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***“Une Nouvelle Vie”*: Health Care and Identity of Congolese Immigrants in Texas**

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Introduction

In recent years, the issue of immigration into the United States has become a popular subject of interpretation and analysis, whether the immigrants themselves are undocumented or in the country legally. With the newly introduced, and acutely controversial, “Obamacare” Act of 2010, the idea of who does and does not “deserve” health care is all the more relevant, and is especially crucial to the lives of any and all immigrants to the US. The debate includes new uses of terminology to more easily discriminate between those who “should be” covered and those who “should not”: the terms illegal, undocumented, legal, temporary, permanent, refugee, asylum seeker, and welfare recipient are all in constant use by the American media.

On the academic front, anthropologists such as Willen (2012a, 2012b) Sargent (2012) have examined the embodied experience of undocumented immigrants, especially concerning their “deservingness” of health care, which lies outside of the purely practical aspects of the accessibility of health care in this country. Rather, they examine the concept of “moral worth,” which often determines whether a group is determined to be worthy of affordable, adequate medical care, by the general public and/or policymakers themselves (Sargent 2012, Willen 2012a). In addition, self-perceptions about how one does or does not belong in society, guided by state-level determinations of “worth” help create “sociocultural spaces” in which immigrants learn to participate in “various forms of civic engagement” (Brettell and Reed-Danahay 2011: 1, 3). These theoretical considerations introduce a crucial new angle to the debate on immigration and the human right to health care: researchers must examine the experience of the immigrants themselves, including the ways in which they and others interpret their moral status. However, there has been a lack of research on whether the same principles of “belonging” associated with

undocumented immigrants apply also to *legal* immigrants who, albeit their ability to work and live without fear of deportation, are similarly excluded in the health care system.

This paper serves as an exploratory study into the self-perceptions of citizenship, deservingness, and inequality of a small population of Congolese immigrants (originating from the Democratic Republic of the Congo) in the Dallas-Fort Worth suburb of Hurst, Texas. This population is unique in that its members are not excluded by an internal sense of “abjectivity” from “illegality” (Willen 2007), but by structural inequalities that affect how they view life in America. Because a good portion of those surveyed were “winners” of the State Department’s Diversity Visa, they are afforded the same legal status as any other immigrant with a green card. However, my research reveals that despite these immigrants’ designation as legally belonging, they face the same, and at times arguably worse, structural constraints felt by undocumented immigrants. Specifically, high health care costs and the difficulty of getting insurance play a major role in how these immigrants view their ability to participate in the idealized American way of life. The surveyed population—in questionnaires and individual interviews—expressed overwhelming dissatisfaction with the efficacy of the American health care system and perceived exclusion from the system. Most participants were uninsured, and like many Americans faced a series of health problems that could render anyone poor in light of the ensuing medical costs, including pregnancy, car accidents, infections, and disease. These factors are worsened by the structural inequality experienced by those who are not deemed “deserving” of state-provided care and thus suffer the worst consequences of the American system of market-based medicine (Rylko-Bauer and Farmer 2002: 476).

In addition to the structural and financial barriers this population has faced in terms of accessing adequate medical care, feelings of disappointment spurred by images and expectations

of life in America loomed large in participants' minds. This paper critically examines visions of an America in which jobs are plentiful and wealth is universal alongside the reality of the situation in which they are thrown upon arrival. In this case, health care exemplifies the almost punitive nature of the American market system and the material separation between "entitlement and exclusion" that echoes throughout many aspects of immigrants' lives (Sargent 2012). This disjunction between expectations and reality is salient in other anthropological work on immigrant health, but here will be more consciously explored. The following analysis expands upon existing dialogues about the impact of "illegal" status on immigrants' self-perceptions of "cultural citizenship" and belonging (Ong 1996, Willen 2012b) by introducing the perspective of visa recipients. Legal immigrants, who in theory have all the necessary tools for a decent standard of living and a path to citizenship, face similar structural hardships, including poverty, untreated medical problems, and crippling debt. This research suggests that the labeling of immigrants as "legal" or "illegal" is not the sole cause of medical inequalities, and implicates a health care system that is tipped against the 11.7 million immigrants in the country today for reasons of class, race, and other privilege (Preston 2013).

Because the interviews conducted for this project took place in an African Sunday School class at a Methodist Church that serves an enclave of Congolese immigrants, it is no surprise that the element of religion emerges in discussions about these immigrants' new lives. In both interviews and questionnaires, participants discussed the role of God in their daily lives, often as a "last resort" solution after experiencing extended poverty, hardship, or disease. The will of God and His plan for their lives consoled those who felt that they had done all they could to improve their situation, and now depended on divine intervention. When viewed within the context of anthropological arguments about "deservingness" and moral worth, the element of

religion is largely unstudied and extremely relevant to conceptions of personal responsibility and agency. Horton (2004), in her study of the differential and arbitrary reckoning of Mexican and Cuban immigrants' medical deservingness by clinicians, argues that particular groups of immigrants are sometimes "implicitly discouraged" from participating in social and political institutions—including health care but also political organizing, social memberships, etc.—due to conceptions of their "undeservingness" as members of the moral community (481). For the small population of Congolese immigrants in question, self-perceived societal exclusion, caused by inability to access adequate health care, creates an increased reliance on religion for an explanation of inequality.

Methods

My work with a group of 15 francophone Congolese immigrants in Hurst, Texas reveals that the concepts of embodied exclusion reach beyond undocumented immigrants. Within this enclave, I surveyed 12 immigrants about their experiences in the US as well as their thoughts on the availability of health care. I also performed extensive interviews with five of those who completed surveys, which elaborated further on the aforementioned topics. While the amount of time these people have spent in the U.S. ranged widely from 3 months to 13 years, all were originally from the Democratic Republic of the Congo, most popularly the capital city of Kinshasa, and attended a weekly Sunday school class, taught in French, at the First United Methodist Church of Hurst. My research also included participant observation in the weekly Sunday school class, providing a broad context for the intricacies of the interlocutors' lives.

This population, characterized by a chain migration started by one of the church's pastors and the creator of the FUMC Hurst African Ministry, is a tight-knit community that lives

in both spatial and social proximity, both inside and outside the church. Interestingly, these immigrants had more in common than apparent at first glance: 5 of the 12 were recipients of the U.S. Department of State's Diversity Visa, a green card lottery "won" by 55,000 foreign-born people seeking immigration to the U.S. per year (U.S. Department of State 2013). This visa is neither easy to apply for nor easy to win, as it requires a high-school diploma and significant work experience in the country of origin in order to apply; therefore, the surveyed population contains a small minority of immigrants afforded a theoretically "quick" means of entering the country (U.S. Department of State 2013). The research reveals, however, that while this subgroup may be "lucky" in a practical sense, their possession of a green card does not directly prelude a sense of stability in society. Ultimately, the interviews conducted within this project reveal how feelings of exclusion and frustration result from not only a lack of legal recognition, but also from symbolic occlusion present in all elements of life—whether they are medical, social, or religious in nature.

The First United Methodist Church of Hurst's African Ministry program was created in 2012 as a response to the high volume of Congolese immigrants entering the area. One of the church's ministers, a Congolese immigrant himself, came to the United States with his family three years before the study began and upon seeing the need for a system of support for those arriving, created the program. In the first years of the ministry's existence, the main programs included the weekly Sunday school class, taught in a combination of French and Lingala, and usually containing a summary of the morning's sermon, and occasional cultural education events with the aim of superficially introducing the primarily white church congregation to (exoticized) Congolese lifeways (African cooking events, etc...). When research began, Sunday school was taught in a cordoned-off section of the lobby that contained a few chairs—clearly unsuitable for

the 10-20 weekly attendees. Throughout the course of the study, this class, aptly named “*Nouvelle Vie*,” or “New Life,” received its own classroom on the second floor, where the rest of the Sunday school classes were already housed.

Background: The Diversity Visa

This population varied individually in terms of immigrant status as well as the reasons for which they came to the U.S. Participants identified themselves as seeking asylum (engaged in the legal process) (1 of 12), joining family members legally (5 of 12), and as Diversity Visa recipients (5 of 12) (one participant chose not to answer the question). However, because of the unique nature of the Diversity Visa or “lottery” process, the following research will focus on the lives of these immigrants, although they are legal in every sense, are not satisfied with their status in America.

The Diversity Visa, created by the Immigration Act of 1990, is described as follows on the U.S. Department of State website: it “makes available up to 55,000 diversity visas (DVs) annually, drawn from random selection among countries to persons who meet strict eligibility requirements from countries with low rates of immigration to the United States” (U.S. Department of State 2013, U.S. Department of Homeland Security 2012). Surprisingly, this brief description and the following denotation of work experience requirements encapsulate all of the information provided on government web pages, leaving large holes about how to apply and what the process will entail. In terms of who can apply, these websites state that the DV process is determined by an applicant’s education and work qualifications, namely that an “entrant must have at least: a high school education or its equivalent; or two years of work experience within the past five years in an occupation requiring at least two years’ training or experience,”

specifically “in an occupation that is designated in Job Zone 4 or 5” (U.S. Department of State 2013).

The website then links to a separate page that contains a list of hundreds of occupations, and classifies each as pertaining to Zone 1 (Little or no preparation needed) to Zone 5 (Extensive preparation needed) (American Job Center Network 2013). Zone 1 jobs include cashiers, cooks, dishwashers, taxi drivers, waiters and waitresses, garment workers and others. Zone 4 and 5 jobs include those that require a major degree and/or years of training, such as computer programmers, human resources managers, medical professionals, biologists, lawyers, surgeons, etc.. (American Job Center Network 2013). At an initial glance, these employment categories appear to be extremely arbitrary, and in some cases, even nonsensical: for example, chemists are classified as Zone 4, while biologists are classified as Zone 5, even though a quick Google search reveals that both require (at most American campuses) 3 years of study (American Job Center Network 2013). For immigrants, whose home countries have different types of higher education that take various years to complete, this American standard of academic and professional rankings is highly inappropriate for global use and reveals the inherent inequalities present in the immigration system: even before these immigrants arrive in America, they are classified and ranked by their “skill” and those applications that are not “skilled” enough are discarded. Even for those who meet these stringent requirements, they are not guaranteed similar work in the U.S. In fact, as discussed in the section on immigrant expectations, the Congolese interviewed in this study universally left highly skilled jobs in the DRC, but due to a lack of English proficiency, are kept within Zone 1 and 2 professions—which pay less and have fewer benefits—upon arrival.

In terms of health care, the State Department online literature on the Diversity Visa is largely silent. The only mention of the provisions (or lack thereof) covered by the lottery are

discussed on immihelp.com, a private online company providing resources on immigration to the United States. Here, it is simply stated that “many insurance companies require that the person have green card [sic] before giving health or life insurance” (Immihelp 2013). There is no indication of any sort of health care provision that accompanies the DV: the recipients, who often work minimum-wage jobs, are forced to afford it without assistance. In fact, as indicated in interviews and questionnaires, only 1/3 (4 of 12) of those surveyed had any type of health insurance. This specific information about the DV—which is dispersed and difficult to find, especially if one does not read English or own a computer—helps to contextualize the conditions of arrival for the Congolese immigrants surveyed in this study. The DV process excludes its recipients from certain aspects of American life by immediately classifying them as “others” in society, albeit legal ones.

Notions of Responsibility and Health-Related Deservingness

“C’est qui veut dire il y a des grands problemes dans le systeme qui ne tient pas [le] compte des pauvres comme moi.”

“It goes to say that there are large problems in the system that do not support the number of poor people like me.” –Congolese man, age 23

Recent ethnographic literature has considered the way in which immigrants are deemed “(un)deserving” of health care as well as ideas about immigrants’ morality and contribution to society (Willen 2012b:814). Willen (2012b) argues that policy makers, health care providers, and physicians alike tend to implicitly or explicitly distinguish between those that “deserve” health care and those that do not. Immigrants, who are often automatically disqualified from

participation in social and political institutions such as the health care system because of their undocumented or temporary status, are especially likely to be denied the “deserving” label because of assumptions about their lack of contribution, lack of belonging, as well as the inherent social and political inequalities created by the immigration process. These immigrants, often labeled “parasites, ‘freeloaders’, and ‘criminal aliens,’” are sucked in to the highly-political American health care system, and because of their “lack of contribution,” are placed at the bottom of the list of those “deserving” care. (Willen 2012b: 814, Newton 2005: 151-153). Willen (2012b), Holmes (2004), Brettell and Nibbs (2010), and Larchanche (2012) all examine the effects of perceived “undeservingness” on *undocumented* immigrants. However, the interviews in this project indicated that the same principles, and ultimately the same feelings of exclusion, are often shared by *legal* immigrants who should theoretically, based on their status as citizens-in-progress, be covered under the reach of medical “deservingness”.

The self-perceived exclusion evident in the surveyed population reveals itself through widespread concerns about the efficacy of health care provision in the U.S. as well as dissatisfaction with the opportunities provided. In a survey of 12 Congolese immigrants, 50% (6) said that they were not satisfied with the health care system, largely citing high costs and punitive practices (not seeing patients who arrive late for their appointment, or making them wait significantly longer to see a doctor). Three answered that they were satisfied, but interestingly, all three also indicated that they had insurance, indicating that the presence of insurance, and therefore the reduction of hospital costs, was important for many in this particular sample. Finally, two of the 12 answered that they had mixed answers and one chose not to answer the question. Of the two that answered “yes” and “no,” one participant (uninsured male DV recipient, age 23), split his answer into issues of diagnosis and treatment. In terms of diagnosis,

or the general assessment of a health problem, this participant was satisfied, stating, “First, the country is very developed and there is also a progression in medical domain that detects disease and gives quick solutions.” This participant, among others, later indicated in their interviews that they saw American doctors as competent, well-educated, and well-equipped to assess the needs of their patient. The problem, then, lay in the cost of the care: “after detection and a [given] solution, the cost of bills to pay is exorbitant and exceeds what individuals make.” The second participant who gave a mixed answer, an insured 61-year-old female DV recipient with significant health problems including rectal bleeding, severe constipation, and possible colon cancer, agreed that the “bills after the consultation are exorbitant,” even with insurance. She then cites an example in which her brother-in-law was billed for \$40,000 in hospital charges when he only makes \$2,000 a month. These stories evoke feelings of hopelessness and frustration with the structural inadequacies of the American market which tend to favor profits over individual health.

The aforementioned woman also expressed issue with the translation services available at JPS medical center in Arlington, a hospital which she attends regularly. She showed me a packet of dense medical information, including instructions on what medicines to take, a summary of her colon cancer scan, and the process of emptying one’s bowels for her ensuing colonoscopy. However, after several consultations, in which it would immediately clear that this woman’s French far exceeds her exposure to English, the hospital could provide her nothing more than a 15-page document that she could not understand. When I looked at the information provided, I saw that an appointment with “Language Services” had been scheduled by the hospital, but that it was weeks later than her consultation and unhelpful for describing the medications she needed to take at present. This woman’s justified frustration with the incapacity of the hospital to

properly inform non-English speaking patients of their medical problems, especially when French is a fairly common foreign language, reveals her feelings of exclusion from the system. She experienced the quintessential “expedited” American health care, in which patients are processed quickly with the primary goal of making biomedical diagnoses.

The inequalities inherent to this capitalist-based medical system are discussed by Rylko-Bauer and Farmer (2002), who critique the “incrementalist market-based strategy that champions cost-effectiveness and profits rather than equity and compassion, while shifting responsibilities for cost-containment onto individual ‘consumers’ of health care ‘products’” (477). Coupled with shortages in medical personnel, hospital beds, prescriptions, etc., the increasing commercialization has been severely detrimental to the level of individual care in many cases (Rylko-Bauer and Farmer 2002:477). In the most practical sense, the problem of cost remains the dominant issue, as the U.S. health care system is the most expensive globally, creating immediate problems such as “greater numbers of insured, widespread rationing of care based on ability to pay, and serious ethical dilemmas for medical practice” (Rylko-Bauer and Farmer 2002: 477-478). These issues are individualized in stories of the Congolese immigrants I interviewed in this study: high medical costs and poor employment opportunities create a vicious cycle in which attaining adequate health care is incredibly difficult. As a result, while these informants possess the necessary paperwork for citizenship, they are excluded from the benefits held by other American citizens due to factors consistent in immigrant populations—language barriers, underemployment, and medical debt. Furthermore, these factors are largely out of the immigrants’ personal control: they are results of a profit-centered medical system that currently lacks anthropologists’ “critical reflection” and an understanding of the falsely-constructed stereotypes surrounding immigration.

Expectation vs. Reality for Immigrants in America

“They told them that when you go to America, you will be rich. You will pick up money everywhere. There is money everywhere in America.” –Pastor and Director of African Ministries at FUMC Hurst

The conception of medical “undeservingness,” as documented through structural flaws in the American health care system as well as the unequal opportunities available for immigrants, is worsened by the disjuncture between what life in America is expected to be, and what it is in reality. In this case, it is not these immigrants legal citizenship that determines their opportunities, but rather similar to what Ong (1996) calls “cultural citizenship.” Self-perceived notions of exclusion reveal how immigrants are often not seen as equal, or even visible, members of society: “As noncitizen, they were full of discardable potential. No matter how hard they worked or how hard they self-disciplined, applied themselves, and self-engineered their very beings, they were to remain on the sidelines, waiting, leading abject lives on the margins of society” (Gonzales and Chaves 2012: 267). This research suggests that this inability to affect one’s “worth” in society is a phenomenon that extends beyond populations of undocumented immigrants. It is the highly moral and emotional judgments these immigrants perceive that create a new type of “abjectivity” (Willen 2007) that pertains to those who are documented.

In an initial interview, FUMC Hurst’s Congolese Pastor and Director of African Ministries conveyed the desperation and frustration felt by members of his community upon arrival in America. He was mainly concerned about expectations that the United States had high-paying jobs aplenty and that economic stability was not difficult to find: “they told them that when you go to America, they’re going to give you big house, they’re going to give you big

jobs...” Interestingly, the Pastor’s use of the word “they” epitomized the sense of othering that these immigrants felt in a place where they were supposedly welcomed. “They” is not only a specific group of people, but rather the well-documented mindset that America *is* wealth. The institutions that these immigrants came into contact with, such as the State Department, only add to these misconceptions: DV recipients are rewarded for their high levels of education and professional activity, implying that the United States wants to take advantage of those skills. However, when the only jobs available are the same ones that the government defines as inherently “lower” in skill, this creates a significant disconnect between these immigrants’ identity in their home country, and identity in America. The overwhelming concept of “starting over” looms large in many of these immigrants’ minds and creates an emotional disconnect between those who have experienced these hardships, and those who have not.

Another factor contributing to the frustrations surrounding failed potential and a lack of control over one’s life is the intellectual gap created when international, in this case Congolese, educational programs are not viewed as having any meaning once in the U.S. One participant (23 year old male DV recipient) expressed his discontent at having completed a degree in Chemistry in the DRC and now being forced to work a low-paying, low-skill job at an airline food service provider simply because he did not speak English fluently: “I went to good schools—I graduated from a University in the Congo...But here, I start at zero.” This interlocutor’s description of his inability to use his education in this new country is explained further in his response to the questionnaire question “What factors brought you to the United States?” His answer, along with a description of the opportunity presented in the DV program, was to “develop his intellectual capacity,” ideally utilizing the American system of higher education. However, the structural inequalities present in both the DV program and the immigration system in general create a

situation in which these immigrants are aware of the “unfairness” of their new lives, but are rendered powerless to change it.

While this anecdote appears to concern about employment and education at its core, this participant’s discussion of missed opportunities was directly connected to his discussion of the issues of affording health care in the U.S. In May 2013, he was involved in a car accident, and although he felt no injuries, was forced to go to the Emergency Room for an examination. At first, he refused the ambulance, as he knew he could not pay for the resulting hospital bill. However, he was taken anyway, and upon realizing that he indeed was not injured, the hospital released him the same day with a \$1535 bill. At the time of the interviews, in July 2013, this participant showed me a final notice letter he had received, and stated that he still was unable to pay. He was extremely frustrated with the fact that he had the skill and education to make more money at a higher-paying job, therefore being able to pay his bills and not risk losing his apartment, but was not “qualified” by American standards. Thus, self-perceptions about worth—whether it is moral, educational, professional, or medical—is highly influenced by the surrounding context of inequality, exclusion, and barred opportunities.

Medicine as the work of God: Reckoning Health Care with Christian Doctrines

“Il n’y a pas moyen d’aller voir la medecin...je risque de mourir, mais Dieu est la.”

“There is no means of going to see the doctor...I risk death, but God is there.” – Congolese

woman, age 40

Religion plays a large part in the lives of the immigrants I surveyed, as the church serves as a place for community gatherings as well as a place to worship in French. In addition to the religious services the church provides, the physical space in which these immigrants gather is

also a meeting place for other projects, information sessions, and classes available. For example, towards the end of the study, the Pastor, in conjunction with a French teacher from the University of North Texas, created an English class meeting two or three times a week in order to facilitate everyday processes that involve English, such as medical forms, job applications, and interviews. Thus, the church is central to the participants' lives, who unanimously stated that they were extremely satisfied with the community at FUMC Hurst in the questionnaire. This project examines the role of religion in three ways: its use as a means of describing good fortune or opportunity, a means of holding the group to a certain standard of religious conduct, and a means of finding a "last resort" of hope when health care options are not available.

The participants' responses questions presented in the study reveal that Christianity is crucial to how this group defines "deservingness" and interprets their social existence in the United States. On one hand, religion presents itself as an opportunity, a miracle of sorts that is relevant in all portions of life. For example, one participant (61 year old female DV recipient) stated that she initially decided to apply for the DV because she "was transmitted a message from God in a dream to enter the U.S." Here, the power of the Christian God is associated with a means of opportunity—the ability to travel and start a new life. In this case, religion serves as a benevolent, guiding force that facilitates life and is a constant reminder of hope. In another example, one participant mentioned in his questionnaire that he appreciated the presence of the church in his life, because it made him feel that he was "always in an alliance with Jesus Christ." The presence of religion, at least in part, provided comfort in difficult times and was expressed by some as a clear asset to daily life.

Religion also served as a "behavior checking" mechanism in favor of living a "Godly life." In one Sunday school class, the Pastor discussed the importance of "the walk towards

perfection,” using the famous father of Methodism John Wesley as an example. “Wesley said that life is not empty. You must *do* something.” Specifically, that “something” included reading the Bible each day, studying the Bible, living a life of prayer, and living a life of service. Upon hearing these expectations, one of the women asked “How does a foreigner live a godly life,” to which the Pastor replied, “It is very difficult, but you must measure it in your knowledge of God.” This woman was picking up on the inherent contradiction in what the Pastor was saying: this group was being held to a standard of worship and service, when their lives provided far more complex and immediate challenges, such as the inability to access and afford medical care, the inability to acquire a well-paying job, and the difficulty of learning English. As a participant in the discussion, I was myself confused at where the line was drawn in terms of religious responsibility: when does the study and practice of religion become a hindrance, rather than an asset, to one’s life? This is especially true when most of the participants are working constantly to feed themselves and their families and have little time to “study the Bible.” This element of incongruity with the ultimate benevolence of religion, as well as the disconnect between the spiritual and practical world, suggest that the structural inequalities in which these immigrants live have an effect on their ability to have unquestioning faith.

Third, religion revealed itself as a means of maintaining hope when this population felt most deceived and ill-served by the American health care system. Many of the participants had serious health problems, and upon realizing that they were severely disadvantaged by the fact that they could not pay for care, feel back on “God’s will” to protect them. In the quote at the beginning of this section, a woman expresses how she feels as if she has no control over whether she lives or dies, but is somewhat reassured by the fact that “God is there.” This placement of medical responsibility on God is arguably a reaction to immigrants’ feelings about their lack of

agency in American society as well as their desire to remain hopeful in extraordinarily difficult situations. Therefore, this paper argues that it is not pure devotion that leads these immigrants to include discussions of God's will in their health discourses. It is also the feelings of hopelessness produced by structural inequalities, lack of health care, and extended poverty.

In an interview with one of the participants (23 year old male DV recipient), the issue of religion came up several times within the larger context of health. When asked what he does when he falls ill, this participant said that in reality he "did absolutely nothing" because any sort of service was financially costly. Faced with this dilemma, he stated that the only thing left to do when experiencing illness or injury is to "pray to my God" and "leave the problem to the medicine of my Savior." Here, religion and health are one in the same, as God's power to heal is seen as transcending any earthly cures. However, it is still unclear whether, if faced with more opportunities to afford care, this participant would feel equally determined in leaving his fate ultimately up to God.

The element of religion is evocative of the relationship that plays out between Christianity and practical life, in a community where much of the opportunities "necessary" for life in America are provided by a religious institution. This research suggests that while the participants do seem to show a great deal of faith for faith's sake, they are not unconditionally supportive of qualifications of living a "Godly life." Rather, religion, in some cases, is used as a last resort, a last bit of hope, after individual agency over one's life, health, employment, and family have been taken away.

Conclusions

In America today, the interrelated issues of health and immigration are extremely relevant for examining the ways in which “deservingness,” agency, and equality are reckoned in a system replete with structural violence and glaring inequalities between those that “belong” and those that do not. Using Willen’s (2012b) concept of “deservingness,” and the moral assumptions that accompany this classification, this project examines the self-perceived “belonging” of a small (n=15) population of immigrants from the Democratic Republic of the Congo. Specifically, in health-related discourses, the research suggests that the ways in which the state classifies its people: “undocumented,” “asylee,” “refugee,” “citizen,” all contribute to a constructed hierarchy of worth in society. Those placed at the bottom of this hierarchy, such as the participants in this study, are highly affected by the ways in which they are excluded.

The quintessential ideal of American individualism exacerbates feelings of responsibility and deservingness for those who are not actively aided, and sometimes, even actively discouraged, by the U.S. government. When immigrants find themselves at a loss for a solution, whether it is for a health problem, unemployment, or a religious dilemma, the surrounding American ideal encourages the acceptance of individual responsibility for one’s life and success. These levels of “ambition,” however, are not useful means by which to judge the moral “worth” of those who, because of societal restraints, cultural stereotypes, and financial restrictions, are aware that this standard is neither achievable nor applicable to their daily lives. Unfortunately, the individualization of blame leaves room for policy makers, physicians, and health care providers to deny all responsibility for a portion of the country’s *illegal and legal* inhabitants.

In order to rightfully correct this tendency to push the blame associated with poverty, poor health, and structural inequality on the victims themselves, medical anthropology must take

initiative in revealing how social hierarchies are created and how those participating in the system are viewed by the state, and how they view themselves. Singer (1995) argues that anthropology is “consciously political”, as it “acknowledges the fundamental importance of class, racial, and sexual inequality in determining the distribution of health, disease, living and working conditions and health care” (81). Thus, anthropology has a responsibility to not only reveal inequalities present in society but to “change culturally inappropriate, oppressive, and exploitative patterns in the health arena and beyond” (Singer 1995: 81). In populations such as this small group of Congolese immigrants, anthropological knowledge has the unique opportunity to merge academic research with social justice movements, and should take advantage of it through an increased understanding of human difference. Health care, as a fundamental human right, and a common issue among all humans, can serve as the center of this discussion and a means by which equality can be created where it does not exist currently.

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