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Caring for Asylum Seekers with Chronic Conditions: A Case Study in New Mexico's Borderlands

Caylyn Rich

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Department of International Development

London School of Economics and Political Science

Houghton Street

London

WC2A 2AE UK

Tel: +44 (020) 7955 7425/6252

Fax: +44 (020) 7955-6844

Email: d.daley@lse.ac.uk

Website: <http://www.lse.ac.uk/internationalDevelopment/home.aspx>

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Abstract

This study explores how service providers in Southern New Mexico inform care for asylum seekers with chronic health conditions. It further analyzes whether deservingness impacts care delivery. Previous research suggests chronic disease is overlooked relative to infectious disease, particularly for asylum seekers in the United States (U.S.) who occupy a precarious position. A qualitative study consisting of a literature review and case study approach were used to respond to this oversight. Semi-structured in-depth interviews with ten participants providing health services at a non-governmental organization (NGO) migrant shelter in Southern New Mexico were gathered before a thematic analysis of the data was conducted. The analysis presents three findings: 1) humanitarianism drives service provider motivations to deliver care 2) travel triage is an essential mechanism of care delivery and 3) service providers enact informal protocols to bridge gaps in care amidst fragmentation. These findings offer insight into an overarching theme coined ‘good enough care’ and contribute to wider debates surrounding health as a right.

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Abbreviations

CAFTA: Central American Free Trade Agreement

FQHC: Federally Qualified Health Center

GDP: Gross Domestic Product

NAFTA: North American Free Trade Agreement

NCD: Non-communicable Disease

NGO: Non-Governmental Organization

UNHCR: United Nations High Commissioner for Refugees

U.S.: United States

Introduction

In 2020, with 50.6 million migrants, the U.S. had the highest number of migrants worldwide (United Nations, 2020), making the Mexico-U.S. land border the busiest in the world. Yet, hardship in these borderlands and the interior of the U.S. escalate threats to migrants' health. Hardship contributes to inequality, as migrants' ability to address health needs is impeded (Quesada et al, 2011) by legal, economic, and political apparatuses which instrumentally perpetuate inequalities and situate migrants as a structurally vulnerable population (Holmes et al, 2013).

Despite clear overlaps, health and migration are frequently interpreted as competing aims (Abubakar et al, 2018). As environmental factors and climate change continue to drive migration (Romanello et al, 2022) greater numbers of people will migrate. This poses challenges to both the U.S. and global health initiatives because increasing pressure will build on health systems and service providers to respond to migrant health needs.

Improved mortality and decreasing fertility explain the demographic transition, which is unfolding globally, albeit at different rates in different places (Dyson, 2011). The demographic transition indicates that as populations continue to age, deaths from chronic disease will also increase. While communicable disease visibility is amplified on the global health stage (Shiffman, 2009), and research on COVID-19's inequitable impact on migrant communities is growing (Okonkwo et al, 2021; Clark et al, 2020) less research devotes attention to the inequitable impact chronic illnesses have on migrant groups. Attention is sparsely devoted to health concerns of asylum seekers as a distinct population of migrants (Beer et al, 2023).

This research highlights a crucial demand in international development studies - to ensure migrants, particularly asylum seekers, can equitably access healthcare for chronic conditions. By exploring how service providers in a U.S. border town execute care delivery for asylum seekers at a short-term shelter organization, this research addresses the following question: ***How do service providers in Southern New Mexico inform care for asylum seekers with chronic conditions?*** Despite best efforts given the resources available to them, this research indicates service providers grapple with complex rationalities, or a combination of discourse and practice,

when informing care. These rationalities are influenced by moral economies, or “the economy of the moral values and norms of a given group in a given moment” (Fassin, 2005). Moral economies invoke discussions of health-related deservingness, or the contemplation of whether one deserves access to quality health care (Willen, 2012). Deservingness is similarly context-dependent and situationally specific (Willen et al, 2016). This highlights the relevance of exploring deservingness in the specific and contemporary context of migration to the U.S. southwest, illuminating a secondary research question: *Does deservingness impact on how service providers deliver care?*

To examine these questions, this research uses a qualitative research design to undertake a case study. A literature review complements primary data collection from semi-structured in-depth interviews with ten service providers affiliated with healthcare delivery in the shelter organization. Data is thematically analyzed to develop the findings of this research. The findings of this study illustrate 1) humanitarianism drives service provider motivations to deliver care 2) travel triage serves as an essential mechanism through which care is provided and 3) fragmentation results in service providers adopting ad-hoc efforts to bridge care. The findings are theorized through a post-structural lens which identifies an overarching theme of good enough care. Good enough care challenges global health objectives by severely restricting the ability to implement health as a fundamental human right.

This dissertation structure begins with a literature review presenting relevant research and profiling the theoretical framework of the paper. Next, the methodology section details the research design and methods used to conduct the research. Then, the findings are analyzed. An overarching theme is explored in the discussion section, followed by study limitations, future research avenues, and policy recommendations.

Literature Review

This literature review opens with definitions of key terms before examining through the concept of securitization how fears surrounding accessing healthcare impact migrants' health

seeking behavior. This is further contextualized through the lens of structural violence and neoliberalism before current biomedical approaches to healthcare are identified and critiqued. Finally, a theoretical framework presents post-structural concepts of biolegitimacy and governmentality which are tools used to interpret the findings from the research.

Terms

While communicable and non-communicable disease (NCD) delineations are intentionally blurred to harness funding opportunities (Farmer et al, 2013; Reubi et al, 2015) NCDs are ordinarily distinguished into four categories: cardiovascular disease, common cancer, chronic respiratory disease, and diabetes (Clark, 2014). To clarify distinctions and honor the terminology deployed by interview respondents, this paper utilizes the term chronic rather than NCD to characterize disease as an ongoing ailment. Chronic disease is collectivized for this project as the focus is on how care is informed rather than incidence and prevalence rates for specific conditions.

For this paper, the terms asylum seeker and migrant are used interchangeably to indicate someone who is awaiting status on their claims. The United Nations High Commissioner for Refugees (UNHCR) (2023) defines an asylum seeker as someone seeking international protection, typically someone who has applied for refugee status or intends to do so but has not yet received a decision on their claim. Importantly, every refugee begins as an asylum seeker but not every asylum seeker will necessarily be recognized as a refugee (UNHCR, 2023). Refugees are typically distinguished as migrating involuntarily and are therefore rendered in policy and practice as more deserving of protection than asylum seekers (Holmes et al, 2016). Merit wanes from this delineation as migrants in general are commonly misperceived to abuse public services as freeloaders (Willen, 2012).

Securitization: Fear of Accessing Services

Contrary to popular assumptions, migrants underutilize services because immigration enforcement incites avoidant behavior where migrants refrain from using services for fear of

being deported (Lopez et al, 2022). This ratifies securitization discourses as anticipated repercussions pre-emptively securitize healthcare services as inaccessible to migrants. The process of securitization usually elevates a matter as an existential threat, typically to the state (Howell, 2014). Securitization in health can be conceptualized by a population (that of resident American citizens) as threatened by another (that of migrants) and in need of protection.

Menjivar (2014) details how the U.S. links securitization through nationalistic rhetoric with immigration control by outsourcing, or pressuring transit countries including Mexico to enforce barriers to migration. Immigration-related discrimination differs for U.S. born Latinos compared to migrant Latinos (Reyes et al, 2022) yet anti-immigration policies targeting undocumented migrants spillover to impact even legal status migrants' perceived discrimination (Almeida et al, 2016). In the U.S., migrants commonly have at least one family member who is undocumented, compounding the threat of deportation for such mixed legal-status families who are afraid of enrolling in programs due to the increased likelihood of interacting with authorities (Castañeda, 2023). Certain authorities may report migrant legal status, resulting in families being torn apart as people are deported. Compounding this fear, the threat of deportation activates a stress response in the body which conflates cardiovascular risk factors (Torres et al, 2018). In such ways, policy legislation negatively impacts migrant healthcare trajectories (Khullar et al, 2019) by deterring health-seeking behavior.

Crépeau et al (2015) argue the importance of creating firewalls, or intentional divides between sectors to distinguish public service provisions from immigration enforcement activity otherwise criminalizing measures drive migrants further underground and further from their rights to access care under international laws. Consequently, those most likely to be needing access to public services refrain from doing so due to fears of being seen as a public charge (Perreira et al, 2018). Public charge rulings streamline power to deport migrants for accessing public services including healthcare (American Immigration Council, 2022). This demonstrates public health is also linked with securitization.

Existing literature problematizes how migrants are stigmatized as carriers of disease and thereby subjected to securitized treatment protocols (Sargent et al, 2011). Resources are prioritized for responding to health concerns when diseases are framed as exposing a risk to others, as many communicable diseases are (Shiffman, 2009; Allen, 2016). For example, under

the guise of securitizing health, Title 42 was sanctioned during the COVID-19 pandemic as a public health emergency to enhance expulsion of migrants under the pretense that migration could lead to communicable disease spread. This simplified deportation capabilities by casting migrants as a public health threat (American Immigration Council, 2022).

The securitization of healthcare is twofold. Firstly, by perpetuating the sense that unique categories of people pose a threat to the general population's health, and secondly by maintaining that the health of American citizens must necessarily be preserved at the expense of normalizing poor health for the outsider population (Holmes, 2018). This suggests the predominant lens of securitization partially serves as impetus for the structural violence migrants face in managing chronic conditions.

Structural Violence and Neoliberalism

Paul Farmer et al (2013) conceptualize structural violence as a form of social suffering where negative health outcomes are driven by historic, economic, and political factors. Structural violence is multidirectional because upstream political and economic forces generate detrimental effects to migrant health. One example is neoliberalism, which promotes reducing state influence and expanding market-oriented policies. Scholars emphasize neoliberalism is a global project (Sparke, 2020; Chorev, 2013) because trade liberalization advances a neoliberal agenda (Glasgow et al, 2016) which largely benefits high income countries at the expense of endangering farmers and local laborers in low-middle income countries. This increases precarity, which broadly refers to the challenges in establishing basic livelihoods and rights (Cabot, 2019; Marshall, 2020) for migrants.

Medical anthropologists Seth Holmes (2013) and Heide Castañeda (2023) agree trade liberalization policies espoused by the U.S., such as the North American Free Trade Agreement (NAFTA) and the Central American Free Trade Agreement (CAFTA), force mobility on populations that could otherwise maintain livelihoods but are pressed to migrate as a last resort given desperate economic circumstances. As the U.S. economy depends on migrant labor forces, health equity is relinquished at the expense of sustaining economic hierarchies (Viladrich, 2019). By identifying how neoliberal imperatives endorse structural violence which jeopardizes

migrants' health by excluding them from equitable care, this paper embraces pleas to reassess the healthy immigrant paradox (Viruell-Fuentes, 2012; Hossin, 2020; Bacong et al, 2021).

Current Approaches to Caring for Chronic Conditions

The healthy immigrant paradox highlights higher observed health status among migrants, despite generally lower socioeconomic standings relative to the native-born population in the U.S. (Castañeda et al, 2015; Viruell-Fuentes, 2007). The healthy immigrant paradox is bolstered from biomedical approaches to care. Biomedical approaches conceptualize disease at an individual level of the body and buoy technical, medicalized interventions (Birn et al, 2017). Biomedical diagnoses interpret chronic diseases as outcomes of the following behavioral risk factors: smoking, alcohol, physical activity, and diet (Reubi et al, 2015).

Glasgow et al (2016) argues that categorizing specific behaviorally defined risk factors for chronic disease management locates value judgements on individual empowerment to make healthy choices, where individuals are expected to adhere to normative ideals of practicing healthy habits. When individuals fail to make healthy choices and instead engage in risky behavior such as excessive smoking, it may be perceived as morally inept. Comprehending risk as a facet of individual choice lends to a “victim-blaming” experience (Viruell-Fuentes, 2007) where migrants are made accountable for their poor health.

The healthy immigrant paradox ironically underlines how migrants spending longer time in a recipient country gradually acquire comparable health levels of the resident population, as indicated by converging health statuses (Bacong et al, 2021). This reinforces notions of acculturation which are repeatedly used in public health dialogue to target chronic diseases (Commodore-Mensah et al, 2018). Despite lacking accounts of systemic racism across population-level inequalities in healthcare settings (Bradby, 2010), differential treatment, racialization and discrimination arise through conceptualizing health outcomes as a product of acculturation (Viruell-Fuentes, 2012). Acculturation narratives contribute to building the hostile environments migrants encounter upon attempting to access healthcare services wherein preconceived notions regarding migrant patients are used to justify discriminatory treatment.

Sargent et al (2011) emphasize how biomedical representations of migrant health elevate structural violence. Biomedical perceptions of engaging in risky practices due to defective individual decisions, behavioral or cultural influence perpetuate a degree of deniability to social and political determinants impacting migrants' ability to access health services (Castañeda et al, 2015; Holmes, 2013). Migrants subjected to a biomedical gaze may be more easily dismissed when their actions do not reflect perceived rational responses to managing their health, further entrenching barriers to care through structural violence.

Theoretical Framework

The causes of inequity in migrant health are widely debated. The structural perspectives presented in this literature review suggest narratives of securitization incite fear and deter migrants from accessing health services. Concurrently, neoliberalism affects processes of migration which influence migrants' ability to access services. Coinciding with biomedical approaches to care, these structural factors heighten the precarious population status ascribed to asylum seekers through structural violence and kindle disparities in health outcomes. While a structural lens provides crucial insight into inequitable health outcomes for migrant populations, to expand upon existing literature, this research draws from post-structural theories of governmentality and biogitimacy to undertake a nuanced analysis of how service providers inform chronic care provision for asylum seekers on a more granular scale.

Post-structural Foucauldian ideas are used to set the theoretical stage of analysis for this research. Michel Foucault was preoccupied with how power was organized in discrete ways that sanctioned survival while simultaneously adjudicating death. He coined this biopower, or what is more colloquially known as the power to 'make live or let die' (Wilson et al, 2023). Foucault also theorized that life and politics intersect; he called this convergence of the political and the living biopolitics. A later iteration of Foucault's concepts of biopower and biopolitics are known as governmentality, which is rendered most applicable in conceptualizing this study.

Governmentality can be referred to as government rationality. Governmentality explains how the control of people and populations is facilitated by monitoring the "conduct of conduct"

(Foucault, 1991). Put differently, government rationalities condition people to relate to and understand themselves in a particular manner (Foucault, 1991). As people and populations' conduct is monitored, they undergo subjectification. This makes power productive.

The emphasis on self-responsibility in the realm of healthcare can be understood through an expanded conception of governmentality referred to as neoliberal governmentality. Neoliberal governmentality considers the self responsible for decisions leading to poor health outcomes. Through a post-structural reading, this does not confer a shrinking of the government as a structural interpretation of neoliberalism suggests, but a shift from formal to informal technologies of control. For example, "biomedical asceticism" or the strict upholding of biomedical dominance (Whitmarsh, 2013) may problematize a patient's noncompliance in adhering to treatment plans while elevating the clinical gaze (Holmes, 2013). This form of neoliberal governmentality enhances provider power over patient experience and feedback. Consequently, neoliberal governmentality suggests power is even more diffuse as a greater number of actors such as service providers, NGOs, and asylum-seeking populations are involved in producing power relations by engaging in or being subjected to aspects of governmentality.

Neo-Foucauldian scholars such as Achille Mbembe (2003) critiqued Foucault's lack of attention to processes of racialization. Mbembe further developed Foucault's theories by referring to the politics which govern death as necropolitics. This concept provides an addendum to irreversible histories of colonial and racist inputs (Wilson et al, 2023) into the organizing of power. Necropolitics is increasingly examined in studies of forced migration (Broqua et al, 2021) and is useful in this study to contemplate 'letting die' as a conscious endeavor.

While the "power *over* life" emphasizes technologies of control, the "power *of* life" proposes a more active interpretation of power (Fassin, 2009). For Didier Fassin (2009) the meaning-making in living importantly conveys how power is established. This is defined through the term biolegitimacy, or the legitimation of rights under the pretense of a suffering body (Fassin et al, 2009). Fassin grounds this term in trauma, which he argues gives people legitimacy to claim rights (Fassin, 2005). Biolegitimacy ultimately implies the ability to convey suffering warrants a legitimate right to care. As perceptions of protecting and caring instantiate certain moral economies, this concept is particularly useful to unpack whether deservingness as a

manifestation of moral economies impacts on service providers' delivery of care for asylum seekers.

Research Aims

Amidst incriminating migration health policies, healthcare providers must increasingly respond to wide-ranging migrant health needs (Zimmerman et al, 2011). Despite playing an important role in patching apertures in health coverage for asylum seekers, less attention is directed towards service providers operating on the ground. This research aims to close this gap by mapping how service providers inform care for asylum seekers at the granular level of policy implementation based in a short-term setting by asking the following research question: ***How do service providers in Southern New Mexico inform care for asylum seekers with chronic conditions?*** Furthermore, to expand on examinations of deservingness in health provision and migrant morbidity (Holmes et al, 2021; Willen, 2012) a secondary research question is explored: ***Does deservingness impact on how service providers deliver care?***

Methodology

Research Design

Drawing from social constructivist thinking, I determined a qualitative research design was most suitable to explore how service providers inform care for asylum seekers. I undertook a case study of an NGO asylum-seeker shelter organization in Southern New Mexico to explore how service providers rationalize care. To make sense of social phenomena (Mason, 2018; Alejandro, 2019) in how service providers inform care, I collected primary data by conducting semi-structured in-depth interviews with a total of ten participants from mid-April until the end of June 2023. I deductively tested theory as my research question presupposes a hypothesis that deservingness affects care. However, I employed inductive reasoning to examine bottom-up

insight from what the interviews revealed. By incorporating a hybrid style of deductive and inductive reasoning, I remained open to a plurality of approaches to inference (Sumner et al, 2008).

The site of Southern New Mexico was selected for its location 50 miles from major entrance ports between El Paso, Texas in the U.S and Ciudad Juárez in Mexico. Southern New Mexico is of interest because it is wedged between two anti-immigration states, Texas and Arizona. These factors, alongside my personal connections to the area, facilitated interviews with participants providing healthcare in the asylum-seeking shelter organization, which remains unidentified throughout this paper to protect the confidentiality of respondents.

Methods

Firstly, to situate my study, I conducted a literature review of peer reviewed material, beginning with a review of journals such as *Immigrant Minority Health*, *Journal of Refugee Studies*, and *Social Science and Medicine*. I then scanned larger databases for related literature from the LSE library, PubMed, Google Scholar, BMJ, and Elsevier. Journals and databases were selected based on whether they populated the most relevant literature for this project. Grey literature and policy documents were sparingly included as this remained outside the scope of my project yet provided important contextual background to clarify evolving regulations on the border.

I used purposive snowball sampling to identify prospective respondents with affiliated characteristics (Palinkas et al, 2015). My inclusion criteria for sampling amassed to whether participants provided services to asylum seekers at the shelter in a healthcare capacity. To be included in the sample, respondents needed to be either volunteer healthcare providers or NGO staff collaborating with the organization's medical team. Respondents included 5 NGO staff and 5 volunteer healthcare providers (see Appendix III).

Interviews lasted between 45 and 150 minutes, on average 90 minutes. I used a 10-question topic guide (see Appendix II) to orient the conversation. During interviews, I utilized probing techniques by drawing upon cognitive empathy strategies to elicit examples from

participants (Small et al, 2022) to elucidate their comments. During the interview process I drafted analytic interview memos to highlight important ideas. This, alongside re-listening to audio recordings before beginning coding facilitated ‘affinity’ (Mason, 2018) with my data and structured the beginning of my emerging themes.

Codes are intended to capture a single idea, reduce excerpts without copying data (Saldaña, 2021), and identify the analytic angle of data (Braun et al, 2022). I distinguished semantic codes by identifying explicit or descriptive ideas from latent codes which typically represent more abstract ideas. Qualitative Data Analysis software is better suited to code larger N-studies of data (Deterding et al, 2021). Given my smaller sample size, coupled with finishing interviews with ample time for analysis, I manually coded my data. To map disconfirming evidence while grouping codes, I used a data matrix by vertically listing participants and horizontally denoting key ideas to determine what percentage of respondents agreed, rejected, or remained neutral on a given idea (Lareau, 2021).

Following Braun et al’s (2022) guide to thematic analysis, after completing two rounds of coding to sufficiently exhaust potential insight from the data, I proceeded to cluster my codes by shared meanings linked through a central organizing concept to construct themes. While developing themes, I screened certain codes as excessive and beyond the scope of my research; speculative explanations for deviant cases suggest further research is warranted to explore other potential themes. Themes remained as candidate themes until further refinement; I returned to the data set and my codes to ensure concordance between the themes developed and the data.

To test the quality of each theme, I wrote an abstract detailing the premise of the theme to confirm it remained distinct from other themes yet internally coherent (Braun et al, 2022). Depth over breadth informed my final selection of themes (Lareau, 2021) before I finally drew from Attride-Sterling’s (2001) framework to construct the overarching global theme. When determining which interview excerpts to include I sought to iterate palpability (Small et al, 2022) by deciphering poignant participant responses that resonated with the themes developed from the codes. Participant’s comments are indicated in this project by indented and italicized quotations.

Ethics and Limitations

This research was granted ethics approval from the London School of Economics and Political Science in March 2023. After determining via email whether participants were interested in participating in this project, I emailed an information consent form to obtain written consent before conducting interviews (see Appendix I). Interviews were conducted over Zoom and were audio recorded and transcribed. My data management plan entailed securely and separately storing anonymized transcripts on LSE's OneDrive. I sacrificed specificity to protect identity by anonymizing participants, who are not identified by name.

To limit data mining (Sumner et al, 2008), interviews with participants from different lines of evidence were initially sought. Unfortunately, legislative and border patrol officials did not respond to email inquiries, obscuring the ability to generate claims from non-service provider perspectives. Further tradeoffs include conducting interviews and the literature review in English despite recognizing interactions between service providers and asylum seekers occurred in languages other than English.

A broad comparative analysis was dismissed because this research aimed to examine care provision in a concentrated context. Qualitative sampling focuses on appropriately generative rather than representative figures (Mason, 2018). In choosing a purposive instead of statistical sampling strategy and setting exclusion criteria for my sample, I limited my research to only capturing the perspective of service providers rather than service users. The time constraints, plus the possible ethical repercussions of conducting interviews with a precarious population of asylum-seekers, influenced this decision. Despite a lower number of interviews, engaging in semi-structured in-depth interviews allowed respondents to freely contribute perspectives, enabling a more nuanced analysis of perception on topics. By focusing on one specific shelter on the border, I achieved saturation with my case study.

Positionality

While triangulation insufficiently corroborates validity as different levels of evidence can branch into varying directions (Mason, 2018) I maintained credibility and rigor of the project (Sumner et al, 2008) by conducting a thorough literature review, transparently linking it to interview data, and adopting an interpretive yet systematic approach to conduct a qualitative thematic analysis of the data, while ultimately practicing consistent reflection throughout the research process.

To practice reflexivity (Sumner et al, 2008) I remained open to my ideas changing. What began as an exploration of migrants' health in general morphed into examining service providers' care delivery for asylum seekers' specifically as the service providers working in this organization provided care for this population. I regularly considered the possibility of uncovering deviant cases by remaining attentive to participants expressing previously unstated perspectives or withholding concerns, thereby indicating some variation of perception on an issue (Lareau, 2021).

I incorporated relational interviewing to acknowledge my role as a researcher (Fujii, 2017) throughout the recruitment and interview process by transparently notifying the participants of my research intentions and interest in this area of study. As an outsider observer neither employed nor volunteering with the NGO, I benefited from increased trust from participants willing to divulge information they may otherwise have hesitated to share. This presented an advantage by enabling me to get close to everyday encounters between service providers and asylum seekers.

Findings

Theme 1: Humanitarianizing Care

The following chapter considers preceding treatment conditions including confiscation of medicines prior to migrants arriving at the asylum shelter in Southern New Mexico. This

compels service providers to draw upon humanitarian rhetoric. As compassion and solidarity motivate service providers to deliver care, moral economies are heightened, pushing asylum seekers to establish claims of victimhood in exchange for care.

Preceding Conditions

Post World War II connotations viewed neutrality inherent to humanitarianism, yet disputes pushing intervention narratives led to evolutions of humanitarianism such as medical humanitarianism (Ticktin, 2006) and new humanitarianism (Fassin, 2012). Rather than evaluating the arc of humanitarianism, this paper broadly defines humanitarianism as seeking to alleviate suffering.

Perilous desert environments in the American Southwest kill many, equipping the U.S. government with a moral alibi to assuage responsibility for migrant deaths (Doty, 2011). Immigration policies construct such moral alibis at the macro level to function as a form of necropolitics (Williams, 2015) by intentionally manufacturing deaths. This is paralleled by inadequate treatment at detention centers, where migrants are sometimes held for prolonged periods (Diaz et al, 2022), deprived of water and food among other substandard conditions (Lee et al, 2023).

“Many migrants say ‘I waited three days at detention, and nobody ever came to see my son...’ because there’s only one doctor or nurse practitioner there to see hundreds of people” (Participant 5, 2023).

Health conditions worsen due to delayed medical care and lack of access to medications in detention centers (Hampton et al, 2022). Asylum seekers’ chronic disease medications are confiscated at detention centers because they originate outside the U.S. This can be conceptualized as a form of necropolitics, wherein migrants face a “living dead” world (Mbembe, 2003) due to human rights abuses (Zimmerman et al, 2011). Ordering survival against greater odds acts as a form of governmentality (Redfield, 2005), deliberately evoked through the purposeful exclusion of asylum seekers’ access to vital medicines.

Governmentality as manifested in U.S. detention centers productively serves to demonstrate asylum seekers are a disposable group. To ensure that preserved lives of migrants remain in precarious positions (Williams, 2015), detention center processes demarcate lives worth saving from lives rendered dispensable. In trying to mend the dispensable treatment of asylum seekers' lives, service providers confront such necropolitical governmentality directly.

“It’s been two months since I’ve written for seizure medications, so either they’re finally keeping their meds, or else the kids with seizures just aren’t making it across the border” (Participants 3, 7, 2023).

If, as a traditional ‘state’ the U.S. government intentionally produces hierarchies to ensure control, then new local actors also exercise such technologies of governmentality alongside those of the state. This can be perceived as a function of governmentality where spaces of governance crosscut each other (Ferguson et al, 2002) because service providers operating in the non-profit sector on the border subsume state responsibility. Service providers resist necropolitical activity by re-acquiring asylum seekers’ impounded medicines and petitioning border patrol personnel to improve processes for returning medications to asylum seekers.

Compassion

The NGO shelter maintains a 48-hour cutoff to ensure migrants recently released from detention have somewhere to go (Participant 6, 2023), resulting in limited capacity to support migrants for more than two days. Nonetheless, in traversing moral economies through the language of security, social justice, and charity (Vogt, 2018), service providers in Southern New Mexico express solidarity and compassion to rewrite preceding treatment conditions. Staff at the shelter label asylum seekers as ‘guests’ at a ‘hospitality center’ as opposed to migrants at a shelter (Participants 6, 10, 2023), replacing a message of unwelcome with welcome.

“Here in New Mexico... there’s more this idea of trying to provide humanitarian aid to folks who are seeking a better life in the U.S.” (Participant 8).

Elevating compassion relies on solidarity between those providing services and the vulnerable population in need of assistance. While compassionate frames based on treating innocent populations are laudable as an alternative to criminalized, freeloading frames, the impetus on migrants to prove their worth is reinforced (Viladrich, 2019). Asylum seekers are automatically considered juridical suspects until proven otherwise (Holmes, 2018) because in legal terms they have no grounds to claim citizenship status. In this place of precariousness, asylum seekers must continually prove their worth. The need to repeatedly prove one's worth is referred to as resilience (Castañeda, 2023).

“Agency to accept our help or not, but the very simplest things we do to restore their humanity, restore their dignity that was stripped from them... It goes far beyond resilient. These folks made it, and many didn't make it. But they just need help, you know?”
(Participant 2, 2023).

By perceiving migrant bodies as universally suffering, care becomes appropriated through humanitarianism as the goal becomes to mitigate suffering by preserving bodily integrity (Ticktin, 2011). Service providers find fulfillment in restoring agency to asylum seekers. Ironically, as agency is perceived to be missing, and the solicitude of providers 'saves' those in need, victimizing portrayals persist. Asylum seekers must maintain victimhood to sustain claims on healthcare access.

As asylum seekers undergo individualized testimonies pulling from conditions of victimhood, the weight of their experiences is unmistakably silenced, and listeners become blind to their histories (Fassin, 2012). Generosity from service providers' goodwill becomes greater than entitlement, exchanging a health rights framework with compassion, which offers a means to a discretionary end (Ticktin, 2011) because it becomes equally as valuable to the giver as to the receiver to offer support. Such “armed love” captures how care as a form of rescue perpetuates oppressive practices (Ticktin, 2011).

Exchanging humanitarian approaches linked to moral economies of who is determined as deserving with a human rights-based approach actively removes the victim of the vulnerable population by subverting exclusive discourses of deservingness based on discretionary compassion with a deservingness based on humanness (Marshall, 2020). Instead of service providers adopting a health-rights outlook where asylum seekers are characteristically

enfranchised to expect care, service providers are currently obliged to utilize a humanitarian perspective to determine whether asylum seekers need care.

Humanitarianism ultimately invokes moral economies (Willen et al, 2016) by computing the value of delivering assistance in proportion to demonstrated need. Yet need and aid are often electively interpreted instead of indisputably distributed. Subsequently, solidarity can be undermined when those whose lives are sacred become demarcated from those whose lives may be sacrificed (Fassin, 2010). When care is humanitarianized, an inevitable lens of deservingness is invoked which perpetuates care as a relational endeavor. The discretion of the caregiver allots or withholds how and what care is distributed to the receiver.

When the telos of living is organized (Ong et al, 2005) around moral economies where certain values are upheld over others, asylum seekers may be further displaced into positions of structural violence. Humanitarian efforts are commendable, and not inherently malevolent, but risk becoming transient fixes for larger structural problems, thus enhancing instead of revoking structural violence in the ways asylum seekers' chronic conditions are managed. Such a governmentality that coerces service providers to embody humanitarianized care entrenches meager results by minimally ensuring equitable responses to chronic disease care for asylum seekers.

Theme 2: Travel Triage

The following section analyzes travel triage, which was developed to determine asylum seekers most in need of medical attention from those who may safely travel onwards to their final destinations. Travel triage is theorized as a technology of governmentality and discussed through bioglegitimacy as discretionary care is determined based on moral claims of suffering.

Holding Off

Service providers implemented the travel triage model to ensure asylum seekers are healthy enough to travel to their sponsors (Participants 1-10, 2023). Travel triage is performed at the shelter's clinic, which consists of two small medical rooms. Two staff members serve as medical assistants and rotate shifts at the clinic to provide holistic care. They follow a brief triage form asking migrants about medical histories and conditions before referring patients to see a volunteer physician to write prescriptions for missing chronic disease medications or if warranted, send patients to the hospital.

"They're almost over the rainbow. They've been through hell on Earth, and they got one more ride to go so they don't want to do anything that might prevent them from going" (Participant 2, 2023).

Asylum seekers' willingness to seek medical attention at the shelter clinic is complicated by a symbolic pressure to distance themselves from the border. It is also influenced by forward pressure from sponsors, who could be family or friends to arrive promptly, even if it means attempting to board a flight or bus while going into labor, as accounted by multiple respondents (Participants 2-7, 2023). An 'almost-there' mentality presides as migrants have been traveling for days to years on end and have nearly reached their destination. This mindset implores service providers to refer only complex cases as a last resort to the emergency department or those needing lab testing unavailable at the shelter to the hospital.

"Sometimes we see diabetes, but most of the time if they've been stable for a long time, it's really more important they get to where they need to go" (Participant 1, 2023).

While healthcare personnel operating outside migration settings might misinterpret asylum seekers' hospital visits as calculated fleecing of costly utilities instead of reluctant necessity (Willen, 2012), the service providers at the asylum clinic recognize patient precariousness and prioritize keeping visits to the emergency department low. Such interventions introduce delays to traveling, raise astronomical fees, and burden already stressed hospital systems.

"We don't cure cancer. It's been a switch sometimes for volunteers. A provider called me one night at 10:00 o'clock and said, 'I found hip dysplasia in a 2-year-old', and I said 'Congratulations, put them on the bus. Refer them to help at the destination. They're not

gonna die from hip dysplasia'... You have to ask, are they better off if I don't do anything? That's a humbling question because we like to do stuff" (Participant 2, 2023).

Intentionally looking the other way is an unstated protocol among service providers who iterate the importance of asylum seekers remaining stable enough to continue traveling. While people actively gain a moral source of legitimacy in testifying to traumatic experiences (Fassin, 2005), a code of the shelter clinic is to refrain from asking too many questions to avoid re-traumatizing migrants. However, occasionally the privacy of the medical clinic elicits responses from asylum seekers to comment on their journey, setting a dismal threshold for treatment.

"It was good, nobody in our group was raped" (Second-hand account, Participants 3, 4, 2023).

Limitations to care are legitimized through the rationality that at least care at the shelter clinic is improved over previous treatment. Time constraints and a lack of sufficient resources for mental health, among other services insinuate the importance of holding off from delivering care. The exhaustion of volunteer service providers who work 40-to-60-hour weeks (Participants 1, 8, 2023) and volunteer at the asylum clinic during their free time further justifies the necessity of travel triage.

While asylum seekers are granted the opportunity to verbally testify to their suffering by indicating medical needs at the shelter clinic, testimonies are received by the discretionary gaze of service providers who grant or deny medical assistance through the adaptation of travel triage. Rather than expecting care unequivocally, only the most biolegitimate sufferers are cared for; those who confront the medical staff, answer 'yes' to a history of or current medical conditions, expend time to see the provider during their brief period at the clinic, and ultimately advocate for their own or their family member's health. In constructing and equivalently responding to the "morally legitimate sufferer" (Ticktin, 2011) service providers confront a discretionary kaleidoscope. While a triage form is utilized to gather intake information, the following process of including or excluding further care for asylum seekers with chronic conditions depends on the discretionary scope of the attending service providers.

Biolegitimacy

Biolegitimacy signifies appealing to the morals placed on one's claim to living (Fassin, 2009). Through travel triage, asylum seekers must identify and convey a matter of urgency to their chronic ailments to obtain care. Without fully knowing the morals applied to them (Ticktin, 2006) asylum seekers must cater to certain claims for a healthy livelihood. Meanwhile, service providers must respond to such appeals as salient enough relative to other asylum seekers requiring chronic disease treatment. Service providers in Southern New Mexico are thereby incited to draw from biolegitimacy to privilege the seriously ill over all other migrants (Fassin, 2012), thereby positioning travel triage as a necessary mechanism to deliver care.

Despite the U.S. spending 18.3% of its national gross domestic product (GDP) on healthcare in 2021 (Rama, 2023), New Mexico is the third most impoverished state in the country, with an average poverty rate of 18.2% in 2019, and a poverty rate of over 25% in the county where the asylum shelter stands (Moskowitz, 2021). While many residents in Southern New Mexico themselves have migrant backgrounds, given that up to a quarter of residents already experience poverty, supplies for permanent locals are prioritized.

“We are limited by the resources that are available to all our community... The system is broken for everybody right now; many people are having problems accessing care and getting things paid for” (Participant 1, 4, 2023).

The pressure to reserve scarce resources for ‘citizens’ before ‘others’ details an ethno-national sense of belonging and indicates it is unfair to expend resources for newcomers vis a vis an already needy population (Gottlieb, 2018). By legitimizing limitations to what services are available to asylum seekers based on resources being scarce for the local population, a hierarchy of deservingness is normalized; asylum seekers are deserving insofar as they do not threaten locals’ resources.

This is not simply a local phenomenon but occurs in migratory contexts around the world. For example, even while clinics strove to provide aid to migrants in Greece during high migration periods, they also instantiated rankings of people as deserving around a juncture of citizen versus non-citizen (Cabot, 2019). Senegalese migrants seeking asylum while occupying

positions as non-citizens in Mauritania were also displaced as less deserving relative to already permanent citizens (Broqua et al, 2021). By existing on the margins of an already taxed health care system, asylum seekers in Southern New Mexico are effectively restricted from appealing to claims based on their health status.

Triage is widely used in medical and migration settings and can be understood as a technology of governance which orders people into categories on account of urgency. Travel triage instrumentally demotes the urgency of caring for chronic conditions for asylum seekers who are perceived to occupy a less deserving subject position relative to ‘regular’ patients. Consequently, travel triage locates asylum seekers as “sub-citizens” disenfranchised from the same claims to health rights as regular citizens (Sparke, 2017). As service providers deploy standardized ‘old technologies’ of governance through triage practiced in regular clinics, they simultaneously utilize advanced forms of technology (Rose, 1999) to shuffle between moral economies which categorize subject positions of patients on a scale of deservingness. Innovative iterations in the Southern New Mexico asylum clinic appropriate travel triage specifically as a new technology of governance.

“In the asylum clinic, it’s robotic at times; you’re getting patients’ signs and symptoms, making a diagnosis, prescribing medications, and then at the end of the encounter there might be this exchange of humanity, like ‘good luck. I hope you make it to where you’re headed.’ And they’re very appreciative but there’s not really the establishment of a relationship” (Participants 3,7,8, 2023).

Providers register the risk of making mistakes when quickly treating patients. They admonish the challenge of establishing even a short-term trusting relationship under time constraints and language barriers as nuance can easily be lost in translation (Participants 2-4, 8 2023). Yet if a less than legitimate biological suffering is detected, care is retained and reserved for permanent locals. In situating the border as a misplaced setting for chronic disease management, under the auspice of travel triage, structural violence is enhanced through withholding, delaying, and minimizing treatment options for asylum seekers and designating resources foremost to locals.

A precarity continuum (Wiertz, 2021) is exposed through a finite supply of medications and providers, challenging health-seeking capacity for ‘regular’ citizens, alongside healthy and

ill asylum seekers. This continuum is navigated through travel triage, ordained as objective but ultimately discretionary. Care regimes based on biologically legitimate deservingness are produced by evaluating which asylum seekers will be seen, and for which health conditions. Travel triage leads service providers to ration care on a discretionary basis of deservingness.

Theme 3: Bridging the Gaps Amidst Fragmentation

The following chapter discusses how while formal referral pathways exist to facilitate further care for asylum seekers with chronic conditions, they incoherently materialize. This creates a fragmented system of access and delivery, compounded by conditions of austerity. As a result, service providers develop ad-hoc measures to bridge care.

Austerity

Funding for the asylum clinic is collected from charitable organizations, small federal grants, and donations (Participants 2, 9, 2023). However, spending flows to support asylum seekers are purposefully opaque to circumvent political polarization (Participant 3, 4, 2023). Despite an entrenched history of migration to the U.S., political posturing seeks to avoid seeming pro-immigration by advocating short-term responses. By producing an imaginary emergency at the border rather than an ongoing struggle, the response to migration is sustained as short-term (Ticktin, 2011).

To begin effectively engaging in thorough chronic disease treatment in the U.S., asylum seekers must be referred to a partner organization capable of providing support by ensuring transportation and manageable out-of-pocket payments for migrants to navigate care at their final destinations. Asylum seekers must reliably establish settlement with their sponsors and be in the small proportion of migrants whose claims are successful in court to obtain insurance coverage. In establishing responses to migration on the Mexico-U.S. border as temporary, asylum seekers'

precarity is reinscribed as they become implicated in a provisional system that anticipates expunging them.

“What to do with the folks that need long term assistance is the million-dollar question - all the shelters struggle with that” (Participants 6, 10, 2023).

An under resourced healthcare system across the country relies on service providers to subsidize vital unavailable services (Horton, 2006). This is further complicated when service providers are restrained by the effects of austerity. A political economy of austerity folds into redistribution challenges in the U.S. and augments health system fragmentation (Sparke, 2017). Fragmentation arises from this shuffling of resources and ultimately leads to a “cycling through” of rationalities (Rose, 1999; Mladovsky, 2020) to respond to priority setting. When emergency aid is prioritized over social justice programs (Fassin 2012) well-intending service providers are left cycling through a perpetual series of rationalities buffered by constraints of austerity.

While volunteer providers can write prescriptions to be delivered to a pharmacy at the migrants’ destination, transportation and expenses may prevent asylum seekers from ever obtaining their medications. Ensuring patients have continued renewals on a prescription is an even greater challenge as many migrants do not have an established provider available or affordable at their destination. Service providers can formally refer asylum seekers to a partner organization tasked with connecting migrants to healthcare available at their destination through such clinics as federally qualified health centers (FQHCs) (Participants 1-8, 2023) which are designed to cover populations ineligible for insurance, yet service providers rarely discover whether asylum seeker patients manage to obtain ongoing care.

“If a child needs to see a pediatrician within a week... I'll give them my phone number, but it's rare that I hear back on whether they're being supported... We can cover their chronic meds for 30 days, but they'll have issues seeing a provider after that because they won't have insurance” (Participant 3,8, 2023).

Exclusive health insurance plans insufficiently explain disproportionate morbidity (Castañeda, 2017). Rather, diverging insurance coverage may intentionally act to divide populations (Birn et al, 2019). Similarly, if short term aid is recognized to be insufficient and ultimately lead to gaps in care, it becomes not a matter of measuring what this is a policy failure

of, but what it means that a policy expected to fail persists. It is reductive to associate health system fragmentation as policy failure if it purposefully produces certain subject positions (Mladovsky, 2020). Rather, producing certain subject positions which exclude asylum seekers from care can be viewed as a spectacle of neoliberal governmentality.

“Sometimes they get upset by the answers we give them, but this is how it functions in this country and everything we do is to help them not get worse” (Participant 5, 2023).

In explaining how to access health services in the U.S., service providers exercise health literacy expectations as illustrated above. This operates as a form of social discipline (De Genova, 2016). Given resources are dictated by donor and state-sponsored funding streams, service providers engage as interlocutors for neoliberal governmentality by promoting cost-effective solutions. They also subtly detail neoliberal governmentality by extolling self-help technologies in the form of health education.

Ad-Hoc Efforts

Neoliberal governmentality situates responsibility on the asylum seeker to address health needs while omitting acknowledgement of barriers to care. Service providers do not intentionally promote neoliberal governmentality but rather rationalize health education for asylum seekers as valuable opportunities to mitigate the disadvantages of occupying a precarious status by preparing migrants as best as possible given poor prospects for adequate health insurance coverage in the U.S.

“You’re 20 years old and your blood pressure is too high. It can damage your kidneys and heart. The time to not be sick at 40 is to take care of this at 20. So, education, especially for people with chronic conditions...Now, can they retain that? Probably not. They’re so stressed their ability to take in new information is limited” (Participant 1-3, 2023).

Other improvised efforts to support asylum seekers include performing forensic medical examinations. These are conducted on an ad-hoc basis given provider training in this field and are used to corroborate an asylum seeker’s account of torture to facilitate claims to asylum

(Participant 1, 2023). Service providers seek to depoliticize sickness and suffering (Holmes, 2013) in attempts to disassociate their work from the political. Yet such procedures as forensic examinations situate the body specifically as a site for political claims (Castañeda, 2023). This exerts a film of biolegitimacy by grounding the asylum seeker's testimony to a moral claim of suffering evidenced through physical marks of torture.

Service providers weather the political bureaucratization of providing care to precarious populations (Martinez et al, 2022; Beerli, 2018) by creating informal 'no ask no tell' policies when treating precarious status asylum patients. While service providers do not envisage themselves performing political acts, they actively provide care without questioning legal status (Participants 1-8, 2023), making their actions inherently political. By collectively disregarding citizenship status, service providers in Southern New Mexico grapple to balance healthcare for asylum seekers within a setting of austerity. With the ending of Title 42, New Mexico revoked malpractice insurance coverage for providers which reduced the number of volunteer physicians qualified to work unless they pay out of pocket for insurance or work without it and risk liability (Participants 6, 7, 2023).

"Asylum seekers' desperation does not necessarily translate into priorities for the people we work with or the people we partner with" (Participant 9, 2023).

In "managing failure" (Mladovsky, 2023) from a fragmented system of health provision, service providers encounter and disseminate complex rationalities on a daily basis, operating in informal ways when resources are siphoned off. This leads to service providers opening the door or restricting access in settings of resource constraint for certain people not on a basis of rights but of deservingness. Consequently, the subject position of hero (Holmes et al, 2016) is not only reserved for the American service provider, but reinforced the more subject positions manage to 'other' asylum seekers as in need and deserving, or undeserving, of care. Spillover effects of delivering care on determinations of the deserving asylum seeker, where families and children are prioritized (Lopez et al, 2022) and men face downward mobility as migrants (Castañeda, 2023) effectively reduces the level of care to a relational-basis rather than a rights-basis. In distinguishing between who is referred for further medical care or who is fortunate enough to have a provider go out of their way to follow up to bridge care, the dismissed categories of people are subtly identified as less deserving.

Discussion

Global Theme: Good Enough Care

Many migrants who come through the Southern New Mexico asylum shelter and other shelters along the border will ultimately be unsuccessful with their asylum claims and will either eventually be deported or forced to identify as undocumented if they remain in the U.S. (Participants 2, 6, 2023). As service providers grapple with a reality that situates robust chronic disease treatment out of reach for asylum seekers, the findings of this research illustrate they draw upon rationalities which evoke applications of deservingness to inform care. Applications of deservingness endorse evaluations of care as good enough. Good enough care serves as a global theme which connects the findings of this research.

This research utilizes a post-structural lens to analyze how service providers inform care for asylum seekers with chronic conditions on the ground. Theories of governmentality and biolegitimacy illuminate how humanitarianizing care, implementing travel triage, and enacting ad-hoc efforts productively shape rationalities. Governmentality functions to emphasize humanitarian rhetoric focused on caring for migrants' lives out of service provider compassion results in certain asylum seekers' health conditions being addressed discretionarily at the expense of letting others go unmanaged. Travel triage functions as a form of governmentality to optimally subjectify migrant patients seeking medical attention to make biolegitimate claims on their suffering in exchange for care. While a valiant response to fragmentation from conditions of austerity, ad-hoc efforts implemented by service providers can be viewed as grounded in concepts of neoliberal governmentality and biolegitimacy.

A post-structural interpretation highlights how rather than perceiving uncompromised rights, service providers defer to compassion and discretion to determine whether asylum seeking patients with chronic conditions require care. This normalizes the humanitarianization of care, the mechanism of travel triage and ad-hoc efforts amidst fragmentation. While qualities of compassion and discretion may be inherent to service providers' roles as healthcare or

managerial professionals, they justify applications of deservingness. Deservingness is formed around emotionally laden, normative rationalities based on certain conditions in relation to the experiences of those determining whether someone is deserving, while rights-claims to health are tethered to universal and empirical boundaries (Willen et al, 2016).

Health as a rights-based framework regards access to healthcare as informed by entitlement (Willen, 2012). Health as a right emerges from a prerogative of equity in how care is dispensed and implies asylum seekers may expect rather than aspire to access healthcare. When healthcare provision is not guaranteed at the same level through a rights-outlook but subject to measurements of deservingness, care as good enough becomes validated. Good enough care perpetuates structural violence by undermining standards of care and reproducing inequitable health outcomes for migrants. Good enough care hinders the capacity to fulfill global health objectives of health as a fundamental human right because it removes the expectation of asylum seekers' entitlement to care, replacing it with a conditional provision of care based on deservingness.

Limitations and Future Research

This paper does not evaluate whether migrants are taught to internalize complicity in applications of deservingness. If asylum seekers encounter perceptions by service providers that they are undeserving and are subsequently disincentivized from interacting with the healthcare system at future points (Holmes et al, 2021) this sentiment may be ineffectually elaborated by only collecting service provider input. Capturing service provider rather than service users' perspectives risks overstating articulations from non-migrant citizens (DeGenova, 2016). In addition, it is important to recognize from a postcolonial standpoint how certain privilege is deployed in prioritizing service provider opinions, which may originate from the global North while sidelining asylum seekers' own assessments of attending to chronic conditions. Consequently, further research would benefit from examining internalized feelings of entitlement and deservingness on behalf of asylum-seeking migrants themselves (Viladrich, 2019; Willen et al, 2016). Exploring the experience of asylum seekers accessing services for chronic conditions once settled would enable a better evaluation of long-term care.

Migrants' vulnerability can be gauged based on factors including gender and sexual identity (Willen et al, 2016), rape cases and violence towards young migrants, as well as transnational parenting impacts on children (Castañeda, 2023). These critical points elevate chronic health conditions, and call for a gendered analysis which was beyond the scope of this research. While this paper purposefully delineated chronic disease from communicable disease, the prevalence of comorbidities warrants further exploration in migrants' ability to access services. Furthermore, with mental health services expanding worldwide (Mills, 2018) it could be fruitful to evaluate distinctions between specific diseases rather than chronic diseases collectively.

Care delivery for migrants is differentiated across the border. In conducting interviews from one organization in one U.S. border town, generalizations regarding these findings are limited to a narrow collection of service provider perceptions and may be unrepresentative of views from different locations along the border, across the U.S., or globally. This research revealed how ongoing demands have led to border town church organizations officially forming as NGOs to supply services to asylum seekers on a regular basis. Given the history of church-based organizations supporting migrants on the border, including the case study evaluated, this research fell short of analyzing religious genealogy and its influence on service providers. Similarly, service providers indicated communal and pseudo-familial ties which prompted their involvement at the asylum shelter (Participants 5, 8, 10). If black and brown bodies are looked upon differently in healthcare (Blair et al, 2013) and race continues to be shaped by relatability in the U.S., then future efforts are warranted to explore whether shared identities between co-ethnic service providers and localized differential racialization affect applications of deservingness (Lo et al, 2021).

Policy Recommendations

Both structural and post-structural policy reform should be promoted to ensure health as a right for migrants. Even if migrants are categorized as biolegitimate sufferers deserving of chronic care treatment, structural barriers including time, funding, human capital, and local demands constrain service providers' ability to deliver care. As a result of austerity and

fragmentation in delivering care, service providers require support to perform their work beyond good enough.

Structural interventions include improving funding and increasing human capital. Additional structural strategies include enhancing social support services amidst cost reductions (Bourgois et al, 2017; Harvey et al, 2022) and expanding follow-up services for health information sharing to expedite treatment for asylum seekers. It is critical such follow-up protocols do not act as surveillance and drive asylum seekers further underground for fear of being identified on medical records. While efforts to improve healthcare services for migrants on legislative levels are unfolding (Mathews et al, 2015; Bauder, 2016), immigration lawyers and political advocates are ultimately necessary as asylum seekers depend on legal status to access public benefits and healthcare insurance. Service providers can wield influence to advocate for legal representation so migrants can access services without fear of deportation.

Institutional norms impact provider perceptions of migrants (Rousseau et al, 2017) and if service providers recognize how hierarchies of deservingness are normalized, acting to disguise discrimination, then they will be better enabled to combat differential quality of care. Incorporating social medicine training to support initiatives which ensure health rights to migrants is encouraging (Holmes et al, 2021), but the responsibility does not land solely on service providers. Multiple actors adhere to intersecting logics of healthcare provision, and appropriate access to care in varying capacity to address variegated health needs on the border (Wiertz, 2021). While networks are paramount to effecting change, they are burdened by intrinsic power asymmetries limiting the impact of initiatives (Shiffman et al, 2016). Stakeholders from multiple fields involved in constructing care regimes must collaborate to mitigate discrepancies between policy and practice to reduce inequalities for asylum seekers.

Through interrogating good enough care, service provider rationalities in daily endeavors are suggested to be inherently incomplete. Rather than focusing on this inherent incompleteness, social science research stands to gain from advancing change at the institutional level to deconstruct deservingness when informing chronic condition coverage for asylum seekers. It is therefore critical to expand conversations in bureaucratic circles and institutions regarding how power relations produce moral economies which impact how health care delivery, clinical

perceptions and treatment models come to be valued. Such discussions can be used to interrogate why the concept of health as a right for asylum seekers is not realized.

Conclusion

By exploring at the granular level how service providers in Southern New Mexico inform care for asylum seekers with chronic conditions, this paper closes gaps in the literature on healthcare access and delivery for migrant populations with chronic illnesses. Through evaluating whether deservingness impacts on how service providers deliver care, insight regarding healthcare as a conditional result of provider-assessed need versus healthcare as a right is expanded.

This study reveals asylum seekers' access to care for chronic conditions is complicated by service providers' overlapping rationalities. Service providers grapple with attributing conceptualizations of moral economies and entitlement to migrant populations (Sargent, 2012). Between humanitarianizing care, implementing travel triage as a mechanism to deliver care, and striving to bridge gaps to care amidst fragmentation, service providers in Southern New Mexico inform care for asylum seekers with chronic conditions in myriad ways.

The findings of this research indicate firstly, informing care through humanitarian channels victimizes asylum seekers, restricting access to care by demanding migrants make morally legitimate claims to their suffering in exchange for medical support. Secondly, service providers inform care through the mechanism of travel triage which confers discretion to grant or deny care, impeding treatment for chronic illness from being an entitlement to being based on biolegitimate deservingness. Thirdly, circumstances of austerity create fragmented infrastructure which challenges service providers to inform care by enacting ad-hoc efforts, doing the best they can with available resources to bridge gaps to care.

It is clear these findings are bound by moral economies implicitly engulfed in care regimes on the Mexico-U.S. border as applications of deservingness serve to justify good enough care. In a landscape of humanitarianized care, travel triage, and fragmentation, service providers are encouraged to utilize rather than interrogate deservingness in everyday interactions. The most

salient testimony of suffering in relation to service providers' compass of deservingness warrants care, rather than an equitable distribution of care.

This presents resounding implications for service provider interventions in migration contexts worldwide. In development discourses, global health targets seek to ensure health as a fundamental right for every human (Meier, 2017). From New Mexico's borderlands to international settings, when applications of deservingness inform service providers' provision of care, health as a right is moderated. As migration continues, greater numbers of asylum seekers will require chronic disease management. To equitably fulfill these health needs, chronic care provision must be conceptualized as a right, from the level of broad institutional and legal policies to everyday interactions between service providers and asylum seekers living with chronic illnesses. Interrogating applications of deservingness which inform how chronic disease is tended and conceptualizing health as a right on the granular level is a step in the direction to more equitably ensure care for asylum seekers with chronic conditions.

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Appendices

Appendix I

Participant Information Sheet and Consent Form

Dear Interview Participant,

Thank you for your interest in this project about migrants' access to healthcare services on the U.S.-Mexico border. In this email, I give you information about the project and ask for your consent to participate. If you agree, please reply to this email, stating your name and that you agree to the statements in the table below to give your consent.

What is the study about?

More migrants travel to the U.S. than anywhere else worldwide. Yet legislation and policies often impact healthcare trajectories for migrants. While much literature has diverted attention to policy-level impacts on migrant health, especially in reference to frames of securitization focused on infectious disease control, this project proposes to address gaps of how informal everyday care politics are resisted and reinforced for migrants accessing care for chronic conditions by relevant stakeholders. This project aims to explore how care politics may influence migrant access to care for chronic conditions. In sum, I am interested in understanding the

barriers and conduits migrant populations in the U.S. face in accessing healthcare for chronic conditions.

What will my involvement be?

Your participation will be as a stakeholder. If you choose to participate and provide written consent, I will schedule interviews with you (anticipated to last from 30 to 60 minutes) to be conducted remotely at a convenient time from now through June. I will use a rough interview guide consisting of about 10 questions to structure our conversation, but we will have plenty of time to address any other topics that arise.

Do I have to take part?

Participation is **voluntary**. There are no negative consequences for you if you decide not to take part in this study. If you decide to take part but then later on you change your mind, you can let me know by June 30th, 2023 (you will not have to give any explanation why). It is also absolutely fine if you feel that you don't want to answer any specific questions – you can just tell me, and we will move on.

What will my information be used for?

Masters dissertation and possible future research or publication.

Will my information be anonymous?

Your participation will be anonymous - your name will not be used in any reports or publications resulting from the study. Furthermore, the interviews will be audio recorded and transcribed but kept on separate secure encrypted platforms.

If you agree to take part in the research, please complete the section below

Your name: (type first name and last name here)

Please read these three statements. If you agree with them, put a X in the boxes below	
I have read this message and had the opportunity to ask questions.	
I agree to participate in the interview.	
I understand that my responses will be kept confidential and anonymous and that my personal information will be kept securely and destroyed at the end of the study.	

Once completed please email this back to me. Thank you!

Researcher name: [REDACTED]

Email address: [REDACTED]

The LSE Research Privacy Policy can be found here:
<https://info.lse.ac.uk/staff/divisions/Secretarys-Division/Assets/Documents/Information-Records-Management/Privacy-Notice-for-Research-v1.2.pdf>

Appendix II

Master Information Topic Guide (follow up questions are indented below standard questions)

1. Please describe your organization's role in working with migrants accessing healthcare services. What are your values and mission, beyond what is publicly available?
2. How long have you been in this role and what motivates you to work in this field?
 - 2.a. Can you please describe your role more specifically? (I.e., what is your day to day like?)
3. In your experience, do migrants have needs for chronic conditions? And if so, what are these needs?
 - 3.a. Have you observed greater demand for certain chronic conditions over others?
4. Can you explain to me, in cases where migrants have needs for chronic care what happens, what is the process like as far as diagnosis, treatment, and follow up?
 - 4.a. What is the referral process like for migrants seeking access to healthcare for chronic conditions?
5. What questions do you typically ask migrants when they are seeking access to healthcare services?
6. What criteria do you look/are there any particular processes for certain groups of people for determining what care to provide and to who and when?
 - 6.a. How is this implemented? How much latitude do you have to decide needs on a case-by-case basis?
7. What, if anything, impacts migrants' ability to access services?
 - 7.a. Do you think there are barriers to providing and/or accessing healthcare services for migrants with chronic conditions?

7.b. What resources impact this and what would enhance provision and access to services for migrants?

8. What is most challenging about your work?

8.b What facilitates your ability to provide services?

9. Have you/your organization undergone training in providing healthcare services or connecting migrant groups to healthcare services?

10. Is there anything I haven't asked that you think is important to let me know?

10.a Are there any contacts you would be willing to put me in touch with you think might be interested in participating in an interview?

Appendix III

Participant List	Title
1	Medical Doctor (Volunteer)
2	Medical Coordinator (Staff)
3	Physician's Assistant (Volunteer)
4	Occupational Therapist (Volunteer)
5	Medical Assistant (Staff)
6	Operations Manager (Staff)
7	Medical Doctor (Volunteer)
8	Medical Doctor (Volunteer)
9	Education Director (Staff)
10	Volunteer Coordinator (Staff)