Precarious motherhood

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

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Chapter 6

Conclusion

Where Are They Now?

In 2021, Beatriz asked me to help her figure out how to secure a deposit for an apartment she really wanted for her family. They had been sharing one bedroom in an apartment with two other families and there was a lot of tension between the tenants, which made Beatriz uncomfortable. She and I tried to find the money for the deposit through various funds and programs at the refugee center, but in the end the landlord wanted more money than Beatriz and her husband could afford, so they let the apartment go. She was devastated, but they kept looking and in 2022 they were finally able to move into a small apartment in Los Angeles. It was a major milestone for them, and Beatriz was so happy to have some privacy for herself and her family. The next year, Beatriz became pregnant with her second child and her family decided to move to another state to be closer to Beatriz's mother and sister. In late 2023, she gave birth to her second child–a healthy girl. Beatriz told me that she was happy to have the support of her family before and after the arrival of her daughter, and to be settled in her new home. She has not shared with me the recent updates on their asylum applications, but I know that she and her husband are both working, and her two children are also doing well.

Unfortunately, things have been a bit more difficult for some of the other women I worked with during my fieldwork. Maria Jesus and her family are still in Los Angeles, and we have kept in regular contact since I left. She and her teenage son are working– both at a grocery store. Her daughter is doing well in school and learning to play the piano through a music program for children at the refugee center. Maria Jesus and I caught up in February 2025, and she shared that while she and her two children had an open application for asylum, they had recently found out that her husband did not. The family had all requested asylum when they arrived in the U.S. in 2018, but for some reason her husband's case had either been dropped or denied at some point without their knowledge.

This made a large impact on Maria Jesus's quality of life. She shared with me that she was *preocupada* because their immigration lawyer, who they had accessed through the refugee center, had not given her a straight answer about the situation. She had phoned multiple times but the lawyer was not returning

her calls, increasing her fears. She was panicking because while she and her children had the right to stay in the U.S. as asylum-seekers, her husband did not. "I'm not sure what will happen. I just have to trust in God," she told me. "My husband cannot work because he doesn't have papers. He went to the lawyer and they haven't told him anything else. We are still waiting for our hearing date. We don't know when it is going to be. [The situation with my husband] is so frustrating and it worries us a lot." Without an asylum application, her husband could not get a work permit, and they were afraid of Immigration and Customs Enforcement (ICE) picking him up off the street and deporting him, so the family was relying on Maria Jesus and her son's income to pay their expenses. She told me they were even more worried now because of President Trump's renewed anti-migrant actions, and unsure of what the future would hold for their family or where they would be able to build a life.

A few weeks later, I checked in again with Maria Jesus and she was still upset by the situation. "They don't give us any hope," she told me. " We're going to have to leave and return to El Salvador and we have no other choice." She refused to consider staying in the U.S. without her husband, but her fears about returning to El Salvador were justified–they had fled threats against their lives from men who had extorted them for money. By March, the family had received some good news when her husband received an appointment to submit his biometrics to the government–a sign that the lawyer had been able to successfully open an asylum case for him. However, the whole family was still confused by the process and waiting to hear any updates from the lawyer or receive a court date. They were also uneasy about her husband giving his biometrics to the government since the second Trump administration had begun cracking down harshly on migrants from Latin America and disappearing them without due process[25] to a dangerous prison in El Salvador, increasing Maria Jesus's dread. While Maria Jesus and her family were still battling the legal precarity that kept them betwixt and between legal statuses (Turner and Turner 1992, Menjívar 2006), she had at least been able to get a work permit in order to get a stable job and they had been able

25 Migrants and asylum-seekers are being round up, detained, and forcibly removed from the United States and sent to third party countries without a trial or a chance to refute allegations that they are "dangerous criminals" (the justification given for their arrest) (Hawkins 2025).

to stay in their apartment near the refugee center, which allowed her to retain a link to the community of friends she had built there. Likewise, the Medi-Cal expansion in 2024 had given her full healthcare coverage, so she had affordable access to her hypertension medication, something she had struggled to afford before.

Karla stayed in Mexico for two and a half years. Our contact was sporadic until the spring of 2023, when we reconnected over Facebook messenger. She shared with me that she and her children had returned to the U.S. in January 2023 and they were living with her sister's family in Georgia. She explained "Nothing was what it seemed [in Mexico]. I suffered a lot of domestic violence with my son's father. I went through hell but thank God we are fine now…I thought it was the best option to go to Mexico, which turned out to be the worst mistake…[Now] I'm going through migration again." I was horrified to hear this update from her, but she assured me that she was okay. Karla expressed relief to be back in the U.S. with her children, and gratitude for the chance to seek asylum again. She told me that her court date had been set for 2025–two years following her asylum application–meaning she would remain in legal limbo for another two years.

In early 2024, Karla updated me that she was working at a restaurant and that her children were doing well. Still, she hoped to move back to California, explaining "I already understand how everything works in California and I find it very hard to get around in Georgia...Here I am not used to [how they do things], everything is far away and many things I can't do on foot." Karla remained, as anthropologist Heide Castañeda (2018) put it, "stuck in motion"–managing life in a new state with family support and without the extra restrictions of the pandemic, but still confronting legal precarity and physical immobility. Without access to a driver's license or reliable public transportation, her movement–and by extension, her autonomy, remained sharply limited.

By spring 2025, Karla and her children were still living in Georgia. But things remained difficult. Karla had secured a lawyer to apply for a Juvenile visa for her daughter Cristina, but she had no asylum lawyer of her own. With her court date rapidly approaching in June, this was a major source of stress. "In this state it is very difficult to get help with lawyers," she told me. The difficulty is not unique

to Karla: the United States simply does not have enough immigration lawyers to meet the needs of its growing asylum-seeking and migrant populations (Sandoval 2024), a reality that became visible as I spent weeks calling and e-mailing the few organizations and lawyers in Georgia that offer pro-bono or affordable legal representation to asylum-seekers on Karla's behalf. I repeatedly ran into dead ends, hearing the same refrain: "We cannot take on new clients for asylum court at this time."

It is notoriously difficult to win an asylum case in the U.S. without legal representation, given the purposefully convoluted system of paperwork and legal requirements in U.S. asylum law (Sandoval 2024), a reality that I saw in both Maria Jesus' and Karla's situations. Even those with legal support struggle. While Maria Jesus had a lawyer, she still did not understand the complex procedures. She had no choice but to trust her lawyer to correctly follow the legal processes to help her family gain asylum. Meanwhile, she was consumed by *preocupación* about her husband's pending case. Similarly, Karla's lack of legal representation and stable income meant that she could not afford a private lawyer, nor the expensive taxi rides to get to Atlanta, where the pro-bono legal offices in Georgia operated. On top of their ongoing legal precarity, Karla and her daughter were ineligible for Medicaid because Georgia has not expanded healthcare access for undocumented migrants (Georgia Pathways to Coverage 2025). Georgia also has strict laws requiring all employers to check the work eligibility of all employees through an electronic federal work authorization program (Georgia Department of Labor 2012), which could become problematic for Karla if the court denies her asylum application and she loses her temporary work permit. For both Maria Jesus and Karla, these overlapping challenges illustrate how State-induced precarity operates–not only through immigration policy, but also through barriers to healthcare, legal support, and economic stability. These conditions have only worsened under the current administration, deepening the insecurity that defines everyday life for racialized asylum-seekers in the U.S.

Access Denied: The Erosion of Care and Legal Precarity

Between 2019 and now in 2025, the United States has systematically dismantled protections for migrant and reproductive rights, creating conditions that render care largely inaccessible for those who need it most. Legal and political shifts across these years have further constrained access to perinatal healthcare, social services, and asylum for racialized asylum-seeking women. In 2019 the first Trump administration passed the Title X[26] gag rule, prohibiting any clinic that offers family planning and sexual health services from discussing abortion or offering abortion care. This rule forced hundreds of clinics to exit the Title X program, leaving millions of people without access to reproductive health care services across the country (Friedrich-Karnik and Easter 2024). While the Biden Administration rescinded the gag rule in 2021, reproductive health and family planning programs across the country had not fully returned to pre-2019 capacity by early 2025, when the second Trump administration began. Currently, the administration promises to reinstate the gag rule on Title X and further decrease access to abortion care and contraceptives under Project 2025, a far-right policy framework developed by the Heritage Foundation, a conservative think-tank (Bernstein, Friedrich-Karnik, Damavandi 2024).

Meanwhile, in June 2022, the United States Supreme Court overturned Roe vs. Wade, eliminating the constitutional right to abortion and handing regulatory power to the states (Center for Reproductive Rights 2022). Progressive states like California and New York have expanded access and added legal protections, but many others moved swiftly to ban or severely restrict abortion. Georgia and Florida now ban abortion after six weeks; Texas and Louisiana have total bans and criminal penalties for both patients and providers (Ibid). Even in states with expanded access, many hospitals–especially faith-based institutions affiliated with the Catholic church–have used the current federal guidelines to deny, limit, or slow life-saving abortive care, relying on the support of the Trump-appointed Department of Justice (Sharp 2025).

In parallel, the administration has ordered all government-funded programs

26 The Family Planning Services and Population Research Act of 1970–landmark federal legislation dedicated to extending access to family planning services, signed into law by President Nixon (United States Congress 1970).

to end diversity, equity and inclusion (DEI) programs, leading to funding freezes for organizations suspected of using their funding for "diversity efforts" (Kusisto and Whyte 2025). The Trump administration has used these efforts as an excuse to cut funding from organizations that they disapprove of, such as Planned Parenthood, by ending funding for federal family planning grants (Kusisto and Whyte 2025). Similarly, the administration has threatened to withhold funding from medical centers that do not alter their implicit bias training to be "race-neutral" (Doshi, Jackson and Chumbes 2025). These moves directly threaten maternal and infant health initiatives designed for communities of color (Cohen 2025), as any program that specifically focuses on health improvements for marginalized racial or ethnic groups risks losing federal funding. Taken together, these attacks limit reproductive autonomy and shrink already-scarce options for undocumented and liminally legal migrants. Fewer clinics, weakened DEI initiatives, and reduced federal support make it harder for perinatal people to decide whether, when, and how to have children safely.

The Trump administration has also moved to dismantle what remains of the U.S. social safety net by allowing the unofficial "Department of Governmental Efficiency" (DOGE) to gut government programs and withhold grants for services across the country (Reuters 2025). As part of this effort, in March 2025, the administration eliminated multiple federal maternal and child health programs under the "restructuring" of the Department of Health and Human Services (HHS) (Glenza 2025). Restructuring has included firing experts in the Maternal and Child Health Bureau, the Center for Disease Control and Prevention's Division of Reproductive Health and eliminating the HHS division that tracked and studied maternal mortality (Glenza 2025, Mandavilli and Rabin 2025). As of April 2025, reports noted that the administration was considering a budget proposal to cut Head Start–a federal program that funds childcare, early childhood education, healthcare, community-based doula programs and Home Visitation programs (Office of Head Start 2025). As many of these programs serve poor women and children of color, these program cuts will likely lead to worsening maternal health outcomes for marginalized women of color throughout the country (Hill et al. 2025), as well as worsening health and development outcomes for the

children who rely on federally funded health and nutrition programs (Associated Press 2025, Schermele ND). As I discuss throughout my chapters, these forms of structural violence that limit options and access to support services that fund children's healthcare, nutrition, and early education programs limit asylum-seekers' capacity to parent their children in a healthy and safe environment, furthering reproductive injustices for marginalized communities.

Federal attacks on the asylum system have also intensified. The Biden administration maintained the COVID-era policies that restricted asylum at the southern border[27] (Stepansky 2021) and continued mass deportations of undocumented migrants (Rojas 2025), demonstrating the bipartisan nature of many of these policies. In 2024 Biden issued an executive order barring almost all asylum cases at the U.S.-Mexico border until the U.S. could, in Biden's words, "gain control of the border, after years of high number[s] of irregular crossings" (Martínez-Beltrán 2024). Following this, in January 2025 President Trump completely suspended the asylum program at the southern border after claiming an "invasion" of illegal immigrants as justification for his action (Martínez-Beltrán 2025). As part of Trump's executive order on "Protecting the American People Against Invasion," in April 2025 the Department of Justice terminated all funding for immigrant legal support services: Family Group Legal Orientation Program (FGLOP), Counsel for Children Initiative (CCI), Immigration Court Helpdesk (ICH), Legal Orientation Program, and Legal Orientation Program for Custodians (LOPC) (Esperanza Immigrant Rights Project 2025, IPTP 2025).

Likewise, the risk of deportation asylum-seeking and undocumented women face if they access reproductive health care or social services for their families is increasing now that Trump has expanded Immigration and Customs Enforcement (ICE) access to formerly "protected spaces" such as clinics and hospitals (Pearson 2025). This will allow immigration officials to enter medical spaces and detain migrants (or anyone who *looks* like a migrant who does not have documentation on their person) while they are seeking care. Lastly, Trump is attempting to end Birthright Citizenship, a constitutional right that grants every baby born on U.S. soil citizenship, regardless of their parents' nationality or

27 The majority of migrants enter the United States through border crossings at the U.S.-Mexico border (Customs and Border Patrol 2025).

migration status (Harrison and Robertson 2025). This would also have a major impact on the capacity of American-born children with migrant parents to access healthcare or social services that are federally funded, and limit their capacity to fully participate in American society by making it impossible for them to receive social security numbers, legally work or rent a home, receive funding for higher education, or access health insurance. Due to these severe immigration policies and through de-funding immigrant legal aid programs, Central American asylum-seeking women and their families–like Karla and Maria Jesus–will remain in a space of liminal legality as they become more likely to be denied asylum (Kuang 2025), stalling their capacity to build a stable life in the United States.

As my research shows, restrictions on reproductive rights, migrant rights, and the cancelling of programs that provide assistance to millions of women and children increase the legal, economic and health precarities that Central American asylum-seeking women and their families experience across the United States. Defunding maternal health programs and nutritional and early education support services that serve predominately poor families, many of whom are migrants and people of color, will only worsen the structural inequalities that continue in the U.S., especially at a time when anti-immigration actions are increasing. As I discussed in Chapters 4 and 5, it is important to recognize that many programs that aim to improve health and social equity for people of color, such as Home Visitation Programs and implicit bias training for perinatal healthcare staff, do not do enough to mitigate nor remove the sources of precarity from the lives of racialized, marginalized women. In Chapter 4 I argue that Home Visitation Programs can increase legal precarity for migrant and asylum-seeking women by increasing State surveillance into their lives and parenting practices. Likewise, in Chapter 5 I note how the failure of implicit bias training to overcome racialized mistreatment due to the white medical gaze can increase health-based precarity through medical mistreatment of women of color, necessitating the use of Community-Based Doulas. Cutting federal funding is not the way to improve the precarious positionality (or mitigate "risk factors" per HVPs) that the State induces for marginalized communities. Based on my findings in Chapters 2 and 3 regarding how asylum-seeking mothers experience health and social services

in California, the under-funding or defunding of services for marginalized communities will likely make life more unlivable for asylum-seeking families and push them to self-deport or otherwise become less visible in society.

Even with California's expanded access to reproductive healthcare and social services, federal policies still impact the funding available to many state-led programs, such as Medi-Cal, which relies on the federal government for 60% of its funding (KFF 2025). Additionally, federal policies such as ICE's remit for deportation and the threat of being labelled a public charge (see Chapter 3) have a chilling effect on Latinx people (Jimenez 2021, Johnson-Agbakwu 2022). Sociologists Andrea Gómez Cervantes and Cecília Menjívar (2020) have found that anxiety caused by a fear of deportation makes Latina migrant women apprehensive about accessing health care services, which I also discuss in Chapter 2. Similarly, health equity advocate Crista Johnson-Agbakwu (2022) has discussed how this fear and anxiety leads Latinx migrants to refuse enrolling in social services that they are eligible for. Therefore, asylum-seeking women's *preocupación* and the mental burden of managing their mother work in such an inhospitable environment are likely to increase significantly as restrictive and punitive laws continue to pass across the country with the support of the current government. Through this section, and the whole of this doctoral thesis, I have made visible the many intersecting harms that the U.S. government is perpetuating against racialized, marginalized groups such as asylum-seekers. Likewise, as I show below, my in-depth ethnographic insight has allowed me to expand the existing literature on precarity, reproductive governance, and reproductive injustice.

Contributions: Precarity and Reproductive Governance in an Age of Reproductive Injustice

Central American asylum-seeking women's experiences of maternal health and motherhood in the U.S. offer a timely addition to the anthropological literature on Latina migrant women (Abrego and Menjívar 2011, Ayón and Garcia 2019, Chavez 2013, Escobar 2016, Gómez Cervantes and Menjívar 2020). I have highlighted how their liminal legal status mirrors the experience of

undocumented Latina migrants (Abrego and Menjívar 2011, Torres 2018), while also producing distinct forms of vulnerability and constraint (Menjívar 2006). Likewise, my research has demonstrated that even in "migrant-friendly" states, State structures such as expanded Medi-Cal coverage for prenatal care and Home Visitation programs serve to maintain or even intensify precarity, rather than alleviate it. This doctoral thesis has explored how economic, legal, and health precarity persistently undermine the mother work of asylum-seeking women–whether through federal legislation that systematically denies them access to health/care services, or through infrastructural barriers that unintentionally or intentionally render services inaccessible. Racialized, gendered stereotypes further shape the birth care they receive: biomedical practitioners often overlook how structural precarity and racialization affect birth experiences and outcomes. Meanwhile, large forces such as the U.S. asylum system, the COVID-19 pandemic, structural racism, and barriers to migrant mobility continue to structure reproductive life.

Philosopher Judith Butler (2009) asserts that the State makes all marginalized groups precarious in one way or another, and Latinx scholar Catherine Ramírez et al. (2021) show how immigration practices manufacture migrant precarity. Similarly, anthropologist Rebecca Galemba's (2023) research explores how wage theft increases precarity for Latino migrant day laborers in Colorado; and anthropologists Susan Coutin (2011) and Kristin Yarris et al. (2015) have explored how political shifts impact how refugees and asylum-seekers are treated in the U.S. However, by focusing on the positionalities of Central American asylum-seeking women–an under-researched group in the U.S.–this research expands our understanding of precarity as a form of structural violence, revealing how it limits access to federally funded care, imposes conditions of surveillance, and reproduces the racialization of Latinx migrants through the white medical gaze in perinatal care.

Crucially, this doctoral thesis offers unique ethnographic insights into how the pandemic converged with an already hostile legal and political landscape, where I was able to witness the impact of various forms of structural violence on asylum-seekers' lives as the façade of "equitable and accessible care" fell

away. Here, I demonstrate how the generalized pandemic-management policies in California failed to account for the structural exclusions shaping asylum-seeking women's lives–especially as anti-migrant rhetoric and policies were cloaked in "pandemic control efforts" and other public health justifications. My findings demonstrate how local liberal policies in Los Angeles, often celebrated under the banner of inclusion, work in tandem with hostile federal immigration regimes to create a state of chronic precaritization. This is evident in the gap between inclusive policy language that guarantees care to all pregnant/postpartum people and children, and the realities of infrastructural violence and legal exclusion. Through my ethnographic engagement, I add to the growing body of literature critiquing reproductive healthcare systems (Wallace, MacDonald and Storeng 2022) by providing insight into systemic gaps that fail to address, or at times increase, immobility, inaccessibility and injustice for marginalized populations.

When we consider this reality vis-à-vis the current anti-reproductive justice movement in the U.S that is working to dismantle reproductive healthcare access and social services for all women, the impact these gaps in healthcare systems have on the reproductive outcomes of women of color becomes unmistakable. Reproductive justice scholars have documented the mistreatment of Black women–and, to a lesser extent, other racialized women–within the U.S. perinatal healthcare system (Bridges 2011, Davis 2019a,b, Nash 2021, Torres 2023), and have called for bridging immigrant rights and reproductive rights in justice work for Latina migrants (Zavella 2016). Others have critiqued the inhumane treatment pregnant asylum-seeking women experience in immigration detention (Heffernan 2023, McFadden, Velez and Ávila 2022). I add nuance to this field by exploring the reproductive injustices faced by Central American asylum-seeking women inside the U.S. that are shaped by the intersection of racialization, their gender, and their legal status. I contribute to this area by examining how structural violence and State-induced precarity govern asylum-seekers' reproductive lives–not just at the border, but within the very institutions that claim to provide care. Through this, I make visible the additional precarities faced by asylum-seeking women beyond those faced by women of color who are citizens and deepen our understanding of the additional risks to reproductive autonomy that liminal legality provokes.

While parenting has been articulated as one central element of reproductive justice (Ross and Solinger 2017, SisterSong 2025) it has received less attention in critical reproductive justice studies (Luna 2020, Sufrin 2017). The reproductive justice framework was developed by and for women of color precisely to go beyond the narrow focus on contraception and abortion that characterized the reproductive rights movement of late 20th century America (Luna 2020, Ross 2006, Ross and Solinger 2017). I contribute to the existing literature on reproductive justice and parenting by showing how legal, economic and health precarity intersect to undermine asylum-seeking mother's ability to parent in healthy and safe environments. I also extend the scholarship on reproductive governance and reproductive justice by examining how infrastructural violence, surveillance, and immobility constrain reproductive autonomy and parenting practices for racialized, marginalized women.

Similarly, I add ethnographic insight into how reproductive governance and asylum systems together shape the parenting practices of asylum-seeking women. Recent research has explored the reproductive controls experienced by migrating and asylum-seeking women at the U.S.-Mexico border (Vergara 2021), and the multiple reproductive and parenting injustices facilitated through structural violence across the migration route and within the U.S. (Bianco 2019, Wilson et al. 2024). As I argue throughout this doctoral thesis, reproductive control is exercised not only through explicit policy but also through the enforcement of "American ideals" such as self-reliance and resilience. These ideals, coupled with the State's refusal to regularize the legal status of millions of racialized undocumented and asylum-seeking migrants, deepen both legal and health-based precarity for marginalized migrant women. In this context, I critique the normative constructions of "risk" as individual acts of deviance that require State intervention (Dodds 2009, Douglas 1992, Lupton 1999, Østergaard Møller and Harrits 2013), showing how Home Visitation Programs shift the burden of good reproduction onto marginalized migrant women by framing care as conditional and disciplinary.

Although the literature on reproductive governance is extensive, relatively few scholars have addressed the methods through which reproductive governance

can be a source of both support *and* suppression for racialized, marginalized women (Bridges 2017, Mavuso and Chadwick 2022, Unnithan 2022). Instead, prevalent literature on reproductive governance has focused on the ways in which the reproductive practices of racialized and marginalized women are controlled through practices of stratified reproduction and reproductive repression (Andaya 2022, Colen 1995, el Kotni and Singer 2019, Morgen and Roberts 2012, Mullings 2022). I explore the ambivalence of reproductive governance in Home Visitation Programs, which *do* offer essential support to migrant/asylum-seeking women even as they intrude upon and regulate their reproductive lives through surveillance and bureaucratic gatekeeping. Through this exploration, the more insidious undertones of reproductive governance of migrant populations through U.S. social welfare systems becomes visible (Foucault 2007), demonstrating the State's ongoing desire to shape parenting practices and control the reproduction of "undesirable" groups (Ross and Solinger 2017).

Following this idea, existing work has shown how both State and non-State actors influence reproductive behavior through various forms of social encouragement or discouragement, economic incentives, restriction of access, and coercion (Andaya 2023, Morgan and Roberts 2012, Solinger 2005, Unnithan 2022). I contribute to this by broadening our understanding of the types of mechanisms that can be considered when interrogating acts of reproductive governance–i.e. infrastructural violence that limits access to care and the everyday immobilities produced by the asylum system. These unintentional and intentional forms of reproductive governance ultimately serve to benefit the broader socio-economic goals of the State (see Unnithan 2022), which profits from migrants' labor and capital without investing in their health, legal status or well-being precisely because migrants are viewed as *undeserving* of care. And as I argue below, this context of State-induced precarity– a form of reproductive violence– systematically erodes the reproductive rights of Central American asylum-seeking women.

Understanding Reproductive Violence through Reproductive Precarity

While reproductive violence is often understood as direct acts of sexual and obstetric violence and coercion around pregnancy and birth (Chadwick and Mavuso 2021, Das 2008), I offer an alternative perspective. Throughout this doctoral thesis, I have shown the quotidian and constant conditions of State-induced precarity that hinder Central American asylum-seeking women from managing their own health and raising their children well in the United States. Following anthropologist Gianna DeJoy (2019), who argues that State policies which inhibit reproductive autonomy should be understood as forms of structural violence, I maintain that State policies and programs that impede reproductive autonomy through precaritization, inaccessible healthcare, and barriers to mother work should be recognized as forms of reproductive violence. In 2025, we witness daily assaults on women's rights and the rights of those made precarious by the State– through harmful policies, and racist, colonial conceptions of belonging and equality. With this in mind, I argue that the frameworks for understanding reproductive violence must attend to the everyday mechanisms that produce and sustain State-induced precarity. These include eligibility restrictions that deny asylum-seekers comprehensive health care and social services; risk assessments that subject precarious women of color to intensified State surveillance; and infrastructural barriers that make care services inaccessible. Together, these mechanisms obstruct reproductive labor–specifically parenting– for Central American asylum-seekers and other marginalized populations.

Reframing precarity-inducing practices and their outcomes as reproductive violence highlights the violent impact of State policies on reproductive subjects whose rights and needs are often denied by those same State policies. Through this, applied anthropologists can work towards targeting these policies for positive change and prepare ourselves to deal with further harms that the current U.S. administration will likely unleash. Specifically, an anthropological approach makes it possible to analyze the successes, or failures, of both liberal and punitive reproductive health policies and programs by creating space to

critique the "complexities of program implementation" through the "multiplicity of actors and interests [and] locales of power and influence" (Wallace, MacDonald and Storeng 2022,3). As suggested by Laverty and De Vos (2021), by centering our understanding of reproductive violence through the rights-based framework of reproductive justice, it becomes possible to see both the structural conditions that impede reproductive autonomy; *and* the structural conditions that have the potential to increase reproductive autonomy. This doctoral thesis has underscored the multiple structures that impede reproductive autonomy and keep asylum-seekers stuck in a space of liminal legality, and examined the physical and bureaucratic infrastructures that restrict access to services and care. Together, these limit whether and how asylum-seeking women can access social and health-based services for themselves and their children. Consequently, reproductive autonomy is restricted by limiting women's choices for health care, nutrition, and social service support, directly constricting their mother work and increasing their *preocupación*.

However, in this doctoral thesis I have also shed light on the potentialities that other service providers and social systems have to further reproductive autonomy, namely, community-based doulas and Home Visitation Programs. California added doulas to the Medi-Cal system in 2023, and although there have been frictions between the state and doulas regarding pay rates and difficulty navigating the registration system (Robles-Fradet 2024), as of early 2025, there were 100 doulas registered on Medi-Cal in Los Angeles County alone (over 900 throughout the state) (DHCS 2025a). With this shift, hopefully it will become easier for more women of color to have a community-based doula (CBD) attend to their birth. However, it is important to note that CBDs are only necessary because of the deeper, more insidious symptoms of implicit biases and structural racism that still imbue the biomedical healthcare system (DHCS 2024). They alone cannot, and should not, be the only line of defense to improve the birth outcomes of racialized, marginalized women of color in California. Likewise, we cannot assume that just because a community-based doula shares communal relationality with their client during childbirth that they will be the most suitable care provider. Yet, there is hope that through their work in the birth space, they

can make room for transformative agency (Béhague et al. 2008) across the broader biomedical perinatal care system. As explained by Béhague et al. (2008), birth supporters–whether family, doulas, or otherwise–have the capacity to see the tensions and conflicts that arise between birthing people and biomedical practitioners because they are outside the doctor-patient power hierarchy. From this position they can mobilize those conflicts through their advocacy work to improve birth treatment and create space for "collective transformations" within the birth system. In the case of CBDs, I argue that they have the potential to make a real impact in how biomedical practitioners interact with all their patients–not just those who have a community-based doula present at birth–by calling attention to spaces of tension born out of racialized biases in California birth spaces and healthcare policies.

Home Visitation Programs, which have proliferated in California in the past decade, have the potential to do more than provide their clients with access to services that help to improve their lives. Social and health-based programs that aim to improve the individual and social determinants of "risk" often fail to transform the broader structural failures that lead to poor health outcomes for those targeted for intervention by the State (Yates-Doerr 2020). Instead, they engage with more palatable "downstream" structural problems (i.e. the lack of safe housing in communities of color) while downplaying the larger "upstream" structural problems that cause downstream problems to begin with (i.e. the structural racism that led to redlining and disinvestment in communities of color) (Yates-Doerr 2020).

Although it is unlikely that Home Visitation Programs can tackle the larger structural issues that cause intersectional precarity in their clients' lives, they could build more effective interventions that would mitigate "risk factors" and promote community organization efforts that would better support all mothers and children. For instance, programs could shift their interventions away from individual mothers and include other caregivers, such as fathers and grandparents. They could create community-centered models that facilitate access to education, social services, and healthcare for the entire community, and hold events to build social connections. Most importantly, they could expand their

educational activities to inform policymakers and health professionals about the real, and detrimental, impacts of State-induced precarity and healthcare inequity that become visible through their interactions with Home Visitation clients. Though these changes, Home Visitation Programs could temper the neoliberal expectations that mothers alone are responsible for their own success and resilience. Not only would this help to alleviate the weight of over-surveillance on individual mothers who utilize HVPs, but it could also re-orient the responsibility for improving children's health, educational and economic outcomes onto the State by calling for more robust and reflexive social welfare systems.

Working Towards Reproductive Justice

As the United States and other countries move towards fascism and authoritarianism, it is imperative that future anthropological research continues to speak truth to power and engage with the uncomfortable truths in our societies. My research has demonstrated the deeply harmful impacts of callous, unethical, and racist policies on the lives of asylum-seeking women. The rights to decide when and whether to have a child, how to give birth, *and the capacity to raise children in a healthy and safe environment* continue to be undermined by anti-reproductive justice policies embedded in federal, state, and local law, and abetted by a fearful and toxic environment of hostility and intolerance. As DeJoy (2019, 46) notes, "Structural violence should be countered with structural intervention." Future research and policy work must expand the definition of reproductive violence to include the everyday mechanisms of reproductive governance and structural violence that erode reproductive autonomy. A broader view of violence is necessary if we are to challenge the harmful reproductive policies and systems that uphold reproductive injustice in the United States.

For example, future anthropological research could inform local and state-level service interventions that promote both mobility justice (Sheller 2018) and reproductive justice by examining how infrastructural violence restricts mobility and thus access to care for various precarious populations in the U.S. Additionally, by including fathers and other care workers within parenting and reproductive governance research, we can better account for the social networks that impact

mother work, child rearing, and family well-being. Long-term ethnographic studies could also illuminate the impact of community-based doulas by examining how precarious groups of women experience childbirth with CBD support, and how these doulas navigate hospital systems and institutionalized care. Through these various projects, anthropologists can contribute much needed research on the workings of health policies and healthcare systems to improve future reproductive health interventions in the U.S. and further afield.

While this doctoral thesis focuses on the multiple forms of structural and reproductive violence experienced by Central American asylum-seeking women in the US, the reproductive rights of all women, non-gender conforming birthers, LGBTQ+ individuals, and others whose reproductive lives are shaped by intersectional discrimination and precarity are increasingly under threat. Reproductive justice for all is essential if we hope to create a society in which safe, supported, and respectful reproduction and parenting are possible. As this doctoral thesis has shown very clearly, change is needed on every front: the built environment, immigration policy, access to food and nutrition, perinatal and postpartum care, affordable childcare, and the infrastructure that binds them.

Such systemic change is possible–and already underway. In Los Angeles, organizations like Frontline Doulas (Frontline Perinatal Liberation LLC 2025) and Happy Mama Healthy Baby Alliance (2025) provide free or low-cost community doula services to women of color. The Refugee Children Center (2025) and the Esperanza Immigrant Rights Project (2025) offer legal support, education, and health and wellness programs to asylum-seeking communities. SisterSong (2025) and the National Latina Institute for Reproductive Justice (2025) continue to fight to protect reproductive freedom for marginalized communities nationwide. As Harsha Walia reminds us, "While power is omnipresent… injustice is not ordained to determine our future. Empires crumble, capitalism is not inevitable, gender is not biology, whiteness is not immutable, prisons are not inescapable, and borders are not natural law" (2021, 254). And I would add: the acts of reproductive violence that the State perpetuates against racialized and marginalized women do not go unseen–or unchallenged.