Alien Mothers, Anchor Babies and the Invading Fetus: Racialized Contradictions and the Birthweight Paradox

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Abstract

The reproductive futures of Latina immigrant mothers have always been subject to scrutiny and a source of anxiety for those who see them as "excessively" fertile or their offspring as changing the composition of the nation. This article builds on ethnographic research among Mexican immigrant women in the prenatal clinic of a large public hospital in New York City. There, even in a progressive institution in a city that prides itself on the welcome it gives to new immigrants, discourses about the purportedly excessive childbearing of immigrant women clash with the ideas that immigrant women and their families hold about building the right-sized family and navigating the treacherous landscape of health care, citizenship and social rights, benefits and discourses. While Mexican immigrant women achieve remarkably favorable birth outcomes in spite of facing many socioeconomic disadvantages, their efforts are not lauded but couched within racialized discourses about immigrant fertility that constrain the ways they imagine citizenship for their US-born children.

"See you soon!" The nurse laughed as she discharged Laura and her new baby from the recovery wing of Labor and Delivery at a large New York City public hospital.

Laura told me, “She thinks we Mexicans have too many babies, that I’ll be back here again next year, but not me, I won’t be.” “Yes, you will, you’ll see!” The nurse then turned to me, “They all say the same, and then we see them again in a year.” Even while she laughed with the nurse, Laura shook her head and repeated, “Not me!”

Achieving rapport with health care providers, sharing a laugh, and imagining that if one were to come back again in a year or more, that someone would recognize her are aspects of care that patients say they admire at this hospital. Nonetheless, “knowing” their patients, for some providers in this setting means locating them within larger racialized discourses about indigent patients, immigrants and the “anchor babies” they are imagined to carry. In this dialogue, the nurse implies that she knows this Mexican patient better than she knows herself. Even while patients are usually treated with kindness in this public hospital, ideas about Mexican immigrant mothers and their fertility, and the value—or lack thereof—of their fetuses can be traced by examining interactions between patients and providers. This article examines the contradictory characterization of Mexican patients in this setting as “model patients” even while their fertility is viewed as rampant and their fetuses as invaders.

This article is based on ethnographic research conducted from 2005-2009 in various sites including the public prenatal clinic of a hospital I call Manhattan, in immigrant-serving organizations, and in Puebla and Oaxaca States of Mexico. A total of 100 women were interviewed, along with health care providers in each site.

In the popular imagination, biological reproduction of Latinas combines with their social reproduction to produce fears about Latino population growth as a threat to

the nation—that is, 'the American people,' as conceived in demographic and racial/ethnic terms (Chavez 2008). This threat materialized not merely because of Latino population growth but also because Latino babies transgress the border between immigrants and citizens. Chavez argues that the fertility of Latinas, especially Mexican immigrants, is subject to even greater scrutiny and anxiety than immigrant women's fertility in general. It is here that the metaphor of leaky national borders converges with that of porous bodies producing babies and the permeable concept of citizenship (Chavez 2008, 71-72). In this article, I examine the ways that the offspring of immigrants are viewed in the contemporary United States as a threat to contemporary notions of citizenship and the aspirational efforts of Mexican immigrant families as they navigate the public health care system.

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With the current economic crisis, anxieties in the United States about borders and bodies have reached new heights. Even while the undocumented youth movement has lent unprecedented visibility to immigrant issues, achieving very prominent platforms (such as the 2012 Democratic National Convention), as well as executive action with President Obama's new policy of Deferred Action for Childhood Arrivals (2012), comprehensive immigration reform has been a non-starter in Congress since 2006. Amidst Tea Party activism and a rise in xenophobic popular discourse, state legislatures have been busily debating proposals to "fix" immigration law due to a purported federal unwillingness or inability to address immigration issues. The most renowned example of such legislation is SB 1070, the so-called "Papers Please" law in

Arizona (officially titled *The Support Our Law Enforcement and Safe Neighborhoods Act*) a punitive bill allowing law enforcement officials to proactively question the immigration status of individuals. However, receiving less of an uproar than SB1070 have been the multiple efforts by some of the same legislators, and others, to amend the constitutional guarantee of birthright citizenship for the children of undocumented immigrants and to limit the access immigrant families have to public services through state and federal-level proposals. Current policy strategies among "restrictionists" consist of removing so-called immigrant "magnets"—the purported services that are imagined to promote migration, including health care, education and citizenship. These efforts also include the promotion of "attrition" or "self-deportation," the implementation of laws that make life in the United States so miserable for immigrants that they will voluntarily depart the country, such as laws that make it illegal to rent commercial or residential properties to undocumented immigrants, obstruct families access to health care and education, and denial of in-state tuition and drivers' licenses. The website of the Center for Immigration Studies offers detailed information about such proposals, which are also promoted in the immigration policy brief on the presidential campaign website of Republican Governor Mitt Romney.

Russell Pearce, Republican state senator of Arizona, who proposed SB 1070 and also a House Bill 2281 banning ethnic studies in that state, told the media in 2010 he was collaborating with Kansas Secretary of State and constitutional law professor Kris Kobach, on legislation he planned to introduce in Arizona that would deny state citizenship to the children of undocumented immigrants. Because the granting of

citizenship is in the federal domain, Pearce hoped that the legislation would produce lawsuits by the federal government to challenge legal precedent on the Fourteenth Amendment that could go to the Supreme Court. At the same time, Pearce belongs to a coalition of lawmakers, the Fourteenth Amendment Citizens Model Committee, who plan to introduce similar legislation in other states and also, were they to have the numbers of votes needed in the Congress, call for a Constitutional Convention to repeal the Fourteenth Amendment at the federal level. Importantly, far from being marginal figures, both Russell Pearce and Kris Kobach, as well as Arizona governor Jan Brewer are among Republican presidential candidate Mitt Romney's advisors on immigration and represent ever more mainstream strands of Republican philosophy on immigration.

It is unlikely that Pearce and his allies will be able to marshal the majority they need in both chambers of Congress to consider a change to the Constitution, much less convoke the 75 percent of states they would need to call a constitutional convention, but it is increasingly clear that their efforts to gut the Fourteenth Amendment's guarantees of citizenship to all who are born in the United States do not require such measures. Instead, their hope may be to legislate via litigation. By passing local and state laws that they are aware would be considered unconstitutional by virtually any legal scholar, these activists may provoke law suits that will not only generate heated debate but face constitutional challenges that, if they achieve their goal, will be taken to the Supreme Court. In this way, they wish to accelerate and manipulate the process of judicial review to set new legal precedent on the Fourteenth Amendment's guarantees. Thus, rather than rewrite the Fourteenth Amendment, they may change the way it has

historically been interpreted to revoke long-standing guarantees of birthright citizenship.

The Fourteenth Amendment was, arguably, the first time that national citizenship was established in the Constitution of the United States. Adopted in the wake of the Civil War, in 1868, the amendment guaranteed equal protection under the law as well as birthright citizenship. It was deemed necessary because previously slaves and their descendants had been denied citizenship, a practice upheld by *Dred Scott v. Sandford* (1857). Contemporary advocates for revocation of the Fourteenth Amendment's guarantees cite some other nations' granting of citizenship based on *jus sanguinis,* citizenship by right of blood, or on lineage to citizens, versus *jus solis*, citizenship based on place of birth (see Knight 2005). They argue that citizenship should be granted only to the children of citizens, not on the basis of birth within the nation's borders. Even while they advocate *jus sanguinis,* it is a policy that has been deeply criticized in some of the European nations where it is law for allowing generations of people born in a country to never achieve the full rights of citizenship and also as a discriminatory process that reproduces ethnic homogeneity and defies contemporary pluralism.

As constitutional scholar Alexander Bickel (1975) points out, citizenship was nowhere defined in the US Constitution (cited in Oboler 2006: 6). Rather than "citizens", the Constitution refers to the "people" of the United States, and its rule was historically interpreted to apply to all of those living within the borders of the nation. However, just as borders represent fraught liminal spaces for the nation-state, immigrants are liminal

figures, defying the definitions of citizenship and belonging from the inside. Their physical presence, sometimes long term, contradicts their juridical outsider status. The children of non-citizens have been subject to particular scrutiny and gate-keeping efforts. Born in the United States, children of immigrants bridge "legitimate" citizenship and "illegitimate" foreignness. Seen by restrictionists as the "anchor" establishing claims for an entire family tree, children of immigrants juridically belong but constantly reinforce the durability of their ties to non-citizens.

Efforts to limit the access of immigrant families to public services often begin with those services consumed during pregnancy, childbirth and early childhood. Supreme Court precedent in *US v. Wong Kim Ark* (1898) established that a child of foreign nationals (excluding diplomats stationed in the United States) enjoys birthright status as granted in the Fourteenth Amendment, irrespective of the citizenship of his or her parents. In *Plyler v. Doe* (1981), the court ruled that the efforts of a Texas school board to deny primary school education to the children of undocumented immigrants violated the equal protection clause of the Fourteenth Amendment: "The Court reasoned that illegal aliens and their children, though not citizens of the United States or Texas, are people 'in any ordinary sense of the term' and, therefore, are afforded Fourteenth Amendment protections" (Plyler V. Doe 1981). Nonetheless, policy and legislative challenges to the rights afforded immigrants and their children have persisted.

Phyllis Pease Chock (1996) traced the discourse surrounding immigrant women's fertility in the congressional debates preceding the passage of the 1986 Immigration

Reform and Control Act, the last comprehensive federal immigration reform, frequently referred to as the "1986 Amnesty". She found a persistent theme of preoccupation on the part of lawmakers (and reflected in broader public discourses) about undocumented women's fecundity. There was a particular fear of women becoming pregnant during their process of legalization, thus upsetting the imagined aim of legalization. In a bait and switch, female immigrant workers applying for amnesty would morph into idle and presumably indigent immigrant mothers and their children. Pease Chock writes: "these women who were 'illegal immigrants' would become legal residents, their children citizens, and both, 'public charges.'" (1996:2). She traces the historical association between (male) citizen subjects, "an income-producing worker, one who is rational and orderly, one who is head of a nuclear family that replicates the qualities of its head-that is, a unit that is productive, self-sufficient, and orderly" versus (female) illegal aliens, "dependent, irrational or disorderly, unproductive and unpaid" (1996:1). In this way, "illegal aliens" are gendered as female and type-cast as public charges, thus turning their children, even when US citizens, into unwanted and by necessity dependent and disorderly drains on public benefits.[1] Far from being seen as the progenitors of a new generation of Americans, they serve instead as an unpleasant reminder of the social and biological reproduction of abject undocumented and deportable workers, which preferably occurs out of sight in distant communities of origin in immigrant-sending countries (DeGenova 2005 and 2010, Chang 2000, Pease Chock 1996). This is what

[1] See http://colorlines.com/drop-the-i-word/ for analysis and critiques of the use of the terminology "illegal alien."

Hondagneu-Sotelo and Avila call the "externalization of the costs of labor reproduction to Mexico and Central America" (1997, 568).

Further, the babies of undocumented women are cast in xenophobic, restrictionist discourses as "anchor babies," who, in addition to their perceived propensity toward being public charges, are seen as an "anchor," lodging the claims of untold numbers of undocumented immigrant relatives in the United States. There is no evidence that such a practice occurs in sociologically significant numbers (Pew Hispanic Center 2011), but that does not prevent the idea of anchor babies from occupying a significant role in the imagination of restrictionists. While there is virtually no legal means for a child born to undocumented parents to do anything to affect the status of her parents until after she turns twenty-one and initiates what can be a decade-long sponsorship process, "anchor babies" are one of the particularly virulent bogeyman narratives among restrictionists. These narratives foster their own progeny: urban legends about women crossing the border simply to "drop" their babies in emergency rooms on the US side and families conniving to conceive and bear children simply for papers. Senator Lindsey Graham (Republican, South Carolina), remarked on cable television, with no empirical evidence: "People come here to have babies, they come here to drop a child, it's called 'drop and leave'. To have a child in America, they cross the border, they go to the emergency room, have a child, and that child's automatically an American citizen. That shouldn't be the case" (Fox News, July 29, 2010).

Anchor babies are defined by the Federation for American Immigration Reform, a restrictionist organization, as "an offspring of an illegal immigrant or other non-citizen,

who under current legal interpretation becomes a United States citizen at birth. These children may instantly qualify for welfare and other state and local benefit programs" (Federation for American Immigration Reform 2009). In spite of the seeming seriousness of this definition, there is no reliable evidence of such a practice of immigrants purposefully timing childbearing to take advantage of U.S. birthright citizenship. According to a Pew study

> 91 percent of undocumented immigrant parents who had babies from 2009 to 2010 had already been here several years; just 9 percent of undocumented immigrants who had babies in the past year had arrived in 2008 or later. The number of children born to at least one unauthorized-immigrant parent in 2009 was 350,000, statistically no different than the 340,000 reported a year earlier. This number represents about 8 percent of U.S. births (Pew Hispanic Center 2011).

How is it that babies—ordinarily considered to be exempt from discussions of politics-- can be the target of such ire? Even amidst anger and anxieties on both sides of the debate about the problems in current immigration policy, how is it that babies could be viewed so abjectly? This is related to the notion of "stratified reproduction," developed by Shellee Cohen, and summed up by Ginsburg and Rapp as follows:

> Stratified reproduction … describe[s] the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered… More broadly, who defines the body of the nation into which the next generation is recruited? Who is considered to be in that body, who is out of it?

> …Thus, put starkly, the concept of stratified reproduction helps us to see the arrangements by which some reproductive futures are valued while others are despised [1995, 3].

Stratified reproduction is a particularly apt concept for examining the despised reproductive futures of immigrant women. It is in prenatal care settings that dominant messages about the inherent value of infant lives and the need to care for them through elaborate prenatal care from the first trimester, to ensure a sound pregnancy, safe birth and healthy childhood clash with the messages given to immigrant women about their excessive fertility and the less-valued status of their offspring.

This article is drawn from a larger study that examined the so-called birth weight paradox, the better than expected birth outcomes for mothers born in Mexico and the subsequent decline in favorable birth outcomes with greater duration of residence in the United States (Gálvez 2011). There is no small irony in the fact that Mexican mothers are hailed by epidemiologists and public health scholars for favorable birth outcomes, at the same time that their fertility is the subject of such great consternation in many public discourses in the United States. They exhibit low rates of infant mortality and low rates of low birth weight in spite of disadvantaged socioeconomic status (in defiance of the usual maxim that wealth leads to health). Rather than looking to a biological answer, the study looked for social and cultural explanations: the knowledge and practices that recent immigrant women bring to the United States, the ways they share them and the circumstances in which they may choose to discard them. The research question governing the study was: How do Mexican immigrant women

navigate the turbulent tides of public opinion, health research, medical advice and service provision in pursuit of health care and resources for themselves and their families? How do they decide which advice to follow and which to ignore as they negotiate between biomedical precepts and knowledge garnered from their own mothers and grandmothers? My research suggests that in fact, the decisions that families make about when, where, and how to have children are profoundly impacted by larger discourses surrounding immigrants and also by families' immigration experiences. Further, the decisions women make about how to care for themselves during pregnancy are shaped by their posture toward life in the United States as immigrants and as parents of future U.S. citizens.

The larger project from which this article is extracted examines the purported cultural advantage of Mexican immigrant women in pregnancy and childbirth and the puzzle identified by epidemiologists as the "birth-weight paradox." This is a subset of the "immigrant paradox," in which first-generation immigrants have more favorable health indicators, by some measures, than their U.S.-born counterparts (Forbes and Frisbie 1991; Landale, Oropesa, and Gorman 1999; Rumbaut and Weeks 1996), and of the "Latino health paradox," in which Latinos demonstrate an advantage over other groups on a number of health indicators (Alegría et al. 2008; Escobar and Vega 2006; Fuller et al. 2009; Taningco 2007; Vega, Rodríguez, and Gruskin 2009).

The birth-weight paradox, also sometimes called the Latina paradox, is that immigrant women born in some Latin American countries with a high prevalence of "risk factors" nevertheless have a "perinatal advantage": they have fewer low-birth-weight

infants than other groups. Mothers born in Mexico, among a few other immigrant-sending countries, tend to have lower rates of pregnancy complications, such as low birth weight, premature births, intrauterine growth retardation, and infant mortality, than might be predicted by their "disadvantageous risk profiles" (Morenoff 2000, 12; also Buekens et al. 2000; Cramer 1987; Forbes and Frisbie 1991; Hessol and Fuentes-Afflick 2000; Landale, Oropesa, and Gorman [font?] 2000; Liu and Laraque 2006; Palloni and Morenoff 2001; Taningco 2007). Low birth weight is a useful measure of birth outcomes because it is an indication of infants born "too small," "too soon," or both. It is an important indicator of risk for neonatal mortality, but even more broadly it is "an important predictor of a number of health and developmental outcomes" (Conley, Strully, and Bennet 2003, 10). This rupture in the formula that "wealth equals health" is considered paradoxical because it conflicts with expectations that poorer women with greater "risk" factors will have more complicated pregnancies and childbirths and because this protection declines over time—greater assimilation into the U.S. health care system results in worse outcomes (Hayes-Bautista 2002; also Alegría et al. 2007; Cook et al. 2009).

Research methods

This article is based on a multisited ethnographic research study that employs several qualitative methods.[7] The study employed ethnographic research methods, including participant observation, surveys, and life-history interviews, as well as quantitative analysis of individual medical records, public vital statistics, and census

data. Research for this book was completed in various sites in New York City and, briefly, in Mexico. In New York City (n = 102), research was conducted at a major public hospital's prenatal clinic in Manhattan and at a community-service organization in Queens, New York; in addition the snowball method was used to contact participants. In Mexico (n = 6), research occurred in both rural and urban settings in Oaxaca and Puebla states. Research was conducted over two years, from 2006 to 2008, with one- to four-month-long intensive periods in each location; and informal interviews occurred over a longer period.

In all, approximately one hundred Mexican immigrant women participated in New York City: sixty-three formal interviews, nineteen anonymous surveys in a hospital setting, and twenty women interviewed in a community organization and as a result of snowball referrals from other participants. All but one of the women were immigrants, born in Mexico. One woman, a nineteen-year-old interviewed during her second pregnancy, was born in New York to Mexican immigrant patients. On average, women in the study migrated 4.5 years prior to our first interview. They had lived in the United States from three months to twenty-one years. The average age upon arrival was 20.7 years. A small number of women migrated as children (also known as the 1.5 generation). Research among Mexicans in New York City offers a snapshot of a recent immigrant community in which the first generation still overwhelmingly outnumbers the 1.5 and succeeding generations.

In addition to pregnant women and mothers, more than a dozen health care professionals were interviewed or accompanied in their clinical practice, including

midwives, obstetricians, nutritionists, social workers, nurses, and physician's assistants in the public hospital in New York, as well as a general practitioner, two midwives, and a botanist in the Rio Blanco neighborhood of Oaxaca City; Ixtlán de Juárez, Oaxaca; and San Antonio Texcala and Zapotitlán Salinas, Puebla.

At Manhattan Hospital, the birth weight paradox, all the rage in some public health and epidemiological circles, has yet to provoke amendment of the treatment of Mexican immigrant women. If the paradox consists of better than expected results, women are still incorporated into protocols that anticipate worse than average outcomes.

What currency does common knowledge about the advantages Mexican women enjoy in birth outcomes have in a system of health care that assumes the worst? A comment by one midwife is reflective of the attitude of many providers toward their most numerous patient population: "I love my Mexican patients, they're so healthy!" Midwives and obstetricians in this hospital are familiar with the birth weight paradox and remark that their Mexican patients come to the hospital well prepared for low-risk, successful pregnancies and deliveries. Some of the reasons providers give for this advantage include hypotheses for the birth weight paradox supported by research: Mexican patients engage in few high-risk behaviors, tend to consume a nutritious diet, enjoy close-knit support systems during pregnancy, etc. Nonetheless, care in this hospital is distributed according to broader logics of risk. Mexican patients, and indeed all the patients in this prenatal clinic (none of whom had private insurance) are assumed

to be eligible for and requiring of an intervention-intensive model of care. At the same time that it features an intensity of intervention practically unheard of in private obstetrical care, that care is paradoxically viewed by many providers and patients within and outside of the system as “shoe string,” “triage” and even “third world” medicine.

In her book (2010), Khiara Bridges documents several instances of the excess of diagnostics in routine protocols of prenatal care at Manhattan Hospital:

> while all pregnant women—with or without private insurance—should expect a test for gonorrhea, Chlamydia, and syphilis during the Pap smear that they receive during their initial prenatal care visit, only Medicaid-recipients are tested for these sexually-transmitted diseases again during their third trimester, and yet again during their postpartum visit (2010:108).

Many women in the study, accustomed to less frequent and less intrusive care from lay midwives in their communities of origin, perceived routine prenatal care in New York City as excessive. Columba told me her first three children were born at home, Ocuapa, near Chilpancingo de Bravo, Puebla, delivered by her mother. I asked her how her mother knew how to deliver babies, and she said that her grandmother had been a *partera* (empirical midwife) and also because of her mother’s own experiences giving birth to thirteen children. When I asked if her mother knew how to manage labor, cut the umbilical cord, and take care of everything, Columba said yes, of course, she did. Columba said that when she realized she was pregnant, a friend had brought her to Manhattan Hospital. I asked what opinion she held of the prenatal care she was receiving at Manhattan Hospital. She told me that she felt that the frequency and

intrusiveness of exams was too much: “Pues en México no nos están checando a cada rato y acá nos están checando siempre…No pues a mí, no me gusta que me estén revisando a cada rato. Me molesto como no estoy acostumbrada” [Well, in Mexico, they aren’t checking us all the time, and here they’re always checking us. And well, I don’t like that they’re always examining me. It bothers me because I am not used to it].

Women in the clinic are also aggressively advised about contraception methods, in a fashion perceived by some to imply that their infants and potential future pregnancies are unwanted or excessive. Public prenatal care regulations in New York State require that women be counseled about contraception at various steps in their prenatal and postpartum care. A nurse asks in her initial intake interview, “cómo te vas a proteger cuando tu bebé nazca?” [How are you going to protect yourself when your baby is born?] and counseled about contraception. For a woman in the middle of her first pre-natal appointment, this may seem an odd question. If she says she wants to have a tubal ligation, the nurse begins the paperwork for informed consent so that everything will be ready for the procedure to be performed when she delivers her baby. If she says condoms, she will be told they frequently fail and she should consider “la inyección” (Depo Provera), or an IUD. If she says she has not considered contraception, she is told she must, not least because she will be asked this question a dozen more times over the course of her pregnancy and her answer dutifully recorded each time. A woman in the study, Jessy, was asked once again about contraception by a registered nurse who had called her in to discuss a diagnostic she needed to complete in her thirty-seventh week of her first pregnancy. She said that she had discussed contraception

already with the health educator. The nurse insisted, and Jessy replied that she planned to use condoms. The nurse responded, “Si eso es lo que quieres, nadie te puede convencer. Tenemos la inyección, cosas más seguras” [If that’s what you want, no one can convince you. We have the injection, more secure options.]

While many of the women I interviewed remarked that the care they received was excessive, virtually all at the same time marveled at what they described as a remarkably humane and generous public health care system in which they received, free of charge, care that they described as being available only to those with money in their communities of origin. Accessing such care nests with immigrant opportunity narratives (Pease Chock 1994), contributing to what I call an aspirational stance that can color the perception immigrants have about life in the United States. Since migration is usually a project undertaken with the hope of bettering one’s life circumstances, accessing prenatal care in what is often viewed as a modern, high-tech hospital is often interpreted by immigrant families as incontrovertible proof of having made strides in accomplishing the goals for which they came. In this way, many women describe their children, from birth, as already enjoying improved life circumstances over their own.

As such, I found that women were quite eager to adopt and adapt to what they viewed as practices and knowledge befitting these new circumstances: advice about caring for one’s pregnancy and child received in the hospital. Instead of building on what was already for many women a rich store of knowledge about self-care practices during pregnancy and childbirth, what most women received could be interpreted as subtractive health care (building on Valenzuela’s notion of subtractive schooling, 1999).

Rather than perceiving and responding to women's enthusiasm and preexisting knowledge, within a subtractive health care regime, health care providers give women partial, overly simplified and sometimes faulty advice, at the same time that they pile on interventions and preventative measures that often could be rendered unnecessary with increased qualitative and empirical clinical effort. This is by no means a phenomenon common only to public prenatal care but is a feature of what many health care providers describe as the inexorable march away from quality clinical care due to budget cuts, billing practices, time constraints and ubiquitous medical technology.

A feature of many migration narratives in this study and in others (Gutmann 1996; Napolitano 2002) is an inclination by migrants to view features of the life they left behind as part of the spectrum of factors leading to migration. In this way, even while nostalgia for family and homesickness may mark many immigrants' experiences, many people also commented in interviews about their bitterness for truncated opportunity, poverty, and corruption. For many people born in rural communities, access to medical care is viewed as a luxury for the wealthy. The home-based self-care practices with which families manage routine and sometimes emergency health care needs are sometimes seen as survival strategies used for lack of other options. Thus, even though the home-based self-care practices are likely a key component in the favorable birth outcomes of recent immigrant women, they are wont to discard many of the practices they bring with them as legacies of poverty and marginalization in their communities of origin.

María Pacheco's experiences during her first pregnancy illustrate some of these dynamics: the eagerness of a first-time mother to ensure the health of her fetus, her inclination to follow medical instructions even when they contradicted her embodied experience, and the rushed and oversimplified clinical dynamic. In this case, the advice she was given by nutritionists had serious consequences. While under prenatal care for her first pregnancy at another hospital in New York City, she was diagnosed with gestational diabetes and sent to a high-risk clinic. She was told to report there every week, where she was weighed and submitted to frequent checks of her blood glucose. She told me that she was struck by the attitude of the other women in the clinic, predominantly "morenas" and "dominicanas" [African-Americans and Dominicans], who she said complained vociferously in the waiting room about the mandates given them in the clinic. "Ellas dicen que si quieren comer un pedazo de pastel, lo van a comer, que nadie les puede decir que no. Pero por mi parte, si me dicen que algo es para el bien de mi bebé, lo voy a hacer" [They say that if they want to eat a piece of cake, they're going to eat it, that no one can tell them not to. For my part, if they tell me I need to do something for the good of my child, I'm going to do it.]

On the surface, María fit a high-risk profile for low birth weight and other pregnancy complications: unmarried at the time (although only in the legal sense), a sixth-grade education, no insurance, low-income, living in the Bronx neighborhood of Mott Haven, a neighborhood with some of the poorest health indicators in New York City (Karpati, et.al., 2003). However, diligence and earnestness are not measured by

such health indicators, and in spite of challenges, María was determined to do whatever her medical care providers told her she needed to ensure she had a healthy pregnancy.

At the high-risk clinic, the nutritionist did not tell María what about her diet was acceptable or unacceptable, but instead gave her a list of foods that she should consume to maintain a healthy blood glucose level. María went to the supermarket, list in hand, to purchase the items on the list. She told me that it was difficult to adopt such a radically new diet so quickly, but she felt it was necessary to do so. For breakfast, she had been told, she should have a half cup of cornflakes with skim milk. For snack, a non-fat yogurt. She was told to eliminate tortillas, which she said she was told would "convertirse en azúcar" [turn into sugar.] She described standing at the stove, warming fresh corn tortillas over an open flame for her husband's meals and being nearly overcome by desire to eat one, but she said she maintained self-discipline and did not consume them. Sometimes she felt faint, as though she had not consumed enough nutrients to sustain her, but she assumed that she was doing the right thing by following the diet she had been given. When she returned the following week to the clinic, at her weigh-in, she was told she had lost 7 pounds. The doctor looked at her, aghast: "Qué has hecho?" [what have you done?]. She replied that she had followed the diet the nutritionist had given her. She told me, "Y me regañaron, me dijeron que había puesto en peligro a mi bebé. Me dijeron que no tenía que hacerlo de un solo jalón, sino de a poco. Pero nunca me dijeron eso" [And they scolded me, they told me I had endangered my baby. They said that I didn't need to do it all at once, but little by little. But they never told me that]. While it is impossible to infer the provider's interpretations of

María's rapid weight loss in the middle of her second trimester of pregnancy, it is clear that the advice she was given was not transparent. Perhaps other patients in the clinic gave the appearance of being or in fact were non-compliant with provider instructions and for that reason, providers may have thought that they needed to overstate the case for dietary restrictions, imagining that their guidelines would not be followed. Or, perhaps the providers assumed that women with low levels of formal education, such as María, would be unable to understand overly specific dietary advice, and decided to give it without thorough explanation. Irrespective of the reasons María was given the advice she was, it is clear that by precisely following it, she potentially brought more risk to a pregnancy already classified as risky, only to be scolded for her obedience to providers' mandates.

Further, the provider who told María she had gone too far in adapting a new diet, was not the same doctor she had seen on her previous visit. Indeed she never saw the same obstetrician twice. Ironically, it is in high-risk clinics that it continuity of care seems least available. High-risk clinics are often staffed by ob-gyns who dedicate one day per month to them. As such, patients like María never have the opportunity to "prove" themselves as compliant and capable managers of their own self-care. Instead, María's risk factors, a quick summary in her medical chart glanced at by a new doctor each week at the high-risk clinic, served as her introduction and arbiter of the quality of care she received. Care is distributed under an assumption of risk, noncompliance and failure to understand instructions.

In these subtle and not so subtle ways, immigrant women are delivered messages about the relative desirability of their offspring and of their capacity as progenitors. At the same time, larger scale conversations are ongoing about immigrants and their children.

In 2006, Elmhurst Hospital in Queens, New York, declared, according to forecasts by the U.S. Census Bureau, that its staff had delivered the 300 millionth American. His name was Emanuel Plata, and he was the child of immigrant parents from Puebla, Mexico (Roberts 2006). Although hospitals around the country claimed to have delivered the auspicious infant, demographers held that, statistically, he was likely to be a Hispanic boy, born in the Southwest (Roberts 2006). Little Emanuel Plata, whether or not he was number 300 million, is a fitting emblem of the current debates over immigration and demographic change. Asked whether he felt lucky that his family had achieved such notoriety, his father reportedly replied, “My baby is healthy. My wife is fine. What more luck do I want?” (Roberts 2006). As various sectors of the United States debate the costs and benefits of immigration and the worthiness of undocumented immigrants for legalization, citizenship, benefits, and health care, Mexican immigrant parents like the Platas are frequently just trying to take care of their families. As sociologist Hondagneu-Sotelo writes, “Women do not come to the United States to have babies, they have babies here because it is where they live and work” ([2001] 2007, 299). It is important that thought be given to the responsibility public institutions and private citizens have for facilitating their efforts.

The mere fact that debates about the Fourteenth Amendment are occurring are evidence that the process of dehumanization of immigrants has reached new extremes. Deploying Giorgio Agamben's notion of "bare life," Nicholas De Genova argues that "if 'bare life' is the vanishing ground of the citizen in the state's disappearing act of 'sovereignty,' it is no less the foundational element of sovereign power that obstinately resurfaces in the figure of the non-citizen" (2009, 248). In spite of popular conceptions—by immigrants and the native-born alike—that undocumented immigrants constitute a disturbance to conceptions of the nation-state at its boundaries, De Genova argues that on the contrary, undocumented immigrants and their labor are a constitutive, integral component of contemporary processes of statecraft and capitalism in Western industrialized nations. Further, we can see the border and border enforcement (and related mechanisms of citizenship and immigration services, work authorization, law enforcement, deportation, etc.) as the means by which the state's sovereignty is produced via exclusionary moves.

The increasing ire about "anchor babies" and their parents is a symptom of the growing reality that the seemingly marginal figure of the undocumented immigrant is in fact at the heart of what the United States is today and will be tomorrow. Efforts by some to restrict access to citizenship to the U.S.-born children of immigrants stand in stark contrast to the earnest efforts of parents to ensure a better future for their children. The pathologization of immigrant aspirational efforts and concurrent demonization of the children of immigrants, as "anchor babies" are one example of many ways that immigrants are excluded from conceptions of the nation-state at the

same time that their presence and the optimism of their efforts to build and provide for families in the United States defy such exclusionary notions.

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