

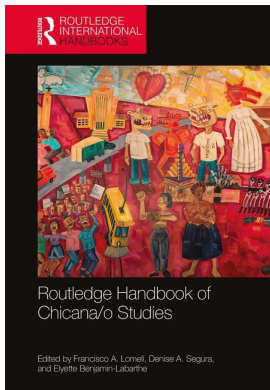
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On: 22 Sep 2023

Access details: *subscription number*

Publisher: *Routledge*

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Routledge Handbook of Chicana/o Studies

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Publication details

<https://test.routledgehandbooks.com/doi/10.4324/9781315726366-12>

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Published online on: 03 Aug 2018

How to cite :- Jonathan Xavier Inda. 03 Aug 2018, *Mobilizing for life from:* Routledge Handbook of Chicana/o Studies Routledge

Accessed on: 22 Sep 2023

<https://test.routledgehandbooks.com/doi/10.4324/9781315726366-12>

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Mobilizing for life

Illegality, organ transplants, and migrant biosociality

Jonathan Xavier Inda

Over the past few decades, health-based claims and matters of life have become central to the citizenship politics of the West (Inda 2014; Ong 2006). In Brazil, for example, the state has followed “a policy of biotechnology for the people,” universalizing access to life-saving AIDS medication in the name of fostering the health of each and every individual (Biehl 2007, p. 8). In France, ill health is now by and large deemed the most credible grounds for conferring legal recognition upon asylum seekers, with individuals suffering from life-threatening pathologies being the most likely to gain official residency permits (Fassin 2001; Ticktin 2011). In the United States, individuals afflicted with a wide range of diseases – from AIDS and mental illness to chronic fatigue syndrome and muscular dystrophy – are taking action and being recognized on the basis of their damaged biology (Landzelius 2006; Rapp, Taussig & Heath n.d.). Across the West, then, individuals have come to make claims on and be recognized by political, medical, and other authorities in terms of “their ‘vital’ rights as citizens” (Rose & Novas 2005, p. 441).

In this context, undocumented immigrants in the United States, despite their legal status and the intense immigration enforcement climate, have also turned to their biology to make citizenship claims. Focusing on the efforts of 14 undocumented migrants to obtain spots on the transplant waitlists in Chicago-area hospitals, this chapter examines migrant health activism in terms of biosociality, a form of citizenship in which individuals and groups come together around a shared biological state or identification – a specific disease, corporeal vulnerability, genetic risk, embodied harm, somatic suffering, and so forth – in order to gain recognition, resources, and care. Biosociality thus amounts to collectivities mobilizing on the basis of their damaged or precarious biology as a way of securing vital rights – the right to life, health, and healing. In the case at hand, undocumented immigrants have come together around organ failure and the general suffering of the “illegal” migrant body, the goal being to achieve access to new organs. Migrant biosociality is about collective entitlement to health services, hope for better treatment, and helping suffering bodies. It is grounded in the belief that undocumented immigrants deserve access to life-saving medical technologies.¹

This chapter takes up the notion of biosociality to understand how undocumented migrants mobilized around their biology to make citizenship claims. It emphasizes that this mobilization took place in a context where the illegality of the migrants served as powerful mobilizing force. Indeed, the migrants did not just mobilize around their biology, but also

around their political status as undocumented migrants. What ultimately brought them together was the suffering undocumented body. Indeed, the biologically damaged and suffering “illegal” body served as crucial source of legitimacy for undocumented access to health care rights.

Biosociality, citizenship, and identity

In his essay “Artificiality and Enlightenment: From Sociobiology to Biosociality,” Paul Rabinow (2005) coins the term *biosociality* to capture how new genetic knowledges and technologies (for example, the mapping of the human genome, polymerase chain reaction, and so forth) are giving shape to novel practices of life. Specifically, biosociality is employed to name the way in which the new genetics is operationalizing nature in such a manner as to model it “on culture understood as practice” (2005, p. 186). The idea here is simply that, as a result of new understandings of vital processes at the molecular level, life (nature) has been opened to all kinds of calculated intervention and reformation. One important manifestation of biosociality that Rabinow discusses is the “formation of new group and individual identities and practices” (2005, p. 188) out of emergent genetic truths. He shows that, through advances in genetic screening practices, individuals can now be revealed to be at risk of developing certain genetic disorders. Significantly, these presymptomatic individuals, as well as those who are already suffering from particular genetic maladies, are joining together into groups to demand recognition and make claims on the use of biomedical research and technologies. For example, there are already “neurofibromatosis groups who meet to share their experiences, lobby for their disease, educate their children, redo their home environment, and so on” (2005, p. 188). It is not difficult to imagine, Rabinow suggests, other such genetics-based groups forming – groups that “will have medical specialists, laboratories, narratives, traditions, and a heavy panoply of pastoral keepers to help them experience, share, intervene, and ‘understand’ their fate” (2005, p. 188). Thus, as vital processes become an object of technical manipulation, we end up with the cultivation of new subjects who understand themselves through their biology and engage in all sorts of life practices aimed at fostering individual and collective health.

One of the more important reworkings of the concept of biosociality comes from Nikolas Rose and Carlos Novas (2005). Drawing on Rabinow, they suggest that biosocial groupings, that is, groups and communities formed on the basis of shared somatic identifications, have become increasingly significant. As they put it, “new forms of ‘biosociality’ and new ethical technologies are being assembled around the proliferating categories of corporeal vulnerability, somatic suffering, and genetic risk and susceptibility” (2005, p. 442). But whereas Rabinow highlights the genetic basis of biosocial groupings, Rose and Novas (2005, p. 450) emphasize their sundry foundations, asserting that such collectivities are premised not just on genetics, but also on other biological conditions – conditions whose causes may be social, uncertain, or contested. The central feature of biosociality for Rose and Novas is thus not genetic commonality but the mere fact of shared biological injury. Indeed, it does not matter that the somatic affliction that brings a group together is not genetic in origin. What matters is simply that the group’s members are united around common biological damage and suffering. Importantly, Rose and Novas not only expand the purview of biosociality (that is, of what constitutes a biosocial group), they also frame the concept explicitly in citizenship terms.² The idea is that biosociality is not just about individuals forming groups on the basis of some sort of biological identification. It also entails these biocollectivities mobilizing in order to gain access to vital rights and resources. Rose and Novas, then, highlight the intimate coupling of biosociality and citizenship – how groups seek to legitimate rights in the name of their biologically damaged and suffering bodies. For them, indeed, biosociality fundamentally involves the linking of collective rights to matters of health, disease, and bodily suffering.

While the concept of biosociality as articulated by Rabinow, Rose, and Novas is quite compelling, I suggest that extrabiological factors, and not just somatic affliction, are key to understanding the making of biosocial collectivities and their quest for citizenship rights. The idea is that, although biosocial groupings do in fact form around specific genetic or disease conditions, from muscular dystrophy and Huntington's disease to bipolar disorder and PXE (pseudoxanthoma elasticum), they frequently do so in contexts where political, racial, gender, and other identities are potent galvanizing forces (Inda 2014; Tutton 2012). So, although biosocial groups might form irrespective of specific identities, they are also often organized explicitly around racial, gender, and other lines. Indeed, various forms of group identity are routinely implicated in the formation of biosocial collectivities.

An excellent example of the extrabiological underpinnings of biosociality is the case of African Americans and sickle cell anemia (SCA). SCA is a life-threatening, autosomal recessive genetic disorder wherein a person's red blood cells, which are normally flexible and round, assume a rigid, sickled (crescent) shape. These abnormal cells can hinder the ability of blood, and hence oxygen, to circulate throughout the body. The symptoms and complications of SCA include swollen hands and feet, frequent infections, delayed growth, vision problems, stroke, pulmonary hypertension, organ damage, and, most characteristically, "sickle cell crises" – periodic episodes of acute and unpredictable pain affecting different parts of the body, typically the bones, joints, legs, arms, lungs, and abdomen. For most people, there is no cure for the disease. So, having SCA often means lifelong suffering and premature death. Although the disease affects a number of populations in the United States, it is most commonly associated with African Americans. Indeed, historically, this population has been disproportionately encumbered with SCA. Significantly, in 1971, in an effort to mitigate the burden of sickle cell suffering in the Black community, the Black Panther Party launched a campaign to combat the disease (Nelson 2012). A central premise of the campaign was that the prevalence of sickle cell anemia among African Americans was a function not simply of genetic inheritance but also of social factors, namely the intentional and pernicious neglect of this population and its maladies by the U.S. medical establishment. The campaign was designed to counter this neglect. Specifically, it sought to challenge health inequality by furnishing African Americans with access to medical services: health education about SCA and its transmission, as well as free genetic screening to test for the disease and for carrier status. The hope was that by dealing with the societal harms that facilitated the persistence of sickle cell anemia and aggravated its effects, the Panthers would go a long way towards reducing incidences of the disease. Through its activism, then, the Black Panther Party constructed African Americans as a biosocial community entitled to health care rights in the name of their biologically injured and suffering bodies. African American biosociality here is linked not simply to sickle cell anemia, but to the common experience of racial marginalization and biomedical neglect, as well as to the yearning for justice and inclusion. Central to biosociality are thus questions of injustice, inequality, and discrimination.

Organ transplants and migrant biosociality

The case of undocumented immigrants and organ transplants represents another important example of how both biological and extrabiological influences shape biosocial group formation. In Chicago, unauthorized migrants have constructed themselves as a community of shared biological identification that is suffering from a malady, namely organ failure that requires a specific medical intervention, an organ transplant. Indeed, they have come to self-fashion in terms of their corporeality and have made claims on both political and nonpolitical authorities as a biocollectivity entitled to vital rights. Notably, the call for undocumented immigrant vital

rights is grounded not just in the precarious biology of this population but also in the shared experience of illegality – a political status marked by social, political, and biomedical exclusion. What I do here, then, is explore undocumented immigrants as a marginalized biocollectivity mobilizing for the right to health and healing. The analysis is divided into two parts. The first focuses on how illegality or undocumentedness has become potent political identity spurring migrant activism. The second part deals with undocumented migrant biosociality – with how unauthorized immigrants have organized around both their shared biology and illegality to gain access to organ transplants and “a shot at life” (Burns 2013).

Illegality and migrant activism

Since the 1970s, crime and punishment have become a central means through which political authorities in the United States seek to govern the conduct of individuals and populations (Simon 2007). This emphasis on governing through crime has had a significant impact on how undocumented migration is problematized and managed (Dowling & Inda 2013, Inda 2006). Indeed, unauthorized immigration has come to be seen largely as a law-and-order issue in the United States. On the one hand, the nation has witnessed rather strong waves of anti-immigrant sentiment in which unauthorized migrants have been cast as lawbreakers. And on the other, the measures employed to govern this population have been extremely exclusionary and punitive. A criminal dragnet has thus been cast over the United States in order to manage the putative “dangers” of migrant illegality.

While undocumented immigrants have come to be heavily policed, they have not stood idly by and accepted the highly punitive treatment to which they have been subjected (Cisneros 2013; Gonzales 2013; Negrón-Gonzales 2013). Rather, they and their allies have actively sought to challenge the anti-immigrant climate and the governing of immigration through crime. Forms of activism in which undocumented migrants have engaged include marches and public demonstrations, labor strikes, hunger strikes for justice, advocating for legalization and political rights, the occupation of churches as a way of gaining sanctuary, and fighting for legal redress for unpaid wages.

Emblematic of migrant activism were the large pro-immigrant marches that took place in the spring of 2006. Across the country, unions, religious institutions, immigrant rights groups, Latina/o organizations, and the general public banded together in varying assemblages to publicly protest immigration policing and their drastic effects on migrants and their communities (Chavez 2008; Cisneros 2013; Hondagneu-Sotelo & Salas 2008; Wang & Winn 2006). Undocumented migrants themselves played an active and key role in these acts of protest. The previous fall, in December 2005, the U.S. House of Representative had passed HR 4437, the Border Protection, Anti-terrorism and Illegal Immigration Control Act of 2005. Among other provisions, the law would have made it a felony to be in the United States illegally and for anyone to provide aid or assistance, including transportation, to undocumented immigrants. Prompted by the bill’s harsh nature, Latina/o and immigrant communities across the country mobilized to defeat the legislation (it was still being considered in the Senate), calling for just immigration reform that included a path to citizenship for undocumented immigrants. Over the course of the spring, principally from March through May, millions of people – including many who were undocumented – took to the streets in cities around the country in support of immigrant rights. On 25 March, for example, 500,000 protesters – many carrying American flags to signify belonging in American society – filled the streets of downtown Los Angeles (Chavez 2008, p. 156). On 10 April, a day organizers called “A National Day of Action for Immigrant Justice,” marches and rallies took place in more than 60 cities, from Phoenix, Houston, and Omaha to Boston, Atlanta,

and Washington, D.C. (Chavez 2008, p. 164; Hondagneu-Sotelo & Salas 2008, p. 221). And on 1 May, more than 1 million people heeded the call to demonstrate in support of “A Day Without an Immigrant” (Hondagneu-Sotelo & Salas 2008, p. 221). The idea was for immigrants to stay home from work in order to show their importance to the U.S. economy. In a number of cities, including Los Angeles, the loss of workers who attended the marches and rallies or simply stayed home greatly affected businesses such as restaurants, markets, trucking, and other service-related enterprises. In the end, while the spring marchers’ calls for more just immigration reform did not materialize, HR4437 did fail to make it through the Senate.

A central aspect of undocumented migrant activism, which was evident in the marches, has been the adoption and deployment of a collective identity as undocumented (Pallares & Gomberg-Muñoz 2016). Indeed, the illegality of migrants has been a powerful mobilizing force driving the call for rights. The adoption of a collective undocumented identity was clear in many of the slogans used during the marches. Important slogans included “We are not the enemy, we are part of the solution,” “*Ya basta de abusar a los migrantes* [Enough with abusing immigrants],” “Today we march, tomorrow we vote,” “*Aquí estamos, y no nos vamos, y si nos echan regresamos!*” [We are here, and we are not leaving, and if they kick us out, we’ll come back!],” and “*Amnistía* [Amnesty]! Full rights for all immigrants” (Cisneros 2014; De Genova 2010). These slogans all suggest a collective we: the undocumented. On the one hand, they speak to the experience of marginality that characterizes undocumented existence: to the ways this population is routinely demonized in the mass media and official discourse as criminals and welfare cheats bent on harming the nation, to how their lack of legal status renders them subject to all kinds of discrimination and abuse (at work and in other spheres of everyday life). On the other hand, the slogans point to how the undocumented have organized around their illegality to demand citizenship rights, claim belonging to the nation, and challenge their representation as alien others who threatened the social body. What the 2016 marches highlight, then, is that the undocumented have refused to be reduced to the status of victims and instead been actively engaged as “undocumented” in civic and political actions.³ While they may leave themselves vulnerable to deportation and hate crimes as a result of their visible activism, the precariousness of their lives leaves them little choice but to fight for the right to become full citizens.

Mobilizing for organs

Importantly, the undocumented have not only mobilized around their “illegality” but also their damaged and suffering bodies in order to gain access to rights and thus prolong their lives. On 29 July 2013, 20 people went on a hunger strike demanding that 14 undocumented immigrants suffering from organ failure be placed on transplant waiting lists at Chicago-area hospitals (Landaverde 2013a). Due to their health conditions, most the migrants were not able to partake in the strike, but many had family members participating on their behalf. The hunger strikers thus included some of the patients themselves, family members, friends, and immigrant rights advocates (Landaverde 2013b). The strike was organized out of the Our Lady of Guadalupe Anglican Catholic Mission in Little Village, a heavily Mexican neighborhood in Chicago’s West Side. The Mission, led by pastor José Landaverde, has been an important center for immigrant rights organizing in the city, in particular around questions of health care. The hunger strikers initially targeted the University of Illinois at Chicago Medical Center. On 31 July, they and their supporters marched from Our Lady of Guadalupe Mission to the Medical Center, where they held a press conference and protest to call attention to the plight of the 14 migrants (Landaverde 2013c). A few days later, the hunger strikers moved their protest to Northwestern Memorial Hospital and subsequently to Advocate Christ Medical Center (Sepúlveda 2013). These three

hospitals were targeted because of their “refus[al] to place undocumented and uninsured people on transplant waiting lists” (Landaverde 2013a). In a letter addressed to Illinois legislators and hospital administrators, the hunger strikers vowed not to end their action until “a concrete system is established to evaluate each case and then place patients on a waiting list for a transplant based on need and not legal or financial status” and “policies are established that ensure affordable medicine for waitlist candidates before and after transplant” (Landaverde 2013b).

This hunger strike was not the first one organized out of Our Lady of Guadalupe Mission. There was a similar strike a year earlier. On 3 June 2012, Sonia Lopez, Hilda Burgos, Lorenzo Arroyo, Catalina Arroyo, and Father Landaverde went on a hunger strike to save the lives of three undocumented migrants suffering from organ failure: Jorge Mariscal, who had lost a kidney due to cancer, and brothers Elfego and Lorenzo Arroyo, who needed liver transplants as a result of amyloidosis, a rare hereditary disease that can result in life-threatening organ damage (Landaverde 2012). According to a press release from the strikers, “All three not only suffer[ed] from life-threatening illnesses but also . . . from the inhumane exclusion of undocumented immigrants from the organ transplant waiting lists” (Landaverde 2012). The hunger strike lasted three weeks. During that time, the strikers organized marches, press conferences, and protests targeting the University of Illinois at Chicago Medical Center and Loyola University Medical Center. They also held meetings with administrators at both hospitals. The hunger strike ended after the Illinois and Loyola Medical Centers agreed to evaluate Lorenzo Arroyo and Jorge Mariscal, respectively, for placement on their transplant lists (Kunichoff 2012). Prior to the hunger strike, Rush University Medical Center had already agreed to take on Elfego Arroyo as a patient. The 2013 hunger strike, then, came on the heels of an earlier effort that was successful in pressing Chicago hospitals to attend to the health care needs of undocumented migrants.

The key issue propelling the hunger strike was the refusal (from the strikers’ perspective) of hospitals to provide undocumented migrants with access to organ transplant lists and the suffering and certain death this population faced as a result of not being able to obtain health care. The stories of the migrants, as well as of their family members and advocates, speak poignantly to this medical exclusion and suffering. Take the case of Blanca Gómez, for example. She was both a hunger striker and one of the migrants in need of a transplant. When she was pregnant a few years prior to the strike, she developed preeclampsia, a complication characterized by high blood pressure and often organ damage (Heffernen 2013). In Gómez’s case, her kidneys were damaged to such an extent that she needed a transplant. According to her, Northwestern Memorial Center and another hospital declined to put her on their transplant waitlists (Fortino 2013; Heffernen 2013). Speaking at one of the protests targeting Northwestern, she pleaded, “Northwestern give us care, because were [*sic*] dying” (Fortino 2013). The stories of others likewise speak to the experience of exclusion and suffering. Carmen García, who participated in the hunger strike on behalf of her son, noted, “Even when my son gets very sick, the hospitals refuse to treat him, and they send him home. . . . My son has no medical insurance, no social worker, no doctor” (Sepúlveda 2013). And Father Landaverde, speaking specifically about one hospital, stated:

University of Illinois at Chicago is a public institution that calls itself a civic leader, a progressive institution . . . and yet they deny treatment to people simply because they are uninsured and simply because they are undocumented. Poor people and those without status are being treated as less than human.

(Landaverde 2013c)

The hunger strikers contended, as Father Landaverde suggests, that a principal reason hospitals were denying undocumented migrants access to organ transplant lists was their illegality.

For example, Oliva Baca, the mother of one of the undocumented migrants participating in the hunger strike, put the issue as follows:

How can they [hospitals] value a piece of paper [immigration documents] over the life of my daughter? . . . For the sake of a piece of paper, they're going to let many people die, because it's not just my daughter. There are many sick people who are undocumented.
(Sepúlveda 2013)

Blanca Gómez made a similar assertion, "They don't want to treat us because we don't have immigration documents. . . . I want to live for my daughter; she's two years old. I want a second chance at life" (Sepúlveda 2013). The hospitals asserted, however, that they did not deny people access to care on the basis of their legal status. In response to the protesters, Northwestern Memorial Hospital issued a statement clarifying their organ transplant policies:

The primary focus of Northwestern Memorial Hospital's transplant program is to save lives and restore health where possible. All prospective candidates are evaluated against a rigorous set of standards; U.S. citizenship is not among them. The criteria for recipient selection are the same for every candidate regardless of citizenship or other immigration status. [They include] such things as medical and psychosocial factors like home life and social environment, and the ability to meet the demands of a lifetime of routine doctor visits and costly anti-rejection medications.
(Fortino 2013)

Advocate Christ Medical Center released a similar statement: "We treat all patients whom we are privileged to serve equally. Citizenship is not a requirement to be placed on the organ transplant donor list" (Burns 2013).

While seemingly paradoxical, both the hospitals and the hunger strikers are undoubtedly correct in their assertions. There is no legislation in the United States that bars undocumented immigrants from receiving transplants (Gupta 2008). Policy 6.2.1 of the Organ Procurement and Transplant Network, a federal entity that regulates the distribution of organs across the nation, states that "deceased donor organ allocation to candidates for transplantation shall not differ on the basis of a candidate's citizenship or residency status in the US" (Baru et al. 2013, p. 365).⁴ Technically, then, undocumented immigrants are not excluded from transplant lists because of their legal status. However, if we delve deeper into the issue, it is precisely due to their illegality that they cannot get organ transplants. The general reason that hospitals reject undocumented immigrants is because they lack health insurance (Ansell et al. 2014). Without insurance, it is simply not possible for them to afford the operation, which can cost hundreds of thousands of dollars, nor the follow-up treatment plan, which potentially requires yearly medication expenses in the tens of thousands for life. But the reason undocumented immigrants do not have access to health insurance is their illegality. Many undocumented immigrants lack private health insurance because they work in precarious, low-wage jobs that do not provide it. And they are explicitly excluded from federally funded public health insurance programs such as Medicare and Medicaid (Gusmano 2012). For example, Medicare typically covers dialysis and organ kidney transplants for people suffering from end-stage renal disease (Goldberg, Simmerling & Frader 2007). However, the Social Security Act explicitly prohibits the federal government from reimbursing states for care and services related to a transplant procedure for any "alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States" (quoted in Goldberg, Simmerling & Frader 2007, p. 17). It is thus the legal status of

undocumented immigrants that *de facto* keeps them from accessing organ transplant lists, even if it is not the explicit reason hospitals exclude them.

Regardless of who was correct, the conviction that undocumented migrants were denied medical care, and thus abandoned to suffering and certain death, because of their illegality was a powerful mobilizing force. Indeed, the undocumentedness of the migrants was key to their biosociality – that is, to their mobilization as a biosocial community. As anthropologist James Quesada has noted, to be undocumented is to be subjected to “cumulative vulnerabilities,” that is, to

the accumulation of hardships that cause ill health: precarious living conditions, exploitative work conditions, low incomes, lack of health insurance, lack of transportation and restrictions on mobility, lack of proper housing, hunger, homelessness, language barriers, social stigmatization, restrictive and punitive immigration policies.

(2012, p. 85)

Said otherwise, the vulnerabilities that illegality imposes on migrants routinely become embodied (Willen 2012). It is thus difficult to disentangle illegality from bodily damage and suffering. Ultimately, then, what the undocumented organ failure sufferers organized around was both their illegality and their wounded biology. They came together as a biocollectivity on account of organ failure, medical exclusion, bodily suffering, and their political/legal status. They were united, in short, by their injured and suffering undocumented bodies.

Significantly, the injured undocumented body served as the basis for making citizenship claims. The undocumented organ failure sufferers basically sought to use their unwell bodies to leverage citizenship rights and entitlements (see also Goldade 2009). The key demands of the hunger strikers, as noted earlier, were for undocumented migrants to be placed on transplant waiting lists and, crucially, for hospitals and politicians to develop policies to ensure that transplants were affordable to all. The strikers were thus not simply asking for access to transplant lists but also for the right to affordable health care. Indeed, entitlement to care was a central part of their agenda. That health rights were a fundamental demand was highly visible at the marches targeting the various hospitals. Protestors carried signs with such slogans as, “Medical care is every human’s right!” “We need our transplants. We are also human,” “Health care for all!” and “Healthcare is a human right, not just for the rich & white.” By demanding the right to health care for undocumented migrants, the hunger strikers and protestors were essentially asking for this population to be included in “the *moral* community of people whose lives, bodies, illnesses, and injuries are deemed worthy of attention, investment, or concern” (Willen 2012, p. 806). The message they sent was that the illnesses of the undocumented were worthy of being treated, that undocumented lives were worth saving. As such, the hunger strike and protests were about accessing health rights as a way to save migrant lives and improve the quality of undocumented existence. The attainment of health rights was thus very much entwined with the prospects of prolonged life. As Maria Isabel Mariano, a migrant in need of a liver transplant, put it, “I am not asking for special treatment. I only want a fair chance to fight for my life” (Kilkenny 2013).

In the end, the hunger strike lasted 11 days. It concluded on 8 August after the last of the three targeted hospitals agreed to begin the process of evaluating the 14 undocumented patients for placement on its transplant list (Burns 2013; Landaverde 2013d, 2013e). Ultimately, a number of the undocumented migrants were placed on waiting lists. Some, including Blanca Gómez, have been able to receive their organ transplants. Others, however, are still patiently waiting their turn at the time of this writing. Unfortunately, one of them, Sarai Rodríguez, passed away before she could be evaluated for placement on Northwestern’s transplant list (Fortino 2013).

Despite the loss of life and the continued waiting for some, the hunger strike was on the whole a success. Particularly significant is that the activism of the strikers was instrumental in spurring legislative action in Illinois to aid undocumented organ failure sufferers. One piece of legislation, Illinois Senate Bill 741 (passed on 29 May 2014), which overhauled the state's Medicaid program, included a provision making non-citizens already receiving state-funded dialysis care eligible for kidney transplantation coverage (Ansell et al. 2015).⁵ Dr. Jose Oberholzer, chief of the Division of Transplantation at the University of Illinois at Chicago and a strong advocate of the provision, estimated that about 200 to 300 undocumented migrants would be suitable for a transplant under the new law (Rodríguez 2014). A second piece of legislation, Illinois House Joint Resolution 98 (adopted 21 May 2014), created a task force charged with developing proposals to expand Illinois Medicaid to include transplantation coverage for uninsured individuals, including undocumented migrants, suffering from any kind of organ failure (Ansell et al. 2015). The mobilization of the undocumented migrants as a biosocial community was thus central to securing access to transplant medicine, and thus health rights and a chance at life, for a population previously largely excluded from such care.

Conclusion

The central claim of this chapter has been that undocumented migrants are deeply implicated in a politics of health and citizenship. It is a politics in which recognition from and demands on political and other authorities are based on the vital needs and suffering of the undocumented body. It is a politics wherein undocumented immigrants' biological status is mobilized in order to gain access to rights. For a community typically excluded from the benefits of biomedicine, the recognition of their biological suffering was an important achievement. Through gaining access to organ transplant lists and health care rights, undocumented organ failure sufferers were given hope that their suffering could be relieved. They were offered the prospect that their lives could be prolonged.

The activism that the undocumented organ failure sufferers engaged in as a biosocial community is significant in that it signifies the political becoming of undocumented migrants (Dowling & Inda 2013). As Peter Nyers (2006) has pointed out, there is an expectation of docility on the part of refugees and the undocumented. Their life tends to be represented in popular and legal discourse as the inverted image of political life. Whereas the citizen is expected to speak and act politically, the unauthorized migrant is supposed to remain silent. But in the context of organ transplants politics, undocumented migrants refused to be quiet. They spoke out against the dehumanizing effects of medical exclusion. And they demanded dignity and recognition, requesting to be seen as worthy of living. The fact that undocumented migrants stood up and spoke thus represents an important act of defiance. They raised their voices in a context that does not recognize undocumented migrants as legitimate speaking and acting subjects. They raised their voices and mobilized for life, health, and healing.

Notes

- 1 For other discussions of the relation between migration and biosociality, see: Goldade 2009, Guell 2011, and Ticktin 2006.
- 2 Rabinow (2005) does discuss how afflicted individuals gather into groups to lobby for their diseases. However, he does not frame this advocacy or activism in citizenship terms.
- 3 The adoption of an undocumented identity has been particularly visible in the case of undocumented youth. For a discussion of identity and the immigrant youth movement see de la Torre III and Germano (2014).

- 4 6.2.1 is the policy that was in effect in 2013. A new policy, 5.4.A, which went into effect on 14 April 2016, similarly reads: “A candidate’s citizenship or residency status in the United States must not be considered when allocating deceased donor organs to candidates for transplantation” (OPTN 2016, p. 53).
- 5 The argument used to convince legislators to support the law was largely an economic one. At the time, Illinois already covered dialysis treatment for undocumented migrants with end-stage renal disease. The state was thus bound to pay roughly \$60,000 per year for the rest of the life of any given undocumented dialysis patient. While a kidney transplant is initially more expensive, it ends up being cheaper in the long run, costing about \$100,000 for the operation plus \$10,000 to \$20,000 per year for anti-rejection medication (Rodríguez 2014).

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