

# **Radical Reproductive Justice**

**FOUNDATIONS, THEORY, PRACTICE, CRITIQUE**

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## Reproductive Justice and Resistance at the US-Mexico Borderlands

ANNA OCHOA O'LEARY and WILLIAM PAUL SIMMONS

### Introduction

Undocumented migrant women and children entering the United States through the Sonoran Corridor in Arizona encounter a series of states of exception that exacerbate their preexisting vulnerabilities. Maria Cristina Morales and Cynthia Bejarano have recently labeled this interlocking web of oppressions a form of border sexual conquest, and in this context, migrant and immigrant women are disproportionately impacted. Not only are they excluded from claiming basic rights, they are also subject to greater governmental scrutiny, and their attempts to access healthcare programs and services for monitoring their reproductive and sexual health have been increasingly obstructed. Though women's agency is severely constricted in this context, it is still present, and often manifests in unexpected ways. Drawing on research of the reproductive strategies of immigrant women, this chapter uses a reproductive justice framework to explore the creative and multiple forms of resistance employed by immigrant women to retain control of their sexual health and reproductive choices in the border region.

We begin by identifying the reproductive justice framework, which helps us to better understand the structural determinants impacting agency and resistance. We then examine a selection of Arizona laws to illustrate how they pose a threat to women's reproductive choices. Finally, we turn to two border-region studies to further explore women's agency and resistance in this context and conclude by highlighting some of the previous findings and positing questions for advancing future research.

### Introducing Reproductive Justice

Attempts to understand the experiences of these women should be undertaken from a reproductive justice framework. RJ has been succinctly described by SisterSong as:

The right to have children, not have children, and to parent the children we have in safe and healthy environments—is based on the human right to make personal decisions about one's life, and the obligation of government and society to ensure that the conditions are suitable for implementing one's decisions.<sup>1</sup>

The RJ movement arose out of frustration by women of color and women with limited economic means with the priorities of mainstream, mostly white women's movements. Mainstream movements have focused heavily on legal battles to ensure women the right to choose their reproductive health strategies, especially abortion. However, the reproductive justice movement problematizes the notion of choice, and focuses on social and economic obstacles to women exercising their right to choose. The RJ movement also tends to look at reproductive health in a more holistic manner, looking at issues such as miscarriage, infant mortality, maternal mortality, and pre- and postnatal care. Reproductive justice also looks at women's health within a broad range of factors that affect women's health and agency, such as women's right to work, marry whom they please, and build the type of family they want. We contend that immigration status is among the factors that must also be considered.

Reproductive justice stresses group rights and community conditions in addition to individual rights. A woman's ability to determine her reproductive destiny is based on the economic conditions and her values, and those in her community, allowing, for example, the ability of couples to limit family size if they desire. The RJ framework thus requires a more sustained engagement with structural factors and their intersections—such as the interlocking webs of immigration-control-related oppression—and more emphasis on the ways already marginalized women are further marginalized through limited reproductive choices. Nonetheless, an RJ framework argues that marginalized populations exercise agency—although constrained and socially contingent—so that phrases like unwanted or unintentional pregnancy need

to be deconstructed as do the many empirical studies that seek to measure women's reproductive "choices."

### Arizona's Twin Assaults on Immigrants and Reproductive Health

For nearly a decade, the border state of Arizona has sustained attacks on both migrant and reproductive rights. These attacks gained momentum in 2004 with nativist legislation coming from the Republican-controlled legislature (fig. 1). The trend culminated when the state's infamous SB 1070 was signed into law by Governor Jan Brewer in 2010. Passed because the Arizona legislature felt the federal government was not doing enough to combat illegal immigration, this "show your papers" law was widely characterized as the most extreme anti-immigrant measure of its time. It was challenged as unconstitutional and on June 25, 2012, the US Supreme Court struck down three of the contested provisions but kept in place the controversial Section 2(B), which requires law enforcement officials to check the immigration status of anyone detained for violation of any other law, including traffic violations, if they have "reasonable suspicion" that the person is in the country illegally.

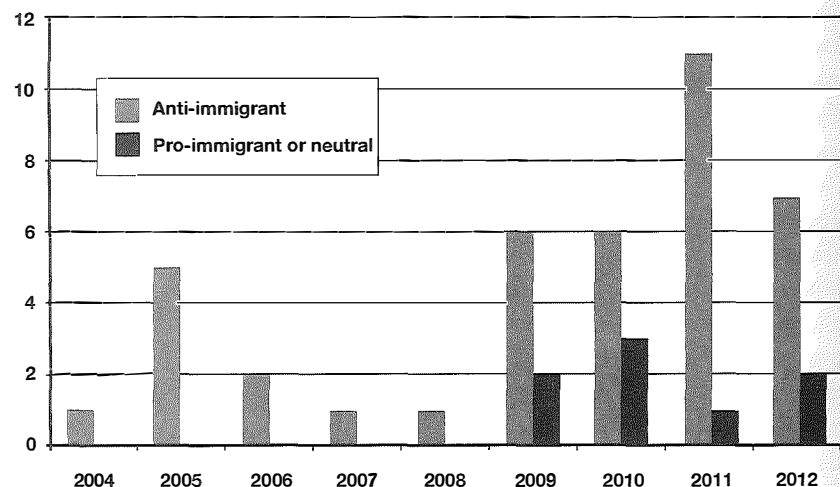


Fig. 1. Numbers of Immigration Control Laws Enacted in Arizona. Data from the National Conference of State Legislatures's Immigration Policy Project and the Arizona State Legislature website.

After SB 1070 was passed in Arizona, other state governments were emboldened to emulate the extreme effort, with many of their provisions partially blocked by the courts. However, Arizona's SB 1070 and its progeny were just the tip of the iceberg, with hundreds of laws being enacted throughout the nation. In 2006 more than five hundred anti-immigrant state bills were introduced across the United States, a trend that peaked in 2007 when the number of bills reached 1,562 as most every state in the union considered some form of immigration regulation.<sup>2</sup>

Laws which restrict immigrants' ability to integrate into the nation's socioeconomic fabric follow a doctrine called "attrition through enforcement" or "policies of attrition."<sup>3</sup> This doctrine is premised on the existence of numerous agencies imbued with inherent authority and already performing the work of immigration enforcement in one capacity or another—such as E-Verify and workplace investigations—that could, or should, be further empowered to enforce restrictions on undocumented—particularly Mexican—immigrants accessing public resources (fig. 2). The result of its application would be laws so utterly hostile to immigrants as to encourage them to "self-deport." However, the problem with this approach is the ahistorical nature of the concept, which fails to consider the long-standing geographical and international con-

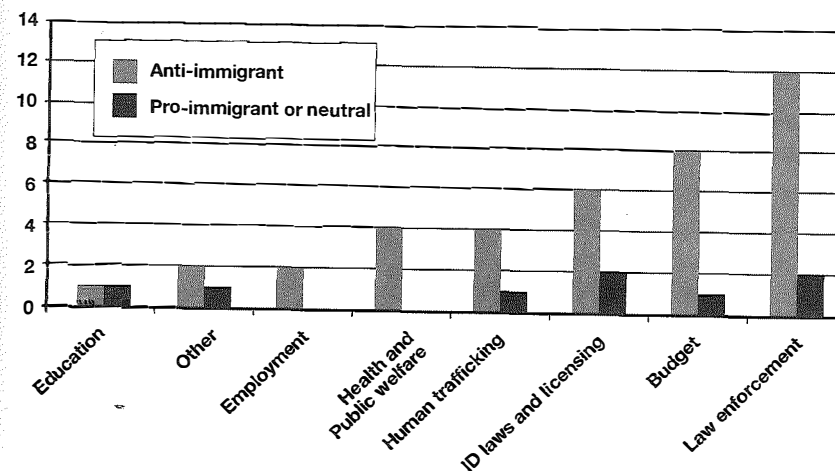


Fig. 2. Immigration Laws Enacted in Arizona by Category of Law, 2004–2012. Data from the National Conference of State Legislatures's Immigration Policy Project and the Arizona State Legislature website.

nections between the United States and Mexico forged over generations of cross-border households and other socioeconomic relationships.

In addition, immigrants have had to contend with repressive local law enforcement measures restricting their mobility. Arizona is home to the Maricopa County Sheriff's Office's notorious "crime suppression sweeps" that started in 2006. Targeting largely Latino neighborhoods, the Sheriff's Office would flood these areas with officers, but these sweeps resulted in very few arrests, mostly for petty crimes.

Anti-immigrant rhetoric together with anti-immigrant policies and media images of immigrants as criminals have pushed undocumented populations further underground. Not only are hate crimes against immigrants increasing, the upsurges nationally in anti-immigrant laws increase migrants' mistrust of law enforcement personnel and social service providers. Indeed, a recent study in Maricopa County, where Phoenix is located, showed that more than 50 percent of Latinos said "they do not feel safe when local law enforcement is involved in immigration enforcement," and close to half said they were "more afraid to leave their house because local law enforcement is involved in immigration enforcement" and thus, were "less likely to contact the police if they have been a victim of a crime because they fear they (or others around them) will be asked about their immigration status."<sup>4</sup> Not surprisingly, policies that repress individuals by making them afraid to leave their home have a generalized chilling effect on healthcare-seeking behaviors.

The state of Arizona passed some of "the nation's most extreme laws that limit women's right to abortion and contraceptive care," with Governor Jan Brewer being labeled one of five governors with the absolute worst records on abortion.<sup>5</sup> A litany of legislative measures were enacted, with many of them now tied up in the courts. For example, Arizona HB 2036, signed into law in 2012, banned almost all abortions after twenty weeks of pregnancy, with a drafting quirk that defined weeks of gestation from the last menstrual period, effectively banning all abortions after eighteen weeks, except those required by a medical emergency. The law was upheld by the federal district court, but struck down by the Ninth Circuit Court of Appeals on May 21, 2013.

HB 2800 signed into law by Arizona Governor Jan Brewer in May 2012 prohibits funding for organizations that perform or provide abortion services, essentially defunding Planned Parenthood clinics in Arizona. A federal district judge issued a temporary injunction in February 2013. However, a similar provision was added to the Medicaid expansion bill passed in 2013. Other restrictive laws remain in effect. One

2009 law requires a physician to perform all surgical and medical abortions. HB 2564, also signed into law in 2009, makes the previously mandated twenty-four-hour waiting period more draconian by requiring physicians to provide the necessary information to women in person at least twenty-four hours before the procedure, thus requiring two office visits with physicians present. The law also requires notarized parental consent to the abortion and allows providers to refuse to make available emergency contraception on "moral or religious grounds." As a consequence, Planned Parenthood was forced to stop abortions at seven of its ten Arizona offices.

In 2013 a law sponsored by Arizona state representative Steve Montenegro amended Arizona Revised Statute 13-3603.02, a class-three felony for anyone to seek an abortion based on the sex or race of the child, or the race of a parent. The law now requires that prior to an abortion, providers must obtain a signed affidavit from the mother stating that her decision is not based on the child's sex or race. Furthermore, the father or maternal grandparents are allowed to bring a civil action on behalf of the unborn child if abortion is based on sex or race selection. Medical personnel who do not report violations of this law may be charged with a felony. The law was immediately challenged by the American Civil Liberties Union, the National Association for the Advancement of Colored People, and other groups; however, the challenge was rejected by a federal district court judge in October 2013. Although the ruling will likely be appealed to the Ninth Circuit Court, the law potentially makes it more difficult for women of color to obtain an abortion and opens up women's reasons for obtaining an abortion to greater legal scrutiny.

Montenegro tried to argue that higher abortion rates among minority women were due to race-selection of fetuses, but disregarded the underlying structural factors, such as poverty and limited access to medical care, that most likely account for the higher abortion rates among resource-poor women of color.

With these laws, two seemingly contradictory trends emerge. On the one hand, health services for immigrant women to help monitor their reproductive and sexual health are being increasingly restricted or denied based on immigration status. On the other hand, there is a growing trend to limit abortion services for all women. The distinctions drawn between immigrant and nonimmigrant women resonate with arguments made by other scholars writing about the use of women's bodies to define nationhood. Referred to as "stratified reproduction," these scholars

have pointed out that political power, based on the structurally unequal distribution of resources determined by existing social divisions, consequently results in the validation of the reproductive future of those with status (e.g., white women), while diminishing those of others, such as Latinas, who do not possess the same status. In Gálvez's words:

[D]eclining birth rates are viewed as a sign of progress and civilization, enabling the fetishization of the child in elite sectors and the marginalization or even the attribution of abject status to the children of the poor. No matter how few children immigrant mothers have, their children are always excessive.<sup>6</sup>

Not surprisingly, the Arizona legislators who support anti-immigrant bills have often been the same ones advocating for antiabortion regulations. For instance, six of the seven legislators who cosponsored HB 2443, the law that bans abortion based upon race or gender, also cosponsored the notorious anti-immigration measure SB 1070 during the previous legislative session.

### The Reproductive Justice Framework and the Borderlands

The increase of women immigrating in search of better opportunities (feminization of migration) is related to numerous factors, but can be understood within the broader context of neoliberalism and globalization. With options for entering the United States legally being increasingly restricted, many resort to living and working in the US without legal authority, and this puts women's reproductive health at greater risk.

From the start, migrant women often must navigate states of exception on their journey to the US, and because of their marginal status they are more vulnerable to sexual assault and other attacks. After reaching their destinations these women face an atmosphere where their civil and reproductive rights seem to be systematically stripped away. We can picture these women as victims of the numerous structural and political factors that cause them to migrate and affect them on the journey, and after they reach their destination, prompt questions about how they navigate these interlocking webs of oppression.

Nevertheless, very few studies have looked at reproductive health at the US-Mexico borderlands for migrant women and adolescents. Here we will focus on two major issues and how they might intersect at the

borderlands: first, the effects of the violence women endure on the migrant journey itself, including the effects of polyvictimization and its sequelae on these women; and second, the ever-changing larger structural factors faced by female migrants including changing attitudes in Mexico and the acculturation process after their arrival to the United States.

### Violence and the Migrant Journey

The corridors of migration are marked by both the vulnerability and agency migrants experience. These experiences themselves are couched within a series of states of exception—where a certain group becomes excluded from rights and government protection. Migration further exacerbates states of exception by the proliferation of ideas premised on binary distinctions between those with legal citizenship and those without, and in turn legitimizes the exclusion and/or demonization of groups considered to have no status. States of exception serve further to normalize a logic and the practice of mistreatment of abject groups.

Migrants, especially women and children, face harrowing paths trying to enter the US. Their journeys have become more dangerous as the border has been militarized and as migration has become a big business increasingly dominated by organized syndicates or cartels. Each year, hundreds of migrants die and countless thousands of others become lost, disoriented, dehydrated, or suffer other traumas in the deserts and mountains of the Southwest. Recent studies have documented particular risks for migrant women, especially sexual violence.

The issue of sexual assault bears weight in our discussion of reproductive justice for several reasons, not the least of which is that many (if not most) of the women migrating are of reproductive age and thus at risk for unwanted pregnancies. In one sample of sixty-six migrant women interviewed in Altar, Sonora, forty-six were of child-bearing age.<sup>7</sup> In spite of this, forty-nine reported that they did not have access to a medical service program, and the birth control methods used by the majority of the women interviewed were limited to condoms and oral contraceptives. Nineteen women in this study reported having had to change contraceptive methods due to their scarcity.

William Paul Simmons and Michelle Téllez found that many women experienced multiple forms of violence in their home villages, along the journey, and once they arrived in the United States. They reported a number of traumatic examples of sexual violence.<sup>8</sup> Marla Ann Conrad



also found that many migrant women who were repatriated to Mexico reported being the victims of a number of different types of violence, including sexual violence.<sup>9</sup> During their migration, the women reported psychological abuse, sexual abuse, and economic abuse. It is clear the immigrant women who cross the border are already experiencing multiple vulnerabilities due to poverty, racism, discrimination, and legal status, and often feel that they are to blame for their sexual assaults. In many ways, the violence against women at the border has become normalized. A Catholic nun who works at the border noted that when she asked migrant women if they had suffered any sexual violations, the women often respond by saying "*lo normal*" (the usual). Simmons and Téllez conclude that "victimization is more of a 'condition' than an 'event.'"<sup>10</sup> Or, as Olivia T. Ruiz Marrujo writes, "Along the U.S.-Mexico and Mexico-Guatemala borders, sexual violence has become [a] fact of life for migrant women."<sup>11</sup> To illustrate, a recent report by Human Rights Watch, *Cultivating Fear: The Vulnerability of Immigrant Farmworkers in the US to Sexual Violence and Sexual Harassment*, shared the story of Patricia M., a migrant farmworker raped by the foreman. With no family in the United States, she did not tell a soul, saying, "I felt very sad and very alone." There was no other work available, so her only option was to continue working at the farm. "He kept raping me and I let him because I didn't want him to hit me. I didn't want to feel pain." Patricia eventually found out she was pregnant.<sup>12</sup>

The physical, psychological, and social effects of the abuses women endure are complex, iterative, and long-lasting. Recent research has shown that this form of multiple victimization, or polyvictimization, is especially pernicious, with each instance of abuse having a cumulative effect on the victim's physical and mental health. Unfortunately, social services set up to protect and aid these victims in Mexico's northern border regions (such as in the state of Sonora) are overwhelmed by the sheer number of cases, and they are mostly ill-prepared to deal with multiple victimizations. Migrant women and children, facing the plethora of anti-immigrant laws in Arizona and beyond, must navigate an increasingly byzantine process just to receive the most basic of physical care. Such laws lay siege to almost every aspect of immigrant's livelihood from employment to education to health.

Indeed, we would expect that anti-immigrant and anti-reproductive-choice laws create a culture of fear and confusion for many migrant women and serve as yet another form of violence they are subject to. Immigrant women who are already marginalized by their status and the

various structural, physical, and daily violence they already face, are not met with humane policies once they arrive in the US, but with more violence. The polyvictimization and its sequelae are undoubtedly exacerbated by federal and state policies.

### Changing Attitudes about Reproduction and Acculturation

We would expect dramatic disparities in accessing reproductive health services for populations of immigrant women, as studies in many countries have documented much poorer health outcomes for immigrants. In addition, many studies document the distinctions between US-born and migrant women's reproductive health. Immigrant women have been found to be very concerned about their reproductive health but possess limited knowledge about choices and limited access to health programs. In general, "immigrant women are less likely to receive adequate reproductive healthcare, including cervical and breast cancer screening and treatment, family planning services, HIV/AIDS testing and treatment, accurate sex education and culturally and linguistically competent services."<sup>13</sup> A study of Mexican-immigrant women in New York City found that women had little knowledge about contraception and did not often see healthcare providers until they were pregnant.<sup>14</sup> Further, according to a policy analysis by the National Latina Institute for Reproductive Health (NLIRH), "The majority of undocumented immigrant women do not have access to affordable health insurance."<sup>15</sup>

It is also necessary to include an understanding of preexisting attitudes toward fertility and knowledge about contraception carried by migrant women as they move to new destinations. Often ignored are the perceptions migrant women retain from the social policies and attitudes toward family size in their sending countries. Francine D. Blau has argued that immigrant women mimic the fertility in their countries of origin and therefore it is important to acknowledge the changes we see in immigrant fertility of Mexican immigrant women in the United States as strongly related to changes in Mexico.<sup>16</sup> Mexico has undertaken significant and successful measures to curb population growth over the years, and a review of the scholarly literature indicates that shifts in attitudes about fertility and corresponding behaviors have been developing for over twenty years. Mexico has undertaken several initiatives to improve reproductive health including the establishment of a Directorate of Reproductive Health in 1995 and providing free treatment for HIV/

AIDS. Mexico has also established a series of policies to benefit the most vulnerable parts of the population. In 2007 Mexico passed a national law decriminalizing abortion during the first twelve weeks of pregnancy. Though many Mexican states have not yet allowed access to abortion, Mexico City provides both public-sector and private abortions, and as of 2012, more than eighty-nine thousand abortions have been performed. Further, the use of contraceptives has increased significantly in the past twenty years as has the "unmet need for contraception."<sup>17</sup> In this way, Mexico's role in forging pathways by which reproductive justice is articulated, understood, and respected must be considered in the attitudinal shifts among immigrant and migrant women.

Once in the United States, research shows that choices about family size and the spacing of children are also commonly influenced by acculturation and desires to provide them a higher quality of life. Moreover, the longer women remain in the United States, the more empowered they are likely to feel to take increased agency over their reproductive health. The ability to control the number and spacing of children also enhances employment possibilities and economic earnings, which when considered with the importance of financial remittances to communities back home, provides a pathway toward greater social status.

Acculturation, the adaptation to different cultural values and behaviors of the United States that comes through the inherently strong connections with other Latinas in the United States and over generations, is also important to consider in this discussion. In her 2009 study, "Differences in Contraceptive Use across Generations of Migration among Women of Mexican Origin," Ellen K. Wilson finds very little change in contraceptive use between first-generation and 1.5-generation—migrants brought to the US as young children—Mexican immigrant women, but the acculturative change is markedly more dramatic between generation 1.5 and US-born women of Mexican origin.<sup>18</sup> In this regard, it is necessary to consider emerging thoughts among more contemporary Latinas as important conduits for acculturation and change. Although other factors have been systematically explored to gauge the impact of acculturation—such as sexual activity, health insurance coverage, education, marital status, income, work, and religiosity—here we will focus on the use and attitudes toward abortion and sterilization.

Christine Dehlendorf and Tracy Weitz report that Latinas have abortions at more than twice the rate of non-Hispanic white women, though less than African Americans.<sup>19</sup> However, another study by the NLIRH reports that much of this disparity can be traced to higher numbers of

unintended pregnancies. Wilson finds that Mexican American women are more like to have unintended pregnancies, compared to immigrant women.<sup>20</sup> The NLIRH reports that when Latinas become pregnant, they are only somewhat more likely to have an abortion compared to white women. In 2004, 22 percent of Latinas' pregnancies ended in abortion, compared to 15 percent of pregnancies among white women.<sup>21</sup> Despite these higher percentages, Dehlendorf and Weitz convincingly argue that women of color and lower-income women suffer from a lack of access to abortion services, which can be largely traced to costs and difficulties in finding abortion providers.<sup>22</sup> Consistent with this contention are findings from Wilson showing that among Latina women in their twenties and those thirty or older, the only mediating variable that had a statistically significant association with contraceptive use among different generations of Latina women was poverty.<sup>23</sup>

These reports and research studies call into question those cultural theories around unintended births in the Latina community that claim that Latinas/os are more "pro-life." For instance, a survey by NLIRH found that Latina women show strong support for access to legalized abortion. For example, 74 percent of Latino/a registered voters agree that a woman has a right to make her own personal, private decisions about abortion without politicians interfering, and 67 percent of Latino/a voters say they would give support to a close friend or family member who had an abortion. The survey also found that Latina women strongly opposed government policies that create obstacles to obtaining an abortion. They also indicated that they were willing to disagree with church leaders on abortion issues; 68 percent agreed with the statement, "Even though church leaders take a position against abortion, when it comes to the law, I believe it should remain legal."

Many RJ advocates worry that sterilization is overrecommended to Latinas and other communities of color. Sterilization is one of the most effective but more expensive of contraceptive options and must be considered in light of larger constraints to accessing healthcare programs. Anna Ochoa O'Leary et al. contend that it may be that increased restrictions to accessing these programs in the United States force immigrant women to consider sterilization as a viable option.<sup>24</sup> The use of surgical sterilization was the most common method of birth control by the eighty women surveyed in research by O'Leary and Azucena Sanchez.<sup>25</sup> Most notable was that this was the most common method of contraception in participants from a subsample of women who belonged to households where they or a member of the family were undocumented. Indeed, Jo-



seph E. Potter et al. found that among Latinas in El Paso, Texas, there was a large unmet need for sterilization "at nine months [from the baseline survey], 65% wanted no more children, and of these, 72% wanted sterilization. Only five of the women interviewed at 18 months had undergone sterilization." Reasons for not getting sterilization included "not having signed the Medicaid consent form in time and having been told that they were too young or there was no funding for the procedure."<sup>26</sup>

In sum, despite the numerous structural obstacles to immigrant women's reproductive health, there is some evidence of women's agency in these studies—much of which can be traced to both the early formation in attitudes about family size—institutionalized through various national-level family planning programs in Mexico, and their settlement among previous generations of Latinas in the United States whose notions about reproductive self-determination shows a growing alignment with the principles of reproductive justice.

### Empirical Studies of Reproductive Justice at the Borderlands

In the most thorough studies of women's reproductive health at the borderlands, the "Border Contraceptive Access Studies," immigration and documentation were not explicitly considered in the analysis as the researchers were focused on influencing the availability of over-the-counter (OTC) birth control. These well-designed surveys included over one thousand women in the El Paso area, approximately half of whom used birth control pills obtained as OTC medication in a pharmacy in Ciudad Juárez, across the border from El Paso, and half got theirs from a clinic in the United States. Interestingly, the border had little direct relevance in this study, besides allowing the researchers to conduct a natural experiment on OTC versus prescription medication. According to Kimberly Inez McGuire, Associate Director of Government Relations and Public Affairs at NLIRH, "Immigrant women in Texas tell us that accessing birth control, cervical cancer screening, and other reproductive care is so difficult here in the United States, they're forced to cross into Mexico in order to get the care they need."<sup>27</sup>

In a second study, the reproductive healthcare strategies of a small sample of immigrant women and their access to these services subsequent to greater anti-immigrant laws in Arizona were studied in 2008–2009 in Tucson, Arizona. For the research, eighty immigrant women

were interviewed using a short demographic and health indicators survey with both open- and closed-ended questions. Researchers partnered with the Mexican Consulate's health referral program, *Ventanilla de Salud*, and El Rio Community Health Center to help recruit research participants. From the data, two subsamples (C and D) were constructed. Using proxy variables extracted from the open-ended questions, the researchers determined those participants in whose households all members were regularized family members or US citizens (for subsample C), or if an undocumented member was present (subsample D). In some cases, the interviewed women were undocumented.

Figure 3 shows the distribution of the sample of women by their period of entry into the United States. To determine the relation between women's reproductive life cycles and the timing of migration, the period of entry into the United States was contextualized within recent major economic developments. The time periods were divided in three major categories: pre-NAFTA, post-NAFTA, and pre-Recession. The pre-NAFTA category includes the women who had been living in the United States fifteen to thirty years or more before NAFTA went into effect in January of 1994. NAFTA undermined many subsistence economies in Mexico, forcing many women to migrate.<sup>28</sup> Not surprisingly, the ma-

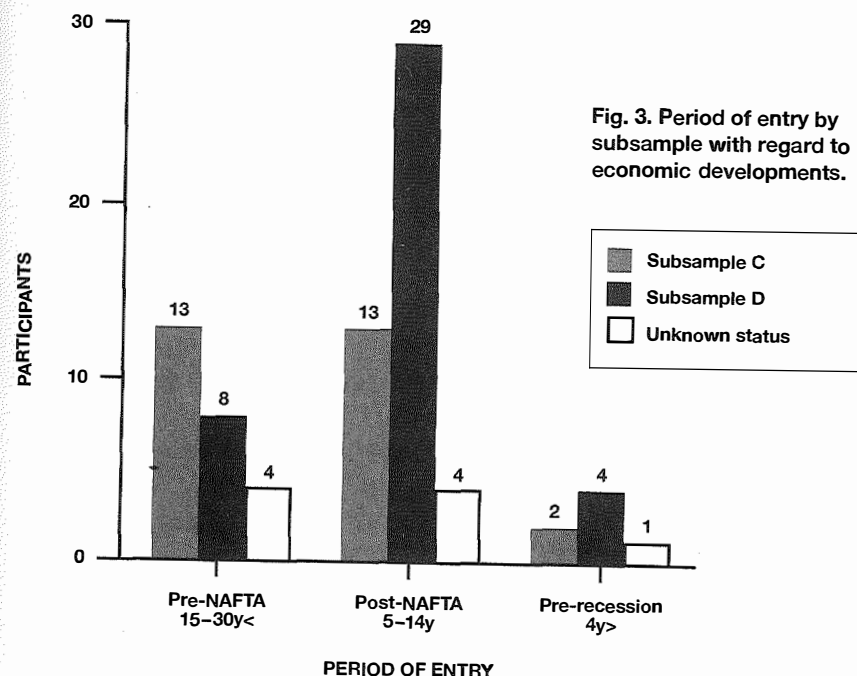
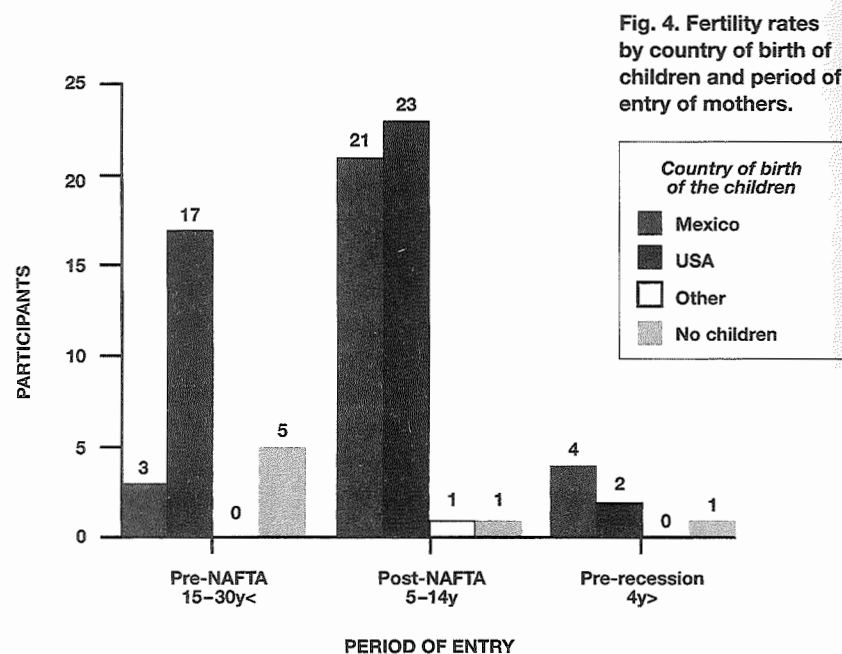


Fig. 3. Period of entry by subsample with regard to economic developments.

majority of the women who are part of the subsample D ( $n=29$ ) entered into the US after NAFTA came into force. Moreover, with more women entering the United States during prime reproductive age, the probability that they would give birth to children in the United States was also affirmed. Moreover, and as figure 4 illustrates, most of the participants entered the US after NAFTA: twenty-one of them entered with their Mexican children and twenty-three later gave birth in the United States. In this way, the consequences of women's migration at peak productive and reproductive age may be one of the least understood consequences of NAFTA.

The results of this study show that even before the proliferation of state immigration control laws from 2004 to 2008, the rate of birth among immigrant women had been steadily declining and is consistent with a 2012 Pew Research analysis that shows that the plunge in births by immigrant women started with the 2007 to 2008 Great Recession. The Tucson research reveals another important point: immigrant women from subsample D ( $n=39$ ) were using the most effective contraceptive methods (hormonal and surgical). This preference could be a strategy to adapt to the restrictive policies regarding immigration and access to public healthcare services. The narratives indicated an under-



standing that by having fewer children, the women could better provide for them. However, it cannot be ignored that the two dominant birth control methods used are also the most cost effective.

A content analysis of the open-ended responses by the women from subsample D indicates it is very stressful for them to apply for healthcare services because they fear being humiliated or being further scrutinized. Arizona law requires the agencies administering healthcare applications to report those that they suspect as being in the United States unlawfully, potentially resulting in their deportation.

### Conclusion: Toward Reproductive Self-Determination

Despite unprecedented recessionary budget crises across the nation, state legislatures have paid inordinate attention to stripping away the rights of migrants and women. Alyshia Gálvez has argued that the fertility of immigrant women, and in particular Mexican immigrant women, has drawn tremendous but unwarranted scrutiny from lawmakers who see them as a drain on public coffers.<sup>29</sup> The idea that their supposed excessive fertility amidst poverty is irresponsible and an affront to progress has been used to garner support for more laws restricting their access to public services. As Jonathan Xavier Inda has pointed out, in the mid-1990s, policymakers became increasingly focused on cost studies that calculated the "price tag" of providing public services to undocumented women and their children.<sup>30</sup> Such studies not only estimated the public costs incurred for Medicaid financed births (including prenatal care), but also the costs of the postnatal care of immigrant women and their children (including supplemental nutritional programs). Immigrant women were largely scapegoated in the 1994 campaign for California's failed Proposition 187.<sup>31</sup> Not surprisingly, with marginalized sectors of society becoming more visible, and more children in schools and health facilities by 1995, US lawmakers legislated the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 which brought greater restrictions on women's access to healthcare services and social safety net programs at a critical time when migration from NAFTA-affected areas would surge.

But herein lies an important contradiction. On the one hand, access to health services that so-called hyperfertile immigrant women might use to control the number and spacing of children is increasingly denied

them, and on the other, the right to access abortion and family-planning services such as Planned Parenthood is also being challenged.

However, it is our contention that though women's agency is severely constricted in the context of migration, it is still present and manifests in many, often unexpected ways. Based on the empirical studies, women use various strategies to circumvent restrictions on their ability to make decisions about their reproductive and sexual health. If the woman is ineligible for services in the United States, she may opt for surgical sterilization or buy OTC contraceptives or abortifacients in Mexico, where they are more accessible and less expensive. If women cannot cross into Mexico due to their immigration status, others buy the medications for them. Many immigrant women are teaching their children about abstinence and birth control and encouraging sex education. However, often these families must pay full price for their medical services, potentially incurring long-term debt.

An understanding of the economic imperatives of how women are strategizing their reproductive choices highlights their agency against great odds. Unfortunately, the academic literature has failed to keep pace with the lived experiences of these women. This neglect is in part because of the twin attacks on immigrant women that make it very difficult to conduct interviews with this marginalized group, especially if they are undocumented. However, applying the reproductive justice framework to the reproductive health of migrants in Arizona raises some fundamental questions that should be addressed in a more sustained fashion. These include:

1. How do abortion restriction laws differentially impact women at different places in their reproductive life cycle?
2. Even if the laws do not directly target Latina women in general, how does the acrimonious atmosphere created around immigrant women impact them?
3. How are the sensibilities of immigrant women impacted by the harsh political rhetoric characterizing them as public welfare burdens and their infants as "anchor babies"?
4. How are reproductive rights experienced by immigrant women, and how do these experiences compare to their expectations?
5. How do the multiple forms of violence these women face affect their reproductive health?

To be sure, overall immigration from Mexico and Latin America has been decreasing sharply since the 2008 US economic recession—also often attributed to increased border enforcement—but foreign-born women still represent a significant portion of all mothers giving birth in the United States. There is strong historical evidence that anti-immigrant sentiment may be weighing heavily on immigrant women as their reproductive choices increasingly become the objects of greater governmental scrutiny. In this context, immigrant women are doubly impacted as their attempts to access healthcare programs and services for family planning information, professional advice, and for monitoring contraceptive use are becoming increasingly restricted. As of this writing, little empirical work has been done on the reproductive choices of immigrant women in the borderlands, where they may suffer greater repression, as a way to understand the reproductive health strategies of immigrant women throughout the United States.

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### Notes

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