

Sarah S. Willen

Department of Anthropology
University of Connecticut

Jessica Mulligan

Health Policy and Management Program
Providence College

Heide Castañeda

Department of Anthropology
University of South Florida

Take a Stand Commentary:

How Can Medical Anthropologists Contribute to Contemporary Conversations on “Illegal” Im/migration and Health?

Of the estimated 214 million people who have migrated from poorer to richer countries in search of a better life, between 20 and 30 million have migrated on an unauthorized, or “illegal,” basis. All have health needs, or will in the future, yet most are denied health care available to citizens and authorized residents. To many, unauthorized im/migrants’ exclusion intuitively “makes sense.” As scholars of health, social justice, and human rights, we find this logic deeply flawed and are committed to advancing a constructive program of engaged critique. In this commentary, we call on medical anthropologists to claim an active role in reframing scholarly and public debate about this pressing global health issue. We outline four key theoretical issues and five action steps that will help us sharpen our research agenda and translate ourselves for colleagues in partner disciplines and for broader audiences engaged in policymaking, politics, public health, and clinical practice. [unauthorized im/migration, “illegality,” social determinants of health, “deservingness,” public anthropology]

An estimated 214 million people—3.1 percent of the world’s population—have left their homes in poorer countries for richer ones in search of a better life (International Organization for Migration 2010). Precise numbers are difficult to establish, but somewhere between 20 and 30 million people¹ have migrated in search of work on an unauthorized, or “illegal,” basis.² Although economically motivated unauthorized im/migrants are by no means a monolithic or unified group, they differ in important ways from other immigrant groups such as refugees, asylum seekers, and victims of human trafficking. Moreover, they have two important things in common: all have health needs, or will in the future, and all are excluded, either in part or in full, from the systems of health care promotion, protection, and provision that

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apply to citizens and authorized residents. Unauthorized im/migrants' lack of access to necessary health care services thus constitutes a burgeoning yet insufficiently addressed global health challenge.

In this commentary, we argue that medical anthropologists ought to claim an active role in (re)framing, (re)defining, and (re)negotiating scholarly engagement with this pressing matter of local, national, and global interest. In our view, medical anthropologists cannot be content simply to describe the health risks and consequences of unauthorized im/migration. This is but a starting point for analysis of a much broader and more far-reaching concern: the often-cited assertion that unauthorized im/migrants' exclusion from local health care systems intuitively "makes sense." Some citizens and policymakers argue that im/migrants categorized as "unauthorized" (or "undocumented," "clandestine," "irregular," or "illegal") simply are not party to the social contracts that link citizens to the broader community. According to this line of reasoning, neither host states nor host societies are obligated—legally, morally, or otherwise—to care about unauthorized im/migrants' health-related needs or invest in their well-being. Put bluntly, they are not regarded as "deserving."

As scholars of health, social justice, and human rights, we find this logic deeply flawed, and we are among a growing group of medical anthropologists, among others, who are committed to using the tools of our discipline to advance a constructive program of engaged critique. We agree with Didier Fassin (2004), who argues that the social and political exclusion of unauthorized im/migrants is grounded in an ideologically patterned moral pronouncement: a refusal to recognize them as complete social beings, or as ratified members of the moral community (cf. Willen this issue). Such declarations of illegitimacy (or, put differently, denials of "biolegitimacy" [Fassin 2009]) authorize policies of "selective blindness" both to unauthorized im/migrants' health needs and to the environments of health risk in which many live and work.

Importantly, these forms of selective blindness do not affect only unauthorized im/migrants; they also have broader consequences for the communities in which im/migrants live and work. Patterns of communicable disease offer one example (Fairchild 2003). In a fast-moving, globally interconnected world, communicable diseases have little respect for, and are poorly contained by, social and political borders. As Paul Farmer has argued,

the most common unit of analysis referred to in public health, the nation–state, is not all that meaningful to organisms such as dengue virus, *Vibrio cholera* O, HIV, penicillinase-producing *Neisseria gonorrhoeae*, multidrug-resistant tuberculosis, and hepatitis B virus. Such organisms proudly disregard political boundaries. [Farmer 2010:158–159]

Yet simplistic explanatory frameworks that posit im/migrants as unidirectional carriers of disease are equally inadequate. Social and epidemiological realities are far more complex, and, as anthropologists, it is our task not only to map out and explain such complexities but also, as Jennifer Hirsch among others has argued, "to reflect on the political implications of the knowledge we produce" (2003:254).

Given the broad scope of this phenomenon as well as the gravity of the issues at stake, now is a unique and opportune moment to reexamine how we think about, investigate, and respond to the health challenges and dilemmas associated with unauthorized im/migration. The current global recession has reinvigorated public discussion about the sustainability of certain economic systems, and it has revived complex questions of social membership, political rights, and moral “deservingness” (Horton 2004; Willen forthcoming-a). Multiple processes of reform—particularly those related to health care—have been at the forefront of public imagination and have been discussed candidly and passionately in the United States, Europe, and other world regions. Meanwhile, in countries that traditionally have received large numbers of economic im/migrants, economic pressures, and especially high rates of long-term unemployment, are fanning nativist sentiments. In the United States, for instance, demographic anxieties run high, especially in relation to what one anthropologist has called the perceived “Latino threat” (Chavez 2008). In North Africa and the Middle East, sweeping revolutionary fervor has generated widespread political instability and led hundreds of thousands of people to flee their homes, including many thousands who have crossed the Mediterranean seeking safety at Europe’s southern frontier. And the devastating impact of the March 2011 tsunami on Japan’s largely invisible population of unauthorized im/migrants, along with its broader impact on Japan, the region, and the world, remains to be seen. Clearly, the matter of central concern in this commentary revolves around a complex set of challenges unfolding in a rapidly changing world.

Framing New Conversations

We offer this commentary with two goals in mind. The first is research focused. The past five years have seen a dramatic increase in the number of medical anthropologists who are committed to documenting the negative health implications of migrant “illegality.” While we celebrate these important developments, we contend that two issues urgently need to be added to this emerging research agenda. We need a clear, robust theoretical framework for research on “illegality” and health within our own field, and we need to put medical anthropology in conversation with partner disciplines that are also in the process of consolidating their research agendas on these issues.

Second, we contend that medical anthropologists need to translate our work more effectively and for a much broader array of audiences. At the moment, few critical medical anthropologists are at the forefront of public or policy conversations about the health needs, rights, and entitlements of unauthorized im/migrants. Yet opportunities to translate anthropology and put it to work outside the walls of the academy abound. An example is illustrative. Immigration played a pivotal role in U.S. debates about health care reform during the first year of Barack Obama’s presidency. In summer 2009, one of us (JM) attended a town hall meeting in Rhode Island hosted by a local congressman during which a PowerPoint slide show listing “myths” and “truths” about health reform ran on a continuous loop. Slides identifying “myths” were followed by others declaring “truths”; for example, the “myth” that unauthorized im/migrants would receive federal funds was followed by the “truth” that the bills under consideration in Congress, and the laws currently

in place, explicitly prohibit the use of federal funds to pay for their health services. Despite the slides' myth-busting intent, once the floor opened for questions, audience reactions reflected the persistent assumption that federal monies would indeed benefit "illegals." The same assumption sparked an outburst just a few weeks later during a joint session of Congress convened by President Barack Obama to lay out his plan for health care reform. When Obama declared that no federal funds would be used to pay for unauthorized im/migrants' care, South Carolina Congressman Joe Wilson (whose state is now home to a substantial population of Latin American immigrants) shouted, "You lie!" (see, e.g., Heyman 2010). Significantly, Wilson's was not a fringe position; according to a poll conducted one month before his outburst, 46 percent of Americans erroneously believed that if health reform passed, all "illegal" immigrants would be covered (Indiana University Center for Health Policy and Professionalism Research and Indiana University Center for Bioethics 2009).

From an anthropological perspective, the play of discourse and power in such exchanges is self-evident. By suggesting that undocumented im/migrants might benefit from federal tax money, opposition voices draw attention away from other important conversations that we should be having—including conversations about class-based and racialized forms of health inequality (Rylko-Bauer and Farmer 2002); about the syndemic interactions (Singer 2009) among "illegality" and other forms of health-related vulnerability and risk (Willen forthcoming-b); about the social and public health costs of failing to provide care (Fleuriet 2009; Ho 2003); and about the many im/migrants who do, in fact, contribute financially to "the system" but remain excluded from its benefits. Moments like the Obama–Wilson exchange offer ideal opportunities for critical analysis of what Briggs and Nichter call "the pragmatics of biopolitical communication" (2009), or the manner in which messages about unauthorized im/migrants' health-related risk, vulnerability, and deservingness are produced, circulated and received. Such moments also invite reflection on the systematic erasure and silencing of other possible critical frames, especially those that focus on the social determinants of health and the "health–wealth" gradient (Commission on Social Determinants of Health 2008).

When public anxiety about immigration is ignited or fanned, it also becomes difficult to discuss the possible unintended consequences of policies that bar undocumented persons, for instance, from utilizing existing public programs, or from joining insurance exchanges created through health reform. Other unintended consequences include bureaucratic screening tools that block access to care not just for noncitizens, but also for some citizens, including members of mixed-status families.

We believe that critical medical anthropology can, and should, play a much more substantive role in contributing to, analyzing, and ultimately reframing both scholarly and public conversations about im/migration, inequality, and health. How might we achieve these goals in the present historical moment, when insistence on unauthorized im/migrants' complete exclusion from federal programs can be recuperated—by Rhode Islanders at a town hall meeting, for instance, or by a hot-headed South Carolina Congressman—as a kind of inverted plot to *include* them in health reform? In the discussion that follows, we explore some specific forms such innovation can and, in our assessment, should take both inside and outside of the ivory tower.

Taking a Stand

This commentary represents the collaborative work of the “Take a Stand Initiative on Unauthorized Im/migration and Health,” which was initiated in 2008 under the auspices of the Society for Medical Anthropology’s (SMA) Critical Anthropology of Global Health (CAGH) special interest group.³ The aim of this initiative is to think deeply with colleagues about the sort of research, bridge building, and communication critical medical anthropologists need to cultivate if we are serious about influencing conversations involving unauthorized im/migrants and their health needs, rights, and entitlements in the realms of scholarship, politics, policy, and health care practice. We are increasingly convinced that to shape conversation and debate, we cannot limit ourselves to using the established tools of our discipline in conventional ways. Rather, we will also need to stretch the bounds of academic expression and scholarly practice by “doing anthropology” not just in scholarly articles and books, but also in collaborative endeavors and in venues more accessible to broader audiences. These include interdisciplinary research initiatives as well as op-eds, community organization newsletters, policy white papers, community meetings, performances, social networking sites, YouTube videos, and blogs.

The urgent need to innovate and broaden our conversational scope extends far beyond the issues of unauthorized im/migration and health that form our focus here. Indeed, the push to innovate, especially in the use of electronic media, is now a hot topic in medical anthropology and in our parent discipline as well, and it is yielding exciting developments, including changes in the format of major journals; increasingly sophisticated uses of video; the cultivation of new target audiences for ethnographic findings; and a growing array of dynamic anthropology blogs (see, e.g., Checker et al. 2010; Igoe 2010; Lende 2010; Nelson 2010; Price 2010). However, it likely will take time for the structures of tenure and promotion to catch up with these innovations in scholarly practice.

In the following section, we offer a brief overview of how, and why, unauthorized im/migration is fast becoming a major topic of global health concern. We then sketch the contours of a research agenda that would locate unauthorized im/migration and health higher up on medical anthropology’s list of research priorities and, furthermore, put our field more squarely in conversation with other, related fields. In the final section, we shift gears to consider what a more publicly engaged anthropology of undocumented im/migration and health might look like and propose five action steps that will help medical anthropologists reframe both scholarly discussion and public conversation about unauthorized im/migrants’ health needs, rights, and entitlements.

“Illegality” and Health: A Growing Global Health Concern

Key economic sectors in many countries rely heavily on the unprotected labors of unauthorized im/migrants, yet politicians and policymakers often neglect, or even actively ignore, the health implications of their presence and labor market participation. Even where attention has been paid to these issues, the basic fact of their “illegality” often places im/migrants in positions of considerable health risk, and improved accessibility, affordability, or adequacy of health care seldom result.

Although unauthorized im/migrants' presence is popularly regarded in many countries as illegitimate or even threatening, hard-line arguments that they possess no health-related rights whatsoever have their limits. For instance, few argue that unauthorized im/migrants should be denied emergency care in life-or-death situations; more often, debates unfold about what constitutes a "real" emergency. At the same time, no host countries have accepted the opposite argument—namely, that unauthorized im/migrants are entitled to exactly the same forms of health care or exactly the same health benefits as citizens. Caught between the extreme options of full exclusion and full inclusion, most host countries are currently struggling to determine how best to respond to the health-related needs of unauthorized economic im/migrants—and, for that matter, to those of other noncitizen populations including refugees, asylum seekers (and failed asylum seekers), and victims of human trafficking.

The range of specific health concerns associated with unauthorized im/migration is wide (Heyman et al. 2009b; Sargent and Larchanché in press; Willen in press), as is the array of possible solutions. As scholars and activist NGOs have begun to demonstrate, a variety of unique, historically situated policies and practices shape im/migrants' health circumstances and influence both official and de facto access to health care services in each "receiving" country context (Platform for International Cooperation on Undocumented Migrants 2002, 2003, 2007, 2009; Médecins du Monde Observatory on Access to Health Care 2007, 2009). In social health insurance systems like those found in the Netherlands, Belgium, and Germany, for instance, compensation for medical services is provided on a fee-for-service basis, and proof of insurance must be presented to receive care. Unauthorized persons are thus at an explicit disadvantage, especially in comparison with other comprehensive tax-based systems like those found in Spain, Italy, and the United Kingdom. Spain has created the legal conditions to provide comprehensive health care coverage to unauthorized persons, although implementation remains a challenge. Italy has not only created a legal framework similar to that of Spain but also made it possible, at least in theory, for im/migrants to access medical care anonymously. The "humanitarian" models of Spain and Italy contrast sharply with "utilitarian" approaches like those of the Netherlands, Belgium, and Germany in which only emergency treatment is available (Romero-Ortuño 2004).

Even in nations with universal health care systems, ideological commitments to universal coverage do not necessarily translate into unfettered access to care for unauthorized im/migrants. In Germany, for example, the country's commitment to universal coverage stands in tension with its strict policy environment. As a result, unauthorized im/migrants remain highly conspicuous when they seek health services, and they are the targets of increased scrutiny. Until recently, providing medical aid to unauthorized persons could potentially be interpreted as a criminal act, and current legal structures continue to create ambiguous situations for health care providers and unauthorized im/migrants who are sick or injured (Castañeda 2009). In Costa Rica, another nation with an established commitment to providing "health for all," im/migrants from neighboring Central American countries are similarly treated with suspicion. Migrants are portrayed as both overly demanding and undeserving of health services, and they have become scapegoats for a system in decline (Goldade 2009). And in France, the provision of health care is a matter of gatekeepers'

and providers’ discretion (Ticktin 2006). In some instances, formally “deserving” im/migrants are denied or blocked in their efforts to obtain needed care (Larchanché 2010). In other cases, health care is provided in ways that disrespect im/migrants’ wishes, or even recapitulate negative, antiimmigrant stereotypes (Sargent 2005; Sargent and Larchanché 2007).

In the United States, policies concerning unauthorized im/migrants’ access to health care historically have been contradictory, fragmentary, or nonexistent, although the legal climate has become increasingly hostile over the past decade. Beyond emergency services, the availability of care for unauthorized im/migrants in the United States varies greatly from state to state and even within states (Marrow 2010). In 2009, as part of a stream of antiimmigrant legislation,⁴ the Arizona legislature passed House Bill 2008, which requires state and local employees to report individuals who disclose their undocumented status in the course of requesting a public benefit. Ultimately, its goal is to limit access to state-funded health care. Prior to Arizona’s HB 2008, one of the most controversial attempts to restrict unauthorized im/migrants’ access to health care was California’s Proposition 187, approved by voters in 1994. Although never implemented, Proposition 187 revealed how public policy issues concerning health care for im/migrants can stir up nativist sentiment. It also anticipated the federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which barred many “legal” im/migrants from publicly funded services like food stamps and Medicaid, ostensibly to prevent social benefits from serving as a magnet for im/migration. Since then, restrictionist tendencies have only increased, largely because PRWORA devolved authority to the states to reinstate or further restrict im/migrants’ eligibility for public programs. In 2005 alone, some 80 bills proposed in 20 states sought either to cut noncitizens’ access to health and other social services or to require that health care providers or institutions notify the authorities when unauthorized patients seek care.

Although the United States provides only a fraction of the social welfare benefits many other countries offer, the existence of large numbers of uninsured Americans ironically might mean that unauthorized im/migrants have a better chance of accessing needed care. At present, the U.S. health care system is in flux as a result of the health care reform bill passed in 2010, which explicitly excludes unauthorized im/migrants from any form of direct benefit. The long-term impact of this monumental health care reform legislation remains to be seen.

These variations among national policies offer a starting point—not an end point—for an anthropology of im/migration and health policy. One important task as we move ahead will be to critically examine the complex processes through which national as well as local policies are created, implemented, interpreted, subverted, and transformed through everyday social interactions (Shore and Wright 1997) and in the clinics, social service offices, online forums, workplaces, and households where such policies come to life.

Theorizing Unauthorized Im/migration and Health

The intersection of unauthorized im/migrants’ current and anticipated health needs, on one hand, and their widespread lack of health care options, on the other, raises a wide array of theoretical, practical, and ethical challenges that merit medical

anthropologists' attention. Some of these concerns have already become objects of ethnographic analysis. Examples include the dilemmas faced by undocumented pregnant women in Germany, who struggle to navigate the health system while trying to avoid deportation (Castañeda 2008); the complex predicament of unauthorized im/migrants in France who are ill and seek protection under the country's "humanitarian clause" (Ticktin 2006); and the struggles of undocumented workers in the United States, whose efforts to access care may be misinterpreted by paternalistic social welfare providers as poor parenting (Horton and Barker 2010) or who may find health care providers quick to "blame the victim" for health problems engendered or exacerbated by structural conditions (Holmes 2007). This growing body of ethnographic work probes a variety of important themes including "illegal" im/migrants' increased vulnerability to illness, injury, and violence; the political, ideological, and bureaucratic obstacles that "naturalize" their experiences of structural inequality and social suffering; and local advocacy and activist efforts to improve im/migrants' access to care.⁵ This list is growing rapidly, and the array of topics requiring ethnographic attention is similarly growing apace. The time is now ripe for a collaborative conversation about the scope and content of a medical anthropological research agenda on unauthorized im/migration and health. Below we identify four theoretical concerns that emerged in our deliberations as particularly worthy of more concerted attention.

1. *"Illegality" as social construction.* First, it is crucial to remember that there is nothing natural or automatic about "illegal" migration statuses or migrant "illegalities." Rather, these are entirely modern constructions—social, political, economic, and ideological, as well as juridical—that are invented and deployed for particular reasons in particular contexts. Along the U.S.–Mexico border, for instance, the very notions of "immigrant," "legality," and "illegality" were constructed, applied, selectively enforced, and repeatedly redefined over the course of the 19th and 20th centuries in response to changing U.S. policies and employer demands (Ngai 2004; Zolberg 2006).

In recognizing that "illegality" is a varied and evolving construction, we are impelled to ask a number of crucial questions. Who is classified as "illegal," under what circumstances, and why? Who benefits and who is harmed by such constructions? How do configurations of migrant "illegality" vary across migration settings and over time? What tools and techniques are deployed in different contexts to "illegalize" or criminalize unauthorized im/migrants? How do local configurations of "illegality" affect im/migrants' health and well-being in material, discursive, and experiential terms? Questions like these are integral to any robust agenda for research on the health implications and consequences of unauthorized im/migration.

Furthermore, we need to pay attention to all three dimensions of migrant "illegality": as a form of juridical status, a sociopolitical condition, and a way of being-in-the-world (Willen 2007). The experiential and embodied consequences of "illegality," both independently and as they intersect with other dimensions of subjectivity (i.e., gender, race/ethnicity, class, individual biography), are particularly in need of investigation. We already know that being classified as "illegal" can generate powerful feelings of fear, disrespect, humiliation, and ridicule and, moreover, that such feelings can both accompany and exacerbate im/migrants' encounters with

stigma, discrimination, denial of services, and other objective forms of exclusion (Fassin 2004; Sargent 2006). We also know that the uncertainty and liminality associated with “illegality” and “deportability” can yield adverse mental health consequences including chronic stress, anxiety, and depression. Less is known about *how* the subjective and objective consequences of “illegality” are embodied in ways that generate health risk or impede injured and ill im/migrants from pursuing needed health care.

One need not be classified as “illegal” to encounter these experientially grounded health consequences. They are also familiar to members of many mixed-status families (e.g., families with undocumented parents and citizen children [Yoshikawa 2011]) as well as people living in “status limbo” (such as those with Temporary Protected Status [TPS]; Coutin 2003; Foxen 2008). The liminal dimensions of im/migrant “illegality” clearly have health consequences at the individual, familial, and collective levels, yet they are just beginning to receive the scholarly attention they demand (e.g., Castañeda 2009, 2010; McGuire and Georges 2003).

2. *“Illegality” and the global political economy: What drives unauthorized im/migration, and who benefits?* Global patterns of structural inequality are the core catalyst of unauthorized im/migration, and both employers and consumers benefit from unauthorized im/migrants’ vulnerable, exploitable, and low-paid participation in local labor markets. Political economic context is thus a crucial component of any satisfactory analysis of the health risks and consequences of unauthorized im/migration and health. A critical political economic lens challenges us to reevaluate a variety of everyday concepts and assumptions, including commonplace definitions of “illegality” and conventionalized understandings of the relationship between unauthorized im/migration and “choice.”

A political economic approach also forces us to critically assess both popular and political assertions about the relationship between such “choices” and broader questions of right, entitlement, and justice. For many im/migrants, migrating is not a straightforward “choice,” but, rather, a strategic effort to mitigate entrenched global political–economic imbalances and improve their own lot and the lot of those they care about most. Often this hinges on the enactment of “renegade moralities” that involve bending certain laws (e.g., host-state immigration laws) to serve basic objectives—for instance, feeding one’s family, paying children’s school fees, or burying deceased parents with dignity—they deem not merely justifiable, but in fact morally laudable (Willen forthcoming-a). Host countries, of course, tend to read such “choices” quite differently, namely as a silent attack on state sovereignty, an attempt to steal jobs from citizens, a drain on government resources, or a pollution of the body politic. These accusations and forms of scapegoating tend to become especially rancorous when im/migrants’ health needs, rights, and entitlements are raised for discussion. Such ideologically charged constructions can also impede scholarly efforts to investigate unauthorized im/migrants’ health needs by imposing funding barriers, obstructing access to research subjects, and frustrating efforts to publish or otherwise disseminate research findings.

We need more studies that unpack not only the practical and theoretical implications of these challenging issues but also the complex moral framings that can influence both our research and our target audiences. For instance, we must be

careful to avoid simplistic portrayals of im/migrants as heroes and host policymakers as cruel villains—or vice versa. Instead, we need to take local moralities as objects of ethnographic analysis. Rather than avoiding difficult research topics such as intergroup exploitation, drug trafficking, and domestic violence, we must instead contextualize and unpack our findings using the powerful analytic tools of our field, including the concepts of structural inequality, structural violence, biopolitics, and biosociality.

3. *“Illegality,” syndemics, and health-related vulnerability.* Not only do unauthorized im/migrants tend to occupy the most “dirty, dangerous, and demeaning” roles within local labor markets, but migrant “illegality” also interacts syndemically (Singer 2009) with other risk factors to exacerbate vulnerability to illness, injury, and exposure to violence at both the individual and collective levels. Syndemics, in brief, is the study of how “two or more afflictions, interacting synergistically, contribut[e] to excess burden of disease in a population” (Centers for Disease Control and Prevention 2010). In broader terms, it constitutes “a way of thinking about public health work that focuses on connections among health-related problems, considers those connections when developing health policies, and aligns with other avenues of social change to assure the conditions in which all people can be healthy” (Centers for Disease Control and Prevention 2010).

Syndemic interactions can have serious consequences for the health of im/migrants and their families and, furthermore, for the broader health of the public. We need ethnographic studies that both investigate and theorize how “illegality” interacts with other manifestations of structural inequality—including occupational hazards; exposure to infectious disease; vulnerability to violence; poverty; discrimination; and structural, institutional, linguistic, and cultural obstacles to health care, among other factors—to put unauthorized im/migrants in positions of health-related disadvantage.⁶ We also need more detailed studies of the care-seeking pathways unauthorized im/migrants pursue when access to health care services is blocked, including self-care and self-medication, border crossing in search of medication or health care services, and utilization of complementary and alternative medical systems (Pylypa 2001; Viladrich 2006). And what happens when unauthorized im/migrants simply cannot access care? What health consequences ensue for im/migrants and their coworkers, family members, local communities, and the broader public?

4. *Rights, ethics, and “deservingness” debates.* Around the globe, debates about unauthorized im/migrants’ “deservingness”—or lack thereof—are ubiquitous in popular, policy, and NGO discussions of unauthorized im/migration and health. Although a handful of bioethicists have begun to contemplate the dilemmas associated with “illegality” and deservingness in a philosophical idiom (e.g., Coyle 2003; Dwyer 2004) and some clinicians have begun to debate these questions in medical journals (Anya 2007; Arnold et al. 2008; Kullgren 2008; Virgilio et al. 2007), few medical anthropologists—or other social scientists of health—have paid it serious ethnographic attention to date (cf. Chavez 2008; Grove and Zwi 2006; Horton 2004; Ruiz-Casares et al. 2010; Willen forthcoming-a, forthcoming-b). We regard

the paucity of anthropological research on these heated and highly contentious debates as a serious gap in current scholarship. Furthermore, these questions raise important points of intersection with the growing literature on the anthropology of human rights (e.g., Castañeda 2011; Goodale 2006; Levitt and Merry 2009; Ticktin 2006; Willen this issue; Wilson and Mitchell 2003). Engaged anthropological analysis of these questions, of contemporary forms and modes of opposition to immigration, and of debates over immigration policy can help denaturalize everyday assumptions about who is or is not deserving of health-related attention, investment, or care (Willen forthcoming-a). The literature on deservingness, responsibility, and downsizing the welfare state offer important starting points for more robust engagement with these questions (Clarke 2004; Goode and Maskovsky 2001; Katz 2008).

Framing Interdisciplinary Conversations: Forging New Roles for Medical Anthropology

The complex health implications of unauthorized im/migration have attracted attention from scholars in a wide array of fields including not just medical anthropology, but also public health, public policy, clinical medicine, nursing, health ethics, sociology, political science, and law, among others. Although the overall quantity of relevant publications is on the rise, a broad review of the literature reveals few organizing frames, or even consistent lines of discussion, either between or in some instances even within fields. In our assessment, the need for cross-disciplinary dialogue is both clear and urgent—and medical anthropologists have important contributions to make.

Two key steps are necessary if we hope to play a leading role in shaping and framing these conversations. First, we must read broadly across this emerging literature and educate ourselves about the issues of greatest concern to colleagues in other fields. Second, we must articulate clearly what medical anthropology can contribute, both empirically and theoretically, to the broader conversations we envision. In part, this will involve seeking out and, where relevant, creating opportunities for cross- and interdisciplinary dialogue. It will also require making our disciplinary strengths and insights accessible to colleagues in other fields, including our attention to historical depth, political economic context, and the play of power; our sensitivity to the impact of ideology on discourse, practice, and social interaction; and our attunement to how multiple layers of social and material context influence the texture and flow of everyday lived experience. At the same time, we must also consider how our own work can benefit from the methodological and analytic strengths of other fields including, for instance, the scope, scale, and precision of epidemiological inquiry and the pragmatic imperatives driving both clinical and policy research.

Our review of the literature on unauthorized im/migration and health reveals a wide array of themes that have begun to attract interest yet clearly merit more concerted interdisciplinary engagement. These include the impact of policies—both inclusionary and exclusionary—on patterns of health care access and utilization (Berk et al. 2000; Cohen 2009; Kullgren 2003; Torres-Cantero et al. 2007); the allostatic load associated with migrant “illegality” (Castañeda 2009; Holmes 2006; McGuire and Georges 2003); and the costs—obvious and hidden, short and long

term—of denying unauthorized im/migrants access to care (DuBard and Massing 2007; Goldman et al. 2005, 2006; Okie 2007). Other key themes include ethical dilemmas and debates, for instance involving clinical limits on health care for unauthorized patients (Coritsidis et al. 2004; Coyle 2003); epidemiological case reporting (Achkar and Macklin 2009); professional ethics (Rousseau et al. 2008); the gap between aspirational notions of the right to health and everyday clinical practice (Cole 2009; Ruiz-Cesares et al. 2010; Willen this issue); and questions of collective social responsibility toward unauthorized im/migrants (Castañeda 2011; Dwyer 2004).

The tasks of setting a theoretical agenda and framing interdisciplinary conversation, however, are only part of the work that lies ahead. Another crucial role for medical anthropologists is to put the knowledge and insights gained through our scholarship more centrally into public and policy conversations. What might a more publicly engaged anthropology of undocumented im/migration and health look like?

Going Public

If the recent American Anthropological Association meeting theme “Inclusion, Collaboration, and Engagement” is any indication, then we can declare with confidence that engagement and collaboration are now mainstream components of our field. Despite such declarations, however, medical anthropology has not yet fully recognized or integrated either new forms of collaborative engagement or new research products that differ from the traditional journal article or book-length ethnographic study. Although many anthropologists have long engaged in collaborative or public projects, it is nonetheless true that “the political economy of academia is not structured to reward individuals building things for a common good outside of the peer-review process” (Price 2010:141; cf. Checker et al. 2010; Bennett and Khanna 2010).

Given the importance and urgency of the issues at stake, we cannot wait for the reward structure of our discipline to change before expanding our efforts to intervene in public and policy conversations about unauthorized im/migration and health. What, then, might we do differently? Below we highlight five steps that critical medical anthropologists of unauthorized im/migration and health will need to take if we hope to forge a balanced, critical, and engaged anthropology capable of shaping public discourse and influencing policy debate about these complex, urgent questions. These steps include (1) listening differently, (2) teaching differently, (3) democratizing knowledge production, (4) translating ourselves, and (5) writing differently.

1. *Listen Differently: Are We Hearing a Full Enough Range of Voices?*

In a recent article on imprisoned African women in Italy, Asale Angel-Ajani poses a provocative question: “Can we be engaged scholars or activist intellectuals,” she asks, “if we do not know how to listen, or if we seek or even demand knowledge that confirms what we already think we know?” (2004:142). Although we are all skilled in various forms of listening, new ways of listening are needed if we hope to contribute meaningfully to public conversation about the controversial

issues engaged here. For instance, we need to listen to how im/migrant groups and other stakeholders—among them local business owners, town officials, border patrol and law enforcement officers, and hospital administrators—talk about the changes taking place in their communities. More specifically, we need to invest in understanding *their* stakes in today’s fraught conversations. Given these diverse positions, how are local economic concerns, identity politics, historical imaginaries, and attitudes concerning deservingness (and undeservingness) folded into debates about im/migration?

According to Josiah Heyman, anthropologists “know far more about immigrants than hosts, which hobbles our ability to understand and contribute to the public debate” (2010). Methodologically, he suggests that we need “to spend time *among the people who respond to immigrants* to understand the bases of both rigid exclusion . . . and of moral connection” (Heyman 2010; emphasis added). One important and understudied group, for instance, includes health care providers who are challenged to deliver care in uncertain policy environments and who increasingly are called on to enforce immigration policies. If we hope to understand the dynamics of both exclusion and connection, or contribute meaningfully to public and policy conversations, then we need to listen to a wider range of informants than usual. We also need to listen without assuming that we already understand actors’ motivations, personal histories, or political investments. Overall, perhaps we would do better to think of our work as “engaged listening,” rather than “giving voice.”

2. *Teaching Differently: Must Our Classrooms Have Borders?*

The classroom is already a valuable site for critical conversation about the practical, political, and ethical challenges associated with unauthorized im/migration and health, but there are compelling reasons to explore new ways to teach differently. For instance, how might we orient our teaching outward and reimagine it as something more than an act we perform several hours each week for tuition-paying students? Higher education is currently abuzz with attempts to add community engagement and service learning to the curriculum.⁷ Given our disciplinary focus on local communities and fieldwork, anthropology has long been recognized as a natural fit for these efforts. One valuable and established mode of “teaching differently” involves service learning opportunities in which students work collaboratively with im/migrant organizations or local health care providers. We need to find more opportunities for outwardly focused learning that will put students into real-world contexts where they can develop nuanced understandings of the practical, policy, and ethical dilemmas associated with unauthorized im/migration and health. We also need to develop new venues for publicizing and publishing research conducted collaboratively with students.

Yet “teaching differently” can, and should, extend far beyond familiar forms of service learning in academic settings. Advocating for policy, for example, is another form of teaching that targets a broader-than-usual audience (Heyman et al. 2009a:23). If we reimagine our teaching roles to include public teaching in advocacy contexts, then we will develop richer, more publicly relevant understandings of what it means to put medical anthropological insights into practice in current

discussions of unauthorized im/migration and health. After all, the strategies that help us communicate effectively in the classroom—presenting clear examples, insisting on attention to social, historical, and political context, and offering compelling concepts and analytic tools—can have a powerful impact in nonacademic settings as well.

3. Democratize Knowledge Production

As Lassiter (2005) reminds us, collaboration has always been a part of anthropological knowledge production. Anthropologists, and especially applied medical anthropologists, have demonstrated the value and effectiveness of community-based collaborative approaches over the past quarter century, and, more recently, a solid critical literature has taken stock of their strengths and limitations (Goto et al. 2010; Minkler 2005; Poehlman 2008; Schensul et al. 2008; Singer and Weeks 2005). But what if collaboration more thoroughly informed *all* phases of the research process, including the processes of defining the research problem and writing up findings? Especially in sensitive areas like unauthorized im/migrant health, medical anthropologists have much to gain by making the process of knowledge production more public, more democratic, and more responsive to the communities with whom we work. Drawing on well-established collaborative approaches to tackle these challenges in new ways is also likely to push anthropological theory, methods, and publishing in fresh directions.

One excellent example of collaborative research that has engaged an unusually broad audience, yielded scholarly insights, and generated concrete policy proposals is the recent project conducted by anthropologists Josiah Heyman, Maria Cristina Morales, and Guillermina Gina Núñez as part of a broad-based coalition of scholars and advocates on the U.S.–Mexico border. Together, these Texas-based anthropologists and their colleagues have created policy proposals, sought to combat the demonization of im/migrants in public discourse, and lobbied local, state, and nationally elected officials to move from a border enforcement approach to one that emphasizes “community safety” (Heyman et al. 2009a:18). In reflecting on the project’s challenges, the authors note the conflicts between traditional academic work and the kinds of training and evaluation that would facilitate more collaborative policy-based research. “We need to train students, practicing social scientists, and academics in these skills,” they write, “and we need to develop both academic and nonacademic models for recognizing and rewarding engagement in the public decisions that shape our collective lives” (Heyman et al. 2009a:26). At present, such thoroughly collaborative research models do not mesh easily with the grant-funding structure or the individual publishing expectations on which so many medical anthropology careers depend.

Recently, some funding agencies have begun to recognize and promote this sort of collaborative work, including the National Institutes of Health, which offers grants for community-based participatory research.⁸ Yet certain aspects of such models merit critique. For instance, they tend to promote short-term collaborations that do not necessarily foster long-term commitment to field sites or involve community partners in the same way that engaged ethnographic fieldwork often does.

An alternative collaborative model can be found in the comparative ethnography of infidelity and HIV risk in Mexico, Nigeria, Uganda, Papua New Guinea, and Vietnam conducted by Jennifer Hirsch and colleagues (2009). This innovative project (which also received NIH support) demonstrates compellingly that comparative ethnography need not be a thing of the past. More specifically, it highlights the empirical and theoretical benefits of a study involving the simultaneous implementation of a single research protocol in multiple settings.

Collaborating with fellow researchers and with the communities in which we work can take our research in new empirical and theoretical directions and foster broader and richer public conversations about the local implications of this challenging global issue.

4. *Translate Ourselves*

Anthropologists once imagined their craft as translators of the strange and exotic. Increasingly, it is *ourselves* that we need to translate for nonanthropological audiences. “Teaching differently,” both for students and for public audiences, is an important piece of this process. We also need to translate ourselves for colleagues in related fields, for instance in public health, clinical medicine, nursing, sociology, political science, and bioethics/public health ethics. Only through such processes of translation can we hope to collaborate across disciplines to effectively design, conduct, publish, and apply research in ways that can improve unauthorized im/migrants’ health.

Even more urgently, however, “translating ourselves” means learning to communicate more effectively with the world outside of the academy. If we hope to participate in public debates about unauthorized im/migration and health, we cannot wait for readers to find our most recent journal articles—which, after all, are difficult to access and prohibitively expensive to anyone lacking a university affiliation. We cannot assume that interested stakeholders, especially those outside the academy, will find us. The onus is on us to seek out new partners in dialogue and develop new audiences for the insights we have to offer.

For some medical anthropologists, like Paul Farmer and Nancy Scheper-Hughes, this kind of translation has meant collaborating with journalists, and it has paid off with coverage in prestigious outlets like the *New York Times*. We can start with something as manageable as a piece in a college newsletter or an op-ed for the local newspaper. In this regard, we can learn from anthropologists like Maria Vesperi and Brian McKenna, who not only write for broad audiences but also offer workshops to help fellow anthropologists become more media savvy. Whatever scale we choose, deliberately seeking out media attention can advance the goals of a public anthropology that aims “to make public issues, not simply to respond to them” (Scheper-Hughes 2009:1). Yet “translating ourselves” is not just about what happens in print. We know full well that conversations about im/migration, cultural difference, deservingness, and human rights occur all the time in our own communities. These conversations may not be taking place on our terms, but when we seek out opportunities to engage in conversation—for instance by attending community meetings, or by engaging with local service providers—we make anthropology more public.

One fraught zone of translation involves the notion of cultural competence. Anthropologists tend to be wary, and rightfully so, of how “culture” and cultural competence have been taken up by health care educators, systems, and providers (see, e.g., Castañeda 2010; Good et al. in press). This can be especially complicated when working with unauthorized im/migrants, who are vulnerable to the imposition of culturalist (as opposed to structural or political-economic) explanations for “noncompliance” with medical advice. As Jennifer Hirsch (2003) reminds us, one of the greatest pitfalls in being called on to act as a “culture expert” is the risk of being asked to affirm or verify misplaced interpretations. How, then should anthropologists respond to opportunities to engage with local practitioners and public health officials who are interested in becoming more “culturally competent”? One useful strategy for navigating this difficult terrain is to work consciously and deliberately to translate ourselves. What if we embraced such opportunities but, rather than playing the part of “culture expert,” instead worked to shift attention toward the role of systemic inequality and structural violence in placing unauthorized im/migrants at health risk? Those of us who adopt such strategies have found myriad new opportunities for teaching and translating, ranging from clinical care contexts to the community forums, budget hearings, and health councils where ad hoc immigration policies are formulated and applied.

5. *Write Differently: Can We Be More Compelling and Accessible?*

Medical anthropologists are no strangers to the written word, but few of us are adept at writing up our research in ways that resonate beyond the walls of the academy. Certainly we cannot dispense with conventional modes of scholarly writing like peer-reviewed articles and books, but we have far to go if we hope to communicate effectively with audiences beyond our students and colleagues. Other valuable genres of writing include coauthored books, policy papers, and publication in accessible venues like newspaper op-eds and organizational newsletters. Blogs offer another important avenue of expression. As a number of anthropologists have demonstrated in the past several years, blogs offer a timely, convenient, and user-friendly vehicle for building new communities of conversation around issues of pressing concern, as the creators and authors of anthropology blogs like *Savage Minds*, *Neuroanthropology*, and *Somatosphere*, among others, have amply demonstrated.⁹

Following the lead of several such blogs, the CAGH Take a Stand Initiative on Unauthorized Im/migration and Health created the blog “AccessDenied: A Conversation on Unauthorized Im/migration and Health” (accessdenied-blog.wordpress.com) with precisely these goals in mind. Among the goals of AccessDenied, as we explain on the homepage, are to challenge readers and contributors “to re-think the political common sense that denies im/migrants access to health care” and to “consider how the increased movement of people across national borders affects the health and health services of receiving communities” (Castañeda 2010). Pitched to a broad audience of scholars, activists, policymakers, and students, among others, the site offers a variety of features including analytic essays, news roundups, a dynamic working bibliography, and suggested “action steps” as well as links to a rich array of relevant online sources. AccessDenied is designed to serve as an open, multivocal public forum, a scholarly resource, and a tool for teaching.

We are eager to expand our readership, and we encourage potential contributors to contact us directly with essay ideas.

Since its launch at the 2009 AAA meetings, AccessDenied has become a valuable new venue for timely, critical engagement with current issues relevant to unauthorized im/migrants’ health needs, concerns, and rights. Blog posts deal with a wide array of current issues and concerns, ranging from the health implications of immigration policies in the United States and Europe (Armin and Reineke 2010; Gomberg-Muñoz 2010; Guarnaccia 2009; Larchanché 2010; Marrow 2010); to the “medical deportation” of ill and injured im/migrants by private hospitals (Plascencia 2009); to the lack of protection for unauthorized women in cases of domestic violence (Parson 2010); to the hypocrisy of public hospitals that permit shamans to conduct rituals on hospital wards while ignoring the socioeconomic conditions that help put im/migrants in the hospital in the first place (Hirsch and Vasquez 2009).

Conclusion

In one of AccessDenied’s especially provocative posts, Didier Fassin probes the foundations of the Obama–Wilson exchange mentioned earlier. Fassin argues that whether Wilson’s assertion “is true or false, good or bad, the remarkable fact is that it seems to take for granted a broad political consensus supporting the exclusion of undocumented foreigners from the plan for health reform” (2010). Here Fassin advances the most fundamental and urgent goal of this Take a Stand initiative: to critique the unspoken—but nearly ubiquitous—assumption that unauthorized im/migrants can and should be categorically excluded from the moral community in which the rest of us live, work, and vote.

How can critical medical anthropologists challenge these assumptions? How might we shape a scholarly agenda capable of enriching interdisciplinary conversations, influencing policy discussions, and engaging with a wider public? In this commentary, we have proposed a number of steps that medical anthropologists can take. First, we contend that a sharper and more robust theoretical agenda on unauthorized im/migration and health should attend to four key concerns: (1) “illegality” as a social construction, (2) “illegality” as a product of the global political economy, (3) the health-related vulnerabilities caused by “illegal” status, and (4) the symbolic and ethical grounding, as well as the shape and form, of “deservingness” debates. Second, given the burgeoning interest in these issues and paucity of analytic frameworks for interdisciplinary conversation, we argue that medical anthropologists ought to step up and take the lead. Finally, we have argued that a more publicly engaged anthropology will require medical anthropologists to (1) listen differently, (2) teach differently, (3) democratize knowledge production, (4) translate ourselves, and (5) write differently.

Around the world, in our home communities and in our field sites, the health-related challenges associated with unauthorized im/migration are growing in both scope and magnitude. At the same time, public discussions about unauthorized im/migration are becoming increasingly polarized and contentious. The rise of anti-immigrant parties and racially motivated violence in Europe, the systematic exploitation of irregular im/migrants in the Persian Gulf, and the 2010 legalization of

racial profiling in Arizona all stand as stinging reminders of how quick politicians, policymakers, and voters often are to cast unauthorized im/migrants outside the bounds of the nation, the body politic, and the moral community. Under these circumstances, simply conducting more research on unauthorized im/migrants' health will not suffice. Instead, we need a reinvigorated critical medical anthropology that intervenes in the public debates through which exclusionary health policies come to be accepted as "common sense."

These are urgent issues, and as medical anthropologists, scholars of health and social justice, and members of broader social and political communities, we have much to contribute. The time to sharpen our research agenda and take part in public and policy conversations about unauthorized im/migration and health is now.

Notes

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1. Estimates suggest that 10 to 15 percent of the world's total im/migrant population of 214 million lack legal authorization (International Labour Organization 2006). These figures do not include unauthorized internal migrants, of whom there are an estimated 200 million in China alone (see, e.g., Zhang 2001).

2. Two notes on terminology are in order. First, we use the terms *unauthorized* and *illegal* relatively interchangeably, albeit with one key point of distinction. We regard the term *unauthorized* as a relatively neutral descriptor, whereas *illegality* always appears in quotes to indicate that we regard it as an object of analysis in itself (Coutin 2003; De Genova 2002; Willen 2007). Second, we use the term *im/migration* to indicate that the boundary between migration and immigration is both porous and shifting.

3. Like the group's recent initiative on the role of critical medical anthropology in global health (Pfeiffer and Nichter 2008), the Critical Anthropology of Global Health Special Interest Group and "Take a Stand" framework have provided an opportune venue for community building among scholar-activists with a shared set of commitments and goals. Other results of our collaborative efforts include a "Working Paper on Unauthorized Im/migration and Health" circulated to SMA members (Willen and Castañeda 2008); an SMA-invited double panel at the 2009 AAA meetings; and a new multidisciplinary blog: "AccessDenied: A Conversation on Unauthorized Im/migration and Health" (www.accessdeniedblog.wordpress.com).

4. The most controversial of these pieces of legislation, and the one that garnered the most national and international attention, was Arizona's State Bill 1070, passed in 2010, which institutionalized racial profiling by granting local police the power to arrest anyone suspected of being in the United States on an unauthorized basis. In 2011, several states followed with similar or even harsher legislative proposals including Utah, Georgia, and Alabama.

5. For a dynamic, interdisciplinary working bibliography of scholarly research on unauthorized im/migration and health, see <http://accessdeniedblog.wordpress.com/working-bibliography/>.

6. See, for instance, Willen forthcoming-b.

7. For those who are new to “service learning” or “community engagement,” organizations like Campus Compact (www.compact.org) offer a useful point of entry into the literature.

8. See National Institutes of Health 2007. It is also imperative to engage with the funding priorities of national grantmakers if we wish to develop an engaged anthropology of im/migrant health. Many agencies are currently unwilling to support research on health disparities or inequities within a transnational framework, effectively hindering research on the effects of migration. Others explicitly exclude research on unauthorized im/migrants from their funding priorities. As a result, scholars must be savvy and creative in attempting to craft research proposals on the health effects of “illegality.”

9. See www.savageminds.org, neuroanthropology.net, and www.somatosphere.net.

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