

## The Body at the Borderlands: Applying a Feminist-of-Colour Disability Studies Lens to the USA-Mexico Refugee Crisis

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### ABSTRACT

From the complications associated with the USA Migrant Protection Protocols to recent reports that United States immigration detention centres are operating at almost quadruple their capacity, news clip after news clip features another story of bodies being violated at the US border. Under United States law, any noncitizen can apply for protection, but recent processing policies at the border complicated the immigration process, especially for migrants with disabilities. With these narratives of displacement in mind, this article begins by examining disability and displacement in terms of both voluntary (migrant workers) and involuntary (refugees) migration at the United States-Mexico border. This article presents an archive of forced displacement under the 'Remain in Mexico' policy with heightened consequences for migrants with disabilities and chronic health conditions. In the analysis of migration legislation, the methodology associated with anti-oppressive practice is used, which assumes that reducing social and structural disparities depends upon disentangling the complex intersections of power, geographical location, and social difference. By combining this methodology with a feminist-of-colour disability studies theoretical framework, which emphasises the institutional and cultural relations that doubly disadvantage certain bodies, the article will trouble distinctions between 'health' and 'disability' in order to reimagine the place of diagnosis for asylum seekers with disabilities.

**Keywords:** Mexico, United States, refugee, disability, feminist-of-colour

### INTRODUCTION

Roughly ten years ago, the United Nations Convention on the Rights of Persons with Disabilities sparked increasing awareness of the issues that migrants with disabilities face at the border, and, in July 2011, the UNHCR responded with specific policy guidance on the matter.<sup>1</sup> Understanding protocols for the identification of disability as foundational for securing access to disability-related services at refugee camps, the UNHCR updated and revised its *Resettlement Handbook* and *Resettlement Assessment Tool* to reflect new insights on the social and environmental factors that shape a person's experience with disability in border zones (Smith-Khan and Crock, 2015: 41). In 2015, Laura Smith-Khan and her colleagues explored the use of these policy developments and mechanisms for identifying those with disabilities at different refugee camps in Indonesia, Malaysia, Uganda, and Pakistan (Smith-Khan and Crock, 2015: 41). Alongside recent developments, her research suggests a need to consider the particular situations of migrants with disabilities at the United States-Mexico border. From the complications associated with the Migrant Protection Protocols to recent reports that United States immigration detention centres are operating at almost quadruple their capacity, news clip after news clip features another story of bodies being violated at the border. Headlines from the past two years alone report instances of asylum seekers struggling to access basic healthcare services, of tear gas being used on migrants, of migrant caravans staging hunger strikes as a means of protest and, more recently, of migrant children being deported during the coronavirus pandemic. Under United

<sup>1</sup> The United Nations Convention on the Rights of Persons with Disabilities took place in Brussels on January 22, 2011. The goal of the meeting was to establish an international minimum standard for the treatment of people with disabilities. Recognising the disproportionate risks and barriers that people with disabilities face, delegates identified strategies for reducing discrimination and expanding opportunities. Only a few months later, the UNHCR revised its *Resettlement Handbook* to acknowledge the specific resettlement needs of refugees with disabilities, citing the 2011 UN Convention as a basis for these changes.

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States law, any noncitizen can apply for protection, but recent processing policies at the border have complicated the immigration process, especially for migrants with disabilities.

With these narratives of displacement in mind, this article begins by examining disability and displacement in terms of both voluntary (migrant workers) and involuntary (refugees) migration at the United States-Mexico border, presenting an archive of forced displacement under the ‘Remain in Mexico’ policy, which suggests heightened consequences for migrants with disabilities and chronic health conditions. It will pay particular attention to contemporary critiques of accessible citizenship and the Humanitarian Asylum Review Process, which resulted in migrants with disabilities or medical conditions being held in deplorable and inaccessible conditions for several months. Next, the article will shift to an analysis of the particular obstacles and risks that asylum seekers with disabilities face there. As these policies are analysed, the methodology chosen is associated with anti-oppressive practice—which assumes that reducing social and structural disparities depends upon disentangling the complex intersections of power, geographical location, and social difference—to understand the specific experiences of a certain population: migrants with disabilities (Burke and Harrison, 2002: 132). Anti-oppressive practice focuses ‘on both process and outcome... [to find ways of] structuring relationships between individuals, [so as to] empower users by reducing the negative effects of social hierarchies’ (Burke and Harrison, 2002: 132). As a method, anti-oppressive practice presupposes that assessing a situation and determining the nature of possible interventions can only happen once we identify the unique needs of populations that are differently disadvantaged by overlapping power relations. By combining this methodology with a feminist-of-colour disability studies theoretical framework, which emphasises the institutional and cultural relations that doubly disadvantage certain bodies, this will trouble distinctions between ‘health’ and ‘disability’ in order to reimagine the place of diagnosis for asylum seekers with disabilities. Because migrants are often homogenised in both scholarship and immigration policy, the article will also point to a need for disability-centric, radical care initiatives outside of the state in an effort to increase the circulation of needed resources for this vulnerable population.

## PART I: SCHOLARLY SILENCES

Few scholarly studies of migration and displacement attend to disability, even though the United Nations Commission on Human Rights and United Nations Convention on the Rights of Persons with Disabilities highlighted the precarious position of migrants with disabilities over a decade ago. In her Introduction to *Libre Acceso*, one of the earliest surveys of the topic, Beth E. Jörgensen explains that the 2013 bibliography of the Modern Language Association listed 579 publications under ‘disability studies,’ but only ‘roughly a dozen [of these] were immediately identifiable as pertaining to Latin American topics’ (Jörgensen, 2016: 7). Although the struggles that disabled migrants experience has been the focus of countless news reports and of field research conducted by non-profit organisations, disability studies remains remarkably Western-centric, even within the highly interdisciplinary subfield known as feminist disability studies. Scholars often extend a similar criticism to migration studies in terms of its treatment of disability. In ‘Disability and Forced Migration,’ Maria Pisani and Shaun Grech note that migrants are often treated ‘with little or no alertness to context, culture, religion, gender, but especially dis/ability’ (Pisani and Grech, 2015: 422). It is well known that refugees and asylum seekers face tremendous risks, but what additional dangers do migrants with disabilities face? As Pisani and Grech acknowledge, ‘migration theory grows without the disabled person, disability studies without the migrant, and practice without the disabled migrant’ (Pisani and Grech, 2015: 421). This article will engage a feminist-of-colour disability studies framework to address the increased hardships that migrants with disabilities face; in turn, it shifts dominant paradigms in disability studies that affirm sharp distinctions between health and disability to reveal ways in which attending to both health and disability can improve the circumstances that migrants with disabilities face at the border.

Scholarship at the intersection of disability studies and immigration studies highlights the long and enduring history of discriminatory immigrant selection processes across geographical contexts. Most of these policies determine entry on the basis of specific criteria that uniquely disadvantage immigrants with disabilities or chronic health conditions. In ‘Immigration and Disability,’ for example, Yahya El-Lahib and Samantha Wehbi criticise immigration selection policies in Canada, which label people as ‘preferred’ or ‘non-preferred’ on the basis of a multi-part merit point system. All too often, immigrants cannot enter Canada because they fail to meet rigid selection criteria, which privileges the able-bodied and those with access to work or education (El-Lahib and Wehbi, 2011: 102). These structural components of the immigration selection process, which especially marginalise people with disabilities, have important implications for countries other than Canada, including the United States, where similar biases shape the migration experience. Recent scholarship by Douglas Baynton and Jay Dolmage traces immigrant selection and restriction in the United States and Europe back to the late nineteenth and early twentieth centuries. As Baynton notes, ‘the concept of “selection,” adapted from animal breeding and evolutionary science, was central to the eugenics project overall as well as specifically to immigration restriction’ (Baynton, 2016: 6). Individuals who were seen as ‘defective’ or less desirable were often denied entry at the port. During this period,

forms of difference that we would not recognise as types of disability today, including poverty and ‘deviant’ sexuality, were often framed as forms of mental defect and used as grounds to exclude certain individuals from entering. These labels, as Jay Dolmage points out, shaped early American immigration policy in accordance with eugenic sentiments that persist today, which continue to have tangible effects for immigrants with disabilities seeking entry into the United States (Dolmage, 2018).

With the focus of this article in mind, it is worth noting that scholars working at this same intersection continue to debate the role of diagnosis within the immigration process. On one hand, as Karen Soldatic and L. Fiske establish in their study on the disproportional detainment of people with disabilities in Australian detention centres, health screenings and diagnosis can unfairly criminalise and justify the incarceration of immigrants with disabilities (Soldatic and Fisk, 2009: 14). On the other hand, as Sultan and O’Sullivan (2001) argue, reports of unfair diagnosis and misuses of medical discourse can actually function as an important step toward abolishing the detention system altogether (Sultan and O’Sullivan, 2001: 593-596). This article will apply a feminist-of-colour disability studies framework to reveal a third understanding of medical discourse and diagnosis: that diagnosis can facilitate access to needed resources within the detention system and can therefore play an important role in helping immigrants with disabilities manage some of the exceptional hardships that they experience at the US-Mexico border.

Without accepting the many flaws of the medical model of disability, it is important to acknowledge that diagnosis often secures access to standardised resources for migrants with disabilities. Feminist-of-colour disability studies shares with feminist disability studies a strained relationship with the traditional social model of disability, as both critical approaches emphasise instead the instability of the classic distinction between medicine and society when race and ethnicity are taken into account. The social model of disability remains widely embraced as an alternative to the medical model of disability. Above all else, the social model of disability assumes that the ability to make choices about and shape the direction of one’s life directly results from improving access to and eliminating the social barriers that prevent those with disabilities from fully engaging with society, rather than from making changes to the body through medical interventions. Under the social model, for example, using a wheelchair does not make someone disabled—rather, entering a space without a ramp does. In contrast, the medical model of disability frames disability as impairment—as a defect or lack that requires treatment or care. Feminist critics of the social model tend to centralise the lived experience of disability, but they insist that the instinct to separate disability entirely from a medical context may not always be desirable. The slipperiness of both the medical and social models of disability therefore becomes especially apparent within the context of migration since migrants with disabilities may not always be diagnosed before they seek entry into the United States, and most migrants with disabilities cannot access quality medical care. In this sense, distance from the label of ‘disability’ ‘is due less to viewing disability as a source of pride, or as a fluid state, and more to disparities...because of inequalities based on class, [ethnicity], language, and geographical barriers’ (Ben-Moshe and Magana, 2014: 106).

For this reason, this article will combine anti-oppressive practice methods with a feminist-of-colour disability studies perspective when synthesising and analysing policies and reports about the treatment of migrants with disabilities at the United States-Mexico border. These frameworks attend to the lived experience of disability and to the political weight of reproducing inequality at the various intersections of human identity. Feminist-of-colour disability studies ‘pays attention to the linkages between the ideologies of ability and the logics of gender and sexual regulation that undergird racialized resource deprivation’ (Schalk and Kim, 2020: 38). Sami Schalk and Jina B. Kim, who named the subfield in 2020, attributed the Western focus within disability studies to the fact that ‘feminist-of-color approaches to disability, illness, and health do not always align with the language, approaches, and perspectives within mainstream disability studies and disability rights activism’ (Schalk and Kim, 2020: 32). Feminist-of-colour disability studies instead attends to the rhetorics of (dis)ability, activism, state violence, and health/care. State-sanctioned laws such as the Migrant Protection Protocols and the Humanitarian Asylum Review Process frame the nation-state as a place of security, but they often fail to defend the most vulnerable populations, including documented and undocumented migrants with disabilities. Both a feminist-of-colour disability studies framework and anti-oppressive practices centralise these forms of exclusion, but they also highlight what Rob Nixon calls ‘slow violence,’ that is less visible forms of violence that often build gradually, including neglect and citizenship-based obstacles to accessing medical care (Nixon, 2013).

## **PART II: AN ARCHIVE OF FORCED DISPLACEMENT**

Per United Nations estimates for 2020, there were over 232 million migrants globally. Of these, 70.8 million were forcibly displaced, 19.5 million are refugees, and 1.8 million are asylum seekers (Bešić and Hochgatterer, 2020: 1). Disability is widely regarded as one of the world’s largest minority groups, with the World Health Organization maintaining that approximately 15% of people have a disability. While firm statistics on the number of migrants with disabilities are difficult to locate, the United Nations High Commissioner for Refugees (UNHCR) ‘Global Trends’ report indicates that over 10 million migrants have a disability (‘Global Trends’, 2021). Countries in the

Global South with the highest numbers of displaced individuals are also those that have significant percentages of people with disabilities (Pisani and Grech, 2017: 421). According to the UNHCR, 'refugees with disabilities are more likely to be sidelined in every aspect of humanitarian assistance due to physical, environmental and societal barriers against accessing information, health and rehabilitation services and human rights protection' ('Refugees and Migrants,' n.d.). Most disabled forced migrants are fleeing extreme poverty, wars, or environmental disasters. In this context, it is important to note that migrants with disabilities face an increased risk of violence and discrimination, but also that forced displacement may actually produce disability. For example, a 2020 Mexican Coalition for the Rights of Persons with Disabilities (COAMEX) report based on the migration route from Mexico to the United States listed several high-risk situations that commonly cause disability, such as escaping a moving train in order to avoid arrest or speed up the journey, involvement in a collision or accident, or finding oneself the victim of violence ('Migration and Disability,' n.d.). Migrants pursuing employment opportunities across the border regularly encounter dangerous situations and have a higher risk of on-the-job injury, even though most of these workers do not have access to health care or disability insurance. As a result of these traumatic experiences, many migrants may develop anxiety, panic, or stress disorders, which can later give rise to a psychosocial disability or mental health conditions.

It is also important to note that migrants with disabilities from Central America are already fleeing dire conditions when they make their way to the border. In 2017, the United Nations Committee on the Rights of Persons with Disabilities reported that Hondurans with disabilities are often victims of gang-related violence and extortion, especially in the indigenous and rural communities wherein a large percentage of those with disabilities reside. Hondurans with disabilities may also experience forced hospitalisation ('Committee on the Rights,' 2017). The conditions for migrants with disabilities from Guatemala are no better, with the Committee indicating that psychiatric hospitals lacked necessary resources and that women with disabilities, in particular, suffered from heightened violence in the form of forced sterilisation ('Committee on the Rights,' 2017). In El Salvador, disability is largely understood as a human right, and the government passed legislation prohibiting disability-related discrimination in education, employment, and health care back in 2001, but it has struggled to enforce these policies (Hotra, 2008). In Central America as a whole, awareness of disability and equal access to opportunities for those with disabilities remains low, and those with disabilities frequently struggle to access basic resources.

It is no secret that migrants with disabilities have long been abused at the USA Southwest Border, but asylum seekers faced heightened precarity in January 2019 and in the two years leading up to the February 2021 announcement of the plan to phase out the Migrant Protection Protocols. Under Section 235 of the Immigration and Nationality Act, the United States government implemented the 'Remain in Mexico' policy on January 25, 2019. The policy drove over 71,000 migrants who were held at the United States-Mexico border back into Mexico, and because only 15 to 30 new applications were considered per day, most refugees waited for several months for their claims to be processed. 41,247 of these 71,000 cases were rejected during this waiting period (Hotra, 2008). Waiting in Mexico is highly dangerous because Mexican law enforcement is intertwined with organised crime. Journalist Lorelei Laird notes that those who were turned away at the border faced 'rampant crime in northern Mexico... [and were vulnerable] to the organized criminals they left their homes to escape' (Laird, 2019). Individuals with disabilities were especially susceptible to criminal violence. Official data on the extent of violence against migrants with disabilities is difficult to find, but we do know that these types of crimes are underreported. According to the United Nations, 'for many migrants, enduring violence may be the better choice than seeking protection from it, where doing so exposes them to risks of retaliation' ('Combating Violence'). At the time the policy was filed, the Department of Homeland Security stipulated that migrants with special circumstances, including "known physical or mental health issues," could not be returned to Mexico ('Disability Rights Advocates,' 2020). However, Human Rights Watch researchers in the border city of Ciudad Juárez discovered that the Mexican government had no 'proper system in place...to screen and identify asylum seekers with disabilities and chronic health conditions,' so hundreds, even thousands of migrants with disabilities were forced to wait in Mexico, despite the fact that they should have been exempt from the process under the aforementioned provision ('Mexico: Risks at Border,' 2019). While these announcements mark the height of immigrant restriction in America, anti-immigrant rhetoric began in 2017, when, as Jay Dolmage points out, US President Donald Trump's order to build a wall and ban immigrants from Muslim countries had 'very powerful rhetorical effectiveness' (Dolmage, 2018: 3). Dolmage argues that even though these orders were reshaped, the US government's anti-immigrant rhetoric sparked forms of stigmatisation that recalled the eugenics movement of the early 1920s.

Combined with the USA Migrant Protection Protocols, the Trump Administration's 'Public Charge' rule further discriminated against migrants with disabilities until President Joseph R. Biden revoked it under the same February 2021 Executive Order. Authorised on August 12, 2019, the rule considered health and disability as factors in green card and visa application decisions. Many people with disabilities or chronic health conditions were deliberately denied admission to the United States because they might one day use public benefits, such as Medicaid or government housing assistance. Hoping to delay the law from taking effect, several states and advocacy groups

filed cases against ‘public charge,’ arguing that it violated federal disability law. While not all of these cases were successful, a federal district court in New York City prevented the rule from being applied during the COVID-19 pandemic. With that said, the rule caused disproportionate harm to people with disabilities and chronic health conditions, along with their families. According to the Center for Public Representation, the rule may have discouraged people from entering the United States, but it also likely dissuaded ‘eligible families from using critical public services for fear of harming their immigration status’ (‘Public Charge’, 2021). For Dolmage, the rhetoric of such a policy alone establishes its harm: ‘When Donald Trump argues that Mexican or Muslim immigrants are violent or criminal, or that countries send their “worst” people as immigrants or refugees, he’s not saying anything new. For over a hundred years...these claims have been made to stoke anti-immigrant sentiment’ regardless of any legislation surrounding these claims (Dolmage, 2018: 3). As Biden dismantles the legacy of Trump’s (racist) immigration policies, disability rights advocates are coordinating large-scale efforts to serve those who were denied protections under these laws, while also challenging the dangerous rhetoric that continues to exist amongst refugee encampments and impact upon lived conditions there.

In this legal context, it is not surprising that migrants with disabilities were rarely granted accommodations and faced obstacles securing access to basic food and health care at border zone holding facilities. While many shelters are privately managed, even the state-run Leona Vicario National Integration Center, which attributed at least one health problem to 86% of the up to 3,000 migrants at the shelter, reportedly has no accessible restrooms (‘Mexico: Risks at Border,’ 2019). Human Rights Watch researchers interviewed several migrants at these shelters in August and September of 2019. One migrant from Honduras reported that she was not given any medication for her high blood pressure, and another migrant from Uganda claimed that his shelter was unable to accommodate the fat-free diet that he needed due to an ulcer. As Mansha Mirza notes, ‘food distribution in camp settings is characterized by long queues and jostling crowds...There is little evidence of disabled people being prioritized during food distribution or being given special food rations when needed’ (Mirza, 2014: 422). Migrants with disabilities who secured food that fit within their dietary requirements or other needed services often paid out of pocket for these expenses because they were not made aware of the government’s state health insurance program. To further confound these issues, Mirza points out that displacement camps actively excluded those with disabilities from ‘livelihood opportunities.’ ‘For camp-dwelling refugees,’ she says, ‘few opportunities exist to live and work outside camps. Such opportunities, where they exist, favor young, educated, and able-bodied males while disadvantaging women, elderly people, and people with disabilities’ (Mirza, 2014: 423). Literacy, education, and skills training courses at displacement camps rarely accommodate the learning needs of migrants with disabilities, and these individuals are therefore effectively barred from gaining certain livelihood opportunities.

Under the Prompt Asylum Claim Review (PACR) policy and Humanitarian Asylum Review Process (HARP), individuals who were not subject to the Migrant Protection Protocols faced prison-like conditions and the prospect of ‘expedited removal’ at the border.<sup>2</sup> Before October 2019, migrants who expressed concern over returning to their home country were granted an interview with an US government Asylum Officer regarding their case, and these individuals were sent to a U.S. Immigration and Customs Enforcement (ICE) detention centre until the interview date. The individuals were also given time to contact an attorney and collect evidence in advance of the interview. However, after the United States government instituted the PACR and HARP programs, these individuals were locked in short-term detention facilities managed by the government immigration service Customs and Border Protection with ‘only 30 minutes to an hour to contact a lawyer or family members before the credible fear interview’ (‘Policies Affecting Asylum Seekers,’ 2020). After this brief period had expired, they were permitted to make additional phone calls. Migrants seeking protection and awaiting an interview with an Asylum Officer therefore had limited time to build a case for themselves before their situation was decided. Besides these difficulties, the PACR and HARP programs arguably forced individuals to endure dangerous living conditions until their hearings. According to a fact sheet prepared by the American Immigration Council,<sup>3</sup>

... although CBP is not supposed to hold anyone in custody for more than 72 hours, individuals put through the PACR and HARP programs are often held for a week or longer. During this time, individuals may be forced to sleep on the floor for days at a time in freezing cells with limited access to hygiene and inadequate food and water’ (‘Policies Affecting Asylum Seekers,’ 2020: 8).

<sup>2</sup> Jointly piloted in October 2019, the PACR (for non-Mexican nationals) and HARP (for Mexican nationals) policies essentially expedited the asylum process, reducing the review process from months or even years to under 10 days. Critics of the programs pointed out that they made it more difficult for migrants to secure an attorney, framing the policies as a fast track to deportation. Both programs ended in March 2020. See the U.S. Government’s January 2021 *Report to Congressional Requesters* for more details on PACR and HARP: <https://www.gao.gov/assets/gao-21-144.pdf#page=7>.

<sup>3</sup> The American Immigration Council is a non-profit organisation committed to securing justice for all immigrants through litigation, advocacy, communication, and research.

Before detainees are placed in a prison cell, officers are required to ‘visually inspect’ detainees for signs of injury or for the presence of a mental, physical, or developmental disability (‘U.S. Customs and Border Protection,’ 2015). These searches are often cursory and fail to account for hidden health conditions and disabilities, such as autism, diabetes, or epilepsy.

The COVID-19 pandemic has helped to call attention to the deplorable conditions at US immigrant detention centres, even though much work remains to be done to improve circumstances. When the pandemic first began, civil rights legal organisations rushed to file injunctions in the US courts to protect the nearly 40,000 migrants in detention facilities from the spread of the virus. These motions were especially critical for migrants with disabilities, who were more likely to suffer from complications were they to contract the virus. Statements outlining early-pandemic facility conditions associated with one particular lawsuit, *Fraihat v. ICE*, pointed out that these environments did not support even the most basic public health guidelines, such as social distancing and access to PPE or hand sanitiser.<sup>4</sup> Disability Rights Advocates, a national non-profit disability rights group, published a report on the injunction, noting that ‘Current ICE protocols do not even consider trying to identify high-risk individuals, much less take the significant steps necessary to reduce the risk of contagion, illness, serious complications, and death’ (‘National Standards,’ 2015). Additionally, COAMEX<sup>5</sup> found that complying with public health guidelines was nearly impossible for many migrants with disabilities since the sinks in washrooms in the detention facilities were often physically inaccessible, which prevented adequate handwashing. Furthermore, many migrants with disabilities needed assistance putting on facemasks or performing daily tasks, so social distancing was not practical (‘National Standards,’ 2015). As COVID-19 accelerated, migrant shelters closed or reduced capacity, forcing some asylum seekers to set up improvised ad hoc shelters en route. Immigration and Custom Enforcement’s failure to respond to the COVID-19 pandemic and provide reasonable protections not only placed already medically-vulnerable populations under increased risk, but also exposed a history of unsafe conditions at detention facilities across the country.

### **PART III: APPLYING A FEMINIST-OF-COLOUR DISABILITY STUDIES FRAMEWORK TO THE MIGRATION CRISIS**

A feminist-of-colour disability studies framework can offer a more nuanced perspective on the U.S. migration crisis for those with disabilities and chronic health conditions. In *The Rejected Body*, Susan Wendell, a feminist philosopher who writes about her experience living with myalgic encephalomyelitis, coins the ‘healthy disabled’ versus ‘unhealthy disabled’ binary (Wendell, 1996: 21). Wendell has the social model of disability in mind here: proponents of the social model of disability resist the way that the medical model frames disability as a matter of health that needs to be treated. She critiques the fact that the social model of disability separates health from disability, arguing that a person can have a disability and be healthy and that a person can have a health condition, but not have a disability. Yet, in considering the topic of migration among those with disabilities, it is not easy to untangle these widely accepted distinctions between ‘health’ and ‘disability.’ As I have already established, deficits in the process for diagnosing and identifying the medical or accommodation needs of refugees means that many migrants with disabilities cannot access basic resources, prescriptions, or medical supplies, which may exacerbate their conditions and turn a treatable health condition into a disability.

The feminist-of-colour disability studies framework put forth by Schalk and Kim in 2020 facilitates the kind of intersectional analysis that traditional, Eurocentric paradigms within the field of disability studies overlook. This is the kind of work that feminist disability studies scholars have been long rethinking, but not from the perspective of race, ethnicity, and migration: ‘feminist disability studies scholars...have been prominent in acknowledging the need to rethink the rejection of the medical-industrial complex, adjusting approaches to the social model of disability, which was developed primarily by white heterosexual men with permanent, stable physical disabilities’ (Schalk and Kim, 2020: 46). Disability is a fluid state; a person may experience disability at any point in his or her life, and while we need not go as far as support that idea that disability is ‘treatable,’ we cannot entirely reject considerations of health and medicine altogether. For example, in order to show how a feminist-of-colour disability studies methodology can help tease out the connections between race/ethnicity, class, gender, health, and ability, Schalk and Kim cite Judith K. Witherow, a Native American/Irish poet and essayist who writes about her experiences as a lesbian with a disability, explaining that:

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<sup>4</sup> A summary prepared by court staff on this case offers further information on the risks that detainees with disabilities faced within these environments and the way that the court classified the case. See the following link for details: <https://cdn.ca9.uscourts.gov/datastore/opinions/2021/10/20/20-55634.pdf>.

<sup>5</sup> COAMEX, or the Mexican Coalition for the Rights of Persons with Disabilities, is an umbrella organization that unites different groups committed to supporting people with disabilities in Mexico.

... coal mining companies and various factories polluted the land and water of my birthplace. Because of this environmental assault, my large family has many health problems. When you add generations of poverty, illiteracy, and abuse by the system, you don't need a crystal ball to determine your destiny (Witherow, 2002: 288).

Although Witherow is writing about the indigenous context, her experience highlights how disability and health cannot be separated from their social, economic, political, and environmental contexts. Like Witherow, many migrants face dangerous labour conditions, such as poverty, malnutrition, pollution, and an inability to access health care. Taken together, these multiple and connected disadvantages mean that accommodation or preventative care is not always an option, which can lead to high acuity situations.

We have seen how migrants with disability are multiply marginalised, but what a feminist-of-colour disability studies framework also demonstrates is the extent to which rhetoric related to health and ability seeps into the discourse surrounding immigration and its resulting policies. For Schalk and Kim, these rhetorical uses are unsurprising; the authors trace discourses of ability and disability back historically, to the institution of slavery in the United States, noting that slaveowners justified the institution by arguing that Black individuals were 'less susceptible to pain, more susceptible to disease, and inherently in need of white care and control' (Schalk and Kim, 2020: 40). Similar rhetoric also supported antiwelfare policies, including the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which framed disability as an illness. In the case of immigration, policies such as 'Public Charge' use the rhetoric of ability to justify a refugee's inadmissibility into the United States. Language such as 'self-sufficient' and 'individuals are inadmissible...if they are unable to care for themselves' frame those with disabilities and chronic health conditions as burdens on the nation and its resources ('Final Rule,' 2021). Not only are migrants with disabilities then framed as usurpers of public resources, but accepting welfare became stigmatised as a form of disability in and of itself. Ultimately, popular discourse pathologises disability, and this language finds its way into policies like the Personal Responsibility and Work Opportunity Reconciliation Act and 'Public Charge' rule. As immigration attorney Kathrin S. Mautino explains in Douglas Baynton's *Defectives in the Land*, "'consular and INS officers often look for other grounds' to justify exclusion, and 'one of the most common is the public charge provision'" (Baynton, 2016: 138). In practice, stereotypes shape officials' interpretations of the employability of a person with a disability. As much as disability studies scholars recognise health and disability as distinct states, the language of health and ability constantly mingle in immigration conversations and policies, shaping outcomes for those who attempt to enter the United States. A feminist-of-colour disability studies framework helpfully provides what a disability studies perspective alone cannot: a window into the extent to which the situation of migrants with disabilities is co-constituted by race/ethnicity, class, and other forms of identity, both at the level of language and at the level of public policy, and a sense that heightened attention to the intersections of health and disability might curtail certain forms of state violence.

These ableist immigration policies thwart admissibility, but they also contribute to state symbolic and actual violence in ways that can exacerbate or produce disability. From the George Floyd and Breonna Taylor police shootings to the fact that incarceration rates for Black Americans are over five times higher than they are for white Americans, instances of state violence are increasingly hitting our social media feeds and TV screens. But as Schalk and Kim point out, there are several forms of state violence that continually escape our notice, whether these take the shape of 'antiwelfare polic[ies], the school-to-prison pipeline, [or] infrastructural neglect' (Schalk and Kim, 2020: 44). The United Nations and other non-profit organisations have widely documented cases of physical violence and what Rob Nixon calls 'slow violence' against migrants with disabilities. Nixon defines slow violence as 'a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all' (Nixon, 2013: 2). Whether the result of racism, discrimination, and/or intolerance, migrants with disabilities are victims of border patrol and police attacks, in addition to threats from organised criminals, within both in transit and destination countries. Although they are writing about Somali, Iraqi, and Afghani asylum seekers in Finland, Karina Horsti and Päivi Pirkkalainen provide a relevant comparative account of the consequences of physical violence: '[f]orced removals may involve physical coercion,' they write, 'and those who carry them out can potentially abuse their powers' (Horsti and Pirkkalainen, 2021). Physical restraint can lead to severe injury and even death. In fact, the non-profit organisation Southern Border Communities Coalition reports that at least 122 people have died because of violence and abuse at the United States-Mexico border since 2010, and this figure does not account for the many others who received life-altering injuries ('Deaths by Border Patrol,' 2021). Brutality is the most obvious form of violence at the border, but this abuse manifests in less visible ways, too. For instance, we know that the Migrant Protection Protocols and 'Public Charge' rule heightened the threat of deportability for migrants with disabilities, which is a form of slow violence. Migrants with disabilities are also less likely to be able to access quality health care, and they face other forms of slow violence (many that migrants without disabilities also experience), including but not limited to verbal and psychological abuse, poor housing or homelessness, prison-like conditions within detention facilities, malnutrition, and difficulty accessing work and a liveable wage.

## PART IV: UNRAVELLED INTERSECTIONS

Although non-profit organisations and news outlets continue to illustrate the dire situations that migrants with disabilities face at the United States-Mexico border with alarming concern, migrants with disabilities remain a hidden population. International human rights exist to protect people moving across borders, yet the needs of migrants with disabilities continue to fly under the radar. Despite the fact that it can be difficult to navigate the tension between who self-defines as or is defined as a person with a disability, migrants with disabilities are repeatedly overlooked within both disability studies and migration studies scholarship. These difficulties are only exacerbated by the fact that USA immigration policy is constantly changing.

Because migrants decide to seek entry into the United States in response to a host of different circumstances, the methods associated with anti-oppressive practice, combined with a feminist-of-colour disability studies theoretical framework, are most appropriate for considering the complex intersections between migrant health, rights, and treatment at ports of entry. Both migrants and people with disabilities often struggle to participate fully in society—whether in Mexico, in the United States, or in regions that they pass through during their journeys to the border. But the combination of disabled and migrant identity proves especially problematic, as migrants with disabilities struggle to access basic resources, health care, medical services, education, employment, housing, and food. With this context in mind, then, it is increasingly clear that we need to strive for a greater understanding of the everyday barriers that refugees and asylum seekers with disabilities face, so that we can begin to imagine appropriate reforms to ensure greater equality of access.

The elevated risks and dangers that migrants with disabilities confront at the US border demonstrates that states and governmental institutions enact and enforce policies that disproportionately affect racialised populations with disabilities. Migrants with disabilities currently manage extreme precarity as they attempt to enter the United States. The archive that this article takes up has indicated that most migrants with disabilities cannot easily or consistently access the resources they need to survive. Immigration policies have both recently and historically homogenised migrants, and procedures are designed with little to no attention to diversity, particularly in terms of disability. Many migrants with disabilities are unable to access standard resources and care because they are not identified as having a disability or health condition due to poor record keeping, language barriers, or the invisibility of their situation.

Given the long history of brutality enacted toward migrants with disabilities, reshaping policies within states and detention centres may not be the best solution to this crisis, and a feminist-of-colour disability studies framework offers important insights into how we can begin to address the complicated relationship between health and disability at the US-Mexico border. Feminist-of-colour disability studies takes ‘into account cultural and religious perspectives on wellness and healing, which may run counter to mainstream white disability studies’ (Schalk and Kim, 2020: 46). On the one hand, applying a feminist-of-colour disability studies perspective reveals that, when we centralise the racialised experience of disability at the border, diagnosis assumes more importance in promoting access to health care and other needed services. On the other hand, this same framework emphasises a need for disability-centric health and wellness initiatives in border regions—initiatives that do not depend on the state or government. In their article, Schalk and Kim briefly name two organisations that are already conducting similar work in other contexts: the National Latina Health Organization and Black Women’s Wellness Day (Schalk and Kim, 2020: 46). Short-term or localised public-health initiatives that acknowledge the specific racial or ethnic circumstances that shape both health and disability challenge the firm distinctions that disability studies scholars uphold between health and disability, but these initiatives would also improve the lived experiences of this hidden population by bringing to light disabled migrants’ universal human rights to protection and quality care.

We can look to Leah Lakshmi Piepzna-Samarasinha’s experiments in curating collective care for a precedent here—for an image of hope and support beyond the state. In her manifesto, *Care Work*, which details efforts to facilitate access to care through informal networks across the United States and Canada, Piepzna-Samarasinha asks: ‘What does it mean to shift our ideas about access and care...from an individual chore, an unfortunate cost of having an unfortunate body, to a collective responsibility that’s maybe even deeply joyful? What does it mean for our movements? Our communities/fam? Ourselves and our own lived experiences of disability and chronic illness?’ (Piepzna-Samarasinha, 2018: 17). Piepzna-Samarasinha assembles narratives of Black and brown queer networks of survival—networks entirely independent of the state, that span the course of a decade. Piepzna-Samarasinha presents example after example of forms of vulnerability that overlap with the lived experiences highlighted in this article. She references individuals who struggle to access state resources without medical corroboration and those grappling with citizenship-related barriers that preclude the use of state-based accommodations. With these barriers in mind, Piepzna-Samarasinha reiterates that ‘state systems are failing, yet “community” is not a magic unicorn, a one-stop shop that always helps us do the laundry and be held in need’ (Piepzna-Samarasinha, 2018: 18). For Piepzna-Samarasinha, community is part of the answer—but not the entire answer. Nevertheless, considering these experiments in collective care with migrants with disabilities in mind



suggests that reform is not an all-or-nothing project: short-term, community-minded and strategic forms of radical care at or near ports of entry can be important first steps in enacting changes that address the disproportionate harm that migrants with disabilities face at the US-Mexico border.

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