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THE GEOPOLITICS OF REPRODUCTIVE HEALTHCARE: LATINA IMMIGRANTS' EXPERIENCES AS NON-CITIZENS AND BIOLOGICAL CITIZENA IN ATLANTA, GA

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THE GEOPOLITICS OF REPRODUCTIVE HEALTHCARE:
LATINA IMMIGRANTS' EXPERIENCES AS NON-CITIZENS AND
BIOLOGICAL CITIZENA IN ATLANTA, GA

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Arts and Sciences
at the University of Kentucky

By
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Lexington, KY

Director: Dr. Patricia Ehrkamp, Professor of Geography
Lexington, KY
2016

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ABSTRACT OF DISSERTATION

THE GEOPOLITICS OF REPRODUCTIVE HEALTHCARE: LATINA IMMIGRANTS' EXPERIENCES AS NON-CITIZENS AND BIOLOGICAL CITIZENA IN ATLANTA, GA

This dissertation examines the experiences of Latina immigrants in Atlanta, GA in accessing and receiving reproductive healthcare. Although Atlanta is a new destination city for immigrant labor, the state of Georgia has passed anti-immigrant legislation, including a 2011 law that allows local police to check immigrants' documentation while investigating unrelated violations. This localization of immigration policing heightens immigrants' risk of detention and deportability. In combination with media discourses of illegality, local immigration policing instills fear in immigrants, which deters them from going out in public in order to perform everyday tasks such as seeing a doctor. Latinas immigrants' ascribed illegality is not only an issue when trying to *access* reproductive healthcare, however, but also inflects their interactions with health service providers. Moreover, legal and pragmatic barriers to reproductive healthcare are bound up with ideological notions of Latinas' reproduction. Drawing from 68 interviews with recent Latina immigrants and immigrant advocates, I detail how experiences of receiving reproductive healthcare foster a "biological citizenship" – which can be defined as the ways in which an individual or group claims inclusion through biological means – that eases Latinas' outsider status. By enacting biological citizenship through the care of their bodies, which are often viewed and treated as undeserving of care, I contend that undocumented immigrants act politically via one of the few avenues that is open to them, albeit one – the care of the body – that is often overlooked. Additionally, they are creating a bit of security in an overwhelming insecure environment.

This research finds that Latina immigrants' access to reproductive healthcare is impeded not only by anti-immigrant laws and inflammatory discourse, but also by pragmatic issues such as lack of health insurance and language differences. Moreover, legal and pragmatic barriers to reproductive healthcare are bound up with ideological notions of Latinas' reproduction. For example, Latinas are frequently portrayed as "hyperfertile" in anti-immigrant discourse. Latina immigrants' reproduction is viewed as threatening to the nation-state and is thus often blatantly or covertly treated to render Latinas as "undeserving" of citizenship and the welfare state. Interestingly, however, in the context

of the aging population of the U.S., there are other discourses making their way onto the scene. These discourses reveal that Latina reproduction, though much maligned, was concomitantly viewed as the solution to revitalizing the eroding lower rungs of the U.S. population pyramid. Additionally, political pundits drew on the trope of the hyperfertile Latina immigrant to construct the hopes of an eventual permanent Democratic majority, which would be facilitated by the exponential breeding of Hispanic immigrants. However, this research corroborates 2015 statistics from the Centers of Disease Control that show that Hispanic fertility is steeply declining, thus undermining the demographic and political dreams which relied on tropes of the hyperfertile Latina.

This study aims to expand conceptions of citizenship by examining reproductive healthcare as a site where risk is negotiated and borders of membership are both constructed and broken down. The lens of biological citizenship emphasizes the political nature of healthcare access and allows for analyzing Latina immigrants' everyday experiences with reproductive health as they are shaped by state policies, anti-immigrant legislation, and gendered portrayals of illegality. In doing so, this study complicates healthcare access and draws out both the non-biological determinants and non-biological implications of this access.

KEYWORDS: immigrants, reproductive healthcare, the U.S. South, feminist geopolitics, health geography, fertility

Rebecca Lane

April 27, 2016

Date

THE GEOPOLITICS OF REPRODUCTIVE HEALTHCARE:
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*For those whom the gulf is too great to bear,
and yet bear it with grace.*

*“Before you know kindness as the deepest thing inside,
you must know sorrow as the other deepest thing.*

*You must wake up with sorrow.
You must speak to it till your voice
catches the thread of all sorrows
and you see the size of the cloth.
Then it is only kindness that makes sense anymore...”*

- From Kindness by Naomi Shihab Nye

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CHAPTER ONE

BODIES, BORDERS, and the MICROPOLITICS of REPRODUCTIVE HEALTHCARE

Introduction

In this dissertation, I unravel the various ideological threads that connect bodies to borders and make reproductive healthcare *more than* reproductive healthcare. Detailing the experiences of recent¹ Latina² immigrants to the United States, I show how seeking and obtaining reproductive healthcare are seemingly mundane tasks that are rife with political meaning. I explore how doctor's offices become microcosms of geopolitical contention, how Latina immigrants' bodies are the medium through which geopolitical battles are being fought, and how this has very real impacts for the health and wellbeing of Latinas and their families. I draw out how public space is implicated in these battles, as well as the medical spaces of clinics and hospitals, which often escape even the critical eye of political geographers.

Situating my research in the Atlanta metropolitan area, I focus on how access to public space and ease of movement through it has been impeded by Georgia's state-level anti-immigrant laws, which work to proliferate inland borders and insecurity in everyday space for undocumented immigrants. Georgia is also a prime site to study the experiences of Hispanic immigrants, because like many other states in the Southeast, Georgia has seen a substantial increase of immigrants from Latin America in the past three decades,

¹ I define "recent" as having been living in the U.S. for 25 years or fewer.

² Throughout most of this dissertation, I used the word "Latina" instead of Hispanic, as I feel this a more accurate description of the women I interviewed, all of whom are from Latin American countries, but not all of whom are ethnically Hispanic. I do use "Hispanic," however, when referring to directly or indirectly to data from the Census Bureau and the Centers for Disease Control, which commonly use the term in their reports.

prompting geographers who study this region to deem it the “New South/Nuevo South” (e.g. Winders, 2006). Thus, in addition to local anti-immigration legislation – also known as the “localization” of immigration enforcement³ – my interviewees’ experiences with reproductive healthcare were also shaped by the fact that Atlanta is a new immigrant destination city, and thereby does not have all of the resources and networks that a longstanding immigrant destination city might have.

Drawing from, 1) 56 semi-structured, in-depth interviews⁴ with Latina immigrants – most of them undocumented⁵ – conducted between April and September of 2013, 2) participant observation and volunteering in some of Atlanta’s clinics and community centers that cater largely to an immigrant clientele between November 2012 and September 2013, and 3) discourse analysis of media chapters about Hispanic fertility in the U.S., I detail how navigating numerous obstacles in order to obtain reproductive healthcare – which includes routine examines, contraceptive care, and prenatal care – my informants negotiated the lines of divide that cast them as undeserving of such care because of the threat their perceived “hyperfertility” poses.

My informants’ use of reproductive health services has several effects. First, it creates a bit of safety in an environment that is categorically insecure for undocumented immigrants on account of anti-immigrant legislation, as well as the precarious socio-economic contexts that the majority live in (Chapter One). Secondly, in using assertiveness to overcome obstacles and receive the type of healthcare they believe they

³ Some literature refers to this phenomenon as “devolution” (e.g. Coleman & Kocher, 2011); I use “localization,” however, in order to highlight the scale and scope of this new immigrant legislation.

⁴ The majority of interviews were conducted in Spanish with the help of an interpreter, who provided in situ interpretations of interviewees’ answers. This is discussed in more depth in Chapter Two.

⁵ I never asked the women I interviewed about immigration status; however, most either volunteered the information in a straightforward manner, or revealed information that indicated that they were either documented or undocumented.

deserve, Latinas foster a biological citizenship – which can be defined as a claim of inclusion on biological grounds – that subverts characterizations and treatment of them as undeserving of such care (Chapter Two). Finally, in being highly concerned with family planning and contraception, my informants confronted and unsettled the tropes that portray them as hyperfertile, and which skew this hyperfertility as either a bane or a boon depending on the conversation at hand (Chapter Three).

Pulling from and adding to a diverse body of literatures, these chapters contribute to broad discussions of I) *localized immigrant policing and the micropolitics of everyday life* and II) *the politics of caring for and not caring for immigrant bodies*. **In what follows in this chapter, I summarize the framework and literature I use to conceptualize – and tie together – these two issues; each literature and my contributions to it are discussed *in further depth* in the empirical chapters, which each contain tailored literature reviews.** The conceptual framework summary in this chapter is followed by a description of empirical chapters and a roadmap for the rest of the dissertation.

I) Localized Immigrant Policing and the Politics of Everyday Life

In order to ascertain how localized immigrant policing impacts Latina immigrants' everyday lives, I have firmly rooted this dissertation within feminist geopolitics⁶, which, counter to traditional geopolitics, envisions power as existing “not in the hands of a sovereign state or individual, but more in relational ways that traverse a spectrum of scales of social life” (Hyndman, 2009: 121). Feminist geopolitics stresses the need to look at the mundane, everyday workings of power, far from the battlefield or the

⁶ Feminist geopolitics is part of a larger literature of feminist political geography, from which I also draw.

stateroom; this scale of study has been called “micro(geo)politics” of everyday life (Coleman, 2009; England, 2003; Staeheli, Kofman, & Peake, 2004). While the women I interviewed are directly affected by decisions made by governmental elites, in that their lives are undoubtedly impacted by anti-immigrants laws drawn up in Georgia’s legislature, my concern is not so much with the creation of the laws themselves, nor with the people who created them, but more with what exactly these laws do on the ground and in the everyday lives of undocumented women. Consequently, rather than looking at the application of anti-immigrant laws, this dissertation explores what the mere idea and knowledge of these laws, as well as discourses of national security that paint Latina immigrants as a social, economic, and political threat, *does* to the daily lives of undocumented Latinas. Taking feminists geopolitics’ cue to view power as relational, generative, and embedded in the micropolitics of everyday life aids in understanding how anti-immigrant laws, even if they are not actually applied, have the power to shape lives.

Dowler and Sharp (2001) have urged geographers to explore how larger geopolitical discourses can inflect the mundane, and vice-versa. In order to do so, they call for feminist political geographers to “ground” geopolitics through the use of ethnography, as well as to keep an eye to the ways in which the nation is performed by the bodies that constitute it. By way of example, Dowler and Sharp cite Sparke’s 1997 chapter about Timothy McVeigh. Sparke demonstrates how McVeigh, a Gulf War veteran, was both subjectified by and constructed his own subjectivity from geopolitical discourses surrounding the war and the U.S. and Iraq’s roles in the geopolitical world order. Additionally, Sparke demonstrates the gendered nature of these discourses, showing how McVeigh’s patriotic masculinity was culled from, among other things, the

“lone warrior-masculinity of Rambo films” (Dowler & Sharp, 2001: 172). Thus, we can see clearly that nebulous discourses and grounded realities do not exclude each other, but in fact constitute each other. Feminist geopolitics thus offers a holistic and multi-scalar approach to the study of geopolitics, one that does not adhere to the either-or binary of the personal and the political. As a result, feminist geopolitics has expanded the scope of the political by investigating how actors and entities that have been placed outside the realm of politics by traditional geopolitical thought – such as the body (Fluri, 2009; Smith, 2009) and gender (Fluri, 2011; Silvey, 2004; Walton-Roberts, 2004) – are shaped by, and in turn shape, (geo)political action and discourse (Coleman, 2009; Dowler & Sharp, 2001; Hyndman, 2001 & 2004).

I draw largely from feminist geopolitical work that examines immigration and (in)security at the scale of the body. While traditional geopolitics has talked about these concepts on a grand scale (i.e., the security of a nation-state) (Agnew, Mitchell, & Toal, 2003), I position myself with political geographers who believe it is important to examine what governmental discourses surrounding security do in the everyday lives of people, or, as Hyndman puts it, “the security of the state but in relation to the security and wellbeing of people who live *in* and *across* its border” (2004: 319). Work within feminist geopolitics that has examined immigration and (in)security has reconfigured the concepts of borders and belonging to include, respectively, internal borders, ranging from those created by increased immigrant policing (Coleman, 2007 & 2009; Ibrahim, 2005; Staeheli & Nagel, 2008; Walker & Leitner, 2011) and the exclusion of those who, like undocumented immigrants, are thought by many not to belong on account of their legal status and perceived difference (Drever & Blue, 2007; Nelson & Hiemstra, 2008). We

can therefore see how arguments about which bodies deserve care and which do not and the “threat” that the reproduction of some women poses are really arguments that can be connected to political beliefs concerning who belongs in a territory and how those people deserve to be treated.

A micropolitical analysis using ethnographic data is especially useful because it highlights the more nuanced machinations of power that play out in everyday interactions. In the case of this dissertation, it hones in on the malleability of the line that separates citizen from non-citizen (Chapters Three and Four), as well as the duplicitousness with which Latina fertility is talked about (Chapter Five). Examining how (non)citizenship is enacted on the ground, instead of assuming it as an *a priori* category that imposes a rigid structure on social interactions, reveals how (non)citizenship is negotiated among all parties involved. To be sure, power is not equal among all actors, but marginalized groups have agency in some situations. For the Latina immigrants in this study, this agency allows them to both claim the rights and enact the responsibilities of citizens through the care of themselves and their families during their reproductive healthcare experiences. Key tools in this agency are assertiveness and proactivity, as will be discussed in Chapter Four.

Relatedly, I draw from feminist geopolitics because I do not want to paint a picture of undocumented Latinas as hapless victims; that is, conceiving of power as mundane and relational draws out the ways in which Latina immigrants enact power to obtain reproductive healthcare, regardless of the obstacles that have been set before them. As Hyndman (2004 & 2010) has stressed, feminist geopolitics attempts to avoid the impulse to be critical and deconstruct without offering any recourse to political action.

Although Hyndman does concede that the deconstruction of normative assumptions and categories is crucial, she also insists that leaving it at that is politically stifling, and that an ideal feminist geopolitics might offer reconstructive outlets for solidarity and political action. In a sea of otherwise bleak moments of mistreatment and inadequate healthcare, I am choosing to focus on instances of Latinas' assertiveness and the inclusion it facilitates not only to give a fuller picture, but also in order to cultivate hope and the possibility for transformation in the face of oppressive hegemony. These "tears" in the fabric of national racism weaken the fabric altogether, and I contend that, if racism happens in ordinary interactions, then its subversion can happen in just the same understated manner. Sedgwick (2004) calls such a perspective "reparative readings." Speaking specifically of the bleakness often presented by studies of sexual and intimate citizenship, Van Doorn states:

[A] reparative mode of conducting research counters the tendency among many scholars of sexual/intimate citizenship to invest too eagerly in identifying limitations and caveats that undermine the concept's potential lines of flight, and allows for articulations of different articulations of the intimate, the political, and the civic. This affirmative strategy, which itself is performative, world-making consequences... (2013: 159)

This perspective puts this paper in conversation with other papers that are emerging about immigrant policing and resistance in states with localized immigrant policing. For instance, Stuesse and Coleman (2014) investigate impromptu networks created using text messages in order to alert undocumented immigrants to police check-points in their neighborhoods.

In order to detail how localized immigrant policing – or the increase in state and local laws that seek to regulate and police undocumented immigrants – impacts

immigrants by increasing insecurity in their everyday lives, as well as how the women I spoke with navigate and mitigate this insecurity, I combine feminist geopolitics, scholarship on immigration and (in)security, and scholarship on geographies of fear and boldness. I use this framework to demonstrate that geopolitics happen at the scale of the body, and that in the case of undocumented immigrants, social reproduction – a sphere of life comprised of tasks that support basic survival, as well as personal and communal growth, such as cooking and going to school (Bezanson & Luxton, 2006) – is the site at which immigrant policing takes place. I argue that medical spaces (as well as the access to, and ease of movement through, public space that visiting a doctor entails) are often ignored in micropolitical analyses, but that they are important sites where policing takes place, and where ideological borders are corporeally manifested (this will be explored more in the “Caring (and Not Caring) for Immigrant Bodies” section below).

i) The Localization of Immigrant Policing and its Impact on Immigrants’ Social Reproduction

As mentioned in the preceding section, immigration legislation and its enforcement has experienced a localization; that is, states and municipalities are now passing and enforcing immigration legislation and working in collaboration with federal agencies like Immigrations and Customs Enforcement (ICE), where once such tasks were predominantly the role of the federal government (Coleman & Kocher, 2011; Walker & Leitner, 2011; Winders, 2007). This is part and parcel of the “securitization of immigration,” a post-9/11 phenomenon in which immigrants are constructed as threats that must be abated through regulation and intervention (Coleman, 2009; Huysmans, 2009; Ibrahim, 2005; Varsanyi, 2008). Thus, at the same time as it has fed off of and

fomented latent racism and xenophobia, the localization of immigration policing has worked to enhance suspicions toward people who are not ostensibly citizens (Staeheli & Nagel, 2008; Winders, 2007). Undocumented immigrants therefore now face intense scrutiny in this new security-obsessed milieu (Coleman, 2007; De Genova, 2007; Miller, 2005; Smith & Winders, 2007; Varsanyi, 2008; Walker & Leitner, 2011). But while this new regime of immigrant policing has increased the number of immigrants who are detained and deported, with deportations reaching an all-time high during President Obama's second term in office (Gonzalez-Barrera & Krogstad, 2014, "U.S. deportations of immigrants reach record high in 2013"), it certainly has not halted undocumented migration. Nowhere is this more apparent than in the U.S. South, which has seen an unprecedented increase in immigrants from Latin America the past three decades (this will be discussed in more depth in Chapter Two) (Grantmakers Concerned with Immigrants and Refugees, 2013, "Immigrants in the U.S. South").

However, Georgia, like many states in the New South, seems to be at odds with its new reliance on immigrant labor, at once wishing to attract immigrants in order to fill the bottom rungs of booming industries, while at the same time pushing immigrants away through laws that make it risky for undocumented immigrants to simply live. This can be seen clearly in the proliferation of – and eventual response to – what are colloquially referred to as the “show me your papers” laws, with Arizona's infamous Senate Bill 1070⁷ leading the way. Like SB 1070, Georgia's Illegal Immigration Reform and Enforcement Act of 2011 (House Bill 87) makes it legal for local police to ask anyone to provide immigration documentation while investigating unrelated offenses, and mandates

⁷ While certain parts of SB 1070 were struck down by the state, the racial profiling element of SB 1070 was ruled constitutional by the U.S. Supreme Court in 2012.

that anyone who cannot provide such documentation be arrested and detained. This is new territory for local law enforcement, as immigrant policing has up until recently been the job of federal officials (Coleman, 2012). In effect, such laws inhere everyday tasks, such as driving several blocks to pick up groceries, with the same risk of deportation inherent in crossing the vast desert of that lies between Mexico and the United States (Coleman & Kocher, 2011; DeGenova, 2002; Harrison & Lloyd, 2012; Martin, 2011). However, HB 87 and laws like it received pushback when it became apparent that this legislation was “bad for business” and productivity because it initially drove many undocumented workers out of states that passed such legislation (Bridges, 2014, “Georgia mayor stood up to state’s anti-immigrant law”; Sarlin, 2013, “How America’s harshest immigration law failed”).

Scholars have suggested that immigrants are interpellated for their productive capacities, but their *social reproduction* – a sphere of life comprised of tasks that support basic survival, as well as personal and communal growth, such as cooking and going to school (Mitchell, Marston, & Katz, 2004) – is something that the state does not want to support (Cravey, 2004; Martin, N., 2010; Pratt, 2004; Smith & Winders, 2008). Guest worker programs, which exemplify the value the U.S. puts on immigrant’s labor, have been scaled down in recent decades (Smith & Winders, 2008) while increased security at the border has made it harder for undocumented migrants to work seasonally in the U.S. and then cross the border to return home. Therefore, unlike previous times in U.S. history, immigrants are bringing their entire families to live in the U.S. and thus their social reproduction must take place entirely in the country (Smith & Winders, 2008). This seems to trouble policymakers and the general populace alike, who are quick to

anger at the thought that undocumented immigrants are using resources of social reproduction (such as public schools and clinics) that are ideologically reserved for citizens. The localization of immigrant policing has thus made social reproduction the site where immigrant policing – both formal and informal – now takes place (Martin, N., 2010; Smith & Winders, 2008; Stuesse & Coleman, 2014).

By investigating the reproductive healthcare experiences of Latina immigrants, this dissertation not only provides ethnographic accounts of how one aspect of immigrants' social reproduction is impacted by anti-immigrant laws, but in doing so demonstrates how the geopolitical borders that are inherent in these laws are in fact (de)constructed, even in interactions in which there is no ostensible immigration policing occurring. While much of the scholarship on the localization of immigration policing has focused on the laws themselves and actual instances of immigrant policing and detention, this dissertation explores undocumented immigrants' everyday experiences with the post-9/11 securitization of immigration and posits that immigrant policing's deleterious effects are not always spectacularly visible, nor are the acts of subversion and resistance against this policing. Localized immigrant policing creates insecure "geographies of fear" for undocumented immigrants; this fear shapes the way undocumented immigrants view and interact with the space outside of their homes.

ii) *Geographies of Fear and Boldness*

Geographies of fear have been a longstanding interest in feminist geography (e.g. Pain, 2000; Simon Hutta, 2008; Valentine, 1989). This literature has focused largely on women and explores how fear of violence shapes experiences of public spaces (e.g. Day, 2001;

Sandberg & Toffelsen, 2010; Valentine, 1989). Geographies of fear literature thus highlights how fear becomes a factor in how women choose to move through space, even as some have called women's fear of violence in public space "irrational" because men are statistically more likely to be victims of violence outside of the home (Koskela, 1997; Sandberg & Toffelsen, 2010). As Koskela points out, women's fear is nevertheless important, as it is indicative of "the degree to which people feel they have control over their lives...In this sense it can be claimed that the groups that suffer the most oppression are the ones that understandably are most afraid" (1997: 304). In other words, fear is an acute indicator of vulnerability in society, and that it should thus not be brushed aside as an irrational concern. Likewise, though most of the women I interviewed did not have interaction with the police in the U.S., fear of policing shapes their everyday realities, and can be viewed as an indicator of vulnerability.

However, in focusing purely on women's fear, geographies of fear literature has been accused of reinscribing characterizations of women as passive victims. Some feminist geographers therefore focus instead on how women display *boldness* in public places (Koskela, 1997; Zárate, 2014). This dissertation looks at how fear and boldness in public space, in addition to medical settings, impacts healthcare access, which nearly always necessitates movement through public space; however, this affective factor of healthcare access is often overlooked in health geography literature, which focuses largely on quantifiable factors like distance and income (Andrews et al., 2014; Rosenberg, 2015). In the following section, I detail how the friction that undocumented immigrants experience in public space is complicit in a regime that views Latina bodies as dangerous and undeserving of care, and how, in caring for their own bodies despite

deleterious characterizations, Latina immigrants are acting boldly and claiming deservingness and autonomy from hackneyed and racist tropes of Latina hyperfertility.

II) Caring (and Not Caring) for Immigrant Bodies

The U.S. has long used biology, health, and medical knowledge to exclude and regulate immigrants, making entry and citizenship dependent on mandatory medical tests, and casting immigrants as threatening because of a perceived lack of hygienic practices and as vectors of infectious disease (Horton, 2004; Horton & Barker, 2009). These constructions have often led to limited membership in wider society (Horton & Barker, 2009; Luibhéid, 2002). Even though undocumented immigrants do not face the rigors of mandatory health entrance examinations, they are not immune from biological policing and exclusion. A cogent and timely example is the fact that undocumented immigrants are explicitly excluded from any of the benefits the Affordable Care Act might provide (Japsen, 2015, “Undocumented immigrants try, but fail to get Obamacare”). More often, however, the attempt to regulate immigrants via issues of biology and health is informal and clandestine, taking the form of microaggressions in everyday encounters, fueled by perceptions of who deserves resources such as healthcare and who does not. By looking at how Latinas’ bodies, reproduction, and deservingness of healthcare are portrayed in common discourses, as well as at Latinas’ actual experiences accessing and obtaining reproductive healthcare, this dissertation is concerned with the ways in which undocumented Latina immigrants are constructed so as to render them undeserving of the same quality of healthcare afforded to legal citizens⁸.

⁸ Though not all citizens, of course, as fair and ethical healthcare has been withheld from other marginalized groups, such as low-income mothers (e.g. Davis, 2003).

While the ascription of “illegal” (De Genova, 2002; Harrison & Lloyd, 2012; Nevins, 2002) certainly plays a large role in shaping healthcare experiences for Latina immigrants, a finer-grained analysis will reveal that Latinas’ “illegality” in particular is tinged with gendered elements that construe Latinas’ very bodies as threats. Latinas are often cast as hypersexual and hyperfertile “scammers” who intentionally reproduce in order to take advantage of state resources, or to produce an “anchor baby” that will one day facilitate their own citizenship (Chavez, 2008; Gutiérrez, 2008; Stern, 2005). Indeed, this characterization has been leveled against “undesired” female immigrants across the globe throughout history. Discussing 21st century asylum seeking in the Irish Republic, Luibhéid (2004) has shown that female immigrants’ reproduction and sexuality has been portrayed as almost a weaponized force in the media’s stories of asylum seekers’ presence in the Republic. Through detailing the uproar over African refugees being given asylum because they birthed Irish citizens (as the country’s then-policy of birthright citizenship dictated that anyone born on Irish soil is a citizen) Luibhéid demonstrates the ideological twisting and turning that must occur in order to turn heterosexual reproduction, something historically thought of as a noble and essential element of nation-building, into something deviant and dangerous when it comes to those who are not welcome to be part of the state (see also Conlon, 2010). The same line of thought is present in calls by groups in the U.S. to change the 14th Amendment, which upholds birthright citizenship, so that undocumented women will no longer use this supposed loophole to “cheat” the system.

Within the epistemological shift that paints some reproduction as deviant, migrant women’s sexuality and reproduction becomes the target of debate and intervention

precisely because it has been constructed as dangerous and thus *in need* of intervention (Conlon, 2010; Luibhéid, 2004). This very public discussion of a “private” topic – women’s reproduction and sexuality – also points to the fact that geopolitics and “security” are inextricably bound to intimate issues, in this case making only certain intimacies acceptable and deeming only certain people’s reproduction part of the nation-building project (Conlon, 2010; Luibhéid, 2004; Oswin & Olund, 2010; Stern, 2005). Because of the prevalent stereotypes about their sexuality and reproduction, Latinas are often viewed as threatening to the nation-state and thus often blatantly or covertly treated as “undeserving” of resources – both public and private – that are ideologically entitled to legal citizens (Chavez, 2008; Gutiérrez, 2008; Yoo, 2008). However, as discussed in Chapter Five, this hegemonic discourse of dangerous hyperfertility overshadows the fact that Latina hyperfertility is in some cases portrayed as a panacea to our demographically aging nation.

I use scholarship on biopolitics to show how immigrants are sorted and filtered into the category of “undeserving” on the basis of such constructions. But I also aim to show how they subvert such constructions and navigate the difficulties to which these constructions ideologically contribute. For this I combine biological citizenship, feminist ethics of care scholarship, and therapeutic landscapes. Using these literatures, I show how, even though they are rendered and treated as undeserving, Latina immigrants care for their own bodies and the bodies of their family. I argue that this is a political act that creates more security for them while at the same time subverting deleterious stereotypes and treatment.

i) Biopolitics and the “Sorting” of Bodies

Foucault discusses the topic of biopolitics diffusely in his lectures, *Society Must Be Defended* (2003) and *Security, Territory, Population* (2009), and later in his *The Birth of Biopolitics* (2008) lectures. He asserts that in “knowing” its population through demography and birth rates, etc., a government implicitly sanctions certain ways of being “normal,” thereby defining the “abnormal” in contrast, and casting those who fall into the latter category into varying form of exclusion. This is a mode of governance that rules not through threat of death or punishment, but instead through the “enhancement” of the life that it deems normal and thus acceptable. In deciding which life to enhance, a biopolitical mentality implicitly views some life as more valuable than other life. Life that has been deemed less valuable is rendered harmful to the more valuable life and an impediment to its enhancement, and so in letting the lesser-valued life “die,” either literally or metaphorically, the health of the nation is more securely guaranteed (Martin, L., 2010). This can be described as the “sorting” mechanism of biopolitics, whereby lesser-valued life is separated out from life that is to be enhanced.

Because of its focus on fostering some lives over others, biopolitics has been applied to studies of immigrants (Luibhéid, 2004; Sparke, 2006; Topak, 2014) and marginalized groups more generally (Evered & Evered, 2013; Guthman, 2009; Li 2010) in order to show how these groups are regulated and excluded, as well as how this sorting is often done in the name of the protection of the nation-state (Fassin, 2001; Hester, 2014; Inda, 2002; Ong, 1995; Zembylas 2010). Much along this vein has been written on Latin American immigrants in the U.S. (Hester, 2014; Inda, 2002), who are sorted and consequently excluded through discourses that portray them as dangerous criminals and

thieves who exploit birthright citizenship. In the sense that biopolitical regimes allow some to “die,” the general disregard for, and outright thwarting of, Hispanics’ social reproduction can be seen as a mechanism for a type of “social death” (Cacho, 2012). In addition to the sorting of populations from above, however, biopolitics also works at the scale of individual subjectivization based on an internalization of “government mentality,” a.k.a. governmentality (Legg, 2005). Drawing from and adding to Foucault’s concept of homo economicus – or the neoliberal subjectivization that ties morality to the “rational” allocation of scarce resources – I show how Latina immigrants act outside of the role that they have been sorted into by internalizing a “rational” governmentality that is often envisioned as beyond their purview.

ii) *Biological Citizenship and Making Bodies Matter*

I argue that experiences of accessing and receiving reproductive healthcare foster a “biological citizenship” – which can be broadly defined as the ways in which an individual or a group “becomes visible” through biological means – that can allay Latinas’ outsider status and the biopolitical sorting which casts them as dangerous and undeserving (Yoo, 2008). Although biological citizenship is currently utilized more outside the field of geography (e.g. Mason, 2012; Rabinow & Rose, 2006; Rose, 2007b; Rose & Novas, 2003) than within it, several scholars have noted its applicability to geographic studies of health and disease (Cadman, 2009; Greenhough, 2010). Scholars of biological citizenship have also demonstrated how claims of citizenship and deservingness can be leveraged through biological discourses created – and actions taken – by the marginalized themselves. The inception of the concept lies with anthropologist

Adriana Petryna (2002), who used the term as a way to describe how claims of deservingness can be made through biological discourses espoused by marginalized populations. Although biological citizenship has since taken on a diversity of iterations, including top-down governmentality approaches which resemble biopolitics (e.g. Mason, 2012), bottom-up approaches of biological citizenship have been touted as critiques of medicalization theory, which attribute doctors and scientists nearly omnipotent power in biomedical relations (Fraser, 2010; Rose, 2007a & 2007b).

While my the women I interviewed lacked political recourse to securing good healthcare because, first of all, most were not legal citizens, and, secondly, their healthcare needs stemmed from routine needs and not a techno-environmental disaster, as in Petryna's Chernobyl study, they constructed their deservingness of healthcare and their right to health around the assertion that all human beings are entitled to these things (this, of course, echoes human rights discourse); additionally, they constructed their deservingness around their role as productive members of their new communities. Availing and acting upon this human right to health confronts and contests the "intricate human dimensions that...undermine health" (Petryna, 2002: 3) for those who are undocumented, as well as the uncaring relationships that are engendered by ideas of legal citizenship and the stereotype of conniving hyperfertility (De Genova, 2002; Varsanyi, 2008).

iii) The Political Nature of Care

I argue that, in a geopolitical milieu where some are explicitly deemed underserving of care, the care of self by those considered underserving is a micropolitical act of

contestation. Feminist ethics of care literature posits not only that care should be held in as much esteem as “productive” labor, but that care ethics are relational and situational, as opposed to being universal (Kershaw, 2010; Lawson, 2009; Popke, 2006). This means that factors such as vulnerability and resilience are considered before a moral judgment and its attendant action are applied in decision of whether to give or to withhold care (Popke, 2006; Staeheli & Brown, 2003). This ethics of care is largely at odds with the caring done in traditional healthcare systems in the U.S., where care is given to those who can afford it. Further, in the case of patients who are perceived to be undocumented, many health service providers act in uncaring ways – ranging from microaggressions to providing faulty information – as a way of invoking and intervening upon the trope of the hyperfertile (and thus dangerous) Latina that runs rampant in American thought.

Indeed, both HB 87 and the Affordable Care Act (which explicitly excludes those without documents from receiving its benefits) provide a legal justification for *not caring* about some people, while racialized stereotypes construe even those living in the same community as strangers who do not deserve care (Yoo, 2008). I contend that in caring for their bodies and those of their families Latina immigrants assert their biological citizenship in a micropolitical act that reconfigures the withholding of deservingness that is imbricated in notions of illegality and xenophobic stereotypes. In doing so, they contribute to feminists’ push to recognize care’s immense importance in social, economic, and political life, as well as its potential for confronting injustice and inequality (Carmalt, 2011; Lawson, 2009; Till, 2012).

iv) Therapeutic Landscapes in Non-Therapeutic Environments

By caring for their bodies despite the many obstacles leveraged against them, Latina immigrants are cultivating therapeutic landscapes within an environment that is largely antithetical to health and security. The concept of therapeutic landscapes was coined by Gesler in the 1990s. He defined the term as, “a geographic metaphor for aiding in the understanding of how the healing process works itself out in places (or situations, locales, settings, milieus)” (1992: 743). While Gesler first used the concept to examine the reparative qualities of “natural” or non-medical settings that were thought to have healing and therapeutic capabilities, such as the Asclepian Sanctuary in Epidauros, Greece (1993) and the Marian Shrine in Lourdes, France (1996), the concept has since been diversely employed by Gesler and other health geographers. Therapeutic landscapes are now studied beyond sites that are exceptionally healing or formally medical, and are viewed as existing conterminously with and within mundane environments (Baer & Gesler, 2004; Milligan et al., 2004; Oster et al., 2011; Wendt & Gone, 2012; Williams, 2002; Wood et al., 2015). Health geographers have thus shown how environments must be consciously curated and strategically navigated in order to foster the “therapeutic” elements (e.g. Alaazi et al., 2015).

Recent work on therapeutic landscapes has also incorporated marginalization and “difference” into assessments of how individuals and groups construct their therapeutic landscapes (Alaazi et al., 2015; Milligan et al., 2004; Smyth, 2005; Wendt & Gone, 2012). However, not much has been written about immigrants and their experiences with therapeutic landscapes, which has promoted Dyck and Dossa to declare immigrants “invisible in the ‘cartography’ of healthy spaces” (2007: 692). In the context of localized

immigrant policing and the lack of deservingness that undocumented immigrants are often afforded, therapeutic landscapes, no matter how tenuous, offer a semblance of safety and security while confronting characterizations of Latina bodies as dangerous and thus undeserving of reproductive healthcare.

Roadmap of Dissertation

CHAPTER TWO: Feminist Research in the New South: Research Site and Methodologies

In this chapter, I first discuss my field site, the Atlanta metropolitan area, and situate my research within the region's transforming landscape of immigration. I then detail the methodologies used to collect the data presented in this research: 1) semi-structured, in-depth interviews, 2) volunteering and participant observation, and 3) discourse analysis. I describe why I chose the methods I did, as well as their strengths and shortcomings while deploying them in the field. In order to adhere to feminist geography's imperative to portray research's situational and imperfect nature, I also provide "stories from the field" along the way.

CHAPTER THREE: Fear, Boldness, and Familiarity: The Therapeutic Landscapes of Undocumented Latina Immigrants in Atlanta

(Therapeutic landscapes and geographies of fear and boldness)

This chapter details how undocumented Latina immigrants living in Atlanta cultivate therapeutic landscapes in an insecure environment. This is a pressing concern, because in addition to the myriad challenges that immigrants face in accessing healthcare in their new communities, undocumented immigrants living in Atlanta face the legal barrier presented by Georgia's "show me your papers" law, which imbues public space with the

risk of deportation for those who are undocumented. This complicates healthcare access by making the trip to the doctor's office risky. The undocumented Latinas I interviewed dealt with this risk and the fear it created through tactics like praying while driving, and by stopping driving altogether. Their therapeutic landscapes were thus shaped by the "geography of fear" that permeated their new communities. This fear presented itself not only in public space, but also in clinics and hospitals, where many of the women I interviewed feared – and sometimes received – bad treatment. In addition to creating therapeutic landscapes by avoiding certain places, the women I interviewed also maintained transnational networks and continued with health practices from home. Combined, these strategies worked to create complex and shifting therapeutic landscapes in an environment permeated by insecurity.

CHAPTER FOUR: Biological Citizenship and the Geopolitics of (Health)Care: the Reproductive Healthcare Experiences of Latina Immigrants in Atlanta

(Biological citizenship, and feminist ethics of care)

Spaces of medicine and ideologies of reproduction are both sites where biology and (geo)politics collide. This chapter explores how the reproductive healthcare experiences of Latina immigrants are scripted by beliefs about citizenship, deservingness of (health)care, and racialized stereotypes about reproduction, and how Latina immigrants act both within and outside of these scripts by using carework, or the work necessary to overcome obstacles to receiving (a good quality of) reproductive healthcare. Heeding feminist geopolitics' call to examine the micropolitics of everyday life, this chapter situates the experiences of Latina immigrants within the multi-scalar manifestations of the U.S.-Mexico border, exploring how "the border" appears at the scale of the body,

especially after the post-9/11 localization of immigration policing. The framework of biological citizenship highlights both the border-building that occurs in medical spaces, as well as the reconfiguration and momentary destruction of borders facilitated by Latina immigrants' use of carework. Biological citizenship is inherently concerned with care and the political implications of this care. This chapter thus contributes to the study of care and its primacy in everyday life, especially as it engenders inclusion and political agency. In addition, this chapter expands the realm in which this care takes place by exploring its manifestations in medical spaces, which are often ignored because of their epistemological distance from politics. Biological citizenship remedies this, exploring the ways that micropolitics are enacted "from below" and diverge from the status quo to create new realities in which Latina immigrants claim deservingness.

CHAPTER FIVE: True Stories and Varied Tales of Latina Fertility in a "Greying" Nation

(Biopolitics and social reproduction)

In this chapter, I look at the varying and contradicting ways that Latinas' reproduction is talked about in relation to productivity and politics, especially in the context of an aging population in a neoliberal nation. The CDC's recent report that Hispanic birthrates have dropped drastically in the past several years has brought underlying notions about Latina fertility to the surface. Although nativist rhetoric about "anchor babies" still rings loud and clear, the drop in Hispanic birthrates has precipitated rhetoric that reveals disappointment at the fact that "hyperfertile" Latinas will not do the job they were seemingly biologically destined to do in the U.S.: to bring youth, labor, and votes to a rapidly aging nation. Using data from in-depth interviews with 56 Latina immigrants in

Georgia, I argue that Latinas' decisions to limit their family size is a result of the precarious social and economic positions they are in. I contend that, in not having enough resources for the "social reproduction" – i.e., the basic necessities of life, like food education (Mitchell, Marston, & Katz, 2004) – of large families, they are acting in their best interest by limiting family size; in this sense, they are becoming homo economicus, or "rational" economic actors whose morality is gauged by their ability to allocate scarce resources. I argue that my interviewees enact homo economicus to the detriment of those who have pinned economic, demographic, and electoral hopes to Latinas' perceived hyperfertility. This enactment of homo economicus veers dramatically from the position to which Latinas have long been biopolitically relegated – as hyperfertile thieves/saviors, depending on the argument being made – and in turn has challenged a future where Latina fertility can be simultaneously reviled and coveted.

CHAPTER SIX: Conclusion: A Work in Review and Mater Economica

In the final chapter of this dissertation, I offer a summation of the analytical framework used to support my arguments, as well as how those arguments are presented in the empirical chapters. I conclude with a discussion of the marbling of obedience, resistance, and gender in the figure of what I call "mater economica."

Conclusion

In this chapter, I have offered a summation of the work presented in this dissertation and its use of, and contributions to, several literatures. These literatures were chosen in order to address two interrelated themes regarding Latina immigrants' use of reproductive

healthcare in Atlanta: I) *localized immigrant policing and the micropolitics of everyday life* and II) *the politics of caring for and not caring for immigrant bodies*. I use feminist geopolitics, scholarship on localized immigrant policing and its impact on social reproduction, and geographies of fear and boldness as a framework for the former theme, while the framework for the second was constructed using the concept of biopolitics, biological citizenship, feminist ethics of care, and therapeutic landscapes. I outlined the remaining chapters of the dissertation, which include the following methods chapter, followed by three empirical chapters that draw from and add to the literatures above.

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CHAPTER TWO

FEMINIST RESEARCH in the THE NEW SOUTH: RESEARCH SITE and METHODOLOGIES

Introduction

This project is an empirical case study that employs qualitative methods within a feminist methodological framework. I use a combination of in-depth, semi-structured interviews, observation, and discourse analysis in order to explore the everyday realities of undocumented Latinas as they pertain to reproductive healthcare, as well as the rhetoric that portrays politically-loaded versions of these “realities” in media representations. In this chapter, I first detail the demographic changes, anti-immigrant ethos and legislation, and culturally-competent reproductive healthcare options in the Atlanta metropolitan area. I then describe each research method I used – including the ones that did not work out as expected – and illustrate their contextuality and varying degrees of efficacy with anecdotes from the field. In keeping with feminist geography’s practice of not obscuring the situatedness and “messiness” of doing fieldwork (Haraway, 1988; Moss, 1993), the stories I tell about my time in the field are open, honest, and revealing of the imperfection and contingencies of research.

I) Description of Research Site

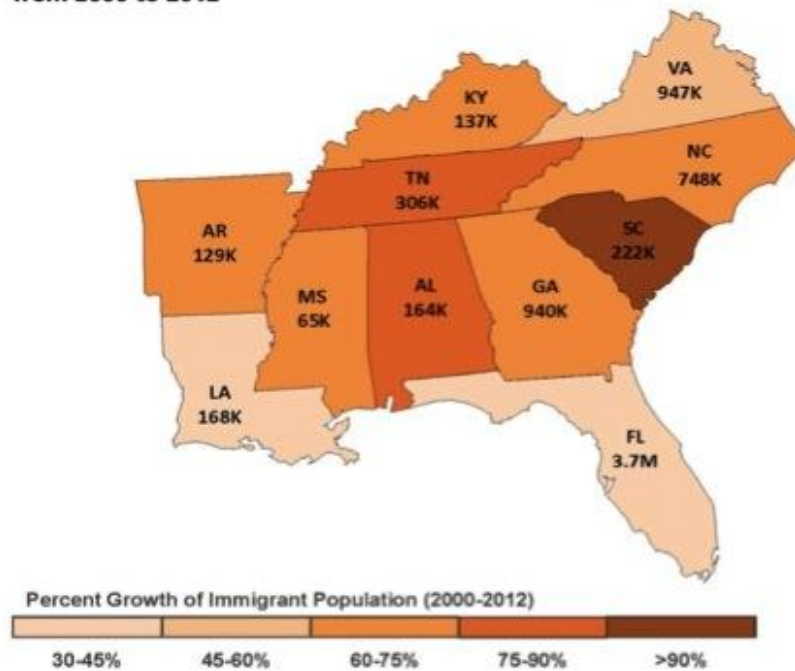
i) The New South and Its Discontents

Within immigration studies, the “New South” is the name given to the area of the Southeastern U.S. that has seen a rapid increase of Hispanic immigrants within the past three decades (see figure 2.1) (Durand et al., 2005; Odem, 2009; Winders, 2005). This

trend is of note because the region has not been historically known for any Hispanic presence, but has instead been long characterized by its black-white divide (e.g. Inwood 2011a & 2011b). As part of the New South, Georgia has seen a dramatic growth in immigration since the late 1980s, when the Atlanta metro area's service and construction sectors – including the teams used to build infrastructure and run facilities for the 1996 Atlanta Olympics – began to draw Hispanic immigrants (Odem, 2009; Singer et al., 2008). As a result, Georgia's Hispanic population has nearly doubled since 2000 (U.S. Census Bureau, 2010). The Atlanta metropolitan area, with a population of over five million people, has received many of these immigrants, as the area has a diverse economy and is home to many stable and growing industries in which immigrants can find employment (City Data, 2011; U.S. Census Bureau, 2010). Singer et al. contend that aside from Dallas, “Atlanta added more jobs than any other metropolitan area in the United States” during the 1990s and continues to supply employment to a large number of immigrants (2008: 6).

Figure 2. 1: The New South

Figure 1. Foreign-born Population in 2012 and Percent Growth from 2000 to 2012



Sources: Mississippi data are for 2009-2011, averaged. MPI analysis of American Community Survey data.

Source (RL): Grantmakers Concerned with Immigrants and Refugees, 2013

The Chamblee-Doraville area, a suburban area just northeast of Atlanta proper, became home to many of these immigrants; this is representative of the fact that immigrants to new destination cities are more likely to live in suburban areas than in cities proper (Dawkins, 2009). This two-town region is bisected by the Buford Highway, an iconic feature which has come to symbolize the diversity of the area, and which quickly became the geographic focal point for my research and interviewee recruitment. As of 2000, whites were a minority in Chamblee-Doraville (24 percent), with the majority being Latinas/os at 54 percent. Asians (14.5 percent) and African Americans (5 percent) form the rest of the population (Odem, 2009). As Odem (2009) notes, both within the Chamblee-Doraville region and within Atlanta itself, Hispanic communities have been able to establish themselves in the community and create urban space for

themselves in the form of churches and religious organizations. Further, driving down the Buford Highway and into cities like Doraville is like taking in a sampling of the world's cuisine and commerce through your windshield: this region is not only known for its Hispanic presence, but being a multi-national ethnic enclave, boasting stores, restaurants, and businesses from a variety of African, Asian, Middle Eastern, and Latin American countries. Indeed, the Buford Highway Corridor has been called one of the most diverse places in the U.S.

But even while Hispanics' predominance in this area of metropolitan Atlanta both reinvigorated the local economy and created an ethnically diverse region in which many minorities have staked a claim to urban space, longtime residents of the region have not always been welcoming, and in some cases sought (and still seek) to remove or regulate as much as possible the urban visibility of Hispanic immigrants. The transition into an immigrant-receiving community often involves some prejudice and hostility on the part of longtime residents and lawmakers towards newly arrived immigrants (Mohl, 2002; Varsanyi, 2008; Winders, 2006) – even if some of those longtime residents are members of the same ethnic groups as the immigrants⁹ (Nelson & Hiemstra, 2008). For example, in the late 1990s, several cities in the metropolitan area passed local ordinances that made it illegal for day laborers to gather on private property (Odem, 2009). Although in the city of Roswell – which shares Fulton County with Atlanta – Latino community leaders were able to secure funding and open a center for day laborers, it was closed just a year after its opening because of the public outcry against it, which included charges that state

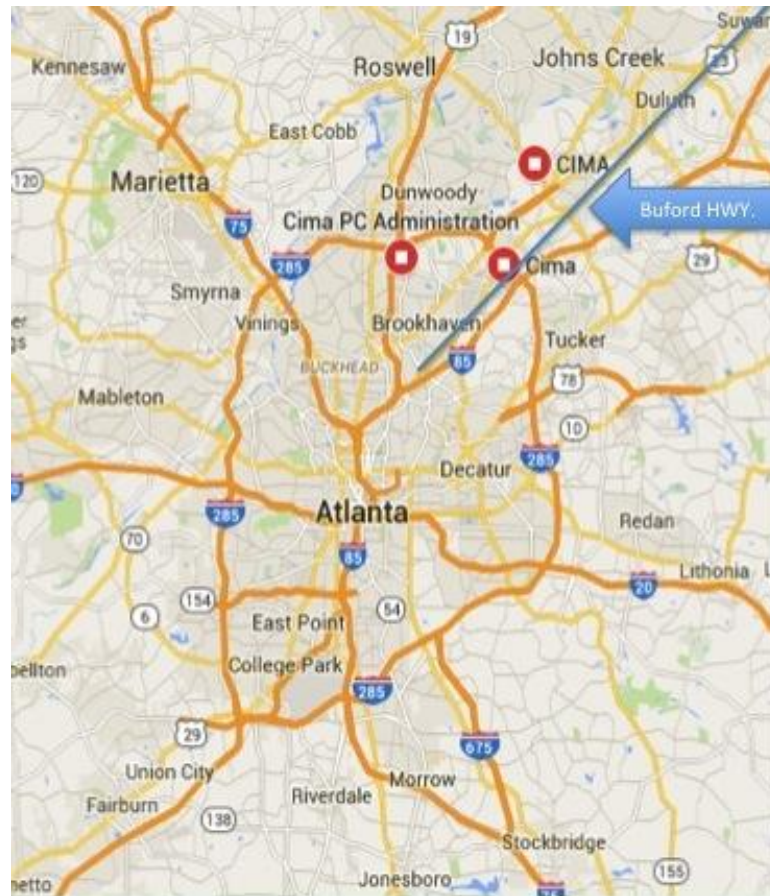
⁹ Indeed, some of the women I interviewed talked about “fake clinics,” which were medical-type storefronts usually operated by immigrants who either posed as medical professionals, or who were medical professionals licensed in their homelands but not in the U.S. The women I spoke to contended that these “fake doctors” preyed on newly-arrived immigrants who did not know the lay of the land.

money was being used to help “illegal aliens” (Bixler, 1999; Odem, 2009). Because so many undocumented Hispanics live in the suburbs and not at a walkable distance from their workplace – whether that be in downtown Atlanta or in a nearby county – driving to work is necessary, though risky because they do not have a driver’s license. In 2003, State Representative Pedro Marin wrote a bill that would make it legal for undocumented immigrants to obtain a conditional driver’s license. The bill was promptly shut down, and, to add insult to injury, in 2005, state legislatures passed a bill which said that only legal residents could get a driver’s license (Moscoso, 2005; Odem, 2009).

Another challenge to immigrants in the Atlanta metro is that, as an emerging immigrant destination, the social and political infrastructure that makes life easier for immigrants (such as abundant and affordable English as a Second Language (ESL) classes and immigrant political organizations) in many established gateway cities seems to be relatively scant and insufficient in Atlanta (Drever & Blue, 2011). However, immigrant support networks have been forming throughout the past three decades. For instance, the Latin American Organization – where, as discussed below, I both volunteered and took Spanish classes while living in Atlanta – is an organization that provides support to immigrants through services like English as ESL classes, helping immigrants find housing, and assisting in navigating complex bureaucracies such as the healthcare system. In terms of reproductive healthcare, another organization at which I volunteered, the Feminist Women’s Health Center, initiated a program called the Lifting Latina Voices/*Levantando las Voces Latinas* in 2007 to, “address comprehensive reproductive and sexual health issues that Latinas face, especially those who are low-income and uninsured.” Centro Maternal Internacional (CIMA) a reproductive healthcare

clinic group that caters specifically to Latina women, is also heeding the demand that this relatively young demographic group presents, and the placement of their three clinics in the northeast suburbs of Atlanta is emblematic of the geography of Hispanic immigration to the region (see figure 2.2). Further, recognizing the obstacles presented by public space for undocumented immigrants and other underserved communities, some clinics and hospitals have initiated “mobile medicine” programs, which send medically-equipped trailers to places – such as the Mexican consulate near the Buford Highway – that are accessible and safe to immigrants. To be sure, however, all of the places mentioned above were crowded and had long wait times whenever I visited them, leading me to anecdotally surmise that the Atlanta metro area has yet to meet the needs of its new immigrant population.

Figure 2. 2: CIMA clinics in relation to the Buford Highway



Source: Google Maps

ii) Localized Immigrant Policing in Georgia

The uneasiness of longstanding residents toward the “new faces” in their communities might be said to be codified through state-level anti-immigrant legislation. Georgia is one of several states (in the New South and beyond) to have passed anti-immigration legislation within the past several years. The Georgia Illegal Immigration Reform and Enforcement Act of 2011 (House Bill 87) requires non-citizens to carry proof of their legal status at all times. HB 87 makes it legal for local police to ask anyone to provide immigration documentation while investigating unrelated offenses, and mandates that

anyone who cannot provide such documentation be arrested and detained. Additionally, the bill requires employers to register all new employees using E-Verify, a government program used to confirm the legitimacy of the information a person provides in order to obtain employment (Redmon, 2011b), much like the Georgia Security and Immigration Compliance Act (Senate Bill 529), enacted in 2007, which requires employers to verify the legal status of new employees.

Georgia has other immigration laws in the works. If passed, HB 296 will require that schools and medical institutions, such as hospitals and nursing homes, keep records of how many undocumented migrants use their facilities and what types of services they receive, while HB 59 would require secondary-education institutions to ask the citizenship status of new enrollees (Redmon, 2011a). Finally, Fulton County, in which Atlanta is situated, has been a member of the Priority Enforcement Program (formerly the Secure Communities Program) since 2010. This joint federal, state, and local program enlists local law officers to participate in immigration enforcement through the use of a national fingerprint database, which aids officers in identifying “criminal aliens.” Once identified, Immigration and Customs Enforcement can detain and deport criminal aliens (Department of Homeland Security, 2011). Although SB 529, the proposed bills HB 296 and HB 59, and the Priority Enforcement Program work to create an environment of insecurity for undocumented immigrants, the bill most relevant to this project is HB 87, as it curbs the mobility of undocumented Latinas and thus affects their ability to go out into public in order to seek reproductive healthcare.

While HB 87 was in effect as I was doing my research in the Atlanta area, the application of the law has since been greatly curtailed (Bridges, 2014, “Georgia mayor

stood up to state's anti-immigrant law"). Although both sides of the political aisle voiced objections to HB 87, my assessment of this curtailment is that it was mostly due to pushback from business owners and encased in a conservative logic. Many municipalities have discontinued enforcing the law with the same intensity as they did in the year after it passed, and the state overturned key portions, such as the provision that sought to make it unlawful for citizens to transport or harbor undocumented immigrants (Bridges, 2014, "Georgia mayor stood up to state's anti-immigrant law"). However, portions of the law are still technically on the books, and the vagaries of the law and its application are enough to continue to instill fear into the lives of undocumented immigrants.

iii) *Reproductive Healthcare and Latinas in Atlanta*

According to the National Council of La Raza's (NCLR) 2009 report, an estimated 41 percent of those who are without health insurance in Georgia are Latina/o. Although the Affordable Care Act provides low-cost health insurance options for those who have the social security numbers necessary for purchasing insurance, immigrants who are undocumented are explicitly denied in partaking in any of the benefits that the ACA offers. Currently, healthcare options are limited for undocumented immigrants, who, if they do seek out healthcare, mostly rely on low-cost or free clinics (NCLR, 2009). The report from the Hispanic Health Coalition of Georgia's (HHCG) 2012 summit shows that there are only about ten facilities that offer low-cost reproductive healthcare in Atlanta. Latina immigrants are more likely to be in their reproductive years than the general female population of the country, and Georgia is no exception. According to the HHCG's 2012 Latino Health Report Card, the fertility rate among Georgia Latinas of childbearing

age is 94%, drastically higher than the 58% rate for Georgia's total population of women of the same age cohort. The same source states that only 55% of Georgia's Latinas initiate prenatal care in the first trimester of their pregnancy, while the rate stands at 78% for Georgia's women in general. However, the Center for Disease Control (CDC) reported in 2013 that the Hispanic fertility rate for foreign-born and native Hispanic had taken a severe nosedive across the U.S. As detailed in Chapter Five, my interviewees' corroborated the CDC data that shows that Hispanics living in the U.S. are having smaller families, despite the Hispanic fertility rate in Georgia being relatively high.

Many undocumented Latinas give birth in emergency rooms in public hospitals, which, in states such as Georgia, are turning into locations where immigration status must be confirmed, and where an undocumented status can negatively affect the quality of service and perhaps preclude treatment altogether (NCLR, 2009; Redmon, 2011a). Thus public hospitals are susceptible to turning into sites of immigration enforcement, and interviewees, as well as various immigrant healthcare advocates and providers with whom I spoke, told me that it was not unheard of for immigrants to be asked of their legal standing while receiving care. In addition to the paucity of affordable reproductive healthcare options, another obstacle undocumented Latinas in Atlanta face is the threat – whether real or perceived – that going to the doctor will put them in danger of being caught; Chapter Three discusses the views of some of the women I interviewed on this matter.

II) Situating and Performing Feminist Research

I undertook this research with a feminist approach and adhered to feminist research methodologies while in the field, being sure to reflect on my own positionality throughout the process and adjusting methodologies as I saw fit. Feminist social scientists have disrupted traditional notions of the field as a discreet locality from which the researcher can step into just as easily as they can step out of. Destroying this social construct of the field as something wholly separate from the home, the academy, etc., has allowed researchers to investigate the ways in which it is constituted by the experiences and assumptions of the researcher themselves (Hyndman, 2001; Nast, 1994). Hyndman synthesizes what many feminist geographers have said about the field, making these three assertions: “as a researcher, one is always in the field; ... by being in the field, one changes it and is changed by it; ... field experience does not automatically authorize knowledge, but rather allows us to generate analyses and tell specific kinds of stories” (2001: 262). Similarly, feminists deconstruct the researcher/research subject binary. Feminist social scientists see the researcher not as an objective authority who merely observes and collects information while in the field, but instead as someone who produces knowledge through social relations with others in the field, including, of course, the “research subjects” (Gibson-Graham, 1994; Hyndman, 2001; Katz, 1994). The implications of this are twofold. First of all, the researcher cannot fully “know” the researcher subject by observing and interacting with them; whatever knowledge they get from this process is *doubly* partial, in that it is both incomplete and biased. Secondly, whatever knowledge they get from this process is produced and context-specific – that is, it is situated (Haraway, 1988). My positionality – as a graduate student, a white woman, a

citizen, an outsider, and a non-mother – shaped my interactions with the women I interviewed and the knowledge that is produced during interviews and focus groups, as well as the way I perceived the on-goings of the organizations in which I observed and volunteered.

Feminist methodology is apt for studying (geo)politics at the scale of the body, as well as for examining differential experiences of health, wellbeing, and healthcare, as feminist health geographers have demonstrated. For instance, in their work on disabled and chronically ill individuals, Chouinard and Grant (1995) and Moss and Dyck (2002) use interviews (as well as, in the case of Chouinard, autobiographical examples) in order to illustrate that the designation of disabled or chronically ill does not fully arise from some inherent defect (or lack) within the body of the individual, but instead often comes from the challenges of a “different” body running up against obstacles in a world made from/for some abstracted idea of bodily normalcy. As a response to mainstream medical geography, feminist health geographers have placed much emphasis on the importance of personal accounts of health and illness in the study of medical geography. Says Dyck, “Talking *to* people, rather than *about* ‘dots on maps’ [referencing Parr, 2002], has been a critical part of a move to include issues of gender, racialization, sexuality, and disability in health geography” (2003: 363, emphasis the author’s). Thus, this dissertation falls in line with a long tradition of feminist research – in health geography and beyond – that sees individual experiences as a vital focus of scholarly attention, as these experiences explicate the nuance of everyday life that quantitative research can sometime obscure.

i) *Restatement of Research Questions*

RQ1: What barriers (legal, socio-economic, linguistic, pragmatic, discursive) exist for recent Latina immigrants' access to reproductive healthcare in Atlanta? How have recent immigration and healthcare laws and their media coverage influenced such barriers to reproductive healthcare?

RQ2: What are the difficulties and risks recent Latina immigrants experience when trying to access reproductive healthcare? What are their actual experiences with obtaining reproductive healthcare?

RQ3: What do the failures and successes in obtaining reproductive healthcare mean for recent Latina immigrants' (biological) citizenship in their new communities and the everyday geopolitics of immigration in Georgia and the U.S.? How do recent Latina immigrants' healthcare experiences shape their identities and understandings of citizenship in Georgia and the U.S.?

ii) *Research Timeline*

I moved to Decatur, Georgia in August of 2012. From August to December of that year, I undertook the first phase of research, which involved trying to get situated in the Hispanic community through volunteering, as well as talking to immigrant advocates and health service providers. The immigrant advocates I spoke to (around 12 total) included clinic administrators, public health researchers who work with immigrants, and immigrant advocacy agency workers. I did not record any of our conversations, but I

refer to some of these conversations tangentially in the empirical chapters. I volunteered at the Latin American Association, an immigrant advocacy organization that provides a range of services and classes, including ESL, employment services, and legal aid. My job as a volunteer mostly involved data entry; as discussed below, this was not ideal for interviewee recruitment, as I had envisioned at the outset of fieldwork. I also volunteered at the Feminist Women's Health Center, where I also performed data entry, as well as tabling at events and festivals. Like my volunteer work at the Latin American Association, volunteering at the Feminist Women's Health Center did not prove to be very fruitful in terms of interviewee recruitment. However, both volunteering opportunities afforded me with helpful connections and an opportunity to participate in and observe organizations that are involved with promoting Latina wellbeing.

I continued to volunteer into the second phase of research, which lasted from January to September of 2013. This phase of research involved performing in-depth, semi-structured interviews. As discussed in the next section, receiving funding from the National Science Foundation in February of 2013 greatly facilitated the recruitment of interviewees, as I was able to hire an interpreter, who also acted as a liaison with the Hispanic community, in addition to being able to provide compensation for interviewees. Together, my interpreter and I interviewed 56 Latina immigrants during the second phase of research.

iii) *Semi-Structured, In-Depth Interviews*

In order to get at the everyday realities of undocumented Latinas as they revolve around accessing and obtaining reproductive healthcare, I used semi-structured, in-depth

interviews. This method proved to be the most efficacious for addressing my research questions, and in the end became the method on which I expended the bulk of my time and resources. I conducted interviews with 56 women total (see table 2.1) with the help of a Spanish-speaking interpreter, whom I will speak more about below. The ages of interviewees ranged from 19 to 60. The average number of children for interviewees was 2.4, and most women were married or had partners.

Table 2. 1: Interviewee Origin, Age, and Number of Children

Pseudonym	Country of Origin	Age	Number of Children	Relationship/Partner
1) Clara	Mexico	28	4	Married
2) Marisol	Mexico	33	2	Married
3) Luna	Mexico	37	2	Married
4) Margarita	Venezuela	26	1	Married
5) Viola	Venezuela	40	2	Married
6) Nadia	Mexico	29	2	Married
7) Sandra	Mexico	52	4	Separated
8) Ursula	Mexico	21	1	Has boyfriend
9) Crystal	Mexico	24	1	Has boyfriend
10) Maria	Mexico	52	3	Has boyfriend
11) Bonita	Dominican Republic	50	3	NA ¹⁰
12) Miranda	Mexico	25	2	Has boyfriend
13) Laura	Colombia	50	2	NA
14) Lupe	Mexico	23	2	Married
15) Lorena	Mexico	48	3	Separated

¹⁰ In some cases, this information was not obtained because of my own oversight and/or the inertia of the interview. In other cases, the information was inaudible in the audio recording.

16) Olivia	Mexico	34	2	NA
17) Talia/Paz	Mexico	46	1	Separated
18) Jasmin	Mexico	36	4	Married
19) Juana	Mexico	20	0	Has boyfriend
20) Yvonne	Guatemala	22	0	Married (husband deported)
21) Carisa	Mexico	36	2	Married
22) Valentina	Mexico	31	2	Single
23) Francesca	Mexico	26	2	Married
24) Elana	Mexico	57	6	NA
25) Sara	Dominican Republic	34	3	Separated
26) Dyanara	Mexico	38	3	Married
27) Felicia	Honduras	58	5	Separated
28) Ana Luz	Mexico	41	2	NA
29) Marina	Mexico	32	6	Married
30) Teresa	Mexico	59	6	Married
31) Jimena	Mexico	60	1	Married
32) Daniela	Mexico	50	2	Married
33) Alejandra	Mexico	47	2	NA
34) Fernanda	Mexico	41	2	Husband in Mexico
35) Keidy	Venezuela	26	2 (1 on the way)	Married
36) Abril	Mexico	36	4 (1 on the way)	Married
37) Rosita	Mexico	28	2	Married
38) Romina	Mexico	22	0 (1 on the way)	Married
39) Blanca	Mexico	32	4	Married
40) Paola	Mexico	39	1	NA
41) Lola	Venezuela	52	2	Married

42) Vanessa	Mexico	26	3	Married
43) Adriana	Mexico	29	3	Married
44) Melanie	Mexico	32	3	Married
45) Alma	Mexico	30	3	Married
46) Violeta	Mexico	34	3	NA
47) Monserrat	Mexico	31	2	Married
48) Manuela	Mexico	37	3	Married
49) Jessinda	Mexico	29	2	Married
50) Graciela	Guatemala	19	0	Single
51) Lucita	Mexico	26	1	NA
52) Anita	Mexico	50	0	Single
53) Rafaela	Mexico	27	3	Married
54) Ania	Mexico	53	2	NA
55) Sonya	Mexico	35	2	Married
56) Mia	Mexico	37	4	Married

Most interviewees worked in some capacity outside of the home, typically in the service industry doing jobs such as hairstyling, cleaning, and selling insurance. Furthest education levels attained ranged from elementary school to graduate degrees, with most reaching and/or finishing high school (see table 2.2). Although an exact measure could not be gauged from interviews, I estimate that most interviewees were of low socio-economic status.

Table 2. 2: Interviewee Education and Employment

Pseudonym	Highest Level of Education	Employment
1) Clara	Finished high school	Insurance agent
2) Marisol	Some high school	Does not currently work
3) Luna	Some high school	Does not currently work
4) Margarita	College	Works in the medical field
5) Viola	NA	NA
6) Nadia	NA	Nail technician
7) Sandra	Some elementary school	Cook in a taqueria
8) Ursula	College degree	Works in the medical field
9) Crystal	NA	NA
10) Maria	Some elementary school	House cleaner
11) Bonita	Some grade school	Works in a salon
12) Miranda	NA	Works in a bakery
13) Laura	Beauty technician school	Works in a salon
14) Lupe	Some high school	Does not currently work
15) Lorena	NA	Works in childcare
16) Olivia	Some elementary school	Does not currently work
17) Talia/Paz	Finished middle school	Hairdresser
18) Jasmin	Beauty technician school	Works in a salon
19) Juana	Finished high school	Works in a cellphone store
20) Yvonne	NA	Cleans houses
21) Carisa	Finished high school	Does not currently work
22) Valentina	Finished elementary school	Works in a restaurant
23) Francesca	Some high school	Works at McDonald's

24) Elena	NA	Hotel housekeeper
25) Sara	Some college	Entrepreneur; sells tamales
26) Dyanara	Finished middle school	Works odd jobs; “knows how to do everything”
27) Felicia	One year of technical school	Babysitter
28) Ana Luz	Beauty technician school; did not finish high school	Works in a salon
29) Marina	Some high school	Does not currently work
30) Teresa	Some elementary school	Hotel housekeeper
31) Jimena	NA	NA
32) Daniela	Has a teaching degree	Works in an elementary school
33) Alejandra	Has a teaching degree	Sometimes cleans houses
34) Fernanda	Finished high school	Does not currently work
35) Keidy	Has a BA in psychology	Does not currently work
36) Abril	Finished high school	Does not currently work
37) Rosita	NA	
38) Romina	High school	Car insurance agent
39) Blanca	Finished high school	Does not currently work
40) Paola	Some elementary school	Not currently working for medical reasons; will go back to dry-cleaning soon
41) Lola	BA in administration	Works in a clothing/alteration shop
42) Vanessa	Got to 9 th grade	Does not currently work
43) Adriana	NA	NA
44) Melanie	NA	NA
45) Alma	Some elementary school	Does not currently work
46) Violeta	Engineering degree	Works in a bakery
47) Monserat	Got to 3 rd grade	Does not currently work
48) Manuela	Some elementary school	Does not currently work

49) Jessinda	Some high school	Works in a store
50) Graciela	Finished high school	Cleans houses
51) Lucita	Some high school	Works in a hotel
52) Anita	BA in management	Works in a cafe
53) Rafaela	Up to 6 th grade	Works in a hotel
54) Ania	No school	Works in a hotel
55) Sonya	Middle school and sewing school	Works at Taco Bell
56) Mia	Up to 3 rd grade	Does not currently work

Informant recruitment proved to be extremely difficult at first. My plan going in to this project was to volunteer at immigrant advocacy and health organizations in order to gain access to the Hispanic population. While I was able to volunteer at two organizations, I was not able to work with Latina immigrants directly. The reason for this was that my Spanish skills were not advanced enough to be assigned to tasks that put me in contact with immigrants themselves. Additionally, and understandably, the Feminist Women's Health Center's Lifting Latina Voices Initiative has a strict "for Latinas, by Latinas" policy, which disqualified me from even observing the initiative in action. I attempted also to recruit interviewees through posting fliers at locations within the Buford Highway Corridor, such as the Latin American Association and CIMA clinics. However, only one woman ever contacted me because of the flier.

Luckily, midway through my research in Atlanta, in February of 2013, I learned that I had won a **Doctoral Dissertation Research Improvement Award (DDRI) from the National Science Foundation (NSF)**. This award allowed me to be able to hire an interpreter, who, unforeseen to me, would also be instrumental in informant recruitment. In April of 2013, I created a flier to advertise the **interpreter** position, which I hung at

the Latin American Association. I promptly got an email from Madelu, a 50-year-old woman from Mexico City who had been living in the Atlanta area for the last ten years. After meeting with Madelu and assessing her qualifications, I hired her on as an interpreter. Understanding my predicament of not being able to recruit women to interview, Madelu agreed to help me by asking friends and acquaintances within the Hispanic community if they would be interested in participating in my study; this project thus utilized snowball and convenience sampling, which, although not ideal on account of potential homogeneity of samples it can produce (Stangor, 2011), nevertheless proved to be extremely effective in recruiting a diverse group of women.

Additionally, Madelu and I often recruited interviewees by sitting in a Mexican bakery on the Buford Highway and telling women who came in about our study. Many of the women agreed to do the interview right away in a quiet area of the bakery. Though I did not envision doing interviews this way, many of the women who said yes to being interviewed preferred doing the interview right away as opposed to setting something up for later in a different location. The bakery was never bustling or too noisy, so this arrangement actually worked out quite well. Some interviews were done at interviewees' homes; this was especially the case for women who were already familiar with Madelu, or women who had heard about this project through a friend. Interviews lasted between half an hour and two hours, and most were conducted in Spanish and interpreted by Madelu in situ. Those on the shorter side were often cut short out of necessity; for example, some women had childcare or work needs that required their attention.

Another benefit of getting the NSF DDRI was that I was able to offer compensation to the women I interviewed, which I chose to give in the form of \$30 gift

cards to stores like Kroger and Target. While in an ideal world interviewees would not need to be “lured” in through monetary gain, given the circumstances of my positionality and that of those I was trying to interview, it would be erroneous to assume that the gift cards did not have an impact on the number of women I was able to recruit. Moreover, as many of these women worked and were mothers, their time was scarce, and some form of compensation seemed only fair, regardless of research ethics.

iv) *Observation*

I was lucky enough to be allowed to observe the waiting room of Grady Hospital’s International Clinic, which serves an immigrant clientele that is predominantly Hispanic. The International Clinic offers a low-cost prenatal care package (\$500), and, even as it is situated in the heart of downtown Atlanta, draws many immigrants – including a large proportion of the women I interviewed – from their homes in the suburbs to receive reproductive care. I observed the waiting room for a total of four times, with each visit lasting two to three hours. As I watched, I took notes in a notebook, but never interacted with the patients and family members seated around me.

Although I had not planned on doing observation in a waiting room¹¹, my time there became invaluable to my research. The women I interviewed often brought up long wait times as one of the main difficulties of accessing healthcare, but the carework – discussed in depth in Chapter Four – that went into planning for and enduring these waits did not fully come through in interviews. Observation is thus a good way to “triangulate” research methods and get an alternative perspective on the matter at hand (Rhoads &

¹¹ This opportunity came about after talking with an administrator for the International Clinic, who welcomed me to observe the waiting room.

Wilson, 2010). During my time observing, I was able to see, for instance, that family members and friends often accompanied a woman in order to look after her children in the waiting room. Snacks and games were also brought along, and the children often played with the toys that were set up in the corner of the waiting room. Additionally, it was not rare for me to see women waiting for two hours or so before being called in to see the doctor.

v) Discourse Analysis of Primary and Secondary Data

I used discourse analysis to pull out and evaluate the main themes of both primary data (interviews) and secondary data (news chapters). This method of analysis assumes that ideologies are present in language, and that, far from being a neutral conduit between physical reality and human thought, language plays a central role in constituting the world (Dixon, 2010; Fairclough, 2001). The secondary data was used largely to build the argument in Chapter Five. For this chapter, I did online searches in order to find recent (from the last five years) news chapters that discussed Hispanic immigration and fertility, especially in light of the CDC's 2013 report that Hispanic fertility was declining more sharply than any other demographic group. Key themes drawn out from this analysis were:

- Hyperfertility among Latinas
- The “theft” of welfare and state resources
- A decline in Latina fertility
- The importance of Hispanic immigrants to the U.S. economy
- The importance of Hispanic immigrants to electoral futures

The primary data gathered from the interviews was transcribed in English and analyzed for main themes. Given that the size of my sample was not unwieldy, I elected to perform this analysis freehand by reading through transcripts and highlighting relevant portions, without the aid of a computer program. I found this to be an efficient and revealing method, as some themes were talked about in different ways that might not have “matched up” using a computer program. Key themes revealed in this analysis were:

- Fear and uncertainty caused by anti-immigrant legislation
- Reproductive healthcare and childbirth knowledge
- Informal networks of care
- Family planning and birth control
- Being assertive with doctors
- Obstacles to reproductive healthcare
 - o Financial obstacles
 - o No insurance
 - o Lack of transportation
 - o Being afraid to drive
 - o Walking and taking public transportation
 - o Rudeness from health service providers and clinic staff
 - o Long wait times to get an appointment
 - o Long wait times in waiting rooms
 - o Lack of time spent with doctor
 - o No interpreter
 - o Difficulty dealing with interpreter

vi) Trial and Error in Focus Groups

Initially, I thought that the use of focus group would greatly enrich the data I could collect. Because of this, I planned to do at least three focus groups with six to eight women each. I also thought that this would be a good method to use in order to mitigate some of the tensions and dynamics between a white, American interviewer and interviewees who are part of a vulnerable group, as in a group setting some might feel bolder as they know that others potentially share their experiences (Anderson & Hatton, 2000; Berg, 2004). Focus groups have proven to be conducive to facilitating conversation among people who share certain experiences, thereby eliciting information that does not always surface during one-on-one interviews (Bosco & Herman, 2009; Secor, 2010; Wilkinson, 1998). As Pratt, who has done focus groups with immigrants says, “Focus groups offer a safe space – literally safety in numbers – in which to discuss issues and experiences, and one in which the authority of the researcher can be challenged and negotiated” (2002: 215).

My interpreter and I arranged a focus group with four women to be held in the apartment of one of the participants. I used the same questions that I used for individual interviews, and while the conversation was lively, there were two main problems with this method. First, Madelu had issues performing in situ interpretation, as the women would often talk one right after another and not give Madelu adequate time to interpret, with one participant even chastising Madelu for not being able to keep up. Except for one woman who was more reserved, every woman in the focus group had a lot that they wanted to say: these women wanted their full stories heard. In the end, I determined that I

could get the same information in a less chaotic manner from one-on-one interviews, and both Madelu and I agreed that focus groups would not work out. Nevertheless, good data was gathered from all of the women in the focus group, and so in the following chapters, I use this data and describe this failed focus group as a group interview.

Conclusion

This chapter has detailed the field site and outlined the methodologies used to conduct research for this dissertation. I began with discussing the Atlanta metro area and the immigration-related changes it has experienced within the past few decades. With a marked increase in rates of growth from foreign-born populations from Latin American countries, Georgia and many of the states that surround it have been characterized by academics as the New South (Durand, Massey, & Capoferro, 2005; Winders, 2006). On the ground, this demographic shift has manifested in a rich and diverse (sub)urban landscape, with the Buford Highway Corridor establishing itself as one of the most ethnically diverse regions in the U.S. However, with this transformation has come vitriol and resistance, as longstanding residents unaccustomed to Latin American culture and susceptible to nativist rhetoric leverage reactionary motives against the new Hispanic members of their community. Such hostility has become codified in a cadre of laws both passed and proposed. But many of these laws – such as HB 87 – have been contested not only on humanitarian grounds, but also because of the very real impact they had on businesses after Hispanic workers were forced to leave communities, either out of fear, or because they were deported (Bridges, 2014, “Georgia mayor stood up to state’s anti-immigrant law”).

I followed the description of the field site with a discussion of the methods I used, first situating my research in the tradition of feminist geography that values micro-scale interactions and the body as a scale of investigation. Interviews are an ideal method for such a project, and they turned out to be very effective for answering the research questions I set out with. However, recruitment was difficult at first, and sometimes interviews were rushed due to the commitments of interviewees. Observation at Grady Hospital's International Clinic was an eye-opening method that gave me further insight into interviewees' contentions that wait times at clinics were exorbitant. Finally, discourse analysis of primary and secondary data helped to draw out common and divergent themes amongst the women I interviewed, and within news chapters that portray Latina reproduction through statistics and stereotypes.

CHAPTER THREE

FEAR, BOLDNESS, and FAMILIARITY: THE THERAPEUTIC LANDSCAPES of UNDOCUMENTED LATINA IMMIGRANTS IN ATLANTA

“Many people think that, if you go to the hospital, they won’t help you because you’re not legally here. Many of my customers, my acquaintances, they’re scared.”

Clara, a 28 year-old immigrant from Mexico who works as an insurance agent

Introduction

I am sitting in an apartment in suburban Atlanta with my interpreter and Marisol, an undocumented immigrant and mother of three who is originally from Mexico. As we are discussing her experiences with healthcare in the U.S., she begins to talk about the health-fortifying foods that she made in Mexico and continues to make here. Among them is homemade yogurt, which she regularly prepares for her family, and which I gratefully accept after she offers it to me. This yogurt is one way that she maintains her health and that of her family, and it is considerably less complicated than the more “formal” routes to wellbeing, such as going to see a doctor. For the cases when she does need to see a doctor, a major obstacle is *getting* there. Marisol has access to a car and knows how to drive, but instead of making a routine doctor’s appointment by car, which would take about 20 minutes, she chooses to get there through a combination of walking along Atlanta’s busy streets and navigating the city’s often-undependable bus system. She picked this doctor because he has a reputation for treating immigrants kindly, but the trip to the clinic will cost her eight hours of her day, long waiting time included. To her, however, it is the lesser evil: by not driving she won’t have to worry about the risk of being pulled over by the police and asked for immigration papers.

This is a common scenario for undocumented Latina immigrants in Atlanta, which is located in what immigration scholars have termed the “New South” (Smith & Winders, 2008) – or the group of states in the Southeastern U.S. that has experienced a drastic increase in immigration from Latin America within the past two decades. Within the same time period, and especially after September 11th, 2001, many states in this region and elsewhere have initiated a localization of immigrant policing, rescaling immigration law from its largely federal purview down to state and municipal laws, which are facilitated by local police officers who often work in collaboration with national agencies such as Immigration and Customs Enforcement (Coleman, 2009; Winders, 2007). Georgia’s own HB 87, passed in 2011, allows police officers to ask anyone for immigration papers while investigating unrelated offenses. While this legislation has been propagated in the name of national security, it has worked to intensify insecurity in the lives of undocumented migrants by making detention and deportation a possible outcome of mundane tasks, such as driving to the doctor’s office (Coleman, 2009; Stuesse & Coleman, 2014). HB 87 prompted many to flee the state, but for those who stayed, like Marisol, the law has become a largely invisible, yet powerful force in their everyday lives. The self-policing immigrants undertake in order to avoid being caught generates new geographies of space and time. If one were to map Marisol’s path to the doctor’s office, the map would seem nonsensical, as it would show a circuitous and time-consuming trek between two relatively close places. To Marisol, however, this route makes perfect sense, as it is a route that lends some sense of control and security to her life.

This paper contributes to health geography's longstanding concern with how place affects health by examining how undocumented Latina immigrants seek health and healthcare in the context of localized immigrant policing in the New South. I combine the concepts of "therapeutic landscapes" and "geographies of fear" to detail the strategies that Latina immigrants employ to foster security through health, and in accessing healthcare, in an environment characterized by insecurity. In addition to the threat of policing, Latina immigrants are acutely susceptible to xenophobic discrimination in a New South city that sees Latin American immigrants' "new faces" as threatening and dangerous (Winders, 2006), and Latina women in particular as threatening due to their perceived "hyperfertile" status (Chavez, 2008; Gutiérrez, 2008; Valdivia, 2007). I therefore examine how fear impacts healthcare access and experiences for undocumented Latinas, both in the forms of face-to-face discrimination, as well as the ever-present, yet intangible, threat of immigrant policing of which it is part and parcel. With deportation as a ubiquitous threat, the Latina immigrants I spoke with invested much energy and time in carefully cultivating the health of themselves and their families, both through formal and informal routes. Like Marisol, interviewees considered doctors' reputation with immigrants before visiting them, and the trip to the clinic was undertaken carefully. As with many immigrants, an important piece of their therapeutic landscapes was incorporating health knowledge from their home countries into their medical treatment here. This included eating certain foods, as with Marisol's preparation of yogurt using techniques from Mexico.

The study of therapeutic landscapes has an innate focus on how place is constitutive of – or prohibitive of – wellbeing, and, importantly, it showcases how

wellbeing is *actively* cultivated in situ. In doing so, this literature draws out how health and wellbeing can simultaneously exist and be absent at the same site for different people (Burgess Watson et al., 2007), as well as how “larger” tides, such as geopolitics and economics, influence the shape and scope of therapeutic landscapes (Dyck & Dossa, 2007). Relatedly, geographies of fear literature focuses on how certain spaces can be conducive to fear and anxiety for some (mostly women), while not others (mostly men). In combining therapeutic landscapes with geographies of fear, I aim to contribute to studies of the active, fragmented, and highly contingent nature of therapeutic landscapes. Specifically, following a review of therapeutic landscapes and geographies of fear and a discussion of my field site and methods, I detail how undocumented Latina immigrants made decisions and undertook actions that would provide some semblance of security through pursuing health and healthcare in a place that could be fear-inducing and dangerous.

The Intertwining Geographies of Fear and Health

The concept of therapeutic landscapes originated within medical geography in the early 1990s with Gesler, who defined the term as, “a geographic metaphor for aiding in the understanding of how the healing process works itself out in places (or situations, locales, settings, milieus)” (1992: 743). Gesler first used the concept to examine the reparative qualities of “natural” or non-medical settings that were thought to have healing and therapeutic capabilities, such as the Asclepian Sanctuary in Epidaurus, Greece (1993) and the Marian Shrine in Lourdes, France (1996). Since then, the term has been diversely employed by Gesler and other health geographers, who have transformed it to include

sites beyond the exceptionally healing, such as formal health settings (e.g. hospitals and clinics) (Oster et al., 2011), places of addiction recovery (Wood et al., 2015), community health organizations (Wendt & Gone, 2012), mundane settings such as domestic gardens (Milligan et al., 2004) and the home (Williams, 2002), and even fictional settings found in novels (Baer & Gesler, 2004). Thus therapeutic landscape can be seen as active tableaux that must be constantly and consciously curated in order to foster the “therapeutic” elements; these landscapes often exist within larger contexts that are anything *but* therapeutic (e.g. Alaazi et al., 2015). In this sense, therapeutic landscapes are reparative, everyday incarnations of people’s desire to enable wellbeing despite living in environments that are often *disabling* of wellbeing. Therapeutic landscapes are thus hardly ever purely therapeutic: “It is already apparent that there can be less positive shades of therapeutic landscapes than have been previously considered.” (Baer & Gesler, 2004: 410).

More recent literature has also highlighted how marginalization and “difference” impact individuals’ facilitation of wellbeing and how this process is situated space (Smyth, 2005). For example, Wendt and Gone (2012) look at indigenous groups in the Midwestern U.S. and Alaazi et al. (2015) explore the health practices of the indigenous homeless population in Winnipeg, while Finlay et al. 2015 et al. and others (e.g. Milligan et al., 2004) have examined the therapeutic landscapes of the elderly. However, little has been written about immigrants and their experiences with therapeutic landscapes, which has promoted Dyck and Dossa to declare immigrants “invisible in the ‘cartography’ of healthy spaces” (2007: 692). In the same breath, Dyck and Dossa also insist that “[t]he gendering of the productive action in constructing healthy space...has received little

attention” (2007: 692). Their study of how two different groups of female migrants living in British Columbia – Sikhs from the Punjab and Afghan-Muslim refugees – make leeway in amending these omissions. They look at how these two groups of immigrants construct healthy environments for themselves and their families using a diversity of modalities, including preparing the foods of their home countries. Dyck and Dossa thus illustrate that therapeutic landscapes are gendered and never purely local, and that home for them should be “understood in the sense of a transnational domain” (2007: 693).

While wealthier migrants and those who are documented may travel back home to maintain connections with their home countries (e.g. Lee et al., 2010), many immigrants are less mobile, and therefore depend greatly on communication technology to sustain the transnational elements of their therapeutic landscapes (Milligan & Wiles, 2010). In the context of localized immigrant policing in the New South, long-distance transnational connections are more necessary than ever, because unlike immigrants living closer to the border (Brown, 2008), and during its less-militarized times, return trips are lengthy and dangerous, therefore forcing migrants to stay in one place. Parsing out the local and transnational topographies of immigrants’ therapeutic landscapes therefore highlights immigrants’ agency and structure in within larger socio-economic and geopolitical contexts.

Health geographers have also investigated how affect and emotions like fear play into therapeutic landscapes. For instance, Andrews (2011) talks about the fear of needles, while Watson et al. (2007) and Oster et al. (2011) discuss how fear shapes women’s childbirth choices in hospitals. Unlike therapeutic landscapes studies that talk about fear in relation to individuals’ phobias and preferences in the medical setting, geographies of

fear literature seeks to connect identity and cultural elements, such as race and gender, to a group's experiences of fear in public space. Geographies of fear have been a longstanding interest in feminist geography (e.g. Pain, 2000; Simon Hutta, 2008; Valentine, 1989). Focusing largely on women, this literature explores how fear (or its absence) shapes experiences of public spaces (e.g. Sandberg & Toffelsen, 2010; Valentine, 1989), such as college campuses (Day, 2001). In drawing attention to how women's geographies are circumscribed by fear, this literature has also questioned the assertion that women's fear of violence in public space is irrational because men are more likely to be victims of violence (Koskela, 1997; Sandberg & Toffelsen, 2010). As Koskela says:

It has been demonstrated that fear is connected not only to the crime-rate but also to *the degree to which people feel they have control over their lives*. A sense of danger is often linked to feelings of uncertainty, helplessness and vulnerability. Thus, fear is closely connected to social well-being: the people who feel most vulnerable in society and have least faith in the future tend to be most afraid. Further, criminal victimisation is often culturally channelled into existing racial and class conflicts. In this sense it can be claimed that the groups that suffer the most oppression are the ones that understandably are most afraid." (1997: 304, emphasis mine)

Koskela hypothesizes that fear is an acute indicator of vulnerability in society, and that it should thus not be brushed aside as an irrational concern. Others note that men's fear may be harder to "capture" because of dominant gender stereotypes in which the tough and fearless male is in contrast to the meek and fearful female; in not reporting fear, some men may be enacting the culturally appropriate script of being tough and fearless, and vice versa (Day, 2001).

Geographies of fear literature has been critiqued, however, for reifying the perception that women are constantly fearful in public. Some feminist geographers therefore focus instead on how women display *boldness* in public places (Koskela, 1997; Zárate, 2014). “Women are not merely objects in space where they experience restrictions and obligations; they also actively produce, define and reclaim space. The interpretation of boldness can be seen as evaluating and analysing women’s capacities, abilities and strengths and using these as means for a potential transformation of power relations, in order to serve the emancipatory aims of feminist research” (Koskela, 1997: 305). It is important to look at fear and boldness in public space in addition to medical settings because the former shines a spotlight on how healthcare *access* – which nearly always necessitates movement through public space – is impeded and enabled by the feelings that vulnerability engenders.

Site and Methods

Since 2000, Georgia’s Hispanic population has nearly doubled – largely through immigration – reaching 819,887 in the 2010 census (the number is in reality higher, of course, because undocumented individuals aren’t included in this count). It is estimated that around 50% of these immigrants live in just four counties: Fulton, where Atlanta is located, as well as the metro counties of Cobb, Dekalb, and Gwinnett; these counties have diverse economies and are home to many stable and growing industries in which immigrants find employment (City Data, 2011; U.S. Census Bureau, 2010). In addition to HB 87, Fulton, Cobb, DeKalb, and Gwinnett Counties were part of the Secure Communities Program (which was replaced by the Priority Enforcement Program in

2015) (Department of Homeland Security, 2011). This joint federal, state, and local program enlisted local law officers to participate in immigration enforcement through the use of a national fingerprint database, which aids officers in identifying “criminal aliens.” Once identified, ICE can detain and deport criminal aliens (U.S. Immigration and Customs Enforcement, 2013).

As an emerging immigrant destination, the Atlanta metropolitan area does not have the extensive social aid structures for immigrants that many longstanding immigrant destinations do. Atlanta’s immigrant support systems are instead relatively nebulous and often difficult to navigate. According to the National Council of La Raza (NCLR) (2009), an estimated 41 percent of those who are without health insurance in Georgia are Hispanic. Although the Affordable Care Act (ACA) provides low-cost health insurance options, immigrants who are undocumented are explicitly excluded from any ACA benefits. Currently, healthcare options are limited for undocumented immigrants, who, if they do seek out healthcare, mostly rely on low-cost or free clinics (NCLR, 2009). For example, the report from the Hispanic Health Coalition of Georgia’s 2012 Summit shows that there are only about a dozen facilities that offer low-cost reproductive healthcare in the Atlanta metro area.

From August of 2012 to September of 2013, I conducted research while living in Decatur, Georgia, on the outskirts of Atlanta proper and adjacent to the Buford Highway corridor, a sprawling and diverse multi-ethnic region where the city’s immigrants are highly concentrated. During this time, I conducted in-depth, semi-structured interviews with 56 immigrants from Mexico (46), Venezuela (4), the Dominican Republic (2), Guatemala (2), Honduras (1), and Colombia (1). Except the three interviews that were

performed in English, all interviews were done with the help of a Spanish-speaking interpreter from Mexico City and translated into English. Interviewees' ages ranged from 19 to the early 60s. The vast majority was of low socio-economic status and had at least one child (five had no children at all). Most interviews revolved around reproductive healthcare and childbirth: that was a top priority of interviewees and the reason most of them saw the doctor. I was careful never to inquire as to the immigration status of anyone I interviewed; however, many were forthcoming and revealed during our interviews that they were undocumented. I estimate that about 3/4 of my interviewees were undocumented. My interpreter and I recruited most women by sitting in a Mexican bakery on the Buford Highway and telling customers who came in about the project. Although I was an unfamiliar white woman, I feel that in situating recruitment within a place familiar and "safe" to my informants and having a Mexican interpreter, I was able to recruit interviewees more easily than I had anticipated.

I chose in-depth, semi-structured interviews because I wanted to uncover the distinct variables that go into health and healthcare decisions. These decisions are irreducible to one single factor, and are often largely determined by "immeasurable" factors (Bissonnette et al., 2012). This is especially notable in the case of immigrants, for whom many diverse cultural considerations go into the decision of when and where to receive healthcare (e.g. Dyck, 1995; Thomas, 2010). Such information is best gleaned from ethnographic research, or, as Dyck puts it, "Talking *to* people, rather than *about* 'dots on maps' [referencing Parr, 2002]" (2003: 363, emphasis Dyck's). Because I wanted to find out how fear and other intangible, aspatial factors would be one such consideration, in-depth interviews about women's experiences was the most befitting

method. This paper thus also contributes to health geography's more recent focus on the *lived experiences* of health and wellbeing (Dyck, 1995 & 2003; Kearns, 1997). Data from interviews was analyzed through close readings of interview transcripts and notes to draw out key themes. In keeping with health geography's imperative to highlight the lived experience, diligence was undertaken to recognize the varying ways in which these themes were presented in each individual interview.

Fear of Immigrant Policing

Fear is not simply a response to an immediately tangible threat, but also a mindset that can take hold in situations where someone feels that they do not have control, leaving them with a sense of vulnerability whose source is multiple (Koskela, 1997). Although the majority of interviewees had never had contact with the police in the U.S.¹², fear and vulnerability was something that permeated their daily lives. For them, accessing reproductive healthcare was an emotionally-wrought and fearful endeavor due to various factors, not least among them the risk from localized immigrant policing. This was especially evident in the case of interviewees who purposefully quit driving after HB 87 was passed¹³; in these instances, women would opt for public transportation or walking (and more commonly a combination of both), turning what could be a relatively short car ride into a trek of at least an hour or more (which of course was always the case for those who never drove in the first place). As most immigrants live in sprawling suburban Atlanta, walkability is not at its prime, and the Buford Highway is a six-lane behemoth

¹² Most women knew of someone, including close family members, who were deported.

¹³ Interestingly, several interviewees who stopped driving after HB 87 reported that their undocumented husbands continued to drive, aligning perhaps with feminist geographers' theorizations that displays of fearlessness are often shaped by notions of a "brave" masculine ideal; this is discussed in further depth in the conclusion to this dissertation.

with few sidewalks or crosswalks. For many interviewees who did not drive, a clinic's proximity therefore sometimes trumped its cost. Jasmin, 36 and from Mexico, told me of a particularly expensive experience: "My pregnancy was high risk, so I had to pay for specialized consultations. I paid \$1000 a month, every ultrasound was extra. But I went there because it was close to home and I cannot drive. I thought that was amazing expensive."

Fearfulness was not limited to those who stopped driving. After the passage of HB 87, many women recognized the danger of driving, but continued to drive because the inefficiency of MARTA, Atlanta's public transportation system, was too risky in and of itself to deal with; this was especially the case for women who worked outside of the home and needed to be at their job on time. Paz, a 46-year old hairdresser from Mexico, told me, "The police, they are making a lot of the stops and taking people. They are not doing that for criminals – they're really looking for immigrants, Hispanics. And we need to get out of this – we need to drive. Even if there is transportation, the transportation is not good. The amount of buses is not good." For these women, driving, though risky, was normalized – a risk absorbed into the reality of everyday life. Many of these women told me how they used "God's license" – or prayer – as a way to deal with the fear and risk. Thus, though driving was normalized, the "normal" experience of driving while undocumented was wrought with stress and ritual, and was no mindless task. Paz went on to describe her experience of driving in the new environment of insecurity:

Every time there is a stop I pray – I pray, I pray, I pray [gets emotional]. ...There are police and I get so stressed. Last Wednesday I got out of job and I saw a patrol behind me. I was trained when I drive – I do that [imitates praying]. And when I saw that patrol, I was crying and when I saw the next car, and the next... When we arrived at

the Latin American Association I flashed my lights to the other car because I was scared for them.... What I wanted was a ride home.

Paz's ritualized praying – something several interviewees reported doing – was a way to create some semblance of control in an insecure situation. Her fear, however, could never be fully abated, but driving was a risk she had to take. She knew that this was a risk that others near the Latin American Association – an immigrant advocacy and education organization – were likely to share, hence her flashing her headlights at another car. Paz's experience illustrates that cultivating therapeutic landscapes sometimes involves grappling with fear. Though HB 87 does not explicitly curtail medical care for the undocumented the way that the ACA does, by imbuing public space with insecurity, decisions about seeing a doctor have to be weighed in the context of whether or not they are pressing enough to merit risking deportation. In the case of my interviewees, who mainly sought reproductive healthcare for prenatal needs and childbirth, seeing a doctor for the health of their child was worth the risk. In using tactics such as praying and taking public transportation, the women I interviewed lessened the risk and demonstrated boldness in a dangerous environment.

Public space was not the only place where interviewees experienced the fear of being “caught.” Unfamiliar with the purview of a doctor's responsibility in the U.S., some saw doctors as authority figures who could potentially ask them for documentation. In these cases, a doctor's office became another “border” to try to cross safely, or to

avoid altogether¹⁴. For instance, Clara, a 28 year-old insurance agent from Mexico with four children, talked about how some women wait until they are in labor to see a doctor:

Clara: A lot of people are scare that if you go to the hospital they won't help you, because you're not legally here. Many of my customers, my acquaintances, they're scared.

Author: But for pregnancy and childbirth, you kind of have to go, towards the end.

Clara: Many people among the community, not particularly myself, they wait until the last moment to go to the emergency room. They don't do *any* care. *Many* people that I know, they don't go at all during the nine months, until they give birth.

In sharing their stories of how fear shaped their ability to be public, as well as how it sometimes stopped some from seeking medical treatment, it was clear that immigrant policing and the threat thereof greatly constrained interviewees' access to healthcare. However, this fear was not completely demobilizing. While forming therapeutic landscapes involved *inactivity*, or not doing certain things or going certain places in order to avoid risk, it also involved acts of boldness: numerous interviewees braved public space, using tactics such as praying while driving, or walking instead of driving, to mitigate both risk and assuage fear.

Seeking Kindness and Respect

The women I interviewed expressed anxiety about navigating a foreign medical system while not being able to communicate fully with doctors, fearing that their treatment would not be as good because they did not speak English. To them, poor treatment was

¹⁴ In talking to an immigrant healthcare advocate, she revealed that a women's clinic popular among Latinas was moved to a different location, in part because it was near a police station and undocumented immigrants were afraid to go to the clinic after HB 87.

both a result of the dynamics of medical interpreting (and a lack of interpreters in many cases), as well as a fear that some doctors would not treat them well because of xenophobic beliefs. A doctor's reputation was therefore a consideration in deciding what clinic to visit, especially among immigrants who had been in the city for several years and had gained a knowledge of the medical terrain through experience and social networks. When I asked what doctors could do to provide better care for immigrants, the number one response was that they should have more patience, as well as some knowledge of Latino culture (i.e., cultural competency). For instance, Ursula, a 21-year old from Mexico, said that, "Doctors should be honest with immigrants and not treat them really bad. On a scale of one to ten [with ten being the most urgent], I would give doctors a ten on the need to be patient." Interviewees spoke of dealing with curtness and hostility from doctors, nurses, and receptionists, which they attributed partly to health service providers' impatience when having to deal with someone who did not speak English. Patience was also discussed in the regard to the amount of time doctor spent with them. The women I interviewed told me how they were surprised at the brevity of their interaction with doctors during appointments, as the doctors they were accustomed to in their home countries spoke to a patient a bit about their lifestyle before delving into diagnosis and treatment. Said Talia: "A good doctor will be more sympathetic and they will be more...eclectic. They will check about your...the place where you live and what you do. So they really help you to find what the real conditions are that are causing your problems." Concerning cultural competency, Lucita – 26 and from Mexico – told me, "Doctors should try to make a cultural bridge with the Hispanic people. If any of them would say just one or two words in Spanish. Even if they just speak two words, I will feel

much better, just because they try to use words to connect with us.” A doctor’s uncouth decorum and culturally insensitive attitude is undoubtedly a result of many factors, including the fact that a New South city like Atlanta is not yet equipped to handle the cultural requirements of those from different countries. Several of the women I spoke to recognized this as one element that goes into a doctor’s behavior. As many women also pointed out, doctors’ bad bedside manners seem also to be a symptom of the inadequacy and overcrowding of American healthcare system in general.

In populating their therapeutic landscapes with doctors who treated them with patience and respect, interviewees thought it was important to both avoid rude doctors – or counter their rudeness – as well as to actively seek kind and culturally-competent care. In regard to the latter, a significant portion of the women I interviewed knew to avoid a certain large public hospital in Atlanta because it has a reputation for treating immigrants poorly, even if the service is relatively affordable. However, in being constrained by so many other factors, interviewees did not have infinite ability to “shop around” for the perfect doctor. Instead many of them used boldness to, in a sense, demand respect and attention when they felt they weren’t receiving it. Many women proudly told me stories about how they stood up to doctors, which resulted in receiving better care. Dyanara, a 38-year-old mother of three from Mexico, described how she did this when she insisted on another nurse after the first nurse could not get a needle in her vein to draw blood during an appointment:

When I was in for the cesarean, she [the nurse] pinch me here twice [trying to insert a needle]. I was working for a doctor and I learned how to do it [draw blood] in Mexico. I was telling her, “You’re wrong, you’re wrong.” And she told me, “Who has studied – you or me?” And I told her,

“No, you don’t do it. Too many mistakes. Another nurse.”
And I didn’t allow her.

Jasmin, a 36 year-old beautician from Mexico, also demonstrated how boldness can be used to garner better treatment: “I already fight with the pediatrician – and he’s Hispanic but he was very mean to me so now when he sees me, he’s, ‘Hi my lady – blah, blah, blah,’ and I’m sure he used to be ‘This woman!’ But that’s when I fight and defend myself and now he treats me with respect.” Jasmin and Dyanara both illustrate feminist geographers’ contention that women are not all-consumed by fear at all times, and that they can exert boldness in situations where one might expect them only to feel fear. Further, they demonstrate how therapeutic landscapes are not merely constructed, but sometimes even fought for through confrontations that are a means to a more therapeutic end.

In light of the poor treatment the women I spoke with faced, it is evident how the therapeutic – in this case, receiving good medical care – can coexist with the non-therapeutic – in this case, the fear, mistreatment, and mental anguish that resulted. When these two things intermingle, a therapeutic landscape might be beneficial in the health sense, but actually detrimental in a psychological and social sense, harkening back to Baer and Gesler’s notion (2004) that therapeutic landscapes contain aspects that are not positive. However, many interviewees sought to reconcile the duality of the therapeutic and the non-therapeutic by seeking out doctors who would be kind, as well as exerting boldness and pushing back against doctors who were not.

Familiarity and Security

As is common with first-generation immigrants, the women I spoke with blended healthcare modalities from both their home countries and receiving communities (e.g. Sime, 2014, Thomas, 2010). Interviewees communicated with family, friends, and health professionals from their home countries not only to obtain health knowledge, but sometimes even medicine itself (before it became unlawful to do so), which was more affordable. Anita, who had no kids and was from Mexico, explained, “I used to receive medicine like that [by mail] but now my mother cannot send me unless it’s with a person and the person is to have – at the airport – the prescription. Before, my mom, she sent me FedEx – now you cannot by FedEx.” Mostly, though, interviewees kept in touch with family back home through phone and email and received health information regularly; this was especially the case for young first-time mothers who did not know many people in the U.S. On account of communication technology, it was clear that, although their mobility was greatly curtailed, interviewees’ therapeutic landscapes transcended the situatedness of their bodies.

Many sought advice on natural remedies and relied greatly on certain herbs and foods – which varied from person to person depending on what country and region they were from – in order to maintain their health. The majority of interviewees who used these remedies purchased them in Mexican-owned and run stores located in immigrant enclaves, such as the Buford Highway corridor, where they felt safe going. Herbal remedies were commonly used for reproductive health purposes. This excerpt of the conversation between Clara and my interpreter (both from Mexico), illustrates the familial sharing and importance of herbal health knowledge:

Author: Do you follow the advice of friends or family?

Clara: Yes, I do. For example, after the pregnancy, they say take basil seed, because all the air that gets in the stomach pregnancy – it helps you return to your size...Also, when I went into labor with my last one, my due date was past, so I needed to take *epazote*.

Interpreter: [To me] It's a very, very native herb. It's a plant. It's great. Also helps you with the menstruation, the monthly cramps. But you cannot take too much, because then you will...

Clara: Abort. Well, miscarriage. There are some people who use this to miscarry. I used it because I wanted to give birth faster, so I did use that.

Author: I didn't know that. Can you buy this in stores?

Interpreter: Yes! In the Mexican stores. I can show you¹⁵.

Clara: As a community, we follow the traditions of our ancestors and what our grandmothers tell us. For example, my grandmother said that the purple onion helps to take out the flames [heartburn].

In taking these remedies, many of which were preventative, the women I interviewed were controlling what little they could – their own bodies, their health – in a place where many aspects of their lives were out of their control. In this sense, remedies from home had both a biological and palliative effect for interviewees, acting as a form of “insurance” against future illness, as well as a way to bring the familiar into an unfamiliar place and ease feelings of vulnerability.

While for the women I interviewed – none of whom had homebirths in the U.S. – being pregnant necessitated going to the doctor's and interacting with them in a medicalized setting, it did not necessitate wholly subscribing to the U.S. brand of childbirth. However, interviewees did not necessarily see an irreparable conflict between

¹⁵ She did indeed thereafter take me to a Mexican store/taqueria to show me the herbs.

their modalities and those of obstetricians in the U.S. and instead created their own hybrid system that drew from both sources. They stated that they followed the medical advice of both their doctors and their families, and if one seemed more logical than the other, then they disregarded the other. (Only one woman reported using no traditional medicine at all, stating adamantly that she was an independent thinker.) They did, however, hide certain practices from doctors. For instance, some interviewees tied a red string around a baby's wrist to ward off *ojo*, or the "evil eye." This was not always taken well by American doctors, who considered the string to be hazardous (of course, my informants viewed it as the opposite – as something protective). In response, some women simply took the string off only when seeing a doctor. Similarly, Jasmin talked about the practice of securing a marble in a newborn's bellybutton. Knowing that her doctor would find it odd at the very least, Jasmin would take it out before doctor's visits, but did not always remember to do this:

Jasmin: Yeah, in the bellybutton you put a marble because the belly can [makes bad sound] can come out, so that's protection. The baby had fever so I took him to the doctor and because he had fever they take out all the clots and [the doctor] was, "What have you done to the baby? You should never do that!" But it's very good. His bellybutton doesn't stick out because we do that.

Author: Did the doctor take it out?

Jasmin: Yes, but I put it in again. I said, "Okay, okay." But when I went back home, I did it again to my baby. But I was very – "Shit! I forgot to take out! I didn't remember!" I always take it out before, but that day [shakes head]...

However, my informants did reveal health knowledge from their home countries when they felt it urgent or necessary. This was the case with Rh blood tests, which many of the women I interviewed saw as very important, but which they did not perceive to be

performed regularly in the U.S. This test is performed to make sure that a mother with Rh negative blood does not “become allergic” to an Rh positive baby; Rh negativity was understood by my informants to be more prevalent in certain Latin American populations, and thus women with family histories of Rh complications felt it necessary to be vocal about this concern. These women proactively told the doctor they were, or could possibly be, Rh negative and needed a shot to prevent complications. Clara told me, “When they checked my blood type [in Mexico], the person told my mother that when I got pregnant, I needed to have a special shot...because the type of blood that I have. My mother always said to remember your blood type...In fact my mother was always reminding me, because an aunt has this kind of blood, and she has a lot of miscarriages.” Interestingly, Nadia, 29 and from Mexico, revealed that when she had her first child in Phoenix, the doctors knew Rh negativity was a big concern among Latinas, but that the doctors who delivered her last two children in Atlanta did not, and other interviewees expressed concern that obstetricians did not seem concerned about their blood type; this is perhaps a result of the fact that doctors in Atlanta have had considerably less experience with Latina patients in comparison to a longstanding destination city like Phoenix.

For the women I interviewed, the use of elements from home to construct their therapeutic landscapes was both practical (e.g., it saved money on doctor’s visits, and it prevented complications in the case of Rh negativity) and palliative in that it created a sense of familiarity and control for interviewees, both inside doctor’s offices and without (i.e., frequenting Mexican stores for herbs). While interviewees were selective about what transnational health knowledge they shared with their doctors, they did not express

much concern about any irreconcilable conflict between this knowledge and medical advice from doctors, and instead used both at different times to their advantage. This illustrates that therapeutic landscapes are complex, malleable, extra-local entanglements of knowledge and practice, as opposed to smooth and stable landscapes that are knowable upon first glance.

Conclusion

The therapeutic landscapes of the women I interviewed were shaped in large part by fear. While Georgia's HB 87 remains an employable *de jure* mechanism to police those without documents, in the absence of its actual application (which has in fact decreased since the time the law was first passed, largely due to pushback from businesses that depend on undocumented laborers), it more often works as a *de facto* mechanism that propels immigrants to self-police. In the case of many interviewees, HB 87 exists as a specter that forced them out of their cars and into the streets. Those who kept driving tried to evade this specter with every trip, and were selective about why they ventured out into public. The recent move by some clinics to deliver secure healthcare directly to the underserved Hispanic population of the Atlanta metro area through "mobile medicine" is recognition of the impediment that public space now poses to undocumented immigrants' healthcare access. Worried that undocumented immigrants would not seek healthcare if it meant driving to far-flung places and risking deportation, providers like Northside Hospital now send equipped trailers out to places where preventative and diagnostic tests, such as cancer screening, can be performed where immigrants feel safe, like their own neighborhoods and the Mexican consulate. This is a step in the right direction for

addressing how fear and vulnerability affect healthcare access, though there is a ways to go: only one of the women I interviewed reported utilizing mobile medicine, and only a handful knew of the option. The risk of deportation did not completely stop my informants from going to the doctor's, at least in matters related to reproduction, when it is arguably imperative to see a medical professional. Bearing on this necessity, some women took steps to ensure that accessing a doctor was done in a manner that mitigates risk. They also sought out doctors that were kind and culturally competent, and when they were treated poorly, many acted boldly and confronted doctors, resulting in better treatment.

Cultivating therapeutic landscapes was also an essential placemaking strategy that infused an unfamiliar environment (and an environment which may also be hostile and unwelcoming) with bits of familiarity, while at the same time trying to remediate the difficulties of dealing with a foreign healthcare system. As such, interviewees' therapeutic landscapes included transnational elements, such as herbs and traditional foods, that lent a sense of familiarity and security in an environment that was very much unfamiliar and unpredictable. Going to a Mexican store to get herbs used in their home countries, for instance, was a healthy act that was met with far less fear than going to see a doctor. However, the fear of being rebuked by a doctor caused them to hide certain practices (such as the red bracelets), while the concern of medical emergency caused them to speak up about others (as with the case of Rh negativity). Moreover, in caring for their health through both formal and informal means, the women I spoke with were exhibiting control over their bodies, an act whose importance cannot be underestimated when so much outside of their bodies was out of their control.

My interviewees' therapeutic landscapes were never fully therapeutic, and were in fact fostered in an environment that could easily be characterized as the opposite of therapeutic for undocumented immigrants: it was risky, stress-inducing, and unfamiliar. However, in taking actions to alleviate the negative elements and incorporate familiarity, the women I spoke with were able to weave together therapeutic landscapes that were *reparative* in that they were conducive to both physical and mental health. Caring for the wellbeing of their bodies was healthy in and of itself, but so was the fact that, in doing so, interviewees were also reaping and sowing a sense of mental peace by feeling more secure in their health, regardless of the actual efficacy of the healthcare. Their therapeutic landscapes were thus dual not only because they at once contained therapeutic and non-therapeutic elements – with the former often being an attempt to assuage the latter – but also because they simultaneously worked to improve and maintain both physical and mental health through cultivating familiarity and wellbeing. This paper thus contributes to the study of the vibrancy and contradictions of therapeutic landscapes while adding to it an emphasis on how fear (and boldness) is an important element in contouring these landscapes for undocumented immigrants in terms of both access to, and experiences of, healthcare. This is an especially urgent concern in light of the way that localized immigrant policing infuses everyday life with risk and uncertainty for undocumented immigrants.

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CHAPTER FOUR

BIOLOGICAL CITIZENSHIP and the GEOPOLITICS of (HEALTH)CARE: THE REPRODUCTIVE HEALTHCARE EXPERIENCES of LATINA IMMIGRANTS in ATLANTA

"A paper doesn't make a difference to a sickness."

Valentina, 31, from Mexico, on why undocumented immigrants deserve healthcare

Introduction

In this paper, I look at how a “mundane” aspect of everyday life – reproductive healthcare – is impacted when localized immigrant policing becomes entangled with harmful reproductive stereotypes to present a web of obstacles for Latina immigrants living in Atlanta. Feminist political geographers have insisted on the importance of examining “micropolitics” in order to unravel how the (geo)political inflects everyday life and vice-versa (Hyndman, 2004; Staeheli & Kofman, 2004); they have also explored the primacy of care in upholding society (Kittay, 1998; Lawson, 2007). Although reproductive healthcare is mundane in that doctor’s visits are typically a routine part of everyday life, it is also an extraordinary site for untangling lines of thought that transcend scale and connect the U.S.-Mexico border to women’s clinics in metro Atlanta, and to women’s corporeality itself. It is vital that the geopolitics that occur in medical spaces at the scale of the body are examined because, as feminist political scholars have described, geopolitics work through the body (Dowler & Sharp, 2001; Mayer, 2004), and at the heart of nation-building projects are ideologies concerning which bodies are deserving of care and which are not (Chavez, 2008; Luibhéid, 2002). Because of their capacity to reproduce biologically, as well as the extensive role they play in social reproduction – or the maintenance of the self and others through everyday tasks (Mitchell, Marston, &

Katz, 2004) – undocumented Latina immigrants *embody* illicit border crossings. Myths about Latinas’ hyperfertility and proclivity for “scamming” the welfare state have justified formal and informal regimes aimed at controlling demographic change and safeguarding the resources of the polity, expressly through forcing or coercing certain unwelcome bodies to stop reproducing other unwelcome bodies (Chavez, 2008; Gutiérrez, 2008; Valdivia, 2007). Interventions upon these myths manifest in many forms in medical spaces. For instance, while the forced sterilization of Puerto Rican women is well documented, Latina women have been the targets of coercive sterilization even on mainland U.S. (Gutiérrez, 2008). More often than not, though, harmful bio-geopolitical notions take on banal disguises, and because of this, ordinary goings-on in medical spaces are commonly overlooked as places where geopolitical battles are waged.

The (geo)political encounters encapsulated in biomedical discourses and actions, however, have been taken up – largely by anthropologists – in the concept of biological citizenship, which can be defined as how individuals and groups “become visible” via discourse that invokes the biological (Greenhough, 2010; Petryna, 2002). I suggest that biological citizenship has great application in political geography – and feminist political geography in particular – because it draws out the micropolitical articulations of biomedicine, something that has been largely ignored within political geography. In line with feminist geopolitics, biological citizenship literature focuses on the ways that inclusion in the polity is claimed not through demonstrations that are outwardly political, but through acts that make up the minutia of everyday life, thereby illustrating how the power to engender political inclusion is not always loud and obvious (Greenhough, 2010). Moreover, biological citizenship departs from studies that invoke governmentality

to examine how biology is a medium of political subjectivization because it illustrates how individuals act *outside* of top-down hegemonic scripts of acceptability in order to imagine and enact new configurations of inclusion (Fraser, 2010; Rose, 2007a & 2007b). The machination of power envisioned by biological citizenship is fitting for this paper, because while the women I interviewed ran up against many barriers and constraints from “on high,” they also actively defied these barriers in order to obtain a good quality of reproductive healthcare, thereby claiming and enacting a deservingness that they are not often afforded.

While I talk about how Latinas’ access to and experiences of reproductive healthcare are greatly hindered by localized immigrant policing and longstanding stereotypes, I also draw out how Latina immigrants fight back in the same arena where they are being targeted – at the level of social reproduction. I argue that they use carework, which I define as performing seemingly small tasks to aid in securing the good healthcare that they are ideologically and actually denied, such as doing research before a doctor’s appointment, interpreting for a family member during a trip to the doctor, and telling a friend which hospital to avoid. This paper thus contributes to and expands upon care literature by demonstrating care’s political virility in the context of medicine and the competing ethics of (un)care therein. Even as Latina immigrants are denied formal care in the form of attention from health service providers, I show how they use carework in order to secure the healthcare they feel they deserve. Additionally, I look at how an ethics of care presents itself in relationships between Latina immigrants, even if they are only acquaintances. As Veronica Crossa (2005) said in response to Susan Smith’s paper on care published in the pages of this journal, “This is the kind of politics that I believe

Smith suggests. A politics which recognizes the practices and interactions of people who ‘happily, defiantly, quietly, routinely or in desperation’ seek for new ways of ‘infusing their homes and neighborhoods with an ethic of care,’ in a context where the predominant ethic is one of competition and self-reliance” (33).

I begin by describing the changing immigration landscape of the American South and the recent trends in immigration to Georgia and Atlanta, as well as the localized immigration legislation recently passed by the state. From there, I work through the relationship between biological citizenship and care. I then discuss the obstacles my interviewees faced while trying to access reproductive healthcare, which came in the form of spatial and temporal obstacles, as well as interpersonal discrimination. I detail the ways in which interviewees used carework to counter these obstacles, or as one woman put it, “Resist how they treat us.” Finally, I discuss how interviewees encountered what they believed to be eugenic and nativist notions in medical spaces, and how these moments have generated acts of biological citizenship that operate on a powerful collective level.

Hispanic Immigration in Atlanta

Georgia and many other southern states have seen a dramatic growth in Hispanic immigration within the past several decades, “disrupting” cultures, economies, and political systems that have long been characterized by a black-white divide (Coleman, 2009; Winders, 2007). Since 2000, Georgia’s Hispanic population alone has nearly doubled. The Atlanta metropolitan area, with a population of over five million people, has received many of these immigrants, with its Hispanic population increasing 72%

between 2000 and 2010 (U.S. Census Bureau, 2010). The metro area, and especially the suburban areas to the north of the city, has a diverse economy comprised of both industry and agriculture, where many immigrants have found employment (City Data, 2011). As a new immigrant destination city for Latino immigrants, Atlanta is in the midst of a major ethnic, political, and economic transformation. Additionally, unlike longstanding destination cities like Los Angeles and Chicago, the support system for immigrants – including provisions such as healthcare – is not entrenched or expansive. According to the National Council of La Raza (NCLR) (2009), an estimated 41 percent of those who are without health insurance in Georgia are Hispanic. While it is hard to say exactly what percentage of those without healthcare coverage are undocumented migrants, it is safe to assume that, due to often informal employment arrangements and a lack of means to purchase private insurance, most of those who are undocumented are also uninsured (Hispanic Health Coalition of Georgia, 2012). Further, the Affordable Care Act explicitly denies undocumented individuals the right to purchase health insurance for themselves using healthcare exchanges. Because they are not likely to have insurance, healthcare options are greatly limited for undocumented immigrants, who, if they do seek out healthcare, mostly rely on low-cost or free clinics (NCLR, 2009). Thus, affordable and culturally-competent clinics are often overcrowded and offer subpar care, with a 2012 report from the Hispanic Health Coalition of Georgia showing that there were only about a dozen women's clinics that fit this description in the Atlanta metro area.

Although these immigrants make up an important part of the state's economy, anti-immigrant sentiment prompted the creation of legislation that sought to push many from the state. Like Arizona's infamous SB 1070, Georgia's Illegal Immigration Reform

and Enforcement Act (House Bill 87), passed in 2011, makes it legal for local police to ask anyone to provide immigration documentation while investigating unrelated offenses. This law mandates that anyone who cannot provide such documentation be arrested and detained. In effect, this law inheres everyday tasks, such as driving several blocks to pick up groceries, with the same risk of deportation as crossing the vast desert of that lies between Mexico and the United States. Since its passage and the exodus it caused from Georgia's fields and factories, the law – though still in effect – has seemed to lose its bite, for employers at least. That is, the powerful backlash from employers who lost those productive, exploitable bodies has curbed the application of HB 87 in many of Georgia's counties. However, it has not lost its bite for undocumented immigrants, who know that the law, though fickle, still exists and can rip family members and friends away at any second (I did talk to several women to whom this happened).

While undocumented immigrants have always undoubtedly experienced friction, be it psychological or social, in performing everyday tasks in public space, the localization of immigrant policing – or the increase in state and local immigration laws, especially after September 11th, 2001 – has effectively worked to criminalize such activity (Coleman, 2007; Coleman & Kocher, 2011). Scholars have explored how state and local immigration laws such as HB 87 operate on the level of social reproduction; that is, they make it difficult for undocumented immigrants to do the “stuff of everyday life” (Smith & Winders, 2008). In public discourse, and on both sides of the proverbial political fence, we see that immigrants are interpolated for their *productive* labor above else (Cravey & Valdivia, 2011) – from liberal arguments that valorize the exploitation of undocumented workers by talking about how immigrants do the work that Americans

“don’t want to do,” to conservative uproar about how local immigration laws are “bad for business” precisely because they take these easily exploitable bodies out of the equation. Smith and Winders (2008) have argued that the demands of flexible production welcome the productive immigrant body while rejecting reproductive body (and, of course, a body can be both at once!). They explain that this is compounded by the fact that a highly militarized border and a paucity of guest worker programs, in addition to the increasing amount of immigration to cities – like Atlanta – that are far-removed from the U.S.-Mexico border (Winders, 2007), make it harder for immigrants to travel back and forth to work seasonally in the U.S. (Smith & Winders, 2008). Increasingly, entire immigrant families are now coming to the U.S. to stay, thereby making the female immigrant body, coded as socially reproductive, an ever more visible presence. Perhaps the most fundamental aspect of social reproduction is biological reproduction itself (Vogel, 2013), a task embodied by females, and which intersects with race and citizenship to make the biological reproduction of some more welcome than that of others (Luibhéid, 2002 & 2004). Because Latina immigrants pose a threat that surfaces in tales of anchor babies and welfare queens (Chavez, 2008; Gutiérrez, 2008), they are viewed as “undeserving” of state resources and are an extremely susceptible target for policing and discrimination.

I conducted research in the Atlanta metro area from August of 2012 to October of 2013. During this time I lived in Decatur, northeast of Atlanta proper, and within close proximity of Buford Highway international corridor, a highway leading out to suburbs such as Norcross and Doraville, where many immigrants live. With the help of a Spanish-speaking interpreter from Mexico City, I conducted in-depth, semi-structured interviews with 56 Latina immigrants who have migrated to Atlanta within the past 25 years. Their

ages ranged from 19 to the early 60s. We recruited many interviewees through simply sitting at a bakery on the Buford highway and telling women who came in about our study. Although my interpreter and I were careful never to ask, many interviewees (about three quarters) were forthcoming about the fact that they were undocumented. I also conducted participant observation in the International Clinic Atlanta's biggest hospital – Grady Memorial – where a low-cost prenatal package is available to immigrant women.

The Body as Border: Biological Citizenship and the Care Inherent

Defined broadly as the ways in which individuals and groups are “made visible” through biological discourse and action, the concept of biological citizenship is a lens that refracts the political to the scale of the body in order to examine how subjects manifest through biological means (Greenhough, 2010). Although biological citizenship is currently utilized more outside the field of geography (e.g. Mason, 2012; Rabinow & Rose, 2006; Rose, 2007b; Rose & Novas, 2003) than within it, several scholars have noted its applicability to geographic studies of health and disease (Cadman, 2009; Greenhough, 2010). The inception of the concept lies with anthropologist Adriana Petryna (2002), who used the term as a way to describe how claims of deservingness can be made through biological discourses espoused by marginalized populations. Petryna interrogated how Ukrainian citizens affected by the Chernobyl disaster's radiation leveraged their “number” – a metric of their degree of radiation exposure – in order to assert themselves as citizens and demand that they be given compensation and aid from the government. Of these sufferers, Petryna notes (2002: 3):

The collective and individual survival strategy called biological citizenship represents a tangle of social

institutions and the deep vulnerabilities of persons...Here the experience of health is irreducible to a set of norms of physiological and mental activity, or to a set of cultural differences. Only through concrete understandings of particular worlds of knowledge, reason, and suffering, and the way they are mediate and shaped by local histories and political economies, can we possibly come to terms with *the intricate human dimensions that protect or undermine health*. Seen this way, health is a construction as well as a contested way of being and evolving in the world. (emphasis mine)

The subjects in Petryna's study appealed to various measures to demonstrate their suffering and consequential deservingness of care and compensation, among them personal stories of anguish and bodily ailments attributed to the radiation. Conversely, while my interviewees lacked political recourse to securing good healthcare because, first of all, most were not legal citizens, and, secondly, their healthcare needs stemmed from routine needs and not a techno-environmental disaster, they constructed their deservingness of healthcare and their right to health around the assertion that all human beings are entitled to these things (this, of course, echoes human rights discourse); additionally, they constructed their deservingness around their role as productive members of their new communities. Availing and acting upon this human right to health confronts and contests the "intricate human dimensions that...undermine health" for those who are undocumented, as well as the uncaring relationships that are engendered by ideas of legal citizenship and the attendant notion of illegality (De Genova, 2002; Nevins, 2002; Varsanyi, 2008).

Although biological citizenship has since taken on a diversity of iterations, including top-down governmentality approaches which resemble biopolitics (e.g. Mason, 2012), bottom-up approaches of biological citizenship have been touted as critiques of

medicalization theory, which attribute doctors and scientists nearly omnipotent power in biomedical relations (Fraser, 2010; Rose, 2007a & 2007b). Medicalization theory relegates very little agency to those who are not biomedical “authorities,” instead portraying them as passive victims of an all-powerful authorities. While biological citizenship leaves room for the disproportionate amount of weight and reverence given to scientific and medical knowledge, it also acknowledges that this knowledge can be co-opted, resisted, and refused (Fraser, 2010; Petryna, 2002). In doing so, biological citizenship elucidates how marginalized groups and individuals act politically in everyday life (Petryna, 2002), much like the scholarship within political geography that reconceptualizes citizenship as an *active*, as opposed to stagnant, status (e.g. Isin & Nielsen, 2008; Staeheli et al., 2012; White, 2008). However, biological citizenship places the medium of power explicitly at the level of the body, something which political geography scholarship often portrays as an *object* that power acts *upon* (e.g. Adey, 2009; Fluri, 2009; Sparke, 2006). In contrast, biological citizenship captures the democratic pathways of power and the ways they shape bodies and borders. Although geopolitical scholars – including a cohort of those who study immigration – have used concepts such as Mbembe’s necropolitics (e.g. Wright, 2011) and Giorgio Agamben’s bare life (e.g. Doty, 2011) to look at how the neglect of certain bodies is political, as well as how bodies are ordered and cared for “from above” as part of a larger process of governmentality and biopolitics (e.g. Adey, 2009; Fitzgerald, 2010; Sparke, 2006), little has been said about care of the body *by oneself* – even as it occurs conterminously with neglect and oppression from without – is a corporeal political act “from below” that confronts and disrupts hegemonic epistemology. While the application of Agamben to

immigration studies has indeed been critiqued (Darling, 2009; Walters, 2008), this paper seeks to go one step beyond critique by focusing on the body and the biological as creative tools for subaltern agency.

Even though those who are undocumented have essentially no agency when it comes to political rights and encounter trouble enacting many civil rights, social rights, such as housing, education, and healthcare, are things that those without papers may lay claim to in their everyday lives, albeit not without difficulties (Martin, N., 2010). This is important because, according to Lister (1997), “Two key arguments for social rights are, first, that they help to promote the effective exercise of civil and political rights by groups who are disadvantaged in terms of power and resources; and, second, that they are essential to the promotion of individual autonomy” (29). These very social rights (and their role in social reproduction) are at stake under the new regime of localized immigrant policing, but they are also where undocumented immigrants are able to fight back (Stuesse & Coleman, 2014). I argue that the carework employed by Latinas in order to obtain (a good quality of) reproductive healthcare and thereby assert their biological citizenship is a micropolitical act that reconfigures the partitioning of deservingness that is imbricated in notions of citizenship and xenophobic stereotypes; by employing this carework, Latinas are able to lay claim to the social right of health. I specifically look at this carework because to focus only on the obstacles that impeded interviewees’ reproductive healthcare would be to offer just half the story, as well as to contribute to the characterization of immigrants as passive victims. It would also be to ignore the feminist imperative to draw care into the limelight and recognize its immense importance

in social, economic, and political life, as well as its potential for confronting injustice and inequality (Carmalt, 2011; Lawson, 2009; Till, 2012).

In addition to unmooring the labor of care from its ideological trappings as the lesser half of productive, masculine labor (e.g. Pratt, 2004), ethics of care scholarship puts forth a relational – as opposed to universal – ethics (Kershaw, 2010; Lawson, 2009; Popke, 2006). Within this formulation, relational specifics, such as the vulnerability and dependency of parties involved, are considered before a moral judgment and its attendant action are applied. Popke (2006) states that, “Caring, in this sense, is not so much an activity as an attitude or orientation, a way of relating to others characterized by the values of compassion and ‘normative concern for inclusion’ [quoting Staeheli & Brown, 2003: 773]” (506). Of course, this orientation is anything but the norm in formal healthcare systems, where differentials of inclusion are determined by numerous variables, including socio-economic status, gender, and ethnicity. In the case of patients who are perceived to be undocumented, many health service providers act in uncaring ways – ranging from microaggressions to providing faulty information – as a way of invoking and intervening upon the trope of the hyperfertile (and thus dangerous) Latina that runs rampant in American thought. Indeed, both HB 87 and the Affordable Care Act (which explicitly excludes those without documents from receiving its benefits) provide a legal justification for *not caring* about some people, while racialized stereotypes construe even those living in the same community as strangers who do not deserve care. This, according to Jean Carmalt (2010), is part and parcel of the “traditional approach of Western moral theorists that prioritizes obligatory duties over supererogatory ones” (301). That is, duties such as not killing are hierarchized over duties that merely seem

kind, though not obligatory, such as helping out a stranger in need. Further, some have talked about the risk of valorizing care through a normative lens that aligns with neoliberal notions of family and individualism (Smith, 2005; Tronto, 2002). The danger here is that caring becomes something only afforded to those immediate to one another, and thus *not caring* for those whose suffering goes unseen becomes commonplace (Cloke, 2002).

Because it is concerned with health, disease, and wellbeing, biological citizenship has an inherent and undeniable occupation with care, and, importantly for feminist political geography, it acutely demonstrates the (geo)political efficacy of this care. Both care and the body have been depoliticized (or never politicized at all) through a universal, individualistic, normative ethics that places caring and bodies outside of the realm of the political (Kittay, 1998). Biological citizenship is a lens that situates politicality at the scale of the body, and caring for the body is unambiguously the medium through which that politicality manifests (Rose, 2007b). Looking at the ethics of care inherent in acts of biological citizenship allows us get a more nuanced view of how care's presence, or lack thereof, shapes inclusion and enables or disables political agency. In a geopolitical milieu where some are explicitly deemed underserving of care, the care of self by those considered underserving is a micropolitical act of contestation. It also demonstrates the geopolitical dimensions of the care of self and family from the point of view of those who are viewed as undeserving of care. While Tronto (2002) has called for an ethics of care that does not solely bolster the neoliberal logic of caring for one's own family at the expense of others, in the context of those deemed undeserving of care, caring for one's family actually goes against the neoliberal logic which makes their health irrelevant. As

illustrated below, because healthcare is seen as a limited resource and therefore safeguarded, the “undeserving” face extra obstacles in caring for themselves and their families through medical outlets, and thus must use informal carework in order to access this protected entity. It is this informal carework that disavows the lack and poor quality of formal care extended to Latinas, and which works to erode divisions between those who are deserving and those who are not. Further, this carework, like care in general (Popke, 2006), is also collaborative in both execution and effect, and thereby contributes to a collective biological citizenship that is greater than the sum of its parts.

“Irrational” Spatio-Temporal Landscapes and Exclusionary Signals

The obstacles that the women I interviewed faced in their reproductive healthcare experiences were both structural and interpersonal. Like structural racism, structural obstacles entail the ordinary tasks and demands of everyday life presenting a disproportionate amount of friction for certain groups and individuals. In the case of my interviewees, intersections of race, gender, socioeconomic status, and immigration status worked to make performing the ordinary activities of everyday life difficult, while also making my informants a target for interpersonal discrimination based on beliefs and stereotypes about their perceived differences. Working in concert, structural and interpersonal discrimination reified interviewees’ status as non-citizens and therefore undeserving of (a good quality of) reproductive healthcare, even in the few cases where my informants did in fact have U.S. citizenship. The U.S. has had a long history of providing inferior and unethical medical treatment to subaltern groups (e.g., the Tuskegee Experiment) as a way to further embed socio-economic divisions and reinforce the

legitimacy of the hegemonic political machine (Horton, 2004; Horton & Barker, 2010; Loyd, 2014). With that being said, it is not my intent to portray the obstacles that the women I interviewed faced as concerted and conscious efforts to “divide and conquer” in all instances. I do not wish to vilify health service providers (with whom I had limited interaction), but, as DeVerteuil and Wilton (2009) put it in their discussion of the connections between addiction treatment services and the welfare state, to point out how “the logic and practice of service providers do not exist outside of relations of power, but nor are they reducible to the broader objectives of the state. Rather they intersect in complex ways with both the macro-scale actions and interests of the state, and the mundane actions of individuals” (465).

A major structural impediment for the women I interviewed was transportation, and this has been exacerbated greatly by the environment of risk created by HB 87. For them, proximity did not carry the bulk of the weight in deciding what doctor or clinic to go to, nor did it mean much in terms of time and convenience. A clinic around the corner may have been hostile to Hispanic immigrants, or too expensive, while one across town may have been welcoming. Therefore if one were to map my interviewees’ clinic and hospital usage, the map would seem spatially non-sensical and be rife with seemingly irrational and uneconomic pathways¹⁶. These pathways would circumvent the plentiful “do not enter areas” marked by a heavy police presence, echoing feminist geographers’ argument that fear is an important factor in how people, especially women, move through space (e.g. Pain, 2010). As a result of HB 87, many of the women I interviewed quit driving altogether out of fear that they would be stopped and detained. These women talked about spending hours just commuting to and from their appointments, whether by

¹⁶ I chose not to create a map, as it would jeopardize the safety and security of the women I interviewed.

walking or by public transportation, or more commonly a mixture of both. While walking in the Atlanta area is especially difficult during inclement weather and in places where there are no sidewalks, using MARTA, the metro area's public transportation system, is tricky because constant traffic congestion means that buses and trains often run late. In Aracely's experience, "The transportation creates so many timing problems. You arrive in time [at the bus stop] just to wait. You wait a long time, but then the transportation arrives so late that you lose the appointment because you don't get there on time." As inconvenient as it may be, walking and waiting for public transportation, often with children in tow, is a way to mitigate at least one of the wrenches that anti-immigrant legislation has thrown into the machinery of social reproduction for undocumented immigrants. Viewed as carework that enables Latinas to enact biological citizenship through receiving healthcare, getting to appointments by means other than driving are micropolitical acts that directly confront the ideological taxonomy which labels immigrants as undeserving not only of services such as healthcare, but also to the right to inhabit public space.

Compounding the "irrationality" of interviewees' spatio-temporal paths to doctor's offices was the fact that, in addition to the time it takes to actually get to an appointment, they routinely spent upwards of an hour in the waiting room; this is more than double the national average (Maat, 2013, "Physician wait times up, expected to keep increasing"). The first of many times an interviewee nonchalantly told me that she usually spends at least an hour in the waiting room before every appointment, I was taken aback. My shock must have been apparent, because my interpreter immediately informed me that an hour-long waiting time was normal for Latina immigrants. These long wait

times are in part a structural deficiency of a city that has had only a short history of receiving Hispanic immigrants. Low-cost, culturally-competent clinics are few and far between, causing overcrowding and overbooking of appointments (Hispanic Health Coalition of Georgia, 2012). I regularly witnessed waiting times of over two hours during my observation of the waiting room at Grady Hospitals's International Clinic. During my observation there, I also saw that many women brought their children with them to appointments, and often an additional family member to watch the children in the waiting room while they saw the doctor. These family members commonly brought food and toys to keep the children entertained, revealing that these long waits were expected and prepared for. Further, it shows that family members were often enrolled to undertake some of the carework that was so vital in interviewees' ability to actually get healthcare; this, I contend, is a creative and collective act of biological citizenship that is directly facilitated by carework.

Many women expressed annoyance at being made to wait so long, but few insisted that it was important to be vocal about it. It was obvious from the perturbed-yet-matter-of-fact manner in which most undocumented women told me how long they wait that they accepted these long wait times, perhaps because rocking the boat was not worth the risk. This exhibits that undocumented women often have to work within the constraints that their precarity imposes upon them even while exercising micropolitical agency, flexing muscle only in times where the risk does not outweigh the potential benefit of speaking out; as illustrated below, however, speaking out was far more commonplace in the examining room than in the waiting room. Luna, who was one of the few documented women I spoke with, felt differently. She told me the advice she gives to

her friends, many of whom are undocumented: “People told me, ‘oh I waited two or three hours here [in the waiting room] and didn’t say anything,’ – and I say, ‘Go and tell them [the clinic staff]!’” This is indicative of how legal status enables modes of micropolitical action in which those without this status are less likely to engage. Together with long treks to clinics, lengthy wait times are an aspect of Latinas’ healthcare experiences that contribute to differential experiences of healthcare. Indeed, for immigrants, the act of waiting (something exceedingly mundane) and the circumscription of mobility are “imbricated with regional and international geopolitics” (Conlon, 2011: 353). Thus, my interviewees’ spatio-temporal obstacles simultaneously draw from and add to the dialectical relationship between immigrants’ lived experiences and broader geopolitical discourses about citizenship and deservingness.

Like structural racism, long wait times are systemic problems that can have discriminatory roots, and that can aggravate already-entrenched problems within underserved communities. Because of these spatio-temporal obstacles, normal life had to be put on pause for at least a good portion of the day in order to visit the doctor. The time consumed by routine doctor’s appointments thus reverberated through the lives of my interviewees. Elizabeth, a 33-year-old mother from Mexico, elaborated on this problem. She told me how going to the doctor’s once took her fifteen minutes by car, but now that she’s decided to stop driving because of the risk of deportation, her commute is three hours each way by bus. Being the mother of three small children, the extra few hours is hugely impactful on her day. She told me, “That day I need to pay a babysitter, I cannot clean my house, and the food will not be made. I mean, it’s a big mess.” This was a typical experience for the women I interviewed, and it makes clear how the localization

of immigration policing intervenes at the level of social reproduction in that it makes everyday life more difficult for those without documents. Further, it illustrates that local immigrant policing impacts lives even when no policing has actually been done. While some might characterize mitigative efforts such as walking and hiring a babysitter as self-policing which upholds the status quo as opposed to contesting it, I argue that this self-policing is a means to both surreptitiously work within and get *outside of* the “police order” (Rancière, 2004) that maintains the status quo. That is, despite efforts to divest undocumented immigrants of the right to be public through HB 87, the women I interviewed found new ways to be public in order to receive reproductive healthcare, which, like many forms of social reproduction, is dependent on the ability to move through public space.

In addition to the structural friction that interviewees encountered, their reproductive healthcare experiences were commonly filled with signals that told them that they are a nuisance, that they do not belong, or worse; I call these exclusionary signals and contend that they echo larger geopolitical rhetoric that portrays Latina immigrants as undeserving of healthcare resources in the U.S. at best, and as criminals who are stealing from the system at worst (Chavez, 2008; Guitierrez, 2008). Although healthcare is something that is not even guaranteed to most Americans, that does not stop many from feeling as though their piece of the pie is being stolen when undocumented immigrants use U.S. healthcare facilities. Thus it is not unheard of for health service providers to safeguard this “right” from those whom they perceive to be illegal. According to my interviewees, health service providers use a variety of measures to sustain these ideological borders, ranging from microaggressions like rudeness, to

providing questionable information about fetal health. These are at the same time *invocations* of and *interventions* upon the trope of the hyperfertile, and thus dangerous, Latina body, as well as a process of cognitive dissonance through which those whose job it is to provide (health)care absolve themselves of the responsibility to provide adequate care to some.

For instance, Keidy, who had two children and was expecting a third at the time of our interview, explained to me that with her first pregnancy, she had many questions and concerns, which seemed to annoy her midwife:

[W]hen you're pregnant you tend to have more infections because of the bacteria and all this stuff, so I was complaining and she never paid attention to me. So she [the midwife] was just, 'Oh that's normal, that's normal.' But it wasn't normal at that point ... So she was very rude. One day she just slammed the door on us.

Similarly, Ana Luz, a 41-year-old mother of two from Mexico, told me that, "I feel that because I don't speak English, they will not give me the same service. They will say, 'I will take a look at this and this, and that's it.' They will not really try to understand."

Like Keidy and Ana Luz, many interviewees felt that doctors and nurses did not give them their full attention while rushing through an appointment, or that they were blatantly hostile. Such moments were simultaneously understood by the women I interviewed as both shortcomings of the American healthcare system, as well as microaggressions stemming from disdain towards Latin American immigrants. For women who did not speak English, the use of an interpreter seemed at times to make the patient invisible. This is made worse by the fact that some doctors encourage professional interpreters to "keep patients on track" during appointments by reminding patients to only answer the doctor's questions (Angelelli, 2004). It is not surprising then, that many interviewees

were not bothered by the lack of professional interpreters in clinics, as that meant that they could use a family member or friend, who did not have to adhere to professional rigor, to interpret for them. In fact, several women told me how they purposefully opted to bring in their own “interpreter” because they felt having someone “on their side” would improve the quality of the care they received during the appointment. This once again demonstrates that, for the women I interviewed, assuaging and confronting exclusionary signals in order to receive a *good quality* of healthcare is dependent on carework, which is oftentimes collaborative.

“Resisting How They Treat Us”

When I asked how immigrants’ healthcare experiences could be improved, Carisa offered a succinct but exemplary statement: “[W]e need to be able to resist how they [health service providers] treat us.” A significant portion of the women I interviewed mentioned “assertiveness” and “speaking up” as tactics to ameliorate the effects of discrimination and mistreatment when dealing with medical professionals, while also stressing the need to be proactive and prepared for appointments. And while not everyone vocalized it in such a way, the actions of many interviewees demonstrated that they did just that. I argue that these were subversive and *caring* acts in which Latina immigrants actively claimed citizenship on biological grounds, even as it was being denied to them. Undergirding my interviewees’ actions is the belief that *all humans* deserve good health and healthcare, a belief which was repeated from interview to interview. This of course aligns with the Universal Declaration of Human Rights’ stance on every human’s right to health, a right, like many social rights, that has taken the back burner to political and civic rights in

regards to having legal teeth (Carmalt, 2011; Carmalt & Faubion, 2010; Fraser & Gordon, 1992). The carework undertaken by the women I interviewed can be seen as ways in which Latina immigrants claim the proverbial human right to health, while at the same time acting as a good (female) citizen would by caring for herself and her family. Moreover, as some interviewees expressed, maintaining their health is vital for the sizable Hispanic immigrant workforce to continue contributing their productivity and labor to their new communities.

About one-third of the women I interviewed used assertiveness in order to get the treatment that they thought, as human beings, they deserve. This assertiveness took many forms, from polite but insistent questioning, to coming to appointments armed with medical information, to direct confrontation. A significant portion of interviewees mentioned “speaking up” as strategy of this resistance, while also emphasizing the need to be prepared for appointments as a way to deal with doctors’ often rushed and dismissive demeanor. Rosita, a 28 year-old mother of two from Mexico, felt that informing herself before each appointment would garner more respect, and thus attention, from the doctor. She felt that, with her first child, her doctor did not fully listen to her, brushing aside anything she said with an air of authoritative knowledge, a term for the silencing happens in medical spaces when a medical professional’s word supersedes that of the patient (Jordan, 1993). When Rosita got pregnant for the second time, she wanted things to be different. She told me that, “With the second baby, I feel that I was treated much better by the doctor because I asked more questions and was more interested. I was more proactive in every way.” This proactivity included doing medical research on the

internet before each appointment, so that she felt more confident when approaching the doctor with a question or a concern.

Likewise, Thalia, a 36 year-old mother of four from Mexico, stressed the empowering effect of going to an appointment prepared:

I think that because I studied more and was much more open, and all that, I had better luck. I think it's important to ask. It's not just because I know more – it's not that I am better than anyone. But I think that because I research how it all goes – like what are your *rights*, which ones are your *rights*. I get references and I know what I want to receive from them [health service providers] before I go. (emphasis mine)

The use of “rights” in Thalia’s statement illustrates the political nascency of these ostensibly biological exchanges, and demonstrates how medical spaces are places where political subjectivity and inclusion are actively cultivated. In the case of Rosita and Thalia, proactivity was employed to counteract behavior from health service providers that minimized and silenced them. This proactivity involved carework in that these women undertook the labor of being prepared and informed for appointments. The care of oneself and one’s community is a lauded responsibility of protecting the health and safety of one’s polity, albeit not one, as feminist scholars have noted, that is viewed as on par with more masculine acts of serving one’s country – which have been called “hot,” as opposed to banal nationalism (Jones & Merriman, 2009) – such as military service. Although the care of one’s self and family through seeking healthcare is a civic virtue contributing to strengthened public health when it is done by citizens, it is criminalized when done by those who don’t have legal status (Brown, 2006), even though illness and disease does not “see” citizenship status. For the women I interviewed to deem themselves deserving of health and healthcare is to question the construction of

(un)deservingness that is bolstered by commonplace notions of citizenship, as well as to elucidate the twisted logic in which a nation's blind adherence to this construction jeopardizes its own health and wellbeing. In procuring good healthcare using carework, undocumented women are acting like citizens in that they are facilitating their own health and, by association, the health of the nation. At the same time, they are reconfiguring citizenship because they are doing these acts as women who supposedly do not deserve such treatment. To do this as a Latina woman who has been ascribed the status of "illegal" and thus "undeserving" is to manifest an incarnation of biological citizenship that is not in line with the oppressive partitioning of legal citizenship, and to demonstrate what White (2008) calls "an aspiration towards openness" (52) and Isin and Nielsen (2008) deem "a sense of the possible and of a citizenship that is yet to come" (4). For biological citizens documented and undocumented alike, this "citizenship yet to come" may very well involve the right to a healthcare system in which patients and their time are more fully respected, which is how most of the women I interviewed described the attitude towards patients in their home countries. Should this be the case, it would be a prime example of how immigrants can shape receiving countries for the better, directly challenging alarmist "browning of America" rhetoric (Chavez, 2008).

I also found that informal medical information networks – which entail friends and acquaintances sharing advice about how to obtain healthcare via word-of-mouth – also played a huge role in "resisting how they treat us." The formation of these networks are collectivizing moments and acts of biological citizenship that have varying degrees of political potency. Stuesse and Coleman have (2014) shown that in states with anti-immigrant laws, collective resistance by undocumented immigrants often entail the

creation of informal, clandestine networks used to disseminate information about which areas are safe for undocumented individuals to traverse and which are not. In the networks my interviewees discussed, women shared information about what tactics worked and what didn't when dealing with doctors, as well as what clinics and hospitals to avoid. Like the networks that Stuesse and Coleman wrote about, the ones the women I spoke with participated in were generated and bound by the care and affinity Latina immigrants felt for one another, even if they were complete strangers. For instance, one interviewee, who is documented and drives, cried as she told me and my interpreter how hard it was to see Latina women pushing strollers along Atlanta's busy – and often sidewalk-less – streets, especially in the summer heat or while it is raining. She told us that she often stops to offer rides to these women, with whom she strongly identifies because she was once in their position. This story exemplifies how community is formed within undocumented populations not only over broader political issues that are often referenced in discussions about immigrants' rights, but also the within the banal minutiae of everyday life, and the common struggles it entails for Latina immigrants; care, I suggest, is the fascia that binds informal medical information networks, exhibiting how caring is a collaborative effort that exceeds the bounds of family.

I witnessed the breadth and power of informal networks during a group interview, when the women – only two of whom know each other before the interview – started talking about the “horror stories” they had heard about a large public hospital in Atlanta. In fact, all but one of the women in the interview had been told to avoid this hospital by other Latina women. For example, Manuela, a 37-year-old mother who had just had a child there, told me: “I don't recommend [the hospital] for babies. And I am not the only

one. There are a lot. It's only for emergencies." Jessinda, 29 and from Mexico, concurred, saying: "I have been listening to a lot of complaints about [the hospital] – about the babies... If you heard all the bad complaints about [the hospital] that we know, you don't want to be at [the hospital]." The informal boycott of this particular hospital was something that was well-known and adhered to among a large portion of interviewees, and it is a way in which undocumented women can exert power and act politically when most of the traditional avenues to do so are closed to them. Moreover, it shows how caring about the health and happiness of friends, family, and strangers is a powerful, yet often ignored, catalyst for such political acts.

Resisting how they are treated is more than just a matter of countering a doctor's bad bedside manner and facilitating informal medical information networks, however; for several of the women I interviewed, it was a matter of life and death, and a direct confrontation with the possibility that latent eugenic and nativist beliefs continue to rear their ugly heads in matters involving women's bodies. For example, while talking about sex education and birth control in America, Maribel hinted at the very fine line between informed family planning choices and coercive contraception:

The education [is good], yes but not with a regimen that you should have it – you will have it [birth control]. It's not okay they should get inside our lives... I know they [health service providers] have been getting inside my friends' lives. They have been trying to convince them to abort, and they even told them, 'Oh, your baby comes with this syndrome or this problem'... That pregnancy will never happen normally because you have this stress – that's not fair. Just because they want you to abort... And finally, the pregnancy was normal – the baby normal – so why do they do that? That's not nice. There are so many cases like that. We had been paying attention on this. We have been observing, asking, seeing – and really, we think that this is a target locked on immigrants.

Maribel and her friends, as well as several other interviewees, were convinced that doctors' actions towards them were directly shaped by racism¹⁷. This is a fear that is not unfounded, as the U.S. has had documented cases of coercive sterilization of Latina women. In the 1970s, several obstetricians in California were tried of coercing their Latina patients into tubal ligation right after childbirth, when women were in no state to make such drastic decisions (Gutiérrez, 2008). This was oftentimes done through the use of consent forms written solely in English given to women who obviously did not know the language. What motivated the doctors' actions in the 1970s was a diverse but interrelated mix of ideologies involving citizenship, overpopulation, and reproductive capacities. During this time, alarmist overpopulation rhetoric was on the rise, thanks in large part to the notion of an impending "population bomb" (Chavez, 2008). Echoed in arguments of so-called food scarcity today, these beliefs implicated women from "third-world" nations as a foundational cause of the problem, and thus necessitated intervention – often clandestinely undertaken by individual doctors – at the biological level. Likewise, the information that my interviewees believed to be eugenic was embedded within seemingly objective/apolitical biomedical knowledge. It is information that is bolstered by the power structures of medical spaces, where a doctor's authoritative knowledge can at times usurp all other forms of knowledge.

More than just the common acknowledgement among the women I interviewed that racist beliefs are motivating doctors to encourage women to abort, community is

¹⁷ I did not talk to health service providers to get their stance on the issue. My primary concern in this dissertation is the experiences of Latina immigrants, so whether or not eugenic notions actually guided doctor's actions is not as important here as much how my informants perceived these actions. It is possible that in some of these cases miscommunication or an interpretation error has taken place and that doctors are not actually pushing to abort. This scenario, however, would still point to the personal anguish and structural injustice caused by a lack of cultural competency.

deliberately being formed around this issue. I learned about this when I talked to Nadia, a 29-year-old mother of three from Mexico. When she was pregnant with her youngest child, her doctor told her that there was something wrong with the child's brain and suggested that it might be a wise choice to terminate the pregnancy. Nadia and her husband were deeply distraught by this, but they chose to go through with the pregnancy. When Nadia went into labor, she and her husband were prepared for the worst, but much to their surprise, their daughter was born completely free of any of the impairments the doctor claimed she would have. Nadia was not happy with her overall treatment at the hospital, and the unnecessary anguish over the incorrect prognosis was the final straw. Nadia's husband, who had acted as her interpreter, decided to voice their mutual anger as they were leaving the hospital. Nadia recounted that her husband told the staff, "You're inefficient, you don't serve us well. You're very bad. Why did you treat her like that? Because we're Hispanics you treat us like that. Why do you do that?"

In sharing her experience with other mothers in her social circle, Nadia soon realized that her experience was not unique – that many other Latina mothers had been told that they should abort. These understandably outraged mothers formed community around their shared experience, and Nadia told me that when she heard I was doing interviews with Latina immigrants about reproductive healthcare, she wanted to be interviewed in order to get their story out. This collectivizing moment, in which Latina immigrants perform an act of biological citizenship through demanding justice, has the power to shed public light on the racism that often silently pervades the treatment of immigrants in medical spaces. Revelations such as these lay bare the connections between stereotypes of Latinas' reproduction, citizenship, and nativist beliefs, and how

they surface in ordinary interactions. Further, they show that perhaps the most primary element of social reproduction – biological reproduction – is an important site at which geopolitical allocation and immigrant policing are taking place, by people (i.e., health service providers) whose job does not entail such duties. The women I interviewed saw the withholding of a certain quality of (health)care to be a form of micropolitical aggression, to which they responded by using caring acts in order to establish themselves as deserving of adequate attention and respect in medical spaces.

Conclusion

While both scholarship and the popular media show how rights and inclusion can be demanded by undocumented immigrants on the public level of protest and activism, this paper articulates the ways in which these same ends can be met through smaller, more intimate acts embedded in the mundanity of everyday life. The women I interviewed actively pushed back against the ideological barriers that deem undocumented Latina bodies as dangerous and threatening, and as bodies which are not deserving of medical care. Additionally, they were able to carve out a bit of safety and security in an environment that has become all the more insecure for undocumented immigrants since the post-9/11 localization of immigrant policing. These are micropolitical tactics that create better experiences for women whose experiences of reproductive healthcare are negatively impacted by geopolitical ideas about who belongs where, and by the ideas about Latina fertility and sexuality with which they are intermingled. By securing better healthcare through carework, they are enacting biological citizenship and neutralizing the microaggressions and outright hostility that

work in the service of legal citizenship's taxonomy of deservingness. In effect, these women are demanding better care and to be treated as citizens, not through protesting in a city street, but by harnessing the power inherent in even the smallest, most routine of interactions. In many cases, this is the only political front in which undocumented women may safely act.

While political geographers have shown the body to be an entity acted upon and influenced by geopolitical notions in deleterious ways, they have largely overlooked the ways in which people can leverage their own bodies and the proverbial right to health for inclusion and better treatment. The women I interviewed reterritorialized their own bodies through challenging the classification of undocumented immigrants' bodies as undeserving of care. Importantly, drawing from biological citizenship, this demonstrates how bodies are not merely pawns for bigger power schemes, but can in fact push back against hegemonic epistemology to "undo" its normalization. The structural impediments to reproductive healthcare that my informants encountered can be viewed as a "polling literacy test" of sorts, one that implicitly strives to safeguard certain resources for those who are believed to deserve them, making the "right" to healthcare decidedly harder for some than others. In using carework to secure good healthcare, the women I interviewed are claiming the right to be cared for and treated as citizens. On a pragmatic level, the carework performed during reproductive healthcare experiences is an impactful tactic in enabling some security and inclusion in a categorically insecure and exclusionary environment, while also facilitating connection and community among those with shared struggles. I argue that Latina immigrants' ability to access reproductive healthcare – and a good quality of reproductive healthcare more specifically – is in fact an act of

biological citizenship, and therefore a move that has resounding political potential. This paper reinvests such caretaking with political potency, for both immigrants and non-immigrants alike. Taking care of the health of one's self and family exhibits a form of care that is often glorified in characterizations of the good American (female) citizen – that is, the care involved in raising healthy and productive members of society. However, as with the ideological double standard that paints some reproduction as virtuous and some as deviant, the fostering of good health among immigrants through formal channels (i.e., hospitals and clinics) is portrayed as contrary to good citizenship, and in fact as potentially harmful to legal citizens for whom these formal channels are ideologically reserved.

The lens of biological citizenship re-envision this care. While it was once something that was destructive of citizenship – as the stereotypes portray – it can now be seen as something that is in fact constructive of (biological) citizenship. This paper therefore casts Latinas' struggles and abilities to receive reproductive healthcare as acts which rupture the everyday borders between citizens and non-citizens – borders which have been bolstered and multiplied by localized immigrant policing and deleterious stereotypes – and “flip the script” on the way that the Latina body performing a (socially) reproductive act is viewed. In obtaining good healthcare and therefore implementing the health of their selves and their families, the women I interviewed enacted some of the rights and duties of “good citizens.” But this is not meant to merely demonstrate the hypocrisy of white women being praised for something for which Latina women are maligned: through detailing Latinas' experiences with reproductive healthcare, I also wish to recognize the importance and dynamics of the micropolitics that occur in medical

spaces. If the everyday is the site where politics happen, and if (geo)politics work through the body, then medical spaces can be seen as high-stakes sites for immigrants to (re)negotiate political belonging. This, of course, is no silver bullet for racism and xenophobia, which the women I interviewed on a daily basis. However, in enacting biological citizenship, I contend that Latinas shore up a confidence that can have catalytic power, resulting not only in better treatment of the women and their families, but also strengthening individual and collective identities among the women themselves. This, I argue, is a powerful moment in the lives of women who know that, in the words of one of my informants, “In true life, we know we cannot talk to politicians – they will not hear us.”

CHAPTER FIVE

TRUE STORIES and VARIED TALES of LATINA FERTILITY in a “GREYING” NATION

Homo economicus is someone who is eminently governable. From being the intangible partner of laissez-faire, homo economicus now becomes the correlate of a governmentality which will act on the environment systematically and modify its variables.

Michel Foucault, *The Birth of Biopolitics*, 2008: 270-271

Introduction

This chapter details Latina immigrants’ subversive enactment of homo economicus by means of birth control and family planning and how it shatters the tales we tell about Latina fertility. Crystalized in the “timeless” trope of the innately hyperfertile “Third World” woman whose adherence to tradition renders her passive and docile when it comes to matters of reproduction, the fertility of Latinas in the U.S. is the object of both ire and desire. Several years ago, however, this trope began to crack: a comprehensive report from the Centers for Disease Control based on data collected in 2013 reported that birthrates for native-born Hispanics had dipped below replacement level for the first time in history, while the rate for foreign-born Hispanics had also plummeted. The likely culprit was the 2008 depression, though birthrates have not been “recovering” on the economic upswing.

Some might assume, based on the dominant discourses that portray Latina immigrants’ hyperfertility as dangerous and conniving, that the news of Hispanics’ declining fertility was met with celebration. To be sure, this attitude is found in droves in the comments sections of online news chapters reporting on the CDC’s news. For

instance, under a Wall Street Journal chapter that suggested that decreased Hispanic birthrates, in conjunction with waning immigration from Latin America, meant fewer future workers, one commenter, lamenting the “continuing lunacy of birthright citizenship,” said: “To those who say we need immigration, any immigration, I draw your attention to the LA Times today reporting that nearly 1 Californian in three is on Medicaid. This is how you get there” (Shah, 2015, “U.S. birthrate hits turning point”). This line of thought envisions Hispanic immigrants as thieves who steal state resources (welfare, education, healthcare, etc.) and, by implication, endanger the safety and security of “law-abiding” American citizens. In short, Latinas and their reproduction are viewed as threatening to the nation. This virulent and timeworn belief is compelling to many and offers a satisfying “Us vs. Them” sense of indignation. Indeed, within the heated discussions of birthright citizenship and “anchor babies” – or mythical babies produced by undocumented Latinas solely to facilitate their own citizenship (Chavez, 2008) – lines of divide are constantly congealing, distinguishing those who are deserving – of rights, of space, of kindness, of dignity, of life – from those who are not.

As loud and prevalent as the trope of the conniving Latina is, I contend that there are newer discourses making their way onto the scene. These new discourses are not vitriolic. They are soft, surprised, and subtly alarmist, drawing on a bevy of contextual elements to present the perfect storm, with Latinas’ reproduction right at the center: the American population is rapidly aging, birthrates among all ethnicities are flatlining, and it is the fertility of Hispanics that has seen the steepest decline. It seems that underneath the derisive discourse of Latinas’ rampant reproduction lies a hope that this supposedly innately hyperfertile group will be the ones to “breed new life” into the rapidly-decaying

youth cohorts of the U.S.'s population pyramid. The CDC's news that Latina fertility is sharply declining has therefore been met with a revealing sense of shock that seems to ask: Who will do the work of reproducing America's exploitable workers and consumers? Who will ensure that the aging population will be supported by working-age people, if not those supposedly hyperfertile "Third World" women? Dovetailing with this demographic concern is the phenomenon of political pundits pinning their electoral hopes and dreams on the backs of the hyperfertile Latina trope. Most prominently, some forecast a permanent Democratic majority that would be achieved through the exponential reproduction of Hispanic voters (who apparently are also inherently Democratic in addition to being biologically hyperfertile). Thus, the hyperfertility of Latinas was not only supposed to save the nation demographically and economically, but also politically, as the ever-fecund Hispanics would be the ones to achieve and maintain the Democratic majority in the country¹⁸.

These new discourses reveal that, underneath the alarmist rhetoric surrounding the reproduction of immigrants, there is also the recognition that the neoliberal, "Democratic" entity is dependent on having cheap, exploitable workers and pliable voters. This duplicitous dynamic was also evident in the roll-out of – and eventual response to – the spate of state-level "show me your papers" racial profiling legislation, beginning with Arizona's infamous Senate Bill (SB) 1070, which made it lawful for a local police officer to ask anyone who they suspected of being "illegal" for immigration papers while investigating an unrelated incident, such as a routine traffic stop. Even as many supported these laws and proclaimed that they would make America safer from the

¹⁸ This is looking less and less like a possibility, as not only are birth rates falling, but more Hispanic immigrants are currently leaving the country than coming over (Lopez & Patten, 2015, "The impact of slowing immigration").

dangers “criminal aliens” pose, it eventually became apparent that, with these laws, many states were shooting themselves in the foot. The passage of House Bill (HB) 56 in Alabama, for instance, prompted undocumented migrant farmworkers to flee the state, leaving fields of produce to rot on the vines (Sarlin, 2013, “How America’s harshest immigration law failed”). Because of these repercussions, some states have overturned these laws, and many have become lax on enforcing them, with most counties and municipalities no longer allotting any lines in their budget to funding local immigration policing (Bridges, 2014, “Georgia mayor stood up to state’s anti-immigrant law”). Business has spoken, revealing the duplicitous nature of America’s feelings on undocumented migrants.

In this chapter, I look at the varying and contradicting ways that Latinas’ reproduction is talked about in relation to productivity and politics, especially in the context of an aging population in a neoliberal nation. Importantly, I connect these discourses to Latinas’ own views of their reproduction and their family planning choices. I use 56 in-depth interviews with recent Latina immigrants living in Atlanta to show that, in line with the CDC’s report, many of my informants were adamant about contraception, family planning, and having small families. They based their decision largely on the fact that it is not feasible to raise a large family in their economically and socially insecure position. Using Michel Foucault’s biopolitics and his concept of homo economicus from his lecture, *The Birth of Biopolitics* (2008), I argue that Latinas’ decision to have few children is demonstrative of their unpredicted subjectivization within the neoliberal economy as “rational” economic actors – “homo economicus” – as opposed to passive subjects whose actions are irrevocably controlled by longstanding, irrational cultural

forces. Foucault states that homo economicus is “an entrepreneur of the self” and “someone who pursues his [sic] own interest, and whose interest is such that it converges spontaneously with that of others” (2008: 270). In detailing the views of the women I interviewed, I reveal a prime example of neoliberalism’s assumptions and contradictions. I argue that my interviewees enact homo economicus to the detriment of those who have pinned economic, demographic, and electoral hopes to Latinas’ perceived hyperfertility. Because the state desires the production and (sometimes) the biological reproduction of immigrants without wanting to provide adequately for their *social reproduction*, the women I interviewed have found it in their best interest to limit family size. This enactment of homo economicus veers dramatically off the script that Latinas have been biopolitically allotted – as hyperfertile thieves/saviors, depending on the argument being made – and in turn has challenged a future where Latina fertility can be simultaneously reviled and coveted.

In what follows, I first situate homo economicus in Foucault’s theory of biopolitics. Then, I discuss how immigrants have been interpolated for their productive capacity without thought for their social reproduction, except to thwart it in some cases. I tie this to how Latina immigrants’ biological reproduction, as something that straddles the production/social reproduction divide, is at once despised and desired, and how in both scenarios, social reproduction is something that is not supported within immigrants’ new communities. I argue that Latinas cannot reproduce exponentially in the insecure social and economic conditions they are in, conditions which do not support the basic necessities of everyday life, such as childcare. In the first empirical section, I analyze quotes from popular news publications to discern how Latina reproduction is portrayed in

an aging nation. Then, I draw from my interviews with Latina immigrants living in Atlanta to discuss how their decision to limit family size is a subversive enactment of homo economicus.

Biopolitics and Homo Economicus

Foucault's concept of biopolitics has been immensely helpful in unraveling the ways in which modern governments rule through "knowing" and fostering the life of their populations. Foucault discussed the topic diffusely in his lectures, *Society Must Be Defended* (2003) and *Security, Territory, Population* (2009), and later in his *The Birth of Biopolitics* (2008) lecture. Foucault conceives of biopolitics as a mode of governance that departs from the earlier penal and juridical modes. Unlike the former, biopolitical regimes rule not through threat of death or punishment, but instead through the "enhancement" of life. Biopolitics works on varying scales, including the "sorting" of populations "from above," and the scale of individual subjectivization based on an internalization of "government mentality," a.k.a. governmentality (Legg, 2005). By collecting and publicizing statistics about a population, norms become solidified and measures of success and development (e.g., birth rates, death rates) become ends in and of themselves. However, a biopolitical mentality views some life as more valuable than other life. In "knowing" its population through demography and birth rates, etc., a government implicitly sanctions only certain ways of being "real" and "normal," thereby defining the "abnormal" in contrast, and casting those who fall into the latter category into varying form of exclusion. Thus, in defining which life is valuable – and *how* life is valuable (e.g., life is valuable when it reproduces) – biopolitical governance decides

which life is *not* valuable, and which life can therefore die, both physically and metaphorically. In this equation, the less valuable life is rendered harmful to the more valuable life, and so in letting the lesser-valued life “die,” the health of the nation is more securely guaranteed (Martin, L., 2010).

As a framework for studying normalization and its attendant exclusions, biopolitics’ application to studies of immigration (Luibheid, 2004; Topak, 2014) and marginalized groups (Evered & Evered, 2013; Guthman, 2009; Li 2010) has been fruitful and illuminating. For example, Sparke examines how the U.S.’s expedited border-crossing program facilitates the “biopolitical production of...privileged business class citizenship” to the exclusion of those who do not fit into that class (2006: 151). Indeed, the “sorting” impulse of biopolitics and its relationship to diversity are highly applicable to studies of geopolitics, immigration, and the protection of the nation-state (Fassin, 2001; Ong, 1995; Zembylas 2010). Much along this vein has been written on Latin American immigrants in the U.S. (Hester, 2014; Inda, 2002). Hester (2014), for instance, writes about how public health regimes sort and regulate female Mexican immigrants. Inda, writing about Latina immigrants in particular, aptly sums up biopolitics’ efficacy in studies of undocumented immigration, stating:

More generally, in the modern state, biopower works to create a wedge between the normal and the pathological, conferring aberrance on individual or collective bodies and casting certain abnormalities as dangers to the body politic. That is, it simply functions as a mechanism for distinguishing those bodily interests that can be represented in the polity from those which cannot, from those against whom society must be defended. (2002: 103)

With the dominant discourse of Latina reproduction being one in which Latinas are seen as dangerous criminals and thieves who reproduce more thieves by exploiting birthright

citizenship, it is no wonder why biopolitics has been applied so frequently to studies of Latina American immigrants. In the sense that biopolitical regimes allow some to “die,” the general disregard for, and outright thwarting of, Hispanics’ social reproduction can be seen a mechanism for a type of “social death” (Cacho, 2012). Beyond the “sorting” impulse of biopolitics, biopolitics shapes immigrants’ subjectivization. Ong, for example, looks at the “making” of Khmer refugees in California through biomedicine, contending that biomedicine, “while attending to the health of [the refugees’] bodies...is also constitutive of the social, economic, and juridical practices that socialize biopolitical subjects of the modern welfare state” (1995: 1244). Ong also suggests that it is important to examine this “making” in conjunction with its refusal on the part of refugees; however, it seems as though those who have used biopolitics thereafter to study immigrants have erred more on the side of looking at how immigrants are sorted and dutifully subjectivized, as opposed to how they resist – consciously or not – this subjectivization.

In the context of an aging population and electoral projections, I suggest that biopolitics’ sorting and subjectivization have a fatal incongruence when it comes to Latina immigrants. Foucault’s neoliberal homo economicus as explicated in *The Birth of Biopolitics* helps to draw out this complexity. Homo economicus makes brief appearances in both *Society Must be Defended* (2003) and *Security, Territory, Population* (2009) as the “partner of exchange” in classical economics. It is not until *The Birth of Biopolitics* (2008), however, that Foucault situates homo economicus within the neoliberal realm. This homo economicus is different from that in the time of classical economics. Neoliberal homo economicus is an “entrepreneur of himself” (Foucault,

2008: 226) and bases “rational conduct” on an economic platform, viewing the “allocation of scarce resources” as the ultimate moral indicator¹⁹:

And we reach the point at which maybe the object of economic analysis should be identified with any purposeful conduct that involves, broadly speaking, a strategic choice of means, ways, and instruments: in short, the identification of the object of economic analysis with any rational conduct...Is not a rational conduct, like that which exists in formal reasoning, an economic conduct in the sense we have just defined, that is to say, the optimal allocation of scarce resources to alternative ends, since formal reasoning consists in deploying certain scarce resources – a symbolic system, a set of axioms, rules of construction, and not just any symbolic system or any rules of construction, but just some – to be used to optimal effect for a determinant and alternative end, in this case a true rather than false conclusion which we try to reach by the best possible allocation of scarce resources (Foucault, 2008: 269).

Homo economicus thus acts strategically and, in theory, individually, applying economic analysis to all aspects of life in order to “rationally” partition the scarce (economic, social, etc.) resources available to them. In this scenario, individual “success” is deemed more rational than any semblance of the “common good,” which works to explain how the importance of the public realm and cooperation has fallen away under a neoliberal regime. Even crime under neoliberalism is a sort of rational form of decision-making by the law-breaker: “The criminal, any person, is treated only as anyone whomsoever who invests in an action, expects a profit from it, and who accepts the risk of a loss” (Foucault, 2008: 253). This can perhaps explain some of the dissonance between the ire leveled at undocumented workers and the employers who break the law by employing them knowingly and in droves. “For the neoliberals, crime is no longer located outside of

¹⁹ Homo economicus and “his” brand of economics-centric rationality, of course, have been talked about in a less critical manner in other contexts, specifically explications of capitalism by economists and philosophers such as Adam Smith, John Stuart Mill, and David Ricardo, as well as in critiques by other more modern scholars, such as Marshal Sahlins (Yamagishi et al., 2014).

the market model, but is instead one market among many others... In this approach, good penal policy should never aspire to completely eliminate crime, but should try to strike a temporary and forever fragile balance between the positive supply curve for crime and a negative demand curve for sanctions” (Lemke, 2001: 10). Likewise, discourses that envision Latina reproduction as the panacea to a graying nation “look the other way” when it comes to the migration status of Latinas. However, such dissonance cannot be held in suspension for long when Latinas act in a way that they were not biopolitically sanctioned, limiting their family sizes and becoming homo economicus in the face of immense economic and social insecurity.

(Re)Production without Social Reproduction in the U.S. South

The empirical data used in this paper situates Latina reproduction within the Atlanta metropolitan area, a burgeoning microcosm of the nation’s duplicitous relationship with Hispanic immigrants. Just like discourses of Latina reproduction, discourses surrounding their position as laborers are duplicitous and paradoxical. This is important, because with employment opportunities for unskilled labor that are relatively plentiful, Georgia and many other southern states have seen a dramatic growth in immigration within the past couple of decades (Singer, 2004; Singer et al., 2008). Since 2000, Georgia’s Hispanic population alone has nearly doubled (U.S. Census Bureau, 2010). The Atlanta metropolitan area, with a population of over five million people, has received many of these immigrants (City Data, 2011; U.S. Census Bureau, 2010). Like many of the states that have passed anti-immigrant legislation, Georgia seems to be at odds with its new reliance on immigrant labor, at once wishing to attract the productive bodies of

immigrant laborers in order to fill the bottom rungs of booming industries, while at the same time pushing immigrants away through laws that make it risky for undocumented immigrants to simply live. Georgia's Illegal Immigration Reform and Enforcement Act of 2011 (HB 87) makes it legal for local police to ask anyone to provide immigration documentation while investigating unrelated offenses, and mandates that anyone who cannot provide such documentation be arrested and detained. Additionally, Fulton County, in which Atlanta is situated, has been a member of the Secure Communities Program (now called the Priority Enforcement Program) since 2010. This joint federal, state, and local program enlists local law officers to participate in immigration enforcement through the use of a national fingerprint database, which aids officers in identifying "criminal aliens." Once identified, Immigration and Customs Enforcement can detain and deport criminal aliens (Department of Homeland Security, 2011). In effect, such laws inhere everyday tasks, such as driving several blocks to pick up groceries, with the same risk of deportation inherent in crossing the U.S.-Mexico border (Coleman and Kocher, 2011; DeGenova, 2002; Harrison & Lloyd, 2012; Martin, 2011). However, because this legislation has been contested by business lobbies, these laws are not uniformly enforced, demonstrating that even as immigrants are feared, they are needed for their productive capacities. For instance, as SB 1070 and its copycats caused exoduses of Hispanic immigrants from participating states, Georgia mayor Paul Bridges was prompted to speak out about how HB 87 stood in contradiction to the Republican value of supporting businesses: "I knew that the reasonable Republican Party I had joined years ago stood for protection of the family, small business, liberty, privacy, and

prosperity. HB 87 put these values under attack. It was unconstitutional” (Bridges, 2014, “Georgia mayor stood up to state’s anti-immigrant law”).

Along the same vein, Latinas’ reproduction is reviled in discussions of anchor babies and birthright citizenship, but coveted in discussions of theoretical future workers or voters. This indicates that Hispanics are desired as merely countable bodies to do labor and to vote, but not as bodies who need sustenance, education, shelter, and access to public space. Thus, immigrants are interpolated for their productive capacities (and *sometimes* for their *biologically* reproductive capacities), but their *social* reproduction is something that is not included in their biopolitical membership in the polity (Cravey, 2004; Martin, N., 2010), which often demands that immigrants get creative in order to be socially reproductive. According to Bezanson and Luxton, social reproduction refers to:

the processes involved in maintaining and reproducing people, specifically the laboring population, and their labour power on a daily and generational basis. It involves the provision of food, clothing, shelter, basic safety, and health care, along with the development and transmission of knowledge, social values, and cultural practices and the construction of individual and collective identities. (2006: 3)

Smith and Winders (2008) explore how the demands of flexible production/accumulation affect the social reproduction of Latino immigrants in the new immigrant destination cities of the U.S. South. Social reproduction demands rootedness, while a flexible labor market does not. Smith and Winders note that, while the working (i.e. productive) immigrant body seems to be somewhat acceptable to longstanding community members, the “idle” (i.e., socially reproductive) immigrant body incites anger. Tensions are rising because the days of the temporary male (guest) worker seem to be gone, and more and more families are coming to stay. Not only are return trips to home countries risky, but it

is increasingly precarious even to stay put, and in these vulnerable places Latinas are finding it a source of security (economic and otherwise) to limit family size because there is not enough means to support social reproduction to sustain biological reproduction at former rates.

The media quotes that I analyze below problematize the productive/socially reproductive divide by looking at how Latinas' biological reproduction, which usually falls on the side of the latter, is talked about in a way that aligns it with the productivity of the nation. However, like the hollow valorization of immigrants' exploitative labor, discussions of their biological reproduction also make no mention of social reproduction, merely seeing immigrants as bodies-without-needs that will produce, consume, and vote. The quotes from the women I interviewed, however, do address social reproduction and the limited means that undocumented immigrants have to, for example, take care of their children. Hester has made note of the difficulties immigrants have in maintaining healthy bodies, and how this problem falls largely on the shoulders of women:

In the United States, the moral and financial burden imposed by neoliberal health promotion regimes weighs particularly heavily on Mexican immigrants whose primary reason for migrating is often economic. In this context, the duty to be well, and the duty to provide overlap...Migrating women feel this burden acutely due to the fact that they are seen as the care providers for their families in the U.S... (2014: 225-226).

As detailed below, the women I interviewed are indeed the belabored care providers of their families. They choose to limit their family sizes because the means of social reproduction are tenuous and the demands on the female immigrant – who, contrary to how she is regularly portrayed, often works full-time in addition to caring for her family – are too taxing for her to be able to support a large family.

The 56 Latina immigrants I interviewed ranged from the age of 19 to their early 60s, and hailed from Mexico (46), Venezuela (4), the Dominican Republic (2), Guatemala (2), Honduras (1), and Colombia (1). Except the three interviews that were performed in English, all interviews were done with the help of a Spanish-speaking interpreter from Mexico City and translated into English. The majority of interviewees were of lower socio-economic class, and their families ranged in size from zero to six children, with the average being 2.4 (just slightly above replacement level fertility, which is 2.1 kids per woman of childbearing age). Using data collected in 2013, the CDC reported that the crude birth rate among Hispanics from all countries living in the U.S. fell from 69.3 children for every 1,000 women in 2007 (pre-recession) to 64.1 in 2010 (when the recession had set in) and continued to decline to reach 62.5 in 2013 (after the economy had reportedly recovered); this is not far off from the 58.7 rate for whites in 2013. My interviewees' decisions to have smaller families corroborates the CDC's birthrate report and sheds empirical light on why Latinas have been more inclined than ever to limit family size. I chose the media chapters I analyze below by doing Google searches for stories about the CDC's 2015 report on birthrates. Although sources such as the Pew Research Center have been reporting declining Hispanic birthrates for years, I chose to hone in on the discussion catalyzed by the CDC's report because it was publicized, as well as the fact that the report and reactions to it coincide with the timeframe of my fieldwork.

Tales of Latina Reproduction, and Their Unraveling

A 2015 Center for Immigration Studies online chapter titled “The Declining Fertility of Immigrants and Natives” cited Jeb Bush’s beliefs about Hispanic immigrants, beliefs which are so widely-held that Bush could say them and come across as espousing common sense:

In June 2013, former Florida Governor Jeb Bush said “Immigrants are more fertile.” He and many others have argued for large-scale immigration on the grounds that America's aging society needs immigrants and their higher fertility to, in Bush's words, “rebuild the demographic pyramid.” (Camarota & Ziegler, 2015, “The declining fertility of immigrants and natives”)

Bush apparently was not looking at statistical data that detailed the declining fertility rates among both native and foreign-born Hispanics, but instead relied on long-held stereotypical notions about immigrants when he pandered to Hispanic voters. Bush’s words are emblematic of the often-unquestioned understanding that Hispanics – and minorities and people from “Third World” nations more generally – reproduce far more than “First World” women. His choice of simply stating that “immigrants are more fertile” without explaining the difference between biological fertility (as in, the ability to conceive and gestate offspring) and the demographic measure of fertility rates (as in, the *total fertility rate* – the number of kids a woman can expect to have in her lifetime – and *crude birth/fertility rate* – the number of live birth per year, per 1000 women), whether wittingly or not, contributes to the perception that Latina bodies are inherently prone to produce more children. Indeed, the biological capacity to have children is often conflated with cultural determinants (e.g., education, employment, etc.) of how many children a woman can be expected to have in her lifetime to present “fertility” as an ambiguous,

intangible matter that inexplicably houses cultural expectation in women's wombs. While immigrants from certain countries do have bigger families than U.S. women in many cases, what is striking about sentiments such as Bush's is that, in its unchecked assumption of the hyperfertility of immigrants, it places "Third World" women in a timeless place where they will always desire and produce large families, even as, apparently unbeknownst to him and others, data has proven otherwise. Such rhetoric feeds the notion that "Third World" women are unchanging and exist outside of the linear path of "progress" that "First World" Women are indisputably on.

Even more revealing was the shock at the fact that birthrates among Hispanics did not immediately bounce back up after the economy began to rebound. For instance, chapters titled "No Hispanic surge on the horizon" (Girdusky, 2015) and "Falloff in birth slows shift to a majority-minority youth population" (Cohn, 2014) contain a sense of surprise that Hispanic birthrates did not automatically recover to their "natural" level after the recession. This points towards an uncritical assumption that immigrants have a natural, inherent proclivity towards large families, and that this proclivity would "recover" as soon as the economy got a bit better and Hispanic women's reproductive machinery somehow got the message. A University of Omaha chapter even points out how the unresuscitated fertility rates after the recession are "challenging some of our assumptions":

U.S. births among Hispanic mothers neared 1.1 million in 2007, but barely exceeded 900,000 in 2013. The changes are challenging some of our assumptions as we project the population into the future. Even if the decline in Hispanic births is temporary and rebounds as the economy recovers, it will take years for fertility rates to climb toward pre-recession levels and the lower fertility rates, especially among Hispanics, might become the new normal. (Reed,

2015, “Fertility rate gaps between races, ethnicities shrinking”)

Accepting the “new normal,” as this chapter refers to Hispanic fertility rates that linger near replacement level, would mean regauging demographic projections that rely on the trope of the hyperfertile Latina immigrant, and to envision Latina women as independent, free-thinkers who are not inextricably bound to backwards cultural ideas of how to live their lives, but instead respond to contextual nuance.

Additionally, the fact that the realization that Hispanic birthrates have decreased and not recovered is sometimes attributed to the Americanization of immigrants; this is another way that Latinas’ ability to change and respond to their context is undermined. Because the CDC report showed that native-born Hispanics’ birthrates have fallen most dramatically, commentators tied this to the perception that living in the U.S. has made Hispanic women act more like American women by adopting a “Western rationality” concerning family size. For instance, a Fox Latino chapter, quoting a Census Bureau employee, said:

“The difference comes from the foreign-born population, that’s what shows a fairly sharp decline,” explained David Armstrong, a Census Bureau statistician. Not only are there fewer Mexican immigrants entering the country and many more leaving it, as PEW indicated earlier this week in a study, but immigrants who have arrived are becoming Americanized. “As you have a larger Hispanic population that becomes acculturated into a culture, rates will drop and become more like rates of natives,” Armstrong said. (Sangha, 2015, “Birth rates among Latinas at an all-time low, as their prosperity continues to grow”)

This quote reveals that the belief that the decision of immigrants to have fewer children is a result of the process of Americanization, which is certainly not a notion without merit (Ellis & Wright, 2005). Indeed, generational differences between immigrants show that,

the longer they are in the U.S., the more likely they are, for instance, to speak English fluently and as their first language (Portes & Rumbaut, 2001). However, the chapter also goes into further detail, discussing how Hispanics are becoming more affluent, and therefore Hispanic women are going to school, working, and postponing motherhood until later in life. Nevertheless, wholly attributing declining births to a vague emulation of U.S. women glosses over other possible factors for the decline with a narrative (“Americanization”) that is so convincing in its familiarity that it easily eclipses all other possibilities. For instance, not many consider that smaller families might be an independent response to the environment of insecurity in which many Latina immigrants live, even after the recession has passed. The women I interviewed – who were all first generation immigrants and mostly of low-economic status – reveal that the trend to have fewer children cannot simply be attributed to Americanization, assimilation, and prosperity (in fact, in regards to the latter, it may be just the opposite). Moreover, many women came from small rural towns in Mexico and now live in insular Hispanic communities in the Atlanta area, choosing mostly to interact with fellow Hispanics in environments where they feel safe, such as their apartment complex or a Mexican grocery store. Even though many had only been in the U.S. for a short time and were relatively isolated from other American women, the women I interviewed insisted on the importance of family planning and sex education, something that many commentators seem to categorize as solely an American value. As discussed in more depth below, my interviewees based their desire to have small families on an independent assessment of variables and vulnerability in their new communities; this departs from the multi-generational and “organic” process of Americanization that is often told²⁰.

²⁰ Furthermore, the total fertility rate in Mexico has fallen to 2.1 (Population Research Institute, 2015)

Filling in the lower rungs of the U.S.'s anemic population pyramid is not all that Latinas have riding on their backs. In the world of party politics, pandering to Hispanic voters has been seen as the key to swinging votes and winning elections, causing some to “portmanteau” the phenomenon as “Hispandering” (Meraji, 2015, “A politician walks into King Taco”). This assertion, of course, is based on the often-unchallenged notion that Hispanic birthrates will remain stable and prolific. On account of the fact that, outside of Cubans in Miami, Hispanic voters in the U.S. today are more likely to vote Democrat than Republican, many political pundits have been banking on the dream of a permanent Democratic majority that would be achieved through the seemingly “inevitable” (and oft-fetishized) “minoritizing” of the American population that has long been seen as the certain result of plummeting white birthrates and ever-high Hispanic birthrates. Such a view not only reifies the belief that Latinas are hyperfertile, but it also naturalizes the idea of an “inherent” political Democratic proclivity. This biopolitical malapropism prompted a blog contributor for *The Nation*, to aptly comment: “It has to be acknowledged: party identities aren’t passed on through the genes” (Perlstein, 2013, “Why a Democratic majority is not demographic inevitability”). Projecting into the future based on the stagnant belief that Latinas breed exponentially, this dream was founded on the assumption that Latinas would produce enough future Democratic voters to one day make it essentially impossible for Republicans to win if enough Hispanic voters were mobilized. Some also note that these pundits cannot even rely on immigration as a “Plan B” to achieve this permanent Democratic majority, because although the U.S. Hispanic

“Hispanic family size in U.S.A. shrinking”), meaning that the declining Hispanic birthrates in the U.S. cannot simply be attributed to a change in geography. It also cannot be attributed solely to the economic depression, as evidence of shrinking Hispanic family sizes existed before 2008 (e.g. Navarro, 2004, “For younger Latinas, a shift to smaller families”).

population typically grows more from immigration than birth rates, even immigration has begun to drop off, while more and more immigrants are returning to their home countries, both forcibly and electively:

Democrats seem to be banking on the high birthrate and continued migration of Hispanics to lead them to a permanent electoral majority... Any future Hispanic growth will have to depend more on immigration than on births, which is contrary to current trends. Analysts and pundits who prophesy a permanent majority based on Hispanic growth need to reexamine their crystal balls. Hispanic birthrates will plateau and decline in America, and democrats will have to look for a different minority group to fulfill their dreams of permanent national dominance. (Girdusky, 2015, “No Hispanic surge on the horizon”)

I suggest that precarious positions and the increasing securitization of migration has made both migration to the U.S. and having large families within the U.S. untenable, thus revealing that the U.S. cannot have it both ways with Hispanic immigrants; that is, they cannot be desirous of their labor and their youth while at once making it nearly impossible to live in the U.S. With the CDC report detailing plummeting Hispanic birthrates, the bubble has been burst.

Homo Economicus Speaks

The key feature of a neoliberal rationality is the congruence it endeavours to achieve between a responsible and moral individual and an economic-rational actor. (Lemke, 2001: 197)

The quote above describes the foundational “rationality” of a neoliberal homo economicus, and it also aptly describes how my interviewees’ views on their reproduction and family size align with neoliberal individualism’s equation of the

allocation of scarce resources with morality and rationality. However, I suggest that in doing this through an intervention upon their reproduction, the women I interviewed are diverging from the script of the hyperfertile Latina immigrant and her biopolitically-sanctioned, paradoxical role as both scourge and savior of the U.S.'s demographic and political futures. The result of Latinas' enactment of *homo economicus* is an acute concern with contraceptive interventions that will limit family size, thus undermining the hopes that Hispanic reproduction would redeem the U.S. of its demographic and electoral woes.

The majority of the women I spoke with – and most commonly the ones under 45 – expressed to me that contraception, family planning, and sex education for their children were of the utmost importance to them. Many did not wish to have more than two or three children, and they took contraceptive measures to make sure that their families would not grow bigger than they had intended. For instance, Juana – who at 20 was sexually active with no kids of her own, but was the caretaker for her 9 year-old brother – said that, “If I could get to 30 [before I have kids], that would be fine. I only want one or two...My mom has six – it’s just too much.” This sentiment was echoed from interview to interview, with many women detailing the actions they were taking to ensure that their families would not get too big. For example, a significant number of my informants opted to undergo immediate post-partum tubal ligation (a.k.a., getting your “tubes tied”) after their last childbirth, which was only the second or third child for many. Laura, from Colombia, got her tubes tied after her second child at the age of 23, shaking her head emphatically when I asked her why and simply saying, “Two is too much.” Relatedly, one of the most common questions I was asked by my informants was where

they could get the procedure done affordably if they had not done so already. The finality and invasiveness of tubal ligation was not lost on me. The more I heard women talk about their experiences with, or desire for, getting their tubes tied, the clearer it became that the decision to have smaller families was not taken lightly, nor was it simply lip service meant to impress me (a white female stranger), someone whom the women I interviewed might have suspected as being judgmental towards Hispanic immigrants. These women were adamant about not having any more children, so much so that many underwent a procedure that, although reversible with another surgical procedure, is nonetheless one of the most drastic and biologically invasive ways to limit family size.

In departure from the common perception that the male partner is in charge of family size and contraception in Hispanic couples from “traditional” backgrounds, which is almost always associated with the gender dynamics of Catholicism in this context, most of the women I spoke to controlled the matter themselves, and set themselves apart from what “tradition” has thus far dictated. Ana Luz’s view on family size and tradition illustrates this:

Ana Luz: It's why I have the two [kids].

Author: Because?

Ana Luz: Because you need to be responsible... You have children and get the husband and have all this because of how the tradition in my family used to be. No. You need to be very conscious that a child is something you bring into the world and it's a long-term commitment.

Author: Like, responsible economics? Care?

Ana Luz: Yes. Because in our tradition you have five or six children. Because I did try to have just several children, which is why I have just two.

Ana Luz's comments are indicative of a departure from tradition when it comes to family size, but, as Ana Luz had only been in the U.S. for two years, worked in a salon, and did not finish high school, this divergence from tradition cannot be explained via the Americanization and/or prosperity narratives that are commonly referenced when talking about immigrants and decreased family size. Moreover, having a husband who took care of birth control did not automatically mean that the couple was bound by traditional marriage roles. Lupe, who was 23 and had two children, was very clear about this when she talked about why her husband took care of contraception. She told me that she was not on birth control because she has never been good about remembering to take pills, explaining that her second child was a result of this, and emphasizing that this dynamic was NOT about religion. In addition to tubal ligation, many used (or were interested in using) birth control pills, condoms, and IUDs; the fertility awareness method (often associated with the related "rhythm" method) was often used alone or in conjunction with the aforementioned contraceptives. Thus, contrary to traditional stereotypes of male-controlled Catholic marriages, where birth control would be considered almost illicit, birth control for my informants was a primary concern of their reproductive health, and a matter which did not seem to conflict with any "traditional" idea of what it meant to be a Hispanic woman, but instead diverged from it on "rational" grounds.

The young women I spoke with broke this mold in many ways, not just in areas pertaining to their reproductive healthcare²¹. Many of them worked outside of the home and seemed to have partnerships with their husbands that did not match up with the

²¹ Sex education was important to my informants as well, and many expressed concern that their children were receiving inadequate sex education in Atlanta's public schools. For some, this meant that it was up to them to teach their children about sex and reproduction. This displays my informants' desire for their children to be secure as well. It also subverts the stereotype of Latin American cultures as being ignorant of sex education, or not being desirous of it.

submissive wife, dominant husband stereotype of Hispanic cultures. For instance, my interpreter and I recruited many interviewees in a Mexican bakery on Atlanta's famous multi-cultural corridor, the Buford Highway. The bakery was run by a woman, and in the corner of the bakery, another woman had rented out a space to run an independent insurance business. When viewed in this light, the decision to have fewer children can neither be *solely* attributed to economic turmoil (i.e., not having more kids because money is tight) or economic prosperity (i.e., not having more kids because women work and obtain education and thus postpone having children), but must also be seen in light of the fact that these women are not the oppressed and downtrodden "Third World" women that inhabit both demographic reports and popular myths.

This, of course, also contradicts beliefs that Latinas are inherently hyperfertile and unwaveringly desirous of large families. In taking control of their fertility and limiting family size, the women I interviewed are acting outside of their biopolitical roles as inherently-hyperfertile-and-thus-irrational: they are taking charge of their own bodies and (economic and social) security by utilizing health services in order to attain their goal of having small families. However, in doing so, they are not avoiding subjectivization completely. As Foucault says, "[E]conomic behavior is the grid of intelligibility one will adopt on the behavior of a new individual. It also means that the individual becomes governmentizable, that power gets a hold on him to the extent, and only to the extent, that he is a homo economicus" (2008: 252). In limiting family size, Latina immigrants in the U.S. are increasingly taking on the role of the "responsible moral actor" and the "entrepreneur of self," thereby enacting "good" womanhood/motherhood in tending to biological matters in a manner that is typically ascribed only to Western women (though

of course not all, as tropes of the “bad” minority mother abound in U.S. culture). Some interviewees vocalized the latter succinctly, describing how their family planning decisions establish themselves as “responsible” members of the polity, even if they aren’t legal members. Some even admonished fellow immigrants who do not act with such responsibility, talking about how it pains them to see Hispanic women with numerous kids in tow. For instance, Talia, who only had one child, suggested a way to de incentivize large families for Hispanic immigrants:

Author: what advice would you give to other Latin immigrants?

Talia: Don't have so many children. I am Hispanic and I get upset when I see these women with a whole bunch of kids. We're immigrants and we do not know the language. Why do we do that? The people who get upset, they have a right to get upset. [exasperated] I know a woman with seven children... There should be an incentive to have less. If the people have a lot of kids the children should receive less money [through government programs]. I bet you they would have not as many children. So that people will think, "Uh oh – no," because if they have more children, they have less income.

However, my interviewees’ actions and beliefs generally challenged the notion that Americanization alone changes women’s perceptions of family size, as many of these women had only been in the U.S. for a short amount of time, and, unlike Talia, not every woman I spoke to talked about their decision to have fewer children as an enactment of social responsibility for immigrants living in the U.S., but instead described it as a personal choice based on their precarious positions above anything else. All told, however, both the varying and shared beliefs behind why the women I spoke with wanted fewer children give qualitative credence to the CDC’s reports of declining birth rates among the Hispanic population, and help to untangle the strands of reasoning that go into

personal decisions that, on paper, look purely “economic.” While most women mentioned finances as a reason why they did not want many children, they also expressed that money was not the only resource in limited supply, and that a parent’s time and attention could not be adequately divided between a bevy of children. For instance, Carisa, who was 36 and had two kids, said:

Author: Do you want more kids?

Carisa: No.

Author: Why don’t you want more kids?

Carisa: They take *everything* that I have. And I also have siblings to help out...Here it’s very difficult. And I don’t think that I need to have twenty to be happy.

Carisa’s feelings also illustrate that, in the absence of formal social support for immigrants, many immigrants form social support networks with their families and friends. While extended families are traditionally thought of as a way that families with many children can be supported, in the precarious context that immigrants are in, having an extended family/social support network can also mean added responsibility, thus impinging on the desire of the women I interviewed to create more responsibility – for both themselves and the people in their support networks – by having many children.

This points to the fact that immigrants’ everyday needs are not supported in their new communities, and that limiting family size is a way to “allocate the scarce resources” needed for social reproduction. A glaring instance of this was the lack of childcare resources available to my interviewees. Since many of them worked, they needed someone to watch their children, but affordable and reliable babysitters were hard to find. Many times they have to leave their kids with a neighbor who they don’t know very well,

and who would accept payments as small as \$5 a day for watching their kids while they work; making minimum wage and below themselves, the women I interviewed could not afford daycare or vetted babysitters. Often, the babysitters who were willing to accept such little money were not trustworthy. Laura, who was from Colombia and has two kids and five grandchildren, said:

They need to have specific daycares for immigrants, because immigrants are going to places where they cannot bring kids – to work, to the dentist, or to court. Because the Latinos, what they do, is that they take the babies to the neighbor, cousins, grandmother, to wherever in this situation. Many of these children have been abused in these places. Because they are very poor [the babysitters], they don't have education, they don't read or write in any language...They blackmail the children so they don't tell the parents [about abuse]...I talk to my daughters, I have five grandkids, and I say to my daughters, "When you don't have anyone to care and you need to go anyplace, bring to me, bring to my job, bring to my house, say to me, 'Mom, please don't do anything that day because I need you to care for my children.'"

My interpreter was very moved by this, and with sadness said, "You touched a good point... It's a huge problem," later telling me stories she'd heard about child abuse and neglect by babysitters in the Hispanic community. Theoretically, these children are the ones who will "youthen" the aging American population, yet they are important only in number: their social needs and wellbeing aren't of concern, which in turn compels my informants to limit family size. This illustrates that, as long as their social reproduction is not being supported, Latinas will limit family size out of necessity.

In a sense, interviewees' decision to limit family size display an enactment of homo economicus that backfires because it is being performed by a group that was thought to be intrinsically stable and "outside" of the changing tides of "progress,"

meaning that their perceived reproductive capacities were theoretically supposed to remain stably prolific alongside the “evolving” and “developing” Euroamerican world, whose members rationally limit family size in relation to prevailing social and economic conditions. This brings to the fore the false assumptions neoliberalism is founded on. First and foremost, neoliberalism’s highly-exploitable pool of undocumented labor is underpinned by the assumption that Latina women will always produce children at an exponential rate, thereby establishing the premise that this labor is disposable and replaceable because it naturally regenerates itself. Further, the fact that Latinas are limiting their family size is proof that their social reproduction is not being supported, even as their production (i.e., labor), and sometimes their biological reproduction, is both overtly and subtly exploited. Champions of neoliberalism cannot expect to have exploitable Latina/o bodies to work and to keep the U.S. young without supporting the basic health and wellbeing of these bodies. The decision to have fewer children can therefore be seen as the transformation of Latina immigrants into the governable homo economicus; however, Latinas have become governable in a way that they were not supposed to become governable. In this sense, their transformation into homo economicus can be seen as, paradoxically, a form of governmentality that is subversive because Latinas’ subjectivization as such was unforeseen. Immigrants from the “Third World” are seen as irrevocably entrenched in their traditional ways. It is no surprise then, that the drop in Hispanic birthrates was met with incredulity.

Conclusion

Discourses of Latina hyperfertility are virulent, and they shape the way people view and interact with Hispanic immigrants. According hegemonic rhetoric, immigrants doing “bonsai runs” (Nevins, 2002) through the border and “dropping” babies like anchors on American soil are contributing to a dangerous “browning of America” (Chavez, 2008) with America’s culture and values being endangered by this impending demographic shift. These discourses are more than just words and should not be ignored, as they have in the past undergirded eugenics programs, both formal and surreptitious (Gutiérrez, 2008). However, quieter discourses – ones with a contrasting view of Latina reproduction – are lurking below the surface. These discourses have big plans for the hyperfertile Latina immigrant: they see her as the savior to the thinning youth ranks of the U.S population, and as the linchpin to a permanent Democratic majority.

The Latinas I spoke to did not fit into the trope of the unchangeably hyperfertile Latina. They expressed a strong belief in family planning, and they talked about how they limited their family size in part because of economic concerns. To them, it not only made financial sense to only have about two or three kids, but it made sense personally as well: as working mothers, they did not have the attention to give to a lot of kids, nor could they ensure their children’s safety in their absence. Childcare for Latina immigrants in Atlanta is tenuous. Unable to afford daycare, many women left their children with neighborhood babysitters while they were at work, though they knew this could be dangerous.

Additionally, many did not have trusted family members to leave their children with, and the ones who did spoke about not wanting to impose on their family, who were just trying to get by as well. Despite all that Latinas have to contend with (and without) in raising

families within precarious economic and social environments, it was still believed that they would reproduce as prolifically as ever before, as if Hispanics were infinitely resilient and could thrive in any environment. Reports that their fertility rates have dropped were consequently met with surprise that revealed a belief that held that Latinas – regardless of place or time – are inherently and innately more fertile than “First World” women. Latina hyperfertility has gone unquestioned even in liberal discourses that tout the “minoritization” of America – to be largely facilitated through the reproduction of Hispanics – as the key to an eventual permanent Democratic majority. However, when Latinas are viewed as independent decision-makers who exist outside of the tropes through which many view them, the error in ascribing stagnant generalizations to large swathes of humanity becomes evident.

From the hegemonic nativist rhetoric of anchor babies to the valorization of Latina reproduction for the future of the Democratic nation, Latinas are discursively placed outside of the trajectory of “progress” that “Western” women are put on. Regardless of context, Latinas were expected to behave in a certain way because of the belief that there is some innate hyperfertility within them, and that this proclivity is enhanced by “traditional” Catholic backgrounds. When the CDC’s report revealed that many Latinas in the U.S. were behaving contrarily to what was expected of them, shock abounded. My interviewees’ actions disrupt dreams that position the Hispanic population in the U.S. as the ones who will save our ailing population pyramid and be the key to success in political campaigns, and they reveal that the taken-for-granted notions that the neoliberal exploitation of immigrant labors are founded upon – namely the unwavering

reproduction of cheap migrant laborers and voters and the abrogation of any concern for their social reproduction – are faulty to the core.

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CHAPTER SIX

CONCLUSION: A WORK in REVIEW and MATER ECONOMICA

Summary and Discussion

In this dissertation, I have detailed how, in accessing and obtaining reproductive healthcare in the Atlanta metropolitan area, Latina immigrants deal with myriad barriers, both structural and interpersonal; in doing so, they encounter, navigate, and confront the ideological beliefs that help to constitute these barriers, such as the notion that undocumented immigrants are undeserving of resources such as healthcare (Yoo, 2008), and that Latina immigrants in particular “steal” this resource through their reproduction (Chavez, 2008). I have thus demonstrated how reproductive healthcare – and, in general, the care of the body and the withholding and impediment of this care – is about more than health and wellbeing, but also about inclusion into, and exclusion from, the polity writ large: it both reconstitutes and contests noncitizenship, as well as the biopolitical “utility” – that of hyperfertile reproducers – that has been ascribed to Latina immigrants in the quieter, emerging discourses.

The experiences of the women I interviewed were unique and varied, but also contained common themes that allowed me to draw the conclusions herein. Specifically, I argue that conceptions of Latina immigrants as dangerous criminals contribute to legislation and discourse that impede Latinas’ access to, and experiences of, reproductive healthcare. But even as these obstacles present challenges for the women I interviewed, the women used tools like assertiveness and proactive planning in order to obtain a quality of healthcare that they were happy with. In acting boldly to procure this care

within an environment that was often hostile and unwelcoming, my interviewees were able to cultivate therapeutic landscapes amidst a tangle of factors that were anything but therapeutic, as well as to lay claim to a biological citizenship that somewhat and sometimes mitigates the lack of agency they have within the parameters of legal citizenship and its associated rights and obligations. Finally, one of the main reproductive healthcare concerns of the women I spoke with was birth control and family planning, and many of my younger informants were adamant about only wanting two or three children. This of course goes against tropes of Latina hyperfertility, and it corroborates studies from the CDC and other sources that show that Hispanic birthrates in the U.S. are in sharp decline. The research I've discussed here contains compelling ethnographic data that confronts the persistent and harmful trope of the hyperfertile Latina.

Like many of the discourses surrounding Hispanic immigrants in the U.S., including the desire for cheap workers paired with the antithetical indignation leveraged at those same workers in matters pertaining to their social reproduction, Latina fertility is often described in conflicting manners. It is at once a specter that threatens the social welfare of those who “deserve” it, while also being viewed as a timeless and dependable source of bodies to replenish the young population of our rapidly aging nation, as well as to fulfill utopian political futures. The duplicity with which Latina immigrants are viewed is indicative of stronghold that nativism has on the American mind, even in the context of the supposed deterritorialization of neoliberalism; while nativism is nothing new, what is new are the internal borders – as well as the increasingly militarized U.S.-Mexico border – that characterize neoliberalism’s supposedly “borderless” world. It is in this schizophrenic milieu that Hispanic immigrants must carve out a living. In the case of the

women I interviewed, security was hard won: it was something that had to be fought for on an everyday basis. Taking a step outside of their homes meant having to contend with the possibility of deportation, and so many women chose to navigate public space with exceeding care, walking and taking public transportation instead of risking getting stopped and asked for papers while driving.

Interestingly, many of the women I spoke with talked about how their husbands or partners continued to drive after the passage of HB 87, perhaps illustrating a response to insecurity that is inflected with gender ideals. That is, mothers are the ones who provide and perform the needs of social reproduction for their families, and the prospect of mothers being deported and separated from their children seems to be more daunting than the prospect of fathers being deported. Additionally, I speculate that gendered performances of bravery (men) and caution (women) contributed to the fact that so many women stopped driving while men continued to do so; indeed, according to ICE statistics, 93% of the 368,644 people deported in 2013 were male (Carroll, 2014, “Majority of migrants deported from U.S. young Mexican men, figures show”). This harkens back to discussions within geographies of fear literature, which notes that, even as men are more likely to be the victims of violent crime outside of the home, women are more likely to report being fearful of being the victims of violent crime in public space, and thus they take precautions to avoid this. But while fear may shape the way that the women I talked to moved through public space, boldness also shaped these geographies. It was in this manner that many of the women I interviewed were able to cultivate therapeutic landscapes that were more conducive to the health and security of themselves and their families than the landscapes without such intervention and careful orchestration.

Although I have talked about how Latina immigrants live in an environment of risk and insecurity – in no small part because of HB 87 – I have also hoped to demonstrate that they are not just passive victims, but in fact active agents who facilitate security through caring for the corporeal wellbeing of themselves and their families. The political nature of such an act cannot be underestimated when the geopolitical lines of divide that manifest in nativist rhetoric center on the supposedly inherent hyperfertility of the Latina body. This characterization, of course, is the basis of why Latinas, and Hispanic immigrants in general, are often viewed as undeserving of healthcare, which is thought to be the right only of legal citizens (Chavez, 2008; Yoo, 2008), though of course not all, as the same arguments that are leveraged against Latina fertility are also lobbed at mothers who are minorities and/or of low socio-economic status (Davis, 2003). Unlike citizens, however, many of the undocumented women that I interviewed could not legally access things like low-cost insurance through the Affordable Care Act, and they also run up against obstacles involving cultural competency in clinics and hospitals. Even as they believed they were mistreated because of stereotypes surrounding their reproduction and ideas of citizenship and deservingness, Latina immigrants also demanded good treatment – thereby claiming biological citizenship through seeking treatment from certain “kind” providers – on the grounds that they deserve it as humans and as contributing members of society. As feminist scholars have noted, the body as a scale where geopolitics takes place should not be ignored, and care is an instrument of political agency. For many of the women I interviewed, caring for their bodies was one of the only political acts in which they could safely and effectively engage; as one of my interviewees aptly expressed, politicians will not listen to undocumented immigrants.

Mater Economica

In assessing how *localized immigrant policing and the micropolitics of everyday life* and *the politics of caring for and not caring for immigrant bodies* intersect to shape the reproductive healthcare experiences of Latina immigrants in Atlanta, I realized the story is more complex than facing and overcoming barriers to access. That is, subversive acts, though transformative, are not the end of the story, and they are often marbled with moments that uphold the status quo. For the women I spoke to, healthcare access simultaneously feeds and is fueled through conduits that connect Latina bodies to geopolitical borders, both ideological and physiological. However, the fibers of these conduits are sometimes tenuous and weak, tearing and connecting to new ports. For example, in acting assertively in order to counter bad treatment from health service providers, some of the women I spoke with were able to connect to a resource – (a good quality of) healthcare – of which they are often construed as undeserving. With that being said, sometimes actions alone are not enough to sever the thick, knotted ideological fibers that portray women who cross the U.S.-Mexico border as criminals and their reproduction as the weapon: despite evidence to the contrary, the trope of the dangerously hyperfertile Latina still runs strong, even as it is currently being pelted with evidence of declining Hispanic fertility.

However, in cultivating therapeutic landscapes and claiming biological citizenship through family planning, I suggest that the women I interviewed have become a version of homo economicus that does not appear anywhere in Foucault's descriptions of the figure, and one which aptly illustrates this marbling of the subversive and the obedient. My interviewees' version of homo economicus might better be described as

“mater economica” – or “the economic mother.” Foucault’s homo economicus – as well as discussions of economic rationality within economic theory – pay little attention to elements of social reproduction, such as mothering and childcare, instead viewing homo economicus as a universal, masculine automaton of the neoliberal system. In this dissertation, I have detailed how the allocation of scarce resources – including care – happens on an intimate level is a security measure and a political move that combines with gender roles to produce a woman whose reproduction is measured and strategic. She is a woman who works, and whose time and attention is in high demand both in the realms of production and social reproduction. Mater economica Latina, the biological citizen who obtains reproductive healthcare and thus fosters security and a semblance of deservingness which she is hardly afforded, is both a rational and dutiful economic actor and a devastating blow to the system that helped to make her.

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