Precarious motherhood

Maternal health/care and the state in Los Angeles, USA

Sigmund, K.R.

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Chapter 1

Introduction

"I'm sad…well, more than sad. I'm *preocupada* (worried) about the situation we're in…" a Salvadoran woman named Monica[1] told me as we discussed her legal and economic situation during the early months of the COVID-19 pandemic in 2020. I was in Los Angeles researching Central American asylum-seeking women's experiences of maternal healthcare and motherhood. My conversation with Monica was one of dozens I had with women from El Salvador, Guatemala and Honduras who shared their concerns over their legal status with me during my fieldwork between 2019-2021. Monica had temporary housing because her daughter was born in California and is a United States (U.S.) citizen, but she had no guarantee that she and her two older children would ever be granted asylum. Monica's *preocupación* (worry/fear) over her tenuous living situation was reflected in another conversation I had with Teresa, also from El Salvador, who felt that: "Our future isn't secure due to the uncertainty of our immigration status… we need to work, we need options to be able to provide for our families and pay the rent..."

In my fieldwork, asylum-seeking women commonly used the Spanish term "*preocupación*" as an idiom of distress (Briggs 1992, Nichter 2010, Yarris 2014) to discuss their fears about their lives as migrants in the U.S. Expressions like this are "socially and culturally resonant means of experiencing and expressing distress" that marginalized women use to voice their discontent in relation to political, economic, and social contexts in their lives (Nichter 2010:405). My informants also used *preocupacíon* to discuss their worries about COVID-19's impact on their ability to care for themselves and their children. As Karla, a Honduran woman, told me: "Well, I wouldn't know what to do. I always think about not getting sick for my kids. They would have no one to care for them...I become depressed or stressed by so much pressure." When discussing their fears about potential COVID-19 infection, the women I worked with linked their tangible fear of getting sick to a wider anxiety about potentially not being able to mother their children effectively: whether due to illness or the legal restrictions on their capacity to access care or earn a livable income– a product of their liminal legal position.

1 All names used in this doctoral thesis are pseudonyms.

Legal Liminality

In the U.S., Central American asylum-seekers inhabit a space of liminal legality, or the gray area between a documented and undocumented legal status, while they await the outcome of their asylum applications (Menjívar 2006). As liminally legal migrants, asylum-seekers are engaged in the legal process of seeking asylum through open court cases, but lack work permits, visas or safe places to live. Following anthropologist Victor Turner's analysis of liminality (Turner and Turner 1992), this places them "betwixt and between" recognition as asylees and receiving the rights and benefits that come with that status and being illegalized as undocumented migrants who must avoid federal recognition to remain in the United States (de Genova 2002, Menjívar 2006). In this doctoral thesis, I demonstrate how such liminal positionality often denies Central American asylum-seeking women the ability to legally support themselves or their families, engendering chronic feelings of insecurity and negatively impacting their health and the wellbeing of their children. This liminal space also leads to ambivalence between how local, state, and federal guidelines for reproductive healthcare and social services define asylum-seekers as either "deserving" or "undeserving" of care (Holmes et al. 2021, Menjívar 2006). Indeed, migrants can shift between states of deservingness depending on whether, and how, they are recognized as having a legitimate right to care by the State (Krause 2018). This ambivalence between varying State guidelines is dependent on multiple factors, such as asylum-seekers' country of origin, whether they have an open asylum application, and the citizenship status of their children (Menjívar 2006).

Throughout this doctoral thesis I use lowercase "state" to discuss situational contexts or the state of California. I use uppercase "State" to discuss power structures that set bureaucratic, legal, and behavioral regulations on people living within the U.S. Here, the "State" specifically refers to the overarching structures of governmentality and biopower (Foucault 2007) which regulate migrants' conduct through self-governance, cultural assimilation and expectations of "good citizenship" through both governmental and non-governmental programming and political rhetoric (de Koning, Jaffe and Koster 2015). And because the definition of terms such as "migrant," "undocumented immigrant," "asylum-

seeker," and "refugee" often overlap, I follow activist Harsha Walia and use "migrant" and "asylum-seeker" interchangeably (Walia 2021). The use of both terms is "not to conflate lived experiences or collapse material differences, but to refuse binaries of forced and voluntary, deserving and undeserving, real and bogus, and to depict irregular migration as an autonomous force defying and exceeding state characterizations and controls" (Walia 2021, 8). I use these two terms interchangeably because the women I worked with referred to themselves as "*inmigrantes*" (immigrants), never asylum-seekers, even though all were in the process of seeking asylum. However, as my opening vignette indicates, they also recognized that, as asylum-seekers without legal status, they were technically "undocumented" under U.S. immigration law.

Support for Latinx[2] migrants vacillates across communities and states in the U.S., even though the U.S. economy thrives off the labor that Latinx migrants provide (Escobar 2016) and industries such as agriculture depend on migrant labor (FWD.us 2022, Holmes 2013). California, where my research is based, is one of the largest asylee-receiving states in the U.S. (OHSS.dhs.gov 2024). In recent years, California has branded itself as a more progressive and welcoming place for migrants and asylum-seekers, offering more protections and benefits to undocumented and liminally legal migrants than other parts of the country (Jones Gast and Okamoto 2016, LACOIA 2021, Newsom 2021). For example, state law bans the police from cooperating with Immigration and Customs Enforcement (ICE) (Haas Institute 2016), and California driver's licenses are available to all state residents regardless of documentation status (Bray 2020). California's public health system Medi-Cal is available to any California resident from birth to age 26, age 49 and up, and all perinatal people[3] up to 60 days postpartum[4] (DPSS 2021). Additionally, California residents with U.S. citizen children can apply for financial, housing, and childcare support through state-funded support

2 A gender-neutral term used to refer to people of Latin American cultural or ethnic identity in the U.S. which encompasses migrants from Mexico, Central America and South America.

3 Following Medi-Cal's website, I use this more inclusive term to acknowledges the diverse identities of people who experience pregnancy and birth–women, men, and non-binary individuals (DHCS 2025b)

4 This reflects the situation during my fieldwork. In 2024 Medi-Cal expanded to include all ages (DHCS 2024).

programs such as CalWorks (Jones Gast and Okamoto 2016, Newsom 2021). As such, California enacts a modern liberalism in its goal to perpetuate social justice through its policies of inclusion and equity (Morgan 2012).

Los Angeles County (LAC), based in Southern California, has been the largest settlement area for Central American migrants and refugees in California in recent decades (MPI 2023). LAC has many migrant-friendly laws that fill gaps within the wider state health and service system to further increase access to health services and social services to undocumented migrants and asylum-seekers (LACOIA 2021). For example, My Health LA was a no-cost health care program funded by the county for all low-income residents (irrespective of documentation status) who were not eligible for Medi-Cal. Up until the Medi-Cal expansion of 2024, My Health LA filled the Medi-Cal service and eligibility gaps and provided free general health care, mental health care, medicine, and medical supplies (MHLA 2024).

Despite these seemingly progressive policies, public health research has shown that high levels of economic and social disparity still negatively impact health, birth outcomes, and early childhood development, especially for Latina and Black women and children in LAC (CDPH 2023b, First5LA 2020, LACDPH-OWH 2017). However, these studies utilize limited quantitative data which lacks the depth of insight that ethnographic research with an intersectional focus would allow by overlooking how multiple forms of disparity impact women's health and capacity to mother their children. Likewise, there is a dearth of ethnographic insight into the State's role in creating and maintaining these disparities for asylum-seekers. As anthropologists Lauren Wallace, Margaret MacDonald and Katerini Storeng (2022, 9) discuss, anthropological analysis of (health) policy and health systems is invaluable because ethnographic engagement allows the "important things happening in the spaces rendered invisible by medical and public health frameworks" to become visible–i.e. the impacts that health policies and systems have on marginalized populations. While on the surface California's policies appear to increase the likelihood that asylum-seeking families will be able to access services and care, it is not so simple. As I discuss in Chapter 3, navigating access and eligibility requirements for these services can be difficult

or nearly impossible for undocumented and asylum-seeking Central American women who may not understand their rights to care, often do not speak English, and lack both technology to access information and reliable transportation to reach medical and social services.

During my fieldwork in Los Angeles, I could see that the tension between the legal status of asylum-seeking women and the needs of their families appeared to increase their *preocupación*. This was visible as they attempted to navigate the asylum system and access the health care and social services that were available for themselves and their children. As I discuss in Chapters 2 and 3, for women who bring their children with them or bear children once they arrive in the U.S., life in the U.S. can be very challenging to manage–full of both bridges and barriers that somehow simultaneously facilitate and hinder access to various forms of care. Indeed, my informants' experiences of frustration, worry, uncertainty, stuckness, and performativity as "deserving" migrants significantly affected their daily lives and interactions.

Social scientists have discussed how health-related deservingness–i.e. what groups deserve access to services and what groups do not– for undocumented migrants greatly impacts their experiences with the healthcare system and their capacity to access care (Holmes 2021, Kline 2019, Krause 2018, Marrow 2012, Yoo 2008). However, the tension between a person legally deserving the opportunity to seek asylum while concurrently being undeserving of equal access to services, care, or support in the U.S. is under-researched (Duncan and Vasquez 2023). Particularly, the ways in which asylum-seekers are expected to perform their deservingness for asylum by exposing their vulnerabilities to the State (Coutin and Fortin 2021) while demonstrating their deservingness for the financial support and social services they are eligible for (Jones Gast and Okamoto 2016) is juxtaposed with the neoliberal social expectation that they will demonstrate their deservingness of social citizenship by being self-sufficient and not "taking advantage" of too many public services (Duncan and Vasquez 2023).

These tensions that lie between demonstrating deservingness and not coming across as too needy as a precarious asylum-seeker were made visible to

me through Beatriz, a Guatemalan asylum-seeker I had befriended at the Refugee Children Center in Los Angeles. On a warm and sunny day in early May 2020 she reached out to me to vent her frustrations. She had learned that some other asylum-seeking families had received financial support from the refugee center to pay their bills in the early months of the COVID-19 pandemic–financial support that she had not received. As I walked through my parents' quiet suburban neighborhood north of Los Angeles I listened as her anger, frustration, worry and pride tumbled out in a stream of fast Spanish through her voice messages:

> *I feel discriminated against. I am not one of those people who go around asking [for money], but I have needs just like the others, and it makes me feel bad that I am one of the people who was there [at the refugee center] without fail every time they needed me to be there and you know it.... And I am not stupid either, I know that if they receive donations it is because they have our data and our photos, and the donations are to help us all, not just the ones they appreciate the most. The situation is difficult for everyone…*

Beatriz felt that she had been performing her role as a deserving asylum-seeker well by showing up to events at the refugee center and allowing them to use her story and photos of her family in their fundraising campaigns. Likewise, she was demonstrating her deservingness as a good neoliberal subject by not "going around and asking for money." But now, the refugee center was not giving her the reciprocal support she felt she deserved for being a "good" asylum-seeker, support that could have helped her family during a difficult time.

She went on to talk about how concerned she was about her husband not being able to find stable work, about trying to pay the rent and their asylum lawyer's monthly retainer fee[5] and realizing that there wasn't enough money for food to feed her young son. I later found out that Beatriz had been unable to receive financial support because the refugee center's emergency fund had run

5 Fees paid by a client to secure the ongoing services of a lawyer (Jhean 2024).

out of money due to the high number of requests for support in the first two months of the pandemic. Still, Beatriz felt frustrated that she had not received the same support that other women had. Beatriz's experience encapsulates many of the sources of *preocupación* that I address in this doctoral thesis: her inability to care for her child in the manner she would like, her worries about their asylum case and their health during the COVID-19 pandemic, and the myriad ways their legal precarity marked them as (un)deserving of equal care or support. These were experiences and frustrations faced by all my informants as they attempted to access the care and services their families were eligible for.

Research Context

In this introduction and the four empirical chapters, I discuss how certain laws, programs, and events shaped the everyday realities for Central American migrant/asylum-seeking women in Los Angeles, U.S. from 2019-2021. The situation is somewhat different in 2025, as I elaborate on in the conclusion. Hearing testimonies of women in Beatriz's liminal position while in the field led me to question how various State systems were creating and deepening *preocupacíon* for Central American asylum-seeking mothers in Los Angeles, and how this was influencing their maternal health and mother work. In this doctoral thesis I use the term "mother work" as defined by feminist Philosopher Sara Ruddick (1989) to describe the holistic labor that mothers perform to provide for their children's basic needs while also nurturing and educating them on social norms. I could see in my interactions with the Central American asylum-seeking women I met that the U.S. immigration system caused a high level of worry in their everyday lives. Meanwhile, the protections and services legally available to them and their children in California, a purportedly progressive state, were not enough–local social and health-based programs were not effectively reaching this community. They were either inaccessible or not robust enough to counteract the legal and economic precarity these women faced, which directly impacted their capacity to care for their children.

Upon arrival to the United States, U.S. Customs and Border Protection detain migrants who lack the legal right to enter the country in detention

centers for anywhere from a few days to seven years (Alvarez 2023, ICE 2025, International Rescue Committee 2024). Those seeking asylum can apply while in immigration detention. If they are deemed to a) have a credible risk of return to their home country and b) deemed safe to release into the U.S. they are "released into the care" of a "sponsor"– a U.S. citizen or permanent resident who agrees to house and provide basic necessities for the asylum-seeker (SALDEF 2024). The U.S Government does not offer financial or housing assistance to asylum-seekers, instead, sponsors are expected to house asylum-seekers until they receive asylee status. If/when they receive asylee status, they become eligible for twelve months of federal financial aid through the Refugee Cash Assistance program that pays for food, shelter, and transportation (ACF 2022).

Immigration and asylum policies have been a near-constant point of contention in U.S. politics for decades (Quesada 2011, Roy 2025). Some states have expanded eligibility for asylum-seekers and undocumented migrants to access state-funded social and health services (USC Dornsife 2023). However, asylum outcomes and eligibility for federally funded health care and social benefits still fall under the purview of the United States federal government (USCIS 2024). For the past two decades, increasingly hostile, nationalist, xenophobic and racist policies propelled by extreme right-wing governance have fueled a backlash against racialized migrant groups such as Latin Americans and Arabs across the country (De Genova 2002, Garrett and Sementelli 2022, Sáenz and Douglas 2015, Torres 2018). Meanwhile, fears about imaginary migrant crime waves and rhetoric about undocumented migrants taking jobs and resources from American citizens have led to increasingly restrictive legislation that limits annual numbers of legal migrants, asylees and refugees (Shear and Kanno-Youngs 2019, Yates-Doerr 2019) and increasing Immigration and Customs Enforcement (ICE) raids to deport "illegal immigrants" (Bialik 2018).

From my previous work experience in public health in Los Angeles, I knew that there was a complicated tangle of entitlements[6] that guaranteed access to certain state benefits for certain groups, various criteria for service eligibility between groups, and siloing between social and health-based services in Los

6 Entitlements are the rights that people have to claim certain healthcare services or benefits.

Angeles County. These various entitlements and eligibilities depended on the governmental agencies funding each individual program, and the overarching goal of each program. This made it difficult for many service beneficiaries to navigate the web of county, state, and federal public health agencies and local non-governmental organizations in Los Angeles. This confusing system was even more complicated during the first Trump administration from 2017-2020. During this time, Trump purposefully underfunded the asylum system to slow down the asylum process (Terrio 2024), and put restrictive policies into place that limited how, when, and where asylum-seekers could make their case (American Immigration Council 2020, Shear and Kanno-Youngs 2019). Under federal regulations, undocumented migrants–a designation which includes asylum-seekers until they receive official refugee status–are not eligible to access the health insurance market or most federally-funded welfare and social service benefits (Healthcare.gov 2021, NILC 2024).

Anthropological and public health research has demonstrated the ways in which the Trump administrations' anti-migrant policies and federal regulations heavily impact migrants' understandings of their eligibility for care and increase fears that accessing social and health-based programs will lead to their capture by ICE or count against them as "public charge"[7], which could impact their chances to become documented migrants in the future (Ayón et al. 2018, Cornelius and Holmes 2020, Farfán-Santos 2019, Fleming et al. 2019, Gemmill et al. 2019, Parrott, Gonzalez and Schott 2018). In addition, multiple scholars have shown how anti-migrant rhetoric and policies have fueled targeted attacks by law enforcement officers on Latinx people in conservative states such as Arizona, Alabama, and Georgia (Ayón, Valencia-Garcia and Kim 2017, Conley 2015, Lanari 2023). Public policy research by Cecilia Ayón and San Juanita Garcia (2019) notes how this discrimination directly impacts Latina's capacity to care for their children: the constant threat of deportation and lack of resources increases parenting stress, lowers parental monitoring of children's behaviors and actions, and limits parents' capacity to positively connect with their children.

7 The term used for public benefits that non-citizens are unable to use if they wish to receive U.S. residency or citizenship in the future (Children's Bureau 2023).

However, limited research has focused on *asylum-seeking mothers'* experiences of motherhood and mother work (see Bianco 2019), and there is a dearth of information on the ways in which federal policies impact migrant life and motherhood in *progressive* states like California (see Menjívar 1999). With ongoing tensions between California's expansion of access to health and social services for all state residents versus federal efforts to curtail access to reproductive health care for all women, in-state policies often conflict with federal mandates and cause confusion about migrants' eligibility for care and services (Gomez and O'Leary 2019). In this context, I needed to better understand how asylum-seekers were experiencing the process of accessing health and social services, and how various service providers viewed and interacted with asylum-seeking women.

As I learned, the tension between federal punitive efforts and state-led support systems created a palpable strain for those working in public health, social services, and health care as well. They often had to negotiate the different allowances and requirements for service allocation for their undocumented or asylum-seeking clients based on different and changing federal, state and local laws. For example, federal laws blocked access to nutrition services for asylum-seekers (including asylum-seeking children), yet asylum-seekers with U.S. citizen children could access nutrition services (CDPH 2023a). As Libby, a Home Visitation service provider shared:

> *I was working with one woman, her husband had his hours cut at work due to COVID, and they had a lack of income. She is undocumented and she declined to get SNAP [food stamps] even though it was for her son, who is a U.S. citizen and therefore eligible, because [she worried] about it possibly counting against her as public charge. Even though it wouldn't count against her…we have received training to talk to our patients about these things and what they are eligible for, but I don't want to tell them something that could easily change depending on new regulations. So I told her about some local*

> *food banks and referred her to the medical-legal partnership we have through [our organization] to address her public charge concerns. She still said no to getting SNAP... because of her fear of public charge…she prefers the food bank because she doesn't want to do anything where the government can access her information, like they could if she applied for SNAP for her son*

While situations like this were frustrating for social service staff, I also came to see that the larger impact of these tensions, contradicting regulations and shifting policies fell on the daily reproductive lives of asylum-seeking women who were concurrently managing service access alongside their status as gendered, racialized[8] asylum-seekers in America. Additionally, the COVID-19 pandemic in 2020 further impacted women's capacities to care for themselves and their children when service provision and everyday life upended.

When the pandemic began, the initial response in California was to temporarily shut down non-essential businesses, keep people at home to limit risk of infection, and discourage people from socializing or performing "non-essential" activities outside the home (Davis 2020). This mandate was almost impossible to follow for marginalized groups like asylum-seekers who have precarious employment and who often live in shared living quarters with other families due to the scarcity of affordable housing and lack of landlords willing to rent to "undocumented" migrants in Los Angeles. Many undocumented Latinx migrants in the U.S. work in jobs that were deemed "essential" during the pandemic, yet they also had little to no job protection, health insurance, or access to stimulus payments or rent freezes (Duncan and Vasquez 2023, USC Dornsife 2023). Likewise, they had higher rates of exposure to COVID-19 due to work and living conditions (Piedra et al. 2022, USC Dornsife 2023). As of 2023, Latinx people were 1.5 times more likely to contract COVID than non-Latinx white

8 Racialization is the process of attaching negative socio-cultural meanings and attributes to different racial groups. Subsequently, these negative meanings/attributes are used to enact and reproduce racism and reinforce marginalization of racialized groups (Gonzalez-Sobrino and Goss 2019).

people in the U.S., 1.8 times more likely to be hospitalized and 1.7 times as likely to die from the virus (CDC 2023, Duncan and Vasquez 2023). More specifically, 46% of pregnant women in the U.S. diagnosed with COVID-19 in the first six months of the pandemic were Latina (Ellington et al. 2020).

Concurrently, federal mandates to try and contain the spread of the virus intersected with ongoing racist attacks against Central American asylum-seekers by President Trump, who used the pandemic as a state of exception (see Chapter 3) to pass executive orders that separated children from their parents when they crossed the border, closed down the southern U.S. border to all migrants, put new policies in place to force asylum-seekers to remain in Mexico until their court date (often months or years in the future), and increased power to Customs and Border Patrol to detain and expel migrants (Crandall-Hollick 2020, Garrett and Sementelli 2022). This, combined with the general fear of infection and death that the pandemic wrought on the world created a situation in which the asylum-seekers I worked with found themselves precariously placed in terms of lacking a sure path to asylum, losing income and lacking a social safety net. They also feared the health and financial toll of a potential COVID infection alongside their aforementioned fear of deportation. Overall, it became clear through the management of the pandemic just how easy it is for the rights of racialized asylum-seekers to be ignored or denied in the U.S.– regardless of their constitutionally-protected right to seek safety (Refugee Act s.643 1980).

It was within this milieu that I began to see how reproductive governance (Morgan and Roberts 2012), state surveillance of poor women (Bridges 2017), structural violence (Farmer 2004) and systemic racism (Bailey et al. 2017, Liverpool 2024) within the healthcare system, social services and asylum system intersect to create and maintain a high level of precarity in the lives of Central American asylum-seeking women. As I will demonstrate throughout the chapters of this doctoral thesis, State-induced precarity can be understood as a form of reproductive violence that directly inhibits asylum-seeking women's capacity for reproductive autonomy, subsequently limiting the advancement of reproductive justice in the United States of America[9].

9 Further discussion of State-induced precarity, reproductive violence, reproductive autonomy and justice come below in the theoretical section.

Research Questions

To explore the various ways in which State-induced precarity limits reproductive autonomy and rights for Central American asylum-seeking women in Los Angeles, I explore various aspects of the socio-political and health-based environment in Los Angeles. Through the four empirical chapters of this doctoral thesis I aim to address the following questions:

1. How does the precarity experienced by Central American asylum-seeking women impact their mother work?

2. How does infrastructural violence create barriers to healthcare and social service accessibility, subsequently increasing asylum-seeker precarity?

3. How is precarity understood and managed through public health initiatives such as Home Visitation programs in the U.S.?

4. How do various maternal healthcare practitioners (e.g. Labor and Delivery Nurses and Community-Based Doulas) respond to precarity in their patients/clients lives?

In the following sections, I first introduce three concepts that aid the reader in understanding the central problem of my doctoral thesis: how precarity, intersectionality and reproductive injustice impact the maternal health and mother work of asylum-seeking mothers. Following that, I discuss the key theoretical concepts that illuminate the manifold processes that engender precarity for Central American asylum-seeking women and discuss how my research engages with these theories. Lastly, I turn to a discussion of my methods and ethical considerations, ending with a short introduction into each of my four chapters.

The Challenges of Migrant Motherhood

Precarity

Migrant motherhood is a well-researched area throughout the U.S. and Europe, particularly regarding how racialized migrant mothers navigate social and healthcare systems while raising children in a new country (Benchekroun 2023, Chakkour and de Koning 2022, Escobar 2016, Farfán-Santos 2019, Gálvez 2019, Johansen 2022, de Koning and Ruijtenberg 2019, Suerbaum 2022). This research highlights the increased legal, social, and economic barriers racialized migrant mothers face when accessing health and social services while also parenting under restrictive state policies. In this doctoral thesis, I will elucidate how such barriers increase Central American asylum-seeking women's precarity. As scholars Catherine Ramiréz et al. (2021, 2) explain, precarity is "more than a condition or status, [it] refers to an existence defined by vulnerability, unpredictability, and insecurity, be it in the realm of work, housing, health, or other aspects of life…" In this context, it can be hard to separate the concept of vulnerability from that of precarity. Indeed, in many works these terms are used interchangeably or used together to define the collective impacts that unstable or insecure situations–whether inevitable (i.e. childhood, aging) or state-induced (i.e. legal status, capacity to work, uneven access to resources) have on the everyday realities of marginalized groups (Butler 2009, Lopez et al. 2018, Oliviero 2018).

In this doctoral thesis I adopt the frameworks proposed by scholar Katie Oliviero (2018) and Ramírez et al. (2021), which distinguish vulnerability and precarity as related but analytically separate conditions shaped by differential access to power, recognition, and care. Vulnerability, as Oliviero (2018) points out, is a fundamental aspect of human life– something all individuals encounter at various moments. Nonetheless, mechanisms of structural violence that oppress certain groups through ideology and policy significantly shape who is situated in conditions of heightened vulnerability, and therefore experiences deeper precarity, within the society (Farmer 2004, Oliviero 2018). In this way,

precarity functions as a "politically induced condition" (Butler 2009, 25) in which capitalist neoliberal states normalize political and social insecurity among social groups whose lives are the least valuable (Butler 2009, Lorey 2015) by affording less social value to those with irregular migration status, chronic illness, old age, or physical/mental disabilities. This valuation is directly visible in State policies that control who belongs, who can work, and whose human capital is valued (Lopez et al. 2018, Oliviero 2018).

While at times State recognition of vulnerability can lead to eligibility for support services, being recognized as vulnerable in the U.S. as a liminally legal migrant can intensify precaritization in multiple ways. As I discuss in Chapter 4, precarious migrant women of color are more likely to be offered places in Home Visitation Programs. However, by joining they face a higher risk of interference by Child Protective Services into their parenting practices. As Oliviero states (2018, 15), "governmental responses to precariousness often deepen processes of surveillance and marginalization, sharpening the instability of some groups like migrants, queers, and women, in the name of redressing the vulnerabilities of another— the national citizenry, heterosexuals, or fetuses." This has the effect of both minimizing their perceived health needs in accordance with the State's notions of deservingness and reiterating their racialized positionality as they interact with health care and social service providers (Bridges 2011, Gálvez 2011).

In the following chapters I further elucidate the nature of precarity and its underpinning processes. In so doing, I build upon existing research on migrant motherhood and expand the existing literature on Latina reproduction in the U.S. Most pre-existing research in this area focuses on the wider "Latina community" (Abrego and Menjívar 2011, Chavez 2013, Escobar 2016), the "undocumented Mexican community," the largest undocumented migrant group in the U.S. (Gálvez 2011, Farfán-Santos 2019, Luibhéid et al. 2018), or on smaller case studies in states with more restrictive migrant policies (Ayón and Garcia 2019, Gómez Cervantes and Menjívar 2020). A growing field of research has detailed the experiences of asylum-seekers at the U.S.-Mexico border (Kocher 2023, Ramage et al. 2023, Vergara 2021) and the dynamics of

gender inequalities experienced by Central American women in their home countries (Pardilla 2016), on the migration route (Wilson et al. 2024) and in the U.S. (Menjívar 1999, Wilson et al. 2024). However, asylum-seeking women in general are greatly under-researched in the United States. In social science research they are often generalized as undocumented migrants (Abrego and Menjívar 2011, Torres 2018), and since they do not neatly fit into any legal categorization, they also face increased vulnerability and marginalization due to "everyday forms of restriction" that generally exclude asylum seekers from legal protection in the U.S. (Abji and Larios 2021, Abrego and Menjívar 2011, Torres 2018:16).

Therefore, in this doctoral thesis I focus on Central American asylum-seeking women in Los Angeles, California and examine their experiences as a particularly liminal group (legally and in national sentiment of deservingness) who face similar exclusions and fears as undocumented migrants. The experiences of the women I worked with offer an excellent opportunity to reflect on the intersectional impacts of politics, policy, and violence on maternal health and motherhood in a seemingly more friendly migrant-receiving state. Through this, I call into question the logics of hostile immigration bureaucracy and the pitfalls of modern liberalism that together limit asylum-seekers' reproductive autonomy through ever-increasing states of intersectional precarity.

Intersectionality

To better conceptualize the detrimental effect that multiple sources of precarity can have on maternal health and mother work, an intersectional framework is crucial. Feminist social scientists have described the complex systemic conditions that build upon each other to produce and maintain inequality for marginalized lives as an outcome of "intersectionality" (Bastia et al. 2023, Crenshaw, 1991, Mullings and Schulz 2006). Following Ayon et al. (2018) in discussing intersecting forms of oppression that Latina migrants experience in the USA, it is necessary to acknowledge that the racialization of non-white women and migrants in the U.S. has historically intersected with the stigmatization of welfare beneficiaries (de Genova 2002, Chavez 2013, Quesada

2011, Ross and Solinger 2017) and ongoing gendered expectations that Latina women bear responsibility for their children's health and development (Vesely Letiecq and Goodman 2019). This stigmatization has fueled fears of Latina hyper-fertility and reproduction rates through the Latino threat narrative (Chavez 2013) and the belief that Latinas are "reproducers of criminality" (Escobar 2016, 5). Both notions have contributed to the vilification of Latina migrants and mothers in U.S. media and political discourse, especially those who are undocumented (Briggs 2017, Gálvez 2011). Together, this rhetoric reinforces criminalization (Abrego and Villalpando 2021) and illegalization (de Genova 2002) of Latinx people by perpetuating the perception that Latinx migrants pose a threat to American culture and society. This, in turn, intensifies the policing of Latinx communities by local law enforcement and ICE (Escobar 2016, Gilmore 2007).

As Journalist Layal Liverpool (2024, 6) observed, "racism is bad for our health and its harms can be particularly acute for people with multiple, intersecting marginalised identities." Following that perspective, in my chapters I discuss how the multiple State-induced precarities that are born out of racialization and stigmatizing discourses do more than increase the barriers to services or fair representation for Central American asylum-seekers. Using ethnographic data gathered from Central American asylum-seeking women and service providers who interact with them, I demonstrate how intersecting forms of precarity have made life unlivable for Central American asylum-seeking migrants in Los Angeles by directly impacting their capacity to move through social, legal and health-based systems to access care for themselves and their children. I illuminate how the multiple precarious states they inhabit link back to specific forms of structural racism, legal violence, and implicit biases women experience when they interact with various professionals and gatekeepers of care. Through this, I demonstrate how various forms of State and non-State support, far from decreasing precarity for racialized, marginalized women, make life more difficult for the women who rely on these resources by being inaccessible or by increasing State surveillance into their lives. I further demonstrate how the intersecting precarities in their lives limit their capacity to control their reproductive lives and how they parent their children in the United States.

Reproductive (In)Justice

As activist Loretta Ross and historian Rickie Solinger (2017, 169) define it "reproductive justice focuses on three basic tenets: the human right to not have a child, the human right to have a child, and the human right to parent children in safe and healthy environments." These principles originate from the original SisterSong statement on reproductive justice, which asserts: "Every woman has the human right to parent the children she already has with the necessary social supports in safe environments and healthy communities, and without fear of violence from individuals or the government" (SisterSong, ND). Developed out of dissatisfaction with human rights discourse in the 20th century that centered white women and their reproductive concerns, a reproductive justice framework functions to recognize the oppressive structures and power imbalances that impede people of color from freely choosing when, and how, to become parents or how to parent their children (Luna 2020, Ross 2006, Ross and Solinger 2017). As such, work to advance the cause of reproductive justice is intersectional by design, critiquing the "intersectional oppression matrix" of gender, race, and class that hinder women of color from accessing safe and reliable health care (Ross et al. 2001).

In Luna's book examining the activism work that SisterSong Collective and other reproductive justice organizations have done to bring reproductive rights into the human rights arena in the U.S., the link between the intersectional oppression matrix and immigration status is clear (Luna 2020). However, Luna also notes that parenting has not been a major focus in reproductive rights activism. This dearth of focus on parenting is echoed in reproductive justice literature, which often focuses on birth and perinatal care (Bridges 2011, Davis 2019a, Galvéz 2011, Oluoch-Aridi et al. 2022, van der Waal 2025) or abortion access (Torres 2023, West 2009). In addition, reproductive justice literature does not often advocate for Latina asylum-seeking women's right to parent their children without State interference. Instead, existing work focuses on the intersection of reproductive oppression and necropolitics at the U.S.-Mexico border (Center for Reproductive Rights 2020, Heffernan 2023, Messing et al. 2020, Vergara 2021), and to a lesser extent on the policing of undocumented Latina's reproduction inside the country (Vera-Rosas 2014, Zavella 2016). In the U.S., reproductive justice advocates call on the State to

fulfil its obligation to provide safe and non-coerced conditions for all women to decide whether, how and when they will reproduce. This includes removing policies of unnecessary interference into reproduction at all life stages (Ross and Solinger 2017, 169, Zavella 2016). However, reproductive *injustice* (Davis 2019a) is more often the reality, marked by racist rhetorics of deservingness, moral judgements about mothers' capacity to parent well, and a denial of access to safe and equitable care–all of which degrade the reproductive work and dignity of women of color and lead to worse perinatal outcomes (Bridges 2017, Davis 2019a, Sufrin 2017).

In this doctoral thesis I draw on the concepts of intersectionality and reproductive justice together to examine how legal, economic and health precarity can inhibit reproductive autonomy for asylum-seeking women of color. These intersecting forms of marginalization deny equitable access to care and services, directly constraining the range of choices available for reproductive health and parenting decisions. As subsequent chapters will show, the denial of respectful care and parenting support for Central American asylum-seeking women stems from their legal status, their gender, the color of their skin, and their economic position. These are precisely the attributes the State flags as targets for governance and surveillance– practices that severely restrict the possibility of a safe, healthy and dignified reproductive experience. Through this analysis, I highlight how the intersection of various socio-political forces that govern reproductive life obstructs the realization of reproductive justice in the United States. In the next section, I outline the anthropological concepts I use to analyze the causes and consequences of precarity for maternal health and mother work among asylum-seeking women.

Understanding Migrant Motherhood and Precarity: Conceptualizing Processes of Violence

As defined by medical anthropologist Paul Farmer (2004, 17), structural violence refers to the "social web of exploitation" through which systems of power act to maintain political and economic dominance by oppressing certain socio-economic and racial groups via policies, institutions, and ideologies that

unevenly value human lives. Across the four chapters of this doctoral thesis, I show that structural violence–and the structural racism that sustains it–manifests in three key domains: legal violence, infrastructural violence, and reproductive governance. Each of these processes constrains the reproductive autonomy of Central American asylum-seeking women in the United States.

Legal Violence

In Chapter 2, "COVID-19 and Decreased Asylum Access: Mother Work, Precarity and *Preocupación* Among Central American Asylum-Seekers in Los Angeles," I analyze how legal violence and structural racism intersect. This chapter establishes the groundwork for subsequent chapters by examining how the COVID-19 pandemic and intensifying U.S. legal restrictions on asylum-seekers (2019-2021) together deepened social, economic and legal precarity in the lives of Central American asylum-seeking mothers in Los Angeles. These conditions profoundly affected their mother work and heightened their *preocupación*.

Legal violence is embedded in U.S. immigration law, which disproportionately harms Latinas specifically through exclusionary policies, criminalization and bureaucratic inefficiency that produce "harmful effects…that can potentially obstruct and derail immigrants' paths of incorporation" (Menjivar and Abrego 2012, 1383, Price 2012). The legal liminality experienced by asylum-seekers while they wait for a decision on their asylum application is a salient example. During this time, they remain vulnerable to deportation and scrutiny by Immigration and Customs Enforcement (ICE), often without full legal protection (Menjívar and Abrego 2012).

Further, asylum-seekers are excluded from comprehensive healthcare, nutrition and cash assistance programs unless they are pregnant or have an "eligible child" (CDPH 2023a, CDSS ND, DPSS 2021). For mothers, whose gendered roles responsibilize them to be their children's primary caregiver (Menjívar 1999, Schmidt and Buechler 2017), this makes it very difficult to care for their families while awaiting a legal status that would allow them access to more social services. During the COVID-19 pandemic, this marginalization intensified as undocumented migrants and asylum-seekers were denied access

to federal relief payments (Crandall-Hollick 2020, Duncan and Vasquez 2023). Legal violence, in this sense, produces a "hostile environment" where structural constraints on daily life undermine the physical health of mothers and children alike (Benchekroun 2023). As I explore in Chapter 2, legal violence fosters a pervasive culture of fear that deters liminally legal migrant mothers from accessing essential services and even leaving their homes, thereby compounding their health precarity.

Entwined with legal violence is the structural racism that particularly marks people of color–especially racialized migrants–as undeserving of state support or protection. Structural racism refers to the combined effects of racial discrimination across social institutions–such as education, health care, housing, employment, social services, media, and criminal justice–that together "reinforce discriminatory beliefs, values, and distribution of resources" against racialized groups that live within a society (Bailey et al. 2017, 1453). In the United States, structural racism is evident in the deeply entrenched logics that privilege the health and socio-economic success of white citizens while systematically disadvantaging communities of color (Liverpool 2024). Examples of this include closing of maternity wards in hospitals that predominantly serve people of color (Liverpool 2024), the limited funding for schools, community centers and clinics in areas inhabited by communities of color (Bloch and Philips 2022, Egede et al. 2023, Gilmore 2007, Pastor and Segura 2020, Saito 2022), and the blame white Americans place on immigrants for their diminishing quality of life (Poblete 2021). The first Trump administration's immigration policies, which disproportionally targeted migrants from "undesirable" countries, further illustrate the racialized logic embedded in State governance (Garrett and Sementelli 2022, Torres 2018).

In Chapter 2 I examine how legal violence and structural racism shape the intersectional, State-induced precarity experienced by Central American asylum-seeking women–which I refer to as legal precarity. To explore these dynamics, I utilize the analytic of *preocupación* to trace women's concerns, worries, and fears as they navigated multiple precarities while mothering their children. Through this analytic, I expand our understanding of the impact that legal violence has on asylum-seeking women. In doing so, I demonstrate how racial and legal barriers

to care exacerbate precarity and undermine the reproductive autonomy and everyday mother work of asylum-seeking mothers in the United States.

Infrastructural Violence, Mobility and Navigation

The hostile environment produced by State policies that target racialized migrant groups is also enacted through infrastructural violence–defined as the "processes of marginalization, abjection and disconnection [that] often become operational and sustainable in contemporary cities through infrastructure" (Rodgers and O'Neill 2012, 401). Infrastructure is one of the key mechanisms through which the State regulates access to health-based services for marginalized women (McIlwaine and Evans 2023). As I demonstrate in Chapter 3, "'I have nowhere to go': Asylum-seeking Mothers' (Im)mobility in Los Angeles," infrastructural accessibility is central to these women's mother work– not just in terms of physical access to perinatal care, but also in relation to bureaucratic regulations around service eligibility. These bureaucratic and physical barriers often bar precarious groups such as asylum-seekers from accessing health-based services, even when they technically qualify for those services.

In this chapter I follow Karla, a Honduran asylum-seeking mother, as she attempts to access health-based resources for herself and her children. To analyze her experience, I draw on the concept of (im)mobility to consider how asylum-seeking mothers are both constantly in motion and simultaneously held in place as they attempt to access care. Their movement through, around, and toward social and health-based services entails a level of what anthropologist Henrik Vigh calls "social navigation" (2006, 2009)–practices shaped by social forces that "push and pull" individuals through constraining and enabling environments (Vigh 2009, 432). Similarly, anthropologist Erika van der Sijpt (2014) has shown how reproductive navigation is shaped by the constraints and possibilities surrounding women's reproductive decision-making. In her work, reproductive decisions are constantly negotiated within a web of social expectations and obligations–such as those involving partners, family members, or in-laws–and it is both the woman's physical body and the social context that can both enable and constrain reproduction.

While this is a useful general framework, I find that the concept of being "stuck in motion" (Castañeda 2018) better captures the interrupted, uneven mobility that characterizes the experience of Central American asylum-seeking women. Anthropologist Tina Harris (2013) has noted how tensions between mobility and fixity constantly lead everyday people in Tibet to alter their pathways in order to overcome physical and bureaucratic barriers that the State enacts in the name of stability or security. However, I found that for women in the U.S. who experience multiple precarities limiting their capacity to move through physical and bureaucratic spaces, new pathways prove difficult to discover. Faced with multiple forms of precarity and intersecting barriers, these women are often unable to make reproductive decisions and access essential care. In such contexts, the social and relational dimensions of reproductive navigation fade into the background, overshadowed by the immediate impact of structural obstacles on their capacity to act. Here, migrant reproductive (im)mobility (Sheller 2020) is revealed through these continual stoppages and delays that restrict or completely hinder asylum-seeking women's access to care and resources for themselves and their children. While moments of forward movement do occur– often shaped by temporary openings in legal, social or health systems– these are outweighed by the persistent effects of anti-immigrant policies, racialized exclusion, and gendered gatekeeping. These forces create enduring "patterns of unequal mobility and immobility" (Sheller 2018, 14) that block asylum-seeking women from overcoming the infrastructural barriers to care.

As I demonstrate through Karla's story in Chapter 3, various barriers to care can be understood through an analysis of (im)mobility, which reveals how both passive (unintentional) and active (intentional) infrastructural violence (McIlwaine and Evans 2023) constrain movement and access. Together, these forms of infrastructural violence control reproduction and parenting practices for marginalized groups such as asylum-seekers by inhibiting both their capacity to move safely through, or remain within, hostile environments (Sheller 2018), thereby limiting access to care for themselves and their children. This constrained mobility increases both economic and health-related precarity, eventually pushing many asylum-seekers to self-deport. As Liverpool writes, "It's

not our identities impacting our ability to access care, it's the system's inability to recognize and understand and incorporate our needs" (2024, 70). This underscores how infrastructural barriers are not accidental, but structurally produced and distributed. In Chapter 3, I build on this insight to examine how barriers to mobility justice and reproductive justice intersect in the lives of asylum-seeking mothers.

Reproductive Governance and Surveillance

Chapter 4, "Home Visitation Programs, Risk, and Precarious Motherhood in Los Angeles," uses the concept of reproductive governance to elucidate how State entities–e.g. the immigration system, public health system, law enforcement entities and non-governmental organizations–control the sexual and reproductive behaviors of certain groups through "legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements" (Morgan and Roberts 2012: 243). In this chapter, I examine how State power over reproduction operates through what Foucault (2007) terms governmentality–the management of populations by codifying norms around reproduction and citizenship. I focus on how Home Visitation Programs (HVPs) enact this logic by identifying "at-risk" mothers and teaching them "good" mothering behaviors and neoliberal self-reliance.

As historian Rickie Solinger (2005) notes, reproductive politics have long tried to solve perceived social, economic, political and moral problems through top-down policies and media-driven public notions around who should reproduce, who should not, and who has the right to make such decisions. The U.S. has a long history of tying reproductive value to those whose reproduction is deemed beneficial to the nation–predominately white, middle-to-upper-class Christian American citizens; while devaluing the reproduction of everyone else, albeit to different degrees depending on how they are raced, classed and viewed in wider society (Colen 1995, Davis 2019a, 2023, Ross and Solinger 2017, Solinger 2005). Black and Latina women are discouraged from reproducing through tactics of cultural shaming of the Black "welfare Queen" (Ross and Solinger 2017) or Latina "high fertility" (Chavez 2004). This discouragement often targets poor women

and migrants and includes aggressive pushing of birth control and sterilization for women of color when they give birth or seek perinatal health care (Bridges 2011, Davis 2019a,b, Mullings 2022). These are clear examples of stratified reproduction, in which the State values and incentivizes the reproductive labor of some social and racial groups while reproduction among other groups is devalued and disincentivized (Colen 1995, de Kok 2023).

For the past century the U.S. government has passed and expanded programs like Home Visitation that work toward implementing both a standardized "American" method of parenting, and a moralistic expectation of self-sufficiency for the people who rely on welfare support (Ross and Solinger 2017). These forms of welfare care explicitly target socio-economic and ethnic groups that the State deems outside the national "norm" (de Koning et al. 2024). Because State actors are deeply invested in children's futures, these welfare programs often blur the line between care and control–embedding punitive governance and surveillance practices within ostensibly supportive interventions (de Koning et al. 2024, Bridges 2017). As I demonstrate in Chapter 4, the "at-risk" designation assigned by HVPs attempts to hold accountable and blame women for their own structural vulnerabilities (see de Kok 2019), without addressing the intersectional precarities shaping their clients' daily lives. This weakens the effectiveness of Home Visitation Programs' resilience-building goals.

I argue that the focus on individual "risk" obscures systemic causes–like poverty and immigration status–and absolves the State of accountability for the precaritization of racialized migrant women. Reproductive governance here operates through what anthropologists Lynn Morgan and Elizabeth Roberts (2012) call moral regimes of reproduction, where the State assigns different values to reproductive behaviors depending on a woman's class, race, and compliance with normative standards. As others have shown (Andaya 2023, Bridges 2017, Galvez 2011, de Kok 2023, 14), factors like family size, marital status, and income become grounds for scrutiny and regulation. Legal scholar Michele Goodwin (2020) and anthropologist Khiara Bridges (2017) have documented how poor, racialized women become subject to more invasive questioning precisely because they are unable to pay for private care. Programs such as HVPs (First5LA

2018, DPSS), community mental health programs (DHSLAC 2025), and nutrition support like WIC (CDPH 2023a) all require sustained monitoring of clients' financial, medical, and behavioral compliance to maintain eligibility. These practices–what anthropologists Richard Powis and Adrienne Strong (2025) call "surveillance-care"– manifest through regular check-ups, drug tests, home visits before a child can leave the hospital, evaluations of mental health and nutritional knowledge, and mandatory health reporting (Bridges 2011, 2017, Goodwin 2020).

Although many women appreciate the support that HVPs offer, there is a dearth of anthropological data on whether such parenting programs genuinely improve parenting practices or instead intensify precarity through surveillance. This is particularly true for asylum-seeking women, whose experiences remain under-examined in studies of reproductive governance. This chapter aligns with Colen (1995) and other anthropologists' (see e.g. Faye Ginsburg and Rayna Rapp 1995) discussions of stratified reproduction and expands their work by highlighting how punitive migration policies intersect with the parenting interventions experienced by Central American migrant/asylum-seeking women. I also add to work on ambivalence in reproductive health programs (Wallace, MacDonald and Storeng 2022, Unnithan 2022) by tracing the contradictions in Home Visitation programs that offer both social and financial support while simultaneously increasing their clients' risk of surveillance. As I argue, it is this tension between moral oversight, surveillance and neoliberal self-reliance that limits Home Visitation Programs' effectiveness in supporting marginalized mothers in Los Angeles County, with profound implications for their privacy and reproductive autonomy.

Reproductive (In)justice, the White Medical Gaze and Transformative Agency

Chapter 5, "Caring for Women of Color: Community-based Doulas' Strategies in Hospital Birth," begins by exploring the limitations biomedical practitioners face in acknowledging or mitigating the specific precarities faced by women of color. Building on Foucault's concept of the medical gaze (Foucault 2003), anthropological work has critiqued the detrimental shortcomings of clinical

biomedical training to recognize the complex impacts of socio-economic determinants of health, especially for marginalized populations (Holmes 2012, Metzl and Hansen 2014). Despite critiques of biomedicine that have led to policy shifts such as patient-centered care (Becker et al. 2014) and greater attention to the social determinants of health (Cooper, Saha and van Ryn 2022), biomedical practitioners still largely practice within the confines of the scientific medical gaze that isolates the disease from the people experiencing it (Greenhalgh 2001). As anthropologist Seth Holmes notes (2012, 879), the medical gaze is especially detrimental when directed towards undocumented Latino migrants, whose suffering is frequently attributed to individual behavior rather than structural inequality.

Extending this research to include racial blind spots, in Chapter 5 I argue that non-racialized biomedical practitioners often view patients through a racialized filter – a "white medical gaze" – that obscures the socio-economic, legal, and gendered conditions shaping women of color's health. This gaze contributes to harmful patterns of medical racism (Davis 2019b), including misdiagnosis, mistreatment, and ineffective interventions. These patterns are often underwritten by outdated stereotypes that cast migrant or minority patients as lacking the knowledge or capacity to care for their own health, reinforcing stigmatizing healthcare policies (Helberg-Proctor et al. 2017, Liverpool 2024, Vedam et al. 2019). This racially charged mistreatment within obstetric care, which anthropologist Dána-Ain Davis terms obstetric racism (Davis 2019b), manifests in violent acts and dehumanizing encounters: forced procedures, denial of care, invasive or aggressive treatment, and verbal abuse (Davis 2019b, van der Waal, Helberg-Proctor and Goodarzi 2025).

For Central American migrants in particular, obstetric racism is fueled by the State's desire to control "undesirable" reproduction (Chavez 2013, Goodwin 2020). Strikingly, this was visible in recent years through the actions of the U.S. Customs and Border Patrol, who have forcibly sterilized detained Latin American migrant women, without their consent or knowledge, when they sought out gynecological care (Chadwick and Mavuso 2021, Palomo, Andersen & Mikkelsen 2021). As discussed by Davis (2019b), obstetric racism is propagated through

the stereotypes and implicit biases that biomedical practitioners have about the reproductive lives of Black women, and how their bodies act and react to pregnancy and medical intervention. In the wider perinatal healthcare system, these biases, and the neglectful care they permit, stem from stereotypes, for example, that Black women can tolerate higher levels of pain (Bridges 2011, Davis 2019b) or Mexican migrant women inevitably have "healthy babies" (Gálvez 2011). These biases lead to medical mistreatment, provider disregard of patient needs, and the denial of equitable and timely treatment in pregnancy care and birth for women of color (Bridges 2011, Chavez 2013, Davis 2019a, Gálvez 2011).

In an effort to mitigate the effects of implicit biases and tackle institutional medical racism, California requires all obstetric biomedical practitioners to complete mandatory implicit bias training and cultural competency training (Cooper, Saha and van Ryn 2022, Mitchell 2019). This aligns with recent policy changes in the U.S. to try and ensure hospitals offer more "patient-centered care" that is "respectful of and responsive to individual patient preferences, needs, and values" to ensure "that patient values guide all clinical decisions" (Becker et al. 2014, 95). However, patient-centered care can lead to unintended intensification of the medical gaze (Gerrits 2014) and diminish patients' willingness to question their doctor's advice. As I discuss in Chapter 5, an unwillingness to question their doctors is a stereotype that biomedical practitioners hold about "Hispanic[10]" women, viewing them as overly respectful and unquestioning of medical advice.

These persistent racial biases continue to structure unequal perinatal care, obstructing the safe and healthy reproduction of women of color. This aligns with Davis' (2019a) framework of "reproductive injustice" and anthropologist Leith Mullings "necropolitics of reproduction" (2020), in which systemic neglect and racialized control persist within perinatal healthcare, enabling the ongoing marginalization of people of color and limiting their successful social reproduction. Against this backdrop, I explore how community-based doulas (CBDs) intervene in hospital birth settings. Their advocacy challenges the institutional racism embedded in obstetric care and expands the scope of reproductive justice. I argue that CBDs, by virtue of their positionality and practices, enact what Béhague et

10 A term used for people who speak Spanish or who originate from Spanish-speaking countries.

al. (2008) call transformative agency: the capacity to mobilize conflict within clinical spaces to improve treatment and create pathways for systemic change, i.e. "collective transformations" within the healthcare system (see also Niy and Diniz 2023).

Transformative agency involves more than informal support or family-based advocacy, which previous authors have focused on in Africa and Brazil (Béhague et al. 2008, Niy and Diniz 2023). Through strategic engagement, CBDs confront medical racism, affirm patient autonomy, and model new forms of care. While these interventions may appear modest on an individual level, I suggest that these acts may accumulate into a broader politics of transformation, with potential to reshape perinatal care practices and institutional culture. In this way, community-based doulas not only protect their clients from harm but also advance reproductive justice for women of color navigating the U.S. birth space.

Returning to Farmer's model of structural violence, I want to highlight that most acts of structural violence are not secretive, nor do they deviate from accepted social standards. They are often legally and socially embedded within institutions and systems, and "defined as moral in the service of conventional norms and material interests" (Scheper-Hughes and Bourgois 2004, 318). As I demonstrate in this doctoral thesis, legal violence, infrastructural violence and reproductive governance constrain maternal health and parenting practices for marginalized groups such as asylum-seekers by inhibiting their capacity to access perinatal healthcare and social services, hindering them from effectively moving through or staying safe within in unfriendly environments (Sheller 2018), and interfering with reproductive autonomy in their mother work.

Methods and Ethics

Methodology

When I began fieldwork in Los Angeles in October 2019, I contacted multiple organizations working with Central American migrants in the region, and I quickly gained access to a local refugee center in Los Angeles County: the Refugee Children Center. Here asylum-seeking families, mostly those from

Central America and Mexico, received community support, access to social workers and asylum lawyers, information about adapting to life in the United States, and nutritional support through a food pantry run by the center. The refugee center opened in 2015 to support the influx of Central American asylum-seekers who arrived at the southern U.S. border, and it offered services to both unaccompanied children and families. I volunteered with the woman's group at the center while also collecting ethnographic data through participant observation. Concurrently, I contacted a maternal aid center in Los Angeles that offered support services to migrant women such as lactation classes, domestic violence education, and health classes in which county health educators[11] would come and educate the women on various health-related themes. They also offered Home Visitation Programs and helped their clients to access services such as health care, bus passes, and food stamps. I began volunteering at the maternal aid center and attended women's lactation and health classes on a bi-weekly basis where I also did participant observation. Lastly, I was able to gain access to the labor and delivery department at a public hospital in Los Angeles as a research assistant for an ongoing childbirth experience study run by the county.

My initial project arc followed what Hardon and Moyer (2014, 256) call "subaltern engagement," in which I focused on the lived experiences and viewpoints of the Central American asylum-seeking women I was meeting in Los Angeles who were attempting to access maternal healthcare while simultaneously managing motherhood obligations. And indeed, this aspect of the project remained throughout the pandemic. At the refugee center I took part in the weekly women's support group, educational and social events for asylum-seeking mothers, and regularly attended holiday celebrations, birthday parties, and community events. I began building relationships with nine women from Guatemala, El Salvador, and Honduras– all of whom had arrived in the U.S. with young children, and some of whom had become mothers to children after arriving in the U.S. as well. Six of the women had partners or husbands and three were single mothers. They ranged in age from eighteen to thirty-five. One had

11 Public health staff who are trained to provide community members with information on health-related matters.

a professional qualification as an accountant; the rest had levels of education ranging from partial completion of secondary school to secondary school diplomas. During my time in the field, half cared for their children full-time while their husbands/ partners worked and the other half worked part-time informal cleaning jobs and cared for their children part-time as well.

In an effort to work collaboratively with the refugee center, I assisted in administrative and event planning activities as needed. I also designed, facilitated, and analyzed data from focus groups with twenty-four asylum-seeking women, assisting the center management who wanted to cater their services to the women's needs and better understand what they had experienced that led them to flee their country of origin, what they had experienced upon the migrant route, and how they were experiencing life as asylum-seekers in Los Angeles. I facilitated the focus groups, with support from the social work volunteer staff at the center. I translated, coded and analyzed the data, then wrote up a final report to present to the staff at the center. This process allowed me to build stronger relationships with the women and deepened my understanding of their collective experiences in Los Angeles.

At the maternal aid center I undertook four months of participant observation and informally spoke to many staff and the migrant women they served. I also held semi-structured interviews with four staff members. I attended lactation meetings and women's health classes twice a month where approximately twenty Central American and Mexican migrant women received breastfeeding support, learned about healthy foods and cooking, and did Zumba (a fitness program that uses Latin-inspired dance). Lastly, my role at the hospital as a research volunteer included spending time in the women's clinic and administering surveys to pregnant women about their experiences with the perinatal care they were receiving at the hospital. During this time, I was in the process of gaining IRB ethical approval from the hospital to speak with patients for my own research.

A few weeks after I finished the focus groups at the refugee center and began my role at the hospital, COVID-19 was declared a global pandemic, and I found myself separated from my field sites and the informants who I had worked so hard to access. My role as a research assistant in the public hospital ended

since I was non-essential staff. Luckily, I had made good contact with a handful of biomedical practitioners and other members of the research collective at different Los Angeles hospitals who I was able to digitally interview for Chapter 5 in mid-2020. The maternal aid center suspended all in-person activities in March of 2020 and they did not need my help during the pandemic. Because I attended events at this location less often than the refugee center, I had not developed close relationships with the women at the maternal aid center before the pandemic began. However, the refugee center kept operating (albeit in a very different fashion) to help the asylum-seeking families to access information, food, monetary support, and legal aid as the pandemic raged on. It was from this point that my research methodology changed to reflect the new reality we were all living in.

Digital Data Collection

When the pandemic began, I shifted to digital contact with the nine asylum-seeking women I had developed relationships with from the refugee center, and this eventually led to digital data collection methods. Following Anthropologists Tanja Ahlin and Fangfang Li (2019), I now relied on the co-creation of field events with my interlocutors rather than field sites. I maintained contact with the women through phone calls and text conversations, we exchanged information, shared memes, and built rapport. Eventually I conducted online semi-structured interviews with each of them to understand how their experiences as asylum-seekers were shaping their mother work and their capacity to access healthcare and social services for themselves and their children. For these interviews, women had the option of an in-person, outdoor and physically distanced interview or an interview through Signal, a secure messaging application. All opted for digital interviews–what anthropologist Deborah Lupton (2020) calls "epistolary interviews", or "asynchronous one-to-one interviews mediated by technology" (Ibid 2020, 11). This method offered privacy, flexibility, and comfort, as it relied on an application that the women already used in their daily lives (Kaufmann and Peil 2019, Sugie 2018).

None of my informants chose to download Signal and preferred to use

WhatsApp, which they already had on their phones. To protect their privacy and secure the data as much as possible, I implemented a security lock on my WhatsApp account and pseudonymized my informants' contact details in my phone. Seven of the women responded to my interview questions and follow-up questions by text, and two sent voice recorded answers to my text-based questions. While this method proved very useful for me, I had little control over when, or whether, informants would respond–epistolary interviewing can lead to higher attrition rates before the interview is complete (Kaufmann and Peil 2019, Sugie 2018), a problem I faced with three of my informants who never completed their full interviews.

When I lost access to the maternal aid center and the hospital, I pivoted to take a "symmetrical view" of health care and social service programs through reflexive dialogue (Hardon and Moyer 2014, 256) by analyzing both providers' and patients' perspectives. In addition to the interviews with asylum-seeking women, I also completed synchronous online interviews over Zoom with both program clients/healthcare patients and the professionals working for those programs. This method was useful because it allowed me to see my informants' reactions, to ask immediate follow-up questions and seek clarification, and to gain all the benefits of an in-person live interview from different locations and contexts (Maddox 2020). I first reached out to county-level staff who oversee multiple Home Visitation Programs in Los Angeles. Subsequently, they helped me contact Home Visitation staff who worked for local non-governmental organizations in Los Angeles, and through them I was able to interview some women who took part in these programs. I wanted to understand how Home Visitation Programs worked to support undocumented and asylum-seeking migrant women who were eligible for services, and how that support either decreased or increased the precarity experienced by migrant and asylum-seeking mothers.

I held online and phone interviews with twelve home visitors, six NGO-based program management staff, four county-level employees who oversee Home Visitation programs, and five mothers who had taken part in the programs. Two were undocumented migrant women: one from Mexico, the other from Central America; two were asylum-seeking women from Central America; and one was a

Native American. Although some preferred to speak over the phone, we usually used video calls, allowing me insight into their expressions and the surroundings that staff and Home Visitation clients were in.

My shift towards reflexive dialogue also led me to reach out to various types of maternal healthcare providers through my network from the hospital and over Facebook. I wanted to regain an aspect of the biomedical perspective that I had lost when I lost access to the hospital, and to understand how care practitioners understood precarity to function in marginalized women's experiences with maternal health care in Los Angeles. While most biomedical staff (understandably) did not have the time or interest in speaking with me during the pandemic, I was able to complete semi-structured digital interviews with one Ob/Gyn (Asian), three labor and delivery nurses (two white, one Latina), one hospital-based midwife who works alongside doulas (white), five community-based doulas (CBDs) (three Black, one Latina, one white), the heads of two local doula organizations who are also trained doulas (one Black one White), and the head of a hospital-based doula program (Latina). These interviews illuminated the ways that racialized, marginalized women can experience mistreatment when receiving biomedical birth care, and what types of alternative care can help to mitigate both medical mistreatment and the multiple precarities women of color face.

Return to In-Person Ethnography

Eventually, I was able to start seeing my asylum-seeking informants in-person again. I helped with food deliveries when the refugee center's food pantry closed for foot traffic and women lacked cars to pick up their weekly food boxes. I also delivered other items that the center collected for the women and their families, such as diapers, hand sanitizer, school supplies, hygiene items, etc. When I would deliver these to the women's homes, I would take the opportunity to talk with them, see how they were doing, and see where they lived. Although COVID-19 severely limited the types of in-depth, in-person data I had originally hoped to gather, I was still able to document how asylum-seeking mothers managed their health and caregiving activities during the pandemic. This included mapping the

distance from their local clinic and public transit, and observing interactions with their children in their constrained living spaces– often single rooms rented in shared houses or apartments, or temporary hotel accommodations serving the entire family. This period of data collection highlighted for me just how difficult everyday life is for an asylum-seeking mother in the U.S. due to the intersectional precarities they face, and how much more precarious life could become within the context of a global pandemic.

Overall, during fieldwork I gained unique insight into the benefits and drawbacks of using face-to-face and digital data collection methods. As discussed by social scientists working with both digital and in-person ethnographic methods, the combination of in-person and digital data collection can foster a deeper understanding both of your informants and the research context (Ahlin and Li 2019, Kaufmann 2018, Kaufmann and Peil 2019). In-person participant observation allowed me to write thick descriptions of my field site and to build relationships with the asylum-seeking women I worked with. This was especially useful for later contextualization and maintaining rapport when I had to shift to digital data collection. By combining in-person participant observation and focus groups with digital interviews and analysis of online public documents, I was able to gain an in-depth understanding of the perceptions and experiences of Central American asylum-seeking mothers, the service providers they engaged with, and the policies and regulations that shaped their eligibility for and capacity to access services and care.

Ethnography at Home

Because I was doing "ethnography at home" by completing my research in the area that I grew up and worked in, I was able to fill some of the contextual holes that digital data collection creates when you can't see anything beyond the limited frame of the screen where your interview takes place. However, as anthropologist Carol Greenhouse (1985) noted, being from a particular part of the United States does not mean that you are intimately familiar with the community that you are researching. I am not Latina, Central American, nor a migrant within the United States. Nevertheless, I had an intimate understanding

of the broader American culture and the more specific Los Angeles culture around asylum-seekers, immigration, health care and state institutions that allowed me to move between insider and outsider as I undertook fieldwork. For me to create a sense of space and place in which to situate my stories and discussions, it was helpful for me to have a basic understanding of the various areas in which asylum-seekers live and work, the public hospitals and NGOs that give services to asylum-seekers, the weather, the infrastructure and the socio-economic milieu in the places that I discuss in my interviews.

My years living and working in and around Los Angeles before fieldwork helped me bypass the orientation phase of life in the field, but also made it easier for me to pinpoint the new spaces and places that I needed to engage with that I had not previously experienced because I had not needed to go there as a white U.S. citizen who had private health care. Therefore, I found myself navigating both native and non-native positions (Qamar 2021) as I came into contact with people who had lived very different lives than me and who were not privileged in the ways I was (am); and "mak[ing] the familiar strange" (Van Maanen 1995, 20) by critically exploring the mechanisms and methods of social and health-based services that I had grown up around. Finding these spaces of discomfort helped me to better articulate in my writing the ways in which the State induced and deepened precarity in the lives of my informants, and how they experienced this discomfort themselves as strangers in a strange land seeking to survive and care for their children.

Analysis

All data collection with my main informants and discussions with some Home Visitation clients took place in Spanish, which I speak and understand at a high intermediate level. I translated my data before beginning analysis, then I checked my translations for accuracy with DeepL, an AI translation platform. Interviews with Home Visitation staff, perinatal health providers and the staff from the refugee center and maternal aid center took place in English. All focus groups and online interviews were voice recorded, with the explicit verbal consent of all respondents. I coded all field notes, interviews, and focus groups

through NVivo, a qualitative data analysis software, which helped me to conduct thematic analysis and discern key themes that situate each chapter and bind my doctoral thesis together.

By engaging with informants from various positionalities, I was able to shed light on the manifold practices and policies that shape the environment in which asylum-seeking women live and navigate motherhood. Through such a comprehensive breadth of data, I was able to deeply analyze the ways in which State-induced racialization, marginalization and precaritization of migrants impact both the health and familial wellbeing of those who are seeking asylum in the U.S.

Limitations

Many of the limitations I faced in completing my doctoral research stemmed from the COVID-19 pandemic. After six months of fieldwork, I lost access to two thirds of my field sites in March 2020, and most of the contacts I had made in those spaces. With this shift, I also lost the capacity to go out and meet new people in the shared spaces where I was interested in gathering data: the community centers, clinics, and NGOs that offered support and services to Central American asylum-seeking women. While I was able to maintain and expand my relationships with mothers from the refugee center through digital methods, I found it difficult to expand this group of informants. Similarly, I was unable to gather data from any men during my fieldwork beyond short, informal discussions I had with a few asylum-seeking men while I was getting to know their wives. The lack of male informants in my data created a visible gap in my findings: how do Central American asylum-seeking men understand and navigate healthcare and parenting in the United States? What were their views on women taking part in Home Visitation programs or giving birth in a U.S. hospital?

Additionally, the lack of in-person data collection I completed with perinatal healthcare practitioners (both biomedical and CBDs) and Home Visitation staff also limited the types of ethnographic data I could gather, and how I was able to interact with these informants, most of whom were one-off digital interviews. I was very appreciative of the contacts I did manage to make through

e-mail, Facebook posts, cold calling, and the generosity of informants whom I met before the pandemic who agreed to introduce me to other people working in healthcare and social services in Los Angeles. While this allowed me to generate a good understanding of how people working in health and social service systems engaged with asylum-seekers and other precarious groups, I also understand that there are other perspectives that I was unable to learn about due to the nature of snowball sampling, perspectives which may well have influenced the conclusions that I came to in this doctoral thesis. I also felt that holding Zoom interviews with people I had never met in person made it harder to build rapport, something I attempted to overcome by beginning each conversation with casual dialogue to get to know each other and ease into the interview.

While I did not intend to exclude queer or non-binary asylum-seekers from my research, I did not knowingly encounter any during my fieldwork. Whether this speaks to a hesitancy on the part of asylum-seekers to make themselves more vulnerable by presenting their sexuality or gender preferences to an outsider, or just due to the size of my pool of informants, I am not sure. However, I recognize that if I had been able to include LGBTIQ+ respondents in my research, this would have added another intersecting level of precarity into my analysis that could have deepened my insights and arguments. Lastly, I recognize that as a white, privileged U.S. citizen who filled an ambiguous role as a "volunteer" at the refugee center, I was unable to fully gain full access to the lives of many of the asylum-seeking women I spoke with. Over time they did open up to me–indeed, many of the women told me that they had "confianza" with me, a sign that they trusted me. However, I also recognize that there were times where their silence denoted a lack of willingness to share certain things with me, a silence which I respected. Therefore, while I do not doubt the truthfulness of what my informants shared with me, I recognize that there is likely deeper truth and complexity to their situations, feelings and actions than I was able to learn while in the field.

Ethics

While in the field and once I began analysis and writing, I remained acutely aware that Central American asylum-seeking women navigate deeply insecure

and often dehumanizing conditions in the U.S. These lived realities reveal the stark asymmetries of power between my informants–racialized, marginalized people with liminal legality in the U.S.–and myself, a white U.S. citizen and researcher. I have been very careful to avoid identifying features in my descriptions of my informants. I use pseudonyms for all informants and in some instances, I have created composite characters by combining features and experiences of different people into one informant to further limit identifiable information. As researchers Jennifer Yim and Peregrine Schwartz-Shea note (2022), making composite characters increases the strength of anonymity for informants, especially in the Internet age wherein it has become far easier to find and "unmask" anonymized people and places based on small details. I wanted to ensure that my research would not increase any migrant's risk of deportation or negatively impact the work of various maternal health programs who might be offering services to liminally legal migrants. I asked for verbal informed consent from my informants to limit any paper trail that could risk exposing their real names. In accordance with data protection regulations, I pseudonymized my fieldnotes, uploaded all fieldnotes and interview recordings to an encrypted University of Amsterdam server after completion and deleted them off my phone or computer.

As researcher Veronika Bilger and geographer Ilse van Liempt observed (2009,12), "Language and cultural factors may also affect people's understanding of what participation in a research project means and in what way it could harm or benefit them." I remained distinctly aware of this during my fieldwork, recognizing that legal liminality and socio-economic status would also come to bear on how the asylum-seeking women understood both my role as a volunteer/anthropologist and their right to participate, or not, in my research. For these reasons, I made sure to regularly remind my informants of my research aims and clarified that I was interested in talking to them about maternal health and motherhood. Because the asylum-seeking women predominately viewed me as a volunteer at the refugee center, I did sometimes feel that they shared certain details of their experiences with me in the hope that I could use that information to help them by acting as a middleman between them and service providers. In these situations, I tried to help them as much as I could, recognizing that my

positionality as an English-speaker could occasionally help them gain access to certain resources or to navigate confusing aspects of Los Angeles bureaucracy. When women approached me with questions or needs beyond my expertise, I referred them to more appropriate staff members at the refugee center who were better equipped to help, given my lack of knowledge about the asylum system and migrant allowances in Los Angeles–information I gradually learned alongside the women.

I also noticed that some women seemed hesitant to talk with me or attend events like the focus groups at the refugee center, and I suspected that their hesitant participation may have been influenced by encouragement from the center's director. In these instances, I never pushed for those women to participate and instead followed the women's lead in our conversations. I made sure to regularly ask the women I spent time with if I could speak with them for my research, and if an informant chose to not answer a question or stopped responding to me over WhatsApp, I respected their choice. This was something I experienced with two of my main informants halfway through 2020, and beyond occasionally checking in on them after that point as part of my volunteer role, I no longer asked them questions as part of my research or tried to encourage them to engage with me. During analysis I often asked for feedback or follow-up questions about our conversations and themes that I found within the data to ensure that I was maintaining an accurate view of the women's experiences. I also undertook follow-up interviews with a few Home Visitation staff and community-based doulas in order to clarify certain ideas or gain a more in-depth knowledge of what I had learned from them about their work in Los Angeles.

From Precarity to Reproductive Violence

I now turn to the empirical chapters, in which I demonstrate how structural violence, racism, and reproductive governance create and sustain precarity for racialized, marginalized migrants–specifically Central American asylum-seeking women– subsequently limiting and deterring their reproductive rights. I discuss how this precaritization is accomplished by limiting their access to economic stability, linguistic inclusion, healthcare, legal recognition, and racial equity

with the white American majority. By tracing how the long-standing precarities faced by Central American asylum-seekers have worsened during the COVID-19 pandemic, my research deepens our understanding of the shortcomings of modern liberalism that attempts to engender social justice through progressive policies. Additionally, when viewed alongside the aggressive, punitive actions of the Trump administration, I demonstrate how these two seemingly disparate ideologies together threaten reproductive justice and the future health of women and children of color in the U.S.

In **Chapter 2**, I explore how Central American asylum-seeking women exist in a space between care and exclusion–a gray area of legality and deservingness that limits their access to many social and health-based services. In this context, they struggle to perform their mother work while also managing the legal requirements of their asylum cases and the economic barriers they face without access to fairly paid employment. In this chapter, I outline how their legal, economic and health-based precarity intensified between 2020 and 2021 through two intersecting phenomena: the dismantling of the U.S. asylum system and the COVID-19 pandemic. As I trace these entanglements between State policies and lived experiences of exclusionary regulations, I demonstrate how even the support services meant to improve reproductive health and parenting outcomes often failed to fully recognize–let alone alleviate– the overlapping precarities my informants face. This argument is developed in greater detail in Chapters 3, 4, and 5.

In **Chapter 3** I discuss how (im)mobility is experienced by asylum-seeking women who struggle to access social and health-based services due to infrastructural violence. These barriers lead to what I saw as asylum-seekers being "stuck in motion" (Castañeda 2018) as they simultaneously hit barriers to access certain services while finding pathways to access others. In this chapter, I follow a Honduran asylum-seeking woman named Karla as she attempts to access health-based resources for herself and her children despite the infrastructural and bureaucratic barriers that she encounters in Los Angeles that limit her mobility. Using the analytic of (im)mobility to think through the ways in which asylum-seeking mothers are constantly in motion yet also held still when

attempting to access different forms of care for their families, I demonstrate that by creating a culture in which infrastructural violence gatekeeps who can and cannot access care, the State continuously reproduces migrant precarity through the policies and institutional expectations that make health-based resources inaccessible.

In **Chapter 4**, I discuss how acts of racialization set asylum-seeking women up for parenting interventions and surveillance by the State when they attempt to access and utilize State-funded Home Visitation Programs. In these programs, the State simultaneously views migrant/asylum-seeking women as risky mothers in need of surveillance, and vulnerable mothers in need of care. Both positionalities push them to prove that they are deserving of support due to their willingness to build "resilience" and "self-sufficiency" to lessen their future need for State-funded support. Yet concurrently, being labeled as "risky" opens them up to higher risks of State surveillance and associated consequences such as having their children placed into care. However, this need to prove their deservingness is constantly in contrast to the prevalent U.S. stigmas that racialized immigrants from Central America are "illegal" and therefore *un*deserving of care or support. Likewise, the centering of risk inside the mother's body absolves the State of its role in their precaritization, and ignores the role that precarity plays in their capacity to parent their children.

In **Chapter 5**, I discuss how racialization and obstetric racism continue to impact the birth experiences and outcomes of women of color in California, despite government efforts to improve maternal health outcomes for women of color through implicit bias and cultural competency training . Due to what I call the "white medical gaze," biomedical perinatal care providers seem unable to fully understand the precarities that their racialized and marginalized patients face, which can negatively impact their births. This white medical gaze appears to perpetuate the implicit biases that non-racialized biomedical practitioners hold about women of color, such as their expectation that Latina patients will not question medical advice. Conversely, I show how community-based doulas might be able to counteract the white medical gaze thanks in part to their communal relationality with their clients, with whom they share experiences

of discrimination and precarity. In this way, they are better placed to advocate against the racial and class-based discrimination their clients face, making space for safe and respectful birth experiences for their clients of color through transformative agency.

In the **conclusion**, I suggest reframing the impacts of structural violence, racism and reproductive governance on Central American asylum-seeking women as chronic, routinized acts of reproductive violence. Reproductive violence includes State-sanctioned oppression, coercion, and neglect that restricts reproductive autonomy, often through capitalist, patriarchal and colonial logics (Chadwick and Mavuso 2021, Das 2008, DeJoy 2019, Laverty and De Vos 2021). While such violence is not hidden, it is frequently rendered socially invisible or politically acceptable–especially when enacted on racialized, marginalized, or illegalized bodies (Rose 2021). Expanding on the work of Laverty and De Vos (2021), I argue in the conclusion that the framework of reproductive violence must also encompass the quotidian, enduring effects of State-induced precarity. These include legal, infrastructural, and bureaucratic barriers that constrain access to perinatal care and erode reproductive autonomy. By expanding the framework in this way, I broaden the definition of reproductive violence beyond overt acts of sexual or obstetric coercion to include the normalized, everyday harms experienced by Central American asylum-seeking women.