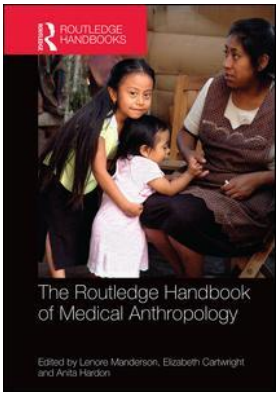

The Routledge Handbook of Medical Anthropology

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Global Quests for Care

Publication details
https://test.routledgehandbooks.com/doi/10.4324/9781315794198.ch12
Elizabeth Cartwright, Lenore Manderson, Anita Hardon
Published online on: 17 May 2016

Mobile Showers, 2015. St. Johns, Oregon, USA.

About the photograph

Diane, who with her husband, is currently homeless in St. Johns, Oregon, exits one of the mobile shower units provided by St. Johns Showers for the Homeless. The mobile shower trailer is equipped with two showers; it comes to the town once a week. "It's a blessing to have a place to get clean," said Diane, "and it's the only one in our area." Jim, back left, and Shannon, back right, volunteer their time driving the mobile shower unit to various locations around Portland, Oregon. They scrub each shower stall after each person uses it, so it is clean and ready for the next person.

This photo is part of an ongoing ethnographic photo documentary focusing on redefining our perceptions of homelessness and poverty, in order to advocate for policy change, social awareness, and to develop community-based participatory programs.

—Mary Anne Funk

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Global Quests for Care

Elizabeth Cartwright, Lenore Manderson and Anita Hardon

Worldwide, growing numbers of people seek health care beyond their home settings and national borders. For some people, this is volitional, as they move to take up new opportunities or to improve their own or their children's life circumstances. Far larger numbers of people move internally and across borders a result of economic and environmental crises, civil war and human rights abuses, or because basic human needs cannot be met in the post-conflict settings in which they find themselves. People move across borders in search of health care and treatments that, in different settings, might be less expensive, more sophisticated, more accessible, or subject to different legislation and control. Increasingly, medical institutions in high- and middle-income countries promote surgical procedures and care to an international market, while pharmaceutical companies and practitioners test out new drugs and procedures in different country settings. In health care, it seems, borders can be especially porous. In this chapter, we explore how and why people seek medical care, treatments and cures across borders, between countries and health systems, and we examine the various implications of this medical travel.

Janzen's (1978) seminal work in medical anthropology, *The Quest for Therapy: Medical Pluralism in Lower Zaire*, focuses on understanding local logics of illness causation and treatment and, once described, on understanding the social relations around treatment decision making and the search for a cure. This foundational description of the treatment-seeking path serves as a jumping-off point for understanding how people navigate the global health care arena. We interrogate how moving one or more parts of the treatment-seeking process to a geographically different location changes individual and family expectations, the resources that people require and might access, the possibility of a cure or life-changing intervention, and eventual outcomes. Medical pluralism within and between countries thrives because of differences in modalities of care, technologies and settings, and what these offer to people who are ill, injured or distressed. We then move to questions of citizenship and belonging, and consider how civil status and legality influence life experiences and the choices available for health and medical care. We end this chapter with a discussion of people who are semi- and permanently displaced—both individuals and larger social and ethnic groups—and the implications of this for access to and quality of care.

The 'quest' is an apt metaphor for how people sometimes need to engage in long and arduous searches across time and space for treatment, a cure or relief from their symptoms. In his discussion of therapeutic decision making and the quest for a cure, Janzen notes the significance of "the composition of the therapy managing group within its social field, the role of the therapist or group enacting therapy; the technique; and the total cost of therapy" (1978: 156). He goes on

to discuss what happens when there is disagreement over the diagnosis and/or over the course of treatment to be pursued, and considers how conflicts are settled at multiple levels. He then traces the multiple options that individuals have with respect to different healing traditions present in their geographical locations. Janzen's work is as applicable now as it was four decades ago; it offers us a framework to examine how the individuals and their families in this chapter use a variety of strategies in conjunction with new medical and communication technologies (as discussed in Chapter 8), in a world interconnected via many forms of physical and virtual transportation.

The idea of volition is central to our examination of the global movements of people. How and why do people move between different regions or countries and what effect does that have on their health care–seeking behaviors? What motivates people to leave their own country specifically to receive health or medical care? Certain movements are made by choice, as is broadly described in the literature on medical travel, but many others travel for economic reasons or because of access to better or different technologies and professional expertise. Others seek health care in unfamiliar settings because of their own migration, necessitated by the larger forces of economic needs, violence or natural disasters. We address this spectrum of possibilities below.

Globalized Care

The global quest for treatments has been referred to by anthropologists and other social researchers variously as medial tourism, medical travel, and transnational and cross-border care—depending on motivation and context (Kangas 2002). Personal care services like health spas and cosmetic surgery in particular have been likened to 'tourism,' and these are often marketed in ways that mirror recreational travel: the opulent settings of some internationally renowned hospitals recall a vacation; medical services may be bundled with holiday activities; often the tourism infrastructure brings individuals to a place, arranging international and in-country transportation, hotels and visas, and brokering the medical services required. Many times this kind of travel takes place at great expense to the individuals involved given their unfamiliarity with the medical setting, including in relation to language, institutional and legal environment, and provisions of care. Sometimes, this type of medical travel is conceptualized as an act of faith or a pilgrimage (Song 2010), the last step, or the last hope, in resolving a particular health problem. When strategizing the quest for therapy, patients and their families use the ambiguities and grey zones in between and around various international spaces to maximize their ability to access what they need, or think they need, to maintain or improve their health and wellbeing.

Many different constellations of people and resources are involved in seeking care in different places in the long and the short term. People with sufficient resources may travel from low- and middle-income countries to international medical research centers and hospitals, wherever they believe they have access to the best care available; oftentimes, they incur serious personal debt to seek care abroad. People may travel from one high-income setting to another, too, in search of the newest medical therapies, those that are most likely to promise extended survival or cure to a life-threatening condition. People may seek care that is unavailable in their home countries for political or religious reasons, or because of the local limitations related to biomedical ethics; this is often the case for people seeking gender reassignment (Aizura 2010), stem cell therapy (Song 2010), in-vitro fertilization or surrogacy (Bergmann 2011; Inhorn and Patrizio 2012; Whittaker and Speier 2010). Conversely, individuals may travel for care to avoid personal debt, both for major procedures and for routine services such as for dental surgery or optometry, hip replacements or coronary stents. Meanwhile, less well-off people in rich countries are at times able to seek medical advice and/or purchase pharmaceuticals that are less expensive in other settings, as has occurred in the cross-border medical travel between the US and Mexico for decades

(Dalstrom 2012). Some medical travelers are migrants who return to their countries of origin for care. In these cases, their capacity to communicate with health professionals in their own language; their understanding of the health system and relations between patients and clinicians; and the availability of family support are all compelling reasons to travel for care. More generally, global treatment seeking and global care occurs because what individuals need or want is not always available or affordable where they live. Transnational medical travel is a way to plug the holes in an inadequate personal safety net.

People who move between countries for medical travel are vulnerable to the legal and institutional constraints, to the immigration and medical structures and securities of different countries; they can be targets of scams, deportations and incarcerations. The rules of a new country, and of what is and is not possible, can be challenging to learn in the best situations. However, it is also true that some people exploit these jurisdictional imprecisions and the gaps in ethics guidelines, surveillance and control, as indicated by the grey areas in relation to experimental biological treatments (Tiwari and Raman 2014) and commercial gestational surrogacy (Deonandan et al. 2012; Pande 2011).

In the following case study, Andrea Whittaker and Chee Heng Leng describe their on-going research on medical travel in Thailand and Malaysia; they highlight that much medical travel occurs for prosaic procedures, like the treatment of chronic infection, for heart surgery, hip and knee replacements, and the like, as well as for conditions such as quadriplegia that may never be resolved.

12.1 Medical Travel

Andrea Whittaker and Chee Heng Leng

People have long traveled across national borders to access health care. In the past such travel typically involved travel by patients from developed countries or elites from developing countries travelling to wealthy countries to access care in high-tech specialized clinics in the US or Europe. Although presently the largest movements of patients are between European countries, there is a growing trade in patients from wealthy countries travelling to low- and middle-income countries such as Thailand, Malaysia, Mexico and India for care. Travel by patients between lower-middle-income countries for services unavailable in their home countries or higher-quality care has become more common. For example, Thailand is an important regional hub for medical care, especially among the growing upper middle classes of Cambodia, Vietnam and Myanmar. Their income allows them to travel for a standard of care not accessible back home. Similarly, Malaysia is an important medical destination for Indonesian patients who constitute over 90 per cent of the foreign patient trade (Toyota et al. 2013).

Medical travel is an assemblage of medical technologies, staff, global air travel, Internet marketing, international accreditation and health insurance. It relies upon pre-existing infrastructure and human resources and draws upon local service and tourism industries. Many governments such as Thailand and Malaysia also support the trade through schemes such as land tax exemptions for the hospitals, special medical visas, incentives for the importation of medical equipment and government-supported marketing campaigns. It is seen as an important source of export revenue for lower- to middle-income countries.

The following case studies were collected between 2008 and 2013 in hospitals in Thailand and Malaysia. Over sixty patients were interviewed in four private hospitals. The stories complicate our views of medical travel—who travels and why. As these stories reveal, people travel for acute and chronic health conditions as well as rehabilitative care; their stay may be transient or very long term. Some people travel across borders regularly for all their health care.

Travel by Indonesians reflects growing dissatisfaction with the quality of care in Indonesian hospitals. For example, Ibu Siti was interviewed in a Penang Hospital in Malaysia accompanied by two of her daughters. She is sixty-two years old from Aceh, with four daughters and two sons. Her husband

is a high school teacher. This is the fifth time she has visited this hospital in Penang. She came to seek treatment for her diabetes and on this trip has also been diagnosed as having a cardiac problem. She first came to this hospital in 2012, to seek treatment for her abscessed leg. She had been to a private specialist in Aceh for a check-up, but did not seek treatment there, as her family heard a lot of stories about poor results of operations in Aceh. Given a long history of insurgency against the Indonesian state, the health infrastructure is poor and Acehnese mistrust government institutions.

> There are stories that leg operations in Aceh causes paralysis, but here, we hear Indonesians get good treatment results, they won't get wounded, so we choose to come here . . . [medical service] better here. Many Acehnese people seek medical treatment here, we have heard about people's experience back in Aceh.
>
> *(Ibu Siti)*

There are many private hospitals in Penang marketing to Indonesian patients. Acehnese started coming to Penang for health care in the 1990s when they traveled by ferry. Now a regular direct flight between Peneng and Aceh has facilitated the movement of patients. For Ibu Siti and her family, the other private hospitals in Penang are too expensive so they continue to come to this hospital. They are paying out of pocket; Ibu Siti and her daughters calculate that the cost of seeking medical treatment in Penang is lower than that in Aceh, even when their air tickets and accommodation are taken into account. They stayed at the same hotel for each of their five visits. They came to know about their hotel through the air ticket agent, who gave them the contact number.

A number of Thai private hospitals specifically cater for their foreign patients with luxurious hotel-like furnishings, translators and culturally diverse cuisines. Unlike the Malaysian hospital catering for Indonesians, these hospitals cater for upper-middle-class patients from the region as well as patients from Europe, Australia and the US. For example, Anh is thirty-nine years old and works as an education consultant in Vietnam. She previously lived for a while in the US. She had flown to Thailand with her daughter who had been suffering from a fever. The family kept her home from school and gave her Tylenol and Advil to stop the fever and took her after two days to a clinic in Hanoi, one frequented by foreigners. The doctor took a blood test: "I talked to the doctor and told her that I was thinking—at that time I was thinking of taking her to Bangkok because we always come here for any kind of medical and then she said 'No, she's fine' and gave her medicines for the fever and the cough." After a few more days Anh and her husband became more worried and so flew her to Bangkok to the hospital. Within forty-five minutes of arriving they had X-ray results and her daughter was admitted with pneumonia. "We didn't plan to stay here this long, we thought it would only be a couple of days. We flew in Thursday night, Friday morning we brought her here. The doctor checked on her and sent her to do an X-ray and we found that she has pneumonia, and really bad. There was a lot of virus throughout and around the lung and that's why we're still here." They intend to stay a further three days until their daughter improves.

Anh joked that she was a 'frequent patient.' Her family always comes to this hospital for care. Her brother came here for care after a stroke and Anh had a sinus operation in the past for which she returns for follow-up care. During the time they lived in the US, she traveled back here to undertake in-vitro fertilization. Her husband had laser eye surgery the previous year and plans to undertake knee surgery later in the year. He comes regularly for health checks and an anti-aging program, as he explained:

> In Vietnam we don't have very good health care system. . . . I think Vietnam has good doctors but the system doesn't allow them to really care for other patients because they work all day long and even after they go home, they have a private clinic at home. You cannot serve hundreds of different people all day, you get tired and you cannot focus on what you do. Facilities in Vietnam are not very good. I don't know if you've been to Vietnam or not but if you go to hospitals there I'm sure you'd be scared. People are just everywhere, on the floor—100% of hospitals in Vietnam are overloaded right now. They don't have a good private hospital like here. They're starting to have some but that's clinics, not full facilities like at a hospital.

For other patients, the trip to Thailand is to seek expertise simply unavailable back home. Not all are wealthy; many undertake loans and debt to pay for their care. For example, in another ward of the same Thai hospital I met with Hagos from Ethiopia. Hagos is thirty-one years old, and a university

lecturer. He was involved in a car accident resulting in neck and spinal cord injuries and quadriplegia. Four days after his accident he and his family decided to come to Thailand for treatment:

> We explored the hospitals in Ethiopia, but the damage is very severe. It was very severe and I need further treatment. So we decided to come to Thailand because we had prior knowledge about this hospital, that they will offer better treatment, and better services. So right after, on the third or on the fourth day that the accident happened to me. . . . I was here. I was very early, and it has been like a month and something since I am here.

A friend who had medical training initially accompanied him on the seven-and-a-half hour direct flight to Thailand. Later his father traveled over to care for him staying in the hospital room with him. He shared a four-bed room with three other patients as they could not afford the private single-bed rooms.

Although Hagos is wealthy by Ethiopian standards he had no health insurance. The family had pooled their savings together to pay for the medical expenses. "We don't have health insurance, medical insurances, so we have to cover the bill by ourselves. So we have decided to cover the bill partly by my family, and partly by my university." Hagos cannot afford to stay for much longer. So far he estimates that he has spent USD 45 000 on his treatment and stay:

> But the only thing now, when you are talking of the price, or whether something is expensive or not, it just depends on where you are, okay? Well, I heard that one of the major customers of this hospital are also Europeans. Why Europeans? Probably in Europe there might be hospitals better than this, but the price is very much higher. So they came here to get quality service with better price. But for us, for Ethiopians, this is quality service with a very expensive price. So whether to tell that something is expensive or not, well it depends where you are, so for us, for Ethiopians, it is expensive, it's a very expensive one.

With his money running out he hopes he will be able to pull himself up so he can get into a wheelchair by the time he has to return to Ethiopia.

> So long as my spinal cord has damage, it will take a very long time for rehabilitation and physical therapies. . . . So after I am able to use the wheelchair successfully I'll go back to Ethiopia, and I will restart my physical therapy then. So we are supposing that just after a week from now, I might be discharged from the hospital. . . . They might not have good rehabilitation services, but the choice is—now the choice is between whether you can or you cannot. . . . In Ethiopia there are some rehabilitation centres, and also we have rehabilitation centres might not be to the standard, but they have at least the minimum materials, and the minimum human resource to run it. In terms of advice for other people coming to the Thai hospital, my advice will be only one [thing]; they need to take it out of their pockets, and their pockets should be full.

Health insurance plays an important role in facilitating medical travel. Many patients have 'portable' insurance which allows them to be reimbursed for treatment undertaken in other countries. Some countries send citizens to other countries to receive care unavailable at home or because it costs less to send them than to provide similar services within their national health systems, in effect, outsourcing their care (Whittaker 2015). Likewise, a number of insurers send their clients to other countries for care to lower costs.

Stories of medical traveled such as these reveal a diverse range of motivations and circumstances surrounding people's therapeutic itineraries. Other studies likewise document the diversity: from cosmetic surgery patients travelling on group tours combining surgery with visits to exotic beaches; patients travelling to circumvent home country restrictions on forms of treatment such as stem cell treatments or commercial surrogacy or commercial ova donation; members of diasporic communities travelling home for care; to patients from countries which lack particular expertise or equipment travelling to undertake treatment in a more medically sophisticated location.

★ ★ ★ ★

There are concerns about the effects of medical travel upon health equity in lower- and middle-income countries such as Thailand and Malaysia. At one level it could be argued that medical travel

allows individual patients such as Ibu Siti and Hagos access to health care they could not obtain at home. Inequitable home health systems lacking universal health coverage and having high health costs or long waiting lists encourage the movement of patients across borders. For example, many of those travelling from countries such as the United States are those who are uninsured or cannot afford their treatment or medications back home. Patients are 'outsourced' by their countries health systems or insurers because of the cost saving such outsourcing represents to the government or insurer. However, medical travel remains inaccessible for those in the poorest health who are not able to travel. Access remains stratified across lines of health status and mobility.

Medical travel also has implications for national health systems. The effects of the trade upon local health systems depend upon the degree of privatization already existing, whether there is excess capacity within the private sector, and the degree of government control, subsidization and regulation exercised over the private health sector. A well-financed public system is an important buttress against an erosion in local health equity for lower-middle-income countries. But even then, experience in Thailand suggests that a two-tiered health system develops with major implications for a brain drain for the health workforce away from public hospitals towards the private hospitals catering for foreign patients (Kanchanachitra et al. 2011). Hazarika (2010) reports that India suffers drastic shortages of 600 000 doctors, 1 million nurses and 200 000 dental surgeons and a shortage of medical specialists in local community health centres while over 75 percent of human resources and medical technologies are in the private sector. Further growth in the private sector due to the growing medical travel trade in India could exacerbate the shortages in the public system as health care professionals move to the better pay and conditions in the private sector.

Finally, the growth of medical travel has implications for patients as citizens. Provision of health care through private or public mechanisms forms an important part of a state's relationship with its citizens. As people travel across borders to receive care, the expectations and relationship with their national health system changes and attenuates and they no longer have the same stake in nor benefits from their citizenship. As the informants in these case histories reveal, home health systems are viewed with suspicion, mistrust and frustration that the same quality of care and services is perceived to be unavailable back home. Rather than being a public good, health care is traded as a commodity, accessible to a mobile few who can summon the financial means to afford it.

Acknowledgments

This research was supported under Australian Research Council's *Discovery Projects* funding scheme (project number DP 1094895). We wish to thank Por Heong Hong who acted as a research assistant for the Malaysian part of this study.

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Above, as Whittaker and Chee describe, people who have the means are able to seek out care in other places across the globe, often where cultural preferences as well as technical needs can be met—hence Malaysia's market advantage in providing care to Muslims from Indonesia, South Asia and the Middle East. Sometimes, specific procedures are sought that are not available to individuals in their home places, but in addition, people's perceptions of *quality* play an important role

in the medical choices that they make. Quality is an ephemeral concept, a mix of information, illusion, deception and hope, and understandings of the strength of professional training, and the technology, diagnostics and medicines that are available in different places. Commercial hospitals and specific surgeries and treatments are circulated and promoted through a variety of communication platforms, via word of mouth, and, in some cases, as covered by government programs (Kangas 2002). 'Doctor-shopping' is a simple way to talk about peoples' search for care and cure, and the forms that this search takes in various situations are telling of locally available technologies and health care systems as well as reflective of cultural notions of healing, ethnophysiology, and possible alternative treatment regimen.

Structural Vulnerability

Although in the medical tourism literature, there has tended to be a focus on wealthier (although not necessarily wealthy) medical travelers, many people engage in the global quest for cures from a very disadvantaged position. Because of their location economically, ethnically and legally, poor people are sometimes forced into seeking care outside of their home terrains. Structural vulnerability is a useful concept for thinking through this situation (Cartwright 2011; Quesada et al. 2011). The term 'structural vulnerability' makes precise the ways in which whole groups of people fall through established safety nets. They are structurally vulnerable because of the economic and political forces and institutions (educational, medical and legal) present in their societies, in conjunction with the ways in which they are discredited, discriminated and devalued by the larger society in comparison to others around them. Importantly, structural vulnerability attends to how individuals have internalized those negative evaluations; this internalization is necessarily partial and is dependent upon the social context and the individuals themselves. The dual descriptive nature of structural vulnerability at both the social group and the individual level makes it a particularly interesting conceptual tool to use in exploring trans-border quests for care. Structural vulnerability in one's home place may lead to medical travel or, conversely, it may be the result of immigrating to another place in search of a better life. Both of these situations point to precarious states of being that are well suited for exploration by medical anthropologists.

While the notion of structural vulnerability has been explored among immigrant groups in the US and elsewhere, another more global aspect to structural vulnerability is represented in this chapter (see also Cartwright and Manderson 2011). Global economic and social hierarchies are constructed from various vantage points of power, and these hierarchies result in overlapping mosaics of difficulties and opportunities for an increasingly 'globile' (mobile and global) world. There are many variations in how nation states react to immigrant groups within their borders. For example, the Roma, Romani, Sinti travelers and gypsies have moved throughout Europe for over a thousand years, and their history is characterized by their need to exist on the fringes of societies, stigmatized and negatively targeted because of their ethnic affiliation and the stereotypes that derive from this. Lorenzo Alunni (2015), in his work with the Roma, describes the effect on their health and wellbeing following their move to Italy from Yugoslavia and the Balkan states predominantly in the 1960s and 1970s. Far from being assimilated into Italian culture, the Roma have kept to themselves, both by choice and discriminatory practices, and live in impoverished camps on the outskirts of urban centers, necessarily relying on limited and at times sub-standard medical care. Those who are especially vulnerable are newer immigrants, still trying to make sense of the organization of social life in Italy and still striving to create social networks with more established Romas. Participants in Alunni's research sought medical help across borders, going to France and back to Romania, when they needed procedures such as dental care or abortions, respectively unaffordable or unavailable to them in Italy. While in France, Roma have access to

more material things than they might in Italy—apartments and more government assistance, for instance—but as described by Alunni, these medical travelers returned home to the camps in Italy because of their affective ties to family and, despite the dismal conditions in which they lived, to the familiarity of their everyday lives.

What health rights does citizenship confer? Within a particular country, how can people access better care for their families? Kate Goldade (2011) illustrates how Nicaraguan women immigrants strategize to have their babies in Costa Rica while they are there working in the coffee fields. Although in the country illegally, the Nicaraguan women are able to receive low-cost or free medical care during their pregnancies, post-partum care and tubal ligations in the Costa Rican hospitals. But their children have an even greater advantage because of the principle of *jus soli* that operates in Costa Rica: they obtain Costa Rican citizenship by virtue of their birthplace. Strategizing care, giving birth, and quests for citizenship highlight some of the biosocial complexities of cross-border approaches used by individuals around the globe (see also Castañeda 2008).

Below, Heide Castañeda describes the heterogeneity of families along the US–Mexico border, and the significance of immigration status to their entitlements to health care services. In a family, one child may be a US citizen, one a Mexican citizen, with parents who may be of different immigration statuses. Families go back and forth in a strategic manner, seeking care, buying pharmaceuticals, and obtaining hospital, medical and other health services. Simultaneously using two health care systems puts the families described by Castañeda into the position of having to endure a double dose of bureaucratic tedium, but this is balanced by the flexibility and a sense of control that comes from working the various constellations of binational medical resources.

12.2 Health Care along the US/Mexico Border

Heide Castañeda

More than 11.5 million people live in economically and socially interdependent communities along the two-thousand-mile-long US/Mexico border, where transnational strategies have always been integral to daily life. Borderlands are ideal sites in which to examine issues of inclusion, exclusion, and the various forms of health citizenship these boundaries imply. Inequalities of access and delivery are particularly sharp in communities along the US/Mexico border, where, in addition to underfunded local public health infrastructures, there are high numbers of unauthorized or undocumented persons, who cannot obtain affordable, quality health care. They remain ineligible for all publicly funded health services except perinatal and emergency care, despite recent health care reform in the US. This un- and underinsurance has broad spillover effects on families and entire communities.

One unique feature of the border region that highlights transnational connections is the heavy presence of mixed-status families, in which members are stratified by juridical categorizations related to immigration status (Castañeda and Melo 2014). Some 2.3 million mixed-status families live in the US (Passel 2011), consisting of variable constellations of citizens, permanent legal residents, undocumented immigrants, and individuals in legal limbo such as recipients of Temporary Protected Status (TPS) or Deferred Action for Childhood Arrivals (DACA). About three-quarters of all children of unauthorized immigrants, and most children in mixed-status families—about 4.5 million—are US citizens by birth. The composition of mixed-status families is not static, as members may move in and out of households and between statuses over time. This complexity and fluidity impacts access to resources for individual members in relation to public institutions especially health care. In addition, the 'illegality' of some family members influences opportunities for all, including those who are recognized as citizens. For instance, despite US citizen children's eligibility for benefits such as Medicaid and State Children's Health Insurance Program (SCHIP), those with undocumented parents access benefits at a lower rate, as parents avoid institutions and limit or delay services for children due to fear of deportation or that enrollment will affect future chances at regularization.

The Rio Grande Valley in the southernmost part of Texas is unique among border communities because of the physical separation created by the river, which splits sister cities with historical

interconnectedness. With a population estimated at 1.3 million and rapidly growing, it is a blending site of communities geographically, socially and economically closely integrated with Mexico. Latinos of Mexican descent account for 89% of the population and the preferred language for 90% of area residents is Spanish. The highly mobile population includes binational extended families and large numbers of people who cross the border daily for work and recreation. Many Mexican citizens can apply for a Border Crossing Card (B1/B2 visitor's visa issued for 10 years at a time), allowing them to cross frequently. However, this mobility only applies to some people. Many are undocumented—having entered the US on an unauthorized basis or overstaying a visa—and so are relegated to life within a small strip along the border. Unable to re-enter the US if they cross back into Mexico, they are also unable to travel to other parts of the US, since this requires inspection at one of the Customs and Border Patrol traffic checkpoints along major roads and highways. As a result, undocumented persons describe being 'trapped' in the region, despite the fact that their Mexican town of origin may be only a 10-minute drive away. Many families on the US side live in *colonias*, unincorporated neighborhoods often lacking city services such as water, electricity and sewage. Nonetheless, despite these disadvantages, *colonias* provide access to low-cost housing and facilitate the maintenance of multi-generational households.

Below, I focus on the experiences of mixed-status families in the US/Mexico borderlands to emphasize the interconnectedness of immigration and health care policies. Because of this convergence in their lives, families and individuals employ specific health care strategies, access informal medical and dental services at a high rate, and engage with transnational opportunities to address illness.

Health Care Strategies of Mixed-status Families

Veronica is 34 years old and has lived in the US for eight years since moving from Reynosa, Mexico, about a 30-minute drive from her current home in Texas. Her husband works in construction, and she is a stay-at-home mother of five children, three born in the US and two in Mexico. Like other parents, she frequently experienced dilemmas when her children, who have different forms of access to the health care system, became ill at the same time, as is often the case with respiratory and other common childhood infections. She and other parents often had to spend the greater part of a day or two visiting first a pediatrician for a citizen child with Medicaid, followed by long waits at charity or community clinics hoping to have any uninsured children seen for the same condition. This results in time off from work, loss of income, and is logistically difficult if no transportation is available. Veronica described the difficult decisions she faces when an undocumented child becomes ill:

> It's very difficult, because those children who have Medicaid and were born here have more privileges, like going to the doctor. I struggle a lot when they get sick because you have to pay for the doctor and sometimes you don't have money. A consultation is very expensive here. Those that have Medicaid, you immediately go to the doctor if they get sick or have an accident. It's not the same for those without, if they fall or get hit. Like one time my girl, who doesn't have Medicaid, fell. She was playing, running, and she banged into a chair and got a bump that swelled up and almost burst open. You know it's something that is worth going to the doctor for, but then you don't have money for it. All you can do is try to get the swelling to go away. It's better to put Vick's [VaporRub ointment] or something like that on it to bring down the swelling. For a heavy blow like that, you have to get X-rays. If that happened to someone with Medicaid you would immediately go to the doctor, because you know your insurance will cover it.

Like Veronica, many parents shared their regret at being unable to take their children to the doctor for an illness or accident for which they would have immediately taken a child with Medicaid. Instead, treatment consisted of home remedies, over-the-counter medications, or, as described below, 'leftover' medications from others. This creates distinctions within the family that even the children notice, as stratified access based on legal status may lead to preferential treatment, resentment, and hierarchal relations within the family.

Maria Elena is a 33-year-old mother of three children, two born in Mexico and one in the US. She and her husband Everardo, a bricklayer, arrived 12 years ago, also from nearby Reynosa. They moved to the US primarily to provide a better education for their children, as "over there, school is very expensive but not very good." Despite the fact that all her children go to school together and are being educated in the same way, Maria Elena recognized that there are distinct advantages for her US-born daughter:

> She's six years old and was born here. She doesn't know anything, she doesn't say, like, 'I'm from here, and you're not,' to her brothers. But the kids do notice: 'Mami, why does she get benefits and we don't?' They see the difference. I tell them, 'son, because you weren't born here. You were born in Reynosa. And she is from here.' The same thing at the doctor's, they see the difference, because I take her since she has Medicaid, but not them. At the doctor's they just ask, 'Do the boys have Medicaid too?' 'No.' 'Ok, then just give them this over-the-counter medicine.'

For undocumented parents and children, sources of formal care include low-cost community health centers, charity care, or the emergency room. Maria Elena explained, "for the adults, well we wait until, honestly, until we're really bad, and they we go to [a community health center] or if we're really, really bad, to the hospital." While it was anticipated that the burden placed on emergency rooms by the uninsured would be remedied with the recent US health care reform (Affordable Care Act of 2010), the large undocumented population in border communities are not among those who can acquire coverage. Despite some structural and institutional changes, the burden of filling gaps in health care will continue to fall on governments and organizations at the state and local levels. This is a unique challenge in many border communities, where public health infrastructure is significantly underfunded. Community health centers continue to be a vital source of medical care for immigrants without coverage; however, there are not enough to serve the entire population.

Informal Practices

As formal systems fail to meet the needs of a large segment of the population, alternative and informal channels of care proliferate. One common practice is the sharing of medications prescribed to citizen children to treat undocumented siblings and parents. As Alan, a 22-year-old undocumented student at the local community college, recalled, "When people prescribed something to my brothers who had Medicaid, they didn't use all of them, we would use them. That is how we would do it." The mutual assistance evident in sharing prescription medications sometimes extended beyond the immediate family. Lisa is a 20-year-old US citizen with one undocumented and two citizen siblings and undocumented parents. She recalled how 'leftover' medication circulated not only within the family, but also in the wider community:

> There's always leftovers. Even the neighbors would call us and be like, 'Oh, my son is coughing,' or 'we have a cough, do you have anything?' 'Oh, yeah, I took her to the doctor and aquí está la medicina que me sobró [here's the medicine that was left over].' So it's always counting down medicines to see who needs it. . . . So it's always been like, handing down medicines, or seeing what we have in the cabinet and always trying to save anything because we can't afford that type of medicine in case someone gets sick.

Medication use is a socially embedded practices, and saving, sharing, and re-using medicines is broadly practiced. Sharing not only serves the immediate need of treating illness but also creates the obligation of reciprocity between individuals (within a family) and households (within a community), an advantage in conditions with limited resources. However, sharing is problematic when, for example, a course of antibiotics is cut in half, rendering it less effective for both people who take them. Thus, a socially valued and pragmatic act of sharing may lead to twice the negative outcomes; half of an antibiotic regimen may be worse than none at all. The wellbeing of US citizen children is thereby directly affected by a family's mixed status.

Another common practice rooted in the transnational reality of daily life is traveling to Mexico to visit health professionals or purchase medications. As Israel, a 21-year-old undocumented college student, noted, "We have people bring medicine over. We'll get flu medicine, penicillin, just regular stuff. Injections, you know." Rather than crossing the border themselves, many people rely on others to bring or send medications. Traveling to Mexico for medical and dental services has been a common practice for several decades, but increased border militarization since 2007 and amplified scrutiny of papers has decreased people's ability to do so. Amanda—who has three children, the eldest of whom was born in Mexico—pointed out, "We can't even go for treatment to Mexico, not even to Reynosa, not even that . . . you can't leave here." As Mexican citizens, they are no longer able to obtain medical care in Mexico because they would be unable to return to their home in the US. Additionally, the availability and affordability of services has been impacted by the 'brain drain' of

physicians and dentists away from northern Mexican border towns due to violence in recent years, coupled with elevated costs as a result of the local narcoeconomy.

As a result of the inability to travel across borders in recent years, there has been an increase in strategies such as purchasing prescription medications offered—unlawfully and in an unregulated manner—by vendors at local flea markets. Based on observations at booths and discussions with vendors, these include antibiotics of various classes, steroids to treat inflammation, insulin, birth control pills, and emergency contraception. Angela, a 39-year-old woman from Zacatecas, sells homemade tamales. She noted that, "If people don't have insurance, they go to the flea market when they have an infection or something and take pills that they buy there. They may not even know what it is. I don't go, I don't do that, but I know people who go there to get injections or some pills." In addition, some practitioners operate out of homes or at flea markets, including dentists licensed in Mexico (but not the US) or nursing assistants who provide injections for a fee (although not legally permitted to do so). Some dentists operate out of their own or patients' homes. Lisa, introduced earlier, noted that, "they do house visits, and I'm sure they're not supposed to, but they do it to help out the communities so we're very thankful for that." Marina, a 42-year-old woman, added:

> There are no dentists here for us. Some come from Mexico and we seek them out in homes, but it is risky for them because they could get caught, could get in trouble. But we need them. My mother has gone to such dentists who are not licensed here. Actually I need to go, too, but I am afraid. It's not the same, like being in a clinic where you know exactly how everything was cleaned, and that they have everything they need. To work out of a house, it could be that they have cleaned everything, but it's better not to do it that way.

These informal practices are the direct result of stricter border policing in previous years and the inability to travel for transnational care-seeking. Due to these limited opportunities to obtain services, undocumented immigrants are forced to seek health care that is improvisational and may pose additional risks.

The Convergence of Immigration and Health Care Policy

The dilemmas and practices described here highlight the need to examine the intersections of immigration and health care policies, as each has direct and indirect impacts upon the other. A number of historical and geographical factors have resulted in the prevalence of transnational connections and identities along the US/Mexico border. This includes mixed-status households, which are a major feature of the contemporary migration landscape (Castañeda and Melo 2014). Experiences of these families—including some 4.5 million US citizen children—have significant implications for the future of health policy and consequences for future immigration reform. In late 2014, President Obama announced a plan that provides administrative relief to up to 5 million undocumented immigrants who have lived in the US for at least five years. The program significantly impacts undocumented members of mixed-status families, protecting them from deportation and allowing them to work legally. What it does not do, however, is provide these individuals with any form of public health benefits or affordable health insurance through the mechanisms of the 2010 reform; in regards to health care access, therefore, their situation remains the same. Other features unique to the region I have highlighted here include an established pattern of transnational care-seeking that has recently been severely curbed as border enforcement has increased, along with high poverty and inequality, which produce and reproduce informal health care practices. Despite limitations, families and communities develop ways to cope with the lack of accessible and affordable health care.

However, the consequences of disparate access to quality care on lifelong health outcomes are well established. Since undocumented immigrants will account for up to 25% of all uninsured in coming years, their exclusion implies serious limitations for the future of health equity in the US. There are stark cultural, political and health implications in the continued existence of a medical underclass comprising over 11 million people. Limited access to health care creates widening disparities for an already impoverished and marginalized group. Specific shifts at the policy level will be a necessity to address this burgeoning public health issue created through the convergence of immigration and health care policy.

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There are many reasons for moving back and forth across the border of the US and Mexico (Cartwright 2011). Poverty and lack of the possibility of economic and educational advancement have led many families to emigrate from Mexico to the US, either formally or informally, over the last fifty years. More recently, intractable violence in Mexico and Central America has led to new waves of people crossing the border, often at great personal risk. Upon arrival and long after that, the life possibilities that are open to new residents are constrained by the legal status that they are able to attain (Cartwright 2011; Holmes 2013; Quesada et al. 2011). Individuals coming from Mexico and Central America move through the immigration system in the US slowly, at best. Many people reside without citizenship or residency papers for years, vulnerable to incarceration and deportation if they try to seek medical care. Others obtain Lawful Permanent Residency (LPR) status that comes with some benefits, the obligation to purchase health insurance and the annual increasing penalties if one does not, and mandatory waiting periods for receiving government benefits of Medicaid and health insurance for children of up to five years in some states (www.healthcare.gov).

Biology, in this case one's state of health, often plays a role in whether or not one can make a move to another country and be allowed to stay there for a length of time. Miriam Ticktin (2011) makes an interesting comparison between the role that biology plays in the treatment of immigrants in France and in the US with respect to the quest to gain citizenship. In France, the official approach over the last twenty years has been to use ill health favorably in the equation of whether or not an individual can stay in the country when he or she arrives there illegally or overstays a visa. Under the 1998 'illness clause,' French immigration law tended towards granting immigrants permission to stay in France if they required medical treatment and if returning to their countries of origin would put them in a situation of not being able to obtain the necessary care. Originally a very humane document, the illness clause has become increasingly restrictive since its implementation with increased agitation from right-wing nationalists and as French mainstream sentiment towards immigrants has deteriorated. By the early 2000s, France had moved away from using illness as the basis of allowing individuals to obtain legal papers to stay in France. With the violent attacks in January 2015 on the French newspaper Charlie Hebdo by French-born Muslims, and the immediate and vicious push-back against immigrants in that country, especially in the suburbs of the large urban centers like Paris (Ellick 2015), the power of the illness clause may be further eroded. In the US, in contrast with France, a 'security-state' ethos prohibits individuals from entering the country or applying for visas if they have communicable diseases of public health significance, severe mental illness or drug addiction, although since 2009 individuals testing positive for HIV virus have not been excluded from entry or from seeking residency.[1]

Below, Susann Huschke explores the precarious nature of living as an undocumented immigrant from another angle. The social services provided by the German state are inaccessible to Eduardo, the Colombian immigrant at the center of her account. Huschke details the human exploitation and deprivation that borders on slavery, experienced by many immigrants, and through this sheds light on how people without official status find meaning in their lives in such a way that makes it possible for them to endure many hardships.

12.3 "I Haven't Paid This Karma Yet"

Susann Huschke

Eduardo and I first met in the spring of 2008. Another Colombian research participant, Mercedes, had suggested that I meet him and briefly told me his story—a story of what some might call modern slavery. Eduardo, she explained, had lived in Germany illegally for over 20 years. He had worked for a wealthy couple in one of Berlin's affluent neighborhoods without ever being paid, and was deprived of basic rights and mistreated in numerous ways. For most people from countries outside the European Union, the only way to legally live and work in Germany would be as a spouse or child of a German national. Consequently, labor migrants enter the country illegally or, as in the case of most undocumented Latin American migrants, come as tourists and stay even after their visa expired. If they find work—and most do—they work illegally.

Eduardo's story sounded like the worst case scenario: no pay, no rights, and very little contact with other people for two decades, trapped in a villa as an obedient servant. Mercedes arranged for me to interview him. I subsequently met him several times over the next three years, and continue to receive updates about his wellbeing via email until today. His story touched and upset me but he also taught me a great deal about the complexity and ever-changing nature of lived experience, the many faces of social suffering, and about human resilience in the face of structural and interpersonal violence.

I first interviewed Eduardo in his tiny, cluttered room in a state-run hostel for migrants and asylum seekers. He had been put there after the police arrested him in the summer of 2007. It was a rather unlikely coincidence (he would argue that it was fate): the police came knocking on his door looking for a neighbor. Due to his poor spoken German, they identified him as a 'foreigner' and asked him for his passport which he couldn't produce: his employers had taken it from him many years ago. The police suspected that he was undocumented and arrested him. In custody, he was diagnosed with tuberculosis and transferred to a hospital. After treatment, his physical and psychological state remained fragile, and his deportation was temporarily suspended. He was allocated a room in the refugee hostel and given access to basic medical care and social benefits. Meanwhile, a lawyer working for the Jesuit Refugee Council took on his case to try and legalize his status.

Eduardo told me that he had come to West Berlin in 1986 when he was already 40 years old in the hope of finding work. Unlike many other labor migrants, he did not leave behind a wife or children, only his mother. A few months after he arrived in Berlin, he found work as a house servant for an Argentinean-Italian couple, employees of the Argentinean embassy. He moved in with them and lived with them for the next 20 years in their four-story villa, cleaning their house and garden. He lived in the cellar, in a room without heating, kept more or less warm by the central furnace providing heat for the house. He had to leave the door open because of the fumes coming from the furnace. About his work situation and the relationship with his female employer, he said:

> They didn't hit me, but verbally, verbally they treated me really bad. . . . I told her at one point that I would prefer if she hit me than being treated in a bad way verbally, I would prefer that. Because getting beaten, there are things you can take for that, right? There are pills and creams to make the pain go away, right? The pain goes away fast. The moral pain on the other hand does not go away, that pain stays. But yes, my God, it was difficult.

His employers ordered him to stay away from the neighbors and the visitors who frequented the place—often international guests and employees of other embassies: "I was afraid of them. They did not allow that I brought anyone to my room, and I could not speak to the people who lived upstairs either. They would always check on me." Eduardo wanted to study German but he was not permitted to leave the house for a language course. His boss threatened to send him back to Colombia any time he disagreed with her—that is, to denunciate him to the police and have him deported.

I got to know Eduardo as a shy and quiet person, a small, thin and sickly looking man with pale skin, blurry eyes and flat cheek bones. He whispered more than he spoke, and avoided eye contact. However, once he realized that I was not going to judge any of his views on life, fate, and spirituality, Eduardo opened up and passionately shared his story with me. His tiny room at the hostel was crammed with old newspapers, on the walls he put up pictures from magazines, mostly of pretty young women. There was no room to sit down, but there was a sense of order to the seemingly chaotic assemblage of collected things: everything had its place.

During our conversations, which lasted hours, I learned about Eduardo's views on what had happened. I discovered that there were loopholes in the otherwise tight regime his employers subjected him to. He told me how he used to ride his bike to the nearby forest, he went shopping at the grocery store, and he also sporadically and secretly worked for other families as a paid domestic worker, earning a little bit of money most of which he sent home to his mother. These contradictions led me to wonder about individual agency in the face of severe political, spatial, economic, or social constraints.

When I first asked him why he had not left, he told me a story of how he had been thrown out of the house by his employers once after an argument, and had considered looking for help from a Christian support organization, but then his employers 'forgave' him and he decided to stay. When we returned to this incident in a second interview, he added the following explanation:

> What happened was that I did not want to leave the neighbors, the other neighbors who were really nice and who I loved very much, I used to visit them. They provided me company, and so I said to myself, now that they [the employers] have forgiven me, if I go [to live elsewhere] I will feel alone. Here, on the other hand, I have those neighbors who I know and whom I greet every day.

Eduardo therefore had good reasons to stay: he appreciated the security and his acquaintances in the house and in the neighborhood. He preferred the known evil, with a measure of comfort and security, to uncertainty.

Apart from the constant abuse by his employers, Eduardo also suffered from his failed attempts to find a partner. He was well aware that marriage was the only way to legalize his status, obtain a permanent visa in Germany, and so earn more money to send home. He explained: "The only thing that could save me was a girl." He was reminded of this by his mother in the letters she sent him, in which she complained: "How long have you been there now? Why have you not sought the visa yet? So much time has passed!" In order to uncover the cause of his misfortune, his mother consulted a diviner back home in Colombia. It was revealed that Eduardo's misfortune with women and his experiences of interpersonal violence and exploitation were linked. They had the same cause: black magic. From then on, Eduardo began to understand that all of his suffering was mainly a spiritual matter. He explained to me that his employer's aggression against him was the work of a *mago negro*, a sorcerer, from Colombia: "He leaves his body and comes to this house [the villa where he lived] and bothers the woman so that she then bothers me. This happened for 20 years and I put up with it." The sorcerer also affects his ability to love: "This black magician with his bad energies does not allow that I love a girl. My feelings are totally blocked. My heart, my feelings are like a rock. It's impossible." Moreover, the sorcerer bewitched Eduardo directly, causing for example itching, raw sores on both his legs, and he made his eyes burn and his stomach hurt: "The sorcerer is sending me acid."

When we talked about how he could protect himself against sorcery, Eduardo pulled out a magazine from one of the piles in his room and showed me an advertisement of a Dutch healer who claimed she can cure a multitude of physical and spiritual ailments. I asked him whether he wanted to get in touch with this healer:

Eduardo: Why don't I do it? Because time hasn't come yet. I have done bad things in other lives. There are no causes without consequences. I was a dirty sorcerer in other lives, too, and I caused the same harm.
Susann: So she can't cure you?
Eduardo: She can cure me!
Susann: Aha, ok.
Eduardo: But it is not the time for her to cure me.
Susann: How do you know it's not the right time?
Eduardo: Because . . . God is just. I have paid a karma in this house. Two karmas, there are two karmas. The one I have now; and the one that I already paid, for 20 years. The police arrested me and I stopped paying the karma. I hope that they give me the visa and I can begin anew to live a life without offending others. There is justice on Earth . . . and she can cure me, but not yet.

In addition to the explanations his mother offered him in her letters, his understanding of suffering was shaped by the teachings of a master, his *maestro*, as he calls him. He had met him years earlier

when he was experiencing economic misfortune in Colombia and was looking for spiritual support. The maestro introduced him to the concept of karma, and gave him one of his main sources of comfort which he still reads: a book by Ramatis, a Brazilian prophet, whose teachings involve extra-terrestrial life and the coming of judgment day.

When I met Eduardo once again in June 2010 to catch up and to see if I could help with his legal case, I was still struggling to understand why in 20 years, he had never attempted to leave the abusive relationship. After the meeting, I wrote in my fieldnotes:

> After repeatedly avoiding a direct answer to my question, he finally replied rather impatiently: "I didn't leave because first of all, I didn't want to, and secondly, because I understood that I was paying a karma." He went on to explain that he had realized early on that he would not be able to leave that place. Even suicide would not have been an option, he explained, because one cannot flee karma by dying; it would simply start all over again in the next life. One cannot avoid or heal suffering, one can only bear it. "Suffering is purification," he said, and "suffering is not gratuitous." Finally starting to feel that I understood his perspective, I commented that it probably became easier to bear the pain once one understood why one is suffering, and he nodded in agreement. Earlier, he had said something similar: "Yes, this gives me strength to continue living."

Eduardo's experience exemplifies the complexity of suffering: there are no simple answers. The ways in which we tell a story matter (cf. Abu-Lughod 2005). Emphasizing the structural violence (cf. Farmer 1997) that shapes the lives of undocumented migrants like Eduardo renders claims of justice and inclusion more powerful. At the same time, I wanted to avoid the pitfalls of representing research participants as 'suffering strangers' (Butt 2002), as faceless, voiceless, and helpless puppets, made to dance (or rather, suffer) in a way that suits the researcher's own political agenda (cf. Huschke 2015a).

Eduardo, one could argue, was caught in a web of abuse and dependency, made up of restrictive migration regimes and woven by those in power to support the global demand for cheap labor in a capitalist economy, in a deeply unequal society. Eduardo had very little agency; he felt powerless in the face of the very tangible effects of structural violence. From his point of view, though, things look somewhat different. He is well aware that he could have left, but this would only have perpetuated the circle of suffering he was caught in. Eduardo's spiritual understanding led him to see his suffering as unavoidable, as a necessary and ultimately beneficial catharsis. He was preoccupied not so much with his immediate physical and emotional wellbeing, but with the long-term effects of his decisions. Further, he did not perceive his living situation as entirely bad: he appreciated the safety and comfort of knowing his way around and being able to draw on a—albeit limited—social network, mainly his neighbors. To understand Eduardo's experiences from his angle helps to challenge the dominant perspective of what it means to be well and healthy: "[The study of individual subjectivity] holds the potential to disturb and enlarge presumed understandings of what is socially possible and desirable" (Biehl and Moran-Thomas 2009: 270).

Eduardo found a way out of the dilemma many of my research participants experienced: their suffering as criminalized, marginalized, and excluded migrants seemed incomprehensible and profoundly unjust. Eduardo saw his suffering as unavoidable bad karma, to be endured, with light at the end of the tunnel: the suffering would end once the karma has been paid. It helped him to achieve a fragile equilibrium, a state of acceptance—although not a state of wellbeing.

At the time of writing, Eduardo lived in a state-sponsored home for the elderly in Berlin. After six years of legal struggle, he was granted an extremely rare residence permit on humanitarian grounds, based on psychological assessments that certified 'a mental illness,' his lawyer told me. The decision also took into account that Eduardo was now nearly 70 years old and had no relatives in Colombia able or willing to take care of him. Obtaining a legal status allowed Eduardo to finally rest, with some peace of mind. When I asked him how he felt now compared to before, he replied: "calmer, livelier." He still feels the pain of being lonely: "I never had the chance to create a home, the sorcerer did not let me." But he has found a friend in a middle-aged woman from Colombia who sees him as a father figure, and he appreciates his new-found stability and safety (cf. Huschke 2015b). Undocumented migrants like Eduardo—many of whom experience anxiety, sleeplessness or depression, social isolation, economic deprivation and exploitation, and physical ailments such as chronic pains and acute infections—ultimately find relief in gaining legal status.

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In some instances, such as those described by Huschke, the tension of not belonging is only partially resolved, even after many years. The ways in which Eduardo makes sense of his suffering are a good example of how people come to understand and give meaning to their plights. Similarly, in their work with Ecuadorian migrants to Italy, Raffaetà and Duff illustrate that these individuals created attachment to place through assemblages of "social, material and affective resonances, experiences and resources" (2013: 342). Over time, these migrants created social spaces and participated in activities that enabled them to interact in pleasurable ways similar to those in which they might have participated at home in Ecuador. Raffaetà's and Duff's emphasis is on the process of 'practicing' place in a way that acknowledges its physicality as well as the affective feelings that migrants develop for it. The deprivations and discrimination against immigrants are such that it is almost inevitable to focus on the negative aspects of their lives, and to overlook the resilience of people, regardless of their legal status, that enables them to care for themselves and others.

Survival Migrants and Global Violence

We opened this chapter with comments on population mobility in the twenty-first century, and above, we have drawn attention to the vulnerability of people who lack legal documents that allow them to stay and that provide them with access to health care and other human services. Far more vulnerable, and increasingly characteristic of global population movement, are those who Alexander Betts (2013) has characterized as 'survival migrants.' In his study of failed and fragile states—countries that often have a prior history of civil war and/or other regional wars, and that lack a viable and competent system of governance—people may move across borders out of desperation. The impetus to move is tied, too, to environmental change and natural disasters, food insecurity, and continued generalized violence that creates precarity both on an everyday basis and in relation to a future (Hedman 2008). Such reasons do not accord with the international criteria for humanitarian migration and resettlement; these require people seeking asylum to show cause, primarily by demonstrating the risks of persecution for reasons of race, nationality, membership of a particular social group, or political opinion. These criteria do not necessarily support requests for asylum and resettlement on the grounds of living under conditions of sustained local violence, economic duress, environmental devastation or protracted civil conflict. Current definitions of asylum seekers and refugees therefore systematically exclude many people from claiming protection. Further, how people are categorized can vary from one

country to another, as not all countries accept this international definition, and often the validity of claims for sanctuary is determined at a national level, as we discuss further in Chapter 16. The United Nations High Commissioner for Refugees (UNHCR) classifies many of these people as 'irregular' migrants or 'people of concern.' Their legal status, the risks associated with their travel, the conditions in temporary and long-term detention camps, some of which have existed for decades, with generations born into the camps, seriously impacts on the health and wellbeing, directly and indirectly, of these seeking sanctuary (Holzer 2015).

As we have shown in this chapter, there are many kinds of global quests for care. Motivations, resources and results differ according to such things as civil status, laws around particular procedures, monetary resources and the larger sociopolitical realities of different places. The complexities of decision making, managing conflicts between family members and others as well as the ever-changing arrays of possible treatments and procedures makes these quests a vital, ongoing field of investigation within our discipline.

Note

1. US Code 1182—Inadmissible aliens http://www.law.cornell.edu/uscode/text/8/1182.

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