

Pregnant, Uninsured, and Undocumented: Prenatal Care for Immigrant Women in South Texas¹

K. Jill Fleuriet²

Abstract

Prenatal care has been shown to improve maternal and birth outcomes, reduce birth- and birth-related morbidity costs, and serve as a means to link medically needy children with health and health care resources. Yet prenatal care options for uninsured, low-income undocumented immigrant women living in the United States are insufficient and frequently inaccessible. In this paper, I use qualitative research to detail and assess U.S. prenatal care experiences among undocumented immigrant women from Mexico. I situate their experiences in the larger context of publicly supported prenatal care in the United States for undocumented immigrant women. I argue that policies targeting undocumented immigrants and low-income pregnant women are misdirected and ineffective because they stem from hegemonic political discourse rather than actual medical needs. I conclude with recommendations to amend policy in order to incorporate prenatal care preferences and expressed needs of undocumented immigrant women. [prenatal care, immigration, reproductive rights, U.S. health care policy]

When one doesn't have the documentation . . . it's difficult to get health care in the United States. They ask for many requirements. If you don't have them, well, you have to go somewhere else. And if you have a [Medicaid] card, they ask for further identification. If you don't have papers, how are you going to have identification? It's very difficult.
– Carmen³, 35 years old, immigrant woman from Mexico City, Mexico.

I think that the Americans get the best medical care, because they have the most resources. And if you're Hispanic [from Mexico], there are times when you don't have sufficient money to see a specialist. – Diana, 35 years old, immigrant woman from Veracruz, Mexico.

Prenatal care has been shown to improve maternal health, child health, and birth outcomes (Chang et al. 2003; Keily and Kogan 1994; Conway and Kutinova 2006), reduce birth- and birth-related morbidity costs (Lu et al. 2000), and serve as a means to link medically needy children with health care and health-promoting resources (Kogan et al. 1998; Alexander et al. 2002). Yet prenatal care options for uninsured, low-income undocumented immigrant women living in the United States are insufficient and frequently inaccessible (Eldridge 2002; Ku and Matani 2001). In one study in Colorado (Reed et al. 2005), undocumented women who gave birth between 1998 and 1999 received significantly fewer prenatal care visits and initiated prenatal care later than all other women.

Despite the fact that recent immigrant women from Mexico have been shown to have better birth outcomes with less prenatal care than other minorities (Acevedo-Garcia et al.

2007; McGlade et al. 2004), a lack of prenatal care among immigrant women from Mexico is associated with a higher risk for low birthweight and preterm babies in the two South Texas counties where I conducted my research. Citizenship is not recorded on birth certificates, but birthplace of the mother is. According to Dr. Karl Eschbach, the state demographer of Texas, 85% of Mexico-born women of childbearing age in these counties are undocumented immigrants (personal communication, Karl Eschbach, 2009). According to natality data from 2001-2005 collected by the Texas Department of State Health Services (TDSHS 2009), Mexico-born women in these two counties were almost four times more likely to have had no prenatal care than US-born women (8.0% versus 2.1%, $p < 0.000$). Among Mexico-born women, those who did not receive prenatal care were more likely to have low birthweight babies (8.1% versus 5.7%, $p < 0.000$) and preterm babies (11.7% versus 9.9%, $p < 0.000$) than Mexico-born women who

did receive prenatal care. Thus within the Mexican immigrant population in these two counties, the relationship between prenatal care and better birth outcomes persists.

It should be noted that the role of prenatal care in birth outcomes is not entirely understood, which would appear to complicate recommendations for prenatal care for immigrant women. The efficacy of formal prenatal care has certainly been questioned (Alexander and Kotelcheck 2001; McCormick and Siegel 2001). There are several reasons for conflicting research on prenatal care and birth outcomes. First, prenatal care can significantly vary in definition, including components and modes of delivery of care. To illustrate, the CenteringPregnancy model (Walker and Rising 2004) incorporates peer education and support into prenatal care. In contrast, the most common form of prenatal care is a series of individual clinical checks and limited exposure to psychosocial support resources (Novik 2004). Second, low birthweight is hypothesized to have multiple causes, some of which remain to be identified. As a result, existing prenatal care, however defined, may not be adequate in content or scope as a preventive measure. A third difficulty is the differential impact of prenatal care on birth outcomes for pregnancies that carry low or high medical risks to the mother or fetus (Conway and Deb 2004). Even in ideal clinical circumstances of managing risk, prenatal care may not be able to prevent poor birth outcomes in high risk pregnancies, thereby statistically obscuring its impact on birth outcomes in lower risk pregnancies.

Nevertheless, certain elements of prenatal care, including psychosocial interventions aimed at reducing smoking and nutritional education and more comprehensive psychosocial support, have been shown to positively impact birth outcomes (Alexander and Kotelcheck 2001; McLaughlin et al. 1989). Also, formal prenatal care has relevance for Hispanic health, extending beyond the immediate pregnancy. Hispanic children have the highest rates of little to no health care (CDC 2002); prenatal care has been found to be a positive entry point for future well-child and maternal care (Kogan et al. 1998; Alexander et al. 2002). Entry into prenatal care can improve maternal health, as well, with

respect to treating obesity and reducing the likelihood of extended hospitalization after birth (Conway and Kutinova 2006). Mexican women without prenatal care are at greater risk for hyperglycemia (Hernandez-Valence and Pacheco 2002). Hyperglycemia is a major risk factor for developing diabetes that would be assessed during prenatal care. Hispanics also have increasingly high rates of Type II diabetes (NIDDK 2002). Thus prenatal care can serve as an important entry point into the health care system and means of moderating risk for immigrant women and their children.

Publicly-funded⁴ prenatal care options for low-income, undocumented immigrant women include Title V⁵ clinics, county health clinics, and community and migrant health centers. There are also charitable organizations that provide prenatal care for undocumented immigrants. These organizations are both private and not-for-profit. Despite these options, there is simply not enough prenatal care for women who are poor and uninsured (Derose et al. 2007). Second, a lack of legal residence creates specific barriers to prenatal care. These barriers include fear of immigration authorities, a lack of health insurance, and lack of knowledge on how to navigate the U.S. health care system (cited in Kullgren 2003). Lack of insurance increases morbidity and mortality risks for infants and mothers (Kaiser Family Foundation 2004; Matthews and MacDorman 2006; Institute of Medicine 2002, 2002b; Kasper 2004; Chang et al. 2003). Each of these barriers is compounded by poverty and language differences between providers and immigrants (Eldridge 2002).

However, barriers alone do not account for the insufficient and inadequate prenatal care received by undocumented immigrants. The prenatal care that is offered through public funding downplays or, at worst, ignores the three factors I studied and present in this paper that have been shown to be crucial in positive birth outcomes: prenatal care preferences, psychosocial health, and material security. Biomedical institutions, such as the American College of Obstetrics and Gynecology (ACOG 2008), and cross-cultural grass-roots organizations, such as the International MotherBaby Childbirth Initiative (IMBCO

2008), agree that material security, psychosocial health, knowledge about healthy pregnancies and births and options for prenatal care, and the power to choose among these options help promote positive birth outcomes. Publicly-funded programs do not provide such choices and thus leave a critical shortfall in overall care for the pregnant undocumented immigrant woman.

In this paper, I critique the absence of these factors in publicly funded prenatal care for undocumented immigrant women using the ethnographic platform of their voices. I first present undocumented immigrant women's experiences with U.S. prenatal care, emphasizing their preferences and the barriers they encounter. Then, I position their experiences within the larger context of U.S. prenatal care and public support for undocumented immigrant communities. I show that despite stated intentions, publicly funded prenatal care encodes cultural assumptions and values that ultimately undermine the potential impact of prenatal care to improve birth outcomes, maternal health, and future child health in undocumented immigrant communities. I conclude with recommendations on how to amend policy to incorporate a more comprehensive and flexible prenatal care model that better suits the needs and preferences of undocumented immigrant women from Mexico and, by extension, other undocumented immigrant communities in the United States.

Methods and Setting

We love living down here [in the Rio Grande Valley of South Texas] because we can go on a weekend down there [to Mexico]. I mean, here is like being there, just getting paid in dollars, you know? It is just the same thing. It's just there's an imaginary line there.

– *Veronica, 20 years old, immigrant woman from Jalisco, Mexico.*

According to the U.S. Department of Homeland Security, “undocumented” or “unauthorized” immigrants are foreign-born non-citizens who are not legal residents of the U.S. (Hoefer et al. 2006:1). There are an estimated 11.6 million undocumented

immigrants in the US. Of these, 6.6 million (56%) are from Mexico (Hoefer et al 2006:1). 3.9 million (35%) undocumented immigrants are adult females (Passel 2006). There are a reported 1,640,000 undocumented immigrants in Texas alone (Hoefer et al 2006:4). The southernmost border region of Texas, locally referred to as “the lower Rio Grande Valley,” has one of the highest concentrations of undocumented immigrants in Texas (Strayhorn 2006).

I conducted research⁶ in the Valley's two most populous counties, Cameron and Hidalgo, which are also the two southernmost counties in Texas bordering Mexico. At 36.9% and 35.9%, respectively, Cameron and Hidalgo have the highest percentage of people in the U.S. below the poverty line for counties with populations of 250,000 or more people (Webster and Bishaw 2006). The Valley has a majority Hispanic population with a large Spanish-speaking component. In 2006, Cameron County's population was 86.1% Hispanic; Hidalgo County's population was 89.5% Hispanic (U.S. Census Bureau 2006, 2006b). Cameron has a partial designation as a Medically Underserved Area/Population, and Hidalgo has a full designation (TDSHS 2007). Formal prenatal care opportunities for undocumented women in the Valley are clinics that are publicly funded or supported by charitable organizations. Of the 130,544 babies born in Hidalgo and Cameron Counties between 2001 and 2005, 66,264 (50.8%) were born to mothers whose birthplace was Mexico (TDSHS 2009). It can be reasonably estimated that 85% (56,324) of these women were undocumented (Karl Eschbach, personal communication, 2009). Eight percent (5,219) of Mexico-born mothers received no prenatal care; 2.1% (1,360) of US-born mothers received no prenatal care ($p < 0.000$).

By virtue of their geography, Cameron and Hidalgo counties are a major immigration destination from Mexico. Immigrants arrive to live with existing friends and relatives in communities with relatively few linguistic barriers. Information about social services is easily obtained in Spanish through Spanish television channels, radio stations, billboards, and staff at social service agencies. Isolation stems mainly from undocumented status and

poverty, both of which limit mobility and social interaction. However, language remains a barrier in health care interactions. While more health care providers speak Spanish in the Valley than elsewhere in Texas, because of a shortage of local health care professionals, Valley hospitals recruit non-Spanish speaking health care professionals from Canada and other parts of the United States.

My research was conducted with women who had managed to gain access to prenatal care, funded either through federal and/or state programs or charitable organizations. Research goals were to: 1) document low-income and immigrant women's prenatal care preferences and experiences and, 2) explore the relationship between preference, experiences, pregnancy and birth epistemologies, and structural constraints. Research proceeded in two stages. The first stage, conducted in 1996, used a survey methodology supplemented with clinic observations. I interviewed 226 low-income Mexican and Mexican American women in Cameron and Hidalgo Counties attending one of three prenatal care clinics: a private biomedical clinic, a community health center, and an alternative Catholic birthing center. My purpose was to identify preferences for prenatal care providers among low-income Hispanic women in South Texas who had accessed different kinds of formal prenatal care. While it included, but did not target, undocumented immigrant women from Mexico, the research was highly suggestive of a distinctive prenatal care experience for this group.

The second stage of my research extended from 2003 to 2005. I returned to South Texas for eight weeks to conduct ethnographic interviews, focus groups, and participant observation with undocumented immigrant women attending the community health center and the Catholic birthing center and the staff at each center. The private clinic was too expensive for this group of women to attend since they had no insurance. This phase of the research was designed to elicit narratives about: 1) pregnancy, prenatal care and birth experiences in Mexico and the United States; 2) pregnancy-related social support; and, 3) barriers to preferred prenatal care and social support due to poverty, immigration, and

citizenship status. As described in Fleuriet (2009, in press), I conducted participant-observation at the Catholic birthing center for twelve non-consecutive days, principally through volunteer clerical work and preparing and joining in communal lunches with the staff. I observed prenatal care and birthing classes, patient-provider clinic interactions, waiting room interactions, and formal and informal conversations among staff and clients, in addition to attending a birth. At the community health center, I spent fourteen non-consecutive days conducting participant observation, which included informal conversations with midwives, the director, nurses, social workers, and administrative assistants, observation of a parenting class, and observations and informal conversations with women in the waiting room. I conducted interviews with clients and staff in Spanish, English, or both, depending on preference. Upon consent, interviews were recorded. Recorded interviews were transcribed by a bilingual graduate student; I regularly checked transcripts for accuracy. Transcripts were analyzed for themes and related quotations using ATLAS.ti textual analysis software. Themes were initially based on interview topics noted above but then expanded or modified to include subjects regularly raised by the interviewees. For example, the theme of prenatal care experiences in Mexico was refined to include sections on sonograms and medical technology, a comparison of lay midwives, certified nurse-midwives, and obstetrical doctors, and roles of female relatives. After initial analyses, focus groups with clients and research reports and discussions with staff were conducted to check early conclusions and interpretations of the data.

The community health center and the Catholic birthing center followed different biomedical models of prenatal care. The birthing center was a not-for-profit clinic and a working Roman Catholic convent. Its clinical staff consisted of certified nurse-midwives (CNM), nurses, and nursing assistants. Its founder, a nun and certified nurse-midwife, created the center to offer family-oriented and midwifery-centered pregnancy and birth services. A guiding principle was minimal medical intervention for low-risk pregnancies and births. Sonograms were done

off-site and only ordered when midwives suspected a condition that could harm the woman or fetus. Births were unmedicated. Another guiding principle was female empowerment through respect and education. Midwives approached clinical encounters as conversations with pregnant women, including them in the decision-making process about their care. Labor and birth were in small birthing cottages on the convent's grounds. Midwives talked of "catching," rather than "delivering," babies, indicating that the authority and power in the delivery process rested with the mother-to-be. Clinical, administrative and religious staff members also participated in outreach to undocumented immigrant families and other very poor Valley families. Outreach programs included food banks, transportation, English and parenting classes, and clothing drives.

The community health center also conducted outreach, though with state and federal funding sources and with a larger and more general focus on low-income families. Its approach to pregnancy and birth was more firmly grounded in a biomedical risk model with the prenatal care provider as the primary authority. Although it started as a midwife-run clinic, the community health center had become closely associated with a regional medical center and hospital and operated under the authority of medical doctors. Prenatal care services typically included regular sonograms. Birth was required to take place in the nearby hospital. Babies were "delivered," rather than "caught," by doctors that arrived in the hospital's delivery room when the women were in the final stages of labor.

Based on the clinics' different approaches to prenatal care and birth, I expected that the women attending the birthing center or community health center would also have different ideas of their agency and the role of prenatal care providers in pregnancy and birth. In turn, I anticipated these different epistemologies would exert more influence over prenatal care decisions than structural constraints such as economic or immigration status. As it turned out, decisions were largely driven by immigration and economic status.

Prenatal Care Preferences and Barriers among Undocumented Immigrant Women in South Texas

Doctors in general don't have much patience . . . [The best midwife] is one that has a good way of being. She is friendly, she makes you feel good. I have heard that other kinds of providers don't treat you well and that, to me, is very important, you know? That they receive you with a smile, that is very important . . . For me, it's better if the midwife is a woman. – *Diana, 35 years old, immigrant woman from Veracruz, Mexico.*

In the 1996 study, I expected that different clinic populations would have chosen different prenatal care provider preferences by virtue of distinctly different clinical approaches to prenatal care and birth. I documented women's prenatal care provider preferences through surveys with 226 Hispanic women, 50% (113) of whom were immigrants from Mexico. The following results pertain only to women who were Mexican immigrants. Mexican immigrant women preferred midwives over obstetrical doctors at both the Catholic birthing center (93.8% preferred midwives) and the community health center (75.0% preferred midwives). I then statistically modeled prenatal care provider preferences, CNM or obstetrical doctor (OB/GYN), using variables known from the literature to influence choice and preference of formal prenatal care provider (see Medrano 1997 for review). These variables were: acculturation, age, attitude toward medical intervention during pregnancy, clinic of attendance, level of education, income, number of children, number of pregnancies, and payment source (see Table 1 below). Due to problematic assumptions in standard acculturation measures (Hunt et al. 2004), cultural identification was used as a proxy for acculturation and was determined for this sample by using a factor analysis of language of birthplace, primary language, language of most familiarity, language on television, place of birth, and cultural self-identification (see Medrano 1997 for factor analysis results). Attitude toward medical intervention was measured by a Likert scale (always, sometimes, or never necessary). A brief scan of Table 1 shows that acculturation ($p < 0.000$), type of clinic ($p < 0.000$) and parity ($p <$

0.038) significantly influenced preference of prenatal care provider. Controlling for other variables did not significantly change these correlations.

That immigrant women preferred a CNM over a OB/GYN was surprising given that 80.2% of births in Mexico in 2007 were attended by a physician (INEGI 2009). Moreover, 93.9% of pregnant women in Mexico in 2000-2003 were seen by a physician at least once during their pregnancies (Secretaría de Salud 2003: 42, 45). Of these women, 89.5% were satisfied with their care (Secretaría de Salud 2003: 45). Another interesting finding was the lack of a relationship between preference and attitudes toward medical intervention. Despite the Texas clinics' different orientations to prenatal care and birth, there was no statistical difference in attitudes among women at the community health center, private clinic, and Catholic birthing center. As I worked with these data, it became apparent the lack of these relationships and the significance of clinic and acculturation variables were most likely a proxy profile for the political, social, and economic realities influencing prenatal care opportunities for undocumented immigrant women. Due to their poverty and lack of U.S. citizenship, these women faced more structural constraints than documented or U.S.-born Hispanic women in locating and accessing resources. I concluded that further research was needed to examine the interplay between access to reproductive health care resources and any possible cultural orientations toward prenatal care and birth and how this interplay affected undocumented women's reproductive health care strategies, preferences, and experiences.

This prompted the second stage of my research and my subsequent focus in 2003-2005 on undocumented immigrant women. I spoke with eighteen women at the Catholic birthing center and sixteen at the community health center. Twenty-eight of these were low-income undocumented immigrants from Mexico, twenty-five (89.3%) of whom preferred midwives. The remaining three did not have a preference of prenatal care provider. Despite having access to prenatal care at the time of the interview, the majority of women had nevertheless encountered barriers in accessing them in the past. Their responses about

informal and formal prenatal care experiences and preferences illustrated both cultural preferences toward gender and pregnancy-related social support and structural constraints on exercising their prenatal care preferences.

Preferences. What the undocumented immigrant women wanted more than anything else was affordable gendered support alongside regular clinical checks to ensure that their pregnancy was progressing normally. Most women preferred midwives, primarily because of their presumed female gender and the perception that women were more intuitive, and thus more supportive, about pregnancy-related changes. For example, Veronica, in her early twenties and in her third pregnancy, reflected on her prenatal care experiences at community clinics for her first two pregnancies and her current care at the Catholic birthing center:

I feel more comfortable with women doctors, maybe because I'm Mexican, but they seem more comfortable in the way they check. We relate more to them. . . . my family taught me that women are the ones that have babies. Women are the ones that know what happens. Men don't know what it is to go through an experience like that, so women know best.

Many of the other women echoed these sentiments. Raquel, a thirty-five year old woman from Veracruz, Mexico, attending the Catholic birthing center, said simply, "I trust a woman more." As Marissa, a twenty-five year old woman from Mihoacán, Mexico, said, "Female midwives can understand you better. They know what's happening to you. The male doctor is colder because he is a man. They can't feel what you're going through." Silvia, a twenty-nine year old from Tamaulipas, Mexico, explained her preference for the midwives at the Catholic birthing center: "I feel more comfortable and trusting with a woman, a person of my same sex. I'll ask her questions when I wouldn't have if it had been a [male] doctor. I feel more secure that she'll have the answers to my questions." One thirty-three year old undocumented immigrant woman from Monterey, Mexico attending the community health center explained, "I'm embarrassed with the male doctors."

Another woman at the community health center, Clara, a thirty-three year old immigrant woman from Monterey, Mexico, blamed her doctor's inability to recognize that she was in labor on the fact that he was male and therefore did not respect her female intuition. She said,

I feel like the doctors don't pay attention to you, they don't explain that this is happening for that reason. No, they don't talk with you. . . . It's because they're men. . . . The benefit of midwives is, in the first place, that they are women... They know more than the [male] doctors what you're feeling. In my case, during my third pregnancy, I told the [male] doctor, "Doctor, I have so many contractions." And the doctor? "No." If you're not giving birth right then, he won't send you to the hospital. He checked and I wasn't dilated, and said I still had time to go before my due date. And I told my husband still, "I already know that the baby wants to come. I feel it." Finally, I went directly to the hospital where I saw a midwife who said, "Yes, the baby's coming right now." . . . and then they had to operate because my blood pressure was high and it turned out I was late to deliver. And the male doctor just didn't understand at all.

These undocumented immigrant women's words demonstrate the belief that they could talk more openly and ask more questions with a female provider. Female providers respect the woman's intuition, recognize the woman's own knowledge about her body, and incorporate these dimensions into the care rendered. Male providers, on the other hand, were thought to lack this respect, shared experience, and intuitive understanding.

The second most discussed prenatal care preference among undocumented immigrant women was a provider who offered informational and emotional support. One woman at the birthing center, Sonia, a twenty-five year-old woman from Tamaulipas, Mexico, said she wanted a provider who "attends me well, that gives me a lot of attention, and that gets after me when I don't do the things I'm supposed to do when I'm pregnant." Another woman at the community health center, Antonia, a thirty-three year-old immigrant woman from Valle Hermoso, Mexico, mir-

rored Sonia's words, saying, "My midwife, I have a good midwife. She is very friendly, attentive, takes care of me, does the best that she can. Always, she is patient." Laura, a twenty-five year-old immigrant woman from Morelia, Mexico, said she liked her midwife at the community health center, because "She explains things that are happening to my body." This preference for someone who could empathize and advise appeared to be rooted in a larger sense of the importance of female social support during pregnancy. However, as Lazarus (1994) and others have noted (Davis-Floyd and Sargent 1997), most women want these things from their prenatal care provider: informational support, respect, open communication, trust, and for many in the US, sufficient biomedical expertise to diagnose high-risk pregnancies using medical technology. What was distinct among undocumented immigrant women from Mexico was a strong preference for female providers.

Barriers. In addition to gendered support from a provider, women and their providers said that structural constraints were paramount in choosing prenatal care. Midwives I spoke to at the birthing center and community health center talked about numerous barriers to care for undocumented immigrant women including transportation to and from the clinics, childcare during the visits, inability to communicate with the provider because the provider did not speak her language, and the fear that immigration authorities would use the clinics as a means to apprehend undocumented immigrants. The former director of the birthing center, a midwife for over twenty-five years in South Texas, said the most common barriers to prenatal care in the Valley are transportation, lack of cultural sensitivity and Spanish language ability among providers, and the inability for women to afford their preferred forms of prenatal care. Another midwife at the birthing center connected U.S. health care policies with the barriers, saying, "[In the United States, we say] you can't have this because you are not documented, and no, you can't go back to Mexico because if you go to Mexico to get this done, you can't come back... There's [sic] no resources when you have a woman who doesn't have the income, who's not documented, but she definitely needs help."

Repeatedly, the undocumented immigrant women spoke of financial barriers to care. Cost was the first reason that they selected either the birthing center or the community health center. Subsequently, they discussed how their decisions were also influenced by the affective care and/or the material support they received through the clinic. Laura said she chose the birthing center because,

In the first place, I don't have papers [that would help me pay] and the other clinics are very expensive. And so here, I pay as much as I can. And here, there is something for my little girl. Look at the toys that the staff has sewn for her to play with. Here, there is clothing for the babies. They give you food; make sure that you are doing well.

While economic considerations were significant for all women, some women balanced cost considerations with their perceptions of a clinic's standard of care. Several women chose to pay more for their care at the community health center rather than return to free care at county health clinics because they considered their care at the county health clinics to be substandard. Four women spoke of attending a county health clinic for prenatal care for previous pregnancies. Not one woman had a positive experience. They found the clinic unclean or the staff insulting or aloof. In the following narrative, Gabriela, a twenty-eight year-old immigrant woman from Veracruz, Mexico, explains her and her husband's decision to travel further to pay for prenatal care at the community health center:

I took note of the care I received with my last baby, my last pregnancy . . . when I was in labor, they gave me a C-section. The stitches the doctor put in were bad. They got infected. I feel like they really did not take good care of me, the clinic was unhygienic. And my first child and my husband didn't like it either. At the time, my husband didn't have good work, but he told me, "We're going to [the community health center] and figure out a way to pay for the care." Here [at the community health center], I am well.

Rosa, a twenty-nine year old immigrant woman from Tampico, Mexico, who attended a

different county health clinic, also considered the care inadequate. She thought the staff had certain negative opinions about women who got free care. These opinions, in turn, shaped the clinical and affective care she received. She said,

When I was going to [the county health clinic for my second pregnancy], they were really ugly. They were not nice, and maybe it's because it's free. . . . They were like, "Well, you couldn't wait to have another baby, huh?" They were really like that. And I don't know, I really didn't like it, and I told my husband, "I don't want to go to that clinic anymore." I love my baby . . . but [according to the clinic staff] you were bad for getting pregnant. So I go [to the community health center], even if we have to pay.

Tellingly, each of the barriers to care cited by undocumented immigrant women and their providers can be easily linked to current national discourses about Mexican immigrants and inadequate prenatal care. These discourses, in turn, drive public funding for prenatal care. The fear of immigration authorities can be logically connected with visible anti-Mexican immigrant sentiment in popular media and images, as well as the increased presence of Homeland Security in the U.S.-Mexico border area. The construction of the U.S.-Mexico border fence, the activities of the Minutemen militia group, and the online pay-per-view border-crossing surveillance cameras are but three more examples of public fear of immigration from Mexico. Wait time, transportation, and cost each reflect the limited vision of prenatal care that is embodied in policy. Language, personality of providers and staff, and male gender of prenatal care providers imply a prenatal care model that does little to acknowledge women's preferences.

Situating Prenatal Care for Undocumented Immigrant Women: Optimal Prenatal Care versus Publicly Funded Prenatal Care

When I went to the hospital, they asked me for a lot of money, and here [at the Catholic birthing center], they didn't ask for anything. And here, well, here, they don't just set you

aside. Here, they give you hugs. They treat you for the entirety of the pregnancy. – *Sonia, 25 years old, immigrant woman from Tamaulipas, Mexico.*

If publicly funded prenatal care programs ostensibly cover undocumented immigrant women, why, then, are these women still encountering barriers? Why does policy hinder an undocumented immigrant woman's ability to exercise her prenatal care preferences? Existing social science research reveals that while publicly funded programs are often designed to provide prenatal care to undocumented immigrant women, they are simultaneously and primarily an expression of underlying social discourse of immigration, citizenship, and reproductive rights. As shown below, these discourses do more to limit, rather than facilitate, access to comprehensive prenatal care.

Two types of health care policies impact prenatal care delivery to undocumented immigrant women: those aimed at undocumented immigrants and those aimed at low-income and uninsured pregnant women. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) severely restricted publicly funded services, including prenatal care, for undocumented immigrants. PRWORA stipulated that undocumented immigrants who cannot establish asylum status have no access to federal public benefits, including Medicaid and its prenatal care. The few exceptions include emergency care, immunizations, diagnosis/treatment of communicable disease, short-term emergency disaster relief, and non-specific case assistance to protect life and safety, such as soup kitchens. Thus, until 2002, the only sources of publicly funded care directly aimed at undocumented immigrants were migrant health centers, which operate under the aegis of community health centers. In 2002, the Department of Health and Human Services expanded eligibility rules so that states could decide whether the “unborn child” of an immigrant woman, who would be a U.S. citizen, was eligible for prenatal care (DHHS 2002: 61956).

Public funding for prenatal care can come from federal, state, or state-federal monies.

Publicly-funded options targeting low-income and uninsured pregnant women include Title V clinics, county health clinics, and community and migrant health centers. Title V clinics are funded through state-federal programs but have been flat-funded for years. This has led to closure of clinics in Texas (Eldridge 2002). County health clinics are state-funded and serve uninsured individuals with incomes of 21 percent or less of the Federal Poverty Line, irrespective of immigration status. Community and migrant health centers are public or not-for-profit clinics located in federally-recognized Medically Underserved Areas/Populations. They are federally funded through public health federal grants (Eldridge 2002). Community and migrant health centers do not require documentation of citizenship and will cover individuals with incomes 200% or less of the Federal Poverty Line.

In general, prenatal care offered through publicly funded programs is not well-designed for a poor population with significant psychosocial stressors. Undocumented immigrant women are one of the groups most at-risk for material insecurity due to poverty and out-of-pocket costs for health/prenatal care, psychosocial stress associated with undocumented status (Sullivan and Rehm 2005) and lack of accessible health care (Eldridge 2002; Sullivan and Rehm 2005). If they have prenatal care, it is frequently fragmented and attenuated due to barriers to care (Kullgren 2003). Prenatal care funded through publicly supported programs typically consists of clinical visits and a limited number of meetings with a social worker to identify crisis situations and potential social services to help mediate poverty. This is the standard medical model of prenatal care in the United States (Novik 2004).

State and federally funded options are also not designed to provide comprehensive material resources and psychosocial intervention and support, nor do they offer more than a standard biomedical approach to pregnancy and birth. Examples of comprehensive material resources include food, clothing, transportation to and from the clinic, and additional health care for the woman and her family. Each of these has

been cited by immigrant women as important factors in prenatal care decisions (Fleuriet in press). Psychosocial intervention and support include increased risk assessment and intervention in maternal and family nutrition, health care, and social dynamics, i.e., domestic violence. For example, McLaughlin et al. (1989: 6) demonstrated that improved birth outcomes among low-income minority populations were associated with “a team of nurse-midwives, social workers, a nutritionist, paraprofessional home visitors, and a psychologist” that “focused on psychosocial support for the mothers, education about self-care, and promotion of health behaviors during pregnancy (good nutrition, avoidance of alcohol and drugs, and reduction of smoking)” and offered prenatal care support groups.

The lack of comprehensive material resources and psychosocial intervention is largely due to long-standing cultural biases against immigrants and public funding for prenatal care. Douglas (1969) and Herzfeld (1993), among others, have underscored the influence of centuries-old political and social philosophies on our expectations about public support and the production of policies regarding public support. American policies regarding public support stem from the legacy of Elizabethan Poor Laws that applied moral judgments to the poor (Dolgoft and Feldstein 2007). They set the precedent of monitoring citizens' productive contributions and collecting taxes for welfare provision for the disabled poor, while punishing the able-bodied poor who refused to work. This legacy is combined with American narratives of individual autonomy, the Protestant work ethic, and the belief that internal, intrinsic motivation is what determines success (Herzfeld 1993). As a result, policy regarding public support was and is structured to focus upon economic productivity of “morally deserving” residents who can be monitored. Since undocumented immigrants from Mexico are difficult to monitor and are perceived as social and economic threats to American “culture” and prosperity, they are correspondingly viewed as undeserving of taxpayer-funded programs (Chavez 2001). To illustrate, in PRWORA, undocumented

immigrants are denied all public support programs except in emergency care or services needed as a result of a natural disaster. Despite poverty and a lack of insurance, pregnant undocumented immigrant women were not eligible for Medicaid-covered prenatal care in PRWORA.

Public support programs are equally molded from national discourse reflective of hegemonic social, economic, and political relations. Undocumented immigrants from Mexico have historically been treated as a spare but overly burdensome workforce that threatens the American social fabric and economy (Chavez 2001). In his 2001 book on mass media images and national discourses over immigration from 1965 through 1999, Chavez found that non-Mexican immigrant groups' images in magazines have been alternately positive, neutral, and alarmist. Yet Mexican immigrant images on magazine covers have been “overwhelmingly alarmist” (Chavez 2001:215). For example, Chavez cites cover titles from *US News and World Report* about Mexican immigration, including: “How Millions of Illegal Aliens Sneak into the US” in 1974; “Time Bomb in Mexico: Why there'll be no end to the invasion of illegals” in 1977; “Illegal Aliens: Invasion out of Control?” in 1979; “The Great American Immigration Nightmare” in 1981; and “Invasion from Mexico: It Just Keeps Growing” in 1983. These titles reflect the message that Mexican immigration puts an inappropriate and excessive strain on national resources. The language in the PRWORA bears this sentiment out: “current eligibility rules for public assistance and unenforceable financial support agreements have proved wholly incapable of assuring the individual aliens not burden the public benefits systems” (as cited in Kullgren 2003:1630).

Chavez (2001) attributes the variable degrees of anti-immigrant sentiment to national economic trends. The economic downturns in the early 1980s and again in the 1990s correlated with an increase in anti-immigrant discourse as reflected in mass media. Reproduction is tied into the discussions, because Mexican women's fertility is considered too high, too much of a burden on medical services (Chavez 2004), and too likely to result in future recipients of public

support. "Women as symbols are harbingers of immigrant families and communities that are capable of reproducing themselves, highlighting the distinction between the concepts of reproduction and production" (Chavez 2001:250). Mexican immigrant women thus become defined by the cultural presuppositions attached to the labels of "immigrant" and "citizen" (Chock 1994).

One example of this misplaced, gendered fear of immigrant Mexican women is the so-called "anchor baby" stories. By U.S. constitutional law, any baby born in the U.S. is a citizen. Furthermore, emergency rooms cannot deny services based on citizenship, and citizens and non-citizens alike can qualify for Emergency Medicaid to cover a portion of these emergency room costs. Public perception is that recent increases in Emergency Medicaid costs are largely due to undocumented immigrant women crossing the border with the express purpose of receiving emergency room labor and delivery services through Emergency Medicaid and having a child that becomes, at birth, a U.S. citizen (Tebo 2007). Babies are thought to become "anchors" for the women and their families to stay in the United States. Yet a child born in the United States does not legally preclude the undocumented immigrant parent from being deported (Tebo 2007). In addition, while there are no reliable or exact numbers on how many pregnant women immigrate to the United States in order to give birth in hospital emergency rooms, circumstantial data suggest very few. Less than ten percent of undocumented and documented immigrants from Mexico who have been in the United States for less than ten years have used any emergency room service, as compared to twenty percent of native-born Americans (UCLA 2005). Moreover, the majority of undocumented families do not have children (Passel 2006). Nevertheless, major media outlets perpetuate the "anchor baby" myth and reinforce public fears of a health care system overtaxed by female immigrants. An April 7, 2008 CBS Evening News story was entitled "Illegal Immigrant Birth – At Your Expense. Taxpayers Foot Bill for Roughly 300,000 Children Born Into Citizenship When Their Parents Are Illegal." The subsequent story focuses on and uses the

pejorative "anchor babies," despite the fact that the 300,000 births are to all undocumented immigrant women, not merely those who came to the United States expressly to have a child. In addition, hospitals do not record citizenship status and so any 'data' about healthcare costs of noncitizens are personal inferences by administrators, at best.

Although pregnant female immigrants are considered a threat, the economic contributions of working immigrants are valued. As a result, policies that reference undocumented immigrants will either discourage use of public services, including health care, and/or provide incentives for immigrant work. For example, California's Proposition 187, passed in 1994, denied all health care, education, and public services to undocumented immigrants. Yet only months after Proposition 187 was passed, California governor Pete Wilson proposed a guest worker program that would encourage Mexicans to temporarily emigrate for wages (Chavez 2001).

Political and moral debates over reproductive rights and personhood further influence policy for publicly funded prenatal care. For example, in 2007, Texas expanded its State Children's Health Insurance Program, or SCHIP, to cover prenatal care for undocumented immigrant women. The moral and political logic behind the reform was that fetuses, by virtue of their deemed personhood, were citizens and thus deserving of benefits deriving from public support. With the SCHIP Perinatal program, prenatal care options theoretically increased for undocumented immigrant women, though prenatal care was still limited to clinical care, psychosocial intervention in crisis situations, and case management with other limited social services available to undocumented immigrants. SCHIP Perinatal was able to expand these Medicaid services to undocumented immigrants because of a PRWORA amendment that allows states to provide care for "unborn [citizen] children" of undocumented immigrants (Department of Health and Human Services 2002). While prenatal care obviously involves the health of the mother, the expansion explicitly excludes any other health care for the mother that is not recognized as having a benefit to the

“unborn child.” This amendment was very specifically designed *not* to address the health of the undocumented immigrant woman. To the contrary, the amendment was created to give health care, via prenatal care, to the “unborn children” of the women (Department of Health and Human Services 2002). Indeed, the use of the word “children” to refer to fetuses demonstrates a particular suite of cultural beliefs about the unborn, which, in turn, largely predetermines policy’s content and coverage.

The amendment’s reasoning highlights current national discourse about fetal and reproductive rights. Women’s rights activists have seen the unborn citizen justification as a slippery slope to reversing *Roe vs. Wade*, but they agree that all women deserve adequate prenatal care (Hennessy and Cliath 2004). Indeed, “the language and the writing of policy and research on policy function is a type of power. Often the primary aim of policy language is to persuade” (Agthorpe 1997:44). In an article looking at SCHIP Perinatal’s social consequences, Hennessy and Cliath note that by using “unborn children” as the key rationalization, SCHIP policymakers are also reproducing existing biases toward women:

Social policy provisions can reproduce gender inequality by considering women worthy of social benefits as conduits for children rather than deserving benefits in their own rights . . . the [SCHIP] rule change devalues women by creating a legal precedent for recognizing fetuses as separate physical and legal entities, with the potential to create an adversarial relationship between a woman and the fetus she carries (2004:1430-1).

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and Texas SCHIP make it evident that prenatal care policies for undocumented immigrants are not influenced by a singular concern to reduce health disparities and improve birth outcomes. They are embedded in hegemonic discourses that privilege citizens over undocumented immigrants and fetal health over child health and the health of adults. There has been no space allocated for hearing what the women themselves want or need in terms of prenatal care. There is an active

disinterest in providing optimal prenatal care that would include outreach to promote a stable psychosocial environment and provide material resources. It is thus no surprise that barriers to optimal prenatal care are so prevalent among undocumented immigrant women whose access to prenatal care is largely controlled by these federal and state statutory policies that reflect broader issues current in American debates over immigration and abortion.

Recommendations to Improve Existing Prenatal Care for Undocumented Immigrant Women: Reframing Policy Discussions and Operationalizing Optimal Prenatal Care

Well, you [need to] have the persistence to come back and show us the changes [that came from these interviews]. . . . This is the second time I’ve been asked these sorts of questions. The first time was thirteen years ago. When I had my little girl, a news channel came and asked questions. It’s been a long time, and I haven’t heard anything . . . at least, I know that other people are interested in changing things. - *Carmen, 35 years old, immigrant woman from Mexico City, Mexico.*

Either by misguided focus or a lack of funding, most publicly funded prenatal care programs fail to fully address specific barriers to care and ignore preferences for care among undocumented immigrant women, thereby making formal prenatal care more difficult to access. Clearly, in order to improve birth and maternal health outcomes for undocumented immigrant women, we need to reframe policy discussions and actual prenatal care delivery. Any health care justification argument supports reformulation. In a health outcomes argument, prenatal care reduces the risk of maternal mortality and morbidity and improves birth outcomes and future child health (Keily and Kogan 1994; Conway and Kutinova 2006). In a cost/benefit analysis, prenatal care as a means to identify pregnancy risk significantly reduces health care costs associated with complicated labor and delivery and preventable health conditions in infants. Elimination of prenatal care for undocumented immigrants in

California, for example, was shown to increase risks for low birth weight and prematurity and significantly increase overall healthcare costs incurred by the women and their babies (Lu et al. 2000). In a human rights argument, optimal prenatal care should be the right of every pregnant woman, regardless of income, citizenship, or any other culturally constructed classification (Rylko-Bauer and Farmer 2002).

The programmatic target of publicly supported health care policy should, at the outset, be healthy mothers and babies. Funding and program components should be designed to promote optimal prenatal care to any at-risk population living in the United States. At-risk should be defined by existing evidence-based research on birth outcomes. It has been demonstrated that poor, undocumented immigrant women are some of the most at-risk women in the country (Eldridge 2002; Sullivan and Rehm 2005; Derosé et al. 2007). Such basic recommendations also apply to poor and uninsured women facing similar barriers to care.

Recognizing women's preferences in health care policy can help to successfully operationalize optimal prenatal care (Institute of Medicine 2001; Novik 2004). In the case of the women I interviewed, their preferences for gendered prenatal care and material and social support through prenatal care providers complement existing prenatal care recommendations by biomedical and cross-cultural researchers studying pregnancy and birth outcomes (Fleuriet in press; ACOG 2008; IMBCO 2008; Davis-Floyd and Sargent 1997). Other basic interventions could help women exercise their preferences regarding prenatal care.

First, women need to have information about prenatal care options and related resources, such as Healthy Start and Women with Infants and Children. Prenatal health information needs to be accessible in the community, so that the knowledge diffuses and is shared with newcomers. An existing model is offered by the *promotora*, or community health worker, programs. Promotoras are community women who are trained in health and health care education; they meet regularly with individual women in the neighborhood, offer meetings about health and health care issues, and serve as

point-persons for outreach efforts by clinics.

Second, in addition to garnering knowledge about the U.S. health care system and public support policies, women need to have the means and autonomy to exercise their options and resources. For example, SCHIP Perinatal needs to be able to provide transportation to and from the women's homes. SCHIP enrollment and related administrative procedures also need to be more accessible. In 2008, a social worker at a South Texas clinic said the biggest problem they had with SCHIP is that local SCHIP office staff had intentionally been reduced to encourage internet applications. Women who live in neighborhoods that lack basic infrastructure are nevertheless expected to be able to access and navigate a U.S. bureaucratic internet site to apply for SCHIP Perinatal. This makes little sense, except as an active attempt to limit women's access to care.

Third, promotora programs should include ongoing community education about healthy pregnancies, childbirth, and children; different approaches to pregnancy and childbirth; and means of accessing resources to actualize healthy pregnancies and childbirth. For undocumented women, resources that outline and explain the U.S. health care system and rights of immigrants should also be available and accessible. Finally, the programs should build in a woman's right to exercise her preferences. The women I interviewed and pregnancy and birth researchers agree: women should be able to choose different prenatal care approaches, such as the standard biomedical model or a birthing center midwifery model (IMBCO 2008), which is based on the Centering Pregnancy philosophy⁷ (Novik 2004).

These recommendations highlight the contributions from the burgeoning field of anthropology of health and health care policy. Other anthropologists, such as Singer (2005), have used ethnography and cultural critique to diagnose the myriad health, sociopolitical, and moral outcomes of policy. These critiques arise from ethnographic research in policymaking institutions (e.g., Paluzzi 2004; Rabo 1997; Towghi 2004) as well as the communities that are impacted by policies (e.g., Fassin 2007; Davis-Floyd 2004). In both research settings, policy is treated as a particular form of sociocultural

process produced by national political and economic discourse and manifested within local communities of actors (Shore and Wright 1997). As such, elements of the policymaking process and implementation, such as prioritization of certain health and health care issues or certain populations, reflect social relations. For example, Singer (2005) uses the life history of a homeless drug addict in urban Connecticut to illustrate how drug treatment programs for the poor are under-funded in large part because of the stigmatized and relatively powerless social position of poor people suffering from addiction. In this context of unequal social relations, certain communities of actors, such as the poor and politically disenfranchised, are left out of the policy-making discussions altogether. By analyzing these social relations and the impact of policy in these communities, cultural critique of policy can occur, and new voices that highlight areas for policy improvement and modification can be heard. ○

RESPONDENTS	OB/GYN	CNM	P-VALUE
Acculturation Level			
Low	15.9% (10)	84.1% (53)	.000
Medium	51.4% (18)	48.6% (17)	
High	100.0% (1)	0.0% (0)	
Age			
18-22 years	21.4% (6)	78.6% (22)	.486
23-25 years	27.6% (8)	72.4% (21)	
26-30 years	25.8% (8)	74.2% (23)	
31-47 years	40.0% (10)	60.0% (15)	
Attitude Toward Medical Intervention During Low-Risk Pregnancy			
Never Necessary	0.0 (0)	100.0% (3)	.165
Sometimes necessary	30.6% (30)	69.4% (68)	
Always necessary	100.0% (1)	0.0 (0)	
Clinic			
Community, Public	25.0% (12)	75.05% (36)	.000
Community, Religious	6.3% (3)	93.8% (45)	
Private	100.0% (17)	0.0% (0)	
Education			
0-8th grade	16.7% (7)	83.3% (35)	.065
9th-12th grade	39.5% (17)	60.5% (26)	
College-Postgraduate	28.6% (8)	71.4% (20)	
Household Income			
<\$12,000/year	22.2% (16)	77.8% (56)	.161
\$12,001-\$20,000	38.1% (8)	61.9% (13)	
\$20,001 and above	40.0% (8)	60.0% (12)	
Number of Children			
0	11.1% (2)	88.9% (16)	.070
1	26.3% (10)	73.7% (28)	
2	25.0% (6)	75.0% (18)	
3 or more	45.2% (14)	54.8% (17)	
Parity			
1	10.5% (2)	89.5% (17)	.038
2-3	27.6% (16)	72.4% (42)	
4 or more	43.8% (14)	56.3% (18)	
Public Assistance for Prenatal Care			
Public Assistance	39.1% (18)	60.9% (28)	.079
No Public Assistance	23.3% (14)	76.7% (46)	

Table 1. Crosstabulations: Profile of Preference for OB/GYN or CNM Among Mexico-Born Respondents

Notes

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2. Jill Fleuriet holds a PhD in Anthropology from Stanford University. She is an Assistant Professor of Anthropology at the University of Texas at San Antonio. She can be reached at the Department of Anthropology, 1 UTSA Circle, San Antonio, Texas, 78249. She may also be reached by email at Jill.fleuriet@utsa.edu.

3. All names are pseudonyms.

4. I have opted to use "public support" instead of the word "welfare" to refer to any prenatal care that is federally or state funded. The term *welfare* has multiple valences, some of which are politically charged. Its ambiguity would detract from my argument, which is, in part, to highlight the political processes informing the public support. For critiques of recent reform on popularly labeled "welfare policies," I refer the reader to Wise et al. (1999) and Morgen and Maskovsky (2003).

5. Title V clinics are clinics that are funded through federal block grants that are administered by the Office of Maternal and Child Health.

6. Research was approved by the UTSA Institutional Review Board.

7. The CenteringPregnancy model promotes empowerment of the pregnant woman through peer group care, support, education and self-assessment. It has three primary components, all of which are manifested in group settings at the Catholic birthing center: clinical assessment, psychosocial assessment and support, and education.

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