This variable is constructed using K-Means Cluster Analysis to identify four groups of roughly equal size: low support, low exclusivity; high support, low exclusivity; high support, high exclusivity; and low support, high exclusivity.

For those regressions presented as part of the analyses, here is where we structured the statistical exploration:

- **Correlates of hunger among undocumented Mexicans in New York**. This is a complementary log-log regression on the dichotomous

response to the question, "During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food" (28% "Yes").

- **Health insurance regression**. This is a complementary log-log regression on the dichotomous response to the question, "In the last 6 months, were you covered by health insurance of any sort?" (10% "Yes").
- **Overall Fair or Poor Health regression**. This is a complementary log-log regression on the dependent variable "Overall Fair or Poor Health." The variable is constructed from the question, "Overall, would you say your health is excellent, very good, good, fair or poor?" Responses of "Fair" or "Poor" were coded "1" (30%) others were coded "0" (70%).
- **Correlates of Mental Health regression**. This is a complementary log-log regression on the dependent variable "Mental Health," which is a measure of the number of days in the past 30 during which the respondent felt that his/her mental health was not good, recoded into a dichotomous variable (7 or more = 1, else = 0) (17%).

IV.
SURVEY FINDINGS

A. *Comparative & Demographic Sample Profile*

1. *SELECTED DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE*

Table 1 (below) provides a rough portrait of the sample's 431 respondents. Bearing out to some degree the popular account of Mexicans in New York City (NYC), the majority of those interviewed (70%) were male. This percentage, however, does contrast with portrayals of migration being an overwhelmingly male phenomenon, as a sizable portion of our sample deviated from that supposed norm with a robust female participation and presence.

Our sample ranged across ages, demonstrating that undocumented migration can span nearly a lifetime. Most respondents were relatively young, though, with 46% of respondents between the ages of 18 and 29 and the average age as 32. Fifty-one percent (51%) of the respondents were married, while 41% reported being single and never married. The remaining 8% were either divorced (2%), separated from their spouse (5%), or widowed (1%). Most of the respondents (67%) had children,

including 83% of women and 59% of men. Overall, only 34% of respondents reported living with their children. However, the likelihood of whether or not a respondent lived with their children was heavily skewed by gender: 73% of females lived with their children, while only 16% of males did.

Household size varied. Only 6% of the respondents lived alone, while 60% lived in a household comprising two to four people, and the remaining 34% lived in a household with five or more members. Males were more likely than females to live in a household with five or more members. Thirty-eight percent (38%) of males lived in households of five or more people, while only 26% of females reported living in a household this size. Thirteen percent (13%) of the respondents were homeless, with this rate fairly consistent across both males and females.

Table 1. Selected characteristics of the sample

Variable		***n***	**%**
Gender			
	Male	301	69.8
	Female	130	30.2
Marital status			
	Single	177	41.1
	Married	218	50.6
	Divorced	9	2.1
	Separated	20	4.6
	Other	7	1.6
Have children?			
	Yes	287	66.6
	No	141	32.7
	Missing	3	0.7
Household size			
	1 (live alone)	24	5.6
	2 to 4	252	58.5
	5 or more	147	34
	Missing	8	1.9

The lowest level of education that most demographic profiles ask about and report is "less than high school education." Because of patterns of Mexican education and because of the potential importance of educational achievement, we broke the categories down into finer

distinctions. What we learned attracts attention. Sixty-eight percent (68%) of those interviewed reported eight years or less of education. Seventy-two percent (72%) of females and 66% of males never reached high school. Seventeen percent (17%) completed some high school or earned a GED. Only 15% of respondents completed high school or went to college.

Slightly more than half of the respondents have lived in NYC for more than five years. Twelve percent (12%) have lived in NYC for less than one year, 34% between one to four years, 28% between five and nine years, and 26% for 10 or more years.

Counting both formal ("on the books") and informal ("off the books") income, respondents reported a mean annual income of $8,955, with a median income of $7,071. Males and females reported a marked difference in income levels: males made a mean income of $9,930 while females earned a mean income of $5,386.

2. *Comparing the Sample to Census Data*

Whether the findings here can be legitimately generalized beyond our sample to the population of undocumented Mexicans in NYC depends upon the sampling method used. As has been described in detail in previous publications, we used a venue-based sampling method wherein we recruited participants from locations in neighborhoods where we thought undocumented Mexican immigrants were likely to be available for a sidewalk study.[67] Given the pitfalls of incorrect sampling and erroneous claims of representativeness,[68] what follows is an initial attempt to justify the claims of our inferential analyses, in comparison to

[67] Nandi, Arijit, Sandro Galea, Gerald López, Vijay Nandi, Stacey Strongarone, and Danielle C Ompad. 2008. "Access to and use of health services among undocumented Mexican immigrants in a US urban area." *American journal of public health* 98 (11) (November): 2011-20. doi:10.2105/AJPH.2006.096222; Hadley, Craig, Sandro Galea, Vijay Nandi, Arijit Nandi, Gerald López, Stacey Strongarone, and Danielle Ompad. 2008. "Hunger and health among undocumented Mexican migrants in a US urban area." *Public Health Nutrition* 11 (02) (February): 151-158. doi:10.1017/S1368980007000407.

[68] Kruskal, W, and Frederick Mosteller. 1979a. "Representative sampling, I: Non-scientific literature." *International Statistical Review/Revue* 47 (1): 13-24; Kruskal, W, and Frederick Mosteller. 1979b. "Representative sampling, II: Scientific literature, excluding statistics." *International Statistical Review/Revue* 47 (2): 111-127; Kruskal, W, and Frederick Mosteller. 1979c. "Representative sampling, III: The current statistical literature." *Statistical Review/Revue Internationale de* 47 (3): 245-265; Kruskal, William, and Frederick Mosteller. 1980. "Representative sampling, IV: The history of the concept in statistics, 1895-1939." *International Statistical Review/Revue* 48 (2) (November 9): 169-195.

similar larger-scale studies, in representing undocumented Mexicans in NYC generally despite the lack of a true probability sample

We compared aspects of our sample to one drawn from the American Community Survey (ACS)'s Public Use Microdata Samples (PUMS)[69] with characteristics similar to those used to determine our sampling frame. Two comparative PUMS samples from 2004 were selected: a national sample and a NYC sample. To be included in the sample, respondents had to be born in Mexico to parents who were not U.S. citizens, and not be naturalized citizens themselves. They had to be 18 years or older at the time of the survey. We also included a third sample from 2008 because that was the only year with a health insurance variable.

Table 2 shows the parallels and differences between our samples and the PUMS data. The average age of the undocumented Mexican population is near the mid-thirties across all the samples. Interestingly, the marriage rates between the PUMS NYC sample and our sample were strikingly close. Roughly 42% of the respondents from both the PUMS NYC sample and our sample reported being single. In contrast, the national data reports 27% of respondents as single. The national sample differed in that it contained proportionately more married and less single respondents.

An interesting pattern emerged when we examined the year of immigration. Before 1996, the PUMS NYC sample and our sample had nearly identical distributions – 19% immigrated before 1991 and 15% between 1992 and 1996. By contrast, fully 47% of the national sample immigrated before 1991, and a total of 70% immigrated before 1996. From 1997 to 2001, 40% of our sample immigrated, whereas the corresponding number for both the PUMS NYC and national data was 23%.

Our sample was notably different from the PUMS data in two areas: gender and education. The gender divide in our sample was quite different from either of the PUMS samples. In both NYC and the nation, the samples were 54% male. By contrast, our sample was 70% male. In addition, our sample was less educated than the PUMS samples. Over 80% reported less than a high school education, for instance, which contrasts with 47% and 59% in the NYC and national samples.

[69] Data was accessed through the IPUMS website (www.ipums.org) on 4-14-2011. Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010.

The variations between samples indicate key characteristics about the populations being surveyed. For instance, it appears that non-naturalized Mexicans in NYC who were included in ACS report a lower marriage rate than those nationally. This follows from the fact that the same is true between the national and NYC populations generally: in 2005, roughly 60% of the full national ACS sample reported being married, while 21% reported that they were single. By contrast, 45% of the New York City sub-sample was married and 35% single.[70] Our sample parallels the NYC demographic in this respect.

However, respondents in our sample reported living in the U.S. for shorter periods than both of the PUMS samples. Census data for NYC points out that 5% of the undocumented Mexican population has been in the U.S. for less than one year, 47% have been in the U.S. between 1-4 years, and 48% have been in the U.S. between 5-9 years. National Census figures are quite similar. The sample for our study consisted of fewer immigrants who have been in the country for more than five years, and more immigrants who have been in the country for less than a year. This indicates that we have reached a less-acculturated population than that accessed by ACS. Our sample also had a lower median income than the ACS samples, $7,071, as compared to $11,230 and $9,000 for the NYC and national populations respectively.

Table 2. Comparison between sample and national level data

Variable (%)		2004 Lopez	2004 NYC	2004 National
Age (mean)		32	33	36
Gender				
	Male	70	54	54
	Female	30	46	46
Marital Status				
	Single never married	41	43	27
	Married	51	52	64
	Separated	2	2	4

[70] Data accessed via IPUMS and tables produced online on 4-20-2011 using the marst and city variables, with age limited to 18-99 years. Dataset was ACS 2004. Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010

Variable (%)		2004 Lopez	2004 NYC	2004 National
	Divorced	5	2	3
	Widowed	1	1	2
Education				
	Less than HS	83	47	59
	HS or GED	10	33	30
	Some college	7	20	11
Formal Income				
	None or not reported	48	27	33
	1-10,000	31	16	15
	10,001-20,000	16	34	25
	Over 20,000	5	23	26
Year entered US				
	Before 1991	18	20	47
	1992-1996	15	15	19
	1997-1999	20	10	13
	2000-2001	19	11	10
	After 2001	28	44	11
	Total (*N*)	431	91	16767

Note: Totals may not add to 100% due to rounding.

B. *Evocative Findings*

Our survey's findings fall into four major categories: 1) access to health care; 2) health outcomes; 3) money; and 4) community support. The data in this survey has been analyzed elsewhere, but has been done so in thinner slices (e.g. access to and use of health services, hunger, or household density).[71]

[71] Nandi, Arijit, Sandro Galea, Gerald Lopez, Vijay Nandi, Stacey Strongarone, and Danielle C Ompad. 2008. "Access to and use of health services among undocumented Mexican immigrants in a US urban area." *American journal of public health* 98 (11) (November): 2011-20. doi:10.2105/AJPH.2006.096222; Hadley, Craig, Sandro Galea, Vijay Nandi, Arijit Nandi, Gerald Lopez, Stacey Strongarone, and Danielle Ompad. 2008. "Hunger and health among undocumented Mexican migrants in a US urban area." *Public Health Nutrition* 11 (02) (February): 151-158. doi:10.1017/S1368980007000407.

1. *ACCESS TO HEALTHCARE*

The most sophisticated literatures about public health, immigrants, and the health of immigrants stress the salience of access to health care.[72] And, characteristically, these bodies of scholarship document and analyze through the variables we used in our survey.

We examined access to health care through four areas of inquiry. We asked (1) whether the respondents were covered by any form of health insurance in the last six months, (2) where respondents usually go to see a doctor, nurse, or physician's assistant for medical care – a doctor's office or clinic, Medicaid/HMO, emergency room in a hospital, drug treatment center, other location, or nowhere, (3) whether respondents see the same person, and (4) whether respondents had been to or received care in an emergency room during the past six months.

a. *Health Insurance Coverage*

To assess prevalence of health insurance, the survey asked respondents whether they were covered by any form of health insurance over the last six months. Eighty-nine percent (89%) of our respondents lacked health insurance. To grasp how striking this number is, consider some basic comparisons: only 14% of the U.S. white population and 27% of U.S.-born Mexicans in the U.S. are uninsured.[73] By contrast, fully 56% of Mexican-born immigrants living in the U.S. and 75% of those Mexican-born immigrants who have been in the U.S. less than 10 years are uninsured.

Intriguing patterns emerge if we filter the overall results through elements central to the rival theory of undocumented Mexican migration. Using one model of analysis,[74] having health insurance was associated with living in a smaller household, having high levels of formal income and social support, and not remitting money to Mexico.[75] Interestingly, however, having health insurance was also associated with lower levels of linguistic acculturation and with a higher likelihood of having poor health limit one's activities.

[72] See *supra* notes 15, 19, and 27.

[73] Data accessed via IPUMS and tables produced online on 4-28-2011 using the hcovany, bpl, hispan and race variables, with age limited to 18-110 years. Dataset was ACS 2008. Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. Integrated Public Use Microdata Series: Version 5.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2010

[74] Model 3, Nandi et al.

[75] Nandi et al. ran a logistic regression analysis on this variable

Further analysis reveals that two additional key characteristics for predicting whether a respondent has health insurance are the person's gender and if they are living with children. In comparing respondents who had no children, respondents who had children living with them, and respondents who had children but their children were not living with them, respondents with children who lived with them were most likely to have insurance (18%), followed by those without children (11%).[76] Those who had children but did not live with them had the lowest rate of insurance (3%) among the three categories. In addition, mothers had insurance 15% of time and everyone else ("non-moms") 9% of the time, and women were more likely than men to have health insurance (17% v. 8%).[77]

Type of employment also predicted access to health insurance: Informally employed respondents were less likely to have insurance, even controlling for day laborer status. Only 4% of those respondents whose sole income source was informal had health insurance.78 Viewing health insurance coverage through both the type of employment variable and the having and living with children variable suggests that respondents with formal income whose children live with them were the most likely to have health insurance (44% and 40%) (See Table 3 below).

Table 3. Predicted rate of health insurance coverage, by type of income source and presence of children in the household.

	Type of income source				
	Other income	**Formal**	**Informal**	**Formal and Informal**	**Total**
No children	21%	13%	7%	23%	11%
Children, but do not live with me	0%	5%	2%	7%	3%
Children live with me	24%	44%	1%	40%	17%
Total	20%	21%	4%	20%	11%

b. *Sources of Care*

The survey asked where people usually seek care. Respondents could indicate a doctor, Medicaid or an HMO, the emergency room,

[76] See Appendix E, Table 6.
[77] See Appendix D, Table 14
[78] See Appendix E, Table 10

nowhere, a drug treatment clinic, or other. The small amount of drug treatment responses and non-responses were then regrouped in with the "other" responses to create a final "other" category. Figure 1 shows the two major sources of care for this sample: doctors and nowhere.

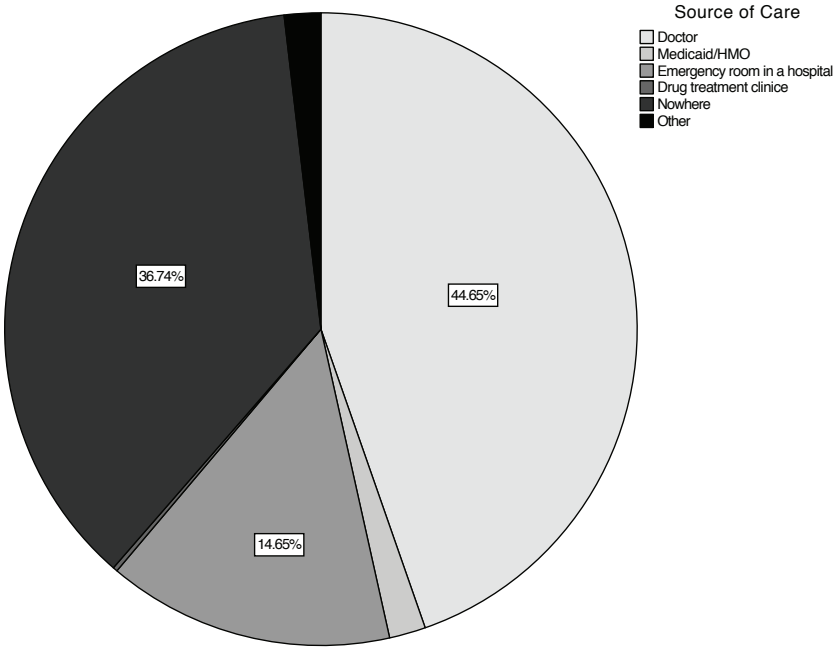

Figure 1. Primary source of care

Fully 37% of respondents answered "nowhere" when asked where they usually go to get health care[79]. This number slightly exceeds but roughly corresponds with the analyses of Mexican-born immigrants living in the U.S.[80] Adult immigrants from Mexico are not very likely to have a place they usually visit for health care and also not likely to

[79] See Appendix G, Table 1.

[80] See, e.g., Marshall KJ, Urrutia-Rojas X, Mas FS, Coggin C. Health status and access to health care of documented and undocumented immigrant Latino women. *Health Care Women Int.* 2005;26:916–936; Chavez LR, Cornelius WA, Jones OW. Mexican immigrants and the utilization of US health services: the case of San Diego. *Soc Sci Med.* 1985;21: 93–102; Berk ML, Schur CL, Chavez LR, Frankel M. Health care use among undocumented Latino immigrants. *Health Aff.* 2000;19:51–64; Goldman DP, Smith JP, Sood N. Legal status and health insurance among immigrants. *Health Aff.* 2005; 24:1640–1653.

regularly see a doctor. People without a usual place of care lack continuity of care and may face unanticipated barriers when they perceive the need to see a health care provider. Missed preventative care may increase costs in later years of delayed treatment.

Our data confirm public health's belief in the power of having health insurance. Compared to uninsured respondents, respondents with health insurance were more likely to see a doctor (64% vs. 43%) and far less likely to go "nowhere" (7% vs. 40%).[81] At least for our sample, health insurance provided the capacity for many to overcome the presumed and demonstrated barriers to care that increasingly concern epidemiologists and have proven so difficult to negotiate.[82]

Women (60%) were much more likely than men (38%) to go to a doctor.[83] Fifteen percent (15%) of women reported having gone "nowhere" for medical attention, a high percentage compared with other populations but low for our sample.[84] In comparing respondents who had no children, respondents who had children living with them, and respondents who had children but their children were not living with them, respondents who had children living with them were the most likely to have visited a doctor (58%) or emergency room (18%), while those who had children who do not live with them were the most likely to see no one (53%).[85] Consistent with the patterns about gender and about living with children, mothers were very likely to have visited a doctor (64%).[86]

Household size also offers compelling evidence with regard to health care sources, often corresponding with other data sets within this survey. Middle-sized households (2 to 4 adults) were the most likely household group to have visited a doctor (49% of middle-sized household members reported going to the doctor). Members of large households (5 or more adults) were the most likely household group to see

[81] See Appendix G, Table 18

[82] Victoria D. Ojeda and E. Richard Brown, *Mind the Gap: Parents' Citizenship as Predictor of Latino Children's Health Insurance*, 16 Journal of Health Care for the Poor and Underserved 555 (2005); Steven P. Wallace, Veronica F. Gutierrez, and Xochitl Castaneda, *Health Service Disparities Among Mexican Immigrants*" (October 2005) Center for Health Policy Research; E. Richard Brown and Hongjian Yu *Latinos' Access to Employment-Based Health Insurance,* from Latinos: Remaking America, Marcelo M. Suarez-Orozco and Mariela M. Paez, eds. (2002).

[83] See Appendix G, Table 13.

[84] *Id.*

[85] See Appendix G, Table 5.

[86] See Appendix G, Table 14.

no one (47% of large household members said "nowhere").[87] To the degree that middle-sized are "family-sized" households, we may indeed be learning about adults with children living with them, and about mothers, and about women. And if large households (with 5 or more adults) include significant numbers of crowded flop-houses of mainly men without children living with them, then household size relates to living with children and gender. In any event, household size is clearly associated with seeing a health provider.

Whether living alone, in middle-sized or large households, those who remit part of their incomes back home to Mexico were less likely to see a doctor.[88] And those who work in the informal labor market,[89] particularly those who worked as day laborers in the last six months, were less likely to have sought medical attention of any sort; in fact, fully 54% of day laborers reported going "nowhere" for medical care as opposed to 31% for those who had not worked as day laborers in the past six months.[90]

For anyone who cares about the well-being of undocumented Mexicans, solace may be found in what time lived in NYC reveals: while the use of doctors stays relatively constant throughout the time undocumented Mexican immigrants stay in NYC, respondents report a decrease in going nowhere for care the longer they stay in the city (see Figure 2).[91] According to our data, the most recent arrivals are the least likely to seek any professional help (72%) and that percentage drops significantly (46%) for those who have lived in NYC for one to four years and then drops again for those who extend their stay to five to nine years (25%) and 10 or more years (19%). Despite the barriers created by restrictive social welfare policies, undocumented Mexicans in our samples apparently learn over time how to access health care.

[87] See Appendix G, Table 7.
[88] See Appendix G, Table 11.
[89] See Appendix G, Table 10.
[90] See Appendix G, Table 12.
[91] Also see Appendix G, Table 9.

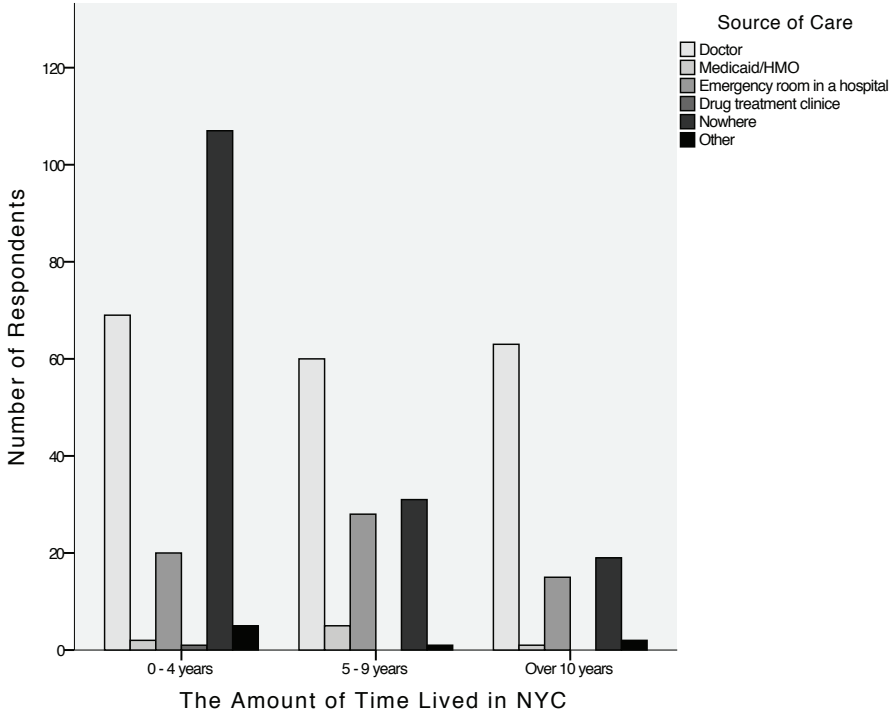

Figure 2. Primary source of care broken out by the amount of time the respondent has lived in NYC

c. *Health Provider Continuity*

The survey asked whether respondents saw the same care provider if they went to the hospital more than once in order to look at provider continuity. Our analysis found that respondents who have children living with them are considerably more likely than those not living with their children to have seen the same doctor if they reported visiting a doctor in the first place[92]. More generally, if respondents see a health care provider, there's a decent chance across categories they'll see the same one again. Still more reason, it would appear, for concern about those who reported going "nowhere" for health care.

[92] See Appendix H, Table 1.

d. *Emergency Room Care*

Over the whole sample, roughly 13% of respondents had been to the emergency room in the last six months. According to our findings, use of the emergency department was associated most significantly with recent poor physical or mental health.

Twenty-five percent (25%) of those with poor physical health (defined as self-reporting feeling physically "not good" seven or more of the last thirty days) used the emergency room compared to 11% with good physical health (defined as self-reporting feeling physically "not good" six or fewer days in the last thirty days)[93]. Twenty-six percent (26%) of those with poor mental health (defined as self-reporting feeling mentally "not good" seven or more of the last thirty days) used the emergency room, compared to 10% of those with good mental health (defined as self-reporting feeling mentally "not good" six or fewer days in the last thirty days).[94]

In addition, use of the emergency room was associated with being homeless, living alone, being older, being a high school graduate, and spending more time in NYC.[95] A higher percentage of respondents who had been homeless used the emergency room (20%) as compared to respondents who had never been homeless (12%).[96] More respondents who lived alone (21%)[97] used emergency rooms than respondents from middle-sized (13%) and large households (11%). More 40 years old and older respondents used the emergency room (18%) than 30-39 year old (13%) and 18-29 year old (11%) respondents.[98] A modestly higher percentage (17%) of those who completed their high school education used the emergency room compared with respondents who did not graduate from high school (12%).[99] Finally, we found a direct relationship between time lived in NYC and increased use of emergency rooms, with the biggest jump being between those who have lived in NYC less than one year (2%) and those who have lived there longer (13% for 1-4 years; 14% for 5-9 years; 17% for 10+ years).

[93] See Appendix I, Table 16.
[94] See Appendix I, Table 17.
[95] None of these associations reached statistical significance, however.
[96] See Appendix I, Table 8.
[97] See Appendix I, Table 7.
[98] See Appendix I, Table 1.
[99] See Appendix I, Table 2.

2. *Health Outcomes*

Consistent with well-developed and reliable research, we inquired about health in particular and overlapping ways. We examined self-ratings of overall health, physical health, mental health, and hunger in order to gain a broader understanding of health outcomes and statuses in this population.

a. *Rating Overall Health*

Data from respondents' rating of their overall health revealed some noteworthy associations. Respondents were asked to rate their overall health on a scale of 1 to 5, where 1 indicated excellent health and 5 indicated poor health.[100]

Several absorbing aspects of this variable are evident from the data. First, there appears to be a trend whereby self-rated health is more likely to be "fair" or "poor" the longer a respondent has lived in NYC.[101] As illustrated by Figure 3 below, respondents who had lived in New York longer (in the 5-9 and 10+ year categories) reported poorer health, while more recent arrivals tended towards "good."

[100] Analysis of this variable using multiple regression analysis is available in an unpublished manuscript titled Gerald P. López and Greg Reaume, *Self Rated Health of New York City's Undocumented Mexican Immigrants* (2013).

[101] An analysis of variance (ANOVA) analysis did not pick this trend up, but this is likely due to the large amount of variability in the group that has lived in NYC for 20 years or more. Collecting a larger sample can reduce this variability and potentially show an effect of time lived in NYC on health.

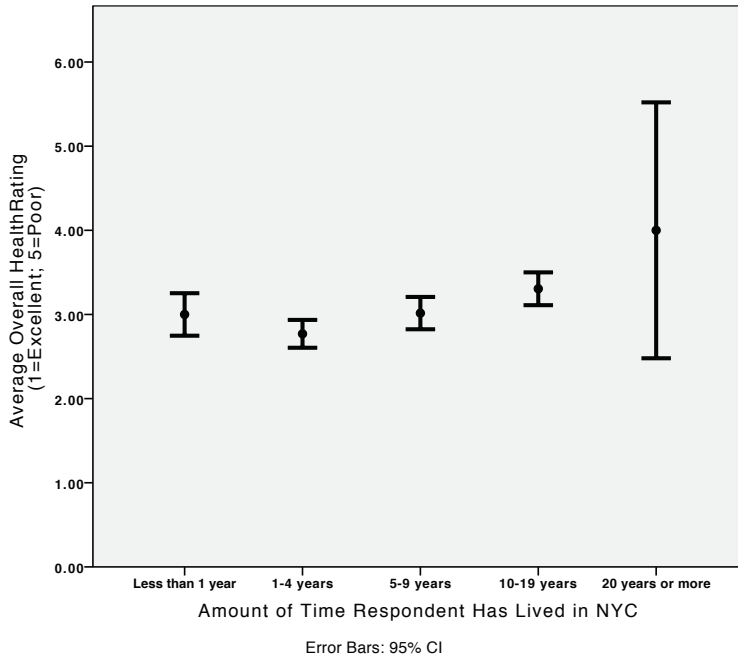

Figure 3. Average self-rated health by time spent in NYC

Second, while it might be assumed that day laborers report worse overall health than the rest of the sample given inconsistent wages, demanding physical work and likely lack of health insurance, this is not the case. Figure 4 below shows the distribution, in absolute numbers, of day laborers' responses to the overall health question. Note that there are more cases (signified by the longer bars) in the group of non-day laborers; this simply shows that more respondents are non-day laborers than day laborers. The critical thing to examine with regards to the health ratings is whether the shape of these two distributions is different. It is clear that they are not.

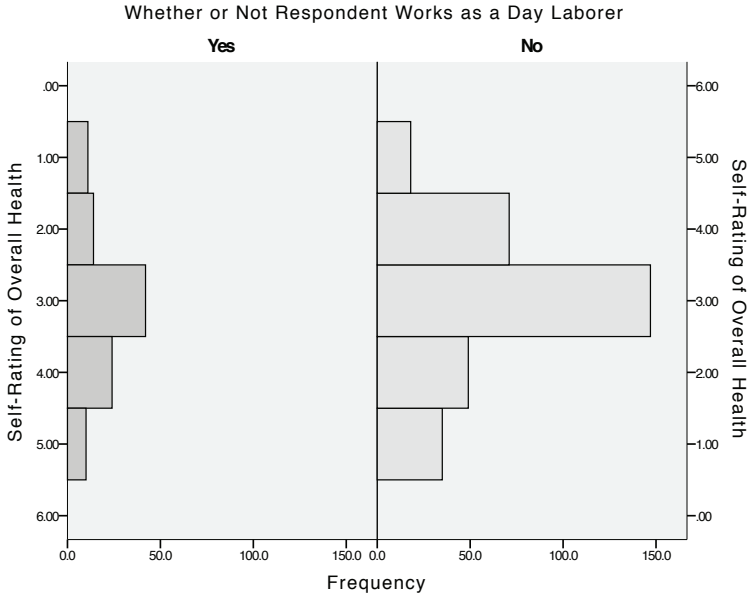

Figure 4. Distribution of ratings of health by day laborer status

While day laborers' self-rated health was no worse than that of non-day laborers', the time lived in NYC variable had an even more pronounced effect on day laborers than on non-day laborers. Day laborers' health was more likely to decline the longer they had lived in NYC as compared to non-day laborers. Table 5 provides a prediction rate for Overall Fair or Poor Health.[102] As it turns out, the predicted rate of Overall Fair or Poor Health is lowest for day laborers who are recent arrivals (6%) and highest for day laborers who have lived in NYC for 10+ years (70%). Among those who have not done day labor work in the past six months, we found a less conspicuous, although still substantial, variation between recent arrivals (28%) and longer-term residents (42%).

[102] Define prediction rate here

Table 4. Predicted rate of overall Fair or Poor health, by Day Labor status and Time in New York.

	Time in New York				
During the past 6 months, did you work as a day laborer?	**10+ years**	**5-9 years**	**1-4 years**	**Less than 1 year**	**Total**
No	42%	23%	24%	28%	29%
Yes	70%	50%	21%	6%	34%
Total	46%	29%	23%	21%	30%

b. *Physical Health & Mental Health*

We asked respondents separately about physical health and mental health, which were each recorded as the number of days in the last thirty they regarded their physical or mental health as "not good."[103]

As might be expected, those who reported higher incidence of "not good" health during the last month also reported more days of productive activity lost due to poor physical or mental health. Correlations show this relationship to be stronger for physical health than mental health.[104]

Poor physical health (defined as feeling "not good" physically seven or more of the last 30 days) correlated most notably to having health insurance and poor mental health. Thirty-one percent (31%) of those with insurance reported poor physical health, as opposed to only 14% without insurance.[105] And fully 37% of those who had reported poor mental health (defined as feeling "not good" mentally seven or more of the last 30 days) reported poor physical health, compared to 11% with good mental health (defined as feeling "not good" mentally six or fewer of the last 30 days).[106] Poor physical health also correlated to hunger and somewhat to homelessness:[107] twenty-six percent (26%) of those who had not been hungry in the last six months reported poor physical health compared to 12% of those who had not been hungry,[108] while 25% of those who had been homeless reported poor physical health compared to 14% of those who had not been homeless.[109]

[103] These variables were associated with each other as shown through their significant correlation coefficient ($r = .376, p < .0001$).

[104] Physical health ($r = .544, p < .0001$) vs. mental health ($r = .450, p < .0001$)

[105] See Appendix L, Table 17.

[106] See Appendix L, Table 16.

[107] Correlation to homelessness not statistically significant

[108] See Appendix L, Table 18.

[109] See Appendix L, Table 8.

Poor mental health correlated to poor physical health and the length of time the respondent had been living in NYC.[110] Forty-one percent (41%) of those with poor physical health reported poor mental health, while only 13% of those with good physical health reported poor mental health.[111] And the results indicate the longer a respondent had lived in NYC, the more likely he or she was to report poor mental health: while 25% of respondents who had lived in NYC 10 years or more reported poor health, only 11% of respondents who had lived in NYC less than a year and 13% of respondents who had lived in NYC between one and four years reported poor health.[112]

Translated into a prediction rate, Table 6 below illustrates that mental health, like overall health, is even more related to time in NYC (Table 23) for day laborers than it is for non-day laborers. Six percent (6%) of day laborers who had been in NYC less than one year were predicted to report poor mental health, while the expected rate among day laborers who had lived in NYC more than 10 years was 45%. Among non-day laborers the rates varied from 6% to 21%.

Table 5. Predicted rate of mental ill-health (stress, depression, emotional problems), by Day Labor status and Time in New York.

	Time in New York				
During the past 6 months, did you work as a day laborer?	**10+ years**	**5-9 years**	**1-4 years**	**Less than 1 year**	**Total**
No	21%	15%	6%	14%	16%
Yes	45%	34%	8%	6%	21%
Total	25%	20%	13%	12%	17%

c. *Hunger*

From our data, we found that 28% of the sample experienced hunger within the last six months and were unable to eat because they could not afford enough food. Hunger was most strongly associated with having been homeless, poor physical health, lacking health insurance, and having worked as a day laborer.

Forty-nine percent (49%) of respondents who had been homeless reported hunger, as compared to only 25% of respondents who had

[110] The length of time correlation did not reach statistical significance, however ($p = 0.039$).
[111] See Appendix M, Table 17.
[112] See Appendix M, Table 9.

never been homeless. Forty-six percent (46%) of respondents with poor physical health reported having gone hungry, while only 25% of respondents with good physical health did so.[113] Thirty percent (30%) of respondents who lacked health insurance reported hunger, as compared to only 11% of respondents with health insurance.

Finally, 49% of respondents who had worked as a day laborer in the past six months reported having been hungry, while only 21% of respondents who had not worked as a day laborer in that same time-frame reported hunger. Figure 5 illustrates the disparity in hunger between day laborers and the rest of the sample.

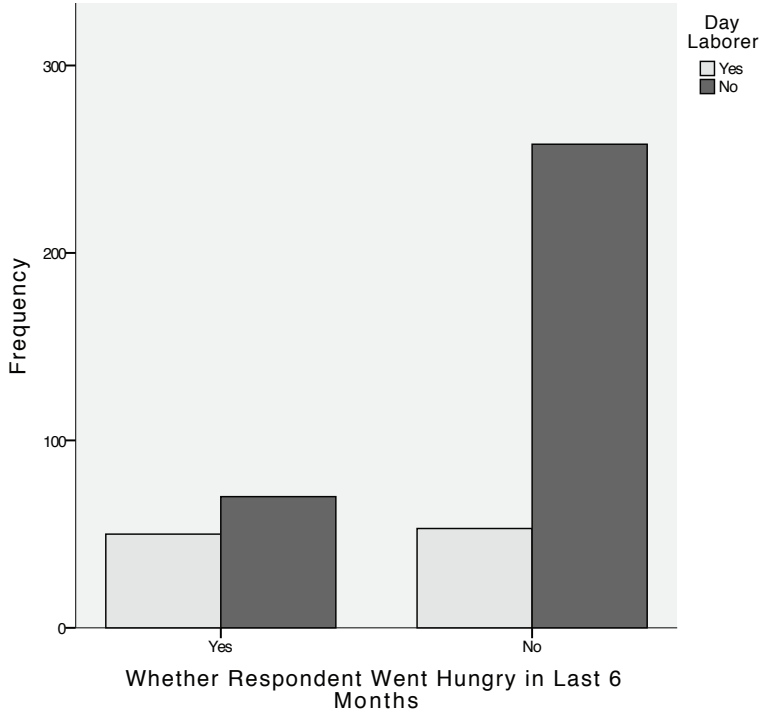

Figure 5. Frequencies of hunger by day laborer status

In the form of a prediction rate, Table 6 illustrates the strong relationship between length of time in New York City, having recently worked as a day laborer, and hunger. Among non-day laborers, hunger is negatively correlated with time spent in NYC. By contrast, day laborers

[113] See Appendix N, Table 16.

who have lived in NYC for five years or more are hungriest. The model predicts that fully 63% of day laborers who have lived in NYC for more than 10 years have gone hungry.

Table 6. Predicted rates of hunger among undocumented Mexican immigrants in NY, by Length of Time in NY and Day Laborer status.

	Day Labor		
How long have you lived in NY?	**Yes**	**No**	**Total**
Less than 1 year	50%	30%	36%
1-4 Years	40%	24%	29%
5-9 Years	53%	23%	30%
10+ years	63%	13%	21%
Total	49%	21%	28%

3. *MONEY*

As the primary impetus for the survey was to gather data about health, we asked questions touching upon both money and community, for these variables are known to influence health. With respect to money, we looked in particular at income and remittances.

a. *Income*

Respondents were asked about their level of income from both formal and informal sources. In the survey these terms were used with a common-sense connation: formal income referred to legal, taxable income, and informal to "off-the-books" income. We also asked about "other" forms of income.

Respondents in this sample did not have high levels of formal income. In fact, a large majority reported no formal income at all. Less than 10% reported a formal income above $30,000. Figure 6 illustrates the sample distribution. Although the distributions of formal and informal income were similar, proportionately more of the sample earned informal income than formal income.

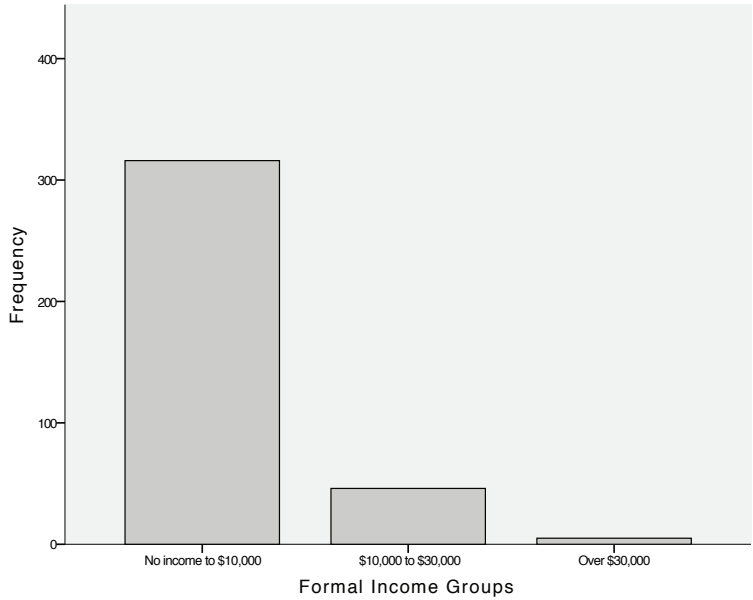

Figure 6. Bar chart of formal income distribution in the sample

Table 7 provides more detailed information and shows how many respondents reported earning no income. As the table displays, over twice as many people reported earning no formal income as compared to not earning informal income. In fact, the sample reported that more money was earned from informal income sources across all levels than from formal income sources.

Table 7. Breakdown of formal and informal income levels

	Formal	**Informal**
Income Level (n)		
Not reported	64	93
None	246	112
$1-10,000	70	135
$10,001-20,000	34	69
> $20,000	17	22

We found that men were more likely than women to have one income source – whether formal or informal.[114] Women rarely earned income from only formal sources, rather gaining income across categories

[114] See Appendix O, Table 12.

or "income packaging." Mothers participated somewhat more than other women in formal labor sectors and drew somewhat more than non-moms on "other" sources of income.[115] Income packaging appeared in various formats, perhaps to match diverse needs, opportunities, and constraints.

Earning only informal income was associated with not having health insurance, remitting, having less education, and having recently worked as a day laborer. Sixty-two percent (62%) of those without health insurance earned only informal income, as compared to 20% of those who had health insurance.[116] Sixty-two percent (62%) of those who remit earn only informal income, compared to 32% of those who do not remit.[117] Sixty-one percent (61%) of those with an eighth grade education or less earned only informal income, compared to 45% of those who had completed high school.[118] A substantial majority of day laborers (78%, compared to 52% of non-day laborers) earned only informal income, while a small minority of day laborers (7%) earned only formal income.[119]

Informal income was also associated with having children but not living with them: sixty-seven percent (67%) of respondents with children not living with them earned only informal income, compared to only 48% of respondents with children living with them.[120] Meanwhile, those with no children were more likely than those with children to have only formal sources of income.[121]

b. *Remittances*

In answering the question "Do you send money to family or friends in your home country?", respondents provided enlightening information. Table 8 shows that a large proportion (85% of the sample) did in fact remit money back to their home country.

Table 8. Proportion of the sample that remits money

Do you send money back to Mexico?	***n***	**%**
Yes	366	85
No	65	15

[115] See Appendix O, Table 13.
[116] See Appendix O, Table 14.
[117] See Appendix O, Table 10
[118] See Appendix O, Table 2.
[119] See Appendix O, Table 11.
[120] See Appendix O, Table 5.
[121] See Appendix O, Table 4.

Instructive patterns emerge when remitting is broken out by other variables, as can be seen in Table 10. The table reveals two clear differences in remitting behavior. Proportionately more men remitted than women (94% as compared to 65%[122]), and those who had children but don't live with them remitted more as compared to those who did (94% compared to 71%[123]).

Table 9. Remitting broken out by selected variables

		Do you send money back to your home country?		
Variable (n)		**No**	**Yes**	**Total**
Sex				
	Male	19	282	301
	Female	46	84	130
Day Laborer				
	Yes	5	98	103
	No	60	268	328
Children Living with Person				
	Yes	41	102	143
	No	23	261	284
Hungry in Last 6 Months				
	Yes	11	109	120
	No	54	257	311
Education				
	None - 8th grade	47	244	291
	Some HS-GED	9	66	75
	HS-Post College	9	56	65
Time in NYC				
	Less than 1 year	10	43	53
	1-4 years	15	137	152
	5-9 years	20	105	125
	10-19 years	19	76	95
	20 years or more	1	4	5

Remitting was also associated with having health insurance (87% of those with health insurance remit, as compared to 71% of uninsured respondents[124]); having formal and/or informal income rather than in-

[122] See also Appendix P, Table 12.
[123] See also Appendix P, Table 5.
[124] See Appendix P, Table 14.

come from "other" sources (only 47% of those with income from "other" sources remitted, compared to 91% or 92% of respondents with formal and/or informal income[125]); and not being a mother (93% of non-moms remitted, compared to 61% of moms[126]).

Over time, respondents continued to remit at a high rate. Generally respondents remitted at about 82% no matter how long they have lived in NYC, with the exception of those who lived there between 1 and 4 years. This group remitted at 90%, perhaps because enough time had passed to find employment, but not so much time that the relationships with those in their home country were attenuated or replaced by new social contacts in NYC.

After examining the proportions above, we decided to run a logistic regression model with gender, hunger and whether a child lives with the respondent as independent variables.[127] We found that gender accounted most prominently for remitting behavior (see Table 10).

Table 10. Logistic regression with remitting as the dependent variable

Logistic Regression	B	S.E.	Exp(*B*)
Constant	2.01	0.25	7.44
Gender	-1.88	0.50***	0.15
Hunger	0.45	0.37	1.57
Child in home	-0.23	0.45	0.79
Child by Gender	-1.38	0.90	0.25
Hungry by Gender	0.54	0.75	1.72

*** $p < .0001$; $\chi^2 = 64.31$***; $N = 427$ (4 missing cases)

4. *Community*

Our rival theory of undocumented Mexican immigration led us to ask questions that we anticipated would help us understand how living arrangements, friendships, and support systems interact with health

[125] See Appendix P, Table 10.

[126] See Appendix P, Table 13.

[127] The dependent variable, of course, was whether the respondent sent money back home. The full model represented the data significantly better than the null model, $\chi^2 = 64.31$, $p < .0001$. When considered alone (*i.e.,* not controlling for gender), chi-square tests show that both hunger and whether a child lives with the respondent influence the amount of remitting behavior ($\chi^2 = 4.54$, $p = .033$ and $\chi^2 = 31.59$, $p < .0001$ respectively). As shown by this model, however, gender accounts for these effects. We examined interaction effects for gender with each of the other variables, but neither was significant.

outcomes, access to health services and regular access to food. We focused on two separate categories, what I call "cultural exclusivity" and "social support."

a. *Cultural Exclusivity*

An element that may be relevant to health is the extent to which undocumented Mexicans associate with other Hispanics, as opposed to non-Hispanics. Cultural exclusivity reflects how homogeneous a person's friends are; the more a respondent associated with only Mexican and Hispanic friends, the higher cultural exclusivity score a person received. We expected that people in our sample would report associating most often with other Latinos, both because of cross-national networks and also because of how much easier it is to integrate into an in-group than an out-group.

To determine the degree of cultural exclusivity, we asked about "the types of people with whom you hang out." To examine this idea, we asked four questions. Respondents chose between 1 of 5 different levels for their response, where one end of the response scale indicated all Mexican or Hispanic and the other end indicated none of these. The four questions were:

1. Your close friends are. . .("All Mexican/Some Mexican/No Mexican. . ." etc.)
2. You prefer going to social gatherings/parties where people are. . .
3. The persons you visit or who visit you are. . .
4. If you could choose your children's friends, you would want them to be. . .

The answers for these survey questions resulted in an interesting pattern. The first three questions were highly correlated and have similar distributions when plotted, but the last has a different distribution. The two bar charts below (Figure 7 and Figure 8) give a sense of this difference. Figure 7 is typical of the distribution of responses from the first three questions. Figure 8 is the distribution of responses to the last question. This shows that although respondents generally preferred to associate with people of similar backgrounds, they hoped that their children would mix with others more than they did.

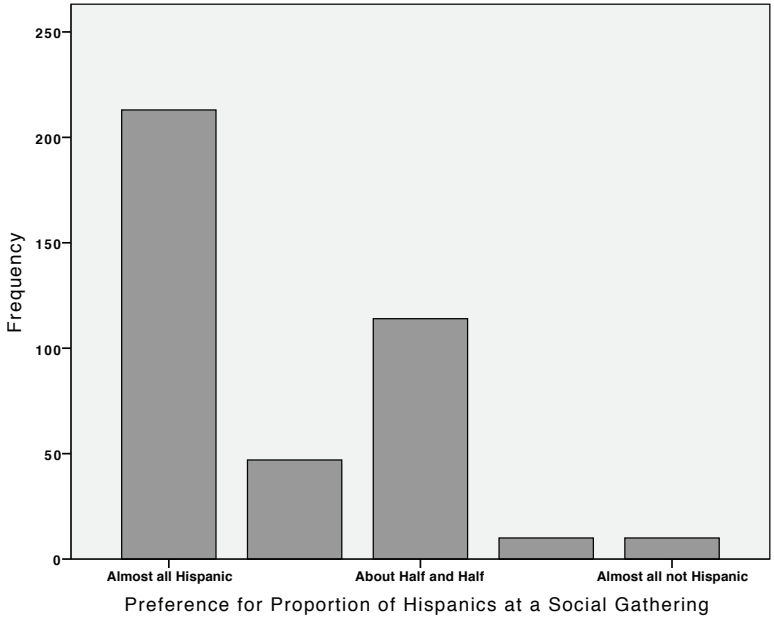

Figure 7. Distribution of preference for social gatherings

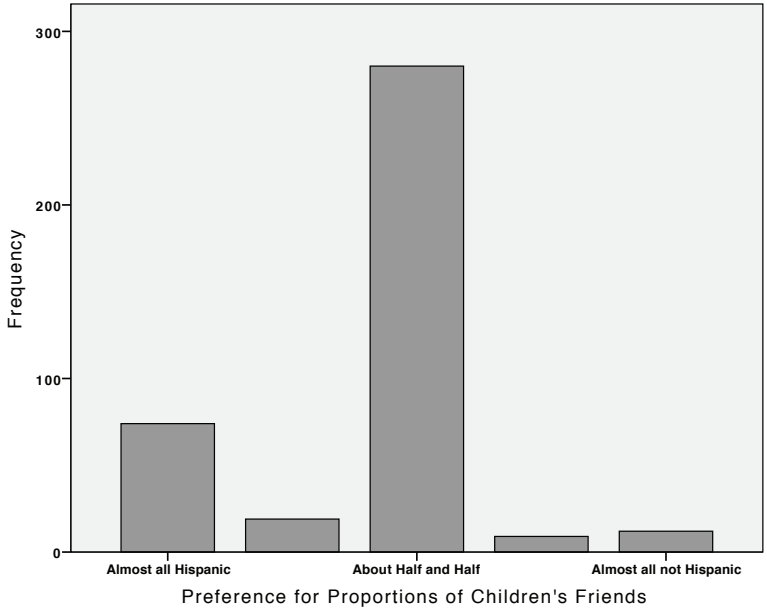

Figure 8: Distribution of preferences for children's friends

As can be seen in Table 11 below, strong relationships exist between each of the first three variables. However, this is not the case with the interactions between the last variable, which asks about their children's preferred characteristics, and the first and third variables, which ask about close friends and visitors, respectively.

Table 11. Correlations between acculturation variables

	Friends	**Social**	**Visits**	**Children**
Friends	1	0.000***	0.000***	0.434
Social	0.397	1	0.000***	0.000***
Visits	0.356	0.351	1	0.074
Children	0.038	0.191	0.086	1

* $p < .05$, ** $p < .01$, *** $p < .0001$. *Note:* Spearman's *rho* analysis indicated that "Visits" and "Children" were also correlated.

Given the strong relationship between the first three variables, we used them to create a score that reflects the respondent's degree of cultural exclusivity. To create the cultural exclusivity score, we summed the response values across the three variables. This results in a variable that can range from 3 to 15. A score of 3 indicates that the person associates exclusively with Mexican, Latino or Hispanic people, whereas a score of 15 indicates that the person associates exclusively with non-Mexican, non-Latino, or non-Hispanic people. A plot of the resulting score shows that the sample tends to associate primarily with other Mexicans, Latinos or Hispanics (see Figure 9).

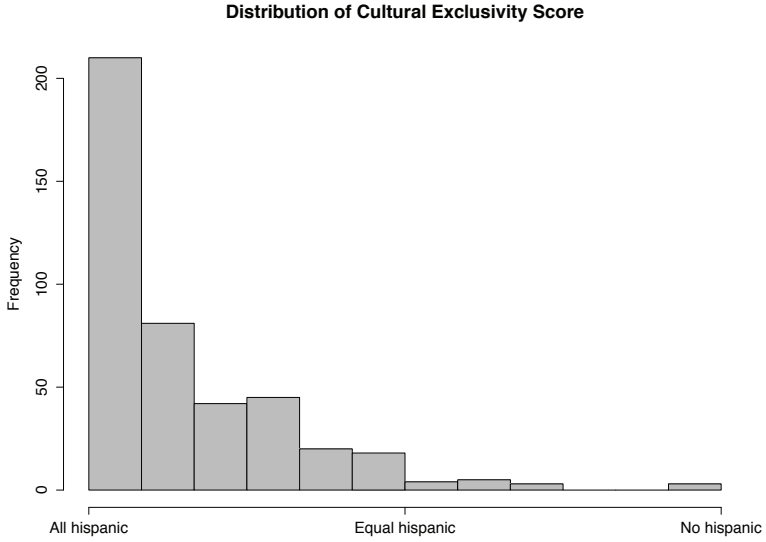

Figure 9. Histogram of cultural exclusivity score

Many things might influence the cultural exclusivity score, and this concept needs further exploration. Interestingly, a regression model with education, marital status, homelessness, and the amount of time the person has lived in NYC explained very little variance in cultural exclusivity.[128]

We did find that cultural exclusivity was positively correlated with the lowest income levels[129] and the lowest education levels.[130] Also, those who live in large households also associated more exclusively with other Mexicans and Latinos.[131]

To check whether the degree of cultural exclusivity influences the level of social support, we ran a regression with it as the independent variable and their social support score (see below) as the dependent

[128] This may have been because of the shape of the dependent variable's distribution. We did run a Box-Cox transformation, but it was not enough to adequately normalize it and the model fit poorly. A better model would utilize ordinal regression on one of the first three variables to get at the influences on acculturation

[129] See Appendix Q, Table 9.

[130] See Appendix Q, Table 2.

[131] See Appendix Q, Table 7.

variable.[132] We found no relationship between reported level of social support and cultural exclusivity.

b. *Social Support*

We also examined social support because of its importance to longevity and good health. Like data about cultural association, answers to these inquiries reveal important qualities about another central network in life. To determine levels of social support, we asked five questions that examined whether the respondent had one or more people available in various situations, from which we created a new variable.

1. To help if the respondent was confined to bed
2. To give the respondent good advice about a crisis
3. To get together with for relaxation
4. To confide in or talk with respondent about problems
5. To love the respondent and make them feel wanted

The response values ranged from 1 to 4, with 4 indicating the most social support. The variable we created simply summed all of the response values.[133] The graph below shows the distribution of the social support score.

[132] Similarly, a chi-square test on the variables after they were re-scaled to match the original variables revealed no relationship between them ($\chi^2 = 10.34$, df=12, $p = .57$).

[133] Summing the response values across the five variables results in a new variable with a range from 5 (low support, because the respondent answered "1" to all five variables) to 20 (if all five variables contained a "4" response), A similar variable was constructed by both Nandi et al (2007) and Hadley et al (2008). Both created a three-category variable by dividing the summed responses to the five questions above into categories of low, medium and high. However, Hadley's cut-points resulted in fewer people in the high social support category than Nandi's (68 versus 122).

Exclusion of respondents with responses outside of 1 to 4 left 409 respondents for each question, which equals the number in our study. We were pleased to find that the item-total correlations were generally strong, ranging from $r = .625$ to $r = .807$ with $p < .01$ for each variable's correlation with the new variable. This indicates that the questions tap a similar construct, which we call social support. Although this item technically does not constitute a social support scale (see Trochim, William, and James Donnelly. 2008. *The Research Methods Knowledge Base*. 3rd ed. Mason: Atomic Dog: Cengage Learning.rochim and Donnelly 2008), this study can be considered a first step along developing such a scale for this population – something that future research should take up.

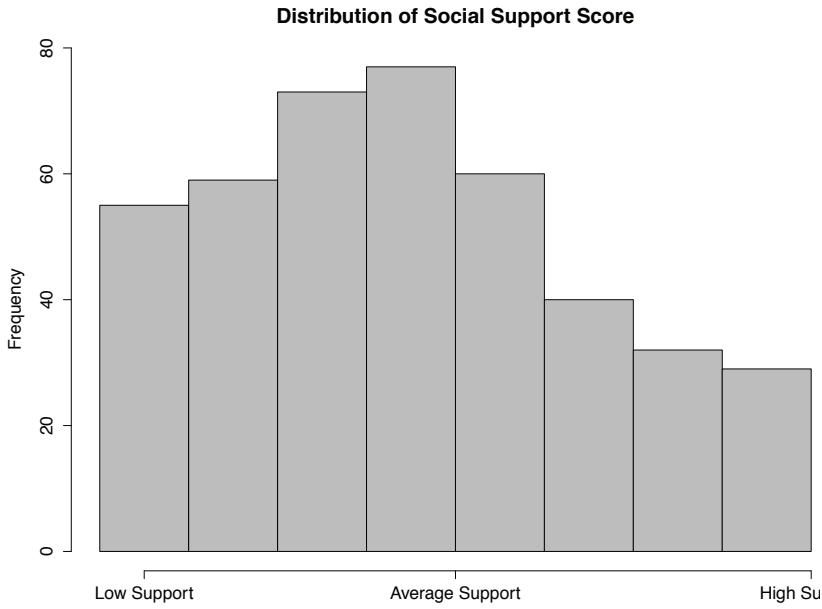

Figure 10. Distribution of social support variable

Table 12 gives the averaged social support score for different sub -groups within the data. Support was stronger for women than for men[134], stronger for those living with their children than those living without their children[135], and correlated positively with length of time in NYC, except for those living in NYC more than 10 years, who appeared to experience a decline in strong social support.[136] These exceptions aside, however, there was not a large amount of variation in this score across these sub-groups.

[134] See also Appendix R, Table 14.
[135] See also Appendix R, Tables 6-7.
[136] See also Appendix R, Table 10.

Table 12. Average social support score for different sub-groups in the sample

	Average Social Support Score
Variable	
Gender	
Male	11
Female	13
Marital Status	
Never Married	11
Married	12
Other	12
Education	
None - 8th grade	11
Some HS-GED	12
HS-Post College	12
Children Living with Person	
Yes	13
No	11
Formal Income	
Not reported	10
None	12
1-10,000	11
10,001-20,000	12
>20,000	14
Formal Income	
Not reported	11
None	11
1-10,000	12
10,001-20,000	12
>20,000	13
Remit Money	
Yes	11
No	13
Homeless in Last 6 Months	
Yes	11
No	12

The midpoint of the social support variable's range was 12.5, but the mean score for the sample was 11.32. We ran a single sample t-test to analyze whether the group's mean as a whole differed from this score.

Interestingly, the group scored significantly lower than the mid-point of the range, $t = -5.08$, $p < .0001$. If the mid-point of the range is taken to indicate an average level of social support, this shows that the sample reports a low level of social support in comparison to that mid-point mark.

In order to summarize the effects of other variables on social support, we ran a backward step-wise regression, with the initial independent variables being gender, whether a person's child lives with them, amount of time in NYC, formal and income formal income levels, and whether the person worked as a day laborer.[137] We reached two conclusions from our analysis. First, respondents' having a child who lives with them strongly predicted reporting stronger social support.[138] Second, day laborers reported less social support than their peers in the sample.[139] Finally, to explore the relationship between social support and cultural association networks, we compared the two. We put together four groups of roughly equal size: low support, low exclusivity; high support, low exclusivity; high support, high exclusivity; and low support, high exclusivity. We found that the two variables were uncorrelated.[140] Interestingly, however, education, having health insurance, and length of time in New York all corresponded with higher social support but lower cultural exclusivity.

V.
Coming Full Circle

What should these findings suggest about how we should think and what we should do about healthissues for undocumented Mexicans in New York City? The answer may well be very little or even nothing at all. The sample is limited and flawed. Even if we regard the sample as adequately representative, we're still only in preliminary stages of analyses. Different patterns may emerge – more salient, more significant – than what we have been able to discern and scrutinize to date. Or they may not. After all, even well-intentioned and earnestly pursued efforts to learn more may end up revealing terribly little of consequence.

[137] This type of regression starts with all variables in the model, and then progressively cuts out the weakest predictors until the most parsimonious model is achieved. The final model explained the data significantly better than the mean of social support alone, $F = 10.26$, $p < .0001$, and explained roughly 7 percent of its variance, $R^2 = .069$.

[138] See also Appendix R, Tables 6-7.

[139] See also Appendix R, Table 13.

[140] r =.00, p = .93

And, yet, how can we help but speculate? What if one of the evocative patterns captures something important? Not important as in "a big idea" around which all else revolves. Important as in it could improve the lives of undocumented Mexicans in New York City. Yes, improve most likely in ways that may well, at once, feel minor to many of us and yet notably better the health of tens of thousands of immigrants. And in the course of boosting the physical and mental health of some in New York City, we could enhance the lives of an extended family dependent upon the well-being of someone who from thousands of miles away routinely sends home survival money. And, at the same time, we could make better the lives of those who live and work with undocumented Mexicans in New York City.

Perhaps prematurely then, and certainly provisionally, let's for a moment wonder about what we have learned. Take hunger, for example. We already knew that hunger remains a big problem in this country and that the rate of hunger is higher for Latinos and African-Americans.[141] Here's the kicker, though: in the language of public health specialists, we already knew, too, that hunger is a specific and modifiable risk factor.[142] Unlike other outcomes and determinants of poor health (say, poverty), we can do something immediately about hunger. And since hunger is so strongly associated with physical and mental health, a wise intervention likely will have cascading effects.

From our study, we now know something about hunger among undocumented Mexicans in New York City. Fully 28% reported going hungry in the last six months, a large number in absolute and relative terms. And hunger cuts across the undocumented Mexican population – across educational achievement, household size, gender, and marital and parental status. While we should wonder about each segment of the population, let's focus momentarily on the most severe case: day laborers. Not only are day laborers the hungriest of undocumented Mexicans, but also fully 63% of those day laborers who have lived in New York City for more than a decade have recently gone hungry. And those who

[141] See generally, Mark Nord, Margaret Andrews, Steve Carlson. HOUSEHOLD FOOD SECURITY IN THE UNITED STATES, 2005. Economic Research Service, U.S. Department of Agriculture (2006); David Barton Smith, *Racial and Ethnic Health Disparities And The Unfinished Civil Rights Agenda,* 24 Health Affairs 317 (2005).

[142] The public health literature about hunger – cast in terms of the continual food insecurity to food insufficiency – provides ambitious illustrations of such analyses and interventions. See e.g., Katherine Siefert, *Social and Environmental Predictors of Maternal Depression in Current and Recent Welfare Recipients*, 70 *American Journal of Orthopsychiatry* 510 (2000).

have been hungry report significantly higher percentages of physical and mental health problems.

The usually uneven and even dangerous nature of day labor draws our attention. Indeed, we should pay acute attention to understanding day labor markets and examining alternatives for normalizing standards of health and safety and wages and hours.[143] But if day labor can be fairly said to have a high association with hunger among undocumented Mexicans (49% have gone hungry recently), the possible back-story may be even more riveting. Disproportionately filling the demand for day labor are those who have children who do not live with them in New York City. They do so, our data says, in order to regularly send money back home (95% of day laborers remit). And they honor the commitment, however complex and even contradictory the motivations.[144] In doing so, they appear to be trading their well-being for household survival.[145]

Obviously public policy officials might want to think again, for example, about the availability and structure of food assistance programs if for no other reason than to improve health outcomes. And those at the local and state level, as much as Congress, ought to regard the question as central to wise governance. Perhaps in the City and State of New York, such an exhortation would not be entirely fanciful. Meanwhile, though, I wonder whether another intervention might not even more immediately target the problem of hunger among undocumented Mexican day laborers. The government agencies, community-based organizations, and

[143] See e.g., Abel Valenzuela, Theodore N, Meléndez E, Gonzalez AL. On the Corner: Day Labor in the United States. On The Corner: Day Labor in the United States. UCLA, Center for the Study of Urban Poverty (2006); Paula Worby, *Occupational health and Latino migrant day laborers: a preliminary exploration, January 2002 (revised version)* 1 *ILE Conference UC Santa Cruz* (On File With Author).

[144] For the genre of recent remittance literature addressing motivations for and impact of sending money home, see e.g., Marianno Sana and Douglas S. Massey, *Household Composition, Family Migration, and Community Context: Migrant Remittances in Four Countries*, 86 Social Science Quarterly 509 (2005); Ernesto López-Córdova, *Globalization, Migration, and Development: The Role of Mexican Migrant Remittances,* Economia 217-256 (Fall, 2005); Catalina Amuedo-Dorantes, Cynthia Bansak, and Susan Pozo, *On the Remittig Patterns of Immigrants: Evidence from Mexican Survey Data,* Economic Review 37 (2005). Work on the new behavioral economics presents, in various forms, an alternative set of assumptions to neo-classical claims, all of which traces its origins to the work of Herbert A. Simon. See e.g., *A Behavioral Model of Rational Choice,* 69 Quarterly Journal of Economics, 99 (1955).

[145] Examples of such trade-offs pervade immigrant life. For analysis of how immigrants cope in the New York City housing market, see Michael H. Schill, Samantha Friedman, Emily Rosenbaum, *The Housing Conditions of Immigrants in New York City*, 9 J. Housing Research 201 (1998).

health facilities whose mission revolves around hunger might well want to build an outreach campaign through networks not typically central to their efforts.[146] Food pantries and emergency kitchens, for example, could reach out to the Office of the State Attorney General and various community-based organizations (including the Center for Community Problem Solving) that regularly work with day laborers and can map day labor sites across the boroughs. In a coordinated fashion, and with the help of the characteristically cooperative Spanish-language media, diverse organizations and institutions could target food, information, or both to large numbers of undocumented Mexican (and other) day laborers. By manufacturing a "weak tie" between social networks, everyday outreach practices might well effectively reach undocumented Mexican day laborers and all with whom they connect.[147]

Or let us wonder about those undocumented Mexicans who live with their children in New York City. Overwhelmingly, these respondents are women and on many fronts they report doing better than their *paisanos*. Especially compared to those who do not have their children living with them, they far less often go "nowhere" for health care (21% compared with 58% of those without children living with them) and reported significantly better access to doctors and others health providers (58% see doctors compared with 21% of those without children). They feel better overall and lose fewer days than non-mothers and men due to poor physical and mental health. They reported being less hungry than men. And they described themselves, at least relative to other respondents, as having strong social support.

So well do these women present such positive characteristics that we might well find ourselves bewildered by but pleased about what is going on. In conversational speculation, health officials underscore that these women may have better health care then men because of obstetric

[146] See generally, James Ohls, Fazana Saleem-Ismail, Rhoda Cohen, and Brenda Cox, *The Emergency Food Assistance System Study—Findings from the Provider Survey, Volume II: Final Report.* (2002) FANRR-16-2, prepared by Mathematica Policy Research, Inc., for USDA, Economic Research Service. Available at: www.ers.usda.gov/publications/fanrr16-2.

[147] Diverse literatures address and explore social networks, employing different rhetorics and methodologies. For the origins of "weak ties," *see* Mark S Granovetter, *The Strength of Weak Ties,* 78 Am. J. Soc. 1360 (1973). For analytical exploration of public service organizational networks and participant levels, *see e.g.,* H. Brinton Milward & Keith G. Provan, *How Networks Are Governed, in* Governance and Performance: New Perspectives 238 (Carolyn J. Heinrich & Laurence E. Lynn, Jr. eds., 2000); Keith G. Provan & H. Brinton Milward, *Do Networks Really Work?: A Framework for Evaluating Public-Sector Organizational Networks,* 61 Pub. Admin. Rev. 414 (2001).

and gynecological (OB/GYN) needs. Or, as part of the changes in migration patterns that the rival theory would have predicted, these mothers living with their children may have followed their husbands and benefited from already established homes and networks. Plausible as each supposition may be, we do not know the answers. In fact, we historically have not asked such questions having not, until very recent years, studied undocumented Mexican women, much less focused upon those who have their children living with them in urban areas like New York City.[148]

Still, why do these women do better? Perhaps they gave birth here. Childbirth and post-natal care qualify in New York City as exceptions to the ban on health services.[149] But citizen children do not qualify their mothers for continuing health care. So what have these women done? Find non-governmental clinics that offer regular care? Find doctors who provide pro bono services? And through what networks have they gained such social capital? Do they connect through their children's school populations? Through faith-based institutions? How do the relatively recent networks through which they operate in New York City compare to the far more mature networks of a place like Los Angeles?

Answers to these questions matter, certainly, in grasping how these women manage. Perhaps as importantly, these women possess practical know-how – transmitted effectively through webs of social relations – that might well qualify as a form of "best practices." Studying seriously how they help themselves and one another would perhaps provide examples about how other undocumented Mexicans in New York City might better deal with health-related concerns; this recognizes the valuable knowledge in the Center's and CUES vision of problem solving traveling in every which direction.

[148] For valuable explorations of gender and household dynamics reflecting and shaping the migration process, see e.g., Khiya Marshall, Ximena Urrutia-Rojas, Francisco Soto Mas, Claudia Coggin, *Health Status and Access to Health Care of Documented and Undocumented Immigrant Latino Women,* 26 Health Care for Women International, 916 (2005); Emiliano A. Parrado, Chenoa A. Flippen, Chris McQuiston, *Migration and Relationship Power Among Mexican* Women, 42 Demography 347 (2005); Marcela Cerruti and Douglas S. Massey, *On the Auspices of Female Migration from Mexico to the United* States, 38 Demography 187 (2001); Emilio A. Parrado, and René Zenteno, Economic Restructuring, Financial Crises, and Women's Work in Mexico, 48 Social Problems 456 (2001); Sharon McGuire, Crossing Myriad Borders: A Dimensional Analysis of the Migration and Health Experiences of Indigenous Oaxacan Women (Ph D Dissertation 2001).

[149] Tanya Broder, *Immigrant Eligibility for Public Benefits* [Reprinted, with permission, from Immigration & Nationality Law Handbook 759 (2005–06 ed.)]

The considerable ingenuity we can readily imagine should not obscure that women who live with their children in New York City endure huge health problems. If these women often do better than others (especially those who are not living with their own children in New York City and men and non-moms), that does not at all mean that, compared to other populations, they do not struggle mightily. Fully 82% do not have health insurance – and their reports of physical and mental health problems would scare almost everybody else. Worse still, what these mothers experience inevitably relates to what their children bear.[150] And since these women are not in the short-run likely to secure jobs in the formal sector, government provides the most obvious answer to the desperate need for health insurance. If California can seriously consider ways of insuring undocumented immigrants, can it be beyond New York?

And finally, on this illustrative list, I wonder about the fact that our data reveals that length of time in New York is positively correlated with fair or poor health. Undocumented Mexicans who live in New York longer reported poorer health than those who arrived more recently. This is true controlling for day labor, income, age and the presence of children. The predicted rate of overall fair or poor health is lowest for day laborers who are recent arrivals (6%) and highest for day laborers who have lived in New York for 10+ years (70%). Among those who have not done day labor work in the past 6 months, a less eye-catching yet still notable variation emerges between recent arrivals (28%) and longer-term residents (42%).

We might well join others in exploring aspects of *Mexicano* culture that may serve to keep health problems within family, kinship, and friendship networks. Could *confianza, familismo, respeto* each contribute in some way to better health in earlier years and worsening outcomes over time? Or could adaptation to health-seeking behaviors of those in New York City explain our findings?[151] Certainly our results may represent a cohort effect. More recent arrivals to NYC may happen to be healthier than earlier undocumented migrants. Or perhaps undocumented Mexicans will turn out to have varied distribution of health

[150] See generally, Kathy L. Radimer, and Mark Nord. 2005. "Associations of Household, Adult, and Child Food Security with Health Conditions: National Health and Nutrition Examination Survey (NHANES) 1999-2002," presentation at the Experimental Biology annual research conference San Diego, CA, March 31-April 5, 2005.

[151] For coverage of such questions, see generally Thomas A. LaVeist, MINORITY POPULATIONS AND HEALTH: AN INTRODUCTION TO HEALTH DISPARITIES IN THE UNITED STATES (2005).

risks (lower rates of immunization, higher prevalence of hypertension, poor quality water and air) and protective factors (diet, rates of smoking, community support).

But shouldn't we investigate still another possibility? Are we witnessing complex dynamics perhaps below the level of cognition? In the beginning, do undocumented Mexicans arriving in New York City merely "lump it" when they feel ill? Without knowledge about how to access care, without any appreciation that they are permitted to be "sick," perhaps they never even note illness. Certainly a parallel phenomenon has been identified in law, where the very process of grieving first requires that someone actually name an injury.[152] Time may not always bring undocumented Mexicans in New York City much comfort and may indeed prove particularly harsh for those women and men who remain singularly or principally in the informal labor market, particularly working as day laborers. Perhaps as strain magnifies over time what they do as part of contributing to transnational survival is learn to label how they feel. And it's not well.

In a broader sense, this all circles back to the two dominant theories of undocumented Mexican migration. The prevailing theory may dictate that all of the health issues here are simply an aspect of the undocumented immigration "problem" – a symptom of a larger, nationwide disease that our lawmakers could do well to just sweep under the rug. But my rival theory would suggest otherwise. In fact, it'd scream for a polar opposite approach. We *should* care about this precisely because, documented or not, immigrants play a prominent, vital role in our communities and everyday lives as fellow people, regardless of their legality. Overlooking their problems only exacerbates the issues at hand, leading to a general lack of awareness, more widespread instances of poor health in immigrant populations, and, most regrettably, thereby feeding into and perpetuating the ignorant attitudes that prop up the prevailing theory. One can only hope that studies such as ours will open more eyes, steadily and effectively, one data set at a time.

[152] For early literature initiating and developing this idea in law, *see e.g.,* William L.F. Felstiner, Richard L. Abel & Austin Sarat, *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming*., 15 LAW & SOC'Y REV. 631 (1980-1981); David M. Trubek, Joel B. Grossman, William L.F. Felstiner, Herbert M. Kritzer & Austin Sarat, Civil Litgation Research Project Final Report (1983); Kristin Bumiller, The Civil Rights Society (1988). For one example of my own contributions to this line of thinking, *see* Gerald P. López, *The Work We Know So Little About*, 42 Stan. L. Rev. 1 (1989).

CONCLUSION

For far too long, too many in New York City have acquiesced in institutional arrangements and problem solving practices that neglect learning about the health of undocumented Mexicans. For far too long, too many in this nation have permitted policy makers to continue to see undocumented Mexican migration through the distorted lens of the prevailing theory. For far too long, too many have let inertia – and perhaps justifications about ourselves and the systems of which we are a part – stand in the way of altering how we approach working together. In gathering evidence through this small-scale sidewalk study, and in analyzing and sharing it over time, the Center and CUES mean to focus attention on how much more we must learn about both the health of undocumented Mexicans and a way of working together that aims at once to be more democratic, knowledge-based, and effective than what has come to feel perhaps natural and unchangeable.

[See Accompanying Document For Appendices]

TABLE OF CONTENTS

Appendix A1

CENTRO PARA RESOLVER PROBLEMAS EN SUS COMUNIDADES

UNIVERSIDAD DE NEW YORK
Una universidad privada que ofrece servicios públicos
245 Sullivan Street
New York, New York 10012-1301

Gerald P. López
Director y Profesor de Derecho
Teléfono: (212) 998-6469
Fax: (212) 995-4031
Correo electrónico: lopezg@juris.law.nyu.edu

ESTUDIO SOBRE LA SALUD DE INMIGRANTES MEXICANOS
RESUMEN DEL PROYECTO

Favor de marcar una de las siguientes:
☐ Participante prefiere leer este Resumen del Proyecto él/ella mismo.
☐ Participante prefiere que la persona haciendo la entrevista le lea el Resumen del Proyecto.

***Si usted conoce la persona que le está haciendo la entrevista puede pedir otro entrevistador para que su privacidad quede completamente protegida.*

Ha sido invitado a tomar parte de un estudio para saber más acerca de inmigrantes Mexicanos y su salud. Este estudio será conducido por el Centro Para Resolver Problemas En Sus Comunidades de la Universidad de New York y por el Centro de Estudios Urbanos de Enfermedades de la Academia de Medicina de New York.

Este estudio no tiene nada que ver con los Servicios de Migración y Naturalización (INS o Migra), que ahora se conoce como Servicios de Ciudadanía y Migración de los Estados Unidos (USCIS).

Si usted acepta ser parte de este estudio, le haremos preguntas durante una entrevista en persona. La entrevista dura aproximadamente 20 minutos y está compuesta de dos partes principales:

1. En la primera parte le haremos preguntas de su salud física y mental, el acceso que tiene a cuidado médico, y de su experiencia como inmigrante.
2. En la segunda parte le haremos preguntas de otras experiencias, como con la discriminación, proceso de aculturación, y apoyo social.

Nosotros queremos que usted sepa de los riesgos que existen al participar. Debido a que algunos temas del cuestionario son de naturaleza personal y sensible, puede ser que algunas de las preguntas le parezcan difíciles de contestar. En tal caso, puede hablar con el entrevistador acerca de cómo se siente usted o puede ser dirigido a un consejero.

Aunque no recibe ningún beneficio directo, al participar en nuestro entrevista, usted nos ayudará a entender mejor las necesidades de inmigrantes Mexicanos como usted. La información que obtengamos se usará para crear y mejorar programas que ayudan a inmigrantes Mexicanos. Además, podemos dirigirlo a un lugar donde conseguir servicios sociales y servicios médicos si usted los necesita.

El entrevistador le ha explicado este estudio y ha respondido sus preguntas. Si usted tiene preguntas adicionales o desea reportar un problema relacionado con este estudio, puede comunicarse con Michelle Fei al (teléfono) 212-998-6453, (correo electrónico) michelle.fei@nyu.edu, o (dirección) 245 Sullivan Street, New York, NY 10012 o con Gerald P. López al (teléfono) 212-998-6469, (correo electrónico) gerald.lopez@nyu.edu, o (dirección) 245 Sullivan Street, New York, NY 10012. Si tiene preguntas sobre sus derechos como participante de un estudio, usted puede comunicarse con el Comité Universitario de Actividades Relacionadas con Personas Que Participan En Estudios, Oficina de Programas Patrocinados, Universidad de New York, 212-998-2121.

La participación en este estudio es voluntaria. Usted se puede negar a participar o puede salirse de la entrevista en cualquier momento sin ninguna consecuencia negativa. Usted tiene el derecho a saltarse o no responder cualquier pregunta que prefiera no responder.

La información que usted nos dé para este estudio se mantendrá estrictamente confidencial. En ningún momento le pediremos su nombre. No tenemos manera alguna de establecer una conexión entre su nombre y sus respuestas ya que se haya terminado la encuesta. Todas las respuestas que nos dé se mantendrán anónimas para proteger su privacidad. La documentación del estudio se guardará en archivos cerrados con llave en las oficinas del investigador principal y del director del proyecto. Los cuestionarios y los instrumentos codificados se guardaran en computadoras con claves secretas.

Usted ha recibido una copia de este resumen de proyecto para mantenerlo en sus propios archivos.

Appendix A1

CENTER FOR COMMUNITY PROBLEM SOLVING

NEW YORK UNIVERSITY
A private university in the public service
245 Sullivan Street, 6th Floor
New York, NY 10012-1301

PROJECT SUMMARY STATEMENT

Please check one of the following:
☐ Participant chooses to read this Project Summary Statement on his/her own.
☐ Participant chooses to have interviewer read this Project Summary Statement to him/her.

*** If you know the person interviewing you, you may ask for another interviewer so your privacy will be fully protected.*

You have been invited to take part in a study to learn more about Mexican immigrants and their health. This study will be conducted by Gerald P. López at the Center for Community Problem Solving at New York University and by the Center for Urban Epidemiologic Studies at the New York Academy of Medicine.

This study has nothing to do with the Immigration and Naturalization Service (INS) – now called the US Citizenship and Immigration Services (USCIS)

If you agree to be in this study, you will be asked questions during an in-person interview. The interview lasts about 20 minutes and is made up of two main parts:

1. The first part will ask about your physical and mental health, access to health care, and immigration experience.
2. The second part will ask about other experiences, such as with discrimination, acculturation, and social support.

We want you to know about some of the risks of taking part in this study. Because some of the topics in the interview are of a personal and sensitive nature, you might find some of the questions in the interview upsetting. In that event, you may discuss your feelings with the researcher or get a referral to a counselor.

Although you will receive no direct benefits, you'll help us gain a better understanding of the needs of Mexican immigrants like yourself by participating in our study. The information we learn will be used to create and improve programs for Mexican immigrants. You will also receive referrals to social services and health services if you need them.

The investigator has explained this study to you and answered your questions. If you have additional questions or wish to report a research-related problem, you may contact Michelle Fei at (phone) 212-998-6453, (email) michelle.fei@nyu.edu, or (mail) 245 Sullivan Street, New York, NY 10012 or Gerald P. López at (phone) 212-998-6469, (email) gerald.lopez@nyu.edu, or (mail) 245 Sullivan Street, New York, NY 10012. For questions about your rights as a research participant, you may contact the University Committee on Activities Involving Human Subjects, Office of Sponsored Programs, New York University, 212-998-2121.

Participation in this study is voluntary. You may refuse to participate or withdraw at any time without penalty. You have the right to skip or not answer any questions you prefer not to answer.

Confidentiality of your research records will be strictly maintained. We will not ask for your name at any time. We have no way of connecting your name to your answers once you finish the survey. All answers you give us will be kept anonymous to protect your privacy. We will keep study documentation in locked files in the offices of the principal investigator and project director. Questionnaires and coded instruments will be saved on hard drives of computers that are password protected.

You have received a copy of this project summary statement to keep for your records.

Appendix A2

UN ESTUDIO SOBRE LA SALUD DE LOS INMIGRANTES MEXICANOS

! PARTICIPE EN NUESTRA ENCUESTA PARA AYUDAR A MEJORAR SERVICIOS EN SU COMUNIDAD!

INFORMACIÓN SOBRE ESTE ESTUDIO:

Es poca la gente que ha estudiado a fondo los problemas que los inmigrantes enfrentan. Todavía menos son aquellos que se han enfocado particularmente en los problemas que enfrentan los inmigrantes Mexicanos. Nosotros en el Centro de Soluciones Comunitarias y en el Centro de Estudios Urbanos de Enfermedades estamos convencidos de que debemos estar bien informados sobre las necesidades que existen en las comunidades Mexicanas crecientes en la Ciudad de New York para poder hacer algo al respecto.

Por esa razón estamos pidiendo la ayuda de inmigrantes Mexicanos como usted. Estamos interesados en hablar con usted y aprender directamente de sus experiencias con todo lo que tiene que ver con su salud, familia, trabajo y lenguaje. Lo que usted y otros compartan con nosotros nos ayudará a diseñar y mejorar programas para resolver problemas que enfrentan las comunidades Mexicanas aquí en la Ciudad de New York.

Le agradeceríamos mucho si participara en nuestro estudio. La entrevista toma aproximadamente veinte minutos. Su participación es completamente voluntaria. Y si usted tiene algún problema, lo podemos referir a algún lugar donde pueda recibir ayuda que tal vez necesite.

INFORMACIÓN SOBRE NOSOTROS:

El Centro de Soluciones Comunitarias de la Universidad de New York se junta con comunidades de bajos recursos, de minorías y de inmigrantes para luchar contra problemas sociales, económicos y legales que reportan los residentes y proveedores de servicios afectados. Al hacer esto, buscamos cambiar la manera en que resolvemos problemas para mejorar la ayuda a nuestras comunidades con necesidades urgentes y metas de largo plazo. Por medio del Proyecto Ayuda a Inmigrantes a Tener Éxito en los Estados Unidos, nos proponemos ayudar a que inmigrantes se adapten a la vida de este país y a mejorar la manera en que, como una nación, recibimos las contribuciones de la diversidad de inmigrantes.

El Centro de Estudios Urbanos de Enfermedades (CUES) colabora con otros para conducir investigaciones multidisciplinarias en la población. CUES se encuentra en la Academia de Medicina de New York ubicada en East Harlem, y se enfoca principalmente en poblaciones urbanas y de bajos recursos. CUES trabaja con residentes y organizaciones de la comunidad para identificar necesidades importantes que se deben investigar. Por medio de estudios e intervenciones, CUES trabaja para que cuestiones de salud en zonas urbanas se entiendan mejor.

PARA PARTICIPAR O HACER PREGUNTAS, FAVOR DE HABLAR CON ALGUIEN DEL PERSONAL AQUÍ O COMUNÍQUESE CON NOSOTROS A:

Centro de Soluciones Comunitarias de la Universidad de New York
Dirección: 245 Sullivan Street, 5th Floor, New York, NY 10012;
Teléfono: (212) 998-6716; Correo Electrónico: law.cps@nyu.edu

El Centro de Estudios Urbanos de Enfermedades en la Academia de Medicina de New York
Dirección: 1216 Fifth Avenue, New York, NY 10029
Teléfono: (212) 822-7219

***"Este estudio no está relacionado de ninguna manera con el Servicio de Migración y Naturalización (conocido como el INS o la Migra) - ahora conocido como Servicios de Ciudadanía y Migración de los Estados Unidos (USCIS)"*

A STUDY ABOUT THE HEALTH OF MEXICAN IMMIGRANTS IN NEW YORK CITY

PARTICIPATE IN OUR SURVEY TO HELP IMPROVE SERVICES IN YOUR COMMUNITY!

ABOUT THIS STUDY:

Few people have studied in depth the problems that immigrants confront. Even fewer have focused particularly on the problems that Mexican immigrants face. We at the Center for Community Problem Solving and the Center for Urban Epidemiologic Studies are convinced that we all must have good information about the needs of New York City's fast-growing Mexican communities in order to better deal with all that they face. And we're working to do something about it.

That's why we're seeking out the help of Mexican immigrants like yourself. We'd like to talk to you to learn directly about your experiences with everything from health to family to jobs to language. What you and others share with us will help us design and improve programs that address problems faced by Mexican communities here in New York City.

We would really appreciate your participation in our study. The interview should take about twenty minutes. Your participation is completely voluntary. And if you're experiencing a particular problem, we can give you referrals to get help you might need.

WHO WE ARE:

The Center for Community Problem Solving at New York University teams up with low-income, of color, and immigrant communities to tackle social, economic, and legal problems that residents and service providers report facing. Along the way, we seek to change the way we solve problems to better help our communities meet urgent needs and long-term goals. Through our Helping Immigrants Make It in the US Project, we aim to help immigrants adapt to life here and to improve how we as a national community embrace immigrants' diverse contributions.

The Center for Urban Epidemiologic Studies (CUES) conducts collaborative, multidisciplinary, population-based research. Housed at the New York Academy of Medicine in East Harlem, CUES focuses particularly on low-income, urban populations. CUES works with community residents and organizations to identify vital research needs. Through studies and interventions, CUES works to bring about a better understanding of health issues in urban areas.

TO PARTICIPATE OR ASK ANY QUESTIONS, PLEASE SPEAK WITH ONE OF OUR STAFFERS HERE OR CONTACT US AT:

The Center for Community Problem Solving at New York University
Mail: 245 Sullivan Street, 5th Floor, New York, NY 10012;
Telephone: (212) 998-6716; Email: law.cps@nyu.edu

The Center for Urban Epidemiologic Studies at the New York Academy of Medicine
Mail: 1216 Fifth Avenue, New York, NY 10029
Telephone: (212) 822-7219

This study has nothing to do with the Immigration and Naturalization Service (INS) – now called the US Citizenship and Immigration Services (USCIS)

Appendix A3

Interviewer ID:		Date:	
Neighborhood:		Shift Time:	
DELIVERED RAP	DOES NOT PARTICIPATE		AGREES TO PARTICIPATE
	For some UNKNOWN reason	Because does NOT QUALIFY	

Appendix A4

Work Product: Please Do Not Quote, Cite, or Share without Written Permission of Professor Gerald P. López, Director of THE CENTER FOR COMMUNITY PROBLEM SOLVING

Center for Community Problem Solving at New York University
The Health of Mexican Immigrants in NYC Pilot Study

Supervisor Checklist

BEFORE YOUR SHIFT
Check schedule to determine how many people are coming
Make note of their interviewer IDs
Review anything you want to cover in refresher training
Assemble materials

- ☐ Clipboards in English and Spanish with the following:
  - Recruiting pitch
  - FAQs
  - Glossary
- ☐ Collated Project Summary Statements in English and Spanish, Survey Instruments in English and Spanish, and Referral Lists
- ☐ Flyers in English and Spanish
- ☐ Sign
- ☐ Table
- ☐ Chairs
- ☐ Hats
- ☐ Stickers
- ☐ Refreshments
- ☐ Pens
- ☐ Crayons
- ☐ Tally Sheets
- ☐ Business Cards
- ☐ Big Envelope for Surveys

If you are arriving as a "Second Shift," remember to:

- ☐ Pull out new log sheets
- ☐ Bring another envelope
- ☐ Pack refreshments
- ☐ Call current supervisor and figure out what kinds of "reinforcements" you have to bring (for example flyers, summary statements, surveys, and referral lists)

Neighborhood Plan – Do you know exactly where you're going, exactly how to get there, and what you will do if there's no one around?

WHEN VOLUNTEERS ARRIVE
Check Attendance – Call folks who are late?
Refresher Training – Have you checked in to know what refresher training is to be about?
Give an Overview of the Day – tell volunteers where you're going and how you're getting there. Make sure you have enough people coming back to NYU (might have to consider size of next shift) to carry stuff. Take only as much stuff as you think people who are returning can carry.

AFTER YOUR SHIFT

- Have you brought filled out survey forms back to Center and put in safe place?
- Have you drafted Neighborhood Report?
- Indicated what copies need to be made?
- Packed up for the next day's shift
- Straightened clinic room

Appendix B

CENTRO DE SOLUCIONES COMUNITARIAS
DE LA UNIVERSIDAD DE NEW YORK

Y

CENTRO DE ESTUDIOS URBANOS DE ENFERMEDADES
EN LA ACADEMIA DE MEDICINA DE NEW YORK

LISTA DE SERVICIOS

PARA PARTICIPANTES EN EL ESTUDIO SOBRE LA SALUD DE LOS INMIGRANTES
MEXICANOS EN LA CIUDAD DE NEW YORK

***

REFERRAL LIST

FOR PARTICIPANTS IN THE HEALTH OF MEXICAN IMMIGRANTS
IN NYC PILOT STUDY

245 Sullivan Street, 5th Floor, New York, NY 10012-1301, 212-998-6716

- A -

African Services Committee			**www.africanservices.org**
Servicios: SALUD FÍSICA/MENTAL, VIVIENDA, INFORMACIÓN, COMIDA ***Services:*** *PHYSICAL/MENTAL HEALTH, HOUSING, REFERRAL, FOOD*			
Dirección ***Address***	429 West 127th Street, 2nd Floor New York, NY 10027	**Teléfono / *Phone***	212-222-3882
		Fax	212-222-7067
Idiomas ***Languages***	Español, Inglés, Amharic, Bambara, Francés, Pulaar, Soninke, y otros dialectos Africanos *Spanish, English, Amharic, Bambara, French, Pulaar, Soninke, many other African dialects*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Asociación Tepeyac de New York			**www.tepeyac.org**
Servicios: SALUD FÍSICA/MENTAL, INMIGRACIÓN, ASISTENCIA LEGAL, TRABAJO Y EMPLEO, INFORMACIÓN, SERVICIOS PARA JÓVENES/NIÑOS ***Services:*** *PHYSICAL/MENTAL HEALTH, IMMIGRATION, LEGAL, EMPLOYMENT, REFERRAL, SERVICES FOR YOUNG PEOPLE/CHILDREN*			
Dirección ***Address***	251 West 14th Street New York, NY 10011	**Teléfono / *Phone***	212-633-7108
		Fax	212-633-1554
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	No
		Servicios para las Personas Sordas ***Services for the Deaf***	No

- B -

La Bodega de la Familia			**www.familyjusticeinc.org**
Servicios: ASISTENCIA LEGAL, INFORMACIÓN, SERVICIOS PARA EL ABUSO DE DROGAS Y ALCOHOL, SERVICIOS PARA PERSONAS ENCARCELADAS ***Services:*** *LEGAL, REFERRAL, ALCOHOL AND SUBSTANCE ABUSE, SERVICES FOR INCARCERATED PEOPLE*			
Dirección ***Address***	272 East 3rd Street New York, NY 10009	**Teléfono / *Phone***	212-982-2335
		Fax	212-982-1765
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	Sí *Yes*

Boys and Girls Harbor		www.boysharbor.org; www.boysandgirlsharbor.net	
Servicios: SERVICIOS PARA JÓVENES/NIÑOS *Services: SERVICES FOR YOUNG PEOPLE/CHILDREN*			
Dirección *Address*	1 East 104th Street New York, NY 10029	**Teléfono / *Phone***	212-427-2244
		Fax	212-427-2311
Idiomas *Languages*	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** *Wheelchair accessible*	Sí *Yes*
		Servicios para las Personas Sordas *Services for the Deaf*	No

- C -

Care Beyond Neighborhood			
Servicios: SERVICIOS PARA JÓVENES/NIÑOS *Services: SERVICES FOR YOUNG PEOPLE/CHILDREN*			
Dirección *Address*	1746 Broadway Brooklyn, NY 11207	**Teléfono / *Phone***	718-453-3529
		Fax	718-453-3529
Idiomas *Languages*	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** *Wheelchair accessible*	Sí *Yes*
		Servicios para las Personas Sordas *Services for the Deaf*	No

Central American Legal Assistance (CALA)			
Servicios: INMIGRACIÓN *Services: IMMIGRATION*			
Dirección *Address*	240 Hooper Street Brooklyn, NY 11211	**Teléfono / *Phone***	718-486-6800
		Fax	718-486-5287
Idiomas *Languages*	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** *Wheelchair accessible*	No
		Servicios para las Personas Sordas *Services for the Deaf*	No

Children's Aid Society East Harlem Center		www.childrensaidsociety.org/eh/	
SERVICIOS: SALUD FÍSICA/MENTAL, SERVICIOS PARA JÓVENES/NIÑOS *Services: PHYSICAL/MENTAL HEALTH, SERVICES FOR YOUNG PEOPLE/CHILDREN*			
Dirección *Address*	130 East 101st Street New York, NY 10029	**Teléfono / *Phone***	212-348-2343
		Fax	212-876-0711
Idiomas *Languages*	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** *Wheelchair accessible*	No
		Servicios para las Personas Sordas *Services for the Deaf*	No

Comité Nuestra Señora de Loreto			
Servicios: INMIGRACIÓN, SERVICIOS PARA PERSONAS ENCARCELADAS *Services: IMMIGRATION, SERVICES FOR INCARCERATED PEOPLE*			
Dirección *Address*	856 Pacific Street Brooklyn, NY 11238	**Teléfono / *Phone***	718-783-4500
		Fax	
Idiomas *Languages*	Español, Inglés, Italiano *Spanish, English, Italian*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	No
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Community Food Resource Center			www.cfrcnyc.org
Servicios: ASISTENCIA PUBLICA, COMIDA, FINANZAS, SERVICIOS PARA PERSONAS DE MAYOR EDAD *Services: GOVERNMENT BENEFITS, FOOD, FINANCES, SERVICES FOR SENIORS*			
Dirección *Address*	39 Broadway, 10th Floor New York, NY 10006 y/*and* 252 W.116th Street New York, NY 10027	**Teléfono / *Phone***	212-894-8094 212-665-9082
		Fax	212-616-4990
Idiomas *Languages*	Español, Inglés, Francés, Creole, Cantonés, Ruso *Spanish, English, French, Cantonese, Creole, Russian*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Community Outreach Law Program			www.abcny.org
Servicios: INMIGRACIÓN, ASISTENCIA LEGAL, DISCRIMINACIÓN, SERVICIOS PARA PERSONAS DE MAYOR EDAD *Services: IMMIGRATION, LEGAL, DISCRIMINATION, SERVICES FOR SENIORS*			
Dirección *Address*	42 West 44th Street New York, NY 10063	**Teléfono / *Phone***	212-382-6678
		Fax	212-221-5318
Idiomas *Languages*	Español, Inglés, Francés, Coreano, Portugués *Spanish, English, French, Korean, Portuguese*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Covenant House New York (Main Office)			www.conenanthouseny.org
Servicios: SALUD FÍSICA/MENTAL, ASISTENCIA LEGAL, EDUCACIÓN, INFORMACIÓN, COMIDA, SERVICIOS PARA JÓVENES/NIÑOS , SERVICIOS PARA PERSONAS ENCARCELADAS ***Services:*** *PHYSICAL/MENTAL HEALTH, HOUSING, EDUCATION, LEGAL, FOOD, REFERRAL, SERVICES FOR YOUNG PEOPLE/CHILDREN, SERVICES FOR INCARCERATED PEOPLE*			
Dirección ***Address***	460 West 41st Street New York, NY 10036	**Teléfono / *Phone***	212-330-0562
		Fax	212-947-2478
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	Sí *Yes*

- D -

The Door			www.door.org
Servicios: SALUD FÍSICA/MENTAL, INMIGRACIÓN, ASISTENCIA LEGAL, TRABAJO Y EMPLEO, EDUCACIÓN, INFORMACIÓN, COMIDA, SERVICIOS PARA JÓVENES/NIÑOS, SERVICIOS PARA PERSONAS ENCARCELADAS **Services:** ***PHYSICAL/MENTAL HEALTH, IMMIGRATION, LEGAL, EMPLOYMENT, EDUCATION, REFERRAL, FOOD, SERVICES FOR YOUNG PEOPLE/CHILDREN, SERVICES FOR INCARCERATED PEOPLE***			
Dirección ***Address***	121 Avenue of the Americas New York, NY 10013	**Teléfono / *Phone***	212-941-9090
		Fax	212-941-9620
Idiomas ***Languages***	Español, Inglés, Bengalí, Cantonés, Creole, Francés, Fukanese, Mandarín *Spanish, English, Bengali, Creole, French, French, Fukanese, Mandarin (The Door also provides translation services for 500 languages)*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	Sí *Yes*

- E -

Exodus Transitional Community, Inc.			www.etcny.org
Servicios: EMPLEO Y TRABAJO, SERVICIOS PARA EL ABUSO DE DROGAS Y ALCOHOL, SERVICIOS PARA PERSONAS ENCARCELADAS ***Services:*** *EMPLOYMENT, DRUG AND ALCOHOL ABUSE, SERVICES FOR INCARCERATED PEOPLE*			
Dirección ***Address***	161 East 104th Street New York, NY 10029	**Teléfono / *Phone***	917-492-0990
		Fax	917-492-0990
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	No
		Servicios para las Personas Sordas ***Services for the Deaf***	No

- F -

Fordham-Tremont Community Mental Health Center			
Servicios: SALUD FÍSICA/MENTAL, INMIGRACIÓN, EMPLEO Y TRABAJO, SERVICIOS PARA EL ABUSO DE DROGAS Y ALCOHOL, SERVICIOS PARA JÓVENES/NIÑOS, SERVICIOS PARA PERSONAS DE MAYOR EDAD, SERVICIOS PARA PERSONAS ENCARCELADAS ***Services:*** *PHYSICAL/MENTAL HEALTH, IMMIGRATION, EMPLOYMENT, DRUG AND ALCOHOL ABUSE, SERVICES FOR YOUNG PEOPLE/CHILDREN, SERVICES FOR SENIORS, SERVICES FOR INCARCERATED PEOPLE*			
Dirección ***Address***	2021 Grand Concourse Bronx, NY 10453	**Teléfono / *Phone***	718-960-0324
		Fax	
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	*Sí* Yes
		Servicios para las Personas Sordas ***Services for the Deaf***	No

- G -

Good Old Lower East Side, Inc. (GOLES)		**www.neighborhoodlink.com/manhattan/goles**	
Servicios: ASISTENCIA LEGAL, VIVIENDA, ASISTENCIA PUBLICA, DISCRIMINACIÓN, FINANZAS ***Services:*** *LEGAL, HOUSING, GOVERNMENT BENEFITS, DISCRIMINATION, FINANCES*			
Dirección ***Address***	525 East 6th Street New York, NY 10009	**Teléfono / *Phone***	212-533-2541
		Fax	212-533-8126
Idiomas ***Languages***	Español, Inglés, Ucraniano, Urdu *Spanish, English, Ukranian, Urdu*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

- H -

HUMAN Rights First		**www.humanrightsfirst.org**	
Servicios: INMIGRACIÓN, ASISTENCIA LEGAL ***Services:*** *IMMIGRATION, LEGAL*			
Dirección ***Address***	333 7th Avenue, 13th Floor New York, NY 10001	**Teléfono / *Phone***	212-845-5244
		Fax	212-845-5299
Idiomas ***Languages***	Español, Inglés, Chino, Francés *Spanish, English, Chinese, French*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

- J -

Job Information Centers at the New York Public Library			**www.nypl.org**
Servicios: TRABAJO Y EMPLEO ***Services: EMPLOYMENT***			
Idiomas ***Languages***	Español, Inglés, Alemán, Cantones, Francés, Italiano, Mandarín, Ruso *Spanish, English, German, Cantonese, French, Italian, Mandarin, Russian*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	Sí *Yes*
Brooklyn Public Library Job Information Center			**www.brooklynpubliclibrary.org**
Dirección ***Address***	Grand Army Plaza Brooklyn, NY 11238	**Teléfono / *Phone***	718-230-2177
		Fax	
Mid-Manhattan Public Library Job Information Center			
Dirección ***Address***	455 5th Avenue New York, NY 10016	**Teléfono / *Phone***	212-340-0836
		Fax	
Queens Borough Central Public Library Job Information Center			**www.queenslibrary.org**
Dirección ***Address***	89-11 Merrick Boulevard Jamaica, NY 11432	**Teléfono / *Phone***	718-990-0853
		Fax	718-990-5162
Queens Flushing Public Library Job Information Center			**www.queenslibrary.org**
Dirección ***Address***	41-17 Main Street Flushing, NY 11355	**Teléfono / *Phone***	718-990-0746
		Fax	

- L -

Latino Commission on AIDS			**www.latinoaids.org**
Servicios: SALUD FÍSICA/MENTAL, EDUCACIÓN, SERVICIOS PARA EL ABUSO DE ALCOHOL Y DROGAS, SERVICIOS PARA PERSONAS ENCARCELADOS ***Services: PHYSICAL AND MENTAL HEALTH, EDUCATION, ALCOHOL AND SUBSTANCE ABUSE, SERVICES FOR INCARCERATED PEOPLE***			
Dirección ***Address***	24 West 25th Street, 9th Floor New York, NY 10010	**Teléfono / *Phone***	212-675-3288
		Fax	212-202-3620
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Latino Workers Center			
Servicios: INMIGRACIÓN, VIVIENDA, TRABAJO Y EMPLEO, DISCRIMINACIÓN ***Services: IMMIGRATION, HOUSING, EMPLOYMENT, DISCRIMINATION***			
Dirección ***Address***	191 East 3rd Street New York, NY 10009	**Teléfono / *Phone***	212-473-3936
		Fax	212-473-6103
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Legal Referral Service		**www.abcny.org/lrs.html**	
Servicios: ASISTENCIA LEGAL, INMIGRACIÓN ***Services: LEGAL, IMMIGRATION***			
Dirección ***Address***	2031 5th Avenue, 2nd Floor New York, NY 10035	**Teléfono** ***Phone***	212-626-7374 212-626-7373
		Fax	212-575-5676
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Little Sisters of the Assumption Family Health Service, Inc.		**www.littlesisters.org/fhm.html**	
Servicios: SALUD FÍSICA/MENTAL, ASISTENCIA PUBLICA, COMIDA ***Services: PHYSICAL/MENTAL HEALTH, GOVERNMENT BENEFITS, FOOD***			
Dirección ***Address***	333 East 115th Street New York, NY 10035	**Teléfono / *Phone***	212-987-4422
		Fax	212-987-4430
Idiomas ***Languages***	Español, Inglés, Francés *Spanish, English, French*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	Sí *Yes*

Loisada, Inc.			
Servicios: SALUD FÍSICA/MENTAL, TRABAJO Y EMPLEO, EDUCACIÓN, SERVICIOS PARA JÓVENES/NIÑOS ***Services:*** *PHYSICAL/MENTAL HEALTH, EMPLOYMENT, EDUCATION, SERVICES FOR YOUNG PEOPLE/CHILDREN*			
Dirección ***Address***	710 East 9th Street New York, NY 10009	**Teléfono / *Phone***	212-353-0272
		Fax	212-473-5462
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Lower East Side Tenement Museum			
Servicios: EDUCACIÓN, INFORMACIÓN ***Services:*** *EDUCATION, REFERRAL*			
Dirección ***Address***	90 Orchard Street New York, NY 10002	**Teléfono / *Phone***	212-431-0233
		Fax	212-431-0402
Idiomas ***Languages***	Español, Inglés, Dutch, Cantones, Francés, Mandarín, Ruso, *Spanish, English, Dutch, Cantonese, French, Mandarin, Russian*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	Sí *Yes*

- M -

Make the Road by Walking		www.maketheroad.org	
Servicios: TRABAJO Y EMPLEO, EDUCACIÓN, INFORMACIÓN, ASISTENCIA PUBLICA, SERVICIOS PARA JÓVENES/NIÑOS ***Services:*** *EMPLOYMENT, EDUCATION, REFERRAL, GOVERNMENT BENEFITS, SERVICES FOR YOUNG PEOPLE/CHILDREN*			
Dirección ***Address***	301 Grove Street Brooklyn, NY 11237	**Teléfono / *Phone***	718-418-7690
		Fax	718-418-9635
Idiomas ***Languages***	Español, Inglés, Hebreo, Bengali, Swahili *Spanish, English, Bengali, Hebrew, Swahili*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

The Maura Clark-Ita Ford Center			
Servicios: EMPLEO Y TRABAJO, EDUCACIÓN ***Services: EMPLOYMENT, EDUCATION***			
Dirección ***Address***	Empleo y Trabajo/*Employment*: 703 Lexington Avenue Brooklyn, NY 11221 Educación/*Education*: 139 Menahan Street Brooklyn, NY 11221	**Teléfono / *Phone***	718-452-0167
		Fax	718-452-5173
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Mt. Sinai Adolescent Health Center			
Servicios: SALUD FÍSICA/MENTAL, SERVICIOS PARA JÓVENES/NIÑOS ***Services: PHYSICAL AND MENTAL HEALTH, SERVICES FOR YOUNG PEOPLE/CHILDREN***			
Dirección ***Address***	320 East 94th Street New York, NY 10128	**Teléfono / *Phone***	212-987-6999
		Fax	212-423-2920
Idiomas ***Languages***	Español, Inglés, Creole *Spanish, English, Creole*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	
		Servicios para las Personas Sordas ***Services for the Deaf***	Sí *Yes*

- N -

Neighbors Helping Neighbors		**www.nhnhome.org**	
Servicios: VIVIENDA, ASISTENCIA LEGAL, FINANZAS, SERVICIOS PARA LOS DE MAYOR EDAD ***Services: HOUSING, LEGAL, FINANCES, SERVICES FOR SENIORS***			
Dirección ***Address***	443 39th Street, Room 202 Brooklyn, NY 11232	**Teléfono / *Phone***	718-686-7946
		Fax	718-686-7948
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

New York Association for New Americans (NYANA)			
Servicios: SALUD FÍSICA/MENTAL, ASISTENCIA LEGAL, INMIGRACIÓN, EMPLEO Y TRABAJO, VIVIENDA, EDUCACIÓN, INFORMACIÓN, ASISTENCIA PUBLICA, DISCRIMINACIÓN, FINANZAS, SERVICIOS PARA EL ABUSO DE DROGAS Y ALCOHOL, SERVICIOS PARA JÓVENES/NIÑOS, SERVICIOS PARA PERSONAS DE MAYOR EDAD ***Services:*** *PHYSICAL/MENTAL HEALTH, LEGAL, IMMIGRATION, EMPLOYMENT, HOUSING, EDUCATION, REFERRAL, GOVERNMENT BENEFITS, DISCRIMINATION, FINANCES, DRUG AND ALCOHOL ABUSE, SERVICES FOR YOUNG PEOPLE/CHILDREN, SERVICES FOR SENIORS*			
Dirección ***Address***	17 Battery Place Building 12-26 Washington Street 7th-9th Floor New York, NY 10004	**Teléfono / *Phone***	718-686-7946
		Fax	718-686-7948
Idiomas ***Languages***	Todos *All*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

- S -

Safe Horizon Anti-Trafficking Program		www.safehorizon.org	
Servicios: SALUD FÍSICA/MENTAL, INMIGRACIÓN, VIVIENDA, INFORMACIÓN, ASISTENCIA PUBLICA ***Services:*** *PHYSICAL/MENTAL HEALTH, IMMIGRATION, HOUSING, REFERRAL, GOVERNMENT BENEFITS*			
Dirección ***Address***	74-09 37th Avenue, 4th Floor Jackson Heights, NY 11372	**Teléfono / *Phone***	212-577-7700
		Fax	
Idiomas ***Languages***	Español, Inglés, Francés *Spanish, English, French*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	Sí *Yes*

Safe Horizons (formerly Victim's Services Agency)		www.safehorizon.org	
Servicios: SALUD FÍSICA/MENTAL, ASISTENCIA LEGAL, VIVIENDA, TRABAJO Y EMPELO, SERVICIOS PARA JÓVENES/NIÑOS ***Services:*** *PHYSICAL AND MENTAL HEALTH, LEGAL, HOUSING, EMPLOYMENT, SERVICES FOR YOUNG PEOPLE/CHILDREN*			
Dirección ***Address***	2090 7th Avenue, 2nd Floor New York, NY 10027	**Teléfono / *Phone***	212-316-2100
		Fax	212-577-3897
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

St. John's Bread and Life Program			www.breadandlife.org
Servicios: SALUD FÍSICO/MENTAL, ASISTENCIA LEGAL, TRABAJO Y EMPLEO, COMIDA ***Services:*** *PHYSICAL/MENTAL HEALTH, LEGAL, EMPLOYMENT, FOOD*			
Dirección ***Address***	75 Lewis Avenue Brooklyn, NY 11206	**Teléfono / *Phone***	718-574-0058
		Fax	718-455-7796
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Shelter and Food for the Homeless (SAFH)			www.safhnyc.org
Servicios: SALUD FÍSICO/MENTAL, ASISTENCIA LEGAL, INFORMACIÓN , COMIDA ***Services:*** *HEALTH, LEGAL, REFERRAL, FOOD*			
Dirección ***Address***	602 East 9th Street New York, NY 10009	**Teléfono / *Phone***	212-228-5254
		Fax	212 674 3782
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Single Parent Resource Center			www.singleparentusa.com
Servicios: EDUCACIÓN, INFORMACIÓN, SERVICIOS PARA EL ABUSO DE DROGAS Y ALCOHOL, SERVICIOS PARA JÓVENES/NIÑOS ***Services:*** *EDUCATION, REFERRAL, DRUG AND ALCOHOL ABUSE, SERVICES FOR YOUNG PEOPLE/CHILDREN*			
Dirección ***Address***	31 East 28th Street, 2nd floor New York, NY 10001	**Teléfono / *Phone***	212-951-7030
		Fax	212-951-7037
Idiomas ***Languages***	Español, Inglés *Spanish, English*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

Solace			
Servicios: SALUD FÍSICA/MENTAL, INFORMACIÓN ***Services:*** *PHYSICAL/MENTAL HEALTH, REFERRAL*			
Dirección ***Address***	74-09 37th Avenue, 4th Floor Jackson Heights, NY 11372	**Teléfono / *Phone***	718-899-1233
		Fax	
Idiomas ***Languages***	Español, Inglés, Francés, Hindi, Urdu *Spanish, English, French, Hindi, Urdu* *(Interpreters can be obtained for other languages)*	**Accesible para sillas de ruedas** ***Wheelchair accessible***	Sí *Yes*
		Servicios para las Personas Sordas ***Services for the Deaf***	No

St. Vincent's Rape Crisis Program			www.svcmc.org
Servicios: SALUD FÍSICA/MENTAL, INFORMACIÓN *Services: PHYSICAL/MENTAL HEALTH, REFERRAL*			
Dirección *Address*	41-51 East 11th Street (Therapy Center) New York, NY 10003	**Teléfono / *Phone***	212-604-8068
		Fax	
Idiomas *Languages*	Español, Inglés, Francés, Italiano, Mandarín *Spanish, English, French, Italian, Mandarin*	**Accesible para sillas de ruedas** *Wheelchair accessible*	No
		Servicios para las Personas Sordas *Services for the Deaf*	No

- U -

United Jewish Council of the East Side, Inc.			
Servicios: SALUD FÍSICA/MENTAL, VIVIENDA, EDUCACIÓN, INFORMACIÓN, ASISTENCIA PUBLICA, SERVICIOS PARA JÓVENES/NIÑOS, SERVICIOS PARA PERSONAS DE MAYOR EDAD *Services: HEALTH, HOUSING, EDUCATION, REFERRAL, GOVERNMENT BENEFITS, SERVICES FOR YOUNG PEOPLE/ CHILDREN, SERVICES FOR SENIORS*			
Dirección *Address*	235 East Broadway New York, NY 10002	**Teléfono / *Phone***	212-233-6037
		Fax	212-285-2693
Idiomas *Languages*	Español, Inglés, Cantones, Hebreo, Mandarín, Ruso, Yiddish *Spanish, English, Cantonese, Hebrew, Mandarin, Russian, Yiddish*	**Accesible para sillas de ruedas** *Wheelchair accessible*	No
		Servicios para las Personas Sordas *Services for the Deaf*	No

Urban Justice Center			www.urbanjustice.org
Servicios: SALUD FÍSICA/MENTAL, ASISTENCIA LEGAL, INMIGRACIÓN, VIVIENDA, DISCRIMINACIÓN, INFORMACIÓN, ASISTENCIA PUBLICA, SERVICIOS PARA JÓVENES/NIÑOS, SERVICIOS PARA PERSONAS ENCARCELADOS *Services: HEALTH, LEGAL, IMMIGRATION, HOUSING, DISCRIMINATION, REFERRAL, GOVERNMENT BENEFITS, SERVICES FOR YOUNG PEOPLE/CHILDREN, SERVICES FOR INCARCERATED PEOPLE*			
Dirección *Address*	666 Broadway, 10th Floor New York, NY 10012	**Teléfono / *Phone***	646-602-5600
		Fax	212-285-2693
Idiomas *Languages*	Español, Inglés, Chino, *Swahili* *Spanish, English, Chinese, Swahili*	**Accesible para sillas de ruedas** *Wheelchair accessible*	Sí *Yes*
		Servicios para las Personas Sordas *Services for the Deaf*	No

Appendix C

Table 1. Demographic profile of survey respondents.			
		Male	**Female**
Age	18-29	46%	50%
	30-39	35%	32%
	40+	19%	18%
Education	None to 8th Grade	66%	72%
	Some HS or GED	19 %	13%
	HS or College	15%	15%
Marital status	Single, never married	44%	34%
	Married, living as married	48%	56%
	Divorced	1%	4%
	Separated	5%	4%
	Widowed	1%	1%
	Other	1%	1%
Do you have children?	No	41%	17%
	Yes	59%	83%
Do your children live with you?	No children	41%	17%
	No	43%	10%
	Yes	16%	73%
Household Size	1 (live alone)	6 %	5%
	2-4	56%	69%
	5+	38%	26%
Homeless	No	87%	87%
	Yes	13%	13%
How long have you lived in NY?	10+ years	19%	33%
	5-9 years	27%	35%
	1-4 years	40%	25%

	Less than 1 year	14%	7%
Income Sources	Other	4%	39%
	Formal Not Informal	21%	11%
	Informal Not Formal	63%	46%
	Formal & Informal	12%	4%
Remittances	No	7%	35%
	Yes	93%	65%
Day Labor	No	69%	93%
	Yes	31%	7%
Hunger	No	67%	79%
	Yes	30%	21%
Overall, would you say your health is excellent, very good, good, fair, or poor?	Excellent	12%	8%
	Very good	15%	14%
	Good	42%	52%
	Fair	23%	22%
	Poor	8%	4%
	Don't Know	0%	0%
Physical Health	No	84%	84%
	Yes	1%	16%
Mental Health	No	83%	81%
	Yes	17%	19%
Health Insurance	No	92%	83%
	Yes	8%	17%
Where do you usually go to see a doctor, nurse, or physician?	Doctor	38%	60%
	Medicaid or HMO	1%	4%
	ER in Hospital	13%	19%
	Drug Treatment Center	0%	0%
	Nowhere	46%	15%
	Other	1%	1%
	8.	0%	0%
	9.	0%	0%

	10.	0%	1%

Table 2.
Demographic Characteristics of Three Samples of Recent Mexican Immigrants in the US and New York*

		National (2000 PUMS)	New York City (2000 PUMS)	New York City (Lopez 2007)
Gender	Male	57%	64%	69%
	Female	43%	36%	31%
Marital status	Single, never married	42%	54%	41%
	Married	53%	39%	50%
	Divorced	3%	1%	2%
	Separated	2%	5%	5%
	Widowed	1%	N/A	1%
Number of own children in household	0	42%	40%	42%
	1	24%	25%	22%
	2	19%	19%	19%
	3-4	13%	12%	14%
	5+	2%	5%	2%

Age	18-29 30-39 40+	66% 21% 14%	59% 17% 6%	46% 34% 20%
Education	None to 8th Grade Some HS or GED HS or College	42% 26% 33%	44% 25% 31%	68% 17% 15%
Years in US	Less than 1 year One to Four years Five to Nine years	8% 48% 44%	5% 47% 48%	16% 46% 39%
Personal Income (median)		$9,000	$11,230	$7,071

Appendix D

7. Tables

Table 1: Volunteer Productivity by Neighborhood	
Neighborhood	Avg surveys per volunteer per hour
Sunset Park	1.7
Port Richmond	1.6
East Harlem	1.4
Queens Cluster*	1.3
Chelsea	1.3
Bushwick	1.2
Astoria	1
East Village	0.8
South Bronx	0.7
Williamsburg	0.6

*Includes Jackson Heights, Corona, and Elmhurst

Table 2: Volunteer Productivity by Outside Temperature	
Temperature (oF)	Avg surveys per volunteer per hour
Up to 40	1.4
40s	1.1
low 50s	1.4
mid 50s	1
Upper 50s — 60	1.6
Upper 60s — 70	1

Appendix D

Table 3: Volunteer Productivity by Week of Survey

Week	Avg surveys per volunteer per hour
1	1.2
2	1
3	1.3
4	1.7
5	1.4
6	1.4
7	1.2
9	1.5

Appendix E

Table 1. Health Access (Health Insurance) by Age				
In the last 6 months, were you covered by health insurance of any sort?	Age			
	18-29	30-39	40+	Total
No	87%	92%	88%	89%
Yes	12%	8%	12%	11%
Skipped	0%	0%	0%	0%
Refuse	0%	0%	0%	0%
Don't Know	1%	0%	0%	0%
Total	100%	100%	100 %	100%
N	202	146	81	429
Chi-square-5.57, df=3, p=0.696				

Table 2. Health Access (Health Insurance) by Education				
In the last 6 months, were you covered by health insurance of any sort?	Education			
	None — 8th Grade	Some HS or GED	HS or College	Total
No	90%	89%	86%	89%
Yes	10%	10%	14%	11%
Skipped	0%	0%	0%	0%
Refuse	0%	0%	0%	0%
Don't Know	0%	1%	0%	0%
Total	100%	100%	100%	100%
N	290	75	65	430
Chi-square-6.62, df=3, p=0.578				

Appendix E

Table 3.

Health Access (Health Insurance) by Marital Status

In the last 6 months, were you covered by health insurance of any	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Total
No	88%	89%	100%	90%	100%	100%	89%
Yes	11%	11%	0%	10%	0%	0%	11%
Shipped	1%	0%	0%	0%	0%	0%	0%
Refuse	0%	0%	0%	0%	0%	0%	0%
Don't Know	0%	0%	0%	0%	0%	0%	0%
Total	100%	100%	100%	100%	100%	100%	100%
N	177	217	9	20	3	4	430
Chi-square=6.31, df=6, p=0.998							

Table 4.

Health Access (Health Insurance) by Children

In the last 6 months, were you covered by health insurance of any sort?	Children		
	No	Yes	Total
No	88%	89%	89%
Yes	11%	11%	11%
Skipped	1%	0%	0%
Refuse	0%	0%	0%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	144	286	430
Chi-square=3.09, df=2 p=0.543			

Appendix E

Table 5.

Health Access (Health Insurance) by Children & Living With/Without Children

In the last 6 months, were you covered by health insurance of any sort?	Children/ Live With You			
	No Children	Don't Live With	Live With	Tot.
No	88%	97%	81%	89%
Yes	11%	3%	18%	11%
Skipped	1%	0%	0%	0%
Refuse	0%	0%	0%	0%
Don't Know	0%	0%	0%	0%
Total	100%	100%	100%	100 %
N	144	144	142	430
Chi-square-23.28, df=3, p=0.003				

Table 6.

Health Access (Health Insurance) by Living With/Without Children

In the last 6 months, were you covered by health insurance of any sort?	Children		
	Don't Live With	Live With	Total
No	97%	81%	89%
Yes	3%	18%	11%
Skipped	0%	1%	0%
Refuse	0%	0%	0%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	144	142	286
Chi-square=19.64, df=2, p=0.000			

Appendix E

Table 7.

Health Access (Health Insurance) by Household Size

In the last 6 months, were you covered by health insurance of any sort?	Household Size			
	One	2-4	5+	Total
No	88%	86%	95%	89%
Yes	12%	14%	5%	11%
Skipped	0%	0%	0%	0%
Refuse	0%	0%	0%	0%
Don't Know	0%	0%	0%	0%
Total	100%	100%	100%	100%
N	24	252	146	422
Chi-square=7.38, df=3, p=0.291				

Table 8.

Health Access (Health Insurance) by Homeless

In the last 6 months, were you covered by health insurance of any sort?	Homeless		
	No	Yes	Total
No	89%	87%	89%
Yes	11%	13%	11%
Skipped	0%	0%	0%
Refuse	0%	0%	0%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	375	55	430
Chi-square=0.77, df=2 p=0.943			

Appendix E

Table 9.

Health Access (Health Insurance) by Time Lived in New York

In the last 6 months, were you covered by health insurance of any sort?	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Tot.
No	83%	86%	91%	96%	89%
Yes	16%	14%	7%	4%	11%
Skipped	0%	0%	1%	0%	0%
Refuse	0%	0%	1%	0%	0%
Don't Know	1%	0%	0%	0%	0%
Total	100%	100%	100%	100%	100 %
N	100	125	151	53	429
Chi-square-16.42, df=4, p=0.173					

Appendix E

Table 10. Health Access (Health Insurance) by Income					
In the last 6 months, were you covered by health insurance of any	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Total
No	80%	78%	96%	79%	89%
Yes	20%	21%	4%	19%	11%
Skipped	0%	0%	0%	0%	0%
Refuse	0%	0%	0%	2%	0%
Don't Know	0%	1%	0%	0%	0%
Total	100%	100%	100%	100%	100%
N	61	77	249	43	430
Chi-square=44.39, df=4, p=0.000					

Table 11. Health Access (Health Insurance) by Remittances			
In the last 6 months, were you covered by health insurance of any sort?	Remittances		
	No	Yes	Total
No	80%	91%	89%
Yes	20%	9%	11%
Skipped	0%	0%	0%
Refuse	0%	0%	0%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	64	366	430
Chi-square=8.20, df=2, p=0.085			

Appendix E

Table 12. Health Access (Health Insurance) by Day Labor			
In the last 6 months, were you covered by health insurance of any sort?	Day Labor		
	No	Yes	Total
No	87%	96%	89%
Yes	13%	4%	11%
Skipped	0%	0%	0%
Refuse	0%	0%	0%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	327	103	430
Chi-square-7.36, df=2, p=0.118			

Table 13. Health Access (Health Insurance) by Gender			
In the last 6 months, were you covered by health insurance of any sort?	Gender		
	Male	Female	Total
No	92%	80%	89%
Yes	8%	17%	11%
Skipped	0%	1%	0%
Refuse	0%	1%	0%
Don't Know	0%	1%	0%
Total	100%	100%	100%
N	301	129	430
Chi-square=16.05, df=2, p=0.003			

Appendix E

Table 14. Health Access (Health Insurance) by Moms			
In the last 6 months, were you covered by health insurance of any sort?	Moms		
	Non-Mom	Mom	Total
No	91%	83%	89%
Yes	9%	15%	11%
Skipped	0%	0%	0%
Refuse	0%	1%	0%
Don't Know	0%	1%	0%
Total	100%	100%	100%
N			
Chi-square=9.62, df=2, p=0.047			

Table 15. Health Access (Health Insurance) by Health							
In the last 6 months, were you covered by health insurance of any sort?	Overall, would you say your health is excellent, very good, good, fair or poor?						
	Excellent	Very Good	Good	Fair	Poor	Don't Know	Tot.
No	87%	94%	90%	85%	86%	100%	89%
Yes	13%	5%	8%	15%	14%	0%	11%
Skipped	%	0%	1%	0%	0%	0%	0%
Refuse	0%	0%	1%	0%	0%	0%	0%
Don't Know	0%	1%	0%	0%	0%	0%	0%
Total	100%	100%	100%	100%	100%	100%	100%
N	46	64	191	99	29	1	430
Chi-square=13.93, df=2, p=0.834							

Appendix E

Table 16.

Health Access (Health Insurance) by Physical Health

In the last 6 months, were you covered by health insurance of any sort?	Physical Health		
	6 Days or Less	7 Days or More	Total
No	91%	79%	89%
Yes	9%	21%	11%
Skipped	0%	0%	0%
Refuse	0%	0%	0%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	362	68	430
Chi-square=9.28, df=2, p=0.054			

Table 17.

Health Access (Health Insurance) by Mental Health

In the last 6 months, were you covered by health insurance of any sort?	Mental Health		
	6 Days or Less	7 Days or More	Total
No	90%	84%	89%
Yes	10%	16%	11%
Skipped	0%	0%	0%
Refuse	0%	0%	0%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	355	75	430
Chi-square=3.53, df=2, p=0.473			

Appendix E

Table 18.

Health Access (Health Insurance) by Hunger

In the last 6 months, were you covered by health insurance of any sort?	Hungry		
	No	Yes	Total
No	87%	95%	89%
Yes	13%	4%	11%
Skipped	0%	0%	0%
Refuse	0%	0%	0%
Don't Know	0%	1%	0%
Total	100%	100%	100%
N	310	120	430
Chi-square=10.38, df=2, p=0.035			

Appendix F

Table 1. Health Insurance Regression							
	I	II	III	IV	V	VII	VII
Constant	-2.532** (0.209)	-2.198** (0.259)	-1.993** (0.491)	-1.927** (0.500)	-2.291** (0.540)	-2.023** (0.714)	-0.838 (1.147)
Female	0.855** (0.298)	0.360 (0.190)	0.304 (0.421)	0.283 (0.425)	0.444 (0.427)	0.409 (0.430)	0.456 (0.425)
Child, does not live with		-1.410* (0.559)	-1.216* (0.563)	-1.180* (0.565)	-1.287* (0.566)	-1.234* (0.573)	-16.389 (1472.164)
Child lives with		0.302 (0.377)	0.425 (0.414)	0.402 (0.417)	0.293 (0.414)	0.185 (0.435)	-1.275 (1.214)
Formal Income			0.506 (0.446)	0.490 (0.453)	0.661 (0.472)	0.569 (0.524)	-1.371 (1.235)
Informal Income			-1.280** (0.482)	-1.225* (0.483)	-1.192 (0.487)	-1.262* (0.511)	-1.867 (1.162)
Formal & Informal Income			0.573 (0.530)	0.593 (0.533)	0.809 (0.549)	0.705 (0.609)	-0.615 (1.213)
Day Labor				-0.498 (0.538)	-0.426 (0.540)	-0.361 (0.550)	-0.647 (0.573)
Physical Health					1.166** (0.338)	1.091** (0.348)	1.204** (0.355)
Live in NY 5-9 years*DayLabor						0.004 (0.388)	0.315 (0.423)
Live in NY 1-4 years*DayLabor						-0.488 (0.427)	-0.363 (0.433)
Live in NY < 1 year*DayLabor						-0.712 (0.805)	-0.637 (0.816)
Total Income						0.008 (0.049)	-0.001 (0.050)
Child, does not live with, formal income							15.458 (1472.164)
Child, does not live with, informal income							15.175 (1472.164)
Child, does not live with, formal & informal income							15.006 (1472.164)
Child, does live with, formal income							2.662† (1.369)
Child, does live with, informal income							-0.844 (1.577)
Child, does live with, formal & informal income							1.744 (1.471)
N	430	430	430	430	430	429	429
Log Likelihood	-140	-134	-121	-120	-116	-114	-107

LR Chi2	7.93	20.08	45.80	46.76	57.06	59.80	73.71
Df	1	3	6	7	8	12	18
Prob > chi2	0.0049	0.0002	0.000	0.000	0.000	0.000	0.0000
**p<.01, *p<.05, †p<.10							

Appendix G

Table 1. Health Access (Medical Care I) by Age				
Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Age			
	18-29	30-39	40+	Total
Doctor	49%	42%	41%	45%
Medicaid or HMO	2%	3%	0%	2%
ER	15%	14%	15%	15%
Drug Treatment Center	0%	0%	0%	0%
Nowhere	34%	38%	41%	37%
Other	0%	2%	1%	1%
8	0%	1%	0%	0%
9	0%	0%	1%	0%
10	0%	1%	1%	0%
Total	100%	101%	100%	100%
N	202	146	81	429
Chi-square=17.89, df=3, p=0.330				

Appendix G

Table 2.

Health Access (Medical Care I) by Education

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Education			
	None — 8[6] Grade	Some HS or GED	HS or College	Tot.
Doctor	45%	47%	42%	45%
Medicaid or HMO	1%	4%	5%	2%
ER	15%	13%	14%	15%
Drug Treatment Center	0%	0%	0%	0%
Nowhere	37%	35%	40%	37%
Other	1%	1%	0%	1%
8	0%	0%	0%	0%
9	0%	0%	0%	0%
10	1%	0%	0%	0%
Total	100%	100%	101%	100%
N	290	75	65	430
Chi-square=10.48, df=3, p=0.840				

Appendix G

Table 3.

Health Access (Medical Care I) by Marital Status

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Total
Doctor	49%	41%	33%	50%	33%	50%	45%
Medicaid or HMO	1%	3%	0%	0%	0%	0%	2%
ER	13%	16%	23%	20%	0%	0%	15%
Drug Treatment Center	1%	0%	0%	0%	0%	0%	0%
Nowhere	34%	40%	22%	30%	67%	50%	37%
Other	1%	0%	22%	0%	0%	0%	1%
8	1%	0%	0%	0%	0%	0%	0%
9	0%	0%	0%	0%	0%	0%	0%
10	1%	0%	0%	0%	0%	0%	0%
Total	101%	100%	100%	100%	100%	100%	100%
N	177	217	9	20	3	4	430
Chi-square-59.15, df=6, p-0.026							

Appendix G

Table 4.

Health Access (Medical Care I) by Children

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Children		
	No	Yes	Total
Doctor	45%	44%	45%
Medicaid or HMO	3%	1%	2%
ER	15%	15%	15%
Drug Treatment Center	1%	0%	0%
Nowhere	35%	38%	37%
Other	1%	1%	1%
8	1%	0%	0%
9	0%	0%	0%
10	0%	1%	0%
Total	101%	100%	100%
N	144	286	430
Chi-square=6.70, df=2, p=0.569			

Appendix G

Table 5.

Health Access (Medical Care I) by Children & Living With/Without Children

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Children/ Live With You			
	No Children	Don't Live With	Live With	Tot.
Doctor	45%	31%	58%	45%
Medicaid or HMO	3%	0%	3%	2%
ER	15%	12%	18%	15%
Drug Treatment Center	1%	0%	0%	0%
Nowhere	35%	54%	21%	37%
Other	1%	1%	0%	1%
8	1%	0%	0%	0%
9	0%	1%	0%	0%
10	0%	1%	0%	0%
Total	101%	100%	100%	100 %
N	144	144	142	430
Chi-square=47.81, df=3, p=0.000				

Appendix G

Table 6.

Health Access (Medical Care I) by Living With/Without Children

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Children		
	Don't Live With	Live With	Total
Doctor	31%	58%	44%
Medicaid or HMO	0%	3%	1%
ER	12%	18%	15%
Nowhere	54%	21%	38%
Other	1%	1%	1%
9	1%	0%	0%
10	1%	0%	1%
Total	100%	101%	100%
N	144	142	286
Chi-square-40.27, df=2, p=0.000			

Appendix G

Table 7.

Health Access (Medical Care I) by Household Size

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Household Size			
	One	2-4	5+	Total
Doctor	50%	49%	39%	46%
Medicaid or HMO	0%	2%	2%	2%
ER	13%	16%	12%	14%
Drug Treatment Center	0%	0%	0%	0%
Nowhere	25%	32%	47%	37%
Other	4%	1%	1%	1%
8	4%	0%	0%	0%
9	0%	0%	0%	0%
10	4%	0%	0%	0%
Total	100%	100%	101%	100%
N	24	252	146	422
Chi-square-38.66, df=3, p=0.001				

Appendix G

Table 8.

Health Access (Medical Care I) by Homeless

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Homeless		
	No	Yes	Total
Doctor	45%	44%	45%
Medicaid or HMO	2%	0%	2%
ER	15%	13%	15%
Drug Treatment Center	0%	0%	0%
Nowhere	36%	44%	37%
Other	1%	0%	1%
8	0%	0%	0%
9	0%	0%	0%
10	1%	0%	0%
Total	100%	101%	100%
N	375	55	430
Chi-square=3.48, df=2, p=0.901			

Appendix G

Table 9.

Health Access (Medical Care I) by Time Lived in New York

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Tot.
Doctor	63%	48%	40%	15%	45%
Medicaid or HMO	1%	4%	1%	0%	2%
ER	15%	22%	11%	6%	15%
Drug Treatment Center	0%	0%	1%	0%	0%
Nowhere	19%	25%	46%	72%	37%
Other	1%	1%	1%	2%	1%
8	0%	0%	0%	2%	1%
9	1%	0%	0%	0%	0%
10	0%	0%	0%	4%	0%
Total	100%	100%	100%	101%	101
N	100	125	151	53	429
Chi-square-94.24, df=4, p=0.000					

Appendix G

Table 10.

Health Access (Medical Care I) by Income

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Total
Doctor	54%	55%	37%	58%	45%
Medicaid or HMO	2%	3%	1%	5%	2%
ER	18%	13%	14%	19%	15%
Drug Treatment Center	0%	0%	0%	0%	0%
Nowhere	23%	29%	47%	14%	37%
Other	2%	1%	1%	0%	1%
8	0%	0%	0%	2%	0%
9	0%	0%	0%	2%	0%
10	2%	0%	0%	0%	0%
Total	101%	101%	100%	100%	100%
N	100%	100%	100%	100%	100%
Chi-square=51.04, df=4, p=0.001					

Appendix G

Table 11.

Health Access (Medical Care I) by Remittances

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Remittances		
	No	Yes	Total
Doctor	53%	43%	45%
Medicaid or HMO	3%	2%	2%
ER	22%	14%	15%
Drug Treatment Center	0%	0%	0%
Nowhere	19%	40%	37%
Other	0%	I%	1%
8	2%	0%	0%
9	0%	0%	0%
10	2%	0%	0%
Total	101%	100%	100%
N	64	366	430
Chi-square=19.87, df=2, p=0.011			

Appendix G

Table 12.

Health Access (Medical Care I) by Day Labor

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Day Labor		
	No	Yes	Total
Doctor	48%	33%	45%
Medicaid or HMO	3%	0%	2%
ER	16%	12%	15%
Drug Treatment Center	0%	0%	0%
Nowhere	31%	54%	37%
Other	1%	0%	1%
8	0%	0%	0%
9	0%	1%	0%
10	1%	0%	0%
Total	100%	100%	100%
N	327	103	430
Chi-square=24.61, df=2, p=0.002			

Appendix G

Table 13.

Health Access (Medical Care I) by Gender

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Gender		
	Male	Female	Total
Doctor	38%	60%	45%
Medicaid or HMO	1%	3%	2%
ER	13%	19%	15%
Drug Treatment Center	0%	0%	0%
Nowhere	46%	15%	37%
Other	1%	2%	1%
8	0%	0%	0%
9	0%	0%	0%
10	1%	1%	0%
Total	100%	100%	100%
N	301	129	430
Chi-square=41.40, df=2, p=0.000			

Appendix G

Table 14.

Health Access (Medical Care I) by Moms

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Moms		
	Non-Mom	Mom	Total
Doctor	38%	64%	45%
Medicaid or HMO	2%	3%	2%
ER	14%	18%	15%
Drug Treatment Center	0%	0%	0%
Nowhere	45%	13%	37%
Other	1%	2%	1%
8	0%	0%	0%
9	0%	0%	0%
10	0%	1%	0%
Total	100%	101%	100%
N	327	103	430
Chi-square=37.74, df=2, p=0.000			

Appendix G

Table 15.
Health Access (Medical Care I) by Health

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Overall, would you say your health is excellent, very good, good, fair or poor?						
	Excel! ent	Very Good	Good	Fair	Poor	Don't Know	Total
Doctor	41%	53%	38%	47%	66%	0%	45%
Medicaid or HMO	2%	2%	3%	1%	0%	0%	2%
ER	20%	13%	16%	14%	7%	0%	15%
Drug Treatment Center	2%	0%	0%	0%	0%	0%	0%
Nowhere	35%	30%	41%	36%	28%	100%	37%
Other	0%	0%	2%	1%	0%	0%	1%
8	0%	1%	0%	0%	0%	0%	0%
9	0%	0%	0%	I%	0%	0%	0%
10	0%	1%	1%	0%	0%	0%	0%
Total	100%	100%	101%	100%	101%	100%	100%
N	46	64	191	99	29	1	430
Chi-square=35.62, df=6, p=0.668							

Appendix G

Table 16. Health Access (Medical Care I) by Physical Health			
Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Physical Health		
	6 Days or Less	7 Days or More	Total
Doctor	44%	50%	45%
Medicaid or HMO	2%	I%	2%
ER	14%	18%	15%
Drug Treatment Center	0%	0%	0%
Nowhere	38%	28%	37%
Other	1%	3%	1%
8	0%	0%	0%
9	0%	0%	0%
10	1%	0%	0%
Total	100%	100%	100%
N	362	68	430
Chi-square=7.23, df=2, p=0.512			

Appendix G

Table 17.

Health Access (Medical Care I) by Mental Health

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Mental Health		
	6 Days or Less	7 Days or More	Total
Doctor	44%	48%	45%
Medicaid or HMO	2%	2%	2%
ER	13%	21%	15%
Drug Treatment Center	0%	1%	0%
Nowhere	39%	28%	37%
Other	1%	0%	1%
8	0%	0%	0%
9	0%	0%	0%
10	1%	0%	0%
Total	100%	100%	100%
N	355	75	430
Chi-square=11.45, df=2, p=0.178			

Appendix G

Table 18.

Health Access (Medical Care I) by Health Insurance

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Health Insurance		
	No	Yes	Total
Doctor	43%	64%	45%
Medicaid or HMO	1%	9%	2%
ER	14%	20%	15%
Drug Treatment Center	0%	0%	0%
Nowhere	40%	7%	37%
Other	1%	0%	1%
8	0%	0%	0%
9	0%	0%	0%
10	1%	0%	0%
Total	100%	100%	100%
N	385	45	430
Chi-square=32.16, df=2, p=0.000			

Appendix G

Table 19.

Health Access (Medical Care I) by Hunger

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Hungry		
	No	Yes	Total
Doctor	48%	38%	45%
Medicaid or HMO	3%	0%	2%
ER	15%	13%	15%
Drug Treatment Center	0%	0%	0%
Nowhere	32%	49%	37%
Other	1%	1%	1%
8	0%	0%	0%
9	0%	0%	0%
10	1%	0%	0%
Total	100%	101%	100%
N	310	120	430
Chi-square=14.47, df=2, p=0.070			

Appendix G

Table 20.

Health Access (Medical Care I) by Health Access (ER)

Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?	Have you been seen or received care in an emergency room during the past 6 months?				
	No	Yes	Skipped	Refused	Total
Doctor	43%	55%	25%	50%	45%
Medicaid or HMO	2%	2%	0%	0%	2%
ER	12%	31%	50%	0%	15%
Drug Treatment Center	0%	0%	0%	0%	0%
Nowhere	41%	I I%	25%	50%	37%
Other	1%	2%	0%	0%	1%
8	0%	0%	0%	0%	0%
9	0%	0%	0%	0%	0%
10	1%	0%	0%	0%	0%
Total	100%	101%	100%	100%	100%
N					
Chi-square=30.49, df=4, p=0.169					

Appendix H

Table 1. Health Access (Medical Care II) by Living With/Without Children			
Have you seen the same doctor, nurse, or physician's assistant for medical care?	**Children**		
	Don't Live With	**Live With**	**Total**
No	47%	24%	31%
Yes	53%	75%	68%
Refuse	0%	1%	1%
Total	100%	100%	100%
N	34	68	102
Chi-square=6.13, df=2, p=0.047			

Appendix I

Table 1. Health Access (ER) by Age				
Have you been seen or received care in an emergency room during the past 6 months?	Age			
	18-29	30-39	40+	Total
No	88%	86%	80%	86%
Yes	11%	13%	18%	13%
Skipped	1%	1%	1%	1%
Refuse	0%	0%	1%	0%
Total	100%	100	100%	100%
N	202	146	81	429
Chi-square=4.12, df=3, p=0.661				

Table 2. Health Access (ER) by Education				
Have you been seen or received care in an emergency room during the past 6 months?	Education			
	None — 8th Grade	Some HS or GED	HS or College	Total
No	87%	86%	81%	86%
Yes	12%	12%	17%	13%
Skipped	1%	1%	2%	1%
Refuse	0%	1%	0%	0%
Total	100%	100%	100%	100%
N	290	75	65	430
Chi-square=3.38, df=3, p=0.760				

Appendix I

Table 3.

Health Access (ER) by Marital Status

Have you been seen or received care in an emergency MOM during the past 6 months?	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Tot.
No	86%	85%	89%	90%	33%	100%	86%
Yes	12%	13%	11%	10%	67%	0%	13%
Skipped	1%	1%	0%	0%	0%	0%	1%
Refuse	1%	1%	0%	0%	0%	0%	0%
Total	100%	100%	100%	100%	100%	100%	100%
N	177	217	9	20	3	4	430
Chi-square-9.38, df=6, p=0.857							

Table 4.

Health Access (ER) by Children

Have you been seen or received care in an emergency room during the past 6 months?	Children		
	No	Yes	Total
No	85%	86%	86%
Yes	15%	12%	13%
Skipped	0%	1%	1%
Refuse	0%	1%	0%
Total	100%	100%	100%
N	144	286	430
Chi-square=1.71, df=2 p=0.635			

Appendix I

Table 5.

Health Access (ER) by Children & Living With/Without Children

Have you been seen or received care in an emergency room during the past 6	Children/ Live With You			
	No Children	Don't Live With	Live With	Tot.
No	85%	89%	84%	86%
Yes	15%	9%	14%	13%
Skipped	0%	1%	1%	1%
Refuse	0%	0%	1%	0%
Total	100%	100%	100%	100%
N	144	144	142	430
Chi-square=4.14, df=3, p=0.658				

Table 6.

Health Access (ER) by Living With/Without Children

Have you been seen or received care in an emergency room during the past 6 months?	Children		
	Don't Live With	Live With	Total
No	89%	84%	85%
Yes	9%	14%	13%
Skipped	1%	1%	1%
Refuse	0%	1%	1%
Total	100%	100%	100%
N	144	142	286
Chi-square=2.53, df=2, p=0.470			

Appendix I

Table 7.

Health Access (ER) by Household Size

Have you been seen or received care in an emergency room during the past 6 months?	Household Size			
	One	2-4	5+	Total
No	79%	86%	88%	86%
Yes	21%	13%	11%	13%
Skipped	0%	0%	1%	1%
Refuse	0%	1%	0%	0%
Total	100%	100%	100%	100
N	24	252	146	422
Chi-square=4.56, df=3, p=0.602				

Table 8.

Health Access (ER) by Homeless

Have you been seen or received care in an emergency room during the past 6 months?	Homeless		
	No	Yes	Total
No	87%	78%	86%
Yes	12%	20%	13%
Skipped	1%	2%	1%
Refuse	0%	0%	0%
Total	100%	100%	100%
N	375	55	430
Chi-square=3.82, df=2, p=0.282			

Appendix I

Table 9.

Health Access (ER) by Time Lived in New York

Have you been seen or received care in an emergency room during the past 6 months?	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Tot.
No	83%	86%	83%	96%	86%
Yes	17%	14%	13%	2%	13%
Skipped	0%	0%	3%	0%	1%
Refuse	0%	0%	1%	2%	0%
Total	100%	100%	100%	100%	100 %
N					
Chi-square=18.08, df=4, p=0.034					

Table 10.

Health Access (ER) by Income

Have you been seen or received care in an emergency room during the past 6 months?	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Tot.
No	89%	85%	87%	77%	86%
Yes	11%	14%	12%	19%	13%
Skipped	0%	1%	1%	2%	1%
Refuse	0%	0%	0%	2%	0%
Total	100%	100%	100%	100%	100%
N	61	77	249	43	430
Chi-square=7.63, df=4, p=0.572					

Appendix I

Table 11. Health Access (ER) by Remittances			
Have you been seen or received care in an emergency room during the past 6 months?	Remittances		
	No	Yes	Total
No	86%	86%	86%
Yes	14%	13%	13%
Skipped	0%	1%	1%
Refuse	0%	0%	0%
Total	100%	100%	100%
N	64	366	430
Chi-square=1.14, df=2, p=0.766			

Table 12. Health Access (ER) by Day Labor			
Have you been seen or received care in an emergency room during the past 6 months?	Day Labor		
	No	Yes	Total
No	85%	88%	86%
Yes	14%	11%	13%
Skipped	1%	0%	1%
Refuse	0%	1%	0%
Total	100%	100%	100%
N	327	103	430
Chi-square=2.58, df=2, p=0.461			

Appendix I

Table 13. Health Access (ER) by Gender			
Have you been seen or received care in an emergency room during the past 6 months?	Gender		
	Male	Female	Total
No	88%	81%	86%
Yes	11%	18%	13%
Skipped	1%	1%	1%
Refuse	0%	0%	0%
Total	100%	100%	100%
N	301	129	430
Chi-square=4.66, df2, p=0.198			

Table 14. Health Access (ER) by Moms			
Have you been seen or received care in an emergency room during the past 6 months?	Moms		
	Non-Mom	Mom	Total
No	87%	82%	86%
Yes	12%	17%	13%
Skipped	1%	0%	1%
Refuse	0%	1%	0%
Total	100%	100%	100%
N	323	107	430
Chi-square=4.02, df=2, p=0.259			

Appendix I

Table 15.

Health Access (ER) by Physical Health

Have you been seen or received care in an emergency room during the past 6 months?	Overall, would you say your health is excellent, very good, good, fair or poor?						
	Excellent	Very Good	Good	Fair	Poor	Don't Know	Tot.
No	94%	86%	85%	88%	69%	100%	86%
Yes	4%	12%	13%	11%	31%	0%	13%
Skipped	0%	2%	1%	1%	0%	0%	1%
Refuse	2%	0%	1%	0%	0%	0%	0%
Total	100%	100%	100%	100%	100%	100%	100 %
N	46	64	191	99	29	1	430
Chi-square-16.64, df=2, p=0.341							

Table 16.

Health Access (ER) by Physical Health

Have you been seen or received care in an emergency room during the past 6 months?	Physical Health		
	6 Days or Less	7 Days or More	Total
No	88%	75%	86%
Yes	11%	25%	13%
Skipped	1%	0%	1%
Refuse	0%	0%	0%
Total	100%	100%	100%
N	362	68	430
Chi-square=11.64, df=2, p=0.009			

Appendix I

Table 17.

Health Access (ER) by Mental Health

Have you been seen or received care in an emergency room during the past 6 months?	Mental Health		
	6 Days or Less	7 Days or More	Total
No	88%	73%	86%
Yes	10%	26%	13%
Skipped	1%	1%	1%
Refuse	1%	0%	0%
Total	100%	100%	100%
N	355	75	430
Chi-square=13.40, df=2, p=0.004			

Table 18.

Health Access (ER) by Health Insurance

Have you been seen or received care in an emergency room during the past 6 months?	Health Insurance		
	No	Yes	Total
No	87%	78%	86%
Yes	12%	22%	13%
Skipped	1%	0%	1%
Refuse	0%	0%	0%
Total	100%	100%	100%
N	385	45	430
Chi-square=4.57, df=2, p=0.206			

Appendix I

Table 19. Health Access (ER) by Hunger			
Have you been seen or received care in an emergency room during the past 6 months?	Hungry		
	No	Yes	Total
No	86%	85%	86%
Yes	13%	13%	13%
Skipped	1%	1%	1%
Refuse	0%	1%	0%
Total	100%	100%	100%
N	310	120	430
Chi-square-0.55, df=2, p=0.907			

Appendix J

Table 1. Health Outcome (II) by Age				
Overall, would you say your health is excellent, very good, good, fair or poor?	Age			
	18-29	30-39	40+	Total
Excellent	13%	8%	9%	11%
Very Good	16%	17%	9%	15%
Good	45%	44%	43%	44%
Fair	19%	25%	30%	23%
Poor	6%	6%	10%	7%
Don't Know	1%	0%	0%	0%
Total	100%	100%	101%	100%
N	203	146	81	430
Chi-square=10.80, df=3, p=0.373				

Table 2. Health Outcome (II) by Education				
Overall, would you say your health is excellent, very good, good, fair or poor?	Education			
	None — 8[6] Grade	Some HS or GED	HS or College	Total
Excellent	11%	7%	14%	11%
Very Good	13%	17%	18%	15%
Good	45%	45%	42%	45%
Fair	24%	24%	18%	23%
Poor	7%	7%	6%	7%
Don't Know	0%	0%	2%	0%
Total	100%	100%	100%	101%
N	291	75	65	431
Chi-square=9.57, df=3, p=0.479				

Appendix J

Table 3.

Health Outcome (II) by Marital Status

Overall, would you say your health is excellent, very good, good, fair or poor?	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Total
Excellent	14%	9%	11%	5%	0%	0%	11%
Very Good	18%	13%	0%	20%	0%	0%	15%
Good	41%	46%	56%	50%	33.33%	75%	45%
Fair	21%	25%	33%	10%	33.33%	25%	23%
Poor	6%	7%	0%	15%	33.33%	0%	7%
Don't Know	0%	0%	0%	0%	0%	0%	0%
Total	100%	100%	100%	100%	100%	100%	100%
N	177	218	9	20	3	4	431
Chi-square=19.74, df=6, p=0.760							

Appendix J

Table 4. Health Outcome (II) by Children			
Overall, would you say your health is excellent, very good, good, fair or poor?	Children		
	No	Yes	Total
Excellent	15%	9%	11%
Very Good	20%	12%	15%
Good	42%	46%	45%
Fair	18%	25%	23%
Poor	5%	8%	7%
Don't Know	1%	0%	0%
Total	101%	100%	101%
N	144	287	431
Chi-square=12.96, df=2, p=0.024			

Appendix J

Table 5.

Health Outcome (II) by Children & Living With/Without Children

Overall, would you say your health is excellent, very good, good, fair or poor?	Children/ Live With You			
	No Children	Don't Live With	Live With	Tot.
Excellent	15%	9%	9%	11%
Very Good	20%	13%	11%	15%
Good	42%	45%	47%	45%
Fair	18%	24%	27%	23%
Poor	5%	9%	6%	7%
Don't Know	1%	0%	0%	0%
Total	101%	100%	100%	101%
N	144	144	143	431
Chi-square=14.20, df=3, p=0.164				

Appendix J

Table 6.

Health Outcome (II) by Living With/Without Children

Overall, would you say your health is excellent, very good, good, fair or poor?	Children		
	Don't Live With	Live With	Total
Excellent	9%	9%	9%
Very Good	13%	11%	12%
Good	45%	47%	46%
Fair	24%	27%	25%
Poor	9%	6%	8%
Total	100%	100%	100%
N	144	143	287
Chi-square=1.17, df=2, p=0.882			

Appendix J

Table 7.

Health Outcome (II) by Household Size

Overall, would you say your health is excellent, very good, good, fair or poor?	Household Size			
	One	2-4	5+	Total
Excellent	8%	12%	10%	11%
Very Good	8%	17%	12%	15%
Good	46%	41%	51%	45%
Fair	29%	24%	21%	23%
Poor	9%	7%	6%	7%
Don't Know	0%	0%	0%	0%
Total	99%	101%	100%	101%
N	24	252	147	423
Chi-square=6.12, df=3, p=0.805				

Appendix J

Table 8. Health Outcome (II) by Homeless			
Overall, would you say your health is excellent, very good, good, fair or poor?	Homeless		
	No	Yes	Total
Excellent	11%	7%	11%
Very Good	15%	16%	15%
Good	47%	25%	45%
Fair	22%	31%	23%
Poor	5%	20%	7%
Don't Know	0%	0%	0%
Total	100%	100%	101%
N	376	55	431
Chi-square=24.32, df=2, p=0.000			

Appendix J

Table 9.

Health Outcome (II) by Time Lived in New York

Overall, would you say your health is excellent, very good, good, fair or poor?	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Tota I
Excellent	6%	10%	16%	8%	11%
Very Good	9%	19%	17%	11%	15%
Good	39%	43%	44%	58%	44%
Fair	37%	18%	20%	15%	23%
Poor	9%	10%	3%	6%	7%
Don't Know	0%	0%	0%	2%	0%
Total	100%	100%	100%	100%	100 %
N	100	125	152	53	430
Chi-square=39.57, df=4, p=0.001					

Appendix J

Table 10.

Health Outcome (II) by Income

Overall, would you say your health is excellent, very good, good, fair or poor?	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Tot.
Excellent	5%	16%	10%	12%	11%
Very Good	10%	16%	13%	30%	15%
Good	48%	40%	46%	40%	45%
Fair	27%	22%	24%	14%	23%
Poor	10%	7%	6%	5%	7%
Don't Know	0%	0%	1%	0%	0%
Total	100%	100%	100%	101%	101%
N	62	77	249	43	431
Chi-square=17.03, df=4, p=0.317					

Table 11.

Health Outcome (II) by Remittances

Overall, would you say your health is excellent, very good, good, fair or poor?	Remittances		
	No	Yes	Total
Excellent	8%	11%	11%
Very Good	15%	15%	15%
Good	49%	44%	45%
Fair	26%	22%	23%
Poor	2%	8%	7%
Don't Know	0%	0%	0%
Total	100%	100%	101%
N	65	366	431
Chi-square=4.61, df=2, p=0.465			

Appendix J

Table 12.

Health Outcome (II) by Day Labor

Overall, would you say your health is excellent, very good, good, fair or poor?	Day Labor		
	No	Yes	Total
Excellent	11%	11%	11%
Very Good	15%	14%	15%
Good	45%	42%	45%
Fair	23%	24%	23%
Poor	6%	10%	7%
Don't Know	0%	0%	0%
Total	100%	101%	101%
N	328	103	431
Chi-square=2.58, df=2, p=0.764			

Appendix J

Table 13.

Health Outcome (II) by Gender

Overall, would you say your health is excellent, very good, good, fair or poor?	Gender		
	Male	Female	Total
Excellent	12%	8%	11%
Very Good	15%	14%	15%
Good	42%	52%	45%
Fair	23%	22%	23%
Poor	8%	5%	7%
Don't Know	0%	0%	0%
Total	100%	101%	101%
N	301	130	431
Chi-square=5.42, df=2, p=0.367			

Appendix J

Table 14.

Health Outcome (II) by Moms

Overall, would you say your health is excellent, very good, good, fair or poor?	Moms		
	Non-Mom	Mom	Total
Excellent	12%	8%	11%
Very Good	16%	12%	14%
Good	43%	50%	45%
Fair	22%	25%	23%
Poor	7%	5%	7%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	323	108	431
Chi-square=4.00, df=2, p=0.549			

Appendix J

Table 15.

Health Outcome (II) by Physical Health

Overall, would you say your health is excellent, very good, good, fair or poor?	Physical Health		
	6 Days or Less	7 Days or More	Total
Excellent	11%	7%	11%
Very Good	16%	9%	15%
Good	48%	25%	45%
Fair	21%	35%	23%
Poor	4%	24%	7%
Don't Know	0%	0%	0%
Total	100%	100%	101%
N	363	68	431
Chi-square=49.13, df=2, p=0.000			

Appendix J

Table 16.

Health Outcome (II) by Mental Health

Overall, would you say your health is excellent, very good, good, fair or poor?	Mental Health		
	6 Days or Less	7 Days or More	Total
Excellent	11%	8%	11%
Very Good	16%	11%	15%
Good	47%	35%	44%
Fair	21%	33%	23%
Poor	5%	13%	7%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	355	75	430
Chi-square=13.90, df=2, p=0.016			

Appendix J

Table 17.

Health Outcome (II) by Health Insurance

Overall, would you say your health is excellent, very good, good, fair or poor?	Health Insurance		
	No	Yes	Total
Excellent	10%	13%	11%
Very Good	16%	7%	15%
Good	45%	38%	44%
Fair	22%	33%	23%
Poor	7%	9%	7%
Don't Know	0%	0%	0%
Total	100%	100%	100%
N	385	45	430
Chi-square=5.89, df=2, p=0.318			

Appendix J

Table 18. Health Outcome (II) by Hunger			
Overall, would you say your health is excellent, very good, good, fair or poor?	Hungry		
	No	Yes	Total
Excellent	12%	7%	11%
Very Good	15%	14%	15%
Good	45%	44%	45%
Fair	24%	22%	23%
Poor	4%	13%	7%
Don't Know	0%	0%	0%
Total	100%	100%	101%
N	311	120	431
Chi-square=13.85, df=2, p=0.017			

Appendix K

Table 1. Poor Health Regression
Coefficients from complementary log-log regression (standard errors in parenthesis)

	I	II	III	IV	V	VI
Constant	-0.484** (0.150)	-0.540** (0.154)	-0.275 (0.226)	-0.380 (0.274)	-0.356 (0.324)	-0.556 (0.359)
Live in NY 5-9 years	-0.596** (0.225)	-0.623** (0.226)	-0.662** (0.227)	-0.613** (0.234)	-0.713** (0.244)	-0.805** (0.292)
Live in NY 1-4 years	-0.856** (0.226)	-0.922** (0.230)	-0.957** (0.231)	-0.873** (0.251)	-0.988** (0.266)	-0.723† (0.306)
Live in NY < 1 year	-0.974** (0.337)	-1.057** (0.341)	-1.130** (0.344)	-1.080** (0.349)	-1.254** (0.369)	-0.770† (0.399)
Day Labor		-0.375† (0.205)	0.355† (0.205)	0.335 (0.207)	0.263 (0.212)	1.180† (0.654)
Total income			-0.036 (0.023)	-0.037 (0.023)	-0.043† (0.024)	-0.040† (0.024)
Age (30-39)				0.047 (0.216)	-0.073 (0.227)	0.060 (0.267)
Age (40+)				0.252 (0.247)	0.107 (0.264)	0.233 (0.309)
Child, does not live with					0.454† (0.250)	0.534 (0.295)
Child lives with					0.084 (0.252)	0.069 (0.286)
Live in NY 5-9 years*DayLabor						0.101 (0.574)
Live in NY 1-4 years*DayLabor						-1.052† (0.632)
Live in NY < 1 year*DayLabor						-2.406* (1.171)
Age (30-39) *DayLabor						-0.703 (0.548)
Age (40+)*DayLabor						-0.786 (0.622)
Child, does not live with *DayLabor						-0.172 (0.558)
Child lives with*DayLabor						0.364 (0.617)
N	430	430	430	430	430	429
Log Likelihood	-253	-252	-250	-249	-248	-240
LR Chi2	17.39	20.57	22.97	24.07	27.94	42.06

Df	3	4	5	7	9	16
Prob > chi2	0.0006	0.0004	0.0003	0.0011	0.0010	0.0004
**p<.01, *p<.05, †p<.10						

Appendix L

Table 1. Physical Health by Age				
For how many days during the past 30 days was your physical health not good?	Age			
	18-29	30-39	40+	Total
6 Days or Less	87%	84%	78%	84%
7 Days or More	13%	16%	22%	16%
Total	100%	100%	100%	100%
N	203	146	81	430
Chi-square=3.92, df=3, p=0.141				

Table 2. Physical Health by Education				
For how many days during the past 30 days was your physical health not good?	Education			
	None — 8th Grade	Some HS or GED	HS or College	Total
6 Days or Less	82%	84%	92%	84%
7 Days or More	18%	16%	8%	16%
Total	100%	100%	100%	100%
N	291	75	65	431
Chi-square=3.87, df=3. p=0.144				

Table 3. Physical Health by Marital Status							
For how many days during the past 30 days was your physical health not good?	Marital Status						
	Single	Married	Div.	Separated	Widowed	Other	Tot.
6 Days or Less	86%	85%	78%	60%	67%	100%	84%
7 Days or More	14%	15%	22%	40%	33%	0%	16%
Total	100%	100%	100%	100%	100%	100%	100%
N	177	218	9	20	3	4	431
Chi-square=1 1.12, df=6, p=0.049							

Appendix L

Table 4.

Physical Health by Children

For how many days during the past 30 days was your physical health not good?	Children		
	No	Yes	Total
6 Days or Less	87%	83%	84%
7 Days or More	13%	17%	16%
Total	100%	100%	100%
N	144	287	431
Chi-square=1.09, df=2, p=0.297			

Table 5.

Physical Health by Children & Living With/Without Children

For how many days during the past 30 days was your physical health not good?	Children/ Live With You			
	No Children	Don't Live With	Live Wit h	Total
6 Days or Less	87%	85%	81%	84%
7 Days or More	13%	15%	19%	16%
Total	100%	100%	100%	100%
N	144	144	143	431
Chi-square=1.79, df=3, p=0.409				

Appendix L

Table 6. Physical Health by Living With/Without Children			
For how many days during the past 30 days was your physical health not good?	Children		
	Don't Live With	Live With	Total
6 Days or Less	85%	81%	83%
7 Days or More	15%	19%	17%
Total	100%	100%	100%
N	144	143	287
Chi-square=0.66, df=2, p=0.417			

Table 7. Physical Health by Household Size				
For how many days during the past 30 days was your physical health not good?	Household Size			
	One	2-4	5+	Total
6 Days or Less	92%	85%	84%	85%
7 Days or More	8%	15%	16%	15%
Total	100%	100%	100%	100%
N	24	252	147	423
Chi-square=1.02, df=3, p=0.601				

Appendix L

Table 8.

Physical Health by Homeless

For how many days during the past 30 days was your physical health not good?	Homeless		
	No	Yes	Total
6 Days or Less	86%	75%	84%
7 Days or More	14%	25%	16%
Total	100%	100%	100%
N	376	55	431
Chi-square=4.44, df=2, p=0.035			

Table 9.

Physical Health by Time Lived in New York

For how many days during the past 30 days was your physical health not good?	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Total
6 Days or Less	81%	79%	90%	85%	84%
7 Days or More	19%	21%	10%	15%	16%
Total	100%	100%	100%	100%	100%
N	100	125	152	53	430
Chi-square=7.15, df=4, p=0.067					

Appendix L

Table 10.

Physical Health by Income

For how many days during the past 30 days was your physical health not good?	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Tot.
6 Days or Less	81%	86%	84%	88%	84%
7 Days or More	19%	14%	16%	12%	16%
Total	100%	100%	100%	100%	100 %
N	62	77	249	43	431
Chi-square=1.30, df=4, p=0.729					

Table 11.

Physical Health by Remittances

For how many days during the past 30 days was your physical health not good?	Remittance		
	No	Yes	Total
6 Days or Less	86%	84%	84%
7 Days or More	14%	16%	16%
Total	100%	100%	100%
N	65	366	431
Chi-square=0.21, df=2, p=0.643			

Appendix L

Table 12. Physical Health by Day Labor			
For how many days during the past 30 days was your physical health not good?	Day Labor		
	No	Yes	Total
6 Days or Less	84%	86%	84%
7 Days or More	16%	14%	16%
Total	100%	100%	100%
N	328	103	431
Chi-square=0.47, df=2, p=0.486			

Table 13. Physical Health by Gender			
For how many days during the past 30 days was your physical health not good?	Gender		
	Male	Female	Total
6 Days or Less	84%	84%	84%
7 Days or More	16%	16%	16%
Total	100%	100%	100%
N	301	130	431
Chi-square=0.02, df=2, p=0.888			

Appendix L

Table 14. Physical Health by Moms			
For how many days during the past 30 days was your physical health not good?	Moms		
	Non-Mom	Mom	Total
6 Days or Less	85%	82%	84%
7 Days or More	15%	18%	16%
Total	100%	100%	100%
N	323	108	431
Chi-square=0.47, df=2, p=0.492			

Table 15. Physical Health by Physical Health			
For how many days during the past 30 days was your physical health not good?	Physical Health		
	6 Days or Less	7 Days or More	Total
6 Days or Less	100%	0%	84%
7 Days or More	0%	100%	16%
Total	100%	100%	100%
N	363	68	431
Chi-square=43.1, df=2, p=0.000			

Appendix L

Table 16. Physical Health by Mental Health			
For how many days during the past 30 days was your physical health not good?	Mental Health		
	6 Days or Less	7 Days or More	Total
6 Days or Less	89%	63%	84%
7 Days or More	11%	37%	16%
Total	100%	100%	100%
N	355	75	430
Chi-square=31.60, df=2, p=0.000			

Table 17. Physical Health by Health Insurance			
For how many days during the past 30 days was your physical health not good?	Health Insurance		
	No	Yes	Total
6 Days or Less	86%	69%	84%
7 Days or More	14%	31%	16%
Total	100%	100%	100%
N	385	45	430
Chi-square=8.83, df=2, p=0.003			

Appendix L

Table 18. Physical Health by Hunger			
For how many days during the past 30 days was your physical health not good?	Hungry		
	No	Yes	Total
6 Days or Less	88%	74%	84%
7 Days or More	12%	26%	16%
Total	100%	100%	100%
N	311	120	431
Chi-square=12.66, df=2, p=0.000			

Appendix M

Table 1. Mental Health by Age				
For how many days during the past 30 days was your mental health not good?	Age			
	18-29	30-39	40+	Total
6 Days or Less	83%	80%	85%	83%
7 Days or More	17%	20%	15%	17%
Total	100%	100%	100%	100%
N	202	146	81	429
Chi-square=1.03, df=3, p=0.597				

Table 2. Mental Health by Education				
For how many days during the past 30 days was your mental health not good?	Education			
	None — 8th Grade	Some HS or GED	HS or College	Total
6 Days or Less	86%	73%	80%	83%
7 Days or More	14%	27%	20%	17%
Total	100%	100%	100%	100%
N	290	75	65	430
Chi-square=6.49, df=3, p=0.039				

Appendix M

Table 3.

Mental Health by Marital Status

For how many days during the past 30 days was your mental health not good?	Marital Status						
	Single	Married	Div.	Separated	Widowed	Other	Tot.
6 Days or Less	70%	85%	100%	75%	67%	100%	83%
7 Days or More	20%	15%	0%	25%	33%	0%	17%
Total	100%	100%	100%	100%	100%	100%	100%
N	177	217	9	20	3	4	430
Chi-square=5.85, df=6, p=0.321							

Table 4.

Mental Health by Children

For how many days during the past 30 days was your mental health not good?	Children		
	No	Yes	Total
6 Days or Less	85%	81%	83%
7 Days or More	15%	19%	17%
Total	100%	100%	100%
N	144	286	430
Chi-square=11.23, df=2, p=0.268			

Appendix M

Table 5.

Mental Health by Children & Living With/Without Children

For how many days during the past 30 days was your mental health not good?	Children			
	No Children	Don't Live With	Live With	Total
6 Days or Less	85%	84%	78%	83%
7 Days or More	15%	16%	22%	17%
Total	100%	100%	100%	100%
N	144	144	142	430
Chi-square=2.93, df=3, p=0.231				

Table 6.

Mental Health by Living With/Without Children

For how many days during the past 30 days was your mental health not good?	Children		
	Don't Live With	Live With	Total
6 Days or Less	84%	78%	81%
7 Days or More	16%	22%	19%
Total	100%	100%	100%
N	144	142	286
Chi-square=1.60, df=2, p=0.206			

Appendix M

Table 7. Mental Health by Household Size				
For how many days during the past 30 days was your mental health not good?	Household Size			
	One	2-4	5+	Total
6 Days or Less	83.33%	82.14%	83.56%	83%
7 Days or More	16.53%	23.64%	16.44%	17%
Total	100%	100%	100%	100%
N	24	252	146	422
Chi-square=0.14, df=3, p=0.934				

Table 8. Mental Health by Homeless			
For how many days during the past 30 days was your mental health not good?	Homeless		
	No	Yes	Total
6 Days or Less	83.47%	76.36%	83%
7 Days or More	16.53%	23.64%	17%
Total	100%	100%	100%
N	375	55	430
Chi-square=1.68, df=2, p=0.195			

Appendix M

Table 9.

Mental Health by Time Lived in New York

For how many days during the past 30 days was your mental health not good?	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Total
6 Days or Less	75%	80%	87%	89%	83%
7 Days or More	25%%	20%	13%	11%	17%
Total	100%	100%	100%	100%	100%
N	100	125	151	53	429
Chi-square=8.37, df=4, p=0.039					

Table 10.

Mental Health by Income

For how many days during the past 30 days was your mental health not good?	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Total
6 Days or Less	80%	86%	82%	84%	83%
7 Days or More	20%	14%	18%	16%	17%
Total	100%	100%	100%	100%	100%
N	61	77	249	43	430
Chi-square=0.85, df=4, p=0.837					

Appendix M

Table 11.

Mental Health by Remittances

For how many days during the past 30 days was your mental health not good?	Remittances		
	No	Yes	Total
6 Days or Less	89%	81%	83%
7 Days or More	11%	19%	17%
Total	100%	100%	100%
N	64	366	430
Chi-square=2.21, df=2, p=0.137			

Table 12.

Mental Health by Day Labor

For how many days during the past 30 days was your mental health not good?	Day Labor		
	No	Yes	Total
6 Days or Less	84%	79%	83%
7 Days or More	16%	21%	17%
Total	100%	100%	100%
N	327	103	430
Chi-square=1.44, df=2, p=0.230			

Appendix M

Table 13. Mental Health by Gender			
For how many days during the past 30 days was your mental health not good?	Gender		
	Male	Female	Total
6 Days or Less	83%	81%	83%
7 Days or More	17%	19%	17%
Total	100%	100%	100%
N	301	129	430
Chi-square=0.48, df=2, p=0.488			

Table 14. Mental Health by Moms			
For how many days during the past 30 days was your mental health not good?	Moms		
	Non-Mom	Mom	Total
6 Days or Less	83%	80%	83%
7 Days or More	17%	20%	17%
Total	100%	100%	100%
N	323	107	430
Chi-square=0.47, df=2, p=0.492			

Appendix M

Table 15.

Mental Health by Health Insurance

For how many days during the past 30 days was your mental health not good?	Health Insurance		
	No	Yes	Total
6 Days or Less	84%	73%	83%
7 Days or More	16%	27%	17%
Total	100%	100%	100%
N	385	45	430
Chi-square-2.97, df=2, p=0.085			

Table 16.

Mental Health by Hunger

For how many days during the past 30 days was your mental health not good?	Hungry		
	No	Yes	Total
6 Days or Less	85%	78%	83%
7 Days or More	15%	22%	17%
Total	100%	100%	100%
N	310	120	430
Chi-square-2.96, df=2, p=0.085			

Appendix M

Table 17.

Mental Health by Physical Health

For how many days during the past 30 days was your mental health not good?	Physical Health		
	6 Days or Less	7 Days or More	Total
6 Days or Less	87%	59%	83%
7 Days or More	13%	41%	17%
Total	100%	100%	100%
N	362	68	430
Chi-square=31.60, df=2, p=0.000			

Appendix M

Table 18. Correlates of mental health among undocumented Mexicans in New York Coefficients from complementary log-log regression (standard errors in parenthesis)						
	I	II	III	IV	V	VI
Constant	-1.733*** (0.138)	-1.320*** (0.207)	-1.356*** (0.306)	-1.209** (0.357)	-1.448** (0.422)	-1.682*** (0.474)
Day Labor	0.031 (0.254)	.440† (0.258)	0.442† (0.259)	0.481† (0.261)	0.519† (0.268)	1.361 (0.840)
Live in NY 5-9 years		-0.285 (0.285)	-0.282 (0.286)	-0.372 (0.297)	-0.333 (0.309)	-0.362 (0.372)
Live in NY 1-4 years		-0.835** (0.309)	-0.832** (0.309)	-0.977** (0.333)	-0.900* (0.352)	-0.443† (0.407)
Live in NY < 1 year		-0.957* (0.458)	-0.948* (0.462)	-1.051* (0.468)	-0.958* (0.493)	-0.412 (0.547)
Total income (natural log)			0.005 (0.031)	0.009 (0.031)	0.015 (0.031)	0.017 (0.032)
Age (30-39)				-0.019 (0.265)	-0.095 (0.282)	0.009 (0.339)
Age (40+)				-0.516 (0.359)	-0.599 (0.377)	-0.306 (0.437)
Child, does not live with					0.172 (0.330)	0.158 (0.397)
Child lives with					0.357 (0.314)	0.327 (0.358)
Live in NY 5-9 years*DayLabor						-0.051 (0.757)
Live in NY 1-4 years*DayLabor						-1.603 (0.862)
Live in NY < 1 year*DayLabor						-1.973 (1.305)
Age (30-39) *DayLabor						-0.429 (0.694)
Age (40+)*DayLabor						-1.182 (0.890)
Child, does not live with *DayLabor						0.046 (0.715)
Child lives with*DayLabor						0.319 (0.747)
N	430	429	429	429	429	428
Log Likelihood	-198	-193	-193	-191	-191	-186
LR Chi2	1.39	11.10	11.12	13.74	15.06	24.85
Df	1	4	5	7	9	16
Prob > chi2	.238	.026	.049	.056	.089	.073

**p<.01, *p<.05, †p<.10

Appendix N

Table 1. Hunger by Age				
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Age			
	18-29	30-39	40+	Total
No	73%	73%	68%	72%
Yes	27%	27%	32%	28%
Total	100%	100%	100%	100%
N	203	146	81	430
Chi-square=0.88, df=3, p=0.645				

Table 2. Hunger by Education				
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Education			
	None — 8th Grade	Some HS or GED	HS or College	Total
No	72%	68%	77%	72%
Yes	28%	32%	23%	28%
Total	100%	100%	100%	100%
N	291	75	65	431
Chi-square=1.38, df=3, p=0.502				

Appendix N

Table 3.

Hunger by Marital Status

During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Marital Status						
	Single	Married	Div.	Separated	Widowed	Other	Tot.
No	73%	72%	56%	75%	33%	75%	72%
Yes	27%	28%	44%	25%	67%	25%	28%
Total	100%	100%	100%	100%	100%	100%	100%
N	177	218	9	20	3	4	431
Chi-square=3.73, df=6, p=0.589							

Table 4.

Hunger by Children

During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Children		
	No	Yes	Total
No	72%	72%	72%
Yes	28%	28%	28%
Total	100%	100%	100%
N	144	287	431
Chi-square=0.0004, df=2, p=0.983			

Appendix N

Table 5. Hunger by Children & Living With/Without Children				
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Children/ Live With You			
	No Children	Don't Live With	Live With	Total
No	72%	66%	78%	72%
Yes	28%	34%	22%	28%
Total	100%	100%	100%	100%
N	144	144	143	431
Chi-square=5.45, df=3, p=0.066				

Table 6. Hunger by Living With/Without Children			
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Children		
	Don't Live With	Live With	Total
No	66%	78%	72%
Yes	34%	22%	28%
Total	100%	100%	100%
N	144	143	287
Chi-square=5.44, df=2, p=0.020			

Appendix N

Table 7. Hunger by Household Size				
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Household Size			
	One	2-4	5+	Total
No	75%	73%	69%	72%
Yes	25%	27%	31%	28%
Total	100%	100%	100%	100%
N	24	252	147	423
Chi-square=1.14, df=3, p=0.565				

Table 8. Hunger by Homeless			
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Homeless		
	No	Yes	Total
No	75%	51%	72%
Yes	25%	49%	28%
Total	100%	100%	100%
N	376	55	431
Chi-square-14.17, df=2, p=0.000			

Appendix N

Table 9.

Hunger by Time Lived in New York

During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Total
No	79%	70%	72%	64%	72%
Yes	215	30%	28%	36%	28%
Total	100%	100%	100%	100%	100%
N	100	125	152	53	430
Chi-square=4.22, df=4, p=0.238					

Table 10.

Hunger by Income

During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Total
No	71%	83%	67%	81%	72%
Yes	29%	17%	33%	19%	28%
Total	100%	100%	100%	100%	100%
N	62	77	249	43	431
Chi-square-9.20, df=4, p=0.027					

Appendix N

Table 11. Hunger by Remittances			
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Remittance		
	No	Yes	Total
No	83%	70%	72%
Yes	17%	30%	28%
Total	100%	100%	100%
N	65	366	431
Chi-square=4.54, df=2, p=0.033			

Table 12. Hunger by Day Labor			
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Day Labor		
	No	Yes	Total
No	79%	51%	72%
Yes	21%	49%	28%
Total	100%	100%	100%
N	328	103	431
Chi-square=28.87, df=2, p=0.000			

Appendix N

Table 13. Hunger by Gender			
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Gender		
	Male	Female	Total
No	69%	79%	72%
Yes	31%	21%	28%
Total	100%	100%	100%
N	301	130	431
Chi-square=4.64, df=2, p=0.031			

Table 14. Hunger by Moms			
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Moms		
	Non-Mom	Mom	Total
No	70%	79%	72%
Yes	30%	21%	28%
Total	100%	100%	100%
N	323	108	431
Chi-square=3.07, df=2, p=0.080			

Appendix N

Table 15. Hunger by Health							
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Overall, would you say your health is excellent, very good, good, fair or poor?						
	Excellent	Very Good	Good	Fair	Poor	Don't Know	Total
No	83%	73%	72%	74%	45%	100%	72%
Yes	17%	27%	28%	26%	55%	0%	28%
Total	100%	100%	101%	100%	101%	100%	100%
N	46	64	192	99	29	1	431
Chi-square-13.85, df=6, p=0.017							

Table 16. Hunger by Physical Health			
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Physical Health		
	6 Days or Less	7 Days or More	Total
No	75%	54%	72%
Yes	25%	46%	28%
Total	100%	100%	100%
N	363	68	431
Chi-square-12.66, df=2, p=0.000			

Appendix N

Table 17. Hunger by Mental Health			
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Mental Health		
	6 Days or Less	7 Days or More	Total
No	74%	64%	72%
Yes	26%	36%	28%
Total	100%	100%	100%
N	355	75	430
Chi-square=2.96, df=2, p=0.085			

Table 18. Hunger by Health Insurance			
During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Health Insurance		
	No	Yes	Total
No	70%	89%	72%
Yes	30%	11%	28%
Total	100%	100%	100%
N	385	45	430
Chi-square-7.05, df=2, p=0.008			

Appendix N

Table 19.

Hunger by Health Access (Medical Care I)

During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Where do you usually go to see a doctor, nurse, or physician's assistant for medical care?									Total
	Doctor	Medicaid or HMO	ER	Drug Treatment Center	Nowhere	Other	8	9	10	
No	77%	100%	76%	100%	63%	75%	100%	100%	100%	72%
Yes	23%	0%	24%	0%	37%	25%	0%	0%	0%	28%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
N	192	8	63	1	158	430				
Chi-square=14 47, df=9, p=0.070										

Appendix N

Table 20.

Hunger by Health Access (ER)

During the last 6 months, were you ever hungry but didn't eat because you couldn't afford enough food?	Have you been seen or received care in an emergency room during the past 6 months?				
	No	Yes	Skipped	Refused	Total
No	72%	71%	75%	50%	72%
Yes	28%	29%	25%	50%	28%
Total	100%	100%	100%	100%	100%
N	369	55	4	2	430
Chi-square=0.55, df=4, p=0.907					

Appendix N

Table 21. Correlates of hunger among undocumented Mexicans in New York
Coefficients from complementary log-log regression (standard errors in parenthesis)

	I	II	III	IV	V	VI
Constant	-1.427** (0.120)	-1.625** (0.225)	-1.837** (0.303)	-1.916** (0.347)	-1.822** (0.382)	-2.350** (0.482)
Day Labor	1.018** (0.187)	0.987** (0.190)	0.994** (0.198)	0.983** (0.199)	0.956** (0.203)	2.218** (0.683)
Live in NY 5-9 years		0.308 (0.276)	0.391 (0.294)	0.422 (0.299)	0.383 (0.306)	0.718† (0.414)
Live in NY 1-4 years		0.162 (0.271)	0.249 (0.289)	0.302 (0.306)	0.251 (0.316)	0.804† (0.432)
Live in NY < 1 year		0.443 (0.323)	0.610† (0.345)	0.649† (0.353)	0.580 (0.369)	1.152* (0.490)
Total income (natural log)			0.023 (0.024)	0.023 (0.025)	0.021 (0.025)	0.026 (0.026)
Age (30-39)				0.059 (0.223)	0.043 (0.244)	-0.124 (0.326)
Age (40+)				0.151 (0.271)	0.150 (0.292)	0.353 (0.375)
Child, does not live with					0.041 (0.255)	0.316 (0.335)
Child lives with					-0.130 (0.271)	-0.053 (0.338)
Live in NY 5-9 years*DayLabor						-0.810 (0.641)
Live in NY 1-4 years*DayLabor						-1.377* (0.654)
Live in NY < 1 year*DayLabor						-1.370† (0.756)
Age (30-39) *DayLabor						0.325 (0.523)
Age (40+)*DayLabor						-0.470 (0.625)
Child, does not live with *DayLabor						-0.618 (0.522)
Child lives with*DayLabor						-0.079 (0.595)
N	431	430	388	388	388	388
Log Likelihood	-241	-239	-217	-217	-216	-211
LR Chi2	27.03	29.19	30.05	30.36	30.81	41.15
Df	1	4	5	7	9	16
Prob > chi2	.000	.000	.000	.000	.000	.000
**p<.01, *p<.05, †p<.10						

Appendix O

Table 1. Income Packaging by Age				
During the last 6 months, did you receive any money from:	Age			
	18-29	30-39	40+	Total
Other	15%	15%	12%	14%
Formal Not Informal	16%	19%	19%	18%
Informal Not Formal	56%	57%	64%	58%
Formal & Informal	13%	9%	5%	10%
Total	100%	100%	100%	100%
N	203	146	81	430
Chi-square=5.29, df=3, p=0.507				

Table 2. Income Packaging by Education				
During the last 6 months, did you receive any money from:	Education			
	None — 8th Grade	Some HS or GED	HS or College	Tot.
Other	17%	8%	11%	14 %
Formal Not Informal	12%	25%	34%	18%
Informal Not Formal	61%	59%	45%	58%
Formal & Informal	10%	8%	10%	10%
Total	100%	100%	100%	100
N	291	75	65	431
Chi-square=23.17, df=3, p=0.001				

Appendix O

Table 3. Income Packaging by Marital Status							
During the last 6 months, did you receive any money from:	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Total
Other	12%	17%	0%	15%	0%	25%	14%
Formal Not Informal	20%	17%	11%	20%	33%	0%	18%
Informal Not Formal	57%	58%	89%	45%	67%	75%	58%
Formal & Informal	11%	8%	0%	20%	0%	0%	10%
Total	100%	100%	100%	100%	100%	100%	100%
N	177	218	9	20	3	4	431
Chi-square=13.08, df=6, p=0.595							

Table 4. Income Packaging by Children			
During the last 6 months, did you receive any money from:	Children		
	No	Yes	Total
Other	3%	20%	14%
Formal Not Informal	23 %	16%	18%
Informal Not Formal	58%	57%	58%
Formal & Informal	16%	7%	10%
Total	100%	100%	100%
N	144	287	431
Chi-square=28.00, df=2, p=0.000			

Appendix O

Table 5.

Income Packaging by Children & Living With/Without Children

During the last 6 months, did you receive any money from:	Children/ Live With You			
	No Children	Don't Live With	Live With	Tot.
Other	3%	9%	31%	14%
Formal Not Informal	23 %	14%	17%	18%
Informal Not Formal	58%	67%	48%	58%
Formal & Informal	16%	10%	4%	10%
Total	100%	100%	100%	100%
N	144	144	143	431
Chi-square=63.54, df=3, p=0.000				

Appendix O

Table 6. Income Packaging by Living With/Without Children			
During the last 6 months, did you receive any money from:	Children		
	Don't Live With	Live With	Total
Other	9%	31%	19.86%
Formal Not Informal	14%	17%	15.68%
Informal Not Formal	67%	48%	57.49%
Formal & Informal	10%	4%	6.97%
Total	100%	100%	100%
N	144	143	287
Chi-square=29.75, df=2, p=0.000			

Table 7. Income Packaging by Household Size				
During the last 6 months, did you receive any money from:	Household Size			
	One	2-4	5+	Total
Other	25%	16%	9%	14%
Formal Not Informal	29%	19%	14%	18%
Informal Not Formal	42%	56%	64%	58%
Formal & Informal	4%	9%	13%	10%
Total	100%	100%	100%	100%
N	24	252	147	423
Chi-square=13.24, df=3, p=0.039				

Appendix O

Table 8. Income Packaging by Homeless			
During the last 6 months, did you receive any money from:	Homeless		
	No	Yes	Total
Other	14%	20%	14%
Formal Not Informal	18%	18%	18%
Informal Not Formal	59%	46%	58%
Formal & Informal	9%	16%	10%
Total	100%	100%	100%
N	376	55	431
Chi-square=5.62, df=2, p=0.132			

Table 9. Income Packaging by Time Lived in New York					
During the last 6 months, did you receive any money from:	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Tot.
Other	14%	16%	10%	25%	14%
Formal Not Informal	27%	14 %	18%	8%	18%
Informal Not Formal	52%	58%	60%	62%	58%
Formal & Informal	7%	12%	12%	5%	10%
Total	100%	100%	100%	100%	100%
N	100	125	152	53	430
Chi-square-18.80, df=4, p=0.027					

Appendix O

Table 10. Income Packaging by Remittances			
During the last 6 months, did you receive any money from:	Remittances		
	No	Yes	Total
Other	51%	8%	14%
Formal Not Informal	11%	19%	18%
Informal Not Formal	32%	62%	58%
Formal & Informal	6%	11%	10%
Total	100%	100%	100%
N	65	366	431
Chi-square=82.31, df=2, p=0.000			

Table 11. Income Packaging by Day Labor			
During the last 6 months, did you receive any money from:	Day Labor		
	No	Yes	Total
Other	17%	6%	14%
Formal Not Informal	21%	7%	18%
Informal Not Formal	52%	78%	58%
Formal & Informal	10%	9%	10%
Total	100%	100%	100%
N	328	103	431
Chi-square-25.46, df=2, p=0.000			

Appendix O

Table 12.

Income Packaging by Gender

During the last 6 months, did you receive any money from:	Gender		
	Male	Female	Total
Other	4%	38%	14%
Formal Not Informal	21%	11%	18%
Informal Not Formal	63%	46%	58%
Formal & Informal	12%	5%	10%
Total	100%	100%	100%
N	328	103	431
Chi-square=89.97, df=2, p=0.000			

Appendix O

Table 13. Income Packaging by Moms			
During the last 6 months, did you receive any money from:	Moms		
	Non-Mom	Mom	Total
Other	4%	45%	14%
Formal Not Informal	21%	9%	18%
Informal Not Formal	63%	42%	58%
Formal & Informal	12%	4%	10%
Total	100%	100%	100%
N	328	103	431
Chi-square=114.31, df=2, p=0.000			

Table 14. Income Packaging by Health Insurance			
During the last 6 months, did you receive any money from:	Health Insurance		
	No	Yes	Total
Other	13%	27%	14%
Formal Not Informal	16%	36%	18%
Informal Not Formal	62%	20%	58%
Formal & Informal	9%	17%	10%
Total	100%	100%	100%
N	385	45	430
Chi-square=29.77, df=2, p=0.000			

Appendix O

Table 15. Income Packaging by Hunger			
During the last 6 months, did you receive any money from:	Hungry		
	No	Yes	Total
Other	14%	15%	14%
Formal Not Informal	21%	11%	18%
Informal Not Formal	54%	68%	58%
Formal & Informal	11%	6%	10%
Total	100%	100%	100%
N	311	120	431
Chi-square=9.20, df=2, p=0.027			

Table 16. Income Packaging by Physical Health			
During the last 6 months, did you receive any money from:	Physical Health		
	6 Days or Less	7 Days or More	Total
Other	14%	18%	14%
Formal Not Informal	18%	16%	18%
Informal Not Formal	58%	59%	58%
Formal & Informal	10%	7%	10%
Total	100%	100%	100%
N	363	68	431
Chi-square-1.30, df=2, p-0.729			

Appendix P

Table 1. Remittances by Age				
Do you send money to family and friends in your home country?	Age			
	18-29	30-39	40+	Total
No	17%	12%	17%	15%
Yes	83%	88%	83%	85%
Total	100%	100%	100%	100%
N	203	146	81	430
Chi-square=2.09, df=3, p=0.352				

Table 2. Remittances by Education				
Do you send money to family and friends in your home country?	Education			
	None — 8`[11] Grade	Some HS or GED	HS or College	Total
No	16%	12%	14%	15%
Yes	84%	88%	86%	85%
Total	100%	100%	100%	100%
N	291	75	65	431
Chi-square=0.89, df=3, p=0.640				

Appendix P

Table 3.

Remittances by Marital Status

Do you send money to family and friends in your home country?	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Total
No	15%	15%	22%	15%	0%	0%	15%
Yes	85%	85%	78%	85%	100%	100%	85%
Total	100 %	100%	100%	100%	100%	100%	100 %
N	177	218	9	20	3	4	431
Chi-square=1.67, df=6, p=0.893							

Table 4.

Remittances by Children

Do you send money to family and friends in your home country?	Children		
	No	Yes	Total
No	10%	17%	15%
Yes	90%	83%	85%
Total	100%	100%	100%
N	144	287	431
Chi-square=3.67, df=2, p=0.055			

Appendix P

Table 5.

Remittances by Children & Living With/Without Children

Do you send money to family and friends in your home country?	Children/ Live With You			
	No Children	Don't Live With	Live With	Total
No	10%	6%	29%	15%
Yes	90%	94%	71%	85%
Total	100%	100%	100%	100%
N	144	144	143	431
Chi-square-31.84, df=3, p=0.000				

Table 6.

Remittances by Living With/Without Children

Do you send money to family and friends in your home country?	Children		
	Don't Live With	Live With	Total
No	6 %	29%	17%
Yes	94%	71%	83%
Total	100%	100%	100%
N	144	143	287
Chi-square-25.07, df=2, p=0.000			

Appendix P

Table 7. Remittances by Household Size				
Do you send money to family and friends in your home country?	Household Size			
	One	2-4	5+	Total
No	25%	18%	8%	15%
Yes	75%	82%	92%	85%
Total	100%	100%	100%	100%
N	24	252	147	423
Chi-square=8.93, df=3, p=0.011				

Table 8. Remittances by Homeless			
Do you send money to family and friends in your home country?	Homeless		
	No	Yes	Total
No	15%	18%	15%
Yes	85%	82%	85%
Total	100%	100%	100%
N	376	55	431
Chi-square=0.47, df=2, p=0.491			

Appendix P

Table 9. Remittances by Time Lived in New York					
Do you send money to family and friends in your home country?	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Total
No	20%	16%	10%	19%	15%
Yes	80%	84%	90%	81%	85%
Total	100%	100%	100%	100%	100%
N	100	125	152	53	430
Chi-square=5.78, df=4, p=0.123					

Table 10. Remittances by Income					
Do you send money to family and friends in your home country?	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Total
No	53%	9%	8 %	9%	15%
Yes	47%	91%	92%	91%	85%
Total	100%	100%	100%	100%	100%
N	62	77	249	43	431
Chi-square=82.31, df=4, p=0.000					

Appendix P

Table 11. Remittances by Day Labor			
Do you send money to family and friends in your home country?	Day Labor		
	No	Yes	Total
No	18%	5%	15%
Yes	82%	95%	85%
Total	100%	100%	100%
N	328	103	431
Chi-square=11.05, df=2, p=0.001			

Table 12. Remittances by Gender			
Do you send money to family and friends in your home country?	Gender		
	Male	Female	Total
No	6 %	35%	15%
Yes	94%	65%	85%
Total	100%	100%	100%
N	301	130	431
Chi-square=59.92, df=2, p=0.000			

Appendix P

Table 13. Remittances by Moms			
Do you send money to family and friends in your home country?	Moms		
	Non-Mom	Mom	Total
No	7%	39%	15%
Yes	93%	61%	85%
Total	100%	100%	100%
N	328	103	431
Chi-square-63.78, df=2, p=0.000			

Table 14. Remittances by Health Insurance			
Do you send money to family and friends in your home country?	Health Insurance		
	No	Yes	Total
No	13.25%	29%	15%
Yes	87%	71%	85%
Total	100%	100%	100%
N	385	45	430
Chi-square=7.78, df=2, p=0.005			

Appendix P

Table 15. Remittances by Hunger			
Do you send money to family and friends in your home country?	Hungry		
	No	Yes	Total
No	17%	9 %	15%
Yes	83%	91%	85%
Total	100%	100%	100%
N	311	120	431
Chi-square=4.54, df=2, p=0.033			

Table 16. Remittances by Physical Health			
Do you send money to family and friends in your home country?	Physical Health		
	6 Days or Less	7 Days or More	Total
No	15%	13%	15%
Yes	85%	87%	85%
Total	100%	100%	100%
N	363	68	431
Chi-square=0.21, df=2, p=0.643			

Appendix Q

Table 1. Cultural Exclusivity by Age				
Degree of Cultural Exclusivity	Age			
	18-29	30-39	40+	Total
0 - Low	12%	10%	12%	12%
1	20%	26%	16%	21%
2	29%	23%	19%	25%
3	28%	35%	37%	32%
4 - High	11%	6%	16%	10%
Total	100%	100%	100%	100%
N	203	146	81	430
Chi-square-13.22, df=3, p=0.105				

Table 2. Cultural Exclusivity by Education				
Degree of Cultural Exclusivity	Education			
	None — 8th Grade	Some HS or GED	HS or College	Total
0 - Low	9%	15%	22%	12%
1	21%	24%	23%	22%
2	23%	28%	29%	25%
3	34%	29%	25%	32%
4 - High	13%	4%	2%	10%
Total	100%	100%	101%	101%
N	291	75	65	431
Chi-square-22.53, df=3, p=0.004				

Appendix Q

Table 3. Cultural Exclusivity by Marital Status							
Degree of Cultural Exclusivity	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Tot.
0 - Low	15%	9%	11%	10%	0%	0%	12%
1	24%	17%	45%	45%	0%	25%	22%
2	26%	26%	11%	10%	33%	50%	25%
3	23%	39%	33%	35%	67%	25%	32%
4 - High	12%	10%	0%	0%	0%	0%	10%
Total	100%	101%	100%	100%	100%	100%	101%
N	177	218	9	20	3	4	431
Chi-square=31.26, df=6, p=0.052							

Table 4. **Cultural Exclusivity by Children**			
Degree of Cultural Exclusivity	**Children**		
	No	**Yes**	**Total**
0 - Low	17%	9%	12%
1	22%	22%	22%
2	25%	25%	25%
3	22%	37%	32%
4 - High	14%	8%	10%
Total	101%	101%	101%
N	144	287	431
Chi-square=15.99, df=2, p=0.003			

Appendix Q

Table 5.

Cultural Exclusivity by Children & Living With/Without Children

Degree of Cultural Exclusivity	Children/ Live With You			
	No Children	Don't Live With	Live With	Total
0 - Low	17%	8%	9%	12%
1	22%	20%	24%	22%
2	25%	27%	22%	25%
3	22%	38%	36%	32%
4 - High	14%	7%	9%	10%
Total	100%	100%	100%	101%
N	144	144	143	431
Chi-square=17.76, df=3, p=0.023				

Table 6.

Cultural Exclusivity by Living With/Without Children

Degree of Cultural Exclusivity	Children		
	Don't Live With	Live With	Total
0 - Low	8%	9%	9%
1	20%	24%	22%
2	27%	22%	25%
3	38%	36%	37%
4 - High	7%	9%	8%
Total	100%	100%	101%
N	144	143	287
Chi-square=1.85, df=2, p=0.763			

Appendix Q

Table 7.

Cultural Exclusivity by Household Size

Degree of Cultural Exclusivity	Household Size			
	One	2-4	5+	Total
0 - Low	37%	12%	5%	11%
1	21%	22%	21%	22%
2	17%	25%	27%	25%
3	13%	31%	37%	32%
4 - High	13%	10%	10%	10%
Total	101%	100%	100%	100%
N	24	252	147	423
Chi-square=24.72, df=3, p=0.002				

Table 8.

Cultural Exclusivity by Homeless

Degree of Cultural Exclusivity	Homeless		
	No	Yes	Total
0 - Low	12%	11%	12%
1	21%	27%	22%
2	25%	26%	25%
3	32%	29%	32%
4 - High	10%	7%	10%
Total	100%	100%	101%
N	376	55	431
Chi-square=1.61, df=2, p=0.806			

Appendix Q

Table 9.

Cultural Exclusivity by Time Lived in New York

Degree of Cultural Exclusivity	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Total
0 - Low	14%	13%	9%	11%	12%
1	26%	22%	19%	21%	22%
2	21%	26%	25%	28%	25%
3	35%	30%	34%	25%	32%
4 - High	4%	9%	13%	15%	10%
Total	100%	100%	100%	100%	101%
N	100	125	152	53	430
Chi-square=12.37, df=4, p=0.416					

Table 10.

Cultural Exclusivity by Income

Degree of Cultural Exclusivity	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Total
0 - Low	10%	17%	10%	14%	12%
1	15%	21%	22%	33%	22%
2	27%	30%	21%	35%	25%
3	37%	29%	35%	16%	32%
4 - High	11%	4%	13%	2%	10%
Total	100%	101%	101%	100%	101 %
N	62	77	249	43	431
Chi-square=23.06, df=4, p=0.027					

Appendix Q

Table 11. Cultural Exclusivity by Remittances			
Degree of Cultural Exclusivity	Remittances		
	No	Yes	Total
0 - Low	12%	12%	12%
1	17%	22%	22%
2	23%	25%	25%
3	34%	32%	32%
4 - High	14%	9%	10%
Total	100%	100%	101%
N	65	366	431
Chi-square=2.12, df=2, p=0.713			

Appendix Q

Table 12. Cultural Exclusivity by Day Labor			
Degree of Cultural Exclusivity	Day Labor		
	No	Yes	Total
0 - Low	12%	12%	12%
1	21%	22%	22%
2	25%	23%	25%
3	32%	33%	32%
4 - High	10%	10%	10%
Total	100%	100%	101%
N	328	103	431
Chi-square=0.21, df=2, p=0.995			

Table 13. Cultural Exclusivity by Gender			
Degree of Cultural Exclusivity	Gender		
	Male	Female	Total
0 - Low	12%	11%	12%
1	22%	21%	22%
2	27%	20%	25%
3	30%	38%	32%
4 - High	10%	11%	10%
Total	101%	101%	101%
N	301	130	431
Chi-square=3.90, df=2, p=0.419			

Appendix Q

Table 14. Cultural Exclusivity by Moms			
Degree of Cultural Exclusivity	Moms		
	Non-Mom	Mom	Total
0 - Low	12%	9%	12%
1	22%	21%	22%
2	26%	21%	25%
3	30%	40%	32%
4 - High	10%	9%	10%
Total	100%	100%	101%
N	323	108	431
Chi-square=4.65, df=2, p=0.325			

Table 15. Cultural Exclusivity by Health Insurance			
Degree of Cultural Exclusivity	Health Insurance		
	No	Yes	Total
0 - Low	12%	11%	12%
1	21%	27%	22%
2	25%	24%	25%
3	32%	31%	32%
4 - High	10%	7%	10%
Total	100%	100%	101%
N	385	45	430
Chi-square=1.17, df=2, p=0.883			

Appendix Q

Table 16. Cultural Exclusivity by Hunger			
Degree of Cultural Exclusivity	Hungry		
	No	Yes	Total
0 - Low	13%	8%	12%
1	22%	20%	22%
2	25%	25%	25%
3	32%	34%	32%
4 - High	9%	13%	10%
Total	101%	100%	101%
N	311	120	431
Chi-square=3.70, df=2, p=0.449			

Table 17. Cultural Exclusivity by Physical Health			
Degree of Cultural Exclusivity	Physical Health		
	6 Days or Less	7 Days or More	Total
0 - Low	13%	6%	12%
1	20%	29%	22%
2	26%	16%	25%
3	31%	37%	32%
4 - High	10%	12%	10%
Total	100%	100%	101%
N	363	68	431
Chi-square=7.83, df=2, p=0.098			

Appendix R

Table 1. Social Support by Age				
Strength of Social Support	Age			
	18-29	30-39	40+	Total
0 - Weak	31%	36%	32%	33%
1	13%	14%	19%	15%
2	16%	14%	14%	15%
3	17%	16%	17%	17%
4 - Strong	23%	21%	19%	21%
Total	100%	101%	101%	101%
N	203	146	81	430
Chi-square=2.88, df=3, p=0.942				

Table 2. Social Support by Education				
Strength of Social Support	Education			
	None — 8th Grade	Some HS or GED	HS or College	Total
0 - Weak	34%	37%	23%	33%
1	15%	9%	17%	15%
2	16%	8%	17%	15%
3	15%	24%	15%	17%
4 - Strong	20%	22%	28%	21%
Total	100%	100%	100%	101%
N	290	75	65	430
Chi-square=11.39, df=3, p=0.181				

Appendix R

Table 3.

Social Support by Marital Status

Strength of Social Support	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Total
0- Weak	35%	32%	22%	25%	33%	50%	33%
1	15%	14%	22%	20%	0%	0%	15%
2	13%	15%	22%	20%	33%	0%	15%
3	15%	18%	22%	10%	34%	25%	17%
4 - Strong	22%	22%	12%	25%	0%	25%	21%
Total	100%	101%	100%	100%	100%	100%	101%
N	177	218	9	20	3	4	431
Chi-square=8.75, df=6, p=0.986							

Table 4.

Social Support by Marital Status

Strength of Social Support	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Total
0- Weak	35%	32%	22%	25%	33%	50%	33%
1	15%	14%	22%	20%	0%	0%	15%
2	13%	15%	22%	20%	33%	0%	15%
3	15%	18%	22%	10%	34%	25%	17%
4- Strong	22%	22%	12%	25%	0%	25%	21%
Total	100%	101%	100%	100%	100%	100%	101%
N	177	218	9	20	3	4	431
Chi-square=8.75, df=6, p=0.986							

Appendix R

Table 5. Social Support by Children			
Strength of Social Support	Children		
	No	Yes	Total
0 - Weak	33%	32%	33%
1	15%	15%	15%
2	12%	16%	15%
3	15%	18%	17%
4 - Strong	26%	19%	21%
Total	101%	100%	101%
N	144	287	431
Chi-square=3.69, df=2, p=0.449			

Table 6. Social Support by Children & Living With/Without Children				
Strength of Social Support	Children/ Live With You			
	No Children	Don't Live With	Live With	Total
0 - Weak	33%	51%	13%	33%
1	15%	11%	18%	15%
2	12%	15%	17%	15%
3	15%	10%	25%	17%
4 - Strong	26%	13%	26%	21%
Total	101%	100%	100%	101%
N	144	144	143	431
Chi-square=53.77, df=3, p=0.000				

Appendix R

Table 7. Social Support by Living With/Without Children			
Strength of Social Support	Children		
	Don't Live With	Live With	Total
0 - Weak	51%	13%	32%
1	11%	18%	15%
2	15%	18%	16%
3	10%	25%	18%
4 - Strong	13%	26%	19%
Total	100%	100%	100%
N	144	143	287
Chi-square=50.46, df=2, p=0.000			

Table 8. Social Support by Household Size				
Strength of Social Support	Household Size			
	One	2-4	5+	Total
0 - Weak	42%	27%	39%	32%
1	25%	14%	14%	15%
2	8%	15%	16%	15%
3	13%	19%	14%	17%
4 - Strong	13%	25%	17%	21%
Total	101%	100%	100%	100
N	24	252	147	423
Chi-square=11.95, df=3, p=0.154				

Appendix R

Table 9. Social Support by Homeless			
Strength of Social Support	Homeless		
	No	Yes	Total
0 - Weak	31%	46%	33%
1	14%	16%	15%
2	14%	18%	15%
3	18%	9%	17%
4 - Strong	23%	11%	21%
Total	100%	100%	101%
N	376	55	431
Chi-square=9.21, df=2, p=0.056			

Table 10. Social Support by Time Lived in New York					
Strength of Social Support	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Tota I
0 - Weak	22%	27%	38%	49%	33%
1	15%	16%	15%	12%	15%
2	21%	13%	12%	15%	15%
3	24%	16%	14%	13%	17%
4 - Strong	18%	28%	22%	11%	21%
Total	100%	100%	101%	100%	101 %
N	100	125	152	53	430
Chi-square=24.83, df=4, p=0.016					

Appendix R

Table 11. Social Support by Income					
Strength of Social Support	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Total
0 - Weak	27%	32%	34%	33%	33%
1	16%	17%	12%	26%	15%
2	23%	9%	16%	7%	15%
3	16%	17%	19%	5%	17%
4 - Strong	18%	25%	20%	30%	21%
Total	100%	100%	101%	101%	101%
N	62	77	249	43	431
Chi-square=19.44, df=4, p=0.078					

Table 12. Social Support by Remittances			
Strength of Social Support	Remittances		
	No	Yes	Total
0 - Weak	25%	34%	33%
1	14%	15%	15%
2	17%	14%	15%
3	18%	16%	17%
4 - Strong	26%	21%	21%
Total	100%	100%	101%
N	65	366	431
Chi-square=2.81, df=2, p=0.589			

Appendix R

Table 13. Social Support by Day Labor			
Strength of Social Support	Day Labor		
	No	Yes	Total
0 - Weak	30%	42%	33%
1	14%	16%	15%
2	15%	13%	15%
3	17%	15%	17%
4 - Strong	24%	14%	21%
Total	100%	100%	101%
N	328	103	431
Chi-square=7.80, df=2, p=0.092			

Table 14. Social Support by Gender			
Strength of Social Support	Gender		
	Male	Female	Total
0 - Weak	38%	21%	33%
1	15%	15%	15%
2	14%	17%	15%
3	15%	21%	17%
4 - Strong	19%	27%	21%
Total	101%	101%	101%
N	301	130	431
Chi-square=13.35, df=2, p=0.0 1 0			

Appendix R

Table 15. Social Support by Moms			
Strength of Social Support	Moms		
	Non-Mom	Mom	Total
0 - Weak	37%	21%	33%
1	14%	16%	15%
2	13%	19%	15%
3	15%	21%	17%
4 - Strong	21%	23%	21%
Total	100%	100%	101%
N	323	108	431
Chi-square=9.41, df=2, p=0.052			

Table 16. Social Support by Health Insurance			
Strength of Social Support	Health Insurance		
	No	Yes	Total
0 - Weak	35%	11%	33%
1	14%	18%	15%
2	14%	18%	15%
3	17%	20%	17%
4 - Strong	20%	33%	21%
Total	100%	100%	101%
N	385	45	430
Chi-square=11.44, df=2, p=0.022			

Appendix R

Table 17. Social Support by Hunger			
Strength of Social Support	Hungry		
	No	Yes	Total
0 - Weak	32%	34%	33%
1	15%	15%	15%
2	15%	13%	15%
3	16%	18%	17%
4 - Strong	22%	20%	21%
Total	100%	100%	101%
N	311	120	431
Chi-square=1.04, df=2, p=0.904			

Table 18. Social Support by Physical Health			
Strength of Social Support	Physical Health		
	6 Days or Less	7 Days or More	Total
0 - Weak	33%	29%	33%
1	15%	12%	15%
2	15%	13%	15%
3	16%	21%	17%
4 - Strong	21%	25%	21%
Total	100%	100%	101%
N	363	68	431
Chi-square=2.06, df=2, p=0.725			

Appendix S

Table 1. Social Support and Cultural Exclusivity by Age				
Cluster Number of Cases	Age			
	18-29	30-39	40+	Total
Low Support, Low Exclusivity	20%	23%	23%	22%
High Support, Low Exclusivity	25%	24%	14%	22%
High Support, High Exclusivity	27%	21%	31%	25%
Low Support, High Exclusivity	29%	33%	32%	31%
Total	101%	101%	100%	100%
N	203	146	81	430
Chi-square=6.84, df=3, p=0.336				

Table 2. Social Support and Cultural Exclusivity by Education				
Cluster Number of Cases	Education			
	None — 8[6] Grade	Some HS or GED	HS or College	Tot.
Low Support, Low Exclusivity	21%	20%	28%	22%
High Support, Low Exclusivity	18%	34%	31%	22%
High Support, High Exclusivity	29%	17%	18%	25%
Low Support, High Exclusivity	33%	29%	23%	31%
Total	101%	100%	100%	100%
N	291	75	65	431
Chi-square=16.81, df=3, p=0.010				

Appendix S

Table 3.

Social Support and Cultural Exclusivity by Marital Status

Cluster Number of Cases	Marital Status						
	Single	Married	Divorced	Separated	Widowed	Other	Total
Low Support, Low Exclusivity	25%	17%	34%	40%	0%	0&	22%
High Support, Low Exclusivity	25%	20%	33%	20%	0%	50%	22%
High Support, High Exclusivity	19%	31%	11%	25%	67%	0%	25%
Low Support, High Exclusivity	31%	32%	22%	15%	33%	50%	31%
Total	100%	100%	100%	100%	100%	100%	100%
N	177	218	9	20	3	4	431
Chi-square=24.64, clf=6, p=0.055							

Appendix S

Table 4.

Social Support and Cultural Exclusivity by Children

Cluster Number of Cases	Children		
	No	Yes	Total
Low Support, Low Exclusivity	23%	21%	22%
High Support, Low Exclusivity	27%	20%	22%
High Support, High Exclusivity	19%	28%	25%
Low Support, High Exclusivity	31%	31%	31%
Total	100%	100%	100%
N	144	287	431
Chi-square=5.35, df=2, p=0.148			

Appendix S

Table 5.

Social Support and Cultural Exclusivity by Children & Living With/Without Children

Cluster Number of Cases	Children/ Live With You			
	No Children	Don't Live With	Live With	Tot.
Low Support, Low Exclusivity	23%	25%	17%	22%
High Support, Low Exclusivity	27%	9%	31%	22%
High Support, High Exclusivity	19%	24%	32%	25%
Low Support, High Exclusivity	31%	42%	20%	31%
Total	100%	100%	100%	100
N	144	144	143	431
Chi-square=35.95, df=3, p=0.000				

Appendix S

Table 6.

Social Support and Cultural Exclusivity by Living With/Without Children

Cluster Number of Cases	Children		
	Don't Live With	Live With	Total
Low Support, Low Exclusivity	24%	17%	21%
High Support, Low Exclusivity	9%	31%	20%
High Support, High Exclusivity	24%	32%	28%
Low Support, High Exclusivity	43%	20%	31%
Total	100%	100%	100%
N	144	143	287
Chi-square=32.25, df=2, p=0.000			

Appendix S

Table 7.

Social Support and Cultural Exclusivity by Household Size

Cluster Number of Cases	Household Size			
	One	2-4	5+	Total
Low Support, Low Exclusivity	42%	20%	20%	21%
High Support, Low Exclusivity	17%	28%	14%	22%
High Support, High Exclusivity	13%	25%	29%	26%
Low Support, High Exclusivity	29%	27%	37%	31%
Total	101%	100%	100%	100%
N	24	252	147	423
Chi-square=19.60, df=3, p=0.003				

Appendix S

Table 8.

Social Support and Cultural Exclusivity by Homeless

Cluster Number of Cases	Homeless		
	No	Yes	Total
Low Support, Low Exclusivity	20%	29%	22%
High Support, Low Exclusivity	24%	13%	22%
High Support, High Exclusivity	27%	16%	25%
Low Support, High Exclusivity	29%	42%	31%
Total	100%	100%	100%
N	376	55	431
Chi-square=8.67, df=2, p=0.034			

Appendix S

Table 9.

Social Support and Cultural Exclusivity by Time Lived in New York

Cluster Number of Cases	How long have you lived in New York?				
	10+ Years	5-9 Years	1-4 Years	Less Than 1 Year	Tot.
Low Support, Low Exclusivity	22%	24%	18%	26%	22%
High Support, Low Exclusivity	28%	29%	18%	9%	22%
High Support, High Exclusivity	27%	22%	28%	25%	25%
Low Support, High Exclusivity	23%	26%	37%	40%	31%
Total	100%	101%	101%	100%	100
N	100	125	152	53	430
Chi-square-18.45, df=4, p=0.030					

Appendix S

Table 10.

Social Support and Cultural Exclusivity by Income

Cluster Number of Cases	During the last 6 months, did you receive any money from:				
	Other	Formal Not Informal	Informal Not Formal	Formal & Informal	Tot.
Low Support, Low Exclusivity	18%	19%	22%	30%	22%
High Support, Low Exclusivity	18%	29%	20%	28%	22%
High Support, High Exclusivity	34%	21%	27%	12%	25%
Low Support, High Exclusivity	31%	31%	31%	30%	31%
Total	101%	100%	100%	100%	100 %
N	62	77	249	43	431
Chi-square=10.85, df=4, p=0.286					

Appendix S

Table 11. Social Support and Cultural Exclusivity by Remittances			
Cluster Number of Cases	Remittances		
	No	Yes	Total
Low Support, Low Exclusivity	17%	22%	22%
High Support, Low Exclusivity	28%	21%	22%
High Support, High Exclusivity	28%	25%	25%
Low Support, High Exclusivity	28%	32%	31%
Total	101%	100%	100%
N	65	366	431
Chi-square=2.20, df=2, p=0.532			

Table 12. Social Support and Cultural Exclusivity by Day Labor			
Cluster Number of Cases	Day Labor		
	No	Yes	Total
Low Support, Low Exclusivity	19%	30%	22%
High Support, Low Exclusivity	25%	13%	22%
High Support, High Exclusivity	26%	24%	25%
Low Support, High Exclusivity	30%	33%	31%
Total	100%	100%	100%
N	328	103	431
Chi-square=10.47, df=2, p=0.015			

Appendix S

Table 13. Social Support and Cultural Exclusivity by Gender			
Cluster Number of Cases	Gender		
	Male	Female	Total
Low Support, Low Exclusivity	23%	18%	22%
High Support, Low Exclusivity	21%	26%	22%
High Support, High Exclusivity	22%	32%	25%
Low Support, High Exclusivity	34%	24%	31%
Total	100%	100%	100%
N	301	130	431
Chi-square-9.15, df=2, p=0.027			

Table 14. Social Support and Cultural Exclusivity by Moms			
Cluster Number of Cases	Moms		
	Non-Mom	Mom	Total
Low Support, Low Exclusivity	23%	19%	22%
High Support, Low Exclusivity	21%	25%	22%
High Support, High Exclusivity	23%	33%	25%
Low Support, High Exclusivity	33%	24%	31%
Total	100%	100%	100%
N	323	108	431
Chi-square=6.14, df=2, p=0.105			

Appendix S

Table 15.

Social Support and Cultural Exclusivity by Health Insurance

Cluster Number of Cases	Health Insurance		
	No	Yes	Total
Low Support, Low Exclusivity	22%	20%	22%
High Support, Low Exclusivity	21%	33%	22%
High Support, High Exclusivity	24%	33%	25%
Low Support, High Exclusivity	33%	14%	31%
Total	100%	100%	100%
N	385	45	430
Chi-square=8.99, df=2, p=0.029			

Table 16.

Social Support and Cultural Exclusivity by Hunger

Cluster Number of Cases	Hungry		
	No	Yes	Total
Low Support, Low Exclusivity	23%	19%	22%
High Support, Low Exclusivity	24%	18%	22%
High Support, High Exclusivity	24%	29%	25%
Low Support, High Exclusivity	30%	34%	31%
Total	101%	100%	100%
N	311	120	431
Chi-square=2.93, df=2, p=0.403			

Appendix S

Table 17.

Social Support and Cultural Exclusivity by Physical Health

Cluster Number of Cases	Physical Health		
	6 Days or Less	7 Days or More	Total
Low Support, Low Exclusivity	22%	19%	22%
High Support, Low Exclusivity	22%	27%	22%
High Support, High Exclusivity	25%	26%	25%
Low Support, High Exclusivity	31%	28%	31%
Total	100%	100%	100%
N	363	68	431
Chi-square=1.13, df=2, p=0.769			