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Chapter 4

Neoliberalizing (Re)production: Women, Migration, and Family Planning in the Peripheries of the State

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Introduction

In this chapter, we highlight findings from a binational study of the reproductive health care strategies of im/migrant¹ women. These strategies were examined in the peripheries of the state, where disturbingly, the risks inherent in migration have reached a certain degree of normalization. Since the mid 1990s, the risks associated with migration, including privation and assault (O'Leary 2008, 2009a) and the increased possibility of death have been aggravated with hardened US-Mexico border security measures (Eschbach et al. 1999, Cornelius 2001, Goldsmith et al. 2006, Hagan and Phillips 2008, Hinkes 2008). While some of these risks are clearly the result of direct personal violence (such as armed assault, robbery, rape and other physical attacks), others are the result of systematic deprivation, which all the same results in suffering and even death. According to Galtung's (1969, 1990) framework for understanding violence, the less visible and less direct forms of violence (structural and cultural) are no less violent than others because they, too, ultimately lead to injury and demise that could have been avoided. We rely on this framework to inform our analysis of the data, and to advocate for policy and a human rights response to the injurious conditions that are produced when the limitation or denial of access to health care services are humanly caused, subsequently ignored, and perpetuated by the state.

In the following pages, we present a summary of the economic and political environment within the Sonora-Arizona migration corridor, which serves as a regional case study that illustrates how access to reproductive health care services is

¹ Within this chapter's binational context, the designation of "migrant" as a person who moves from place to place to work can be incorporated into an "immigrant" category in view of border enforcement policies that have disrupted ancient patterns of circular migration that now makes border crossing more difficult and dangerous. Former migrants are thus forced to assume more lengthy stays in the US that are quasi-permanent in character, making them immigrants in the absence of any intention or legal authorization to reside permanently.

systematically put out of reach for impoverished populations seeking to improve their conditions. The cross-border context is critical for seeing how barriers to accessing systems of health care service are reflective of public attitudes about im/migrants. The cultural environment thus plays an important role in promoting and sustaining adverse public policies and practices. Common misperceptions both in Mexico and the United States support the idea that migrants in general are imprudent (Inda 2006) and therefore undeserving (King 2007). Together with the lack of empirically informed discussions about root causes of immigration that might lead to solutions, the lack of appreciation for the dire conditions they face on the border arguably compliments a form of state violence in which both states, the US and Mexico, are complicit. In Altar, Sonora, for example, overburdened social service agencies in its northern part of the state leave women's needs unsupported. In Arizona, resources are denied and increasingly restricted due to anti-immigrant politics aimed at curbing migration from Latin America to the United States (O'Leary 2009b, O'Leary and Sanchez 2011). Consequently, im/migrant women—indeed entire families—are affected by systematic constraints rooted in culture and the symbolic hostilities that impede humane solutions.

A short description of the research provides a policy-relevant background to the female migration experience. We then focus on our findings with respect to im/migrant women's productive roles and family planning practices. In this work, we adopt an approach that highlights the linkages across borders in the lives of migrant women. Our results are used to argue that the feminization of migration collides with the increase in policy-driven restrictions to health care support in general and constitutes a form of state-supported violence. We find that for im/migrant women, negotiating the current adverse conditions coincides with needs arising from their arriving at critical junctures within the female life cycle—when both reproductive and productive activities are most important for sustaining their families and households. By situating immigrant women's reproductive and productive strategies at the crossroads of political, economic, and social adversity we hope to bring attention to how the state works to normalize the violation of fundamental human rights such as the right to fair employment, to travel or migrate safely, and to lead healthy and productive lives.

Economic and Political Contexts of the Altar-Arizona Migration Corridor

One of the major features of Mexican migration is the growing importance of medium and small size geographical locales that facilitate the migration northward, especially for women (Wilson 2009). Altar Sonora is such a locale. Its proximity to the Arizona border has made it into a new "center" of national and international attention as the busiest and most dangerous migration corridor along the US–Mexico border (Valdéz-Gardea 2007b).

At the same time, having access to health care service is an important resource that impacts women's inevitable integration into labor markets, and vital to

the human and cultural development of both host and sending communities. Reproductive health care strategies were thus examined in light of migrant women's increased exposure to various types of dangers associated with migration including death and violent assault as well as the less dramatic but no less life-threatening conditions, such as when access to health care services and resources in settlement communities are limited or denied. This regional case study has far-reaching implications when the steady increase in migration in general to the United States from Mexico and Latin America since the 1960s is considered, and that the most significant change has been the greater participation of women (Marcelli and Cornelius 2001). This is due in part to the negative impact of structural adjustment programs [SAPs] resulting in the progressive impoverishment of Mexico's agricultural sectors and diminishing employment opportunities (Labrecque 1998, Marchand and Runyan 2000, Crummett 2001), a combination known to produce the feminization of migration (Sadasivam 1997).

Altar

Altar, Sonora, has emerged from a virtually invisible cattle-ranching and agriculturally based economy of approximately 16,000 inhabitants to become the "waiting-room" for international migrants (Valdéz-Gardea 2008, 2009). This has much to do with the implementation of the Southwest Border Strategy² in 1993 that resulted in tighter control of well-established crossing areas by US border enforcement agencies and the resultant redirection of migrant traffic away from urban areas towards the high-risk desert areas of Sonora and Arizona (Nevins 2007; Cornelius 2001). In peak periods, as many as 2,500 migrants are estimated to arrive daily to the "periferia fronteriza" (borderland periphery) of Altar, Sonora, which sits in the nearly forgotten margins of the state (Valdéz-Gardea 2008, 2009). Since the shift of migrant traffic through Altar, its population has grown considerably, in part due to the numerous services and businesses that cater to the needs of migrants (Valdéz-Gardea 2006b, 2007). However, in the course of growth, it has also been challenged with keeping up with the demands made on its public health infrastructure, which was until 2010 limited to a mobile Red Cross station located in the church plaza. This station is no longer available but in 2008-2009 migrants had available a paramedic and a small clinic run by Mexico's national public health agency *Secretaria de Salubridad y Asistencia*. Nearby still are a dozen or so private medical offices which are, because of the cost, unaffordable for most of the resource-depleted migrants who arrive in Altar. In urgent cases, patients are transferred to Caborca, Sonora approximately 25 minutes away by car. The stress on public health service infrastructure brought about the increase in migrant populations is not unlike that found elsewhere wherever migrant populations are found. Studies show that

2 This strategy involved the intensification of border closures known as Operation Hold the Line (1993), Operation Gatekeeper (1994), Operation Safeguard (1995). See also Lind and Williams, this volume.

among migrants there is an increased prevalence of unwanted pregnancy, sexual violence (Rademakers, Mouthaan and de Neef 2005), and sexually transmitted diseases, including HIV/AIDs (Organista, Organista and Soloff 1998). Problems with health service delivery also arise from poor communication, including those stemming from language and communication differences and not knowing how the health system works, uncertain living conditions, ambivalence regarding the use of contraceptives, and problems accessing information about contraception. Migrants are particularly affected having left behind supportive networks and other resources only to find support in settlement communities limited or denied (*Population Report* 1996). For women, especially, various types of risks associated with migration have emerged over the years and all indications are that migration is becoming for them increasingly hazardous (Monteverde García 2004). Complicating the potential of risk is drug-related violence in the area. This has politically driven demands for increased military intervention.³ Consequently, the intensification of “low intensity conflict” (Dunn 1996) and hypermasculinized culture along the border have put women at ever-greater risk of violence (Falcon 2001, Urquijo-Ruiz 2004, Ruiz Marrujo 2009).

Tucson

Once on the United States side of the border, migrants commonly face immigration enforcement actions that restrict their access to health care, and hence, expose them to further risk. In Arizona, in particular, migrants contend with the effects of the state’s legislative activity that has, since 2004, increasingly scrutinized their access to public services (O’Leary 2009b). In this way Arizona provides a fitting context for understanding how exclusion threatens im/migrants and their integration into destination communities. In keeping with Galtung’s (1969) theory of structural violence, preventing individuals and groups from reaching their full potential is one form of violence along a violence continuum. Although dramatic, direct personal violence is not always observed, the undercurrents of racism and xenophobia structure deprivation along the social divisions already present in society, such as class, gender, race and ethnicity. This thus contributes to the social determinants of health, well being, quality of life, human development, and longevity.

Frustrated by the US Congress’ inability to pass comprehensive immigration reform, Arizona’s legislators like those in many other parts of the United States began to adopt policy measures in an effort to deter immigration. In 2004, a law similar to California’s 1994 Proposition 187 was passed by voters. However, California’s law was ultimately ruled as unconstitutional, whereas Arizona’s was upheld (Mariscal 2005). In both states, support for the initiatives coalesced around immigrants’ use of public resources, and paralleled the generation of myths about

³ For a comprehensive discussion of how the militarization of the border and the heightening of the terror of border crossing are related to the development of anti-immigrant sentiment, see Wilson (2000).

of immigrants’ use of publically-funded programs, especially healthcare. King (2007) lists these popularized myths as:

- U.S. public health insurance programs are overburdened with immigrants.
- Immigrants consume large quantities of limited healthcare resources.
- Immigrants come to the United States to gain access to healthcare services.
- Restricting immigrants’ access to the healthcare system will not affect American citizens.
- Undocumented immigrants are “free-riders” in the American health care system.

Later, in 2005, Arizona House Bill 2030 again brought the electorates’ attention to immigrants’ access to public programs. It was supported by popular misrepresentations of immigrants as welfare-seeking intruders and resulted in the amending of a section of the Arizona Revised Statutes related to the state’s indigent healthcare system, the Arizona Health Care Costs Containment System [AHCCCS], by making it a requirement for Arizona state government employees to verify an applicant’s immigration status with the Department of Homeland Security’s Secure America with Verification and Enforcement [SAVE] program before providing services. Other affected agencies and programs were:

- the Department of Economic Security [DES]—adoption services and all welfare programs.
- the Department of Education [DOE]—the family literacy program and adult education.
- public universities and community colleges—in-state tuition rates, tuition waivers, scholarships, and state-funded tuition assistance benefits.

The bill also replicated the provisions already contained in the federal 1996 Personal Responsibility and Work Opportunity Reconciliation Act, which among other things had put a five-year ban before recent immigrants become eligible for federally funded public benefits programs. Inada (2006) argues that placing entitlements at the center of public debate proliferates discriminatory tendencies by making immigrants increasingly visible and the subject of scrutiny. Indeed, research by Marchevsky and Theoharis (2008) shows that immigrants, based on their appearance, language use, and facial characteristics, may be more likely to be more scrutinized by officials charged with implementing public policies. They demonstrate that because officials are influenced by the public discourse and prejudices, their decisions result in the denying of eligible applicants from applying and receiving much-needed public benefits.

In 2006, the 47th Arizona State Legislature proposed nearly 37 immigration-related bills (see O’Leary 2009b, appendix). These were but a fraction of the 570 anti-immigrant state-level bills introduced that year across the United States in a trend that would triple the number of anti-immigrant bill introduced to 1562

in 2007 (Figure 4.1). Many of these replicated or hardened established federal immigration-enforcement responsibilities (Harnett 2008). Although debate over immigration is not new (Hagan and Rodriguez 2002), localized responses to the “broken” US immigration policy (Harnett 2008: 366) has resulted in the further exclusion of not only immigrants, but their children as well—many of whom are US-born and by all accounts eligible to apply for entitlement programs (Fix and Zimmermann 2001; Yoshikawa 2011). Such legislative acts appear to be creating a “chilling effect” (Ferreira-Pinto 2005) that prevents many Latinos from using community services, including those dedicated to health care because of the threat of deportation that immigrants face with hardened enforcement measures (Wilson 2000) or sheer humiliation (Romero 2008, O’Leary and Sanchez 2011, see also McDermott and Sanmiguel-Valderrama, this volume).

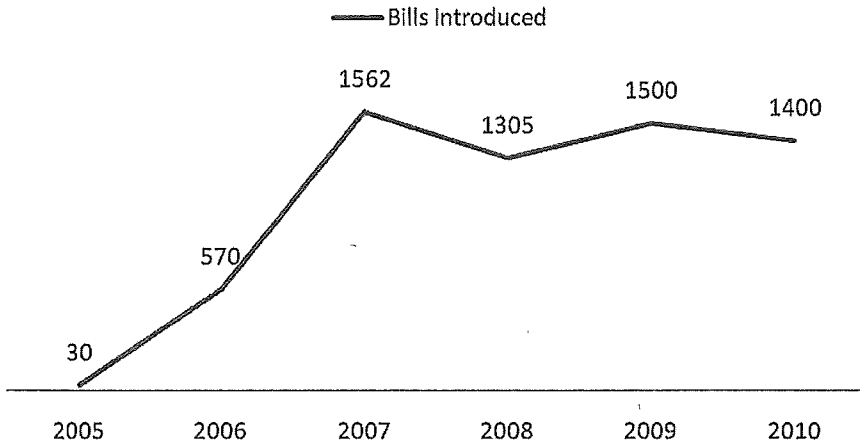


Figure 4.1 State-level Anti-Immigrant Legislative Trend 2005-2010

Michelson (2001) argues that high-profile political events, such as California’s Proposition 187 campaign in 1994, shifts public attention to immigration issues, and these succeed in negatively altering the attitudes towards immigrants. The media attention on these propositions, and the public anti-immigrant rhetoric they aroused (Wilson 2004), raised fears of discrimination for all Latino groups, regardless of immigration status. Inda (2006) dubs these tactics “anti-citizenship technologies,” which led to the 1996 Illegal Immigration Reform and Immigrant Responsibility Act [IIRIRA]. IIRIRA worked to *incapacitate* “troublesome, unethical beings” by formally restricting, and containing how they manage their existence (Inda 2006: 24).

In a final blow in the process of disenfranchising immigrants from health care, in November of 2009, after the conclusion of the data-gathering portion of the research, changes to Arizona Revised Statutes (A.R.S. 1-501 and A.R.S. 1-1502)

were implemented as a consequence of Arizona house bill HB 2008. Sections One and Two of these statutes makes it a class 2 misdemeanor if any employee administering local, state or federal public benefit fails to report a discovered violation of federal immigration. If the employee’s supervisor fails to direct the employee to make the report, the supervisor is also guilty of a class 2 misdemeanor.” Similar to the provisions made under proposition 200 in 2004, the system for electronic reporting to Immigration and Customs Enforcement [ICE] when violations of federal immigration law are discovered was applied. The provisions of HB 2008 were enacted into law in Arizona in 2009 as we were concluding our field work. By June 2012, President Obama, through a Department of Homeland Security directive, ordered the temporary cessation of deporting non-US born children of undocumented im/migrants who met a range of requirements (see McDermott and Sanmiguel-Valderrama, this volume) and to make them, also temporarily, eligible to obtain certain documents for work, school, and other services. However, this executive stop-gap measure in the wake of the failure of the US Congress to pass the “Dream Act” has been met with much hostility by Republican-controlled legislatures at the state and federal level, and it is still unclear how effectively such children will be spared the chilling effect of state-level statutes.

Binational Research

Contemporary globalization has forced researchers to reconsider any approach that is limited by national boundaries (Wimmer and Schiller 2003). Referred to as methodological nationalism, scholarly conventions of the past regularly took for granted the idea that societies were naturally bounded units, much like “containers” of social phenomenon. This framework has paralleled popular notions about nationhood and sovereignty, where mobility and movement across borders was seen as an aberration rather than the norm (Wimmer and Schiller 2003: 579). However, increasingly since 9/11, scholars have moved away from this approach because it ignores the role of the cross-border experience in localized developments. This is why emerging forms of binational research have greater potential for providing insight into problems that are transnational in nature. Thus, binational research—one that involves the deliberate and simultaneous coordination of teams of researchers on two sides of the border—inserts an important practical dimension into the process of answering questions about populations shared by two countries. In the present case, the shared population (women im/migrants) embodies transnational productive and reproductive processes (Wilson 2000). With greater mobility across borders, issues of sexually-transmitted diseases, child-birth, and child-care are borderless and have long-term implications. As such, research into these processes requires a multi-sited approach (in both the US and Mexico), which in turn raises methodological issues about how researchers delimit the social field for research. The state of flux in which migrants women find themselves is inherently challenging for research. It prevents researchers from establishing long-term relationships with any interviewee

or opportunities for follow up questions. However, conceptualizing the field site as temporal within a larger process of mobility and follows Hannerz's (1998) suggestion for organizing transnational research, where migrants are momentarily immobilized somewhere between two points of reference, rather than at the start or end of their migration journey.

In contexts where research participants are displaced persons (as in Altar), or forced underground by laws (as undocumented populations in Arizona), the social field is conceptually transformed, so that methodologically, scholars can grapple with cross-border movements and processes as an inevitable force of history.

The present binational research project⁴ was conducted by researchers at the Colegio de Sonora (Hermosillo, Sonora)⁵ and the University of Arizona's Binational Migration Institute (Tucson, Arizona).⁶ One of the project's goals was to analyze the reproductive health care strategies of im/migrant women that are adopted as they become increasingly active participants in cross-border migratory movements. Three areas of reproductive health were examined: pregnancy (including prevention, counseling, termination, and prenatal care), sexually-transmitted diseases (including HIV/AIDs, detection, prevention, and treatment), and post-partum care including the risks posed to mothers and children by conditions such as malnutrition, anemia, infection, or depression.

Methods

The research in Altar concentrated on migrant women who had settled there or were en route to the north. The Altar team used a mixed methodological approach including the use of rapid appraisal techniques [RATs], which combines different types of field methods along different phases of research. Survey research aided the collection of demographic information (age, origin, and reproductive health history) from migrant women. Sixty-six surveys of women who had at resided in Altar at least five years were administered. The survey instrument contained four sections and explored (a) the family unit, (2) the journey to Altar, (c) life in Altar, and (3) their state of health. Qualitative methods, including ethnographic techniques such as participant observation, in-depth interviews, and focused interviews were used to gather data from the selected respondents (Clift and Freimuth 1997). In-

depth interviews of women in route to the North were conducted. One objective was to give voice to women's perceptions and concerns about their vulnerability during the migratory process, about their strategies and access to health services, and about their stay in Altar, and the obstacles that they had encountered. In addition, researchers probed into what resources or interpretative frameworks had been provided by health care service providers to women seeking reproductive health care services such as contraceptives, medical attention for STDs, or medical care for pregnant or nursing mothers. A case study approach was used in analyzing this qualitative data. This was perceived as critical advancing for appraising the social climate that had direct bearing on the safety and health of migrant women in Altar, and would be used for cross-border comparison of the structural and social determinants of reproductive health care in settlement communities such as Tucson, Arizona. Migrant women's situations in Altar illustrate an important complexity of migration, which cannot be reduced to a simple round-trip process. Family networks, contacts, and the prior border-crossing experiences increase the chances of success and result in social capital accumulation that transcend national boundaries (Wilson 2009, Fussell 2004, Granberry and Marcelli 2007).

The research in Tucson, Arizona was essential for providing a balanced and truly binational exchange of timely information between neighboring states. Like their Altar counterpart, the Tucson research team used mixed methods that entailed a short demographic and health indicators survey and in-depth interviews with im/migrant women. The Tucson team partnered with the Mexican Consulate's health referral program, *Ventanilla de Salud*, and community health workers from *El Rio Community Health Center in Tucson* to identify 80 respondents who had solicited reproductive health care services or resources, half of which were women who were responsible for the healthcare needs of at least one undocumented individual and are therefore not eligible to receive services.⁷ The closed-ended questions were entered in the program, PASW Statistics (formerly known as the Statistical Program for the Social Sciences, SPSS) for quantitative analysis. The open-ended, qualitative interviews were tape-recorded and transcribed for later content analysis. Like their Altar counterpart, the Tucson team used mixed methods consisting of a short demographic and health indicators survey and in-depth interviews with

4 The present study, "A Multidisciplinary Binational Study of Migrant Women in the Context of a U.S. Mexico Border Reproductive Health Care Continuum," was generously funded by the Programa de Investigación de Migración y Salud [PIMSA] in 2008-2009, Health Initiatives of the Americas [HIA], University of California, Berkeley.

5 Colegio de Sonora Obregón 54, Centro Hermosillo, Sonora, Mexico 83000.

6 The Binational Migration Institute at the Mexican American Studies Department at the University of Arizona, (César E. Chávez Build., PO Box 210023, Tucson, Arizona USA 85721) seeks to comprehensively document and analyze the interaction between migrants and immigration enforcement authorities.

7 The term, "undocumented" is saturated with ambiguity and its variety of meanings have both real and symbolic consequences for immigrants that have been difficult to identify and measure (Plascencia 2009). In the US, where this becomes an issue, there are different ways for individuals to fall into an immigration category that prevents most from legally working and residing in the US. Thus, for definitional purposes, we rely on (Cornelius 1982: 378) to help us formulate a description of "undocumented" as that individual who enters the US without inspection and without official authorization, may have entered legally but has subsequently overstayed the term limit of their visa, who may have entered legally and is legally present but is not a legal *resident* (and therefore not entitled to public benefits), is present without the legal authorization but is not apprehended at the time of the interview, and "not under "suspension of deportation" orders at the time they are studied.

women who had settled in Tucson. Undocumented im/migrant women, as a doubly marginalized population, face greater uncertainties as females, who because of gendered prescriptions negotiate on a daily basis an array of activities determined by both reproductive and productive responsibilities after they have settled in the United States (Wilson 2000). Content analysis of in-depth interviews of immigrant migrants, some of whom would be undocumented or have experienced the fears and tribulations of having at least one member of their families who was at risk of being discovered and repatriated and whose perspectives have been historically ignored, thus contributed to the data. In this way, the research would examine structural processes, including those emanating from both increased migration and deliberate policies designed to restrict population settlement by denying basic social services, known and “policies of attrition” (Vaughan 2006).

Data and Results

By considering the dramatic rise in the number of women migrating from Mexico and their age and point within the reproductive cycle in which they find themselves, the denial or restriction to reproductive health care services is even more onerous. In other words, for migrant women, negotiating institutionalized adverse conditions collides with critical life-cycle needs when both reproductive and productive activities are central for sustaining families and households.

Women's Life Cycles and Reproductive and Productive Roles

A significant Mexican migration trend is its progressive feminization, and an increase in the participation of women in the workforce who are from rural and urban areas alike (Wilson 2009).⁸ Although the migration of women has always been critically important, until the 1980s they received little scholarly attention. The rise in immigrant women settling in the United States is in part due to changes in US immigration policies, and specifically, due to the approval of Immigration Reform and Control Act of 1986 (also known as the Simpson-Rodino Act). This immigration policy reform provided for newly legalized immigrants to apply for family reunification of members living abroad.

Earlier studies focused largely on men's economic activities in settlement communities (Cerrutti and Massey 2001). However, more recent investigations show that female migration is now more independent of men's economic activities (Donato 1994). Their participation in the international labor market has changed

⁸ A recent study by the Urban Institute's Immigration Studies Program showed that undocumented women living in the United States represent 41 percent of the migrant population. There are about 4.5 million men over the age of 18, and 3.2 million women without legal documentation.

qualitatively in that they are often migrating alone and not necessarily as wives seeking reunification with their spouses (Donato 1994), but rather in search of their own work opportunities and with varying goals (Valdéz-Gardea 2006). Women leave their communities with several objectives in mind, have higher levels of education than their predecessors come, and come from a variety of social and economic conditions (Smith and Tarallo 1993, Hondagneu-Sotelo 1994, 1997, 2001, Hondagneu-Sotelo and Avila 1997, Valdéz-Gardea 2006a). Nevertheless, several scholars share the opinion that the data are still quite poor and that study results are often contradictory (Álvarez 2004, Gonzalez 2004, Velasco 2004).

Domestic and international migrations are certainly some of the most disturbing consequences of structural adjustment economic policies implemented by the Mexican government. These policies have produced enormous social and economic disparities, job insecurity, and generally increased social vulnerability. Women and children are the most affected (Marchand and Runyan 2000, McCarty 2007). International agreements such as NAFTA have also pushed women to seek out opportunities in cities, and ultimately towards the northern border, and beyond (Hirsch 2002, Barndt 2007). Women from the economically hard-hit communities are thus joining the movement of migrants to the north and the United States in ever-increasing proportions.

A primary feature of contemporary northwest Mexico is the constant movement of migrants who move into the region permanently or move through it in route to the United States. The constant movement of people brings important challenges to Mexico's receiving communities. Challenges include the lack of infrastructure, shortages of potable water and quality housing, inadequate waste disposal services, and lack of health services. The foregoing becomes more acute in face of an urban development policy that is unclear and insufficient to cover the population's need. This causes a disorderly growth of informal economies in communities where “no one controls, no one governs, and no one orders” (Santibañez 2004: 5). Migrant women face this situation when they arrive to Altar. The following highlights some data that shows how the challenges faced by Altar shape the health experiences of women.

Of the women surveyed in Altar (N=66), the principal reason given for their migration was to search for work and a better quality of life. Not surprisingly, most of the women interviewed come from some of the least developed states in Mexico, Chiapas and Oaxaca (See Figure 4.2). This is important to consider in terms of how vulnerability for women migrants who come from these states is structured. These are states that are disadvantaged in terms of basic indicators of “well being” such as average education level, household infrastructure, and access to health services, according to Mexico's National Institute of Statistics (*Instituto Nacional de Estadística y Geografía*, known by the acronym INEGI). The distribution of the sample is consistent with the shift towards more migrants coming from the less developed states of Mexico, which includes Chiapas, Oaxaca, Guerrero.

Few women openly admitted their desire to cross into the United States. However, they were asked about their ultimate destinations. The largest number of

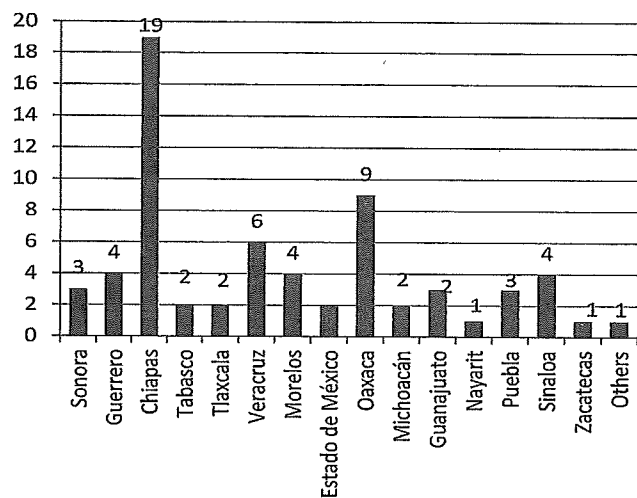


Figure 4.2 Mexican State of Origin for the Altar Sample

this sample (22) responded with California, after which Florida (six) and Arizona (three) were reported. Five reported that Altar was their final destination. Of this sample, 50 percent reported as married, and the rest reported being single (“solteras”), with three specifying that they were divorced and the rest, living in

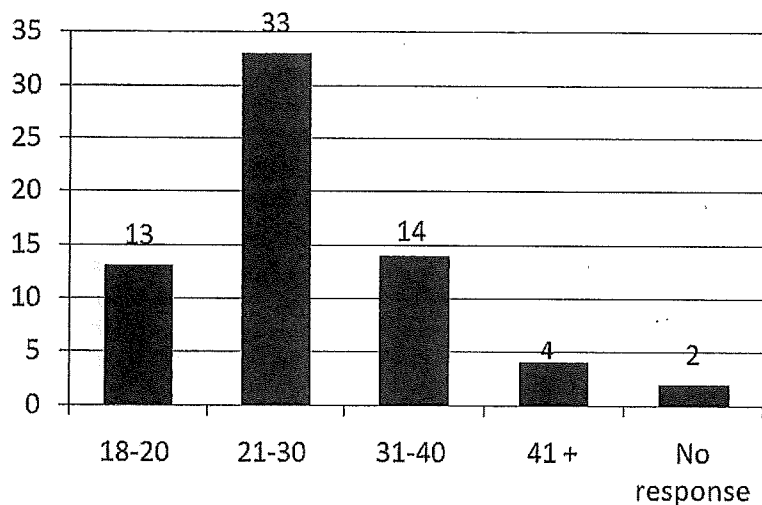


Figure 4.3 Ages of Women in Transit (Altar Sample)

a common-law relationship. The majority of this sample (46) was of reproductive child-bearing age (See Figure 4.3).

Of these migrant women surveyed in Altar, 49 reported that they did not have access to a medical service program. Only five reported that they had access to services by Mexico's indigent health care program (*Seguro Popular*), or health care insurance for dependents of the *Instituto Mexicano del Seguro Social* [IMSS] program. The women were asked if they counted on the services available in Altar in case that they become sick. Of the 49 who reported that they did not have access to a medical service program, 45 had gone to the health center in Altar (*Centro de Salud de Altar*) but that due to the lack of available services and specialists, they resorted to self-prescribed needed medications from Altar pharmacies. Four women from the 49 without access to medical services reported having paid a private physician for emergency care. Because of the lack of specialists, they had to go for services in the closest city, Caborca, to see a physician and buy their medicines. The lack of medical service infrastructure limits women who were under treatment in their communities of origin. For example, Mariana (19)⁹ who came from Veracruz commented:

En Veracruz iba con médicos particulares pero aquí (Altar) tengo que ir al Centro de Salud o viajar a Caborca para ver a un especialista. Yo padezco de una enfermedad que era atendida por mi doctor allá en mi tierra, pero aquí no se puede ni comprar el medicamento que tengo que tomar por mi enfermedad.

[In Veracruz I would go to private medical doctors but here (Altar) I need to go to the Centro de Salud or go to Caborca to see a specialist. I suffer from an illness that my doctor back home treated me for, but here it is not possible, nor can I buy my medicine that I need].

The birth control methods most used by the majority of the women interviewed in Altar were the condom and oral contraceptives. In their communities or origin, some women used certain types of these contraceptives. However, in Altar, choices were limited due to their scarcity. Nineteen women reported having had to change their contraceptive methods due to the scarcity, as explained to the researcher by the respondent from Veracruz:

Yo tuve que dejar las pastillas y ahora me cuido con el ritmo. Las dejé de tomar (pastillas) porque no encontré aquí porque hasta de eso carece Altar, no había de la marca que yo usaba en Veracruz ni de otra, ahora tengo que estar contando.

[I had to stop the pill and now I take care using the rhythm method. I had to stop taking (the pill) because I could not find them because Altar lacks even that. I

9 These are pseudonyms of the women interviewed, used to protect their identity.

could not find the brand (of pill) that I used in Veracruz nor any other kind. Now I have to be counting].

In summary, the women coming through Altar come primarily from resource poor states and are therefore more like to be economically disadvantaged once their arrive. The primary reason given for migrating is consistent with this disadvantaged starting point: they migrate in search for better employment opportunities in order to have a better quality of life. Because these women tend to be of child-bearing age, the concerns over the availability of contraceptives are paramount. Many if not most are single. An overwhelming majority have no access to health care services. Having a child will complicate achieving the goal of finding work, but more importantly, not having access to medical services and choices may pose serious health risks. These risks are preventable by providing adequate indigent health care and family planning programs. One has but to ask why these programs involving relatively low technology and a good measure of political will are inadequate.

In Arizona, much like throughout the United States, harsher measures to control immigration have emerged in recent years by way of an extension of securitization: more border walls, virtual fences, surveillance, workplace raids, the privatization of immigrant detention, and “enforcement first” Section 287(g) agreements between state and municipalities.¹⁰ Arizona policy makers have amended state laws to require applicants to show proof of citizenship to access a number of services and to require agencies administering state and local public benefits, under penalty of law, to verify applicants’ immigration status. These laws fail to consider those within families who may be eligible for services, and thus creates a “chilling effect” in accessing services (Ferreira-Pinto 2005).

It may be argued that the state’s inability or refusal to recognize the role of anti-immigrant rhetoric in fueling anti-immigrant policies in spite of empirical evidence that can promote a civil dialogue about the benefits of immigration is a form of state or political violence against im/migrants in general, and women in particular. Violence is perpetuated though “indirect” means: through structural violence that systematically limits access to necessary social services to already impoverished and at-risk populations. Moreover, attitudes articulated through public discourse and the distribution of misinformation about immigrants (deliberate or not) serves to normalized their harsh conditions. For example, immigrant women have been much maligned as self-serving beneficiaries of the welfare state who only long to give birth to US-born “anchor babies.” The results shown in Figure 4.4 challenge this notion as women in the Tucson sample are actively seeking ways to prevent becoming pregnant through surgical sterilization. This disparaging and

10 A federal statute, Section 287(g) of the 1996 Immigration and Nationality Act [INA], permits the federal government to delegate immigration enforcement power to state and local authorities. In January 2011 this program was operating in 72 jurisdictions through the United States.

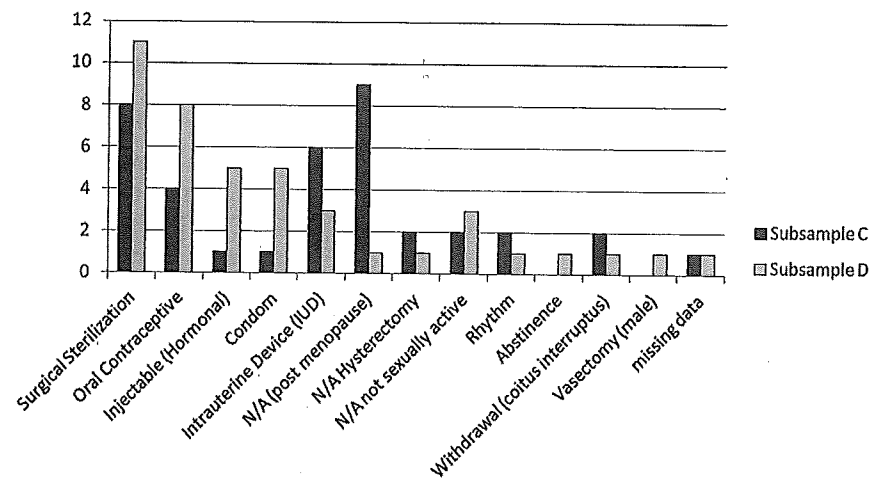


Figure 4.4 Current Method of Contraception, Tucson Sample

dehumanizing way that they and their children are referred to is cultural violence (Galtung 1990), and helps win support for acrimonious policies.

In the Tucson research, the goal was to examine two purposeful subsamples of im/migrant women to appreciate the relationship between immigration status and access to health care services in this settlement location. Two subsamples were compared. The first (C) were households whose members were all eligible for health services. The second, (D) were those households in which one member was ineligible for receiving the services—presumably due to their “undocumented” immigration status.¹¹ There were nine households where a determination about the type of household could not be made. The women in subsample D, were on average younger (30 to 40 years) than those in subsample C, but older than the majority of women in the Altar sample. An explanation for this is that it takes time to become “settled.” In other words, the immigrant women were no longer women “in transit.” Most (24) of the women in subsample D (where legal status of a household member might pose a problem) had entered the United States after 2000, approximately double the number (12) of those who had entered the United States between 1990 and 2000.

11 Fear of becoming objects of scrutiny introduces methodological challenges and the inherent reluctance on the part of respondents to provide answers that can incriminate them and further jeopardize their well-being. To determine which subsample the respondent represented, we used proxy variables rather than direct questions about the legal status of household members. This is consistent with early research by Cornelius conducted during similar anti-immigrant political context in California. Elsewhere (O’Leary and Sanchez 2011) we address challenges of collecting data from respondents who may be suffering from low-level but constant threats to their livelihood, and assaults on their dignity.

How the sociopolitical environment affects access to health care was a central question of the study. Respondents were asked if they were participating in any type of health insurance program and these responses were examined according to subsample (C and D). Following the idea that the combined anti-immigrant rhetoric and the ensuing restrictions in health service deliver policies may produce a "chilling effect" on health care access (Ferreira-Pinto 2005), our null hypothesis posits that there is no difference between subsamples C and D. Table 4.1 shows the X^2 (Chi-Square) test results of the comparison of these responses showing that there is significant difference between the two samples. Considered within

Table 4.1 Chi-Square Tests for Subsample (C and D) Differences in Access to Insurance

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.622a	1	.006		
Continuity Correction ^b	6.338	1	.012		
Likelihood Ratio	7.893	1	.005		
Fisher's Exact Test				.008	.005
Linear-by-Linear Association	7.514	1	.006		
N of Valid Cases	71				

Note: a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 12.68. b. Computed only for a 2x2 table.

Arizona's policy trends, the difference may be attributed to the impact of greater restrictions and its anti-immigrant rhetoric.

A content analysis of the narratives lends support to an interpretation of the statistical test shown in Table 4.1. For some respondents the issue of access was not that they did not have the required documents, but rather that they did not have *all* of the documentation necessary and with them at the time they applied to a program. Fifty-nine percent stated that they had dealt with this difficulty for accessing services, and 41 percent did not report having issues. In addition, a majority of the respondents (65 percent) stated that they had felt in some way un-welcomed, discriminated, or otherwise made to feel uncomfortable by agency staff members.

It may be that increased restrictions may force upon women the use of surgical sterilization as the preferred method of birth control by those women in both subsamples, and especially for those in D (where legal status of a household member might pose a problem). Follow up questions did not include asking women where and when they had had this surgical procedure, and merits further research. Figure 4.4 shows this distribution of contraceptive use by subsample, and reveals that oral contraceptives is the second most utilized method of birth control for this subsample.

Discussion of Structural and Cultural Violence: Theoretical Considerations in Explaining State Violence

In this chapter, we highlighted findings from a binational study of the reproductive health care strategies of im/migrant women. These strategies were studied in the context of the risks inherent in migration, the result of historical neglect of displaced and impoverished populations such as those in Altar, Sonora, of xenophobia, poverty, and prejudice in Tucson, Arizona. Border enforcement measures have consistently disregarded the root causes of migration, resulting in greater privation and the greater likelihood of death, injury, and assault for destitute migrants. The binational research approach holds great potential for providing insight into problems that are transnational in nature, by capturing a population that immersed and temporarily caught up two systems that cannot accommodate critical life-cycle needs. This context is critical for understanding the rationale for the research, which sought to understand how access to reproductive health care services is made more difficult for migrant women in both Mexico and the United States. The data supports the argument that the institutionalized and normalized obstruction of women's access to reproductive health care services when the health and well-being of families is hanging in the balance, constitutes a form of state violence—exhibiting simultaneously elements of both structural and cultural violence as described by social science theorist Johann Galtung (1969, 1990) and medical anthropologist Paul Farmer (2003).

According to Galtung's framework for understanding violence, the less visible and less direct forms of violence (structural and cultural) are no less violent than the direct, the more visible and physical forms, because they too ultimately lead to harm. Ultimately, all forms of violence work to sustain each other. For example, in Mexico, neoliberal policies work to normalize the marginalization or exclusion of many from related social and citizen benefits, including the right to employment, to travel or migrate safely, and the right to health and health care access (that are structural forms of violence). In the United States, exclusion has increasingly and dramatically been structured politically by way of legislative proposals and ordinances since 2005, affecting all aspects of immigrant life. However, in Arizona as elsewhere in the United States, the denial of health and human resources to certain immigrants correlates to anti-immigrant discourse (cultural violence).

Increasingly, provisions contained in policy measures call for more public funding for more immigration enforcement and increasingly make demands of agencies administering state and local public benefits, under penalty of law, to scrutinize applicants' immigration status through federal electronic verification systems and to report to federal authorities those applicants for public benefits whose legal status makes them ineligible. This results in a "chilling effect"—an internalized reluctance to apply for available social services out of fear, intimidation, and/or lack of information. It is worth repeating that while many immigrant families may indeed be *ineligible* for many public services, there is also considerable probability that because of its mixed-status composition (Fix and Zimmermann 2001, Talavera 2008, Yoshikawa 2011), among them is a family member who *is* entitled. Therefore, to avoid additional scrutiny, even those who *are* eligible for public services may *not* participate in entitlement programs, potentially with harmful consequences.

The increased militarization of the US–Mexico border since 1994 (see Lind and Williams, this volume) has disrupted age-old circulation patterns of migration and has resulted in an increase in the risk of migrant death, armed assault, and sexual assault—what Johan Galtung (1969, 1990) might regard as the "tip of the iceberg" of violence that is promoted and sustained again through structural and cultural means. The shift from more established patterns of circular migration to more permanent settlement in the United States places additional burdens on im/migrants to manage and adapt to changing political and social conditions. Moreover, current policies do not consider the possible long-term health outcomes that are being structured by the implementation of these enforcement only policies. Evidence points to a destabilization of the vital social determinants of health of a broad range of community members when future generations of non-immigrants are considered (Capps et al. 2007). Burdens placed on extended social relations to those who have been identified for exclusion populations are expected become increasingly challenged, potentially resulting in a breakdown of the cohesive social ties that mitigate stress stemming from the struggle to adapt under trying circumstances. If one considers that health is highly dependent on how society is organized, migrant and immigrant populations whether in transit or in destination cities are expected to experience sustained stress (and its health consequences) due to economic instability—exploitation, poverty, food insecurity, discrimination, and harsh working conditions. All of these conditions place them at increased risk of preventable illness and premature death. Historically, improvements in the overall health of populations are correlated with social reforms that have improved the conditions for vulnerable members of society, such as the young, single mothers, and the elderly. Further reduction in these will only reduce health equality based on the divisions present in society. In the United States, nearly one in ten US families with children is a mixed-status family—a family in which at least one parent who is a noncitizen and one or more children are US citizens (Fix and Zimmerman 2001), for an estimated 340,000 in 2008 (Passel and Taylor 2010). More mixed-status families are being created by Obama's 2012 directive giving temporary

documented status to some non-US born children of undocumented im/migrants. Thus, measures taken to enforce immigration-related laws inevitably impact non-immigrant extended family members living in other households who may assume additional economic burdens of providing refuge and support for those directly impacted by the law (Capps et al. 2007). Our findings with respect to im/migrant women's contraceptive use and family planning practices can be used to argue that the feminization of migration parallels the increase in economic and policy-driven restrictions for supportive services, which is a form of state violence. We find that for migrant women, negotiating the current adverse conditions coincides with needs arising from their arriving at critical junctures within the female life cycle—when both reproductive and productive activities are the most vital for sustaining families and households and are currently the most threatened. Helping perpetuate privation via *structural* impediments is supported in large by socially constructed denigration of immigrants: or *culturally*-constructed impediments. Consequently, im/migrant women—indeed entire families—are not only affected by politically-driven and state-imposed material and legal constraints to necessary resources, but also by unchallenged and unabated and state-supported means of inflaming of social hostilities.