Onward: An Ethnography of Latina Migrant Motherhood During the COVID-19 Pandemic

Jessica P. Cerdeña

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Abstract

Onward: An Ethnography of Latina Migrant Motherhood during the COVID-19 Pandemic

Jessica P. Cerdeña

2021

This dissertation evaluates the experience of Latina migrant mothers living in New Haven, Connecticut amid the COVID-19 pandemic. I ask: How do Latin American migrant women accommodate traumatic histories and motherhood amid a global public health and economic crisis? This ethnography demonstrates the powerful ways women cope with histories of trauma and ongoing structural adversity. Using the metaphor of the monarch butterfly, I consider processes of migration from Latin America and adjustment to life in the U.S., motherhood including the sacrifices women make for the betterment of their children, and metamorphosis, or transformations in response to the COVID-19 pandemic and ongoing structural vulnerability. Using person-centered ethnography, oral history, and archival data, I constitute intersubjective experiences within their political, social, historical, and cultural contexts. In Part I, “Migration,” I re-evaluate the demographic category of “Latinx,” consider patterns of migration from Latin America to New Haven, examine relationships between the Black and Latinx communities of New Haven, and trace movements of collective organizing for empowerment of the New Haven Latinx community. In Part II, “Motherhood,” I narrate the lives of migrant mothers, attending to their experiences of state failure in Latin America, ongoing structural violence in the U.S., and adaptation, focusing on the ways women orient themselves toward the futures of their children. I coin the terms “strategic coupling” to
characterize the ways women engage in romantic and legal relationships with men to access social, political, and financial capital; “imperative resilience” to describe cognitive and social strategies of survival and resistance to oppressive regimes; and “intergenerational fortitude” to refer to the ways women harness the wisdom, experience, and values of their maternal forbearers to better support their children. In Part III, “Metamorphosis,” I discuss the embodied and sociopolitical impacts of the COVID-19 pandemic on migrant populations, interrogate the racialization of Latina pregnancy and birth and experiences of bureaucratic disentitlement in the process of care-seeking, and discuss policy solutions to mitigate the harms of structural vulnerability for Latin American migrant mothers. Through this engaged and ethnographic work, I aim to promote structural competency for scholars and clinicians and advance health equity for migrant communities.
Onward: An Ethnography of Latina Migrant Motherhood during the COVID-19 Pandemic

A Dissertation

Presented to the Faculty of the Graduate School of Yale University

in Candidacy for the Degree of Doctor of Philosophy

by

Jessica P. Cerdeña

Dissertation Director: Marcia C. Inhorn

December 2021
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It was a Saturday morning, and I was in clinic. I cupped my hands around my thermos and took a sip of burnt coffee, sliding my tongue along the back of my gums to loosen a glob of peanut butter from that morning’s breakfast; Costco peanut butter sandwiches and coffee can feed a crowd on the cheap. I rolled back into the desk chair, opened my binder, and reviewed my notes from my last session with this patient.

Eulalia was fifty-seven, separated, with one daughter. Originally from Mexico, she had been living in the states for the past twenty years—first in Long Island and now in New Haven. She was referred to me after screening positive for depression in her medical visit, where her student providers were treating her for a host of issues, including back and knee pain, headaches, and bladder prolapse. Eulalia’s initial PHQ-9—a depression screening measure—was 17, suggesting moderately-severe depression. Together, we were completing psychoeducation sessions to help her understand and manage her stress, particularly as it relates to her experience as an immigrant. I traced my pen over the bulleted notes I had made at during our last session on stress and migration.

- migrated with ex-husband in search of work opportunities
  - ex-husband unfaithful, manipulative —> separated
- remarried
- new spouse U.S. Citizen, controlled finances
  - daughter witnessed abuse
- priest told her to protect daughter, seek fresh start
- moved to New Haven, worked as tailor
- daughter withdrawn, failing
  - attempted suicide with medication overdose
- now living with father
- believes trauma from husbands’ abuse pushed daughter to suicidal thoughts

My pen rested on that last line.

About forty minutes after our scheduled appointment time, I received a text that Eulalia had arrived. I walked to the waiting room to meet her: upon seeing me, the creases around her eyes and the corners of her mouth split into a smile. She removed her hat, uncovering smooth black hair with a few rebellious grays springing from her temples. I led her to the clinic room and we each took a seat.

I slid my fingers across my white presentation binder and turned to the section on social support. Before I could finish reading through the content of the educational module, Eulalia interrupted me.

“My daughter is everything to me. She and I only have each other. But she wants to leave to go back to live with her father in Long Island. She thinks things will be better there. I am so afraid for her.”

Hot tears streamed down Eulalia’s face.

“She tried to kill herself this weekend,” she stammered. “She took all the pills out of the medicine cabinet and tried to take them. I found her when she was starting on the second bottle. We took her to Yale, but we told them it was an accident, that she’d
misread the label. Praise God, she was okay. But I am so afraid for her. I think this is all my fault.”

Eulalia sobbed, heaving deeply as I handed her a box of tissues. When she caught her breath, we started talking about her relationships with other mothers, with her pastor, and with her church community. Together, we developed a plan to respond to her daughter’s cries for help while increasing her self-care activities. Over the next six weeks, I saw Eulalia cry less. In our last session she told me,

“She’s gone to live with her father for the summer. I’ll never understand, but I have to accept it. She’ll come back to Connecticut to finish her senior year of high school. My hope is for her to go to college, to have a better life. She’s so bright.”

Although the tense pitch of her voice revealed her pain, Eulalia exuded a confidence I had not seen before. Somehow, sharing her suffering had lessened it.

Eulalia’s story pierced me, shaping the way I conducted future psychoeducation sessions with migrant patients experiencing depression. As I gently interrogated about their relationships with their children, I learned more and more about how these individuals—particularly migrant mothers—feared their traumas affected their children. Whether immigration detention, financial stress, child sexual abuse, or intimate partner violence rose to the top of their list of stressors, many of these women felt that their children’s emotional or psychological conditions resulted in part from their mother’s wounds.

I was not familiar with the literature on intergenerational trauma at the time I conducted these sessions with Eulalia and other women like her. However, when I began
my Ph.D. coursework in the fall of 2016, I came across a recent article that seemed to address what I had observed.

The study, led by Dr. Rachel Yehuda, a professor of psychiatry and neuroscience at the Mount Sinai School of Medicine, discussed associations of DNA methylation—a form of epigenetic modification—at a gene involved in the stress response among parents who had been exposed to the Holocaust prior to having children, and the children themselves. In other words, the study demonstrated—albeit weakly—a biological embedding of parental trauma on the epigenomes of their offspring.

This potential for biological underpinnings of intergenerational trauma drove me to further research, and supersized the index for questions I had developed. By what mechanisms could parental (specifically maternal) trauma influence offspring? How do mother’s narratives of trauma correspond to epigenetic signals? Do epigenetic modifications at stress-related genes actually affect the stress response? My dissertation would seek to answer all of these questions, using a bio-ethnographic approach.

**Impacts of COVID-19**

However, the COVID-19 pandemic derailed these plans. I had intended to collect salivary samples from mothers to assess methylation levels on white blood cells and buccal (cheek) cells. I also planned to measure cortisol levels in mothers’ hair during their third trimester to evaluate stress responsiveness throughout pregnancy. With newborn infants, I had hoped to measure cortisol reactivity, or the difference between cortisol responsiveness prior to and following a stressor, or their 2-month pediatric
vaccinations. I set out to discover a missing biological link that might explain multigenerational patterns of mental distress.

As COVID-19 restrictions took full force in March 2020, investigators like me were barred from conducting in-person research, particularly with biological specimens. Rather than devising a complicated system of mail-in sample collection and retrieval, I decided to switch gears and strengthen the ethnographic, life history, and theoretical foundations of this project. Though I no longer collected biomarkers, I believe the rich ethnographic accounts presented here more fully narrate the phenomenon of intergenerational trauma and coping.

This adjustment, though initially disappointing, has helped me to address one of my greatest concerns with my originally proposed research: What do I do if the biological data tell a different story than my interlocutors? How can I avoid reinscribing racially essentialist notions of Brown people as biologically inferior if it turns out trauma has epigenetic consequences? What forms of data really matter for the lives of the communities I care about? These questions had nagged me for nearly four years.

On May 27, 2016, the Atlanta Black Star posted a Facebook video with the caption: “Slavery Happened A Long Time Ago? Scientist Are Now Saying the Trauma May Be Encoded In The Genes of Black People.” In it, psychiatrist and neuroscientist Dr. Rachel Yehuda discusses her recent paper on intergenerational transmission of epigenetic marks in children born to survivors of the Holocaust (Yehuda et al. 2016). The makers of the video extend Yehuda’s findings to racialized trauma, suggesting that the mental and physical anguish endured by Africans who were captured during the transatlantic slave trade may be “encoded in the genes” of their descendants. To comment on this
phenomenon, the video turns to Joy DeGruy, a social work scholar and author of *Post-Traumatic Slave Syndrome*. DeGruy argues that it is “not plausible” for Black Americans to have averted stress-related illness due to the multiple traumas the generations of their ancestors sustained over hundreds of years. As of July 2021, this video has been viewed more than 4.7 million times.

Viewer responses reflect widespread feelings of affirmation. One top commenter on the video notes, “I knew this before I [sic] was even scientifically know [sic] by looking at the hurt and anger in my mothers and elders.” Another insists, “black ppl [people] did not need science to prove that if a people are made to be mentally, physically, spiritually, financially and socially oppressed ...while tortured and tamed, the effects thereof will essentially carry on down through their bloodline.” For these viewers, molecular evidence of the trauma of slavery is redundant and unnecessary: the narratives and embodied experiences of their relatives and ancestors reveal more than could any chemical tags on DNA.

However, many members of the academic community have received the early findings of social epigenetics research with greater enthusiasm. Scholars across fields of biomedicine, philosophy, sociology, and anthropology have acclaimed the potential for epigenetics to characterize the biological impact of social forces (Kuzawa and Sweet 2009; Non and Thayer 2015; Thayer and Kuzawa 2011; Shannon Sullivan 2013; Chung et al. 2016) In particular, biological anthropologists Zane Thayer and Chris Kuzawa emphasized the promise of epigenetics to reveal how factors like social and economic inequality “get under the skin” to create health disparities (Thayer and Kuzawa 2011). Calling it a “science of social science,” medical physicist Emma Chung and her cross-
disciplinary team of social science and biomedical scholars claim epigenetics can transform social science by forging a “social epigenome” that encompasses the “myriad miniscule interactions that are at once socioculturally and materially, relationally and biologically situated” (Chung et al. 2016). These commentaries reflect a keen, transdisciplinary interest in novel opportunities for epigenetics to bridge the life and social sciences and to translate into interpretable information such methodologically elusive phenomena as racism, trauma, and poverty.

Seeking to enrich the bank of data characterizing the “social epigenome,” the National Institute for Minority Health and Health Disparities (NIMHD) and the National Cancer Institute (NCI) created a funding opportunity in 2016 dedicated to “Social Epigenomics Research Focused on Minority Health and Health Disparities.” In the funding announcement, the Institutes state their intent to support investigations that identify and describe the mechanisms that influence gene function in a way that modifies health risks in minority populations. The announcement elaborates further in its Research Objectives:

The overarching objectives of this initiative are to (1) advance the science of epigenomics focused on minority health and health disparities, (2) expand approaches for understanding epigenetic mechanisms by which social factors lead to biological changes that affect health disparities, and (3) promote epigenetics research to better diagnose disease risk or resiliency among disadvantaged populations. Successful projects will support human-based epigenomic research, with a particular focus on the identification and study of human epigenetic marks that are of social origin or are substantially influenced at a population level by social processes.

Through these grant opportunities, the National Institutes of Health, emblematic of the scientific ‘mainstream’, endorses fitting epigenomics research as a missing link between social factors and inequitable health outcomes. No longer a fringe idea advanced
by a contingent of socially conscious scientists, “social epigenomics” has gained traction with the world’s largest funder of health research (Viergever and Hendriks 2016).

The academic and lay person responses to the promises of epigenetics remain out of sync. The research community believes that “social epigenetics/epigenomics,” that is, the study of environmentally sensitive molecular modifications to the genome that correspond to social processes, hold the key to understanding the biological underpinnings of health disparities affecting socially disadvantaged communities. By contrast, members of these communities express a belief that epigenetic evidence merely corroborates what might already be understood from listening to their family and life histories.

COVID-19 restrictions forced me to focus on the power of narrative for understanding complex phenomena like intergenerational trauma. In her book *The Social Life of DNA*, referring to the forensic investigation of the remains of the formerly enslaved man, Venture Smith, Alondra Nelson asks, “Why is there a need for scientific support of Smith's life history if historians declare his account a sufficient source in and of itself? Why is DNA analysis deemed to proffer more valuable or reliable information about a man's familial history than his own words?” (A. Nelson 2016). This issue also resonates on a personal level.

**Positionality**

Although I first approached this project as a clinician, this subject echoes my family history. My grandmother is Chilean. My great-grandfather was Mapuche, an Indigenous man from rural southern Chile, who married a Yugoslavian woman and moved to the United States. My grandmother, like many Latinxs with strong European
heritage, identified more strongly with her Slavic background—evidence of the pervasive anti-Indigenous racism in the Americas. Although it was his second language, my great-grandfather primarily spoke Spanish, but spoke a broken Serbo-Croatian-Slovenian with my great-grandmother. My grandmother never fully learned Spanish, married an Italian man, and his mother and sisters inculcated her into the traditions of New York Italianism, effectively overshadowing her Chilean culture. Even now, despite their dark features and high cheekbones, my aunts and uncles choose not to identify as Latinx; in fact, they actively resist the label, deluded by the racist mirage of assimilationism and the allure of Whiteness.

I am Indigenous, but I am not an Indigenous scholar. I have no attachment to the Mapuche actively exercising territorial autonomy and protesting economic inequality. Apart from a DNA test, a family tree, and my solidarity, I have no current ties with these communities. I am affected by historical and cultural loss. At the same time, my heritage makes this project more personal.

During my oral qualifying exams for this project, I discussed the types of trauma Latin American migrants confront during the process of relocating to the United States. One of my examiners listened intently, then furrowed their brow. “I am not convinced that these types of experiences constitute ‘trauma,’” they said.

I froze. I felt as if they had balled up my exam and lodged it deep in my esophagus. What do you mean? I wanted to ask. I felt hot tears fill my sinuses. I muddled through an answer, sputtering out words like ‘precarity’ and ‘violence,’ interspersed with a few statistics. I received the word that I had passed, accepted the congratulations, and went to my car to cry.
I could not explain it at first, but those words felt visceral. They undermined the premise of my work: my observations as a clinical student and later, I understood, the new meanings I had created about my family.

In the following weeks, I thought more about my grandmother. She grew up poor in Hell’s Kitchen. Her father, though kind, struggled to express himself and their time together passed largely without words. Poverty strained her parents’ marriage, and though they barely spoke the same language, they argued constantly. When I ask about my great-grandmother, all I hear is, “She was mean.” My grandmother cared for her younger siblings, all while enduring the emotional abuse of her mother and the silence of her father.

It is not possible to attribute my grandmother’s mental illness entirely to her social circumstances and her status as the child of immigrants. But as I listen to her narrate her life, it is hard for me to believe that the structural vulnerability her family endured did not contribute to the development—or exacerbation—of her bipolar disorder. When examined through the lens of intergenerational trauma, I see a woman who develops mental illness after confronting her mother’s verbal abuse and her father’s withdrawal after fleeing displacement from his community’s ancestral lands. Hearing from a trusted mentor that Latin American migrants do not experience trauma called into question my family’s history.

Again, I do not claim to be part of the same community featured in this research. I have lightness, U.S. citizenship, and unaccented, native English proficiency, which is not true of many of my interlocutors. At the same time, my ethnic ties to my interlocutors and my narrative relationship to my research hypotheses have compelled me to constantly
examine the origins of my claims to knowledge; mine, like all knowledge, is situated (Haraway 1988).

Importantly, this is not a decolonized dissertation, not even close. Although the idea for this project emerged from community concerns, this work exhibits many of the pitfalls of colonialist anthropology, White academia, and my education at predominantly White institutions. I have attempted to democratize this study by engaging my interlocutors and oral history narrators in my interpretations of the data and plans for dissemination, and by working with undergraduate research assistants who hail from similar communities. At the same time, I acknowledge the power hierarchy imposed by my approach to research and seek to further disrupt it in my future scholarship.

This dissertation

This dissertation attempts to evaluate the experience of migrant motherhood amid the COVID-19 pandemic, demonstrating the powerful ways women cope with histories of trauma and ongoing structural adversity. I ask: How do Latin American migrant women accommodate traumatic histories and motherhood amid the COVID-19 pandemic? Although this work examines many aspects of social suffering, it is not a ‘pornography of pain.’ I do not believe it is necessary for those with relatively greater social, cultural, political, and financial capital to experience symbolic proximity to ‘sufferers’ to engage in moral action (Dean 2003). Instead, I intend to characterize the strategies women employ in response to structural—and global—disadvantage, and the ways policies can foster reproductive and mental health equity.

To this end, I speak to community health workers, community organizations, clinicians, social workers, and policy makers. As a physician-anthropologist in training, I
aim to bridge the sectors with the power to enact structural reform with those that directly influence the health and social conditions of migrants. I hope that, by reading this dissertation, clinical workers—like I was as I cared for Eulalia—can enhance their structural competency (Metzl and Hansen 2014) to promote health equity.
Introduction

"This is how we push onward": Célia's Story

I met Célia and her new baby at their apartment complex in East Haven, Connecticut before COVID-19 restrictions precluded in-person interviews. As I entered the shadowy building, kicking off the freshly mown grass from my shoes, I noticed the mailbox for her apartment was scribbled with iterations of her and her husband’s surnames: The uncommonness of multiple surnames in the U.S. often provokes confusion in bureaucratic settings like medical registration or mail delivery.

I tapped the apartment door, clutching the congratulatory gift bag I held for Célia and her family. Almost immediately, Marcelina, Célia’s sister-in-law opened the door and ushered me in, her face glistening with sweat and her hair swept into a ponytail.

“Thank you, you are too kind,” she said, setting the gift bag on the countertop. “Célia will be out in a minute.”

A little boy with short, dark hair sat on a potty chair in the living room watching Nick Jr. in Spanish. His shirt, printed with the characters of Paw Patrol, rode up to reveal a round belly curving over his squatted legs.

After a minute, Célia appeared, wearing plaid red flannel pajamas and a thick elastic band across her belly. She smiled softly, her face heavy with fatigue.

“How’s the baby?” she asked Marcelina.

“Sleeping,” Marcelina answered quickly, adjusting saucepans on the stove. “He’ll probably want his milk soon.”

I peered into the bassinet to see a wrinkly face framed by downy black hair. The baby’s fists stretched toward his face as he wriggled in his white swaddle blanket.
I reached to the gift bag and handed out the diapers, fruit, and slippers I had brought. Célia thanked me and called to her older son, Alonso, offering him an apple. Alonso rushed over, pants at his ankles, as Marcelina hurried to yank them over his bottom. He grabbed an apple and took a too-big bite, smiling at me.

Célia and I sat at the small round table in the kitchen and began to talk. She shared the story of her migration, her adjustment to the New Haven area, and her birth. Back in Ecuador, Célia had studied to be an accountant, earning the equivalent title of a CPA or Certified Public Accountant. She took a job as a bookkeeper at a large company. Despite working over sixty hours each week, Célia could barely pay her mortgage and other household expenses. Then, their first baby was born, and her husband lost his job.

“Our country only offers jobs to young people,” Célia explained. “They want you to be young, but also to have work experience. It’s very contradictory. At 40, you’re already old… they’d prefer a 20- or 25-year-old. If you can find a job, the options are limited. You have to take jobs that demand a lot of time for little pay. It’s not worth the sacrifice of so many hours away from home, away from your son or your wife when your salary barely covers your expenses. You cannot even look for a job, thinking, ‘Well, with two jobs, I could help my family’ because the first job demands you to work all day, ten to twelve hours.”

“They want you to have a bachelor’s degree to wash dishes,” Marcelina added, rolling her eyes.
“You face a tough decision. You think, ‘I’m going to be away from my country, my family, everything I know. Here, I am with them, but I can’t feed them.’ We cannot live on love alone.”

Célia stood among the fortunate few I interviewed who was able to obtain a family tourist visa to join her husband in the U.S. She came with her then eight-month-old baby.

“We told her to be careful,” Marcelina explained. “In Ecuador at the time, children were being kidnapped. So, we said to her, ‘Don’t let your guard down. If you have to lose the suitcase, drop it, but don’t let go of the baby for any reason.’”

Abruptly, Gabriel, the newborn, let out a high-pitched yell.

“It’s okay, mi amor, we’ll solve it together,” Marcelina crooned. She jiggled Gabriel in her arms and passed her to Célia, who snuggled him to her breast to nurse.

When they arrived in the U.S., Célia took a job cleaning houses while her husband worked in construction.

“Here, the work is harder, but you get paid enough to get by,” Célia told me. “I got used to it. I like to work. I would finish at 3 or 4 in the afternoon and come home to serve my husband and my son soup for dinner, to prepare his lunch for the next day. In my country, I could never see my baby.”

Everything changed when the pandemic hit in March 2020. Célia stopped working to avoid exposures while pregnant and to take care of her son. Meanwhile, her husband was laid off for several weeks from his construction job. As he resumed work, the entire family feared he would bring the virus home.
“At first, it was very drastic,” Marcelina described. “He would come home and undress at the door. Even the baby panicked and if his father tried to hug him, he’d yell ‘no!’”

“It was pretty traumatic,” Célia commented.

Yet, despite losing work, Célia’s family strategized and worked through their issues.

“I talked with my husband about how we could cut back our expenses and ease our stress,” Célia elaborated. “When you have children, you have to be calm for them—not act tense or fight. This is how we seguir adelante [push onward].”

From intergenerational trauma to moving onward

Célia narrates the challenges of living amid social failure and her strategies to adapt and push onward, or seguir adelante. Her story is both exceptional and ordinary: Her experiences of undercompensated work and insecurity in Ecuador resonate throughout my interviews with other women, and yet her advantage at arriving in the U.S. on a tourist visa is a privilege few others shared.

In many ways, Célia’s story exemplifies the ways my dissertation research surprised me. I thought I would study intergenerational trauma, although I did not limit my study to women who reported traumatic histories. Célia endorsed none of the experiences of migration-related trauma I assessed. Her symptoms—scored a 5 out of a possible 80—did not meet clinical criteria for post-traumatic stress disorder (PTSD), but rather reflect her precarity as an undocumented migrant woman from an unstable situation in her home country. Célia endorsed unwanted memories of stressful
experiences, primarily recalling the poverty and attendant violence in Ecuador, memories that often resurge as she watches Spanish news. Célia also reported hypervigilance and mistrust of others given her role as a mother of two young children living unauthorized in an unfamiliar country.

Célia also narrated powerful ways of adapting to her shifting social circumstances. She worked long hours in Ecuador, hoping to support her husband and infant son. When her husband’s and her salaries could no longer meet their expenses, Célia made the difficult decision to leave and resettle in New Haven, fearing all the while that her son might be kidnapped during the trip. Once in New Haven, she quickly took up work cleaning houses—betraying her university education in accounting—grateful for work that paid fairly and allowed her to return to her family before the evening. To make ends meet, Célia told me she and Marcelina occasionally cooked and sold typical Ecuadorian dishes, including *humitas* or steamed corn cakes, for extra income. When the pandemic challenged their finances, she sought support from local diaper and food banks, including the migrant mutual aid organization, Semilla Collective.

I further had not anticipated conducting my research amid a global pandemic. Célia’s story relates both the interpersonal impact of the pandemic—the stress of her small son fearing contracting the virus from her working husband—as well as the economic fallout. My research encountered women in some of the most challenging times of the pandemic, as they juggled job loss, reduced pay, illness and death of friends and family, remote schooling for their children, mask mandates, and the inability to access pandemic relief benefits like increased unemployment or stimulus checks. In this
way, my research provides a contemporaneous glimpse of the impacts of COVID-19 on urban migrant mothers.

Methodological approach

This dissertation relies on person-centered ethnography to capture the experiences of migrant mothers. This approach seeks to characterize human behavior and the subjective and intersubjective experiences of the interlocutor. Person-centered ethnography provides a high-resolution image of the interrelatedness between individuals and their social, material, and symbolic contexts. In medical anthropology, this methodology permits interrogation of the ways historical, political, social, and cultural contexts constitute human behavior, psychology, and biology (Bernard and Gravlee 2014). Specifically, I conducted in-depth, semi-structured interviews with 65 women between January 2019 and May 2021. These interviews spanned sociodemographics, migration histories, experiences of social adversity and adaptation in the U.S., health and reproductive histories, attitudes toward parenting and motherhood, and responses to the COVID-19 pandemic. I completed follow-up interviews with 12 women and life history interviews with 3. Follow-up interviews with postpartum women addressed birth experiences, particularly considering COVID-19 restrictions, parenthood and infant care, and social support. Life history interviews occurred in an open-ended format and often included experiences of childhood, especially parent-child relationships, education, labor, social relationships and romantic partnership, migration experiences, and motherhood. Each interview lasted between 45 minutes and 4 hours: In total, I completed just shy of 100 hours of ethnographic interviews.
My original biomarker study required a sample size of 98 to detect a significant difference in methylation levels at my primary gene of interest. As I began to approach code saturation, I determined, in consultation with my dissertation advisor, my final target number of interviews; I achieved thematic saturation with considerably fewer interviews (Lowe et al. 2018; Guest, Namey, and Chen 2020; Hennink, Kaiser, and Marconi 2017).

Due to the COVID-19 pandemic, I conducted most of my interviews (93.8%) over the phone. This approach posed various challenges: Connections and audio quality sometimes fell short of ideal, and I could not offer the same affirmation and encouragement as my nonverbal cues might have in person. I also faced additional challenges with interpreting responses as I could not read body language signals for comprehension, discomfort, and truthfulness. For instance, though no women in my study reported being raped during migration, I could not evaluate whether these responses may have reflected withholding due to shame or cognitive avoidance. At the same time, phone interviews also afforded multiple advantages. I could ‘meet’ women in their homes, amid their busy lives, rather than confining the interview to a conference room in the prenatal clinic, which I had originally planned. The flexibility of the phone call also allowed interviews to pause and recommence, or to take place at atypical hours like seven in the morning or six o’clock at night. Prior research demonstrates that phone interviews are both reliable and valid when compared with in-person interviews (Cook et al. 2003; Pattnaik et al. 2020).

Vignettes constructed from these interviews and surveys incorporate light editing for clarity and brevity. I further pseudonymized all participants to protect confidentiality.
In rare situations of extreme concern for individual privacy, I altered narrative details to further anonymize accounts.

Finally, I employed historical techniques of oral history interviews and archival research to describe patterns of Latin American migration to New Haven and consequent shifts in social and political relations. I conducted these oral history interviews with thirteen individuals, including journalists, politicians, activists, and community leaders with ties to the Latinx population of New Haven, amounting to 22 hours of discussion. I further incorporate findings from archival and demographic research—both from personal archives and library sources—to corroborate these oral history narratives.

The Yale Human Investigation Committee (HIC) for biomedical research approved my study. I relied on women’s trust in providers at the Women’s Center at Yale-New Haven Hospital, who often directed women to me. Although I initially recruited women through informal conversations in the clinic waiting rooms—or in examination rooms prior to or following prenatal care visits—after the onset of the pandemic, this strategy shifted to flyer-based recruitment and post-visit phone calls to obstetric patients who identified as Hispanic/Latina or indicated Spanish as a preferred language.

Given the sensitive topics addressed in my interview schedule, including histories of trauma exposure, I worked closely with the Women’s Center social worker and a team at the Hispanic Clinic of the Connecticut Mental Health Center to preserve the mental health and wellbeing of any women who became distressed during the conversation. I also trained in Mental Health First Aid, and motivational interviewing, substance use intervention, and psychoeducation at the Hispanic Clinic. Fortunately, no woman became
acutely upset during our conversation; still, I partnered with on-call mental health clinicians who could intervene if the need arose. To recognize the time women invested in our discussions, I offered a $100 pre-paid gift card for participation in an initial interview and a $50 pre-paid gift card for follow-up interviews, including postpartum and life history interviews.

Although the original project included biomarker collection that COVID-19 restrictions precluded, this ethnographic final work draws relies on individual narratives to build upon the rich literatures on embodiment and local biologies. Defined by social epidemiologist Nancy Krieger as the lifelong biological incorporation of material and social conditions, embodiment refers more broadly to a mode of presence and engagement in particular sociocultural milieu; of understanding the body and physical intermediary between health and the actions of society, government, and culture (Krieger 2005; Csordas 1990; Scheper-Hughes and Lock 1987). In her study of survivors of terrorism and civil war in rural Peru, anthropologist Kimberly Theidon discussed how trauma might be embodied across generations, elaborating on a belief proposed by her interlocutors of suffering transmitted through a trauma-exposed uterus or “the frightened breast,” la teta asustada (Theidon 2012, 43–44). La teta asustada conveys the belief that trauma can manifest across generations as cognitive impairment or health challenges such as epilepsy (Theidon 2012, 44). This idiom reflects the collective assumption that a profound emotional or social experience can influence the biology of a person’s offspring.

Within the embodiment paradigm, the concept of “local biologies” refers to how, rather than a universal biology that remains inflexible across time and space, history,
politics, and culture can all modify the template leading to varied expressions of health and disease (Lock 1993b; 1993a; 2015). The concepts of “situated” (Lock 2017; Niewöhner and Lock 2018) or “exposed” biologies (Wahlberg 2018) push against the interpretation of “local biologies” as inherent differences in human populations, rather underscoring the specific entanglements between human bodies and their material and cultural milieu. This includes poverty, famine, war, genocide, radioactive waste, and “dysfunctional nations” (Lock 2017, 11).

To assess correlations between traumatic experience, subjective narratives, and psychopathology, I also carried out surveys of migration-related trauma and trauma symptoms, using the instrument proposed by Keller et al. (2017) and the PTSD Checklist for the DSM-5 (Weathers et al. 2013). Although I present some findings of these instruments, I juxtapose these with subjective renderings of traumatic histories, highlighting the limitations of rigid instruments to assess wellbeing. Similarly, I completed the Edinburgh Postnatal Depression Scale with postpartum women and note the ways that a focus on biomedical symptoms fail to attend to the more complex interconnectedness of social experience and psychology.

**Introducing my interlocutors**

The women who shared their lives with me hailed from diverse areas in New Haven County. Although a plurality claimed the City of New Haven—particularly the Fair Haven and Hill neighborhoods—as home, others built their homes in West Haven, East Haven, Branford, Hamden, and Waterbury. The average age of women was about 31 years old and the length of time they had spent in the U.S. varied widely from 2 months to 24 years with an average stay of 7.8 years. With few exceptions, women lived in
rented homes, either apartments or townhouses; some who migrated alone rented a room in apartments or trailer homes with extended family or friends. Two-thirds of women already had children, ranging from infants to late teenagers: Twenty percent of already mothers had children they left behind in their home countries. More than half subjectively reported living in poverty—or nearly evading poverty—while the remainder identified as middle class. Most women were out of work due to the pandemic and those who retained employment worked in food service, health or childcare, housekeeping, or factories and distribution centers. I discuss further the economic and social impacts of the COVID-19 pandemic in Chapter 8.

**Monarch butterflies: a metaphor for migration and adaptation**

In his poetic, memoir-esque novel *On Earth We’re Briefly Gorgeous*, Ocean Vuong parallels the sacrificial move his mother made alongside the migratory patterns of monarch butterflies.

Female monarchs lay eggs along the route. Every history has more than one thread, each thread a story of division. The journey takes four thousand eight hundred and thirty miles, more than the length of this country. The monarchs that fly south will not make it back north. Each departure, then, is final. Only their children return; only the future revisits the past.

I employ this image of the monarch butterfly to visually imagine the lives of the mothers in this study. Monarchs are beautiful, simultaneously delicate, and capable of extraordinary feats. They are the product of a gruesome transformation from squishable, wriggly caterpillars into brilliantly painted, felt-winged fairies. This metamorphosis represents both “post-traumatic growth” (Tedeschi and Calhoun 1996) and adaptation amid constraint.
Most of my interlocutors planned to stay in the U.S. indefinitely: only eight (12.3%) had considered returning to their home countries. The permanency of the monarch’s migration characterizes the transgenerational histories of most women. Their children do not experience either the robust social support or the unrelenting insecurity of their home countries. They build lives for themselves as children of immigrants, with the cultural loss, liminality, “ni de aquí, ni de allá” (“neither from here nor there”), and tenacity such an identity requires.

These concepts of migration, motherhood, and metamorphosis capture key features of the narratives related by women in this study. Ultimately, I hope that this image of elegance and strength will prevail over any pitiable accounts of suffering. These women are so much more than their worst moments: The creativity, fortitude, and patience so many demonstrate allows them not only to survive amid trauma and structural vulnerability, but also enables them to soar.

Outline

Part I of this dissertation, “Migration,” centers on the history of Latin American migration to the New Haven area, a small coastal city along the I-95 corridor between New York City and Boston. This section reviews early settlement by Puerto Rican farmworkers, the demographic transition following influxes from Central and South America, and the formal and informal means of social and economic organizing of the Latinx community. Given New Haven’s reputation as a largely Black city, I examine the entanglement of Black and Latinx history in New Haven, including moments of
contention and cooperation. I further review ongoing consolidation of Latinx political power and community policy objectives.

Part II, “Motherhood,” narrates the ethnographic accounts of my interlocutors. Extracting from life history interviews, I discuss the impacts of state failure, or violence perpetrated on the part of governments to sow conflict and inequality. I then review migration histories and descriptions of migration-related trauma, underscoring the shortcomings of traditional trauma assessments and diagnostic thresholds. I discuss women’s recruitment of social support, specifically in male partners—which I call “strategic coupling”—in their pursuit of stability and security. I propose the term “imperative resilience” to describe the ways these mothers cope with the aggravated effects of structural vulnerability, racism, and disease. Finally, I discuss intergenerational patterns of mothering and the ways women accommodate their mother’s parenting approaches in their own interactions with their children.

Part III, “Metamorphosis,” addresses the impacts of the COVID-19 pandemic on migrant mothers and their experiences of healthcare-seeking. Engaging syndemic theory—and the compounding impacts of structural racism and infectious disease (C. C. Gravlee 2020)—I examine the consequences of the spread of the pandemic and governmental responses on Latina women. I then examine the strengths and shortcomings of healthcare delivery to migrant mothers, particularly their experiences of racialization. Finally, I focus on policy action, highlighting the work of local community organizations and the ideas imparted by interlocutors for strengthening systems of social support for migrant communities and mothers more generally.
PART I: MIGRATION
Chapter 1: What is Latinx?

Latinxs are the largest racial or ethnic group in the United States, numbering 60.6 million and constituting 18.5% of the population as of 2019 (U.S. Census Bureau 2020). By 2030, Latinxs are expected to comprise nearly 30 percent of Americans (Vespa, Medina, and Armstrong 2020). Latinxs are also the youngest racial or ethnic group in the U.S.: one-third of the nation’s Latinxs is younger than 18 years old (Noe-Bustamente and Flores 2019).

Latinxs—which is a gender-neutral term for “Latino/as,” abbreviated from Latinoamericanos—are a remarkably heterogeneous group. Latinx/o/a is an endonym referring to origin in or heritage from Latin America, including individuals who trace their roots to Central and South America and the Caribbean. Thus, a Quechua-speaking rural Indigenous Ecuadorian, a Spanish-speaking mestizo Costa Rican, a Totonaco-speaking coastal Mexican, a Creyol-speaking Black Haitian, and an Italian-speaking White Argentine may all identify as Latinx in the United States. In addition, many descendants of Spanish settlers in the southwestern U.S.—the hispanos, tejanos, and californios—who became U.S. residents after the Treaty of Guadalupe-Hidalgo in 1848 may also identify as Latinx/o/a (Haverluk 1997; Nostrand 2010). Responses to the needs of the Latinx community must therefore attend to pluralities in racial identity, language, origin, and migration history (Silva, Paris, and Añez 2017).

In this chapter, I discuss the heterogeneity of the U.S. Latinx community, highlighting the contradictions within this category. I then examine both the endogenous and exogenous politicization of Latinidad, including their relationships to immigration enforcement and racial hierarchies. I discuss the implications of monolithic
configurations of Latinxs in health disparities research and finally elaborate on my selection of the term “Latinx” (vs. Latino/a or Hispanic) to refer to this ‘population.’

**Latinidad as contradiction**

“How have heterogeneous Latin American-origin groups come to be imagined—and to an extent imagine themselves—as part of a pan-ethnic whole?” sociologist Michael Rodríguez-Muñiz asks in his book *Figures of the Future* (2021, xvi). “What forces have been at play and what have been the consequences?”

As an exercise in positionality, I asked each of my research assistants to reflect on their intersectional relationships with the broad umbrella of *Latinidad*. Their responses reflect the complex entanglements of race, politics, and gender in this category. One student explains,

I identify as an afro-latino and to tell you the truth it has been very difficult trying to reconcile with my Latinidad. I did not always identify as Afro-Latino because for the longest I wasn’t aware of such a label. My mom and grandma are both Afro-Boricua and I still, because of the way Latinidad is presented, did not associate them with being black as a child. People have this image in their head of what a Latinx person is and this image contributes to the erasure of black and indigenous Latinx folk. I identify as Afro-Latín because to not do so would be an offense to my ancestors that were forcibly removed from Africa and brought to PR [Puerto Rico] as slaves. I know because of my proximity to blackness that these ancestors exist and that I am a product of their exploitation. I honor them every day that I am alive because their blood runs through my veins. Identifying as an afro-latino has also been difficult for me though because I am fair-skinned as a result of my multi-racial identity. Navigating identifying as black and what that means for me is something I worked on for a very long time. Ultimately, Latinidad has really complicated the journey to embracing and understanding my identities. The struggle to get to where I am today though has made me very critical of Latinidad. I always fight for a more inclusive definition and it made me realize how diverse Latinidad actually is.

This narrative pulls at the tensions between *Latinidad* and racial identity, particularly articulations of Blackness. History suggests that activists constructed “Hispanic/Latino” as an organizing category distinct from Blackness. Historian Sonia
Lee proposes the concept of “bifurcated racialization” to explain the way that Latinxs—particularly Puerto Ricans—imagined themselves as “exaggerated opposites” to Black Americans.

Puerto Rican elites saw black “militancy” in contrast to Puerto Ricans’ “patience,” just as black leaders saw African Americans’ racial identification as “black” as politically more radical than Puerto Ricans’ ethnic identification as “Puerto Rican.” Within this configuration, Puerto Rican elites constructed “Hispanicity” as an ethnic identity that was mutually incompatible with “blackness” to justify their desire to organize separately from African Americans (S. S.-H. Lee 2014, 14).

This tension is particularly salient among the Puerto Rican community of New Haven, which first established a Latinx social group in New Haven. Chapter 3 further examines the friction between the Latinx and Black communities of New Haven, including the challenges of Afro-Latinidad.

As the first student nodded to the way Latinidad erases “[B]lack and [I]ndigenous [L]atinx folk,” another echoes this sentiment, focusing on her experience as an Indigenous Mexican American.

Coming from an indigenous migrant family means amazing things for me and complicates so much more. It’s about learning what my migrant communities mean when they refer to “their” Mexico while thinking about the Japondarhu (lake) and chiquicaztle (stinging medicinal herb) from “my” Mexico and the nostalgia I get from eating tamales in East LA and New Haven.

Part of my relationship to Latinidad and Indigeneity often meant feeling like an outsider with my peers. I did not feel comfortable enough to speak about things that were taboo with my “real” Mexican friends and much less the greater American population. Sacred practices around health and grooming stayed within the family and our compadres. I remember feeling afraid that I would be bullied by others for sharing my stories about the temazcal (communal sweat bath) in Mexico and the way we recreate it in CA alongside all 5 women in the household. I would keep quiet about my mom’s healing abilities and the way I met so many other kids because their families would bring them to our house for a limpia and sobada. My parent’s native languages were also rarely heard in the household, until recently, we are now an outspoken quadrilingual household.

These experiences are continually being shaped and loved more outspokenly by all of our family. My perspectives on Latinidad are that latinidad has never truly benefitted my family and people like us. It cannot encompass (nor should it) the complexities and resistances to Latinidad. My family and I mainly use it in white spaces and white politics to refer to ourselves for outsiders. I think that is the best it gets.
*Latinidad* cannot fully capture the richness of Indigeneity, including Indigenous language, connection to the land, and spiritual practices. It is an imperfect category that, as this student notes, conveys a particular legitimacy in “[W]hite spaces and [W]hite politics.” Taking a more analytical tone, another student adds,

Latinidad and I have an extremely rocky relationship. I understand its purpose within the racial contexts of the US and its potential as an organizing political tool but it also has a dark history as an agent of colonization. The phrase derives from the concept of Latin Europe, a bulwark against the Nordic-Anglo axis of white supremacy and imperialism. France used the rhetoric of Latin Europe to root itself as the inheritor of Rome and justify the conquest of Latin America, where Spain had failed. Napoleon’s failed invasion of Mexico allowed Latin Americans to reconfigure this latinity, instead proclaiming it as a shared identity against the imperializing European powers. In this sense, latinidad works as anti-imperial agent but its conceptualization as a shared identity sinned in homogenizing populations. States like Mexico, Costa Rica, the Dominican Republic, Paraguay, etc. used latinidad as a neocolonizing tool to render populations as uniformly mestize or mulate. The dichotomy of population left out Indigenous and Black communities; states sometimes even forced miscegenation, committing terrible atrocities of sexual violence. In addition, the issue of Mexican hegemony has become a terrible problem within the Latine community, where curricula, activism, and media representation buttress Mexican nationalism (erasing afro/indigenous nations) and centering mestize voices. To the latter point, an example is the recent centering of Mexican voices within the ICE [Immigration and Customs Enforcement] concentration camp discourse in the US, wherein many Mexicans spoke of “la raza” and “nuestros hijos” even though about half of border patrol consists of Mexican-Americans and about half of those in ICE detention are Black immigrants, specifically from Haiti. My point being that conversations of Latinidad center white, light-skin latines of higher income countries without addressing the anti-Blackness and anti-Indigeneity of our “raza.” Yet, for simplification purposes, I still tick off the Latino box in the census. I am a person of contradiction :/.

*Latinidad* is, by nature, contradictory. It is perhaps politically useful, yet individually invalidating. As philosopher Linda Martín Alcoff argues, *Latinidad* both “invokes histories of colonialism, slavery, and genocide” that may shortchange Black and Indigenous Latinx people, while presenting “a thorn in the side of ‘manifest destiny,’ ‘leader of the free world,’ and other such mythic narratives that legitimize U.S. world dominance” (Alcoff 2000, 39). As such, *Latinidad* carries both pain and political power.

Rodriguez-Muñiz echoes this sentiment in his analysis,
The fact remains that appeals to and articulations of Latinidad (or Latino-ness)—as with other ethnoracial categories—do not arise out of nowhere. They stem from, and are marked by, complex, shifting, and stratified colonial relations that have systematically centered particular raced, gendered, classed, and sexual experiences and systematically marginalized others (2021, xvii).

I confronted this problem of Latinidad throughout my research process. Well-intentioned scholars frequently asked me, “Why this population? Why all of Latin America? Why not just recent migrants?” I argue that the experiences of racialization—and sexualization—in the U.S. unify my interlocutors, even if some do not fully subscribe to the label of “Latina” or “Hispanic.”

*The politicization of Latinidad*

Rodríguez-Muñiz further articulates the political nature of conceptualizing a Latinx population. He notes that demographic populations do not merely exist, they are constructed and freighted with political judgments. Rodríguez-Muñiz argues, “population trends cannot be studied, known, or managed apart from the political relations, social imaginaries, and statistical techniques and conventions through which we constitute populations” (2021, 7). He terms this sociopolitical configuration of demographic groups “population politics,” noting how the state produces difference through its construction of demographic categories.

I remember in my first-year university course, “Latino/a Experiences in the United States,” the professor, Dr. Erika Conti, instructed us to read works by political scientist Samuel P. Huntington, who criticized Latinx communities for failing to assimilate into ‘American’ norms. Huntington sided with many right-wing political commentators who advanced a “Latino threat” narrative and stoked fears about a *reconquista* or re-conquest of the American southwest (Chavez 2013). The class—largely
comprised of first- and second-generation Mexican immigrants and a few others from South America and the Caribbean—revolted. How dare we legitimize anti-Latinx political vitriol? Assimilationism is racist! What does this mean for our group—a scholarship named for a late Puerto Rican university student?

Regardless of whether we chose to accept it, the narrative of Latinxs as linguistically, culturally, and politically separatist prevailed, and Dr. Conti wanted to prepare us. Violent media characterizations of Latinxs as “invaders” and racialized others stoked xenophobia and promoted the denuding of citizenship rights.

In his book, *The Latino Threat*, anthropologist Leo Chavez examines this fiction, noting the contested conceptualization of citizenship. “A legalistic definition of citizen is not enough,” Chavez argues. “Other meanings of citizenship—economic, social, cultural, and even emotional—are being presented in debates, marches, and public discourses focused on immigrants, their children, and the nation” (2013, 13).

The production of cultural citizenship as the establishment of difference from the dominant society occurs bilaterally, both as “a process of self-making and being made within webs of power” (Ong et al. 1996), echoing Foucauldian schemes of subjectification and disciplinary control (Foucault 1983).

Conceptions of cultural citizenship cannot be divorced from processes of race-making and enforcement of racial hierarchies. Notably, though the U.S. Census considers “Hispanic/Latino” an ethnicity, this position pits Latinxs against Black Americans, encouraging the “dominant racial narrative that African Americans ‘deserve’ their place at the bottom of the hierarchy, while, in contrast, putting Latinos into the dominant ethnic narrative in which striving 'immigrants' overcome the odds to assimilate” (L. Gómez
Early Latinxs—particularly Puerto Ricans—negotiated their political treatment in contention with Blackness, noting phenotypic differences of softer hair and lighter skin (S. S.-H. Lee 2014). In truth, European heritage confers citizenship benefits to Latinxs who carry the “phenotypic passport” of fairer complexions and clearer eyes (Gonzales 2016). As with Italian, Irish, and Polish immigrants of the past (Guglielmo 2004), Latinxs construct their teleologic narratives of self as destined toward Whiteness.

Anti-Blackness and colorism pervade the experience of Latinidad, both in Latin America and in the U.S. Dominicans walk in the shade to avoid darkening just as they undergo hair relaxation and keratin treatments to ‘correct’ their pelo negro or pelo malo (Black hair or ‘bad’ hair), tendencies that grew from assertions of Dominican superiority over Haitian neighbors. Latina women endure directives from their mothers not to bring home a man “any darker than me,” provoking scandal if they date darker Latinos or Black Americans.

Latinx imaginations as non-Black at worst and White at best find expression in White supremacist attacks by Latinxs against Black people. George Zimmerman, who murdered 17-year-old Trayvon Martin on February 26, 2012, citing his role as neighborhood watch coordinator and his suspicion of Trayvon’s lifted hoodie, has a Peruvian mother and identifies as “Hispanic” on voter registration forms. Nikolas Cruz, who killed 17 people and injured 17 others in the 2018 shooting at Marjory Stoneman Douglas High School, grew up in an adoptive Latinx family and inveighed against Black, Latinx, and Jewish people; White supremacist organizations claimed him as their own despite his Spanish surname. Latinidad has always been constructed in tension with Blackness in politically exclusive and sometimes violent manners.
Latinx as race (vs. ethnicity)

The Latinx national narrative collectively remembers its origins in *mestizaje*, or racial miscegenation, reinforcing ties to Europeans (Wertsch 2007; L. Gómez 2020). Historically, the Spanish Empire in Latin America enforced a caste system based on ancestry and physical characteristics. Whiteness conferred advantages such as land ownership, which incentivized *blanqueamiento*, or “whitening,” through race-selective marriage. Nations advanced the *blanqueamiento* agenda through policies to attract European migrants and obstruct movement from Asia or Africa (L. Gómez 2020). As such, many Latin Americans (and Latinos) trace their lineages to the Iberian Peninsula through Spanish family crests and surnames, shoring up their claims to Whiteness, or near-Whiteness. In Census inventories, more than half of Latinxs assert they are White (Cohn, Brown, and Lopez 2021). Sociologist Julie Dowling notes that Latinxs “who identify as ‘white’ cling to whiteness not in spite of but because of their position as a stigmatized group” (2014, 133).

However, perceived, symbolic proximity to Whiteness matters little in the American racial terrain. Dowling adds, that self-proclaimed ‘White’ Latinxs “are not generally recognized as white by others. Hence, it becomes quite clear that they do not truly ‘own’ whiteness as it is not a valid social identification for them” (2014, 133).

In her analysis of Latinidad as a racial category, sociologist and lawyer Laura E. Gómez describes intersecting vectors of race as self-identity and race as assigned by others (2020, 3). Regardless of self-classification, most White Americans view Latinxs as
racialized minorities. This distinction defines my delayed acceptance of my Latin American heritage.

Growing up, I understood myself as culturally Italian and racially White. Then, as a child actress, casting directors barred me from auditioning for White characters, particularly in the summer when my skin darkened to a deep brown. My talent manager instructed me to avoid sun exposure and to wear lighter foundation makeup and straighten my hair to expand my eligibility for White roles. My Cuban aunt urged the same, both punishing and teasing me with the name “negrita” [Blackie] when I spent too much time on the beach. Despite my best attempts to conform, casting companies funneled me toward roles as the recovering offender living in a halfway house or the hypersexual teenage temptress, even asking me to voice over darker-skinned cartoon characters and dolls. After leaving acting, my college peers in the Midwest cemented my identity as not-quite-White. The too-familiar exchange of

\begin{verbatim}
Them: Where are you from?
Me: I was born in New York.
Them: No, where are you really from?
Me: I guess I grew up in New Jersey.
Them: But where are your parents from?
Me: …New York.
\end{verbatim}

hindered my full acceptance into my majority White academic community. Then, when I was pulled over by police for the first time and saw that the ticket ticked me off as “Hispanic,” I came to realize that, regardless of my self-conception, the world viewed me as “Other.”
Latinxs in health disparities research

The sociopolitical manipulation of the Latinx category raises multiple challenges in assessments of Latinx health disparities. Certainly, people of color living in the U.S. have a shared history of structural violence. Medical anthropologists have theorized that the political oppression, racial discrimination, economic exploitation, and social marginalization exerted through structural violence are embodied by its victims as illness, disease, and premature death. For instance, physician-anthropologist Paul Farmer traces the “biosocial history” of AIDS in Haiti, linking contemporary conditions of poverty to the island’s former status as a French slave colony, consecutive dictatorial regimes, and decades of U.S. occupation (Farmer et al. 2004). Within this framework, health disparities may be understood as the output of a culturally legitimated machinery of oppression.

If all racial and ethnic minorities in the U.S. have suffered under this power inequality, what then is the utility of studying Latinxs together a distinctive category? Latino Studies scholars have pointed to the unique positionality of Latinxs within ongoing struggles over immigration, racism, and colonialism, particularly a politics of U.S. interventionism formalized through the Monroe Doctrine (Flores 1997; Hayes-Bautista and Chapa 1987). When studying adverse health outcomes faced by Latinxs, it is important to consider the historical conditions of structural violence in Latin America that have engendered steep gradients of resource access and opportunity.

However, due to the enormous diversity across Latinx populations, scholars must generate thoughtful hypotheses regarding the drivers of these disparities. For instance, hypothesizing an association between colonial legacy and hypertension would yield
different predictions for a Puerto Rican man and an Argentine woman of recent European extraction. Similarly, a Black Dominican and a White Chilean would likely have different outcomes in a study on the relationship between racial discrimination and pregnancy outcomes. By treating Latinxs monolithically, this predictable variation is lost as noise.

**Generational considerations**

All people with Latin American heritage may be considered “Latinx,” regardless of whether they are first-generation or fourth-generation immigrants. This introduces two important sources of variation that are contingent upon a person’s time spent in a new ecological and cultural environment: evolutionary mismatch and acculturation.

**Evolutionary Mismatch**

The theory of evolutionary mismatch suggests that traits that may be adaptive in one environment may lose their value or become disadvantageous when translated to a different environment. Spatial mismatch, the mismatch that occurs when an organism moves to a new environment, has been shown over the past several decades to affect immigrant populations. For instance, Japanese men who migrated to the Hawaii were twice as likely to die from cardiovascular disease, most likely due to dietary changes such as increased consumption of red meats, dairy, and other animal fats (Robertson et al. 1977; Stearns and Medzhitov 2016). In addition, migrants from low- and middle-income countries to high-income countries report increased rates of asthma and atopies, suggesting an interplay between environmental hygiene and immune regulation (Rottem, Szyper-Kravitz, and Shoenfeld 2005; Leung et al. 1994; R. Rosenberg et al. 1999).

This mismatch has also been shown to be sensitive to the length of time in the destination country. One study of Bangladeshi migrants found that women who spent
their childhoods, especially prior to puberty, in energy-rich, low-pathogen environments in the UK had up to 103% higher levels of salivary progesterone and an earlier maturation than women who develop in less optimal conditions (Núñez-de la Mora et al. 2007). Another study conducted in Sweden on asthma in migrant populations found that international adoptees and children born in Sweden by foreign-born parents used asthma medication at rates three to four-fold higher than foreign-born children. Further, the odds ratios of asthma medication usage declined persistently with age at immigration (Bråbäck, Vogt, and Hjern 2011). These findings suggest that grouping foreign- and U.S.-born Latinxs into a single group may prevent researchers from capturing the plastic responses that occur as Latinxs transition and acclimatize to new ecological conditions.

Mismatch theory can be used to examine the increased prevalence of cardiovascular disease (CVD) among Latinxs. Considering CVD as a result of spatial displacement to an environment that differs from that for which the bodies of Mexican people were adapted, we would predict that shifts away from traditional Latin American diets and patterns of physical activity toward a ‘Western’ lifestyle would be associated with the development of cardiovascular disease (Eaton, Konner, and Shostak 1988). Traditional Latin American diets have largely consisted of mostly cereals, vegetables, roots, and grains, although specific ingredients vary across countries and regions (Bermudez and Tucker 2003). Although increased consumption of processed foods had been documented in the 1980s, during the 1990s every Latin American country had lower mean available energy supply relative to the U.S. (Bermudez and Tucker 2003). This suggests that pre-migration diets may more fittingly address caloric needs—and more closely approximate target dietary fiber content and nutrient density—relative to the
heavily subsidized, highly processed, high-fat, high-sugar products accessible to low-income migrant communities. Among Latinxs, transition to the U.S. has been overall associated with decreased fruit and vegetable intake, decreased consumption of rice and beans, increased dietary fat and salt intake, increased sugar and sugar-sweetened beverage consumption, and reduced breastfeeding (Pérez-Escamilla and Putnik 2007). These dietary changes are associated with increases in overweight and obesity and risk of CVD in this population (Gordon-Larsen et al. 2003; Daviglus et al. 2012). Moreover, U.S.-born Latinxs are more likely to report histories of coronary heart disease and stroke as well as risk factors for CVD (Daviglus et al. 2012), suggesting this effect becomes more pronounced with increased exposure to environmental discordance. Mismatch theory would posit that Latinxs originating from pre-migration populations with lower levels of market integration (e.g., more rural, Indigenous communities) might experience greater risk than those whose bodies have already acclimatized to obesogenic environments.

Acculturation and English-Language Proficiency

Many of the changes in the health profile of immigrants have been attributed to acculturation. Among Latinxs, acculturation has been associated with harmful effects on diet and substance use as well as improvements in healthcare use and access, such as use of preventive care services, insurance coverage, health screenings, and general health care use (Lara et al. 2005). Acculturation is generally defined as the process by which individuals acquire the attitudes, values, customs, beliefs, and behaviors of the dominant culture, such as language and diet (Abraído-Lanza et al. 2006). However, acculturation is rarely a unidirectional process and advances in acculturation theory instead consider the
process to be complex, multidimensional, and sensitive to several interacting factors (Rudmin 2003). Moreover, acculturation research generally acknowledges the presence of only two cultures, overemphasizes acculturation ‘typology’ rather than variation, underemphasizes structural factors, and considers acculturation as one monolithic variable rather than according to separate relevant indicators (e.g., valuing individualism vs. familism in a study of depression) (Rudmin 2003; Abraído-Lanza et al. 2006). Due to its complexity, acculturation is difficult to operationalize and current instruments may reflect bias and ethnic stereotyping (Hunt, Schneider, and Comer 2004). It is important to exercise caution when attempting to consider ‘acculturation’ cumulatively as a health risk or protective factor.

Considering this more concretely, the process of acculturation likely varies by community of origin or the amount of cultural capital a person has accumulated prior to migration. For instance, a university-educated Chilean who has many family members living in the U.S. may undergo a different ‘acculturative’ experience than a rural Mexican who grew up speaking Mazahua, an indigenous language. In fact, both national origin and education have been shown to modulate health outcomes commonly thought to be influenced by acculturation. A study of smoking behavior among Latinxs revealed that while acculturation was positively associated with smoking in women, smoking behavior was decreased by higher education levels. The authors also found differences by national origin, with Central Americans exhibiting the lowest smoking rates and Cubans and Puerto Ricans showing the highest (Pérez-Stable et al. 2001). These findings hint at the need to consider cultures of origin at the sub-regional level and to adopt more complex models of acculturation.
Language acquisition is a useful variable within acculturation theory that is particularly relevant to healthcare utilization. As an example, compared with English-speaking Latinxs, monolingual Spanish speakers are less likely to use healthcare services and to have a regular healthcare provider (Weinick et al. 2004). Latinxs with fair and poor English proficiency report 22 percent fewer physician visits (Derose and Baker 2000). In addition, if Latinxs are able to speak exclusively in English at their health visits, they are more likely to have private insurance coverage and spend less time uninsured (Weinick et al. 2004). These data suggest that English language acquisition may be a valuable variable to parse out from more general, and potentially reductionist, acculturation tools as a way of assessing protective healthcare behaviors.

A robust acculturation theory may help understand the “epidemiologic paradox” of low birthweight among Latinxs (Fuentes-Afflick, Hessol, and Pérez-Stable 1997). Latinx infants show similar rates of low birthweight relative to White people despite low socioeconomic status; however, this finding is inconsistent across generations. For instance, foreign-born mothers have low birthweight infants at a lower rate than U.S.-born mothers and Puerto Ricans have a higher rate of low birthweight relative to Latinxs of other origins (Fuentes-Afflick and Lurie 1997; Fuentes-Afflick, Hessol, and Pérez-Stable 1997). Since the pathophysiology of preterm birth, which is often associated with low birthweight, may involve premature activation of the maternal hypothalamic-pituitary-adrenal axis, or exaggerated inflammatory responses (Moroz and Simhan 2018), acculturation theory would predict that changes in attitudes and behaviors that specifically increase maternal stress or inflammation would elevate risk of low birthweight. One source of maternal stress might involve a decline in social support and
provisioning of pregnant women, while a likely source of greater inflammation would be an increase in cigarette smoking. Although existing evidence suggests that “cultural factors” protect foreign-born Latina women from giving birth to low-weight infants (Fuentes-Afflick, Hessol, and Pérez-Stable 1997; Guendelman et al. 1990) and that substance use increases with greater acculturation (Zambrana et al. 1997; Lara et al. 2005), further research is needed to elucidate the relationship between specific cultural values, practices, and behaviors and improved pregnancy outcomes.

Given the considerable environmental and behavioral transitions associated with migration, clustering Latinxs from multiple generations into one group can result in misleading claims about the health of this ‘population.’ Judicious applications of mismatch theory and acculturation theory can inform hypotheses and guide population stratification based on community or culture of origin, language proficiency, and other pertinent demographics.

**Phenotypic discrimination and intersectionality**

Racialized hierarchies have favored those who appear to have a more European pedigree. As a result of their blended ancestry, Latin Americans are extremely phenotypically diverse. Census surveys throughout Latin America have variously classified people as “black,” “Indian,” “mestizo,” “mulatto,” “moreno” (dark brown), “pardo” (light brown), “white,” “European,” and “Spanish,” conflating appearance with heredity (Alcoff 2000; Wade 1997). Across Latin American history, a person’s color has determined their value and Whiteness has consistently topped the social strata. Social inequalities have been formed along racial lines through discrimination in education, employment, marriage, and social networking (E. Telles 2014).
This pattern has translated to the United States, shaping the life chances of Latinxs. According to sociologist Christina Gómez, “lighter skinned or more European featured (i.e., thin lips, aquiline nose, blue eyes, blond and straighter hair) individuals do better than darker skinned individuals of the same group” (C. Gómez 2000, 94). Multiple studies have shown that darker-skinned, indigenous-looking Latinxs fare worse economically and receive less schooling than their lighter-skinned, European-featured counterparts (Arce, Murgia, and Frisbie 1987; Murguia and Telles 1996; E. E. Telles and Murguia 1990; Espino and Franz 2002). In addition, darker-skinned Latino men are disadvantaged in the workplace relative to their lighter-skinned peers (C. Gómez 2000). These findings demonstrate a structural bias against darker-skinned Latinxs, which may impact their health outcomes through access to health services and treatment.

Race-based implicit bias has been shown to influence healthcare decisions and may disadvantage Latinxs with darker phenotypes. One study demonstrated that physicians with increasing bias against Black Americans were less likely to administer thrombolysis treatment for myocardial infarction (A. R. Green et al. 2007). Other studies suggest that Black female patients are treated with lower doses of pain medication for the same complaints as their White and male counterparts (Weisse, Sorum, and Dominguez 2003; Bonham 2001). These findings suggest that dark-skinned Latinxs may be more vulnerable to race-based implicit bias in healthcare, which may contribute to health disparities within the Latinx population.

In addition to the effects of structural racism, perceived discrimination may also contribute to health disparities among Latinxs. In the United States, racial discrimination has been shown to drive health disparities, with Black Americans having particularly
poor outcomes relative to White people (Gee 2002; D. R. Williams, Neighbors, and Jackson 2003; Araújo and Borrell 2006; Gee et al. 2006; D. R. Williams et al. 2009).

Despite the well-documented effects of phenotypic discrimination among Latinxs, only a few studies have examined the role of discrimination in health disparities among Latinxs (C. Gómez 2000; Pascoe and Smart Richman 2009; Ryan et al. 2006; Ayón, Marsiglia, and Bermudez-Parsai 2010). Phenotypic discrimination may represent an additional variable by which Latinx populations may be sub-stratified.

A final important consideration is that of intersectionality, or the ways in which multiple axes of identity, difference, and disadvantage intersect to produce diverse outcomes (Crenshaw 1991; Cole 2009; Viruell-Fuentes, Miranda, and Abdulrahim 2012).

Emerging out of the Black feminist movement, which drew attention to the overlapping oppressive structures of racism, sexism, and classism in Black women’s lives, intersectionality theory problematizes the isolation of singular identities and emphasizes the need to employ multiple frameworks to conceptualize social problems (Crenshaw 1991; Viruell-Fuentes, Miranda, and Abdulrahim 2012; A. Y. Davis 2011; Hill Collins and Bilge 2016).

This chapter has already discussed multiple structures that may converge in the lives of Latinxs, including race (or phenotype), nationality, language proficiency, and education level. Others that have not yet been explored include socioeconomic status, gender identity, sexual orientation, and ability. These may work together to produce distinctive patterns of health disparities. For instance, one study found that gay Latino men have exceptionally high rates of psychological distress, with 80% experiencing depressed mood, 44% reporting anxiety, and 17% admitting to suicidal ideation (Díaz et
Another study found that while prevalence rates of chronic health conditions were similar among minority women of different ethnicities, lesbian and bisexual women evidenced higher behavioral risks and lower rates of preventive care than heterosexual women (Mays et al. 2002). Additional research has shown that education and income significantly modify racial and ethnic health disparities, suggesting that considering race or ethnicity alone can generate misleading conclusions (Krieger et al. 2005; D. R. Williams et al. 1997). These multiple, crosscutting dimensions of identity and difference may privilege certain subsets of Latinxs over others with respect to health outcomes.

**A note on terminology**

Over the past several decades, activists, scholars, and politicians have debated the ‘correct’ term for this growing population of migrants from Latin America and their descendants. The 1975 Ad Hoc Committee on Racial and Ethnic Definitions, created under the Nixon administration, debated multiple terms, and despite lack of consensus, settled on “Hispanic” for the purposes of Census classification (Fears 2003).

Many activists rejected the term, asserting its ties to colonization and Spanish imperialism. They favored “Latino,” which refers to Latin American geography and the Romantic linguistic origins of the diaspora. “Latino” emerged as the preferred term for people of Latin American origin in the 1980s, largely in response to the increasingly bureaucratized word, “Hispanic” (Hayes-Bautista and Chapa 1987; del Olmo 1981; 1985). Beginning in the 1970s, the Federal Office of Management and had applied the term “Hispanic” to 12 million Americans of “Spanish origin or descent” and it first appeared on the U.S. Census in 1980. Aiming to promote equal opportunity, Congress resolved to include data collection on this population in future censuses (Alcoff 2000;
House Joint Resolution 92 1976). However, the term of reference chosen for the 1980 census, “Spanish/Hispanic origin or descent,” bred confusion: Which Americans ‘counted’ as Hispanic and stood to benefit from affirmative action measures? In his 1987 article in *The American Journal of Public Health*, David E. Hayes-Bautista and Jorge Chapa raised a number of conceptual questions with this classification: “Is a Spaniard Hispanic?... Is a Cape Verdean Hispanic? Is a Filipino Hispanic? Is a Brazilian Hispanic? Is a Brazilian identical to a Cape Verdean? Are both identical to a Portuguese?” (1987, 65). The term “Hispanic” obscures the distinctions between European Americans and the multiple groups originating from countries colonized by the Iberian Empires. Further, millions of Spanish-speaking Latin Americans with Indigenous or African lineages do not claim Spanish heritage and cannot be accurately called “Hispanics” (Comas-Díaz 2001).

“Latino” is largely favored for its grassroots origins and its reaffirmation of precolonial identity (del Olmo 1981; Oquendo 1995; Comas-Díaz 2001). Although some have argued that the creation of a pan-ethnic identity was largely foisted upon the community by outsiders, the call for pan-Latin American identity can be traced to the anti-imperialist writings of Simón Bolívar and resurged under the Brown Power political movement of the 1960s and 1970s (Alcoff 2000; Comas-Díaz 2001). By the 1980s, Puerto Rican- and Chicano-owned popular media publications began using the term “Latino” in their marketing campaigns, aiming to foster community across the broader Latin American immigrant population (del Olmo 1981). Mexican American editorialist Frank del Olmo noted in 1985 that “Latino” was already a common term of self-identity:

Walk into a Latin American barrio, from East L.A. to Miami’s Calle Ocho, and ask people what they are. You’ll get all kinds of answers, including Latino,
Chicano, Boricua, Cubano, Mexicano. But unless you wander into the offices of some government-funded poverty program, you won't hear people call themselves "Hispanic" (1985).

In the 1990s, feminist scholars began proposing alternatives to “Latino” including “Latino/a” and “Latin@.” Latinx originated online in the queer community in the early 2000s and gained traction roughly a decade later. Unlike the binary terms “Latino/a” or “Latin@,” Latinx and other x-carrying signifiers (e.g., chicxs for chicos or “kids,” todxs for todos or “all”) are intended to be gender-neutral and fluid, affirming the diverse gender and sexual expression within the Latinx community. Although some have argued that the use of Latinx perverts the already gender-incongruent Spanish language, and renders pronunciation difficult (Hernandez 2017), others appreciate its transgression against imperialist linguistic prescriptions and the emphasize the effect of gender neutralization on inclusion for trans and non-binary Latinxs (de Onís 2017).

Latinx is not a perfectly encompassing term. First, because of its reference to Latin American origin, Latinx does not explicitly include Hispanos, or people living in the Southwestern U.S. who trace their origins to Spaniards who settled the area beginning in the late 16th century (Nostrand 2010; Haverluk 1997). Although most writers and scholars agree that Hispanos are also Latinos/Latinxs (Vaca, Anderson, and Hayes-Bautista 2011; Andrés-Hyman et al. 2006; Sanchez 2016), Hispanos have a vastly different ancestral history relative to immigrants from Latin America and their descendants. Second, according to a 2013 survey, 77% of Latinxs do not use broad terms like “Hispanic” or “Latino” to identify themselves, instead preferring national origin terms (e.g., “Mexican,” “Cuban”) or calling themselves “American.” This may be explained in part by the fact that 69% of those surveyed do not see a shared culture
among Latinxs. Among those who do have a preference, “Hispanic” is favored over “Latino” by a roughly a 2-1 ratio (Lopez 2013); however, internet search data suggests that “Latino” and “Latinx” are increasing in popularity (Google Trends 2018b; 2018a).

The U.S. Census uses both “Hispanic” and “Latino” and defines someone who identifies with either term “as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race” (U.S. Census Bureau 2018). According to this definition, Spanish immigrants may be considered ethnic minorities and the vague “other Spanish culture or origin” descriptor may be interpreted to include Filipinos. Given the homogenizing effect of racial and ethnic categories, the differences in the particular experiences of Indigenous migrants—and their relationship to longstanding Indigenous communities the U.S.—may not be appreciated (Bartlett et al. 2007; Castellanos 2017). The ambiguities and mounting controversies surrounding these terms underscore the need to outline the purpose of using any ethonym more carefully to describe this diverse population.

I do not believe any of my interlocutors identified as Latinx: Most related to their national origins or used the terms “Hispana” or “Latina.” Why, then, do I use the term “Latinx?”

The use of the ‘x’ in Spanish language emerged long before the mid-2000s and served to Indigenize a colonizer’s tongue for Mexican Americans (e.g., Xicano/Xicana). However, nowadays, the ‘x’ further connotes the possibility of nonconformism, of deviance, in a culture frequently treated as a monolith. As queer Mexican-Cuban journalist and activist Paola Ramos writes in Finding Latinx, many young children of Latin American immigrants experienced “an ache for change… an ache that craved more
unity, acceptance, and inclusion—an ache that simply wanted us to be seen (2020, 8).

And so, through its resistance, the ‘x’ in Latinx soothes that ache.

Queer and gender-nonconforming Latinos who had faced discrimination in their own households could relate to that ache. So could Afro-Latinos who had once been told they didn’t “look Latino enough.” And transgender Latinas who were continuously reminded they weren’t “really Latinas,” Asian Latinos who had never been asked about their background, Cuban Americans who wanted to part ways with their family’s long history of conservatism, young Latino men who never found a voice in the criminal justice system, mamis and abuelas who wanted to pave a different path for themselves, Gen Zers who had once been ridiculed for “not speaking Spanish,” midwestern Latinos who felt completely “neglected,” Latinos in the Deep South who said they were “forgotten” by all of us, indigenous migrants whose history had been erased, and millenials in border towns and rural communities who wanted a greater platform than those typically given to those residing in the far edges of the country.

In short, I use Latinx as an umbrella term, as an act of resistance. Even “Latine,” which certainly flows more seamlessly in both Spanish and English speech, conforms to conventions of a colonizer’s language. Although I support the use of the ‘e’ in gender-neutral versions of Spanish words (e.g., “Bienvenides a todes”), I continue to favor “Latinx” precisely because of its dissent against the shapes formed by European tongues and palettes: After all, the Kichwa ‘q’ and ‘ll,’ the Nahuatl ‘tli’ or ‘tl,’ and the ‘d’ for ‘th’ in African American Vernacular English contort the American oropharynx.

**Conclusion**

In this chapter, I examine the position of Latinxs within the U.S. racial hierarchy, emphasizing the sociopolitical construction of this population and manifestations of its heterogeneity. I then address Latinidad as a racial vs. ethnic arrangement to White hegemony, noting historical origins of colorism in the Latinx community and the distinctions between self-identity and legibility to White people. I then discussed how treatment of Latinxs as a monolithic group—despite generational and phenotypic differences—has produced inconsistencies in the health disparities literature. Following
this discussion, I underscore my choice of the term “Latinx” to capture the multitudinous expressions of Latinidad, including racial, gender, sexual, and generational diversity, and in resistance against dominant social schema.

This chapter raises several important points for consideration of Latinx studies scholars. First, we must question the meaning of “Latinx,” recognizing the unintended consequences of population politics. We should ask ourselves, “Is Latinidad the most salient descriptor of this community” and consider whether other variables, like language proficiency or insurance coverage might be more relevant to our hypotheses. We should recognize and examine the influences of intersectional identities and interlocked power structures in shaping life possibilities for Latinx communities. The health experiences of phenotypically ‘White,’ English-speaking Latinxs likely diverge widely from those of dark-skinned, monolingual Spanish-speaking Latinxs.

This dissertation centers first-generation Latina migrant mothers, regardless of racial phenotype or ‘acculturation.’ Here, the principal characteristics that define this population include non-nativity and maternity, allowing examination of the convergent forces of xenophobia and gender discrimination in conditioning the lives of these women and their children. In the next chapter, I review demographic changes in the New Haven and Connecticut communities, highlighting the ways Latin American migrants imagined themselves and established footholds in society.
Chapter 2: Latin American Migration to New Haven

From 1960 to 2014, the Latinx population in the United States increased nearly nine-fold, and the population is expected to reach 119 million by 2060 (U.S. Census Bureau 2014). In this time, the foreign-born Latin American migrant population has increased by more than twenty times, comprising 6 percent of the total U.S. population as of 2014 (Stepler and Brown 2016). This excludes the undocumented population, which has been estimated at 10.7 million (Pew Research Center 2018).

Approximately 78 percent of undocumented immigrants are from Latin America, with 56 percent originating from Mexico. In 2005, 42 percent of the adult undocumented population was found to be women, despite stereotyped images of undocumented immigrants as unaccompanied, “young, male workers” (Passel 2006). This statistic exposes the potential for gender hierarchies intersecting with the structural vulnerability of undocumented immigration to lead to gender-based traumatic violence.

Despite regional declines, in the city of New Haven, the Latin American migrant population continues to grow. The area saw a 35 percent increase in Latin American migrants between 2000 and 2010, and the group grew to constitute 27.4 percent of the population (U.S. Census Bureau 2010; New Haven Independent 2011). In 2014, New Haven received a bolus of migration from Central America, particularly of unaccompanied minors, and this pattern continues (Orson 2014). Statistics on migration likely underestimate the number of undocumented residents living in New Haven, which has designated itself a “sanctuary city” and is informally recognized as a “safe” destination for people seeking to resettle in the U.S. without, or prior to, legal processing (M. O’Leary 2016). On a grassroots level, organizations like JUNTA for Progressive
Action, Unidad Latina en Acción, and Integrated Refugee and Immigrant Services provide resources and collective bargaining power for undocumented immigrants suffering legal and workplace exploitation. Officially, the New Haven administration also demonstrates a commitment to protecting undocumented immigrants. In January 2017, then-New Haven Mayor Toni Harp and U.S. Representative Rosa DeLauro defended the community against federal deportation raids, upholding the city’s priority to “safeguard the well-being of all New Haven residents,” including undocumented immigrants (Stannard 2017). In this spirit, New Haven has also provided sanctuary to Nelson Pinos, a 43-year-old Ecuadoran man and father of three who has been resisting a deportation order despite living in the U.S. for 26 years (Villavicencio 2018). The combination of a growing Latin American migrant population and a reputation as a place of safety and “opportunity” for undocumented people makes New Haven a fitting setting in which to approach questions of trauma and survival among Latin American migrants.

In this chapter, I synthesize oral history, archival, and Census data to examine the history of Latin American migration to New Haven, including shifts in demographics and community needs.

*Census data and "population politics"

Social Michael Rodríguez-Muñiz divides the history of U.S. “population politics,” including demographic changes in the Latinx community, into three “sedimentary” layers: First, at the beginning, rests the White supremacist “demodystopia” of settler colonialism up through eugenics movements of the early twentieth century; second lay the foundations for the “Latino Threat” narrative and demographic growth of “unwanted” populations through the 1970s; on top is the third layer of “Hispanic” civil rights and
advocacy efforts to statistically assess the Latinx population in the U.S. to advance civil rights (Rodríguez-Muñiz 2021).

New Haven fits neatly into this lamellar narrative of history. During the era of colonization, English Puritans displaced the Quinnipiack Native Americans to establish a planned colony around nine square blocks in 1666. Moving forward, in the twentieth century, migration of Puerto Ricans and, later, other Latin Americans raised concerns about poverty, unemployment, welfare reliance, and overpopulation. Finally, advancement in politics and social organizing has resulted in huge wins for the New Haven Latinx community. This chapter centers on the second layer; chapters two and three overlappingly cover the second and third layers.

In my original pursuit of a Latin American history of New Haven, I sought out Census data. I thought, “Surely the U.S. government can tell at least part of this story.” I found myself surprised. Although I could track the growth in the Latinx population over time in the U.S., in Connecticut, and in the city of New Haven, tracing the early pockets of Latin American migrants throughout the city proved more difficult.
Figure 1: Map of New Haven with neighborhood boundaries. Fair Haven is the predominantly Latinx neighborhood in the northeast area of the city (indicated in light pink). The Hill neighborhood surrounds Yale-New Haven Hospital in the southern area of the city (indicated in pale yellow). Map courtesy of DataHaven.
Figure 2: Growth in the Latinx community (by percent share of the population) in the U.S., the state of Connecticut, and the city of New Haven, between 1970 and 2010, using decennial U.S. Census data.
I dived deeper, to assess the Census tracts where many Latinxs live today. Fair Haven is the city’s recognized Latinx neighborhood: Walking down Grand Avenue, the main thoroughfare of Fair Haven, towards the water, it is easy to transport yourself to urban Latin America with various restaurants, bodegas, and money transfer businesses brandishing Mexican, Ecuadorian, Peruvian, and Puerto Rican flags. The Hill surrounds Yale-New Haven Hospital in the south of the city. The original settlement of Puerto Rican migrants—and historically the locale of immigrants transitioning to full-time homes in the city—the Hill now includes large shares of Black and Latinx residents.

On reviewing the Census tracts corresponding to the Hill and Fair Haven neighborhoods, I found a striking pattern: Though the proportion of Latinxs increased in both the Hill and Fair Haven neighborhoods over time, Latinxs in Fair Haven surpassed those in the Hill as a share of their respective communities.
Figure 3: Growth and neighborhood shift of the Latinx community in the Fair Haven and Hill areas of New Haven, between 1970 and 2010, using decennial U.S. Census data.
Using historical city directories, I tracked patterns of Spanish surnames and mapped them along the city. In 1965, I found names like Colón, Rodriguez, Jimenez, Garcia, and Gonzalez—mostly belonging to men—clustered in the side streets around the hospital surrounded by vacant lots and buildings. Nearly all these names occur on the list of most popular surnames in Puerto Rico. At that time, the arteries of Fair Haven—Grand Avenue, James Street, and Ferry Street—were almost exclusively Italian, with a few American-sounding names, like Jones and Green, which I suspected belonged to Black residents. By 1970, I found Melendezes, Perezes, Alvarados, Torreses, Hernandezes, Maldonados, and Vasquezes in Fair Haven. Although some of these names, like Melendez and Torres, were common in Puerto Rico, others, like Hernandez, were more prevalent in Central and South America, perhaps signifying a demographic shift. To flesh out these details, I sought out community leaders who had spent decades in the city to tell me the story of how their neighborhoods transformed around them.

*The early Puerto Rican community*

I pulled up to Norma Franceschi’s home, a white ranch with a neat front yard, on a Saturday morning. As I organized my notes and the bag of pastries I had brought, a narrow figure appeared in the front doorway.

“Pull over here, behind the house!” the figure, a woman, shouted. “People drive like mad men on this street—they’ll swipe your car.”

I followed instructions and then gently tapped the storm door. Inside, two small Yorkshire Terriers announced my arrival, yapping loudly, their tails whipping back and forth. In a moment, Norma appeared and ushered me inside. Her hair, once blonde and now almost entirely silver, was pulled into a neat bun. She lined her eyes with blue and
had applied lipstick for our meeting. Her shoulders hunched slightly forward, no doubt a result of the loads she had carried for so many people during her long life.

I sat at the dining room table—covered with lace—and noticed a map of Italy on the wall beside a sepia-tinged photograph of a man and woman, the man resting his hands on the seated woman’s shoulders.

“Those are my parents,” Norma smiled, setting down mugs of coffee. “They moved from Italy to Argentina right after they got married. Not so dissimilar to my husband and me!”

During all the prior interviews I had completed, each person told me I had to speak with Norma: She would know all about the history of migration to New Haven and had supported so many migrants in their transitions to the city, her bodega on Main Street in Fair Haven serving as an informal social services hub when no other existed.

“We got married very young,” Norma shared, her eyes glinting. “When we first got here, it was very difficult because nothing was in Spanish. You went to the hospitals and at the hospitals, there were no interpreters. No Hispanics.”

Norma migrated to the U.S. with her husband in 1970, just a few years before a military junta took over Argentina in a coup d’état.

“Fair Haven was all Italian. There was only one single Spanish business,” Norma told me. On reviewing directories from that era, I learned that the business was a Puerto Rican grocery store owned by a man named Victor Berrios. At the time, most Latinxs—then Puerto Rican—organized in the Hill and in the rural areas surrounding New Haven.
“Nothing was available because, at that time, the only Hispanics here were Puerto Rican. But the Puerto Ricans did not live in New Haven: The Puerto Ricans lived in Guilford, because in Guilford, they harvested tobacco.  

“The gringos—the gringos were the Americans, right?—they went to Puerto Rico and looked for Puerto Rican labor and brought it here. They had these big sheds where they would bring people and then, after the harvest, they would send them back. At the time, many stayed, but the Puerto Rican colony was in Guilford, oddly enough.”

A New York Times article from 1992 entitled “Problems Temper Puerto Ricans’ Success” detailed the history and social struggles of the Puerto Rican community of New Haven. “Beginning with a small group of people who traveled to Connecticut in the 1930’s to work on vegetable and tobacco farms and later settled in New Haven, the
Puerto Ricans have grown into a community with deep roots in the city’s political and cultural life” (Rierden 1992).

Lee Cruz, a community activist who works for the Community Foundation of Greater New Haven, who is Puerto Rican himself, fleshes out this history.

A lot of people don’t realize that when Puerto Ricans first came to Connecticut, they didn’t come to New Haven for the factory jobs like in New York, which actually my mom did in the ‘50s. They came to pick apples in Guilford. The migrant community was moving up and down the coast [of Connecticut], following various products. And the owners of these farms and in the surrounding area really started recruiting Puerto Ricans. From Puerto Rico, it was easy because they were U.S. citizens, you know? Just get ‘em on the plane and get ‘em off the plane.

These early migrations of Puerto Ricans coincided with the economic development program called “Operation Bootstrap,” which sought to modernize Puerto Rico’s economy by disrupting the former plantation sugar-based feudalistic system and increasing manufacturing and exportation to the mainland U.S. However, the collapse in employment for rural sugar cane farmers drove relocation to the mainland, a pattern that peaked in the 1950s. During the 1930s, an estimated 1,800 Puerto Ricans left the island each year for employment in the U.S.; by the 1950s, that number had reached 43,000 (Ayala 1996). Unlike other regions of the U.S., like the Southwest, where the earliest Latinxs came from Mexico, the original Latinx population in Connecticut was entirely Puerto Rican.

Over the following decades, the Puerto Rican community in the New Haven area established a vibrant social and cultural life. Lee adds, a big smile on his face,

[There are] pictures of Puerto Ricans playing congas [wooden drums] on the green in Guilford from the 1930s and 40s because that was the only place they could congregate, because they didn’t live in houses. They couldn’t, like, sit in front of their houses. They lived in these big, long shacks. And then, on the weekends, they would meet each other on the green in Guilford.
That first generation of Puerto Ricans confronted intense discrimination, workplace abuse, and language barriers that hindered their integration into the greater New Haven community. Later, after many had transitioned to manufacturing jobs in the city during the 1940s through ‘60s, these jobs—and the availability of affordable housing—began to dwindle, forcing many islanders to turn to government aid. Lydia Torres, formerly a youth development advocate for the Puerto Rican community says, “I blame the system for damaging the people of my country. We have always come for jobs, not food stamps and drugs.”

Many community leaders argue that the U.S. government failed Puerto Rican workers. Celestina Córdova, a longstanding leader in the Puerto Rican community shared that after serving in the Korean War, he went to the U.S. employment agency for work.

“Once they saw my surname,” he said, “they told me ‘We have a job for you: it’s working on a farm.’ I thought they would give me a job as a foreman. I had never worked on a farm.”

Córdova was assigned to pick vegetables like tomatoes and cabbages for a pitiful wage. “When Hispanic people go to look for a job,” he explained, “there was no job for them. They made Puerto Ricans do the dirty work at lower positions.”

To meet the growing need for social and cultural organizing, Córdova, along with other local Puerto Ricans, established the Spanish Cultural Association of New Haven in the Hill neighborhood in 1965, with the objectives to unite, represent and strive for the interests and rights of the Spanish-American community of New Haven; to help raise the standard of living of said community especially the cultural and socio-economic levels and to awaken underlying talents and abilities by means of beneficial program activities.
The Spanish Cultural Association deeply invested in education and youth development. They launched two programs: “Proyecto Comprensión” [Project Comprehension] for educational enrichment of Spanish-speaking youth and “College Bound,” which provided college and career counseling, tours of universities, and financial aid to Puerto Rican high school students.

“Our Hispanic children wasn’t graduating from high school,” Córdova exclaimed in a 1992 interview. “They was quitting school in the eighth grade, ninth grade. We saw the need for us to organize.”

The Spanish Cultural preceded the current Latinx community advocacy non-profit, JUNTA for Progressive Action, which opened its doors in 1969. By that time, many Puerto Ricans had begun renting homes in the Hill neighborhood of New Haven, near Yale-New Haven Hospital, or purchasing property in the Fair Haven neighborhood.

Puerto Ricans also established cultural and religious hubs. The Second Star of Jacob Church, a Pentecostal institution, opened its doors in the 1960s and became a center for organizing in the Puerto Rican community. Beyond playing congas in Guilford, Puerto Ricans also celebrated multiple festivals to preserve culture and tradition, including the Fiestas de Loíza, which honors St. James, Santiago Apóstol, one of the original twelve disciples of Jesus.
Puerto Ricans, as the Latinx majority, dominated culture and politics through the 1990s. Cruz described the Latinx community as 85 percent Puerto Rican when he arrived
in New Haven in 1983; according to Norma, the remainder were “Cubans who had fled the Bautista era” and other “upper class” Cubans who had escaped from Fidel Castro.

John DeStefano, who served as New Haven’s mayor between 1994 and 2014, told me that “In the ‘80s… it was a largely Puerto Rican population with some Cuban feel, some Mexicans. But all the institutions of the community that were Latino were dominated by Puerto Ricans, with, in my view, distinct cultural awareness of who was Puerto Rican and who wasn’t.”

In the late 1980s, this pattern began to shift.

**Demographic shifts in the late 20th century**

Norma explains,

Well, after ’71, Argentineans began to arrive because in our country, the problem of the military takeover began. Those horrible years… the military killed people. If you were a student, especially of medicine, they would make you disappear. When the guerillas were wounded, they could not obtain doctors so they were looking for medical students to save them. All that was so horrible that we began to emigrate.

After us, the Colombians began to arrive, because of the same problem. They had the FARC [Fuerzas Armadas Revolucionarias de Colombia or the Revolutionary Armed Forces of Colombia] and the guerrillas. After that, came the Peruvians, who also had problems in their country.

In the 1980s in Peru, the Sendero Luminoso [Shining Path], a militant Maoist organization, began an attempt to take over the country, conducting indiscriminate bombing campaigns, assassinations, and sexual assaults, channeling funds from drug production and trafficking to support their activities. The economy collapsed and hundreds of thousands of Peruvians, including my husband’s family, fled to the U.S. (Palmer 1994; López 2015). According to accountant and Puerto Rican economic leader,
Pete Rivera, Peruvians established a foothold in businesses like grocery stores, meat markets, and restaurants.

Latinxs also migrated from other areas of the country. Norma notes, “In California and Texas, they began to run out Mexican immigrants, harassing them, mistreating them, and abusing them. So [the Mexicans] saw the north as a mecca.” Similarly, many moved out of New York City due to drops in wages and increases in costs of living, particularly in the Washington Heights neighborhood. These microeconomic shifts brought in a surge of Dominicans and Ecuadorians.

When Puerto Rican lawyer and activist Kica Matos began working for JUNTA in 2000, she said,

I noticed almost immediately after I started that many of the people who came to JUNTA for services were not Puerto Rican. People who did not look like they were Puerto Ricans… by the cultural approach, the accent, the clothing, sometimes physical features. Culturally, what you’re eating is not Puerto Rican… A significant number of them appeared to be from Central and South America, with a significant number from Mexico. As I started getting a little bit more familiar with the landscape, it seemed like a significant number of Mexicans who were relocating to New Haven were either from Tlaxcala or Puebla. And that’s when I really started realizing, wow, this is a Spanish-speaking population that is not Puerto Rican.

The influx of migration from Central and South America presented new issues for the Latinx community of New Haven. “Now you had an undocumented population,” DeStefano explains. “They did not want to play prominent, visible roles because of their immigration status.”

Norma Franceschi recalls the day she realized the dramatic change in the community and its needs.

I left my home at 6:25 to open my store at 7am. I had gone to Apicella’s, to the bakery, to pick up fresh bread and I go to open the store. And there, right in front of me, is one of those trucks that you rent, a UHaul, right? The driver stops, opens the back door and you could see, boy, how many people got out there! And I say to myself, “What is this?” It looks like someone had stepped on an ant hill. And one of my employees, María de Jesús tells me, “Norma, those are Mexicans.” And they began to run everywhere. “These are
coyotes that are bringing people,” María de Jesús said. So, I say, “and where are they going, Mari?” She says, “they are renting a room.” They told me that there would seven or eight people in one room, and that the *gringos* are taking advantage. They would rent these lofts without bathrooms, so they couldn’t relieve themselves or bathe.

Here, the needs of the Puerto Rican and Central and South American communities diverged drastically. Whereas Puerto Ricans pursued higher education and livable wages, the new migrants focused on basic needs like housing and sanitation. The difference between U.S. Citizen Puerto Ricans and undocumented Central and South Americans drove a wedge in the Latinx community.

“There were divisions,” DeStefano observed when he took over as mayor in 1994.

“It was culture. They spoke Spanish, but they didn’t speak *that* Spanish. You began to see a particular community emerge in Fair Haven, around St. Rose of Lima’s church. That’s where the community began to coalesce and organize themselves.”

While Puerto Rican cultural and political organizing centered in the Hill and the Pentecostal Second Star of Jacob Church, Central and South Americans coalesced into a community in Fair Haven, around the Catholic Santa Rosa de Lima church. Father Jim Manship, a former priest of Sta. Rosa de Lima says that when he first joined the parish in 1999, the community was largely Puerto Rican with “just a smattering of Mexicans.” But then, “Between 2000 and 2005, the parish had really transformed itself,” Manship explained. “It was no longer a predominantly Puerto Rican community: It was a very diverse community with a strong presence of Mexicans from Los Reyes, Michoacán and from Tlaxcala.”

Later, he added, “you had, you know, a growing and vibrant Ecuadorian community. People from Manabí, from Quito and Cuenca, Morona Santiago, Guayaquil. So, there was quite a diversity of Ecuadorians coming in, some migrating out of New York, many not having family directly here in New Haven.”
Civil unrest and economic downturn in the 1980s drove many out of Ecuador. By the early 2000s, an estimated 55,000 Ecuadorians lived in the state of Connecticut, enough to justify the establishment of a Consulate in 2008, the first consular office of a foreign government in New Haven since Italians had opened one in the Wooster Square neighborhood in 1910 (Appel 2008).

Matos, who at the time of the installation of the consulate, worked in City Hall clarifies that “the Ecuadorian consulate set up shop in New Haven, both because it was an immigrant friendly city, but also because of the significant number of Ecuadorians that were moving to New Haven.”

The influx of Latin American migrants transformed the Fair Haven neighborhood of the city, an area in the eastern part of the city, framed by the Quinnipiac and Mill Rivers, that had long welcomed European immigrants. Matos explains,

Fair Haven has always been, historically, the neighborhood in New Haven where migration stories begin, be it German or Russian or Italian or Polish or Jewish or Black from the Great Migration north. A lot of these immigrant folks have settled in Fair Haven first before moving on and establishing themselves, benefiting economically and then moving on. And the last waves were African Americans and then Puerto Ricans. And then all of a sudden these Latines were showing up and they weren't Puerto Rican. But nobody was really paying attention.

In the late 2000s and early 2010s, New Haven experienced a surge in migration from Guatemala.

“Suddenly, in 2010 or 2012, there was this influx of moms and kids from Guatemala,” Megan Fountain, lead organizer of the immigrant rights organization Unidad Latina en Acción shared. I guess, through word of mouth, they heard about us.”

Guatemala at the time confronted its own civil unrest and economic collapse. Following the civil war, which erupted over land disputes and dispossession of the
Mayan Indigenous community, the agricultural economy floundered. This, along with effects of climate change, which reduced the harvest outputs, and drug-related conflict over poppy fields along the Mexican border, drove many young Guatemalans out of the country. “There were a bunch of moms and teens who had just crossed the border and gotten detained, who had asked for asylum,” Fountain explains.

This influx also transformed the linguistic needs of the community, which up to that point, had been exclusively Spanish. Fountain adds,

We had more Indigenous folks coming in. Prior to that, we had, like, one family from Mexico who spoke the Indigenous language Totonaco from Puebla, from Sierra Norte de Puebla, Mexico, but we really didn’t have a lot of Indigenous folks. But then with these Guatemalan folk, a lot of them spoke Mam. Some of them speak Q’anjob’al. Some of them speak Kaqchikel. Most of them speak Mam. And yeah, it just like, ushered in a new dynamic at ULA [Unidad Latina en Acción].

By this time, the Latinx community in New Haven had become largely Puerto Rican, Mexican, and Ecuadorian, with a growing contingent of Guatemalans, a mix that reflected a radical departure from the near-exclusive Puerto Rican community of the latter twentieth century and the networks of European immigrants before them. By 2012, over half of migrants to the city of New Haven were from Latin America and the Caribbean, with massive increases in migrants from Mexico, Ecuador, Guatemala, and the Dominican Republic (Buchanan and Abraham 2015). John Curtis, a Spanish-speaking journalist and immigrant rights advocate notes, “What I have observed is that there seem to be three big communities in the New Haven area: The Puerto Rican community, which is largely in the Hill, the Mexican community in Fair Haven, and the Ecuadorian community in East Haven.”
Latinxs in New Haven today

Today, 103,000 immigrants reside in New Haven, half of whom are undocumented and at risk of deportation (Vera Institute of Justice 2020). 84,200 immigrants in New Haven have lived in the country for more than ten years. Collectively, immigrant households in New Haven contributed $339.8 million in state and local taxes and $659.2 million in federal taxes (Vera Institute of Justice 2020).

As the Department of Commerce released the 2020 Census results, New Haven learned that Latinxs had become its largest ethnic group, increasing by 15 percent while the remainder of the city grew by just 3 percent. Now, Latinxs lead other groups, representing 30.6 percent of the population, while 30.4 percent identify as Black, and 27.6 percent identify as White (Kainz and Breen 2021). The city, particularly the Fair Haven neighborhood, currently braces for a large resettlement of Afghan refugees fleeing the resurgence of the Taliban (Vallejo 2021).

“In my community of Fair Haven, 19,000 people live here, 62 percent are Latino,” Lee Cruz says. “Of that 62 percent, we have 18 or 19 nationalities represented. The vast majority, well over half, are either Puerto Rican, Mexican, or Ecuadorian.”

Just as the U.S. claims itself to be a country of immigrants, the City of New Haven “is and always had been a city of immigrants,” according to Kica Matos (Zahn 2018). In 2016, the political analytics site FiveThirtyEight determined that the New Haven metro area was most demographically similar to the U.S. overall based on age, educational attainment, and race and ethnicity (Kolko 2016). As in the broader U.S., the gains of the immigrant community in New Haven have sprung from collective action and
organizing, and careful coordination and competition with other racially and ethnically minoritized groups.

In the next chapter, I discuss the relationship between the Black and Latinx communities of New Haven, highlighting ways in which the two groups have supported and contested one another over the past several decades.
Chapter 3: Enredados: Entanglements of the Black and Latinx Communities of New Haven

On July 24, 2020, members of Unidad Latina en Acción banded in front of the marbled steps of New Haven’s City Hall. Two children strung up a banner that shouted “Nada sobre nosotros sin nosotros”—Nothing about us, without us—a rallying cry for these immigrant and workers’ rights activists. A mother and her son held another banner declaring “Black Latino United,” a reminder in a time of trending hashtags affirming #BlackLivesMatter that Latinx communities share many experiences with Black Americans.

Within a few minutes, Mayor Elicker emerged from behind the vaulted glass doors, his pale blue button-down shirt fluttering along his thin frame. John Jairo, ULA’s key organizer, kicked off the event: the signing of an executive order to renew New Haven’s status as a “Welcoming City” that grants equal protection to all migrants, regardless of their citizenship status.

“This is something we have been fighting for… for so many years,” John said. He described initiatives dating back to 2006 and the improvements in the new order, specifically its commitment to disciplining city employees who violate it.

“New Haven has a history of being a welcoming city and today we are here to reaffirm that history and to strengthen protections for our residents,” Mayor Elicker said.

Following the mayor, activists and community leaders shared their stories fighting for this change and the promise of security it meant to them. The crowd swelled with equal parts frustration and hope. Invited as an expert on intergenerational trauma and the
health effects of immigration enforcement, I spoke about the need to expand healthcare to undocumented (im)migrants.

To close the event, Jayuan Carter, a young Black man with a gentle face but stern expression, took the podium. As Jayuan spoke, he grasped the wooden stand, hunching his tall frame over it. John Jairo interpreted his words into Spanish.

I wanna say that in physics, two objects cannot stand in the same place. And with that being the case, it’s time for the Black and Brown community to come together. For each action, there is a reaction. And knowing this, it is time that the Black and Brown community who are currently competing for space—we’re competing for jobs, contracts, housing, food, and so on. But now it’s time we bring new options to the economic system… In recent times, Black Lives Matter has been chanted throughout this country. Large corporations have invested into Black-owned banks; however, that is not enough. What about the Hispanic and Latinx community? In closing, economics is a team sport. And the Black and Brown communities have to unite. We have to unite to ensure we have options to obtain what is real freedom. Thank you.

As Jayuan called for the Black and Brown community to come together, cheers erupted from the crowd. Years of competition, colorism, and collaboration coursed beneath his words like pressurized water through a rusted pipe: ready to burst.

As I began fieldwork for my dissertation project on intergenerational trauma in the Latin American migrant community in New Haven, I could not ignore this palpable energy among and between Black and Latinx folks. This chapter compiles data collected from ten oral history interviews with nine individuals as well as archival sources documenting Black and Latinx histories from the 1960s through the present. I describe these as enredados or entangled histories, meaning Latinx history cannot be fully narrated absent Black history and vice versa. This conception is informed by Natalie Molina’s relational formation of race, by which racialized and oppressed groups like Black, Latinx, and Asian populations, constitute and form themselves not only relative to dominant White populations but also relative to one another (Molina, HoSang, and

**History of the Black and Latinx Communities in New Haven, Connecticut**

Race and class define the neighborhoods of New Haven. Fair Haven consists of working class Latinx immigrants; many of the Latinxs that constitute 30.3 percent of the population of New Haven live there. Dixwell and Newhallville are predominantly poor and Black and a bulk of New Haven’s 41,000 Black residents—or 31.5 percent of the population—live in those neighborhoods (DataHaven 2020). In West River and the Hill, working class Black and Latinx folks live in the shadows of the Yale-New Haven hospital system. Meanwhile, wealthy White and Asian professionals and university professors populate the East Rock, Downtown, and Westville neighborhoods. The groups rarely cross the boundaries of Prospect Avenue, State Street, and Hamilton Street (see Figure). Kica Matos, a Black Puerto Rican lawyer and immigrant rights activist, describes it this way:

And you look at the 10 neighborhoods, right? The city is broken into 10 neighborhoods and you mention a neighborhood. And immediately what comes to mind is the race. Right. And the economic affiliation with the neighborhood. So, word association. Fair Haven, what do you think about Latin—Latines, you think about immigrants and you think about mostly working class. When you say East Rock or Westville, what do you think about? You think about young…in… in East Rock, I think about young white professionals who are affluent. And when I think about Westville, I think the more established wealthy people when you think about Newhallville, what do you think about you think about black folks and you… you think about working class and poor folks. And so my perception of New Haven is that it is, it is a very racially segregated city and it’s entrenched when you look at it geographically and you break it down by neighborhood.
Figure 6: A racial dot map of New Haven, Connecticut. Blue dots correspond to White residents; Green dots correspond to Black residents; Orange dots correspond to Latinx residents; and Red dots correspond to Asian residents. This map demonstrates that White and Asian residents primarily live in the Downtown and East Rock neighborhoods, surrounding the Yale University campus, as well as toward the suburb of Hamden. Black residents primarily concentrate in the Dixwell and Newhallville neighborhoods, which is separated from the East Rock neighborhood by Prospect Street. Latinx residents generally live in the Hill (south of where I-95 bisects New Haven) and Fair Haven (the eastern sector, separated by I-95 and I-91) neighborhoods. Latinx and Black residents tend to overlap in the Hill, near the Yale-New Haven Health buildings (Cable 2013).

A study by Reardon and Bischoff (2011) showed that the proportion of New Haven area families living in neighborhoods at the extremes of “poor” or “affluent” rose from 6.4 percent in 1970 to 30.5 percent in 2007, one of the most rapid increases of neighborhood income polarization in the U.S. This segregation by race and class traces
back to redlining, the set of policies by which Black and other families of color were systematically denied loans based on racist perceptions of investment risk (Marcuse 1979; W. Smith 1975). “Residential Security Maps” produced by the Home Owners’ Loan Corporation (HOLC), a New Deal-era agency that helped finance loans for homebuyers, function as some of the most illustrative artifacts of twentieth century redlining. These maps color-coded areas based on notions of lending risk: the “best” areas with the highest potential for investment returns were colored green and received an “A” rating and those considered financially risky, or “hazardous,” were colored red and received a “D” rating (see Figure).
Figure 7: 1937 HOLC Residential Security Map of New Haven, Connecticut. Green areas correspond to "A" or "First grade" ratings; Blue areas correspond to "B" or "Second grade" ratings; Yellow areas correspond to "C" or "Third grade" ratings; Red areas correspond to “D” or “Fourth grade” ratings (R. K. Nelson et al. 2020)

Social trends further define the neighborhoods. Dixwell, for instance, served as a refuge for the formerly enslaved and became a focal point of Black organizing. The Varick African Methodist Episcopal Zion Church became New Haven’s first Black
congregation: in 1915, Booker T. Washington delivered his final public speech just one month before his death (Fuchs 2017). In 1820, twenty-four formerly enslaved founded Dixwell Avenue Congregational United Church of Christ after they were forced into the balcony of their former place of worship. The Reverend James W.C. Pennington, who was born into slavery in Maryland in 1809, became the Church’s first Black pastor. The Church later harbored escapees on the Underground Railroad and defended captives fighting for liberty on the Amistad ship, which made berth in New Haven (Robinson 2012; O’Leary 2018). Due to segregation, Dixwell became the only area in which Black families settled and served as a focal point for social life including balls, lodges, and other social organizations. The famous Dixwell Community House, affectionately known as “the Q House,” offered organizing and development programs for Black youth. New Haven’s first Black mayor, John Daniels, attributed his success to his early days at the Q House: “I don’t think I would’ve ever become mayor of the city of New Haven without the Q House,” he said. In 1962, the first Freddie Fixer parade launched when a beloved physician and the first Black police commissioner of New Haven, Dr. Fred Smith, launched initiatives to repair urban blight in the Dixwell and Newhallville neighborhoods (The Ethnic Heritage Center 2010). The parades continue as a major celebration in May of each year. In other words, the Dixwell neighborhood has a rich tradition as a center of Black history and culture.

Similarly, the Fair Haven neighborhood, currently the major Latinx barrio of New Haven, has been shaped by trends of welcoming immigrants from multiple origins. Beginning with German Jewish families in the 1840s, Fair Haven also welcomed Black migrants fleeing racist violence and depressed economic conditions in the South, Swedes
seeking economic opportunity, Poles seeking work and ethnic liberty, Ukrainians escaping Russian persecution, and southern Italians pursuing refuge from a repressive and exploitative government. From the mid-nineteenth through the twentieth century, Grand Avenue, the aorta of Fair Haven, and its major arteries like James and Ferry Streets, hosted Jewish synagogues, German and Ukrainian meat markets, and Italian Catholic services and mutual aid societies (The Ethnic Heritage Center 2010). In the late 1960s and early 1970s, Fair Haven began to shift demographically from a predominantly Italian and eastern European neighborhood to an increasingly Puerto Rican one. In 1965, Puerto Ricans established the Asociación Cultural Hispana or the Spanish-American Cultural Association (Cordova 1993). The Association served as the precursor for JUNTA for Progressive action, a social services organization for Latinxs in New Haven, which last year celebrated its fiftieth anniversary (Ponzio 2019). The trend toward increased Latin American migration intensified as in the 1990s, new migrants from Central and South America made their homes in Fair Haven.

Historically, just one neighborhood emerged as a proverbial ‘melting pot’ both for Black and Latinxs: The Hill in southern New Haven. In fact, the first Puerto Ricans who settled in New Haven first established themselves in the Hill, not in Fair Haven.

“A lot of them [Blacks and Latinos] didn’t cross lines,” Pete Rivera, an accountant and leader in economic development among the Latinx community shared with me. “Mostly, Latinos will stay in Fair Haven and most Blacks will stay in Dixwell area. And then there would be a mixture in the Hill. That was really the only mixing place.”
Although homes in the Hill are mostly multifamily constructions over one hundred years old, reflective of the communitarian immigrant labor that once crafted them, the rotting wood and peeling paint reveal the transient nature of the Hill community. Just one-third of Hill residents own their own homes, and few families have generational heritage rooting them in the Hill. Despite this, the Hill bears a rich legacy of community organizing. Carlisle Street in the Hill South once hosted a Freedom School for Black history and culture (Gibson-Brehon 2017). Efforts by the Black Panthers in New Haven advanced organizations like the Hill Parents Association, which aimed to improve social conditions of Black and Latinx communities in New Haven (Y. Williams 2020). In this way, such racial integration facilitated political advancement.

In this next section, I examine this political advancement, basing my analysis on oral history interviews with prominent Latinx leaders in the Hill neighborhood and in New Haven.

“*It isn't literally Black or Brown: It's Black and Brown*: Black and Latinx Leaders in New Haven Politics

As Alderman representing the Hill from 1987 to 2015, and former Chairman of the Board of Alderman Black & Hispanic Caucus from 2006 to 2011, Jorge Perez is particularly well poised to comment on the political relationship between the Black and Latinx communities in New Haven. When I asked him about any alliances or competing interests between these groups, Commissioner Perez told me this:

There's always been an interesting relationship, right? You have people like Walter Brooks who lived in the Hill community and was a State Rep who got it and he couldn't survive without the Latino support. And we couldn't survive without his support, right? Or, we could not do as well as we did without his support, right? And then you had other
leaders who saw us as threats, right? Because I always was seen as a threat to Daniels for running for mayor, even for DeStefano, right?

As a leader of the Latinx community and a longtime Alderman, Jorge Perez seemed a natural choice for New Haven’s first Latinx mayor. Many believed he would run against John Daniels, who became New Haven’s first Black mayor, and even against John DeStefano, Jr., whom Jorge Perez ultimately supported. Yet instead, many Latinxs in New Haven united with the Black community to back the Daniels campaign.

In the moment, many Latinxs were hopeful for change under the Daniels administration. In an interview with a journalist in 1992, when Daniels was still mayor, Jorge Perez said,

We [Hispanics] believed the first Black mayor would improve conditions for all minorities. We did quite well. We got more Latinos appointed to commissions than we ever did before. For the first time ever, we had a Latino named to the [mayoral] cabinet. For the first time ever, we had the Latino head of a major department: Frank Alvarado, of building code enforcement… He [Daniels] did quite a bit for the Latino community. It’s tremendous [for the] psyche to see people that speak like you do, look like you do, in powerful positions where you’ve never seen them before. Doors have been opened that were never opened before.

Yet, when I followed up on that interview nearly thirty years later, Commissioner Perez’s tone had changed:

I mean, the best way I can answer that question is and we do have the benefit of hindsight right at this point, right? Exactly. So, I mean, you look at the beginning, and you look at the condition of things, right? And then you look at the end, whatever that end is. Right? Now, are they any better? At the end of the day, I mean, whether it was the African American community or whether it was the Puerto Rican community, Mexican community, Latino community… or the city as a whole, were we any better off, you know? I would argue that history would say no. Unemployment was not significantly or statistically any better off for any, in particular, the African American or the Latino community. I would argue the poverty rate was not significant—or definitely not statistically different—in those communities. And I would argue that because of this, because of the disappointment that people had and the fact that he did not leave at the top of his game, that he probably made it hard for another minority to take that position any soon.
In many ways, John Daniels would not have been elected without the support of prominent Latinx leaders like Perez. The failure of the Daniels administration to improve conditions like unemployment in New Haven, particularly for the Black and Latinx communities, prompted some Latinx leaders to push their own choice for mayor. After Daniels, some advocated for a Jorge Perez candidacy; others wanted another rising Latino political star, Tomas (Tommy) Reyes to launch a campaign for mayor.

Many considered Tommy Reyes, at that time a six-term Alderman representing the Hill neighborhood, a “wheeler-dealer who will cozy up with those in power.” In a 1992 interview with the New Haven Register, New Haven’s local newspaper, Reyes said “They [those in power] have the cookie jar, and I have to dip into the cookie jar to provide service to my constituents” (Hirsh 1992).

The push for Reyes did not sit well with members of the Black community. Latino accountant and business development leader, Pete Rivera, described the tension this way:

Basically back when we did a run at the mayor's office with Tom [Reyes]… the problem was that we were getting a lot of pushback from the Black community because the Black community wanted their person. And what happened was that, after Daniels, the Black community started trying to consolidate more power, to the point where they weren’t interested—they were interested in working with us, but as long as we helped them, not us moving ahead. So there was always like, a, like when Tommy was gonna run we were like ‘yeah we need that, first Hispanic, you know, Mayor’ and they were like ‘ah, you know, now’s not the time, ’cause we’re tryna get another Black mayor’ or positions or things of that nature.

John Artis Yopp, a Black Alderman and member of the Omega Psi Phi fraternity from Howard University, lost to John DeStefano in the Democratic primary by a 4-to-1 margin (M. E. O’Leary 2013). DeStefano went on to defeat his Republican opponent,
Kevin Skiest, with 80 percent of the vote, in what was considered to be the most lopsided election in city history (Mitchell 2013).

Jorge Perez and Pete Rivera backed DeStefano, and he became the longest serving mayor after a twenty-year tenure. DeStefano gained national recognition for his creation of a municipal identification card, the Elm City Resident Card, in 2006. The municipal ID card recognized undocumented immigrants as residents of New Haven, allowing them to open bank accounts, access libraries and public parks, and pay parking meters (Bailey 2007). In addition to other pro-immigrant initiatives such as the establishment of New Haven as a “welcoming” city that would not cooperate with federal immigration authorities or inquire about immigration status (Shell 2019). This prioritization of the needs of immigrants left some members of the Black community feeling left behind. When DeStefano stepped down in 2014, Black New Haveners saw potential in Toni Harp, a seasoned politician with experience as a former alderwoman and state representative—and a Black woman—to restore investment in the needs of the Black community.

Lee Cruz, a community organizer in the Fair Haven neighborhood and director at the Community Foundation for Greater New Haven, a services-oriented non-profit, recapitulated this history:

When John DeStefano, who I think had been converted into really seeing... he comes from an Italian background... how 'these people are not unlike our people... when we came, you know, we suffered some of these same things. So, I'm going to do this because it just makes sense. It's only that, you know, it's a different country.' But all of that kind of went by the wayside under the Harp administration because that, my sense is, is that because the feelings were that there was so much pent up need, desire, frustration in the Black community around a number of issues that they felt they had been unjustly treated. It wasn't that they were saying, let's not help the Latino community. It's that their focus was on issues that more widely affect the Black community. No recognition at all that there are many Black Latinx people... not a huge number in New Haven, but still that it
isn't it isn't literally Black and White or it isn't literally, Black or White. *It isn't literally Black or Brown: It's Black and Brown* [emphasis added].

Black and Latinx leaders had demonstrated their power to shape elections when they joined forces, for instance, by collaborating to elect New Haven’s first Black mayor, John Daniels. However, perceptions of competing interests between the two groups and singular allegiances on part of politicians perhaps stymied collective advancement. Daniels was supposed to advance the cause of all people of color, but his ineffectiveness with respect to the economic and social standing of Latinxs violated their loyalty to him. Latinxs buoyed DeStefano’s rise to city hall, so he responded to Latinx activism promoting municipal ID cards and “sanctuary” policies. As the pendulum swung back, Black voters supported Toni Harp, who attempted to reform conditions on health care and gun violence but fell short. Then again, the Black and Latinx communities banded together to vote her out and elect Mayor Justin Elicker.

Immigration lawyer and activist Kica Matos describes this tug-of-war dynamic in racial politics as follows:

> When you think about the political landscape of the city, you know, a lot of it is old style you know it's a largely Democratic city and old-style democratic machinery politics, which is that as a politician, as a public official, you look after the interests of those who voted you in. And so, as a result, elected officials who are Latino represent mostly the interests of the Latine community. When you think about public officials, right? Who's on the board of aldermen? It's very rare that you find public officials who are representing more than one constituent, er constituency, which means that a lot of the alliances that people engage in are quite transactional.

In summary, Democratic politics in New Haven both fractured and united Black and Latinx communities. When united as a voting bloc, Black and Latinx residents collectively elected the first Black mayor—and ousted the first (Black) female mayor. Yet, when the city never weathered that ‘rising tide to lift all boats’, Black and Latinx
political operatives again found themselves pitted against one another as each attempted to advance the candidate that would selectively represent the interests of their community.

In the next section, I discuss how community organization from the 1960s through the 1990s served to advance the economic interests of both the Black and Latinx communities in New Haven, specifically redirection of antipoverty efforts and investment in Black- and Latinx-owned businesses.

*Economics as a Team Sport: Black and Latinx Coalitions in Antipoverty Initiatives and Business Development*

In his speech in July 2020, Jayuan Carter alluded to ongoing competition between the Black and Latinx communities with respect to economic survival, portraying the two groups as clambering over one another to get ahead. In reality, exploitative and profit-driven employers foment this contention by seeking to hire workers for the lowest wages possible. Megan Fountain, an activist and co-leader of the immigrant rights organization ULA, which hosted Jayuan Carter, discusses how this breeds resentment between the two groups:

> You have, like, huge unemployment in the African American community. And then you have all these undocumented immigrants who are working, like, overtime, right? And so, the employer should be giving one job to an African American and one job to an immigrant, but instead they give a huge work burden to the immigrant, which is robbing the African Americans of a job—It's not that immigrants are taking jobs away from African Americans… But employers are taking jobs from African Americans because employers would rather hire an undocumented person who is super exploitable. And as a consequence, you have unemployment. And that unemployment like impacts the African American community disproportionately because of the racism of employers.

This exploitation on part of employers is largely invisible: its overt consequences, the competition for “space… jobs, contracts, housing, food, and so on” that Jayuan
detailed in his speech inflames tensions between Black and Latinx residents of New Haven. Despite this, since the 1980s, Black and Latinx communities in New Haven have mirrored patterns of alliance in civil rights era New York City to advance their economic interests. Jayuan Carter hearkened to this history, calling for a revitalization of previous urban antipoverty initiatives:

Mayor Elicker, we spoke and we both agreed, it’s time to talk and create equity for all of our communities. As our executive officer, we need your partnership to finance… to finance the new reconstruction era through a public bank. With said bank, we can create a domestic Marshall Plan so the profits can return back to the community instead of bonuses and shareholders.

Carter’s call for a domestic Marshall Plan echoes a proposal by the same name put forth National Urban League President Whitney Young in 1964. Many key elements of the plan, which called for $145 billion in investment in poorly resourced inner cities, informed President Lyndon B. Johnson’s War on Poverty (National Urban League 2017).

The transactional nature of democratic politics evident in New Haven also played out in the implementation of Johnson’s antipoverty and civil rights programs: leading Democrats did not view Latinxs, particularly Puerto Ricans, as critical to their voter base and thereby did not seek to mitigate the economic disenfranchisement of Latinxs (Lee 2014, 140). However, in New York City, Black and Puerto Rican organizers used the War on Poverty structure to foster cross-racial spaces to legitimize receipt of antipoverty resources for both Black and Latinx communities (S. S.-H. Lee 2014, 164).

In New Haven, Black and Latinx community activists built solidarity through the Hill Parents Association (HPA). Established in 1965, the HPA initially prioritized administration and supplies for the Prince Street school but pressed onward “and began to get involved in larger issues affecting minorities in New Haven” (Y. Williams 2001).
Motivated by Black power paradigms, the HPA retained its community focus, rejecting outside White leadership and national priorities as seen in other organizations like the National Association for the Advancement of Colored People (NAACP) and the Congress of Racial Equity (CORE). As a local organization of invested—predominantly poor—Black and Puerto Rican parents, the HPA expressed strong reactions to early antipoverty initiatives sponsored by the Johnson administration, particularly the Community Progress Initiative (CPI).

New Haven was one of the first targets of the 1960s War on Poverty. In 1962, CPI became the first community-based antipoverty agency. Imbued with idealism, CPI set off with hundreds of thousands of federal dollars with the task to solve urban poverty.

"The Government set us up to fail," commented Idella W. Howell executive director of Community Action for Greater Middletown, a CPI successor in a neighboring Connecticut city. "It gave us some money and told us to go out and get rid of poverty within 10 years. Then it started cutting off our funding" (Rierden 1991).

Community organizations like the HPA criticized CPI’s mismanagement of funds and its lack of responsiveness to community input. A group of predominantly Black and Puerto Rican organizers formed a reactionary coalition called People Organized in Neighborhood Trust (POINT); a member described their interactions with CPI as follows: “Maybe if the CPI came, they would realize that we have nothing and would ask what to do with their money; but when we talk to them no one is there”

Similarly, a reporter discussing the interface of POINT with CPI for Modern Times, an independent paper for working people, described the tensions accordingly: “The problems POINT faced with the CPI are very similar to the hardships that poor
Puerto Ricans, Blacks, and Whites in New Haven have suffered in dealing with this ‘anti-poverty’ government agency.”

CPI dissolved and the federal government stripped its funds. Its successor, the Community Action Agency, established in 1977, more effectively responded to community-identified needs for services such as job training, transportation, and family support (Rierden 1991).

Accountant and business development leader, Pete Rivera, who moved to New Haven with his family in 1978, articulates strong, Reaganesque sentiments against government support.

There’s a famous, eh, Black economist—French economist—who said the reasons minorities fail in politics is because they do it backwards... as to the way it should be done. The way you should achieve political greatness, or political power, is you work to achieve economic power... and once you’re economically strong, then you aspire to political power. Minorities, we bypass the economic power—we go from being poor, shit project-dwellers to others to seeking political power…
I say [to undocumented people], ‘You know what? This the way to move ahead. Don't be dependent upon the government, be one that the government depends on. If the government depends on you, no matter if you're illegal, the government is gonna keep you here. It's only when you're dependent on the government that they're going to get rid of you.’

In 1982, Pete Rivera opened his own accounting business and began assisting primarily with tax preparation in the Latinx community, as he and his wife were the only Spanish speaking accounting team in New Haven at the time. Rivera recognized a need for increased support for Latinxs interested in starting their own businesses and so he launched the Spanish American Merchants’ Association to facilitate skill-building and resource exchange for would-be Latinx business owners. Rivera’s work garnered attention from key policymakers, both at city hall and the University of Connecticut, which had been tasked with administering a small business development program throughout New England. Rivera’s attitude toward economics echoes Jayuan Carter’s: that it is a “team sport.”

I could get a lot of things done simply by making certain phone calls and really bringing like minds together... I got to know a lot of the Black community… I knew a lot of the major players…Actually, I was a member of the NAACP in New Haven. And I used to go to the meetings, you know. And I was, I became an, they made me honorary member of the Greater New Haven Business and Development Association, which was the Dixwell Avenue group for Black businesspeople. Right…So with respect to business, as I did a lot of the businesses in the Black community, I did a lot of classes at the Greater Haven business and professional associations for Black communities, I also started doing classes for the Hispanic community, in Spanish.

Rivera later launched initiatives for Hispanic Chambers of Commerce in the major municipalities of Connecticut, including Waterbury and Stamford, to foster connections to more powerful lending agencies and mutual insurance benefits. Many of these Chambers still exist today.
Jorge Perez, Commissioner of Banking since 2015 after 23 years of service on the New Haven Board of Alders, views his primary responsibility as upholding equal opportunity and racial justice. As Commissioner, Perez sees himself as a “cop” who must ensure that Black and Latinx individuals seeking credit do not fall prey to historic patterns of discrimination. If you are Black or Latinx he says, “the system is unfair, the system is not equitable.” However, overcoming these inequities to obtain a mortgage, which allows you to save money, accumulate wealth, and invest in your children’s education, in ways “that you otherwise wouldn’t be able to, [provides] opportunities,” according to Perez.

Rivera and Perez discuss economics as a means of advancement against racial injustice. Although Rivera partnered with the public sector, he decries social safety nets and promoted independent entrepreneurship. “Uncle Sam will always be on your butt if you are dependent on a government program, or you are dependent or you’re someone that has to be taken care of. But if you come here and create jobs, illegal or not, the government’s gonna love you,” Rivera says. By contrast Perez sees government as central to leveling the playing field for racialized populations seeking economic opportunity. Despite their different approaches, both recognized the need for partnerships across the Latinx and Black communities, much in the same way prior generations of Black and Puerto Rican residents in the Hill joined forces to reform the CPI.

In this next section, I trace patterns of this unity against a common enemy, specifically racial injustice and police brutality, from 1970 through the present. I discuss Black and Latinx solidarity around the Black Panther trials and May Day protests and
police violence against Malik Jones in 1997 and against Latinxs in East Haven in the late 2000s.

“The Enemy of My Enemy is My Friend”: Black-Latinx Organizing for Racial Justice

On May 1, 1970, thousands gathered on the New Haven Green for protests demanding a fair trial for members of the New Haven chapter of the Black Panther party for charges related to the murder of 17-year-old Alex Rackley. In the weeks leading up to the protests, the Panthers and their allies drummed up support among sympathetic students along the Eastern U.S. through teach-ins, speeches, and pamphlet distribution. One shouted, “WHAT CAN HAPPEN TO THE PANTHERS CAN HAPPEN TO YOU TOO” and quoted Pastor Martin Niemöller’s poetic confession regarding the Holocaust: “First, they came for the Communists…Then they came for me—and by that time no one was left to speak up” (Coalition for Defense of the Panthers 1970).

Although White allies featured most prominently in coverage of the protests and the trial, Latinxs at Yale and in New Haven provided strong backing for the Panthers’ cause, recognizing their shared struggles. Yale University graduate students in the Spanish department held teach-ins in partnership with the Latinx community highlighting “the analogies in the Black community which are related to the Panther trial” (Yale University 1970b). Members of the Young Lords of New York came to speak to the Hispanic Cultural Association at Yale prior to the May Day events to discuss “oppression and repression in the U.S. urban centers to the Puerto Rican community” (Yale University 1970a). The Comité por un Puerto Rico Libre expressed “its complete solidarity with the United Front for the Defense of the Black Panther Party” and its
“complete support of the liberation struggle that has to be waged in the ghettos of this country” in which the Black Panther Party was playing “a crucial role” (Yale University 1970a).

On June 15, 1970, the week that the trial began for one of the Panthers, Lonnie McLucas, the Modern Times published a column in Spanish entitled “Buena Razon para Temer a las Panteras” or “Good Reason to Fear the Panthers.” In it, the author argued:

History teaches that when Black people rise up against their oppressor, they are stifled with brutal force. From the slave uprisings to the murders of the Panthers the situation has not changed. The Panther with the rifle is thus saying to the police “We are going to defend our homes and communities with our lives.” In other words, the days of effortless lynching and killing are over. Furthermore, the Panthers tell the truth about capitalism and racism: how only a small group takes advantage, while most of us suffer. The Panther Party has often repeated the fact that it does not want a racial struggle, but a participation in a struggle of the very poor against the wealthy rulers of this country. They point out that their motto is "All Power to the People." This refers to all workers—Black, White and Brown. The Panthers are serious about alliances with other oppressed groups. They have an alliance with the Young Lords, a Puerto Rican group that is very active in New York and Chicago...

Latinxs felt a fierce affinity toward the plight of the Panthers. Banking Commissioner Jorge Perez, when reflecting on the bonds between Black and Latinx communities explains this fierce bond this way:

Most of the partnerships were partnerships that continued… the enemy of my enemy is my friend [emphasis added]. I always feel that those relations that were true and sincere relations where people were willing to put their neck on the line and sacrifice everything, you know, to tell your story.

This sentiment—of powerful bonds forged against a common enemy—threads together experience of Black and Latinx solidarity against racial oppression, whether in economic terms, as Perez suggested, or in criminal justice, as with the Panther trials and subsequent instances of police violence and resistance against intervention from federal immigration authorities. I will discuss these latter two cases here.
On May 30, 1997, Malik Jones was shot at least four times by East Haven police in a parking lot near his home in the Fair Haven neighborhood of New Haven, after a chase resulting from his driving “erratically” (Tuhus 1997). The officer who fired the fatal shots claimed Jones’ vehicle backed toward him, and when he pulled forward, the officer feared Jones would back into him. At that point, the officer broke Jones’ window with his gun and fired several shots point blank. However, according to reports from witnesses, including Samuel Cruz, a passenger in the car with Jones, Jones maneuvered the vehicle to avoid hitting another police car that had stationed in front of him.

A separate question asks why Jones fled East Haven police in the first place. Conventional wisdom at the time, articulated by Patricia Snowden, a witness for the Jones family during the trial, suggests racial bias on part of the East Haven police department. Snowden, a Black woman, testified to harassment and sexual assault by East Haven police officers during unrelated arrests for motor vehicle violations. In addition, a former East Haven police chief testified that after Jones’ death, officers off duty wore softball shirts with the words “Boyz in the Hood,” which they acknowledged had racial overtones (T. D. Williams 2003). John Curtis, a Spanish-speaking journalist in New Haven since the early 1990s, shared with me his understanding of the situation:

It give[s] you some insight into how people perceive the East Haven cops. The reason, I suppose it was that this young man [Malik Jones] freaked was that he’d heard bad things about East Haven cops and didn't want to be pulled over there. Yeah, well, that may give you some idea what… what the relations were like back then.

This perception of East Haven cops as maliciously racist resurfaced in the late 2000s as Latinx migrants began moving across the eastern shore from Fair Haven into East Haven. Father James Manship, former priest of Santa Rosa de Lima Parish, a
predominantly Latinx parish in Fair Haven that served as a center for immigrant services and activism, narrates the story of the shift in racialized targets of the East Haven police.

There was a changing feeling on East Main Street, which some of the bodegas... It's in the spring of 2008, ahm, one of the guys came over and told about what it sounded to me like a police riot at Los Pares [The Pairs] at the bar. The cops just came in swinging and fighting and beating people up. And he was one of them, had his lips split, you know, and he was, you--he was in tough shape. And so that's what I see, there's something going on here and then toward the mid-summer, that's when a family... so, a woman, you know, the kids in the minivan go to route, go on to Route 80, go into East Haven to get some groceries, she gets stopped by Officer Spaulding [former East Haven police officer] because she has a Pennsylvania plate in the parking lot of the store. She committed no moving violations whatsoever. He just had E.S.P. [extrasensory perception], you know, said, "Oh! She must not have a driver's license and or insurance and the car is not registered here." So, that’s the pretext that they use. So they impounded the car, can't drive the car, you don't have insurance, you have to send somebody to come over. So, so they call up a family member and live with family members of the same situation. So, he took his plates and his car and left them all out there on, you know, on the side of the road. And it was a game for them. Matter of fact, East Haven police called it the Border Patrol, Route 80, East Main Street where they would sit and looking at the people coming in. They were looking at inbound traffic, not outbound, the inbound traffic who was coming in? This also on the service road. Where Wendy's is and Home Depot, you're coming in there, so Officer Spaulding would sit there in that little V on the exit ramp where the stoplight is, and he would look for folks. So, he would stop Brown folks coming home from oftentimes from the farms, you know, out in bishop's orchard and whatnot, coming back from work and then run them down on the service road, harass them, take their car, and began turning them over to immigration.

East Haven police officers also lingered outside Latinx-owned businesses, harassing customers and demanding driver’s licenses. Father Manship was famously arrested in 2009 for attempting to record this behavior (Negroni 2009). This, along with testimonials accumulated by parishioners of Santa Rosa de Lima, catalyzed a federal investigation of the East Haven police department. The probe resulted in the FBI arrests of four East Haven police officers and civil agreement to reform the entire department (Polansky 2017).

This march toward reform of the criminal justice system and the ongoing unity of Black and Latinx communities in New Haven resurfaced this past year in antiracist
responses to the high-profile police murders of George Floyd, Breonna Taylor, Ahmaud Arbery, Tony McDade, and others. On June 11, 2020, ULA hosted a “Latinos for Black Lives” silent march against police brutality, calling for “Black and Latino United in Action” and summoning the words of the Zapatista movement in Mexico: “Our silence is our cry of resistance! / Let our protest birth a silence / To hear the footsteps of the departing tyrant” (Fountain 2020). Later, on August 15, 2020, Emma Jones, the mother of Malik Jones, led a march down Grand Avenue, the main thoroughfare of the now predominantly Latinx neighborhood of New Haven, calling for justice and police accountability (Sonnenfeld 2020). The year prior, Ms. Jones’ advocacy led to the successful creation of a civilian review board in New Haven to “monitor, review and independently investigate civilian complaints of alleged police misconduct” (Dignan 2019). Thus, the sense of struggle against a “common enemy” of racial oppressors remains evergreen.

**Future Considerations for the Latinx and Black Communities in New Haven**

In this chapter, I have traced the entangled histories of Black and Latinx communities in New Haven across politics, economic advancement, and antiracism. I have provided evidence suggesting that even when Black and Latinx coalitions attempt to pursue their interests independently, their efforts tend to overlap and inform one another. Oftentimes, alliances are strategic and mutually beneficial: political mergers strengthen voting power, pooling of economic resources increases opportunity for Black and Latinx business owners, and united racial justice activism garners greater attention and policy change.
However, the intersection of *afrodescendencia* (African descent) and *Latinidad* as well as anti-Blackness within the Latinx community and xenophobia in the Black community further complicates discussions of the entanglement of Black and Latinx histories. Where do Afro-Latinxs fit in the Black-Latinx narrative? How do sentiments of colorism—particularly anti-Blackness—within the Latinx community and anti-immigrant attitudes among the Black community interrupt potential for true Black-Latinx solidarity?

These questions, though not unique to New Haven, remain open in this city. Megan Fountain, co-director of ULA, discusses how, following Immigration and Customs Enforcement raids in New Haven in response to the creation of the municipal ID card, White supremacist groups infiltrated Black churches, stoking xenophobia.

There was this anti-immigrant group that had ties to White nationalists. They had ties to this group called the White Wolves in Connecticut. But they developed a name, they developed just a name called like Southern Connecticut Citizens for Immigration Reform. They disguised themselves as an immigration reform group. But they were anti-immigrant and they were White supremacists. But they recruited an African American spokesperson. They had this one token Black guy. His name is Alan Felder… And then this group actually published a flier to try to turn African Americans in New Haven against Latinx immigrants. The flier… the flier has a photo of Frederick Douglass on it. And then they misquoted Frederick Douglass… it had a quote from Frederick Douglass out of context where Frederick Douglass was talking about like the influx of immigrants into the United States, and the flier basically says, like African Americans are like oppressed by those immigrants who are stealing your jobs. And they started going to Black churches and passing out these fliers.

Although support for immigrants in New Haven ultimately surmounted this xenophobia, particularly under the leadership of Mayor DeStefano, the leaflet campaign revealed anti-immigrant bigotry and tensions—particularly around competition for jobs—that persist today. On the other hand, ULA experienced its own fracture in 2019 due to accusations of sexism and anti-Blackness. Several members left the organization and denounced it on Facebook; one prominent member started a separate organization, the
Colectivo Semilla or Semilla Collective, which hosts its public meetings exactly at the same time as ULA’s.

Importantly, I have demonstrated that Blackness and *Latinidad* in New Haven *son enredados*, or entangled, and cannot be fully understood independently of one another. Future considerations, and movements, for Black and Latinx solidarity in New Haven should account for the perspectives of Afro-Latinxs—particularly Black Puerto Ricans and Dominicans—and undocumented West Indians, as well as the tensions arising from xenophobia and anti-Blackness within Black and Latinx communities, respectively.
Chapter 4: Social Movements and the Production of a Connecticut Latinx History

When I lived in New Haven, I felt a part of the Latinx community. I could walk to Fair Haven for groceries and my favorite mangonadas and show up to rallies and protests with Unidad Latina en Acción. I distinctly remember pacing the fringes of Criscuolo Park, at the border of the Fair Haven and Wooster Square neighborhoods, where I lived, while heavily pregnant with my son, chatting with the older Latinos who played dominoes in the shade by the bus stop. Since moving to the suburbs, one of the ways I have stayed connected with Fair Haven has been through community walks led by Lee Cruz. Although I had attended a few formal “tours” in medical school, I now showed up with my mother-in-law and toddler just for an opportunity to speak Spanish and get some exercise.

The establishment of the Fair Haven walking routes reflects a powerful dynamic of community organizing that has distinguished the local immigrant Latinx community. In this chapter, I trace hubs of community organizing around issues of housing, immigration, health, and economics.

**Housing and urban safety**

After witnessing the unloading of a truck of undocumented Mexican immigrants in Fair Haven and learning about the squalid conditions in which they lived, Norma Franceschi dedicated herself to improving housing in the community.

“Nobody imagined that there were so many immigrants,” Norma told me. She took it upon herself to raise the issue with the Board of Alders and the Livable City Initiative (LCI), a private-public partnership aimed toward improving neighborhood
safety and housing quality. She turned to Rafael Ramos, then deputy director of LCI and the founder of a Spanish-speaking community theater in Fair Haven.

I turn to him, that crazy peeled coconut, and say, “Look, Rafi, there’s a problem here.” And I told him what was happening. Then he says, “Norma, I can’t bring in all these people.” So I say, “hey, let’s go for a walk. I’m going to take you to where these people are living.” I take him to this place where the landlord is Greek and I tell him he has people in this place who have no water. The pregnant woman living on the second floor showed him the hose and bucket she had to clean herself a bit. And I showed him people who crammed into a room, some sleeping in the closet with a mattress on the floor to have a little privacy. So, when Rafael saw all that, he picked up everyone and put them into a temporary hotel and started fining the landlords. He would scare them into action.

Issues of landlord abuse and worker exploitation persisted into the 2000s, summoning the efforts of Fair Haven’s informal immigrant-aid network and organizations like JUNTA for Progressive Action and Unidad Latina en Acción (ULA). The team would arrange temporary housing with sympathetic landlords until workers could find new apartments and jobs. JUNTA’s emergency fund would cover any expenses in the interim. On a personal level, John Jairo Lugo, the founder of ULA would connect migrants with others in town and help them navigate the local supermarket. Kica Matos would invite people to barbecue at her house and to summer concerts on the Green (Bass 2007). In this way, this lattice of support both formally and informally resisted infringement on the rights of the immigrant community.

As the Ecuadorian community grew in Fair Haven, they established a collective to purchase land and dilapidated homes and construct new ones. This act of community solidarity and resistance has led to increased homeownership and wealth accumulation.

Apart from formal workplace and housing abuse, immigrants also confronted threats of violence. Edith Ortiz, a Puerto Rican woman who arrived in New Haven in 1966 told *The New York Times* that at school, students threatened her with switchblades,
shouting “Why don’t you go back to Puerto Rico?” “They wouldn’t believe me when I said I was an American citizen,” Ortiz recalls (Rierden 1992).

In the 1980s, issues with gang violence erupted throughout the city.

“There were crimes every day, deaths,” Norma explained. “The Latin Kings and the Ñetas would fight on the street corners, for the territory. And then people started shooting.”

Fears of gang violence tore apart Fair Haven, prompting many businesses to shut their doors and prompting a mass exodus of earlier European immigrants, particularly Italians, from Fair Haven. Latin American newcomers began to fill that void, transforming the culture of Grand Avenue, Fair Haven’s main thoroughfare.

Later, in the 1990s and 2000s, undocumented migrants became targets for theft and assault.

“People were targeted,” DeStefano explains, “because of their appearances, that they probably were Mexican, probably didn’t have a bank in town, probably had cash on them at all times.”

Norma adds, “They were killing immigrants. They were attacking immigrants to steal their wallets and stab them and all that.”

Father Jim Manship recalls that these attacks on immigrants became a major concern among his parishioners.

“We had a lot of violence against immigrants,” he says. “Thuggery, people assaulting immigrants and robbing them and things like that. There was one of these little hoodlums that would go and bust windows and slash tires just to make people’s lives miserable.”
“Just prior to my arrival, there was a Guatemalan immigrant who was stabbed to death just outside the convent. This was a huge thing for the community,” Manship explains, “So we went at it.”

Manship collaborated with his parishioners to address the local district manager of the police force. They shared their experiences of fear and violence and succeeded in obtaining extra patrol cars to improve security in the neighborhood.

Together, Latin Americans in Fair Haven overall improved their standards of living and, now that they had become a majority, began to claim the neighborhood as their own.

**Health and environmental activism**

“It wasn’t that long ago, maybe thirty years ago or so, the Latin Kings were a huge thing in New Haven,” Lee Cruz launches into a historical account before a tour group of bright-eyed first-year medical students. “For those of you that don’t know, go look up the Latin Kinds. Really big proponents of crack cocaine. We had national gangs like the Bloods and the Crips. And New Haven was a fairly dangerous city to live in. From the mid-‘80s to the mid-’90s, the police department, the DEA—Drug Enforcement [Agency]—Firearms and Tobacco, and the Department of Justice got together to address the issue of crack cocaine and the Latin Kings. So, the residual effect has resulted in people feeling unsafe walking the streets.”

Cruz gathers the students into a huddle in the shaded, northeast section of Criscuolo Park, in front of a large map of the Fair Haven neighborhood punctuated by green and blue trail lines, the walking routes.
“A lot of people, about a decade ago, at the Yale School of Public Health were talking about behavioral health. Researchers say, look, you know, eat healthy and get eight hours of sleep and exercise, that has limited value when you’re holding down two or three jobs, when you don’t speak the primary language of the country, when you come from another culture. So, folks were interested in how we can incentivize people to do things that are good for them, like walking. So, you know, I like to say, we ha the peanut butter and they had the chocolate and by combining those things, we came up with the idea of a walking trail, or two walking trails in our neighborhood.”
Lee triumphantly relates the efforts to establish the trails.

We got a local architect to help us with planning the routes. We got funding from the Yale School of Public Health. We raised just as much money ourselves in the neighborhood. We bought six signs and printed 10,000 cards and hand them out to
students at K through 8 schools. What we wanted to do is to encourage students to take this map home, show it to their guardians, their parents, their grandparents, ask them, “can we walk around and look for these birds and look for this river.” That way, the kids can activate the adults in their house around walking.

Lee announces the success of the program with pride. He says they were able to put together the entire project with just a few thousand dollars, a feat that would have been impossible without the committed action of residents. Although the impact of the walking trail program has not been formally studied, Lee says that people living along the streets of the routes constantly see folks looking for the signs and markers, circulating along the planned paths.

As the Fair Haven community gained strength and unity, health and environmental justice rose to the top of the list of neighborhood priorities. Early on, with the support of the Alliance for Latin American Progress and the Community Foundation for Greater New Haven, the Fair Haven clinic set up shop out of Columbus School on Grand Avenue, providing medical care two evenings per week. In 1980, the clinic received federal funding, becoming a federally qualified health center. Over the years, the clinic expanded its services to include prenatal care, chronic disease prevention, dental care, and school-based health programs. As of 2018, the clinic served 18,000 patients over 80,000 office visits each year (Fair Haven Community Health Care 2021).

Beyond Fair Haven Community Health Center [FHCHC], residents worked to establish service networks to address maternal-child health, infectious disease, and trauma recovery. Norma Franceschi recalls,

“There were pregnant women who were afraid to get care. Many had venereal diseases.” Norma says that immigrant men would seek out White prostitutes and then carry home infections to their partners and spouses, who also became pregnant. “That’s
when we found a lot of gonorrhea, syphilis, many mothers who even tested positive for HIV. The pregnant women were also not taking their vitamins, and all that. Then the clinic [FHCHC] began to take notice.”

Advocates at Fair Haven pushed for services to promote maternal health and reduce infant mortality, a grave issue at the time. This led to the expansion of care to prenatal services and coordination with the city’s Head Start program. In 2003, the Progreso Latino fund, a community-based financial support organization, picked up much of the costs of Head Start outreach to New Haven Latinxs.

Local leaders also pushed to address the high burden of chronic disease in the neighborhood.

“We had a lot of Hispanic people with diabetes, but it was untreated,” Norma told me. In response, Katrina Clark, then director of the FHCHC organized a fundraising walk and health fair to promote diabetes diagnosis, treatment, and education. In 2004, a group of Yale medical students partnered with the FHCHC to open a free clinic on Saturdays, which still fills the healthcare gaps for many undocumented and uninsurable individuals.

Health issues in the community also stemmed from environmental contamination, including lead poisoning and air pollutants.

“In Fair Haven, there is lead on the sheet rock,” Norma explained, referring to the age of the neighborhood’s buildings and histories of applying lead-based paint. “They had not removed the lead, understand? They had not scraped it, just covered it over.”

Lead-based paint was not the only source of lead poisoning in the neighborhood. Oil tankers run by Shell and Gulf lined the Mill River, leaking lead and gasoline into the water and the soil. Due to overcrowded conditions, Lee Cruz adds, many households
would park their cars on the grass outside their homes, leaking oil onto the ground and tracking it inside where crawling and toddling infants would touch it and shove it in their curious mouths.

“There was so much lead in the soil by my house that my chickens got lead poisoning!” Lee starts to laugh. “As far as I know, my chickens are the only ones to have undergone chelation therapy. They have since died, but not of lead poisoning!”

Standing along the Mill River in Criscuolo Park, Cruz describes additional sources of contamination and its impact on poor, minoritized communities like Fair Haven.

“If you take a map of the United States,” Lee says, the timbre of his voice intensifying, “The demographics of where people of color live—whether those people are Black or Latino or Indigenous—and you overlay that on top of a map of the things in our country that cause the greatest contamination and the most health problems, we find that those maps area eerily similar. There’s a part of the United States that’s known as Cancer Alley, right down through Missouri and Texas, alongside all the oil refineries. So, I’m just going to point out a few examples of our own in New Haven.”

Lee grasps his straw hat with one hand and extends the other upward along the Mill River.

The oldest continuous-use power plant in New Haven, English Station, closed down not because of pollution, but because of the deregulation of electricity in the 1980s. So they closed the station down, which had been open since like 1890, built by Polish workers. The owner wanted to sell it. Nobody would buy it. And so he found some business people to take over. They were supposed to clean it up. But they wanted to open it back up as a power plant so that when it was a hot day like today in Fairfield County or Litchfield County, two of the most affluent counties in Connecticut, when people there turned on their central air conditioning and the electricity went up, this plant would come on and fuel them. So the community organized.
We had a meeting where we said, “Can we just have a show of hands of how many people in the room either have asthma or someone in your family has asthma?” Every hand in the room went up. And so, we told them, “Your asthma is going to be exacerbated on a day like today when that plant goes on.

Activists ensured that the plant would not reopen; yet, five years after the original clean-up agreement, the executives and regulatory agents involved continue to debate the extent of the contamination and whether the original building can remain for mixed use without posing health hazards to residents.

“Now take a look at those uncovered piles,” Lee says, pointing to hill-sized mounds of white and brown. “The white pile is salt, and the brown pile is sand, and that’s for all the towns in Connecticut that don’t have their own salt. For all the highways in Connecticut.”

Previously, Lee explains, the town of Mystic had its own salt refineries but, as a much more affluent town, taxpayers pushed for it to be shut down.

“Notice that nothing but the hardiest reeds grow on either side of that street [with the piles],” Lee points out. “The salt gets blown off the top, falls on the soil, gets absorbed in the water, and it kills the trees. That’s an ongoing fight.”

After relating this ongoing struggle, Lee describes a victory with a local owner of a cement and gravel company on the other side of the Mill River.

“Luckily, the owner is someone we know. He put a fifty-foot barrier from the river to the road.”

Then Lee points across the river to the highway bridge.

“That’s I-95,” he says. He thrusts one arm in one direction, and does the same with the other, pointing, “Florida. Canada.” Then he adds, “15 billion dollars were spent to build that bridge. And that wind is blowing all of the pollution this way. Some of these
things we’ve tried to fight but there’s just no way to win when there are so many things that we’ve got to stop.”

“We haven’t lost everything and we have a historic presence,” Lee says, the love of his community evident in his voice.

The Fair Haven community has made monumental strides to improving the health of its residents, but many challenges remain. The neighborhood continues to exhibit higher rates of chronic disease and obesity relative to Connecticut and U.S. Averages (Xi 2013). The neighborhood was also heavily hit by COVID-19, as seen in the maps below from April 2020 (Register Staff 2020). Fair Haven is in the northeast part of the city; if you imagine the city as a giant kangaroo, Fair Haven is the hip and rump.

Figure 10: Hotspot map of COVID-19 cases in New Haven, with racial and ethnic breakdown.
Earlier this year, community leaders and activists again hit the streets in service of health justice, this time encouraging residents to get vaccinated against the virus. The volunteers dispelled myths regarding needs for insurance and lawful presence to receive
the vaccine and helped residents without internet or cars schedule and attend appointments (Leonard 2021).

In the next section I discuss organization around immigration rights, an issue intricately linked with health equity.

**Immigration**

The swell of the undocumented population in New Haven shifted the attention of organizations like JUNTA toward the legal needs of the community.

“Their solutions were not the same [as those of Puerto Ricans],” Kica Matos explained, “because many of their issues directly related to their undocumented status. If somebody came to us and said, ‘Hey, I’m having a problem with my landlord and I’m being ripped off’ and we’d offer them options, inevitably what you would hear from that person is ‘Well, I don’t really want to pursue that course of action because he threatened to call immigration on me’ or ‘I’m afraid that if I start advocating for myself like you’re suggesting, then I’ll be evicted and I’ll have no recourse.’ So that’s when I really started getting involved in immigration law.”

In the early 2000s, Kica summoned her contacts at the Yale Law School to set up legal clinics outside of JUNTA. She also started raising money to focus on advocacy for the undocumented community. In 2006, millions across the U.S. protested proposed immigration reforms under the Bush administration, particularly the Border Protection, Anti-terrorism, and Illegal Immigration Control Act of 2005 (H.R. 4437), which proposed to harshen penalties for immigrants and classify them, and anyone who assisted their entry into the U.S., as felons. On March 25th, nearly 1.5 million participated in La Gran Marcha in Los Angeles. On May 1st—May Day, later nicknamed “A Day Without
Immigrants—thousands of migrants abandoned their low-wage, labor-intensive jobs to demonstrate their contributions to society (García Bedolla 2014).

Megan Fountain, co-director of Unidad Latina en Acción, was an undergraduate student at Yale at the time.

“There was this massive mobilization. The biggest protest in the history of New Haven since 1970. And it happened on May 1st, 2006. I saw this huge mobilization of immigrants, you know, people who I didn’t normally see in New Haven in my day-to-day life as a student. All of a sudden, they were right there, in the New Haven green.”

That same year, New Haven established a policy of non-cooperation with federal immigration authorities. Then-Mayor DeStefano aimed to build trust between the city and its undocumented residents. He hired Kica Matos as Deputy Mayor for Community Services and together they sought to implement a series of policies to protect immigrant rights. The first involved formalizing the New Haven Police Department’s former “don’t ask, don’t tell” policy with respect to inquiring about immigration status, effectively prohibiting city authorities from doing so and establishing New Haven as a “sanctuary city.” That summer, they began setting in motion plans to create municipal I.D. cards for undocumented residents (Medina 2007; Wucker 2007).

Father Jim Manship had previously identified the need for local I.D. cards among the parish community of Sta. Rosa de Lima.

“The discussion started around I.D. cards, but it wasn’t progressing very quickly on a city level,” Manship explained. The delay likely occurred due to DeStefano’s reelection campaign, as the proposal for municipal I.D. cards prompted a backlash from conservative pundits on national media streams. “Some of our leaders came forward to
produce a parish I.D. Card. So we did. We made these little laminated cards for 800 parishioners."

Manship says that the church leadership determined the criteria for the cards, whether consulate identification or home country passports. In the process, they found that the parish community included people from eighteen countries and fifteen Mexican states. Even though the parish I.D. cards conferred limited political capital, they were important to the community. “Bottom line was, you’re here and you have standing,” Manship asserted. “We see you, we recognize you. You are part of us, and we are part of you.”

Likely due to these strong, pro-immigrant advances, federal immigration authorities punished New Haven. On Wednesday, June 6, 2007, thirty-six hours after the city’s Board of Alders had approved plans for the municipal I.D. cards, Immigration and Customs Enforcement (ICE) agents swept in starting at 6 in the morning and arrested 34 people.

“It was like 5 in the morning,” Norma tells me, “and Mari calls me saying, ‘La migra came and they took everyone. Then I called Kica and she called the mayor and the police. “And then I call the church and I said, ‘Father Jim, they’re taking all the immigrants!’”

Thirty of the arrested were parishioners at Sta. Rosa de Lima. Immediately, the Fair Haven community began working on guardianship paperwork for children whose parents had been arrested. Next, they began raising funds to bail the migrants out from detention centers in Boston and Rhode Island.
“I don’t think anyone was actually deported,” Norma says. “The Yale Law School, they fought like lions.”

The Yale Law School’s Worker & Immigrant Rights Advocacy Clinic (WIRAC) represented eleven men who claimed that twenty immigration authorities had invaded their homes, without warrants or consent, illegally seizing and arresting them. In 2012, they achieved a landmark settlement. The men received $350,000 and all pending immigration proceedings against them were ended (Connors 2012).

Under the Freedom of Information Act, Unidad Latina en Acción identified emails between the Connecticut state police and ICE that indicated coordinated retaliation against New Haven for its pro-immigrant policies.

The New Haven community remains actively engaged in immigration debates and service provision for newcomers. In 2008, Sister Mary Ellen Burns, a Catholic nun and graduate of Yale Law School launched the Apostle Immigrant Service, which provides legal counsel to immigrants in the New Haven area.

“There were no places that were offering general legal services—no non-profit within New Haven County, let alone the city,” Sister Mary Ellen explains. “So, people would come to the church and ask questions about different immigration processes and we realized that, not only could we do this [provide legal aid], but, frankly, it was a matter of efficiency.”

Apostle Immigrant Services now leads among legal aid provision in New Haven for Latin Americans as well as migrants from Asia and Africa. “We treat everyone who comes with dignity, respect… to be warm, loving, and caring,” Sister Mary Ellen adds, nodding to her Catholic inspirations.
Today, two major organizations lead the immigrant rights movement in New Haven: Unidad Latina en Acción, of which Megan Fountain is co-director, and the Semilla Collective, a newer offshoot of ULA, founded by Fátima Rojas. Lee Cruz, who is godfather to Fátima’s children says, “Both of them have hundreds of people signed up who are undocumented, and they’re helping them with everything from food security to health, to jobs, to housing, to legal support—the whole nine yards.”

Fátima is an undocumented migrant who crossed the border with her family years ago while Megan is a White U.S. citizen who speaks Spanish fluently. Both are known and trusted in the community. During COVID-19, ULA and Semilla each tackled the needs of the undocumented migrant community from different angles. Semilla established a mutual aid fund and food garage to support migrants. ULA also provided cash assistance as well as baskets with food, hand sanitizer, and masks for families who had lost work or contracted the virus.

“We have 300 members, which means that thousands of people in New Haven do not have an organizing home. We don’t need to compete or criticize one another,” Megan says.

Up next on the agenda for these organizations involve advocating for abolition of ICE, expansion of healthcare access, and a path to legalization for undocumented migrants. The New Haven immigrant networks remain passionate about this work.

**Economic development**

“In 1982, I opened up my own company, Rivera and Rivera Associates, with my then-wife who used to do translations at the federal courthouse, interpreting treasury documents. We would do the accounting, bookkeeping, and taxes.”
Pete Rivera pulls down his black face mask and takes a long sip of coffee across the booth from me at the Greek Olive diner.

“There weren’t a lot of Spanish speaking business groups, so we got a lot of experience statewide with respect to what we were doing.”

Pete had moved to New Haven in 1978 from the South Bronx after serving during the Vietnam era. He used his G.I. benefits to get an accounting degree through the University of Connecticut system and began a bookkeeping job before launching his own firm. Having worked with Latinx businesses and churches, Pete quickly recognized the need for the community to organize and represent its interests. He established the Spanish American Merchants Association in the 1980s.

Around the same time, UConn had launched a small business development program and sought business experts who could expand services from the broader New England area to high-need communities in Connecticut.

“They basically contacted me and asked if I would be interested. I became a business counselor and eventually came to be regional director for the program as a result of my interaction with the business community.”

Still, local pastors like Father Jim Manship and other community leaders came to Pete saying that the Spanish-speaking community continued to face disadvantages in areas of economic development. Pete became involved in direct assistance to immigrants attempting to open small businesses.

“By 1988, I was probably solely responsible for about 95 percent of the new businesses of immigrants,” Pete bragged.
Pete also began teaching business classes, ultimately translating a statewide economic curriculum in Spanish. “I must have done hundreds of classes. I got to know Hispanics everywhere. I was like, ‘yeah, this is God’s work,’ you know?” Pete then determined that immigrant entrepreneurs needed representation in city politics.

“We didn’t have a voice, you know, businesspeople did not have a voice,” Pete explained. “So, I went back to all my clients on Grand Avenue—98 percent of them knew me and owed me. And I told them, you know, ‘guys, let’s get together and form this group.’”

Mayor DeStefano had also proposed the idea of a Latinx business program, but any time a city official from the Economic Development Administration went to interview local merchants, no one would answer their questions. One of the alders asked Pete surreptitiously, “Is there a mafia in Fair Haven? Are you, like, the leader of the mafia?”

According to Pete, Latinx business owners, many of whom were undocumented, did not trust city hall. Pete stepped in as a liaison to facilitate the establishment of the Grand Avenue Merchants Association. Norma Franceschi remembers and appreciates Pete’s role in bringing the association together.

“Pete Rivera helped me a lot with immigrants,” she says. At first, the attempt to revive Grand Avenue largely fell on her and her friend and employee, María de Jesús. They took brooms and began cleaning and sweeping the street. As they recruited other locals, they began to clean up trash and power wash the building fronts to rid them of graffiti. With Pete’s help, the community leaders started to meet. Overcoming their original distrust, they collaborated with a city lawyer to complete the 501(c)(3) form to
establish the Grand Avenue Village Association in 1999. The organization began assisting merchants with increasing client capacity, financing, generating profit, and developing the Fair Haven commercial corridor. According to Norma, the organization convinced business owners to agree to a minimum wage and to resist attempts to install parking meters, which were believed to deter low-income consumers from patronizing Grand Avenue businesses.

Pete felt strongly that it was important for Latinx business owners to expand into other racial and ethnic markets. In his view, limiting Latinx businesses to Latinx consumers would hold businesses back.

“I’d tell people, let’s look at the Hispanic community as your saving grace. You could probably pay rent with the Hispanic community alone. But you want to be rich, so you better sell to the White community.” He taught this lesson to all the students of his business classes. To facilitate networking with other businesses and industries, Pete helped set up the Hispanic Chambers of Commerce in Waterbury, Stamford, Bridgeport, and Hartford. Through these memberships, Latinx business owners made inroads throughout the state and benefited from tax credits previously unknown to them.

To Pete, the best way for an undocumented person to get ahead is to start a business. He shared with me success stories of an undocumented Argentinean woman who started a cleaning business and brought in four million dollars each year, supporting over 100 employees. He talked about women who had transitioned her home daycare to a commercial building in Milford, becoming one of the largest childcare providers in the area. He spoke about Mexican men who had grown their landscaping and construction company to 200 employees, earning between five and six million dollars a year.
“Pull yourself up by your bootstraps,” he says, betraying his Republican politics.

A 2014 survey of businesses in downtown New Haven found that 53 percent were owned by immigrants. Immigrant-owned businesses in greater New Haven were more likely to be small businesses, propelling job growth and innovation, and more likely to provide jobs relative to native-born owners (M. Buchanan and Abraham 2015). David Casagrande, a longtime New Haven resident and graduate of the Yale School of Forestry and Environmental Studies said back in 2016, “Hispanic immigrants are ‘saving’ neighborhoods like Fair Haven in New Haven from economic decay and crime.”

Relationship with Yale University and Yale-New Haven Health

“You can tell when you’re at Yale… and when you’re not at Yale,” the police sergeant told the first-year medical school class during the security orientation, her voice rising at the tail of each phrase. “And when you’re not at Yale, we can’t protect you.”

I narrowed my eyes. I could tell the difference between Collegiate Gothic and Post-Modern. I knew the campus boundaries. And I also knew that crowned windows and manicured lawns would not guard me from crime.

The sergeant veiled her words, but her point was transparent: Any threat to our safety comes from the ‘others’ that fall outside the privileged elite of which they had taught us to consider ourselves a part. “Yale” was a group, not a place; a marker of merit, a badge of belonging built on the ‘accomplishments’ of White imperialists (Minor 2015).

Since its inception in Old Saybrook in 1701 and relocation to New Haven seventeen years later, Yale University harbors a fraught history with local residents. At its original home in Old Saybrook, Yale trustees confronted frustrations on the part of
Connecticut colonists due to its inconvenient location in the northeast sector of the state; to avoid long commutes from areas like Hartford and the southern coast, many students opted to seek instruction from their local pastors rather than from the University faculty. When the trustees accepted a bid from the City of New Haven to host the University, residents of Old Saybrook took to the streets in protest (Connecticut History 2020).

When Elihu Yale, a representative of the British East India Trading Company, donated books and funds to the newly relocated University, Yale took his name and cemented its ties to extraction and colonization. As waves of immigration in the nineteenth century disrupted the concordance between the homogenous, Puritan ideology of the University affiliates, antagonism brewed between the college and the public over allocation of resources. Why should tax dollars support esoteric studies benefiting an aristocracy? In addition, students living in dormitories angered their neighbors with disorderly conduct and mismanagement of waste. In the twentieth century, universities like Yale received federal sanction and funds to clear out local areas as part of “urban renewal” programs that displaced thousands of locals (Warren 1976).

In the City of New Haven, this process is best exemplified by the creation of the Oak Street Connector. Former Yale News director and then-Mayor Richard “Dick” Lee proposed a road that would direct traffic from the Connecticut Turnpike—a section of Interstate 95—toward downtown New Haven. The road dissected communities historically home to Black Americans and immigrants, shattering a once vibrant neighborhood. The move reflected a partnered interest on part of the City and the University to invest in luxury economic development at the expense of affordable housing and to prioritize the interests of suburbanites over those of city dwellers. A
manifesto authored by residents of the north Hill neighborhood, which suffered the
greatest blow from the construction of the Oak Street Connector, calls the redevelopment
agency an “invading army” on a “rampage,” asking the mayor:

Mayor Lee, what respect you have had for them. Your fame rests on violence,
vioence to the “law and order” of their lives, their very right to exist. This
violence is worse than looting and firebombing. It is disrespect for human life.
What are looted stores compared to their looted lives? (Gillette 2007)

By the 1980s, urban renewal in New Haven screeched to a halt. In response to
uproar, the Connector was never fully completed, its eight lanes of asphalt halting at the
sooty, concrete “Air Rights Garage,” where hospital employees still station their cars
(Stewart 2018). Since 1960, the percentage of city land dedicated to parking for suburban
commuters increased by nearly 300 percent (Johnston 2016). Residents of the Hill
continue to complain about the razing of their homes for public projects that benefit
outsiders. One resident and community activist, Dawn Gibson-Brehon, told me that she
does not think Yale will stop its encroachment on the Hill until it reaches the border of
West Haven.

Also in the 1980s, New Haven ranked as the seventh poorest major city in the
nation while the University endowment began skyrocketing, outplacing inflation with
returns exceeding ten percent each year (Yale University 2013). Its tax-exempt status
prevents Yale from disbursing its wealth to the city to compensate for its tremendous
drain on public services including police, fire, and sewage.

Being a Yale graduate student, I often sought opportunities to foster partnerships
with the organizations with which I collaborated for my research, including Fair Haven
Community Health Care, the Community Foundation for Greater New Haven, JUNTA
for Progressive Action, and Unidad Latina en Acción. The responses were unequivocally negative: They agreed that Yale only cares about itself.

The economic advancement of the Latinx community in New Haven has occurred despite, rather than because of Yale University and Yale-New Haven Hospital. Residents remain wary of Yale and the conflict between its interests and theirs. Notably, although Yale University employs the largest number of residents of the City of New Haven—and Yale-New Haven Health is the largest employer in the state of Connecticut—only one of my interlocutors reported working for either corporation. Animosity and resentment—with fleeting moments of gratitude for student volunteers such as at HAVEN Free Clinic—largely characterize the relationship between the Latinx community of New Haven and Yale University.

**Conclusion**

In this chapter, I reviewed the advances of the Latinx community in New Haven through efforts in community organizing. I discussed achievements in housing and urban security, healthcare and environmental justice, immigration rights, and business. I note how these achievements occurred in tension with the self-serving expansionism and wealth hoarding of Yale University.

As I spoke with many of my sources, we discussed the need for Latinx youth to understand the history and progress of their communities. Héctor Vega, also known as DJ Red or El Colorao (the red head), a personality for Bomba, a dedicated Spanish radio station spoke about how the movement to remove the statue of Christopher Columbus in New Haven showed respect for his roots.
“I come from an island that was discovered by him,” he tells me. “He discovered an island that was so small, but so great in power, in humanity, in wealth. We say that Puerto Ricans are perfect because we mix three races: Spanish, Indian, and African. We are all one.”

Kica Matos, herself a Black Puerto Rican woman who identifies as Afro-Latina says,

As a Black woman, as a Latina, we are often very dismissive of our own work. It doesn’t feel significant. It feels like you’re just fighting with everything you have. And when you achieve victories, you may, you know, for a day savor the moment but then you turn to the next big battle because there’s always another big battle to have.

Malcolm X said, “If you stick a knife in my back nine inches and pull it out six inches, there's no progress. If you pull it all the way out that's not progress.”

“The knife is still there!” Kica shouts. “I can still feel it!”

Both Héctor and Kica speak to the power of historical consciousness, of feeling part of a greater, resilient whole, and also to the challenges of embracing that history due to legacies of colonization and slavery and ongoing oppression.

In this section, “Migration,” I traced the history of Latin American migration to the greater New Haven area. I began by troubling the concept of Latinidad, emphasizing the exclusionary aspects of the term—particularly with respect to Black and Indigenous Latinxs—and how the application of an endonym to such a heterogeneous group may blur data on health outcomes. I discussed the potential for Latinx to serve as a radical expression of inclusivity for people with Latin American heritage of all generations and racial self-ascriptions, including queer and non-binary individuals. Given their entangled histories, I reviewed practices of competition and collaboration between the Latinx and Black communities of New Haven from the 1960s through the present. I then discussed
early patterns of migration from Puerto Rico and demographic shifts in the Latinx population over time, noting how the current population predominantly represents Puerto Rico, Mexico, and Ecuador and became the largest racial and ethnic group in the city of New Haven in 2020. Engaging the concept of population politics, I examined the potential for narratives surrounding demographic statistics to both empower and vilify the Latinx community.

On December 9, 2020, Connecticut Governor Ned Lamont announced that Connecticut would become the first state in the nation to require all high schools in the state offer courses on African American, Black, Puerto Rican, and Latino studies beginning in 2022. Then-Connecticut Education Commissioner and current Secretary of Education Dr. Miguel Cardona commented, “Identities matter, especially when 27 percent of our students identify as Hispanic or Latino and 13 percent identify as Black or African-American. This curriculum acknowledges that by connecting the story of people of color in the U.S. to the larger story of American history. The fact is that more inclusive, culturally relevant content in classrooms leads to greater student engagement and better outcomes for all” (Lamont 2020). Apart from one book published in the 1990s on Puerto Ricans in Connecticut, I could not find any comprehensive sources documenting the history of the Latinx community in the state, particularly in New Haven. In addition to foregrounding my ethnographic research, I hope that this narrative of New Haven Latinx history can serve as a tool of empowerment for those who have long resided in the city and those who are brand new, either by birth or migration, to understand the collective power of the community.
PART II: MOTHERHOOD
Chapter 5: "They're bought, they're sold": Corruption and State Failure in Latin America

“Miss, I’m very sorry…” Lidia halted, her voice betraying the easy confidence of our earlier conversation. “I’m worried that my details could be… exposed…and the truth is… very concerning. Above all for the safety of my family.”

I reassured Lidia that her information would remain confidential and that she was welcome to share no more than she felt comfortable.

“In Honduras, my husband was a doctor. He worked for the Ministry of Health and for the Attorney General's Office. He was the coroner in the area where we lived,” Lidia began tentatively. “What happened is that, about a year ago, my husband began receiving anonymous letters at our door. After a couple of months, my husband moved us to a town about twenty or thirty minutes away, saying it was so I could be closer to my work.

“But we were only there about a month when he tells me, ‘Look, my assignment has been changed and we need to move to the city.’ The city was about six or seven hours away and I asked myself, ‘How could it be that we just unpacked the last box from our move a few days ago and now we have to move again?’ My husband said again that it was due to his job. So, we moved and found a new school for my son.

“After about four or five months, I noticed my husband acting more strangely. He never said anything to me, but I could tell and I would ask him about it but he would never say anything. Until one morning, before going to work, he woke me up and said, ‘Look I need to talk to you.’
“He begins to tell me about months of letters threatening him, his job, and our family. I asked him, ‘How come you haven’t told me anything?’ and he just said ‘I didn’t want to worry you.’ So, when those letters kept arriving at our home—even after we had moved to another town—he thought it would be best for us to move to a more distant city, and he had arranged for us both to keep our jobs there.

“That morning, he had found my car with the entire passenger side beaten in. The doors were sunk in and it was badly destroyed. And he had found a note that said, ‘As much as you want to hide, we know where you are—and we know where your wife and son are.’

“So, we had to move again. My husband has family in rural Oaxaca, so we went to visit them. And when we came back, there was another note saying that no matter how hard we tried, we would not be able to escape them, they would always find us.

“We didn’t know what to do. We had already changed addresses a number of times and they had still found us. So, we had to report to the authorities.

“The police said they were going to protect us. They said they would assign us security, that they would stand outside the house for us. But it never happened. We never saw any movement from the police. No one was outside the house. No one knocked on our door to say, ‘We’re here in case of any suspicious activity.’ I mean nothing, nothing, nothing.

“We had a tourist visa that we’d received three years prior, by the grace of God. We had no choice but to leave. We took one suitcase each. I didn’t even say goodbye to my parents.”
Lidia and her family stayed with a relative for a few months while they settled in New Haven. Her husband took a job in landscaping to support them.

“The truth is it has been quite tiring. I mean, it was quite a drastic change. It was a tremendous change for, for all three of us. In Honduras, my husband was a professional, a doctor. And now what does he do? He had to learn to use tools… He came across people from our own country or from neighboring countries who—because he does not have the experience—have treated him very badly. The changes in his body, in his face, in his hands has been…” Lidia trailed off. I imagined her shaking her head in pain and disbelief on the other end of the phone.

“He says, ‘This is just what it is. It is nice to learn a little of everything because we do not know when it might be useful, not only for us, but to be able to help others.’ And yet he comes home and plays with my son and my son says, ‘Daddy, your hands hurt me.’ And my husband says, ‘Well, yes, look: My hands are hurt.’ And my son tells him, ‘Yes, but don’t touch me with your hands, you’re hurting me!’”

Lidia’s family applied for political asylum, but their lawyer tells them that their case is complicated given that they overstayed their visas. Due to the COVID-19 pandemic, their case has not yet been processed.

“We move around with the greatest caution,” Lidia explains, “Because we’re already here, illegal, you know?”

_The 'new' violence of Latin America_

Lidia’s story exposes the deeply personal impact of sociopolitical violence in Latin America. Threats against her husband—her home region’s expert medical
examiner—and the failure of state officials to protect her family forced Lidia to migrate to the U.S. on a soon-to-expire family visa. There, her physician husband took a job in landscaping to make ends meet, stomaching attacks from his compatriots regarding his lack of manual labor skills. Although some choose to migrate voluntarily, for a rebellious youthful adventure or a “grass-is-greener” mentality, migration often results from expulsion due to the failure of the state to protect its citizens. In this chapter, I discuss the forms of state failure and violence that shape individual realities in Latin America, impelling hundreds of thousands to flee each year.

Violence pierces the long contours of Latin American history. From colonization, African enslavement, and Indigenous genocide in the fifteenth through eighteenth centuries, to political conflicts and brutal dictatorships amid state modernization in the nineteenth and twentieth centuries, to social strife during state destabilization in the contemporary period, each era of Latin American history features acts of inhumanity perpetrated by dominant social and political groups against subordinate ones. Each iteration of violence transmits across individuals and communities through the futures of historic and transgenerational trauma, yet the current sociopolitical upheaval—including assaults and homicides as well as the holes in social safety nets—most directly informs decisions to migrate. This ‘new’ violence reflects social disruption and political failure in gestures toward democratization (Pearce 2010).

Contemporary violence in Latin America erupts through a confluence of factors including social inequality, poverty, drug trafficking, and judicial weaknesses. All these forms of violence uphold existing social orders, maintaining the elevated status of wealthy, land-owning men.
Much of the literature on state failure refers to the near-total disintegration of state institutions and resultant civil war, often using case studies in Sub-Saharan Africa. However, in Latin America, formal, post-authoritarian, ‘democratic’ state institutions exist but may fail to fully execute their functions or achieve legitimacy in the eyes of the public. Systemic flaws in the region include unreliable electoral politics, lack of governmental accountability, economic inequality, social exclusion, and violence. State failure thereby undermines citizenship and the foundations of democracy through its inability to uphold the rule of law and defend the citizens’ security. When the state loses its grip on the use of legitimate force, “drug lords, violent political entrepreneurs and gangs of disenchanted youths rule supreme” (Koonings and Kruijt 2004, 2). This failure—and the violences it permits—breeds fear and distrust, shattering the social fabric and producing embodied effects on physical and mental health.

**The multiple violences of social inequality**

Social inequality engenders multiple violences that force families without political or economic power into a permanent underclass. To be sure, social inequality is an inevitable feature of market economies. That said, extreme forms of inequality may be maintained and legitimized through constraint of citizen rights, specifically resistance to policies of economic redistribution, social integration, and welfare (Oxhorn 2001; Marshall 1950).

Many migrant women relate their frustrations at the high cost of education and inadequate wages. Priscila, a 38-year-old woman from Tlaxcala, Mexico told me: “I finished studying, but in my country, you sometimes have to pay to get a job. For
instance, for me to get a job as a math teacher in a rural area, I had to pay 20,000 pesos [$1,000]. And even then, I could only get a part-time job. I didn’t have any connections.”

Her peer, Almudena, from the same region said her father sold land to meet the multi-thousand-dollar fee for her teaching examinations, internship, and union dues. “He was so angry when I left because he had sacrificed so much for my career. But what could I do? I could barely meet my expenses with what they paid me.”

Célia, who featured in the Introduction of this dissertation, lamented that in Ecuador “everything is expensive. Let’s say a father in a family earns $400 a month, working from 8am to 8pm. You have to pay electricity, which is $50 to $100 a month. Then groceries are maybe $150. And that doesn’t include fruits and vegetables! We lived on the coast where there were plenty of melons, grapes, apples, things like that, but we couldn’t afford them. You can only buy the most basic foods, like lentils and beans. And then, of course, you have to pay the mortgage. Even with two salaries, it was not enough to support ourselves, let alone our son.”

Ysabel, a graduate of nursing school in El Salvador says that the only job she could get paid $80 a month. “At $80 a month, no one can survive,” she told me.

These women describe what economist John Roemer (1998) defines as “inequality of opportunity,” by which ‘circumstances’ including race, gender, and family background displace ‘efforts’ like educational attainment and work input as determinants of economic advantage. This perversion of neoliberal preponderance on individual responsibility calls for public, social action. A quantitative assessment of inequality of opportunity in six Latin American countries found that between one-quarter to one-half of inequality in economic consumption occurs due to differential circumstances. In
particular, Indigenous- and African-descended groups experience the greatest opportunity
deprivation (Ferreira and Gignoux 2011).

Gender inequality merits particular attention in Latin America, given pervasive
and harmful gender stereotypes persisting from the era of colonization. My conversation
with Ascención, a 32-year-old mestiza woman from Chiquimilla, Guatemala reveals how
preservation of gender inequality restricts the citizenship rights of women.

**Ascención**: In Guatemala, you get used to the economic failure. Sometimes my children
would go without eating because there was not enough money.

**Jes**: So you had trouble finding work?

**Ascención**: Yes, it is difficult to find work there. There’s work, but they’ll only hire men.
Eventually you get used to it. And so, in order to push my children forward in life, I came
[to the U.S.].

Studies demonstrate gendered variation in access to and control over resources,
indicating that household income is not always pooled across members (Braunstein and
Seguino 2018). In Latin America, despite relative gender parity in educational attainment,
women’s economic advancement lags in comparison to men. Women are less likely to
participate in the labor force, largely due to biases regarding gender norms, or enduring
perceptions that women should disproportionately shoulder household responsibilities.
Reduction in household income inequality through policies including public investment
and increased minimum wages improves gender equity. However, except for Chile, social
spending programs throughout the region remain limited (Grugel and Riggirozzi 2012).

Advances in social programs—as seen in Ecuador, Bolivia, and Argentina, for
instance—emerged by force. Powerful social uprisings, particularly among women, labor
organizations, and Indigenous groups, forced state actors to respond to demands for
higher public spending. Protest against water privatization in Bolivia crushed the
reelection hopes of Gonzalo Sánchez de Lozada, leading to the ascent of Evo Morales, the Indigenous leader of the union of coca producers. In Ecuador, Indigenous movements ousted two presidential administrations, eventually electing Rafael Correa, who increased spending on hospitals, roads, and schools (Becker 2013). Following the 2001 economic collapse in Argentina, working class activists achieved an increased minimum wage for non-unionized workers, expansion of health benefits, and universal financial support for families with children (Grugel and Riggirozzi 2012). Still, leftist social organizations have decried the inadequacy of these reforms, indicating the futility of ambitious social welfare agendas that lack the support of the conventional oligarchy (Becker 2013; Solimano 2004).

In addition, drug illegalization and enforcement have promoted infighting among subordinate social classes. Local violence enacted by gang leaders—and abetted by law enforcement—permits social control over common citizens. Fear coerces compliance with territorial control by gang leaders and economic imperatives due to the advantages of gang-organized robbery and drug trafficking drives young people to criminality (Strocka 2006). Limited capacity of the state to contain criminal violence—or, in some cases, its complicity in such non-state violence—as well as the failure to prevent citizens from taking justice into their own hands attests to the political nature of these so-called “social” or interpersonal forms of violence (Cruz 2016).

Social inequality and criminal violence in Latin America directly implicate U.S. interventionism. Several scholars have reviewed the harms of economic, political, and militaristic involvement of the U.S. in various parts of Latin America (A. G. Green 2007; Corva 2008; Holmes 2013; Public Citizen 2016). Their findings indicate that U.S.
promotion of neoliberal economic policies, including free trade agreements like NAFTA, and expansion of the “War on Drugs” southward produced conditions of displacement and dispossession as well as dangerous practices of drug trafficking. U.S. drug enforcement and border control policies, in particular, opened the potential for multi-billion-dollar enterprise for smuggling drugs, weapons, and people. The lucrative nature of the industry breed political and judicial corruption.

**Police as instruments of structural violence**

Judicial weakness echoes throughout Lidia’s narrative about leaving Honduras under threat of violence from the beginning of this chapter. Failure of police to protect her family demonstrates how institutionalized or structural violence drives migration (Galtung 1975). However, police also reproduce violence to preserve gendered and classed hierarchies of social order. A study of 234 migrants from Central America found that just one-fourth had reported experiences of threats or violence to authorities and, of those, only 11 percent described police intervention as effective (Keller et al. 2017).

Elvira, a 35-year-old woman from the Dominican Republic, shared with me how the police protected her cousin’s abusive husband.

“In my country, justice is not like what it is here,” Elvira explained in defeated tone. “He was a man. He was a lawyer. He had connections. So, no, they did nothing.”

Elvira’s somber testimonial signals how the criminal justice system serves to preserve the social and political capital of dominant groups, in this case, educated and well-connected men.
In a story that echoes Lidia’s, Juana—a 26-year-old from Zacatlán, Mexico—relates how her sexual assault fell below the threshold of concern for her local police force.

“I would walk twenty or twenty-five minutes to school and for some reason, I had this feeling of needing to look back… like a voice said, ‘bebita, over here.’ I turned around and saw a man following me. I wanted to start running, but it was too late and he attacked me.

“He took a razor and held it to my neck, yanking my hair. I couldn’t even scream. I was so afraid he would kill me. Then he pushed me to the ground and got on top of me. I thought he would rape me. I was shaking. But just then a combi (city bus) came by and he ran off.

“I left to make a claim to the police, but in Mexico, the laws are not very good. I talked with the police, but they didn’t believe me. They thought I might be making it up because I had no evidence. Still, they promised me that plainclothes officers would stand guard outside the school, but they were never there. So, nothing was done.

“This is why I am so afraid to go back. I could never forgive myself if something happened to my daughter. It is very unsafe, what with the violence, the robberies, the kidnappings. And the police refuse to do their job. They’re bought, they’re sold.”

Ascención adds to this story of police corruption.

“You can file a complaint, but they don’t do anything. Sometimes you can try to pay them if you have money. If you don’t, they [the police] pretend they don’t know anything.”
Lidia, Elvira, and Juana describe how state failure occurs through the weaknesses of the criminal justice system. Fourteen women in total (21.5%) related experiences in which the police ignored their reports or failed to enact justice. Through these means, the police act as arms of the oligarchy, preserving the interests of wealthy, connected men. Underclass citizens then take drastic measures to ensure justice for their communities. Juana explains,

“There’s no law to help people. People have to do justice by their own hands. There was a man in a village near mine who had raped a girl, but he was never arrested and he went on to hurt others. The town got together and lynched him. They tied him up and beat him. They demanded justice because the law did nothing. Your courage and anger rise up when you see that the police doesn’t do their job.”

State failure as a driver of migration

This impunity, and its attendant insecurity, keeps Juana and women like her in the U.S., despite immense struggle. Lidia details the pain of thrusting her son into a strange country.

“It’s totally different—the language, the customs—it’s impossible. Even my son felt it because he keeps saying, ‘Mami, I want to go back to my old life. When are we going to see my ita [grandma]? What about Luna and Sol [our puppies]? I want to bring them because if not, they won’t remember me anymore.’

“It’s so stressful for him to speak English. He asks me, ‘But mami, why can’t I speak English?’ And to everyone on the street, or at Walmart or the grocery store or the laundromat, he asks ‘Do you speak Spanish? Do you speak Spanish?’ He wants to play and interact with others, but he can’t. It’s so difficult.”
The decision to migrate is fraught with danger, destabilization, and isolation. Yet, despite the often-devastating shortcomings of the U.S. social and economic systems, the advantages to life in the U.S. outweigh the struggles.

“This is a country of opportunities,” Célia tells me. “Here, you can apply for daycare, which is very expensive in my country [Ecuador]. We have security. We have a stable environment.”

Juana adds: “There are so many privileges of this country. There are good opportunities to study, good schools, good jobs. I could never risk my children suffering the insecurity and violence if we were to go back. No, I’m not going to leave and return where things are not right.”

Eight women (12.0%) cited civil unrest and violence in their home countries as reasons for staying in the U.S. In short, state failure not only drives transnational migration, but it also upholds it. A state’s inability—or neglect—to provide adequate protection and assistance as well as full citizenship rights to all undermines peace and stability (Deng 2004). The production and maintenance of a civically-stripped underclass in Latin America spawns a new underclass of ‘illegals’ in the U.S. that serves as a cheap and exploitable labor force (L. Green 2011). I further discuss the implications of this construction of ‘illegality’ in the next chapter.

**Conclusion**

In this chapter, I argue that state failure and the multiple violences it produces drives migration from Latin America to the U.S. I characterize state failure as the miscarriage of citizen-building through inadequate social and economic assistance. This failure creates inequalities of opportunity by which personal characteristics like race,
gender, and familial social status impede the expected attainment of economic advantage through intensive schooling and labor. Despite efforts to expand social welfare programs in Latin America throughout the 1990s and 2000s, ongoing protests by Indigenous, women, and labor activists reveal the deficiencies of these attempts. Moreover, weaknesses of the criminal justice system—particularly the neglect and corruption of law enforcement agents—reinforce an architecture of structural violence and perpetuate physical violence throughout the region. I argue that the conditions of state failure result from global economic and political forces, particularly histories of U.S. Interventionism in Latin America. Nevertheless, these failures both drive and maintain patterns of migration to the U.S., even as migrants suffer social insecurity and economic exploitation.

In the next chapter, I recount the narratives of violence imposed through immigration enforcement and the ways women weigh their motivations to migrate against these dangers.
Chapter 6: Migration

Anahi

“We came through the desert,” Anahi, a 40-year-old woman from Guatemala told me. “There were no houses, no food, no water. We had to buy food at the border and load it into our backpacks for the journey. We spent eight days walking through the desert, carrying water, food, and whatever else we could bring. There was nothing there, only thorny plants and sand. Everything is dry. There is no water in the ground.

“When immigration tried to find us, we would hide on the ground in ditches or under the bare pines. Sometimes we would fall asleep for a while. We walked at night, on our hands and feet, because it was so hot. When the heat was too much, we would lay among the trees waiting for the temperature to drop so we could continue the next day. In areas where immigration security was too tight, the coyote would tell us we couldn’t pass—we’d have to get out of there. We walked for far too long…

“Eventually, we ran out of food and water. We entered into Arizona and passed through a ranch with animals and horses. We were so thirsty, we had to drink from the animal troughs.

“We huddled in a car toward Kansas, but it was snowing heavily, and the car crashed and flipped over. We ran through the snow, and each got lost in the darkness of the night. A policeman eventually caught me and another traveler. He said had we been four or five people, he would have arrested us. But instead, he let us go and we continued on to where we had family in New Haven.”
“We were three or four women and thirteen men in the group,” Caridad, a 34-year-old from Peru explains. “If we had to run, we women knew we’d be left behind.

Caridad spent three months traveling from Peru to the Mexican border: She had to pay off multiple soldiers and border guards to arrive safely.

“They gave us a backpack with water, some fruit, and some canned food. The water was so heavy, I didn’t want to carry it. And the canned food was awful—it weighed so much, didn’t give much energy, and made us sick. Two of the women became very ill, vomiting everything they took in, and they had to turn back.

“On the second or third day, I couldn’t carry it all anymore and I left almost everything behind. Another Peruvian man in the group helped me carry my gallon of water. Despite all that, I became very dizzy. The man took out some oranges and pressed them to my lips. He told me I needed to go to the river to drink some water. I couldn’t walk and so he carried me on his shoulders and brought me water from the river. We had to hide in the divots in the ground from the immigration planes overhead.

“When border patrol found us, the man and I managed to hide in some bushes. But they caught the other woman—the niece of another traveler—and sent her back to Mexico. The uncle crossed back to find her and try again.

“Then it was just twelve men and me. I tried to lead: I thought, ‘If they start running, where will that leave me?’”

After several more weeks of travel, Caridad arrived in New Haven.
“It’s safer here—in Peru, they’ll shut the lights out on the bus and steal the necklace right off your neck. It happened to me, gave me a huge red mark,” Caridad explained. “Here in New Haven, you can carry your purse to the store without worry.

“Plus, in the summer it smells like the ocean,” she adds, the smile radiating through her voice.

In this chapter, I examine the process of migration as a determinant of health among Latin American mothers residing in Connecticut. I begin by discussing driving forces for migration, underscoring how political economy—constituted by regional governments and narrower social networks— informs migration decisions. I then characterize the specific challenges of migration, specifically border crossing. In this section, I narrate the harms of gender-based (threatened) violence and the sequelae of the legal violence of border and immigration enforcement. In the following chapter, I characterize the powerful ways women recruit resources—both personally and socially—to seguir adelante, or push forward, enacting what I call “imperative resilience,” or a necessary and structurally enforced practice of empowerment despite social vulnerability.

**Painful passages: The imprint of migration-related trauma**

The Sonoran Desert, where many Latin American migrants cross, is an arid region covering approximately 100,000 square miles in southwestern Arizona and southeastern California, as well as most of Baja California and the western half of the state of Sonora, Mexico. It is the hottest North American desert with limited rainfall and accordingly inhospitable terrain. Between 2000 and 2014, 2,721 human corpses were found in Arizona alone. The migrant body count measures the effectiveness of a policy called “prevention through deterrence,” which seeks to inhibit border crossings by making them
more hazardous. Selective border patrol forces many migrants to cross the Sonoran, subjecting them to harsh conditions that for many results in dehydration and death (De León 2015).

To revisit the metaphor of the monarch butterfly: Like immigration enforcement, southerly winds funnel monarchs into a central flyway over Texas, crowding monarchs together along their more than 3,000-mile journey. As climate change and urbanization lead to unendurable travel temperatures and declines in milkweed, monarchs face a fate akin to that of overexposed humans passing through the Sonoran.

Anahi and Caridad speak to the immense physical toll migrating across the Sonoran takes. These women endure dehydration, exposure, and the unique precarities of being a woman among majority-male groups. Both women were lucky: They arrived at their destination intact and unstained by encounters with immigration authorities. Many are not so lucky, risking multiple attempts to cross after environmental and legal hazards force them back.

During the process of migration, Latin American migrants confront hazards such as thievery, kidnapping, rape, extortion, dehydration, and assault (Vogt 2013; 2018). However, other traumatic events—including war, terrorism, political persecution, and natural disaster—may occur prior to migration and contribute to the decision to leave (Perreira and Ornelas 2013; Chu, Keller, and Rasmussen 2013). Women are more likely to experience severe types of trauma such as rape, physical violence, trafficking, and forced prostitution (Watts and Zimmerman 2002; Miller et al. 2007). After settling in the U.S., these women further experience high rates of intimate partner violence as their vulnerable social positions may predispose them to control by their partners (Mendenhall
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Perreira and Ornelas (2013) refer to harrowing migration experiences as “painful passages.” In their study of 281 foreign-born adolescents and their parents living in the U.S., they found that 29 percent of foreign-born adolescents and 34 percent of foreign-born parents experienced trauma during the migration process. Of those with traumatic histories, 9 percent of adolescents and 21 percent of their parents were at risk for post-traumatic stress disorder (PTSD) (Perreira and Ornelas 2013). In this way, the process of migration serves as a social determinant of health: Constructively interfering global and local sociopolitical forces—including economic factors, governmental structures, and “legal violence” (Menjívar and Abrego 2012)—that shape migration further produce health advantage and disadvantage (Castañeda et al. 2015).

Trauma threatens life or bodily integrity, often involving a close encounter with violence or death (Herman 1997). However, trauma also encompasses the emotional response to such exposure: the psychic ‘scars’ left by tragic and painful events (Fassin and Rechtman 2009). Trauma is therefore “a clinical and social event” (Panter-Brick et al. 2015, 822–23), in which individuals’ subjective memories of trauma shape, or rupture, sense of coherence in their lives, influencing their symptoms of mental illness. A bio-ethnographic approach to the embodiment of trauma—and its potential transmission to the next generation—recognizes the mutually constitutive nature of biological and social forces.
Migrants, including refugees, asylum-seekers, and voluntary migrants, are especially susceptible to trauma and its sequelae. A study of 7,000 refugees seeking resettlement in Europe and North America found their prevalence of PTSD to be roughly ten times higher than among the age-matched general population of the destination countries (Fazel, Wheeler, and Danesh 2005; Schouler-Ocak 2015). The term “migration-related trauma” has been used to refer to trauma surrounding departure or displacement from a country of origin and relocation in a destination country and applies to the experiences of many of my interlocutors (Wiese 2010; Lerner, Kertes, and Zilber 2005; Chou 2007; Perreira and Ornelas 2013).

**Theories of migration**

Conventional theories of migration often refer to “push” and “pull factors,” that is, economic disadvantage as an outward driver of emigration and economic opportunity as a magnet for immigration. These examinations, informed by the work of nineteenth century German-English geographer (1889), features economic principles intended to predict human behavior based on assumptions of rational choice, supply-and-demand, and maximization of profit (O’Reilly 2015). This neoclassical (and dichotomous) economic framing disregards the multifactorial contributors to the incredibly disruptive act of migration. Among the women in this study, forty-six (70.8%) cited economic insecurity or opportunity as a reason for their migration, leaving nearly a third who left for more personal reasons.

Newer theories of migration recognize the many intervening factors—including social networks and individual emotional experiences—that both facilitate and hinder migration (O’Reilly 2015). U.S. migration expert notes that push and pull factors are like
“battery poles” in that both are necessary to start a car or initiate a migration process. However, following that initial charge, other variables determine who chooses to migrate and where they go.

In his metaphor of monarch butterflies, Ocean Vuong notes, “Migration can be triggered by the angle of sunlight, indicating a change in season, temperature, plant life, and food supply.” As with monarchs, the decision to migrate can certainly result from urgent deprivation, but it can also be deeply personal, “a change in season” (Vuong 2019).

In this section, I discuss three emergent themes regarding migration decisions that emerged from my ethnographic interviews. First, I discuss economic precarity and opportunity, drawing on more orthodox framings of migration. Next, I echo concepts from Chapter 8 on violence and state failure, focusing more on interpersonal experiences of violence. I then review decisions motivated by family reunification and romantic partnership. Finally, I relate accounts of migration choices driven by a sense of curiosity or rebellion, a voluntary form of migration more common among women from Mexico. In this way, I hope to assess both constraints to individual agency and the ways it triumphs.

Importantly, none of these trends exists in isolation: as Martin notes, multiple factors to converge to inform migration patterns. Through this ethnography, I highlight the complexity and multifaceted nature of these choices.
Reasons for migrating

Economic precarity and opportunity: When the political becomes personal

In the introduction, Célia and Marcelina spoke at length about economic insecurity in Ecuador.

Marcelina: There has always been insecurity. You have to be careful.

Célia: Yes, mostly because there is no work. There, if you have it, it’s always unstable—it’s not a safe bet.

Marcelina: The salaries are low.

Célia: And, like we said, unreliable.

Marcelina: You have to do a lot of work.

Célia: It’s a lot of pressure.

Their inability to earn enough to support their families, despite working extended hours, prompted them to turn toward the U.S. for an alternative way of life. In many instances, a partner or childless friend travels first to test the waters and report back. In their case, Marcelina had migrated with her husband first to Spain, and then to the U.S. She was thrilled by the increased pay, multiple job opportunities, and networks of supports for migrants in New Haven and urged Célia to join her. Célia’s husband, Eduardo, who had just lost his job around the time of the birth of their first child, migrated first. After three months of painful separation, Célia joined him.

Célia: I came alone with my eight-month-old baby.

Jes: How did you decide then, in November 2018, that it was time for you to leave?

Marcelina: They wanted to take advantage of the coming holidays. He had a stable job and said to me, “Why don’t we see if they can come now and we can spend Christmas together?” He talked with Célia and she said yes. They also missed each other.
In this way, Célia’s decision to migrate—and the timing of her travel—stems from both economic disadvantage and the desire to unify with her family.

Célia and her family were fortunate to receive tourist visas for their entry into the U.S. After paying a fee and completing an interview at the U.S. consulate during which authorities evaluated her family’s assets, identifying documents, and motivations for travel, Célia and her husband were determined to have legitimate reasons for temporary travel in the U.S. and to be at low risk of overstaying the 180 days granted by the visa. Many other migrants confront the riskier option of crossing the border. In these cases, opportunities in their home country are so restricted that women feel they must hazard their safety in pursuit of a better life.

Lucía, a 43-year-old from Tlaxcala, Mexico says she left for the U.S. “to seek a better life.”

“I was a single mother,” she explains. “I worked alone, the dad wasn’t in the picture. I was working as a kitchen assistant, making and selling food and so on. There’s an expression, ‘In life, when you don’t get help, you just have to cope.’ You have to make a better opportunity for yourself.”

In Lucía’s case, single parenthood exacerbated the impact of limited job opportunities and low pay. She had dropped out in her second semester of college because she could no longer afford to continue; consequently, her only options for work included dishwashing, domestic help, or food service. When she had her daughter and her partner left her, Lucía struggled to meet her regular expenses as she balanced work and childcare.

“The single woman must always fight harder,” she tells me poignantly.
Lucía spent $3,000 to hire a coyote, or smuggler, to guide her across the border, a process that took a week. She hopes that her children—her now thirteen-year-old daughter and five-year-old son—will finish their education, a goal she could not achieve, so that they can have a better future.

“I want my children to study, especially the girls, so they can get ahead. I don’t want them to depend on a man or anyone else. May they be strong women who ask for what they want, without relying on their husbands or family members or anyone else.”

Célia and Lucía are united in their pursuit of better opportunities for their families. Although they differ in the costs—financial and physical—incurred through the migration process, the confluence of economic conditions and personal motivation impelled them to make this sacrifice.

In a similar vein, Noelia, a 40-year-old from Chiapas, Mexico, recounts,

We couldn’t find work. It was the economy. Sometimes we couldn’t even buy our everyday food. And then, like twenty years ago, we had a daughter who died because we didn’t have the money to take her to the doctor. So we decided to come here. I couldn’t stay there after my daughter passed away… I didn’t want to be where I had those painful memories, knowing we couldn’t save her.

For Noelia, the impact of poverty and economic inequality resulted in family tragedy. Although material deprivation certainly sparked the charge that ignited her migration journey, but it was the emotional experience of losing her daughter that finally spurred the act of migrating.

Noelia spent $2,500 for a coyote to pass her from Chiapas to New Haven. She told no one she was leaving, fearing either she would die in the desert or, if she did arrive successfully, that gang members would presume her family had money and blackmail them.
“When they know that someone comes here, they’ll rob and steal from [their family]. They’ll blackmail them, threatening to kill them if they don’t pay up.”

Noelia was the only woman in a group of sixteen: The men resented her, thinking that if they ran into immigration authorities, they would all be caught because of her.

“Thank God, I had a lot of help from the coyote,” she told me. “He cared about me, told me it would be okay. He even gave me serums so that I wouldn’t get too dehydrated. He was a very, very good person.”

Shockingly, Noela and Lucía paid the lower range of coyote fees, which varied between $2,500 and $13,500 with an average of around $7,000. Lucía explains,

Now, the coyotes no longer work on their own, like they used to. Now, they’re under the control of the gangs, the mafia. The gangs force the coyotes to smuggle people or drugs. They charge up to eight thousand, ten thousand dollars. That’s why now it’s so difficult to cross because they have to pay the mafia so they can keep working.

Thus, migration entails both personal upheaval and often significant financial investment. It is a complicated choice: Although few women in this study decided to leave as a spur-of-the-moment decision, most contemplated migration for months to years prior to acting.

The convergence of political, economic, and individual factors echoes a common refrain in social science literature, of when “the political becomes personal,” and vice versa. Overemphasis on broader political and economic forces—as in conventional push-pull migration theory—overlooks the very personal impact of those forces on the decision to migrate. Likewise, inattention to structure can promote problematization—or even pathologization—of the individual, without recognizing the ways psychology and behavior respond to violent social architectures.
In the next section, I focus on these more personal experiences of violence, narrating how family threats or sexual harassment and stalking ultimately forced women from their home countries.

"They just kill": Personally mediated violence as a force of migration

It was difficult to hear 19-year-old Ysabel at first. She spoke softly and tentatively, and I had not yet upgraded my audio equipment to facilitate phone interviews. She initially offered two-to-three word replies to my questions, yet as we eased into the conversation, her story further unraveled.

“In my country, we lacked the money to buy food,” Ysabel explains. “Since we worked in the field, we couldn’t earn much.”

At first, I categorized Ysabel’s motivation for migrating as strictly economic, but when I asked her whether violence was a concern, she said, “yes, that too.”

“These bad people came into our community,” Ysabel elaborated. “They killed people, just like that, without fear. We were afraid to walk down the street because they have no mercy, they just kill. I was so afraid. It was not easy to walk the streets.”

Cañar, Ecuador, the Andean province located in south-central Ecuador, has not escaped much of the gang-related violence and petty theft that characterize the region. The Overseas Security Advisory Council (OSAC), in partnership with the U.S. State Department, warns U.S. travelers that the region is a “critical-threat location” due to limited judicial resources (See Chapter 8) that permit homicides, armed assaults, robberies, sexual assaults, and home invasions (2020). In addition, Indigenous resistance to territorial encroachment and neoliberal economic policies result in violent clashes between Cañari communities and government officials. Ysabel, who grew up speaking
Quechua and identifies as Indigenous, fears her life would be in danger if she returned to Ecuador.

Like so many others, Ysabel was motivated to migrate, at least in part, by economic reasons. However, her experience of “everyday violence” (Scheper-Hughes 1992) ultimately drove her to leave. Violence, in its various configurations, is practically ubiquitous in Latin America due to economic inequality and state failure. Yet, the presence of violence alone is often not enough to drive emigration. Personal experiences of violence, such as the murders Ysabel witnessed in her community, instill a very particular fear that propels migrants toward new homes.

Like Ysabel, Verónica and her husband worked in the fields, in their case, in a rural village in the San Marcos region of Guatemala. They, too, lived in poverty: Verónica only studied up to sixth grade, which limited her job prospects. Given her location near the Mexican border, along known drug-trafficking routes, Verónica was particularly susceptible to cartel violence.

Verónica: My husband worked as a caretaker for a melon farm. There, as he was working, they shot him. And the threats kept coming. So, we had to leave.

Jes: Oh wow, how horrible!

Verónica: Yes, so with his being assaulted and the economic conditions in our country, there was no way we could stay there.

The success of the farm rendered it a target for more lucrative operations in poppy-seed farming, which can generate high profits in the opium trade. Although Verónica’s husband did not own the farm, his proximity to ownership as a manager rendered him prey to extortion efforts by drug leaders. When Verónica and her husband realized that the threats would not let up, they determined they had to flee for their safety.
Drug-related violence constituted the norm in her region, but Verónica had believed that her family’s rural isolation—and their relative poverty—would shield them from attack. However, once the threats became personal, as her husband dodged literal bullets, Verónica, her husband, and her nursing baby made the trek across the border.

In the cases of Ysabel and Verónica, community- and nation-wide patterns of violence took struck a personal toll. For Aida, the experience of violence was highly individualized.

“Yes, there was economic instability in my country,” Aida comments, speaking about her home in Honduras. “But that was only secondary. Really, it was because a man there was harassing and bothering me.”

Aida told me how, beginning when she was 16 years old, a man at church began stalking her.

“I was a dancer at the church,” Aida told me. “He would always wait for me as I left. Then, at night, somehow, he would always find me. He told me I was pretty, that I had a good body. It made me feel so uncomfortable, his words.”

Aida shared her concerns with her mother, who did not know what to do. On the one hand, they both feared she would be raped, or even killed; on the other, they knew the police would not believe her.

“Of course, I’ve heard of cases when a woman has already been raped or killed, then the police will intervene,” Aida deplored, “but by then, it’s too late. I didn’t want to happen to me what happens to so many girls there.”

The stalking only worsened over the next few years. At one point, when she narrowly escaped assault after the man cornered her, Aida decided she had to leave.
“It’s not safe there. Even with thousands of cops, you’re not protected,” Aida explains, echoing the narratives from Chapter 9. For her, the frustrations of working five days a week—and studying on the weekends—and still lacking the resources to support herself, her mother, and siblings was not alone enough to justify the risks of migration. Yet, when stories of vicious machismo and gender-based violence became her own, Aida took her chances. Despite everything, she says, “I’m also glad that I could—that I had the opportunity to search for new possibilities and create a new life here.”

*Family reunification*

A smaller subset of interlocutors emphasized family reunification as the primary motivator behind their decision to migrate. This rationale aligns closely with the priorities of U.S. Immigration law over the past half-century. Specifically, the Immigration and Nationality Act of 1965, also called the Hart-Celler Act, abolished the prior quota system based on national origins, preferring family members of U.S. citizens and permanent residents. This reform shifted the “color line” of immigration to the U.S., leading to influxes of migrants from Latin America and Asia whose claim to “Whiteness” failed relative to their Irish, Polish, and Italian predecessors. In her book *Fictive Kinship*, sociologist Catherine Lee argues that U.S. immigration policy has always centered family reunification, even under draconian schemes like the Chinese Exclusion Act of 1882. These regulations, which devise criteria for ‘legitimate’ families worthy of reunification, center those whose gender, class, and racial or ethnic characteristics align with ‘American’ ideals (C. Lee 2013). In other words, framing immigrants as assimilable—or “like us”—constructs policies of inclusion and exclusion.
Marisol, a 34-year-old from Michoacán, Mexico, describes how she came to the U.S. when she was a young teenager.

“My mom was already here… with all her family and her siblings,” Marisol explains. “My mom sent for me. I came here with other people who brought me here, but my mom paid.” Her father had a good job working at a sugar and honey plant, but when friends of his tempted him with the higher wages they earned in the U.S., he decided it would be best for the family to come.

Marisol’s father obtained a work visa and had to return to Mexico every six months, but her mother stayed on—undocumented—working in a factory. Although the allure of economic opportunity spurred her parents to migrate, Marisol and her siblings came solely to be with their parents.

The system is not intended to support women like Marisol. Migrants like her parents who live under “liminal legality” (Menjívar 2006)—or an in-between status that affords social security numbers and work permits without the security of permanent residence or citizenship—are not meant to bring other family members into the U.S. Yet the pull of familial support, often coupled with unfavorable socioeconomic conditions, encourages migrants to circumvent the ‘official’ mechanisms of reunification (e.g., visa or residency sponsorship) to join their relatives.

For women from the Caribbean, transnational barriers are often more permeable. Puerto Ricans, as U.S. citizens, are free to move between the island and the mainland as circumstance dictates. Dominicans and Jamaicans, due to proximity and vast diasporic communities in hubs like New York City, often visit family in the U.S. as a rite of passage, and some then decide to move.
Antoinetta, a 23-year-old from the Dominican Republic, visited her family multiple times on a tourist visa before deciding to settle in the U.S.

“We had so many family members who lived here [in the U.S.]—some in New York, in Boston. So many from my dad’s side had lived here for a long time,” Antoinetta shared. For her, life in the U.S. was familiar, part of her world as a niece and cousin. So, when her husband moved to New Haven for work, it made sense to join him.

“I hadn’t planned on staying here, but my son’s father asked me to stay. Now I want to stay here for the rest of my life. I want to become a citizen,” Antoinetta tells me, with confidence.

Because of her regular family visits in the U.S. and the broad network of support she enjoyed with her husband, mother-in-law, father, and extended relatives, Antoinetta transitioned to life in the U.S. with ease.

“I adapted quickly,” she tells me. “I liked this country, how a person can become independent and get ahead. I can tell you that I haven’t had a hard time here or anything.”

Having multiple relatives living as permanent residents or citizens also increased Antoinetta’s familiarity with social safety nets, like Medicaid insurance, called HUSKY in Connecticut. She also could lean on a broad network of kin for support with childcare or unexpected expenses. For her, the move to the U.S. paralleled a within-country migration of convenience, as a U.S. native might relocate from their college city back to their hometown for familial support when expanding their family.

"I was young": Migration as an act of rebellion

Almudena, a 34-year-old from Tlaxcala, Mexico left her home urged by a strong desire for independence.
“I finished my education when I was about 22 years old. I had a boyfriend that I knew for four years before coming here [to the U.S.]. So, well, he told me that he was coming here when I finished studying and then would come back to Mexico, but I finished studying, worked, and he didn’t come back. So, I decided to come here.

“I went to look for him and I was surprised to find that he was already married. But by then I had already decided I was coming, and it had cost me so much to get here.”

Immigration authorities arrested Almudena on five separate occasions. At one point, she spent two months in detention.

“To be honest, nothing was missing in my life,” Almudena admits. “My parents weren’t high-class, but we were middle-class, comfortable. I had finished studying and all that was left was to work and enjoy life, right? But I couldn’t do it.

“At that age, sometimes you get into a rebellious stage… I never thought about the consequences. And yes, the desert is very dangerous, but at that age, you don’t think about those risks.”

Ana Paula, a 41-year-old from Ecuador who migrated when she was also 22, repeats this thinking.

“I was young, right? I didn’t think much about coming.” Although Ana Paula states that her decision was partly motivated by the weak economy, really it was just about “getting out of the house.”

“When I was back in Ecuador, I was working in a post office but I was only making about $140 a month. As a high school graduation gift, my mom took me to visit my uncle here. I just fell in love with this country. And so I went back again a few years
later. By that time, I was 21 and I really wanted to be independent, but I knew I would never be able to because of my income.

“So, you know, I spoke to my parents, and I say, you know, I'll probably go there [to the states] and make some money, for like two years and then come back. But those two years just became nineteen!”

Ana Paula says that her parents had stable jobs, their own home, and enough finances to live comfortably. She originally planned to “just make money and probably go back and buy a house or a little farm, and a little car” so she could avoid “worrying about paying a lot of bills.” However, after a year or two, she had a good job, her own car, and enough money to live the way she wanted.

“It was easy to find a job and make money,” she explained breezily. “I was going out and coming back at whatever time I wanted. I didn’t have anybody telling me what to do. I kept telling myself ‘Just one more year, one more year’ but I just fell in love with being here. It wasn’t worth going back when I could have the things I wanted—a job, a place of my own, a car—here. I always tell my mom, if I had to do it all over again, I would.”

Ana Paula exhibited many of the hallmarks of a long-term U.S. resident: She spoke English comfortably, owned her own business, and cared for her children and her parents, whom she had persuaded to join her in their advancing age. She rented the same home, with a backyard, for several years, so it almost felt like her own. Ana Paula lived out her own version of the mythical ‘American Dream.’

This cluster of women who enact migration as rebellion parallels findings by anthropologist Leo Chavez in his study of Mexican migrants to San Diego. Many left
“for adventure” and to satisfy curiosity about what life is actually like in the United States” (Chavez 1992, 33). Yet, this spirit of adventure often collapses under the weight of everyday violence and marginalization. As one of Chavez’s interlocutors poignantly summarizes, “I came for adventure to the richest country, where we live like dogs” (1992, 34).

For Almudena and Ana Paula, youth perhaps exaggerated their motivations to migrate and minimized the risks. Ana Paula enjoyed a much safer passage, arriving in the U.S. on a tourist visa. Almudena, on the other hand, suffered multiple arrests and incarceration. Their stories shed light on an often-unappreciated dimension of migration: choice. All migrants—including refugees—ultimately choose to leave their home countries. For many, economic deprivation, war, natural disaster, or community violence force their hand, yet others make the move willfully from a position of relative comfort. Medical anthropologist Alyshia Gálvez describes the Mexican women in her study as having “projects” to “improve” or “overcome” their life chances, _superándose_ (2011, 19).

Social policy scholar Nando Sigona cautions against “constructing undocumented migrants as passive and agency-less subjects overdetermined by structural conditions” (2012). Experiences of migration vary according to intersectional social positions, including the social and financial capital that enables a migrant to obtain a tourist visa.

Returning to the image of the monarch butterfly, monarchs _know_ their chances of surviving the winter are much greater in a warmer climate. Yet, it is not only the temperature that drives them south: Even amid relatively weak environmental cues, monarchs seem to have an internal timer, modulated by epigenetic signaling, that rouses
them to move (D. A. Green and Kronforst 2019). Both intrinsic and extrinsic factors converge to drive migration; the relative strength of each varies by individual.

**Border crossing**

Imagine: You’re twenty years old—a woman—and you decide to leave home. There is nothing for you there: no job, no money, a hungry family, and threats of robbery and rape looming every time you leave the house. You decide you must leave. You only tell two people, maybe your parents, maybe your siblings. You do not want anyone to know about your departure because you might not make it. That, or your family could be kidnapped or threatened if they know you headed north. You catch a bus through the countryside—or if you’re lucky, a flight to the border. From there, you meet up with a dozen or so travelers—mostly men—and a “guide” (*coyote*) who is so young, he has just the shadow of a mustache at the corners of his lips. Friends warned you that the men might rape you and you decide crossing the border is worth the risk. You wait for nightfall, then take your backpack with a gallon of water and set out on foot across the desert. If you’re lucky, you cross in three nights, or maybe five, resting amid the sparse trees or in the ditches to flee the blistering heat. For some, it takes even longer. Then, one night, you see flashes of lights. The boy guide yells, “Run!” and everyone scatters. You try to keep up but eventually give in and surrender yourself to immigration authorities. They take your prints and toss you into a cell with thirty others, with one toilet in the corner. *La migra* either lets you out with a court date—if you are savvy enough to request asylum or carry a baby on your back—or dumps you back in Mexico so you can try again.
This chapter began with narratives like these, chronicled by Anahi and Caridad. Here, I examine the specific traumas that migrants encounter, often knowingly, deciding that they are risks worth taking. I consider specifically the effects of gender-based violence and the “legal violence” of immigration enforcement as contributors to health outcomes.

**Gender-based violence**

“There were several people,” Jackelín, a 40-year-old from Tacaná, San Marcos in Guatemala explained to me. “We had to follow one person, and then another, and then another. I think there were, like, three or four guides.

“One of the guides was a man who was about fifty years old. He told me that I… that I should stay and live with him. That he was going to give me everything. That he already had his mulher [woman]. I said no, that I had no intention of doing that.

“He pushed me to have sex with him. He told me, ‘if you don’t accept, I’m going to leave you out in the dirt.’ And he said, ‘You have no one, you have no one here, and now you’re in another country so you can’t do anything.’ I was afraid inside, but I told him that he had no right to harm me. He laughed and said, ‘Oh yeah? How can you prove it? Who do you think is going to look out for you?’ I answered, ‘My family that I have there [in the U.S.].’ And so, he said ‘What can your family do? Your family is there, and you are here. You are in my hands.’

“After that, he started treating me badly. He no longer paid attention to me. He would leave me behind and wouldn’t wait for me. At one point when we were walking, a
very big thorn—as big as a nail or a screw—got in my shoe and cut up my food. But the man was already so upset with me, he refused to wait for me. I was scared that he would leave me there, lost, in the desert.

“I did get lost once. The guide, he left me and two others behind and so we spent the night alone. I don’t know if you’ve heard of those animals, they’re like big dogs, they call them coyotes. They are huge and they eat people. We slept under the trees, and we could hear the coyotes coming closer, shrieking and howling. We had no idea whether or not we would live. It was terrifying.”

Although the guide never directly abused her, his threats, intimidation, and ultimate neglect in the face of rejection rendered Jackelin’s journey far more precarious.

Fear of rape emerged among the most common concerns for women who crossed the border. I heard many variations of the same dread.

**Priscila:** There were those rumors… that they touched women. There were also a lot of criminals and groups from other countries began, they began to assault and abuse women. But you take the risk if you want a better life, the life you want to lead.

**Adelina:** It was ugly, you know, traveling as a woman. The men are very macho. I was afraid of rape.

**Ysabel:** I thought our coyote would grab us when he was high on marijuana, because there were two of us women. I was so afraid he would rape me.

**Almudena:** For women, it was more dangerous because they would abuse us. They assault and abuse you if you’re a woman.

**Jeaneth:** There are people who tell stories saying they were raped. Thank God that didn’t happen to me.

**Meliza:** I was afraid because they warned us there were people who would come and attack the group. There was a risk they would rape my sister and me, and the other women who were in the group.

**Juana:** One, I was very afraid that I would be raped. Two, I was afraid I would not be able to survive the weather as we crossed. They were all men and they were all ahead of me—it was very difficult to keep pace as a woman. So yes, I was very afraid those two things would happen to me. But then I had no other choice, I was already there and I had to be strong and now I have to wipe my tears and move on because there was no other
option. I had to give myself the courage, because it was only me. There was no one who took care of me. It was my turn to wipe my tears and continue praying to him and asking Diosito with all my heart to give me strength, fortitude and keep moving forward.

Fortunately, none of the women with whom I spoke described sexual assault during their crossings, a ‘fact’ that may be influenced by experiences of shame and denial. Many, like Jackelín, were harassed, intimidated, and threatened with abandonment. These fears are not unfounded: Up to 90 percent of women migrants suffer sexual violence. Likewise, threats of leaving women behind to cope in the desert alone takes a ghastly toll. In their study of bodies recovered along the migrant trail, the Binational Migration Institute found that women had 2.87 times greater odds of dying of exposure relative to men (Rubio-Goldsmith et al. 2006).

The unique plight of women migrants often receives less attention in scholarly work on migration, given that most individuals apprehended at the border are single men (Caldwell 2021). Several scholars have described the specific hazards women confront, including gender-based violence (Fortuna, Porche, and Alegria 2008; Watts and Zimmerman 2002; Miller et al. 2007). Women’s choices to migrate—intentionally risking rape and abandonment—further highlights their agency. None of my interlocutors failed to recognize the risks: They undertook careful calculations of their pasts and futures in their assessment of the violent landscape of migration.

How should we understand the role of threatened violence and the gender differential in risk? Gender-based violence is often invisible: Even penetrative sexual assault rarely leaves marks on the body. Despite the absence of a scar, such violence persists into the futures of those who experience it, reconfiguring the realities of survivors and how they understand their social worlds. Anthropologist Carolyn Nordstrom notes
that these violences have a “tomorrow,” leaving behind “shattered selves, confidences, futures” (Nordstrom 2004, 226). The most endorsed trauma symptom endorsed by my interlocutors involved harboring strong negative beliefs about the world, such as “no one can be trusted” and “the world is completely dangerous.” These enduring attitudes shape how women relate to others and to their environments.

This also underscores the limitations of clinical instruments for assessing trauma. The tool I used asked about experienced sexual violence and threatened sexual violence separately, allowing me to account for the common experience of potential assault. However, my index of trauma symptoms fell short of fully capturing the warlike mistrust of others and lingering fear many of my interlocutors carried.

Almudena, who feared sexual assault at the hands of her polleros [smugglers], confronted thievery, and endured two months in immigration detention describes a psychological state akin to shellshock:

Some of these things hurt too much, you can never fully recover. When I first got here, it was different, difficult. Why couldn’t I just lead a happy life? I was filled with negativity, everything bothered me. From there, you decide to pull away from people. I stopped talking with my cousins and my friends at work. It’s like no one can understand what happened.

Almudena describes patterns of avoidance and mood change characteristic of PTSD, yet her score on the PCL-5 was a 2: The instrument failed to record her psychological sensitivity in the way deep ethnographic engagement did.

Almudena and I spoke at length after the conclusion of the ‘official’ semi-structured interview about the support she needed. We spoke about services that would benefit her and the power of listening.

Humanity needs to know these stories, right? About us immigrant women. People do not know… it is honestly incredible that this is happening in humanity. Why build the walls,
right? Or the borders? Without these barriers so many people would not expose their lives… because so many people have died right there in the desert. Why not just give us a permit so you can let us in to work?

Almudena had never told anyone else about her experiences of near rape. The vulnerability and intimacy surrounding gender-based violence—and the fear of not being believed—fosters isolation, as Almudena recounts. Feminist anthropologists have commented on the profound care work they undertake with women survivors of sexual violence. Ethnographic research requires dedication to and solidarity with communities. As such, anthropologists often engage in translational aid, engaging their social capital to render legible the needs of interlocutors to those in power (Backe 2020; D.-A. Davis 2013; Craven et al. 2013; Anzaldúa 1987). As a medical student and ethnographer trained in psychoeducation and mental health first aid, I often found myself providing psychological support and liaising between women and clinical resources. When mental health concerns exceeded my capacity, I connected women with mental health support. When women confronted deprivation—or when their isolation prevented them from fulfilling their needs—I facilitated social services like mutual aid and nutritional support. In some cases, my father-in-law and I delivered boxes of donated food to women experiencing intense social and economic stress. As such, my ethnographic engagement took the form of care work, tuning my attention as a Spanish-speaking woman and mother to the intimate needs of my interlocutors.
Cages and hieleras: Conditions in immigration detention

“When I crossed the border, immigration authorities caught me,” 19-year-old Ysabel recounts. “I had arrived in Arizona, but they took me to Texas. I was there for a whole week.

“Being in jail was horrible,” she goes on. “There were no windows, no way to look outside. If it was night or day, I didn’t know. And the food was terrible.

“They told me it was called la hielera [the ice box], the place where they locked me up. It was freezing. They gave us these aluminum blankets, which helped a bit but not much. It was so cold; I got a bad nosebleed—a lot of blood came out and I couldn’t get it to stop. They just gave me some ice and some kind of pill to make me stop bleeding.

“There were like thirty or forty of us locked in the cell—I didn’t count. The bathroom was disgusting, open in the cell covered by just a few bricks. It smelled awful. I had no freedom to move about, I was locked in there the whole time. Some of the guards would intentionally wake us up when we were sleeping, banging on the doors. Some just walked around the cell to try to catch us doing something.”

Almudena describes being stripped down, inventoried, and deposited at the border each of the five times immigration authorities detained her.

“They would grab us, put handcuffs on our wrists, and ask us to remove our shoelaces, belts, and anything we carried. We had to let our hair down. If we wore rings or earrings, we also had to remove them. They separated the women from the men—they arrested so many of us. From there, we had to wait until it was our turn to give them our information. They took photos of us and fingerprinted us. And then they would just take
us back to our cell until they would let us leave. They would grab, like, fifteen people at once and just dump us at the border, leaving us.”

Ascención, a 34-year-old from Chiquimula, Guatemala, recounts her imprisonment with her two children.

“It was like a refrigerator, a hielera. The room felt very cold. They would wake you up and undress you. You couldn’t even lay down, it was so crowded. They took away my oldest son, who was 14 at the time, to be with the men. But he was a kid, not an adult! Eventually I had to sign some papers and they sent me to a shelter where I could call my family.”

**The production of ‘illegality’**

I conducted my fieldwork at a moment in which the system and conduct of immigration authorities confronted intensive scrutiny. In the spring of 2018, the “zero tolerance” policy against irregular migration imposed by the Trump administration cruelly separated thousands of migrant children from their parents, hundreds of whom have not yet been reunited as of this writing (M. J. Buchanan, Wolgin, and Flores 2021). U.S. Congresspeople shared evocative photos of detention conditions, often featuring unbathed children on cots with tin foil blankets, surrounded by chain-link ‘cages.’

The conditions in detention evoke analyses by French philosopher Michel Foucault on the modern penal system, specifically, the way judicial punishment lays hold to the “soul.” Officers certainly subjected Ysabel to physical discomfort in the form of crowded conditions, rationing of food, freezing temperatures, and sleep deprivation. The cumulative dehumanizing effect of this form of penitentiality runs deeper. The panopticism of guard surveillance and the targeting of migrant bodies for disciplinary
control grooms them for subservience, docility, and compliance within the American underclass (Foucault 1977).

Here, it is necessary to examine the criminalization of irregular migration and the “legal violence” of immigration enforcement. I attempt to position migrant bodies as locales of regulation, emphasizing the role of the state in defining legitimacy (Castañeda 2019).

Salvadoran sociologists Cecilia Menjívar and Leisy Abrego developed “legal violence” as an analytical category to understand the punitive and disciplinary functions of the law, specifically the way it harms migrant bodies. They argue that immigration policies purposefully construct ‘illegality,’ restricting the movement of some while permitting the admission of others, producing undocumented migrants (Menjívar and Abrego 2012).

In fact, U.S. immigration policy has historically engaged racist, exclusionary practices that welcome migrants as cheap sources of labor while considering them undeserving of state protection. The 1790 Naturalization Act required each naturalized citizen of the U.S. to be a “free white person” of “good moral character,” reflecting racialized politics intended to preserve Anglo-American ideals and uphold White supremacist organization (Treitler 2015). This orientation persisted with the Chinese Exclusion Act of 1882, which banned immigration and naturalization of Chinese nationals, and the 1921 Emergency Quota Act, which set caps for immigration from countries outside the Western hemisphere. By contrast, the Immigration Act of 1864 and the Bracero Agreement of 1942 established contracts for migrant labor to address U.S. worker shortages, meeting capitalist needs on farms and in factories. Thus, U.S. political
leaders have created and negotiate laws to allow U.S. employers to access—and exploit—migrant workers while closing pathways to full attainment of the rights of citizenship. In this way, border enforcement epitomizes racial capitalism: Subjugation of Brown, migrant bodies advances neoliberal interests.

Canadian activist and scholar Harsha Walia writes, “U.S. border rule reveals seamless relations between the carceral administration of genocide and slavery at home and imperial counterinsurgency abroad, domestic neoliberal policies of welfare retrenchment and foreign policies of capitalist trade, and local and global regimes of race” (2021, 26).

U.S. policy has carefully configured the category of “illegality” as a sociopolitical condition characterized by an unequal power relationship to the state (N. P. De Genova 2002): Unlike citizens and permanent residents, undocumented migrants cannot make claims to security, which compounds their vulnerability. Without immigration law, there would be no ‘illegals’; “If there were no borders, there would be no migration—just mobility” (N. De Genova 2017).

The “territorial passage” of crossing from home country to the U.S. involves separation from familiar social groups and structures, and transition and incorporation into the new society (Chavez 1992). For many migrants, the latter process remains incomplete for the duration of their lives. As such, they are folded into the nation without becoming part of it, instead remaining excluded and abjectified (Chavez 2013).
Conclusion

In this chapter, I reviewed the manifold reasons migrants choose to relocate to new destinations, including economic precarity, violence, family reunification, and youthful rebellion. I discuss experiences of migration-related trauma, focusing on the unique challenges women migrants face and the harms of immigration enforcement, including the production of ‘illegality.’ I have attempted to study migration through lenses of agency—and its constraints—noting how U.S. Immigration policy purposefully generates categories of exclusion. In the next chapter, I discuss the impacts of this exclusion as I assess the embodied experience of ‘illegality’ and structural vulnerability.
Chapter 7: Adelante

I met Teresa at the Yale-New Haven Hospital Women’s Center, a reproductive health clinic, prior to COVID-19 shutdowns. She was enchanting, with smooth trigueña or honey-wheat-colored skin and eyes that crinkled at the corners when she flashed a bright smile. Even without makeup, her lips hinted a perfect pink color that reminded me of ripe guava fruit. Her dark, downy hair fell neatly at her back, against her black jacket and white scarf. Teresa shared with me her process of obtaining a tourist visa from Ecuador to the U.S., where she has lived for five years.

“I introduced myself with my cousin, who helped me because he had a stable job with a good income,” Teresa explained. “We acted as if we were a couple. Thank God, they gave me the visa. Now, I had the opportunity to come and I accepted, with pains in my soul for leaving my mother and daughter. I made the decision so as not to see her suffer: I would suffer so she wouldn’t have to.”

When Teresa departed Ecuador at the age of 24, she left her 3-year-old daughter under the car of her mother. She says, “with God’s blessing,” she will obtain papers for her mother and daughter to live with her.

“I’ve always been a tough woman, a luchadora [fighter]. I was nervous because I didn’t know the language. It was so hard to leave everything in my country, to be alone, not knowing anyone or being able to count on anyone. I thought, ‘I’m going to get lost out here,’ but then again, I’ve always been curious and I knew I could move on.”

Teresa met her partner on Facebook while she was living in Ecuador and quickly merged her life into his upon moving to the U.S.
“We had never met in person. I didn’t really know who he was. You know how some people appear to be one way on Facebook and then they can turn out to be totally different.”

At first, their relationship was “beautiful.” Then he became possessive and controlling.

“I think part of the problem was alcohol,” Teresa reasons. “He would go out drinking and come home and humiliate me, even beat me.”

Teresa tells me that her father physically abused her mother, even threatening her with guns, knives, and machetes. Her shared history of violence bonded her to her mother, who remained determined and independent.

“Once [my husband] hit me when we were out in public and someone called the police. I was so afraid of what they might do to me. But they made him take anger management classes and he’s been a lot better since.

“I think the pregnancy is the news that changed everything,” Teresa continues. “At first, when I found out, I was a sea of tears. I did not want to have his baby. What if he kept mistreating me? What life am I going to have? I came here with the purpose of making life better for my mother and daughter and this pregnancy was now an obstacle. I thought about aborting. I wanted to die sometimes. I just wouldn’t want to exist anymore.”

Things changed for Teresa when she sought advice from her brother, who helped her open up to her mother and daughter. They took the news well and Teresa felt encouraged.
“Thank God, now with the blessing of the baby, my partner has changed a little. He hasn’t yelled at me or humiliated me. He’s more passive. He doesn’t go out anymore, doesn’t drink. He went through his classes and asked for my forgiveness. This baby we’re having has made him behave better and take responsibility.

“And my daughter is happy that she is going to have a little brother. She has even picked out some names for him—she’s very intelligent. Seeing her reaction helped my resolve.”

Given her emotional migration and experiences with intimate partner violence, I asked Teresa to tell me more about how she handles difficulties in her life.

“I try not to think about it,” she tells me. “I let time pass until I forget. No one supports me. I encourage myself to salir adelante [push forward]. I keep fighting. I get closer and closer to the goals I have set for my life. I will fight harder and harder to get a good job, save money, and get papers for my mother and daughter.”

Structural vulnerability

Teresa’s narrative illustrates the particular susceptibilities women migrants face and her powerful resolve to seguir adelante, or push past them. She made the painful decision to leave her young daughter behind, along with her mother, and pursued a relationship with a U.S. citizen who she believed would help her establish a new life. Her selection of partner exhibits a pattern I term “strategic coupling,” by which women engage in romantic or legal relationships with men in order to access social, political, and financial capital. In Teresa’s case, her marriage promised social integration into New Haven and a future green card. After just three months, the power imbalances in her relationship degenerated into abuse, including publicly witnessed physical assault. Due to
her undocumented status, Teresa feared the interaction with the police. Though she did not state it explicitly, I understood that she had avoided reporting the times her husband beat her at their home out of fear of deportation. Despite these adversities, Teresa engages in cognitive strategies of avoidance and problem solving, an approach I call “imperative resilience.” Her experience of intimate partner violence echoes the abuse her mother suffered at her father’s hands, strengthening the relationship between mother and daughter. Teresa counts her mother among her inspirations and seeks to emulate her in her relationships with her children. I name this transmission of qualities of strength and adaptability from parent to child “intergenerational fortitude.”

In this chapter, I examine conditions of structural vulnerability encountered by migrant women living in the U.S. Medical anthropologists define structural vulnerability as

An individual’s or a population group’s condition of being at risk for negative health outcomes through their interface with socioeconomic, political, and cultural/normative hierarchies. Patients are structurally vulnerable when their location in their society’s multiple overlapping and mutually reinforcing power hierarchies (e.g., socioeconomic, racial, cultural) and institutional and policy-level statuses (e.g., immigration status, labor force participation) constrain their ability to access health care and pursue healthy lifestyles (Bourgois et al. 2017).

As such, I attend to experiences of ‘illegality,’ racism, both interpersonal and institutional, and poverty, as well as their intersections, describing how these violent realities prime women’s embodied experiences. I then emphasize the way that women salen adelante, siguen adelante, or sacan adelante a sus hijos, pushing, continuing, and carrying their children onward. I discuss strategies of strategic coupling and imperative resilience as social and cognitive coping techniques, as well as the influence of intergenerational fortitude in cultivating intrinsic capacity.
Anthropologist Aihwa Ong describes the process of crossing the border, either by plane or on foot, and taking up a new life in the states as a dynamic and often brutal process of “self-making and being made” in relation to the state (1996, 737). Undocumented status—or ‘illegality’—represents a specific power inequity of migrants who established their residence in the U.S. through extralegal means. Undocumented migrants must constitute themselves as ‘citizens’ in a sense of belonging within the national population and territory, meanwhile recognizing their racial, cultural, and economic exclusion from hegemonic White social structures. This necessity encourages attempts to hide markers of this stigmatized status through concealment (Gonzales 2016).

In my many conversations about immigration and health policy, U.S.-born folks often ask me why migrants do not just “wait in line” for admission into the U.S. This oversimplified complaint ignores the restrictiveness of U.S. immigration policy. ImmigrationRoad.com maps out the various pathways toward permanent residency, punctuating its flow chart with frequent red stop signs reading “Sorry!”
Figure 13: This flowchart maps nearly all paths leading to a green card, or permanent residence: employment-based (peach), family-based (blue), diversity visa (pink), and immigration through investment (aqua). Two methods exist for obtaining a green card: (1) adjustment of status for people who are already in the United States (peach), and (2) consular processing for individuals who are outside the U.S. and must go through visa interviews at U.S. Embassy or consulate abroad (yellow). These two routes are also illustrated in the map. In rare cases, individuals may qualify for multiple pathways.
Consider my family’s case as an example: My husband’s uncle José traveled from Peru to the Mexican border in the early 1980s and crossed, wearing a full suit his mother insisted would protect him from arrest. In 1986, President Reagan signed into law the Immigration Control and Reform Act, which legalized nearly all undocumented immigrants who had arrived prior to 1982, including José. When my husband’s family migrated in the early 1990s to evade widespread terrorism and economic downturn, José was able to sponsor my in-laws, my husband, and his twin brother for permanent residence. The process took twelve years: Had the adjustment of status occurred two months later, my husband and brother-in-law would no longer qualify as minors. After obtaining residence in 2011, my husband waited ten years to accumulate the funds for the naturalization application and biometric assessments. He became a citizen in 2021, nearly twenty years after migrating. ‘Lawful’ migration requires patience and the privilege of circumstance, which are unavailable to many migrants.

Many migrant women I met lived under “liminal legality,” an in-between status or gray area of documentation (Menjívar 2006). These included recipients of Deferred Action for Childhood Arrivals (DACA), temporary protective status (TPS), and asylum court hearings. As the Trump administration attempted to end the DACA program and TPS for migrants from El Salvador and Nicaragua, and as the pandemic postponed many immigration court dates, the political condition of these women grew even more precarious.

‘Illegality,’ a condition that applies to nearly 11 million Americans, structures social opportunities and access to services (Lopez, Passel, and Cohn 2021). Anthropologist Sarah Willen encourages us to think beyond ‘illegality’ as a “juridical and
political status” or “sociopolitical condition,” and to understand more deeply the ways ‘illegality’ “generates particular modes of being-in-the-world” (2007, 11). This notion of “embodied illegality”—and its defining features of exclusion—determine health (Willen 2012b; Quesada 2011; 2012).

Under harsher immigration enforcement, migrants experience worse health and more mental distress, and migrant parents are less likely to seek health benefits for their U.S.-born children (Rhodes et al. 2014; Martinez et al. 2015; Castañeda 2019). Fear of deportation—or of losing a caregiver to deportation—is associated with inadequate prenatal care for pregnant women and higher rates of depression, anxiety, emotional distress, and hypervigilance in children (Rhodes et al. 2014; Vargas and Ybarra 2017; Rubio-Hernandez and Ayón 2016; Zayas et al. 2015). Jackelín shared with me her personal account of fear and distress and her transition to a more hopeful posture.

“Before, I was scared. I learned to drive and, when a police car passed by, I would start shaking because I thought they would stop me or give me a ticket. But I realized that they only look for people who do something wrong. On the contrary, people like me are victims—the police can protect us. That helped ease my mind. Now, I feel safer if I see a police car. I trust that they are here to protect us from any problem, as long as we don’t harm anyone.

“I have the same value as people who have papers,” Jackelín tells me, her voice triumphant. “I have rights. No one has the right to harm me just because I am not a [legal] resident here.”

Many women shared Jackelín’s attitude: Though they harbored fears of deportation down deep, at the surface, they believed they were safe as long as they stayed
out of trouble. Camila, a 36-year-old woman from Puebla, Mexico explains these opposing beliefs.

**Jes:** Are you afraid of getting into trouble because of your legal status?

**Camila:** Yes. Sometimes yes.

**Jes:** Are you afraid that the police will find you?

**Camila:** Well, no. I don’t know, I mean, I’m not doing anything wrong. Sure, I am here in a different situation [being undocumented], but I don’t worry that I’m doing something I am not supposed to.

Although many women felt they were not at risk of imminent deportation if they complied with local laws, this ‘compliance’ involves many sacrifices and compromises, including spending more time at home, avoiding driving, and restricting their social networks to people of *confianza,* or trust.

Maribel, a 33-year-old from Cuenca, Ecuador describes her rationale for avoiding close friendships in her instructions to her son.

I’ll be talking to my son and he’ll say something like, “they’re my friends, they’re my friends.” And I sit him down and say, “Mijo, they tell you they’re your friends, but they’re really just your schoolmates.” Right? You don’t know who their parents are, where they come from. I mean, you have to get along with your classmates, sure, but you don’t have to get close to them because you don’t know the environment people live in.

Maribel relies on her family for social support, engaging in friendships as a performative obligation for social integration. She admits to going to birthdays or other gatherings with work colleagues but does not consider them true friends. In this way, Maribel’s ‘illegality’ structures her social world.

‘Illegality’ also strains relationships among members of mixed-status families. Nikki, a DACA recipient from Jamaica, describes her resentment toward her U.S. citizen brother for playing fast and loose with the law, whereas she felt she needed to toe the line.
You know, I think one of the things that just bothered me and made me constantly upset with my brother was like, ‘You are an American. The things that you are afforded in this country, I am not.’ He never had to go through the poverty that I went through. I just thought he took so many things for granted.

In her book *Borders of Belonging* investigating Mexican American families living in the Texas borderlands, anthropologist Heide Castañeda describes how undocumented members of mixed status families undergo an “erosion of ontological security or confidence in the reliability and constancy of their social environment” (Castañeda 2019, 51). By contrast, citizen members—or those who have successfully adjusted their status—may experience “survivor’s guilt” and additional responsibilities as family representatives (Castañeda 2019). Just as this mixed status drives wedges between family members, it can also forge bonds given mutual interests in protection. Susana, a 30-year-old Ecuadorian who herself benefited from DACA, describes how she and her citizen siblings insulated their undocumented mother until she was able to adjust her status.

“I was afraid knowing my mother was illegal,” Susana tells me. “My brother, my sister, and I had to protect her.” This meant assuming responsibilities of driving, earning appropriate wages, and communicating with landlords, healthcare providers, and other ‘officials.’

In this study, the women who adjusted their status mostly did so by acquiring citizen spouses. Only two successfully applied for and received asylum. In their study of Central American migrants, physician and human rights expert Allen Keller and his colleagues found that 70 percent of study participants met criteria for asylum (2017); yet, just 300,000 of the world’s 26.4 million refugees (about 1%) originate from Latin America, most are from the Middle East As such, many grasped at an elusive hope for legal status that remains out of reach.
In the next section, I discuss how processes of racialization, both independently and in conjunction with immigration status, contour women’s life opportunities.

**Racism**

“Have you experienced discrimination?” I asked Nikki Campbell, a 34-year-old from Mandeville, Manchester Jamaica.

“Oh, I could write a book,” she answered in an exasperated tone. “I had this one client one time who said, ‘I’ve been so nice to your kind.’ Yeah, there was that. And then I had one other client call me a Black ‘n-word’ bitch. Yep, I remember that. I think I also remember one of my teachers from high school saying, ‘Oh, you’re pretty for a Black girl.’ There was that.

“There’s also a lot of ‘Oh, you’re not like the others. You know, you’re so articulate.’ Those are… pretty much textbook stuff. Oh, also! Once, I used to nany for a little bit and I went to pick up one of the little kids from a party and the host of the party offered me watermelon. And I said, ‘no, thank you.’ And she said, ‘Oh, I thought you people liked watermelon.’ That one I’ll never, never forget. That was probably three years ago. I also really try to avoid police confrontation.”

Nikki self-identified as Jamaican, as a dark-skinned Latina, and as an immigrant. But within the U.S. racial scheme, everyone treated her as Black. She describes the culture shock of moving from Jamaica—where everyone looked like her—to Florida as a teenager.

“My dad moved us to what had to have been one of the Whitest neighborhoods around, basically. We were the only Black family in that entire section. Mmmhmm. But
now, I realize, you know part of it was the fact that that area was very Republican. My sisters and I did okay. My brother did not do well at all.”

Nikki’s younger brother, Dante, who had a certain tendency to flout rules—a behavior Nikki resented due to her own precarious immigration status—had frequent run-ins with the police.

“So, my dad was a truck driver. He was always away. And my stepmom was like a low-level accountant for a furniture store. So, she was never really home,” Nikki explained. “I was the oldest one and I took care of my younger siblings. Dante was three-and-a-half, four years younger to me, and I think he struggled because he didn’t really have a father figure at home. We see that a lot with families who have an absent father figure. Shit hit the fan, you know. My brother got into a lot of trouble.”

She described how Dante would fire at birds with his slingshot, or take mail from other people’s mailboxes, behaviors that caught the attention of the police.

“It’s a federal offense,” Nikki said. “And when you’re the only minority family in the neighborhood, it really freaks you out.

“I remember one time it was like 2 o’clock in the morning and the police were knocking on my bedroom window because they were bringing my brother hime. He had been out riding his bicycle in the middle of the night because he was bored, you know? He was just a kid like that. But then it becomes this big thing in the neighborhood, like, ‘Oh, of course, there’s trouble at the Campbell house.’”

Dante was not the only Black man in her family who endured additional scrutiny from law enforcement: Her dad faced it, too.
“My dad was arrested in Florida,” Nikki told me, her tone with a hint of resignation “They stopped him for like a taillight, or something. And they said that he had weed in the car, but he didn’t. And the police were just like, ‘Well, we know how you Jamaicans are.’ My dad also had a registered firearm, but he didn’t have it on him, and they targeted him for that, too. Thankfully, they let him go home later that night.”

Given her personal and familial experiences with racism, Nikki hoped her soon-to-be daughter would enjoy a society that treated her with greater respect.

“My hope is that she won’t have to go through the same struggles that I’ve gone through,” Nikki sighed. “You know, she’ll clearly be seen as a Black woman. But I hope that there’ll be a little bit more respect and more equality, hmm? That her life will be just a little bit easier. A more level playing field.”

Nikki’s embodied expression of Latinidad distinguishes her from many of my Indigenous and mestiza interlocutors. Most Americans read her as Black and relegated her into the underling status of American Black folks, a condition that had been legally reinforced over hundreds of years through enslavement, dispossession, and constitutional discrimination. Being both Black and undocumented—Nikki is a DACA recipient and lives in “liminal legality”—Nikki confronts criminalization both for her skin tone and her immigration status (Ramos 2020). The UndocuBlack Network, a multigenerational coalition of undocumented, and formerly undocumented, Black people calls for “truly inclusive immigrant rights and racial justice movements that advocate for the rights of Black undocumented individuals, provide healing spaces, and community to those with intersecting identities” (UndocuBlack Network 2021). Within a framework of structural
vulnerability, Nikki and other undocumented Black folks, confront overlapping violences of racism and ‘illegality.’

However, many Latinas confront a different experience of racialization. They may recognize unequal treatment but feel unsure of how to attribute it: Is it my accent? My inability to speak English? My race? My immigration status?

Much of this confusion results from the contentions around the racial classification of Latinx identity, an issue I discussed in detail in Chapter 1. In fact, many of my interlocutors struggled to assign themselves to conventional racial categories.

Common responses included:

Jackelin: I think I’m mixed race. I have difficulty with that question when asked. I don't know how to answer.

Camila: I don’t know my race. I know I’m not White.

Raquel: I don't really feel like I have any race because I don't identify by a race—I don’t know how to describe myself. If you ask me, actually, when I fill out a hospital form and they ask for race, it concerns me. Why treat me differently if I'm Black, White, colored, Indigenous… right? I mean, I guess, historically, I would be mestiza because Chileans were colonized by the Spaniards. We’re Indigenous mixed with Spanish, meaning mestizos, but I don’t consider myself any of that actually.

Mildred: I don’t know [my race]. Well, I've always identified myself as Hispanic, I don't know. I guess just Hispanic.

Elmira: I don’t know whether to say I’m Hispanic or Black, maybe. I know I’m Hispanic. Maybe mixed race.

Leocadia: Well, I’m brown. Not Black, not super brown, or White. I guess like a mix.

Noelia: I think I should be White because I’m Hispanic… um, yeah. White, I think.

Lidia: I don’t really understand the question. Mmm… maybe mestiza?

Cintia: I’m Latina. I don't know. I don't really know what to say, because I don't consider myself White. I don't consider myself Black. I don't consider myself... To me, I'm just Latina. I don't like to talk about it. Whether you are brown, whether you are White, to me, we are all the same.

Carla: I don’t know, because usually I’d just say Latina or Puerto Rican. It’s not like there’s a color palette. But yeah, I usually choose ‘White.’
Gladys: My race? You mean, not Latina? Mmm… I guess I’m White then.

Jenifer: Ummm… I think I’m the second thing you said [mestiza].

Amalia: Aren’t I just Hispanic?

Meliza: We’re supposed to be American Indians, right?

Rosa: I don’t know, I’m just Hispanic.


Delia: I don’t know [my race]. It is most likely mixed.

Inés: I wouldn’t know how to say… What is mestiza, again? I think I’m Indigenous, or mixed. Something in between.

This dilemma of self-classification revives Laura E. Gómez’s argument for the treatment of Latinx as a distinct racial identity, noting the contradictions between racial categories Latinxs choose and the one ascribed to them by others (2020, 3). It is also worth noting the incompatibility between the U.S. racial classification system and those of other countries in Latin America. For instance, in Brazil, citizens can self-identify within the categories of branco (White), pardo (Brown), preto (Black), amarelo (‘yellow’), and indígena (Indigenous) (Instituto Brasileiro de Geografía e Estatística 2011, 34–35).

Many of my interlocutors blamed experiences of discrimination on their perceived social class or English proficiency. Susana, a young Ecuadorian woman who spoke both English and Spanish fluently, relates how a medical assistant insulted her intelligence, presuming she did not understand.

“So, it happened right here [in the clinic],” Susana tells me. “There was a Hispanic woman who was going to draw my blood. And she told me to hold my arm like this. And mind you, I understand both English and Spanish. And so, I did what she said
and then she goes, ‘Oh no, move it like that.’ I wasn’t really sure what she meant for me to do. So, then she says to her friend, ‘Oh these girls don’t understand anything.’ And I got so pissed off! I told her, ‘I understand what you’re saying.’ It was just crazy: I was being discriminated against for being Hispanic by a Hispanic woman.”

Ysabel, who does not speak any English, commented, “Oh yeah, some people are racists. They’ll see I don’t speak English, I try to ask some questions, and they don’t want to help. They get angry, like we’re bothering them or something. They don’t even try to help us.”

Although English has become routinized in commercial spaces, the U.S. has no official language. Collectively, Americans speak more than 350 languages, the most common of which, after English, is Spanish. However, mounting ant-Latinx racism, stoked by the Trump administration, has spurred a movement to formalize English as the requisite mode of communication (King 2017).

Perception of belonging to the Latinx race confers stereotypes about language ability and social position. Raquel, who also speaks English well, shared how she went to the post office to mail a package to her sister and was called a “freeloader.”

“The man saw that I was pregnant and thought I had just come here to have my baby and take advantage. But this pregnancy wasn’t in my plans! I’d had two losses—I didn’t think my uterus could carry a baby. It was a total surprise, for me and for my husband. People think that everyone who comes here wants to have children, or what do I know, to get more benefits. But it was not like that in my case. I have many, many plans. I have an incredible desire to keep working. I didn’t come to this country trying to profit off anything.”
In her historical and sociological analysis of Black reproduction, Dorothy Roberts observes,

As both biological and social reproducers, it is only natural that Black mothers would be a key focus of this racist ideology. White childbearing is generally thought to be a beneficial activity: it brings personal joy and allows the nation to flourish. Black reproduction, on the other hand, is treated as a form of degeneracy. Black mothers are seen to corrupt the reproduction process at every stage. Black mothers, it is believed, transmit inferior physical traits to the product of conception through their genes. They damage their babies in the womb through their bad habits during pregnancy. Then they impart a deviant lifestyle to their children through their example. This damaging behavior on the part of Black mothers—not arrangements of power—explains the persistence of Black poverty and marginality. Thus it warrants strict measures to control Black women’s childbearing rather than wasting resources on useless social programs (1999).

Drawing parallels to the Brown, migrant body, Roberts’ analysis suggests that migrant pregnancy should be criticized, criminalized, and curbed to prevent the transmission of undesirable traits like freeloading. I further examine the issue of Latina reproduction in Chapter 9.

In summary, racism creates conditions for inequitable treatment and racialized experiences vary according to intersections of phenotype, or skin color, language ability, and documentation status. In the next section, I discuss the issue of class—specifically membership in the lower classes—as a determinant of embodied migrancy.

Poverty

Raquel’s urgent desire to divorce herself from the “freeloader” label emerges in response to longstanding stereotypes of migrants as parasites who spawn “anchor babies” as part of a plot to circumvent laws and earn government aid (Chavez 2013, 176). This characterization represents an “abjectification” of migrant women, a manner of repulsion and expulsion that establishes them as an “Other” (Butler 1990; Gonzales and Chavez...
2012). Many women assimilate this abjectification, exhibiting attitudes of internalized racism to distinguish themselves from undeserving, exploitive migrants. Most of my interlocutors described themselves as poor, or lower class. Regardless of their current work status, many emphasized their commitment to participating in the labor force, supporting themselves, and not taking welfare. Several condemned migrants who abused social services, particularly amid the pandemic. Raquel tells me,

“When I lost my job in New York, we went looking for food. So, my husband and I both lined up at a food bank, to make sure we got enough given that there were two of us. But I saw people who lined up, got their food, went home, and then came back! I mean, there were women and children there—couldn’t these people stand to consider those who really needed the help?”

One form of aid that many women felt they needed, without shame, was healthcare. Nearly all women benefited from some form of healthcare assistance, whether through private programs available through Yale-New Haven Health or public health insurance.

Priscila, a Mexican woman who had lived in the U.S. for fifteen years, distinguishes healthcare support from other forms of welfare, asserting her entitlement to the former.

For example, I’m pregnant right now, right? The only thing that I have ever asked for during all my pregnancies is medical support because it is very expensive. But from there on out, nothing else. But there are other people who ask for food, who want help to pay the rent… they ask for help to pay their bills, electricity. All kinds of things. And I say, I mean, if the baby is mine and I wanted to have a child, and I choose to keep it, it’s my responsibility. If I were in my country, the government would not give me anything. Here, you get pregnant, and they give you financial aid. Here, there are various [medical] programs to help pregnant women, and to that, I say, ‘Okay, sure.’ But some people take too much advantage.
Here, Priscila stipulates pregnancy as a category of deservingness, a form social labor that merits compensation. She distinguishes this from financial support in the postpartum period and beyond. The ‘deservingness’ of pregnant women resonates across settings: In her study of the morality of healthcare provision for unauthorized migrants living in Tel Aviv, Israel, medical anthropologist Sarah Willen found that migrants most believed that the government should pay for prenatal care and delivery expenses (2012a). Willen attributes this to values of social reciprocity by which migrants view their care as compensatory for their contributions to society, both economically and socially.

Priscila also confesses that she sought medical aid for her husband when he developed cancer.

I got support because it was cancer, and I was the only one who was providing for my household. My husband was ill for three years in his battle with cancer. Between bringing him to the hospital, I could not work as much. I even sent my children to live with their grandmother [in Mexico] but I still had to send them money. So yeah, I was the only breadwinner, I had to pay my bills, my rent, everything, all while supporting my husband in his illness. And so, yeah, I got help. But it really bothers me that other people think that they’re in the same situation and take too much advantage.

Priscila considers herself exceptional: She narrates her receipt of medical aid for her husband’s cancer in the context of her as a worker, mother, and sole “breadwinner” for her family. In her view, she ‘deserves’ healthcare support because of her participation in the labor market. However, as medical anthropologist Alyshia Gálvez notes, this attitude “reinforces neoliberal models of citizenship that offer only a narrow spectrum of rights in exchange for labor” (2011, 43).

Foucault dissects the power architectures of healthcare and social welfare by distinguishing between “the good poor and the bad poor” (1980, 185). The ‘good’ or working poor may be ill or infirm but deserve therapeutic intervention or material
assistance so that they can be transformed into a useful source of labor. By contrast, the ‘bad’ poor are willfully idle and thieving (Foucault 1980). He states,

> At the point when the mixed procedures of police are being broken down into these elements and the problem of sickness among the poor is identified in its economic specificity, the health and physical well-being of populations comes to figure as a political objective which the ‘police’ of the social body must ensure along with those of economic regulation and the needs of order.

Priscila constitutes herself as one of the “good poor,” whose prenatal care and other medical assistance serves the needs of society. Part of her self-conception as exceptional relates to the absence of universal healthcare in the U.S. and the high costs of medical care, an issue I revisit in Chapter 13.

> “I applied for nothing but medical support, which is the most, the most important. Why? Because if I work, my children will have enough to eat. It is my business, it is my responsibility—it is not anyone’s responsibility. No one came and said hey, you know, have a son and I'll help you support him. No.”

This ‘bootstraps’ mentality must also be understood in the context of threatened changes to “public charge” rules under the Trump administration. In 2019, the Department of Homeland Security issued 84 Federal Regulation 52,537, which amended criteria for admissibility to the U.S. or adjusted status, considering any migrant who received public benefits for more than 12 months in any 36-month period a likely “charge” on the federal government and thereby unworthy of citizenship or permanent residence; the rule was revoked in March 2021.

As Gálvez notes, many migrants pay a “sweat equity,” often paying income taxes, property taxes, and sales taxes while receiving little in return (2011, 43). Medical anthropologist Seth Holmes similarly found that many of the migrant farmworkers he
worked alongside fully recognized the injustice of paying federal taxes, effectively sustaining the Social Security program, while failing to benefit from social programs (2013, 188–89). Nikki, a DACA recipient, references her economic contributions in her complaint against her ineligibility for state insurance.

“I work. I pay taxes. I’ve been here since I was eleven years old,” Nikki reasons. “And yet I don’t qualify for HUSKY [Connecticut Medicaid]. In Connecticut, you can only get insurance for your pregnancy. I got it just for being pregnant with my son and then for six weeks afterward—that’s it!”

Nikki believes that her “sweat equity”—along with her longstanding presence in the U.S.—entitles her to Medicaid. However, Gálvez cautions against “disproportionately valorize immigrants' labor contributions and ignore the (unremunerated, unaccounted for) labor of social reproduction that makes them possible” (2011, 43). Likewise, Willen calls for situationally-specific moral assessments of ‘deservingness’ that account for the practical impacts of healthcare disenfranchisement (2012a).

Regardless of their relationship to systems of social support, many women reported intense economic anxiety, particularly amid job loss due to the COVID-19 pandemic. Women also commonly reported dependence on partners—or other family members—for income, a condition that intensified their sense of precariousness.

Célia, for instance, says that her greatest source of stress is finances. “I worry that my husband will suddenly be without a job, because he supports the house,” she explains. “For instance, the week I was hospitalized [for delivery complications], he asked for the whole week off to help me. But now that means he didn’t work for a week, so we might
not have enough for the rent. I mean, I really needed him with me, to help me, but I worry so much about how it will affect our finances.”

Roughly half of my interlocutors told me that their money runs out by the end of the month, meaning they have little breathing room in their budgets for situations like illness, work slowdowns (e.g., wintertime cuts to landscaping work), or other emergencies. This requires compromises on food quality, ‘luxuries’ like cable and internet, and the ability to send remesas or remittances to support children, parents, and siblings back in their home countries.

“My partner always says, ‘you have to cover as much of your legs with the blanket as far as it reaches,’” Yaiza, a 36-year-old from Ecuador quips. “You have to live half-comfortable to have your food to live.”

The interlocking oppressions of ‘illegality,’ racism, and poverty constrain life prospects for many migrant women. Yet strategies of coping, and harnessing intrinsic and community resources, permit them to salir adelante.

**Strategic coupling**

I had asked Priscila about her housing situation when she launched into a chronicle of her romantic relationships.

“Well, what happens is that… so my first husband and I separated. I was with him for three years. But I quickly met another person,” she explains. “We were married for almost ten years. He had health problems, cancer. He passed away three years ago. Well, after he passed away, I met someone else and now we are together. We can say it is a stable relationship and we live in a house.
“And with this new partner, I try to be better for him and for my children. Thank God, both he and them accepted each other. And so, we are together—we’re better off that way. When my children need something and he can do it, he does it.

“So, I think we have thrived together. My children no longer have their father, but they have him [my partner]. And, with the arrival of the new baby, we will all assimilate to this new life.”

Priscila frames her current partnership in economic and logistical terms. Her partner helps with her children and has enabled her family to live in a house. Although he is not the father to her older children, he fills the void left by the passing of her former husband. As Priscila says, her family is “better off” with him and they will fully integrate as a unit when her new baby arrives. For Priscila, this new partner provides financial support for her and her family as well as the labors of childcare and attention, which enables her family to function while Priscila maintains her employment as a restaurant worker.

Priscila also implicitly characterizes her current pregnancy as a tactic of unifying her blended family and asserting the legitimacy of her romantic relationship, which has not been validated through formal marriage.

“Although I love this man—the father of this baby—the death of my husband left a void, for my other children, for me,” Priscila tells me in a dispassionate tone. “I have always had the support of a partner. I’ve been fortunate to always have people on my side—I’ve never felt alone. Marriage is learning, it is living together, it is making and undoing, getting angry and becoming content again. This baby just gives us all new hope.
“So yes, yes, I have my children, I have a job, I have the main pieces in place to save and to salir adelante, more than anything, that, to salir adelante.”

Priscila articulates her wish for this new baby to provide “hope” for her new family. This pregnancy ratifies her current relationship, which, in turn, advances her goals of accumulating wealth, working, and continuing onward (saliendo adelante). Priscila says she loves her partner yet couches that avowal within her aims of preserving and strengthening her system of social and financial support.

Notably, Priscila asserts her independence with fervor, telling me, “No, I don’t depend on him. He doesn’t depend on me either. We spend so much, he earns so much, I earn so much, and everything comes together.” However, she admits, “Well, now that I’ve stopped working [as I approach my due date], maybe yes [I depend on him].” She later adds that she does not want her daughter to lean on anyone else in her future and says that she sets a model for this by never “stretching out my hand and saying, ‘give me’ because I don’t have it.” To her, co-dependence with her partner enables her financial security, her own venture toward the American Dream.

Other women express their pursuit of romantic partnership as a link to social networks, or traces of familiarity from their home communities. Almudena tells me, “In my culture, we children are very attached to our parents. We always depend on them, you know? Here, kids go to university and they’re already independent, no longer living with their parents. Back home, I went to university and still relied on my parents. I didn’t cook, I didn’t know how to do anything because I would come home from school and my mother already had food for me. She washed my clothes—I didn’t
do anything for myself. And so, I didn’t know my husband before I came here, but I felt this emptiness from not having my family.”

At that point, Almudena began sobbing. “He has his whole family here. I saw that everyone walks by his side. And so, I tried to build a friendship with him because he had so much here. While I had to eat alone and warm myself up something to eat or even cook, he had everyone who cooked for him. And so, when he was alone, I would start talking with him. Eventually we started dating and a love was born, and we decided to get together. That’s how it happened.”

Almudena’s husband satisfied her need for community and a sense of companionship amid her isolation as a solitary migrant woman. Upon their marriage, Almudena’s husband folded her into his robust social network, affording her a home-away-from-home. When I asked her about her forms of social support, she cheerfully cites her in-laws.

Similarly, Ascención describes her marriage in terms of this familiarity and potential for logistical support.

“He’s from my hometown,” Almudena shares. “When I met him, he had a car and he would give me rides as a favor. Sometimes, he would drop me off at the hospital or clinic or take me to the Walmart. And he would pick up my child’s medicine for me. That’s how I got to know him. And so, the year we met, I told him that I wanted to give him… that I wanted to have his baby.”

Ascención bonded with her partner over their shared roots in Chiquimila, Guatemala and grew to appreciate his company through his kindness toward her older son and his ability to provide her with transportation. In exchange, Ascención offered to
“give him” a baby, solidifying their bond and her commitment to him. Thus, reproductive labor emerges as a remunerative act that sanctions practices of strategic coupling.

Other women designate their relationships as retreats from intimate partner violence, or as attachments to procure ‘legal’ residence. Gladys did both.

“I started working in a company painting houses in Queens and most of my clients and work colleagues spoke English, especially the owner. So, I had to learn English. At the beginning, I tried but it was so difficult,” Gladys cried. “So, I had this neighbor, this next-door neighbor, who was from West Virginia and didn’t speak any Spanish and we got along. I would ask him questions like, ‘wait, how do you say this?’ And I would just make him repeat it. I learned a lot with him, and eventually ended up marrying him.”

In addition to his support with learning English as a native speaker, Gladys’s first husband, Daniel, was also a U.S. citizen and, if they remained married for five years, could provide her with a pathway toward a green card. He also could provide cover for an unintended pregnancy.

“At the time, I had become pregnant with this stranger from Portugal, but I didn’t want anything to do with him. I called my mom and she told me, ‘You can get married or you can have an abortion.’ I didn’t want to have an abortion, so I remembered this neighbor and I called him up—he was living in Texas at the time—and I told him I was pregnant, and I didn’t know what to do. [Daniel] had fallen in love with me when we were neighbors. I told him, ‘We can pretend or just marry and get divorced or whatever’—I just wanted to get my mother out of my hair. I didn’t really love him, but I
knew that he loved me. In the back of my mind, I also knew that he could get me a green card. So, I went down to Texas, and we got married.”

Unfortunately, their marriage devolved into patterns of violence and abuse, in part due to Eric’s undertreated bipolar disorder.

“He used to treat me so badly, so poorly. He used to beat me. It turned out he was a very bad guy. It was like hell—I suffered a lot in that pregnancy. He raped me and he attacked me. I was pregnant, and still he beat me. I was so miserable. So, I just left him because I couldn’t stand it anymore.”

Gladys left for Connecticut and had her baby alone—no husband, no green card. As she struggled to get on her feet, a friend recommended she apply for a green card as protection from her experience of domestic violence.

“I connected with these counselors at a place called Safe Connect. They got me a lawyer and helped me apply for my green card. After three years, I got it. And then later I applied for U.S. citizenship.”

Still, alone with a young child and scarred from her history of abuse, Gladys sought refuge in a man named Elias. He provided her with financial security and allowed her a reprieve from work to care for her older daughter and the second child they had as a couple. Elias also treated her with deep respect and kindness, a drastic change from her relationship with Daniel. With this newfound stability, Gladys invited her elderly parents to live with her in New Haven. Tragically, shortly thereafter, Elias died of a heroin overdose and her father contracted colon cancer. Now Gladys supported two children, a desperately ill father, and her mother—a household of five—through her own salary as a housekeeper. Then COVID-19 hit, and her work declined by fifty percent.
“I could no longer make it. I thought I would have to move my whole family into a one-bedroom apartment.”

But then, she met Nicolás, who understood her situation and began to help with picking up and dropping off her kids and supporting her father at his medical appointments. And so, although the pregnancy came as a surprise, and Gladys and Nicolás were not married or living together, they welcomed the news as an opportunity to formalize their arrangement. They agreed that Nicolás would help Gladys with the new baby, while her parents cared for the older two. By merging their finances, Gladys felt she no longer had to worry about paying rent and credit card bills, or about supporting a new baby.

“He’s going to be with us,” Gladys assures me about Nicolás. “He’s going to be there for our child and he’s going to be responsible. I feel that I no longer have to worry.”

Each of Gladys’s three marriages provided her with social, economic, or legal benefit. She married Daniel to avoid stigma from her accidental pregnancy and with the hope of obtaining a green card. She married Elias for financial support and for reprieve from the abuse she endured at Daniel’s hands. She partnered with Nicolás given his support for her multigenerational family. Each of these relationships sought to advance Gladys’s goals of financial stability, social support, and legal recognition—and she ultimately achieved all three.

Although maneuvers in strategic coupling may help women fulfill their own aims, this practice also renders women vulnerable to the harms of gendered power imbalances. Pregnancy, emotional fragility following trauma, economic dependence, and ‘liminal legality’ contingent upon the continuance of marriage place women in precarious
situations that can exacerbate tendencies toward intimate partner violence. Nearly one in twelve women relied on their husbands for ‘legal’ residence and more than half depended on their partners for income. These imbalances enable abusive partners to control and manipulate migrant women. Whereas Gladys benefited from an informal network that connected her with domestic violence support, most women lack these resources and face cultural and linguistic barriers to accessing services. Abusive partners—through tactics of financial control and restriction of movement—may further prevent women from acquiring the help they need (Mendenhall 2012). Finally, lack of trust in authorities due to unauthorized presence may prevent women from pursuing support should the opportunity present itself. Together, these factors contribute to high rates of intimate partner violence against migrant women (Holtmann and Rickards 2018; Raj and Silverman 2002; Kyriakakis 2014). I return to the issue of policy support for survivors of such violence in Chapter 13.

**Imperative resilience**

Resilience refers to “the process of harnessing resources in contexts of significant adversity to sustain end goals” (Panter-Brick et al. 2015). Unlike the concepts of “positive psychology,” or “competence,” resilience considers the influence of social environment on an individual’s ability to adapt to difficult life circumstances (Rutter 2012). An interdisciplinary approach to resilience recognizes the contributions of the individual—at the genetic, epigenetic, cognitive, and emotional levels—as well as their family, society, and culture (Southwick et al. 2014). Because the benchmarks of social functioning and adaptation are negotiable across cultures, resilience research requires
interrogation into the biological and ontological dimensions of well-being (Panter-Brick and Eggerman 2012). Finally, resilience is best conceptualized as a trajectory—a process of adaptation or sustained healthy adjustment—over time (Bonanno 2004; 2012).

Interpretations of resilience are frequently fraught: Many understand resilience to be a fixed characteristic akin to “toughness” or “grit,” rather than as a process of rational action. When I discussed the relevance of the resilience concept to my interlocutors with my research assistants, many cringed.

“At La Casa [Cultural, the Latinx cultural center at Yale], we talk a lot about resilience, like it’s something White people think we have for ‘making it’ here,” one of my students explains. “But that’s not it at all. I mean, we’re resilient because we have to be.”

Theories of resilience tend not to conceptualize it as a mode of resistance to oppression, but my interlocutors reveal that this is exactly the dynamic at play. Resilience is not an ability or a choice, it is a conditioned response to the multiple violences of racism, sexism, immigration enforcement, and economic inequality. As such, I propose the term “imperative resilience” to describe the strategies women employ—cognitively, emotionally, and socially—to ‘get by’ in the face of overlapping adversities.

Priscila tells me that she cannot afford to let her emotional responses interfere with her ability to handle stress: Instead, she focuses on problem solving.

“Let’s say I do not have something that I should,” she explains. “For example, this month I only had half the money I needed to pay the electric bill. I couldn’t make that bill this month and so next month I’m going to have to work more hours to cover it.
If I get angry about it, things will just get worse—it won’t solve anything. So, I just try to calm down and look for solutions to be more economical and more organized."

Priscila seemed almost puzzled by my questions regarding how she “bounces back” from stress or other difficulties in life.

“I try to keep things simple,” she shrugs. “If I complicate things, I’m not going to solve anything at all. If I complicate things, I get home in a bad mood and take it out on my children. But they are my responsibility—I have to be the responsible one. If I get angry and yell and scream to let off steam, it solves nothing in the end, quite the opposite. It makes things worse.

“I just have to calm down and look for solutions. I have to accept and endure.”

These themes of acceptance and endurance—and the desire to shield children from stress—echoed throughout my interviews. Women felt it was their responsibility to minimize their affective responses to difficult circumstances to preserve the emotional and physical health of their children, and their pregnancies.

<table>
<thead>
<tr>
<th>Name</th>
<th>Home country/territory</th>
<th>Age</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susana</td>
<td>Ecuador</td>
<td>31</td>
<td>I just try not to think of the thing that is stressing me. I just treat it as a learning process. I just have to face things and get ahead. I don’t feel those emotions. I just try to focus on getting ahead.</td>
</tr>
<tr>
<td>Ysabel</td>
<td>Ecuador</td>
<td>19</td>
<td>I don’t stress. Whenever something seems stressful, I just don’t think about it. I’m just like, ‘it’s whatever, there’s going to be another day where you can make it better.’ I try to brush it off or look for advice. There’s things that people probably went through that you’re going through, you know? Who understand the situation and can help you through it.</td>
</tr>
<tr>
<td>Adelina</td>
<td>Puerto Rico</td>
<td>21</td>
<td>I try to talk to my husband and we figure out how to get things under control. If it’s because of finances, then we talk about it and economize. If you have children, you</td>
</tr>
<tr>
<td>Célia</td>
<td>Ecuador</td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Ethnographic table of comments describing imperative resilience
<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
<th>Age</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elvira</td>
<td>Dominican Republic</td>
<td>30</td>
<td>have to be calm for them—they should not feel tense or see a fight. Everything can be overcome.</td>
</tr>
<tr>
<td>Nikki</td>
<td>Jamaica</td>
<td>33</td>
<td>You have to just accept it and adapt, create something nice out of it so you don’t focus on the bad. I try to think positive, stick to my plans, and always have a steady mind. I don’t throw in the towel easily. I am strong. I endure. I have been through things and I have overcome them. I try not to think about things because if you dwell on them, you feel sadder.</td>
</tr>
<tr>
<td>Jackelín</td>
<td>Guatemala</td>
<td>40</td>
<td>I just deal with things because I feel like I don’t have a choice.</td>
</tr>
<tr>
<td>Marcela</td>
<td>Ecuador</td>
<td>34</td>
<td>I try not to focus on the negative things that are happening. Everything can be managed, everything has a solution. I believe that God has a plan, a purpose for each person. I make my plans, and if it is God’s will, they will be fulfilled. I learned how to face things as an adult. I know I can get ahead. I am confident. Life is just like this sometimes. There can be moments of pain, of storms, of disease, of other difficulties, but as long as I serve God, my soul will go to Him. My body stays.</td>
</tr>
<tr>
<td>Juana</td>
<td>Mexico</td>
<td>26</td>
<td>I just stay calm. I am very aware then I can change something, and when there’s nothing I can do about it, I let it go. I’ve faced difficulties in my life and I have overcome them. I try not to ruminate on them. I had to be strong. I consider the difficulties in my life not to be a big deal; I just learn from them.</td>
</tr>
<tr>
<td>Ascención</td>
<td>Guatemala</td>
<td>34</td>
<td>I just stay calm. I am very aware then I can change something, and when there’s nothing I can do about it, I let it go. I’ve faced difficulties in my life and I have overcome them. I try not to ruminate on them. I had to be strong. I consider the difficulties in my life not to be a big deal; I just learn from them.</td>
</tr>
<tr>
<td>Camila</td>
<td>Mexico</td>
<td>36</td>
<td>I just stay calm. I am very aware then I can change something, and when there’s nothing I can do about it, I let it go. I’ve faced difficulties in my life and I have overcome them. I try not to ruminate on them. I had to be strong. I consider the difficulties in my life not to be a big deal; I just learn from them.</td>
</tr>
<tr>
<td>Jeaneth</td>
<td>El Salvador</td>
<td>30</td>
<td>I just focus on the simplest, most practical solutions. I know that everything that happens... everything is temporary, everything has a reason, a “why,” and sometimes it is just not worth getting so frustrated by the small things. I want to fight and to get ahead.</td>
</tr>
<tr>
<td>Karina</td>
<td>Ecuador</td>
<td>42</td>
<td>Everything that has to happen happens, but you have to hold on and know how to get ahead. You can’t stay put, you can’t get stuck. You have to get ahead.</td>
</tr>
<tr>
<td>Mirelia</td>
<td>Dominican Republic</td>
<td>39</td>
<td>The Bible says that everything works for the good. We must face things and learn from them. We have life and so we must please God and move forward, try to overcome, try to get our families ahead.</td>
</tr>
<tr>
<td>Name</td>
<td>Location</td>
<td>Age</td>
<td>Strategy</td>
</tr>
<tr>
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</tr>
<tr>
<td>Leticia</td>
<td>Guatemala</td>
<td>33</td>
<td>I try not to put too much importance on things. When I feel stress, I try to relax, to not think about anything. I just tell myself, “Keep going. Do not let yourself fall apart.”</td>
</tr>
<tr>
<td>Nieve</td>
<td>Ecuador</td>
<td>19</td>
<td>I just try to be positive. Everything will be okay. It will work out. Maybe I’ll talk with my husband and we’ll make a plan. I don’t worry.</td>
</tr>
<tr>
<td>Marisol</td>
<td>Mexico</td>
<td>39</td>
<td>There are times when I get up at dawn and try to pray a lot, to listen to God, so as not to feel anger at everything that has happened to me. I ask for peace and then I become stronger. I listen to Christian recordings that help me focus on overcoming and keeping a positive mind. I believe that, through my faith in God, all things will pass.</td>
</tr>
<tr>
<td>Marta</td>
<td>Ecuador</td>
<td>24</td>
<td>I try not to think about it so much. I try not to be too affected. I think everything happens for a reason.</td>
</tr>
<tr>
<td>Ivette</td>
<td>Ecuador</td>
<td>24</td>
<td>I try not to think about it too much. If something difficult happens, I try to take it easy, to find solutions. I try, with my son, to do things in the house to distract us, to release some of that pent up stress. I take it all in stride. Always looking up, don’t look back. Let this push me ahead and move forward to build a better future for my children.</td>
</tr>
<tr>
<td>Anita</td>
<td>Puerto Rico</td>
<td>39</td>
<td>I try to find a purpose in everything. I can cry and talk to someone who can help me make sense of things. But in the end, I’m going to have a child, a child that I have to fight for.</td>
</tr>
<tr>
<td>Mildred</td>
<td>Mexico</td>
<td>33</td>
<td>I think I’m strong. I think the fact that I’m responsible for my children and that they depend on me helps me to be strong. Difficulties will always be there.</td>
</tr>
<tr>
<td>Noelia</td>
<td>Mexico</td>
<td>40</td>
<td>I just try to stay positive and seek help when I need it.</td>
</tr>
<tr>
<td>Aida</td>
<td>Honduras</td>
<td>26</td>
<td>I just try to handle it, push it from my mind, and let it pass. I don’t have any family or friends here, only my children. And so I have to learn to deal with things on my own.</td>
</tr>
<tr>
<td>Lidia</td>
<td>Mexico</td>
<td>25</td>
<td>I try to be a very positive person. Everything happens for a reason. And in negative situations, I try to find the positive. A solution. Getting ahead, pushing ahead, as always.</td>
</tr>
<tr>
<td>Meri</td>
<td>Ecuador</td>
<td>26</td>
<td>I believe I am strong, that I can move forward. I always like to be positive, to find the solution and not cause more problems.</td>
</tr>
<tr>
<td>Vanessa</td>
<td>Puerto Rico</td>
<td>39</td>
<td>I’m normal, I’m human. I get angry. And when I do, I try not to think about it and try to relax. I’ll inhale, exhale, focus on calming my body, and then when I feel more relaxed, I analyze the situation, look at the pros and cons, and make a plan.</td>
</tr>
<tr>
<td>Carla</td>
<td>Puerto Rico</td>
<td>21</td>
<td>You can’t let one thing stop you. You have to keep going. I just encourage myself, try to push myself harder.</td>
</tr>
<tr>
<td>Linette</td>
<td>Puerto Rico</td>
<td>26</td>
<td>I try not to let things overwhelm me. I try not to overthink things. I’m always saying, you know, I’m going through this because God has a plan for me. I try to encourage myself and believe that things will get better. I always have that mindset that’s like, “well if you want it to work...”</td>
</tr>
<tr>
<td>Name</td>
<td>Country</td>
<td>Age</td>
<td>Statements</td>
</tr>
<tr>
<td>---------</td>
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<td>------------</td>
</tr>
<tr>
<td>Gladys</td>
<td>Ecuador</td>
<td>41</td>
<td>I have no other choice. I just have to turn to God and trust that things will be okay. I try not to stress over things that I cannot change. And it works. I feel stronger and stronger over time, to be honest.</td>
</tr>
<tr>
<td>Amalia</td>
<td>Peru</td>
<td>37</td>
<td>I don’t think things are just destiny—you make your own destiny. You have to live by your own decisions. You have to think about the risks, whether things are worth it, and figure out how to fix it. I have my own will to survive and to move ahead.</td>
</tr>
<tr>
<td>Patricia</td>
<td>Ecuador</td>
<td>27</td>
<td>We all have difficulties and we have to know how to resolve them. To not let them overwhelm us and focus on the here and now. Problems will pass, right?</td>
</tr>
<tr>
<td>Nely</td>
<td>Mexico</td>
<td>24</td>
<td>I try to calm down and try to see things from a different perspective. Maybe I’ll talk to my husband. I have to be stronger because my parents aren’t here with me. I try to recover quickly, knowing everything happens for a reason.</td>
</tr>
<tr>
<td>Sonia</td>
<td>Colombia</td>
<td>36</td>
<td>I stay positive and try to calm own. I’ll drink some yerbabuena [mint] tea and think of my baby, my son. I try to accept the things that happen, however difficult they may be, trusting in God and His will.</td>
</tr>
</tbody>
</table>

Jenifer, a 32-year-old from the San Marcos area of Guatemala, faced an extreme stress when she developed thyroid cancer and doctors told her she might not survive.

“When they gave me the bad news, I started to worry. But then I sat and thought, and I realized that in life, we have to fight for everything. And so, I tried to focus on other things. I don’t forget, I know it’s there, but I try not to think about it so that I’m not thinking about this awful thing, this awful thing, all the time.”

Jenifer tried to avoid considering the consequences of her disease.

“In Guatemala, we only had to worry about whether we had food to eat, how we were going to buy things. Here, even in my condition, I knew my family would be provided for.”

This knowledge brought Jenifer peace. In some ways, she resigned herself to the possibility of dying.
“Then again, I looked at my children and thought, oh God, my children are so young. I thought about leaving them with their father so that I could die, and they would never know. And at the same time, they smiled at me, they hugged me… they kind of gave me strength to keep fighting and to get ahead for them.”

On first glance, the coping strategies deployed by both Priscila and Jenifer—emotional numbing and intellectualization, repression, and cognitive avoidance—might appear maladaptive. In fact, strategies of avoidance coping have been associated with worse life stress and depressive symptoms (Holahan et al. 2005). However, on further examination, these women also deploy multiple positive coping strategies, including problem-solving, benefit-finding, altruism, and personal or spiritual growth. Although Priscila might suppress her emotional reactions to stress, she does so out of concern for her children. Instead, she focuses on practical solutions, like adjusting her budget and work hours. Similarly, at first Jenifer seemed to avoid the harsh and painful reality of her potentially terminal illness. She then reveals that she considered pragmatic issues, such as economic provision for her family, and identified with the warmth and kindness of her children to build strength and cultivate sentiments of generosity.

I admit, I found myself in awe of these women who—despite immense economic adversity and limited social support—maintained attitudes of optimism and orientation toward their goals. As a mother of a young child who enjoyed the support of a dual-income partnership and familial support with childcare, I was humbled by my psychological challenges relative to the mental fortitude these women exhibited. The juxtaposition of my struggling mental health amid a relatively resource-rich environment
and the self-assurance of my interlocutors despite resource limitation prompted me to reflect on my conventional understanding of “resilience.”

Social worker and resilience theorist Michael Ungar states that “resilience is a shared quality of the individual and the individual's social ecology, with the social ecology likely more important than individual factors to recovery and sustainable well-being for populations under stress” (2011, 17). Ungar cautions against assessing “personal agency” and ignoring “the larger influence of sociopolitical, economic and cultural factors that shape developmental paths” (2011, 19). Yet, if intrinsic attitudes and behaviors play a small role in determining well-being, how can we make sense of the persistence and psychological health of these structurally vulnerable women?

I thereby conceptualize this practice as “imperative resilience,” as a strategy of survival and resistance to oppressive social regimes. Imperative resilience is a performance that becomes actualized through consistent practice. The necessity of suppressing negative emotions, emphasizing the positive, and strategic problem solving reflects not an inherent “grit” or “toughness,” nor does it stem from advantages in social and material resources; rather, this obligation arises from social injustice as a form of opposition, a way of summoning personal and social capacity to fill the voids left by society.

Monarch butterflies—with just a three-to-four-inch wingspan—travel fifty to one hundred miles in a day during their migration, flapping their wings five to twelve times per second. This incredible feat is not merely for sport: The monarchs must migrate expediently and efficiently to survive. As the days shorten and the temperatures drop in their breeding areas across the U.S. and Canada, monarchs understand that soon their
primary source of food, milkweed, will soon dry up, leaving them to starve. They overwinter in the mountains of central Mexico, shielded by a microclimate of oyamel fir trees that blanket the monarchs from extreme temperatures. As the days lengthen and the temperatures warm, this once protective climate now threatens the monarchs with overexposure, prompting them to leave their roosting sites. Mated female monarchs leave first, blazing a trail that their offspring will continue over the next three to four generations. These delicate insects undertake these impressively long and exhausting migrations because of environmental constraint. They thereby summon their intrinsic capacity for flight—and favorable air currents—to accomplish this awe-inspiring investment in generational survival.

Understanding “resilience” as “resistance” calls to mind the social programs launched by the Black Panther Party. The Panthers considered health as a key marker of disparity between Black and White people in the United States. They saw that healthcare exemplified the economic, social, and ideological oppression of Black people and sought to wrest control of health outcomes from White-dominated establishments, much in the same way enslaved individuals engaged in alternative medical practices to preserve their health and resist their conditions of bondage. As such, the Panthers sought to take charge of their own health, promoting individual hygiene and summoning community resources in the form of free breakfast programs, and testing for sickle cell disease. Through these acts of self-care and preservation, the Black Panthers condemned the neglect of the federal government and empowered Black communities (A. Nelson 2011).

I understand the social programs initiated by the Black Panthers in the same way I understand the perhaps unexpected buoyancy of these Latin American migrant women:
as resistance to structural violence, or imperative resilience. Although the Black Panthers demonstrated this capacity at the level of the collective, these women enact imperative resilience as individuals constrained by structural vulnerability and empowered by their “projects” of pushing onward.

Catherine Panter-Brick and Mark Eggerman emphasize the need to “examine the intersection of structural resilience and psychosocial resilience in terms of how the fabric of a society impacts individual mental health trajectories” and further conceptualize resilience as a “trajectory, a sense of meaning-making that orders the world and gives coherence to the past, present, and the future” (2011, 369, 385). Although Panter-Brick and Eggerman ascribe this resilience to culture, I consider these positive trajectories a manner of psychosocial rebellion against oppressive structures. Women integrate religious beliefs, self-conceptions of strength, and altruistic concerns for their families to “fight” against social and economic subjugation and to salir adelante or “move onward.”

**Spirituality**

When Norma Franceschi arrived in New Haven, the first item on her to-do list was to find a church. “I looked for the church because I needed it.”

Norma, a Catholic, taught with the church for nineteen years and always considered it a home. Over her time in the area, she observed that many new migrants either did not or could not access religious services. Early on, few churches had the language capacity to serve a growing Spanish-speaking congregation, many migrants could not attend services due to work commitments, and others—particularly those from rural areas—engaged in syncretic practices, like worshiping *Nuestra Señora de Santa*
Muerte (Santa Muerte) or Our Lady of Holy Death, that Norma and many local priests considered to be “witchcraft.” Over time, the parish communities of Santa Rosa de Lima, where Father Jim Manship preached, and Our Lady of Guadalupe swelled to serve more than one thousand parishioners at Sunday mass. The long-standing Pentecostal Church, Star of Jacob, opened a second site in Fair Haven and provided a haven for many of the Protestant migrants, most of whom came from Puerto Rico.

However, amid the COVID-19 pandemic, when I conducted my interviews, many churches cancelled in-person services. Although some in the area offered virtual options for attendance—through Zoom or Facebook Live—most were not available as a source of community support, particularly to those who had migrated within the past two years. Despite the absence of a community of worshipers, many women derived strength from their faith.

**Jes:** And what gives you hope in everyday life?

**Jackelín:** That God is with us and gives us life. Another day dawns and with the life God has given us, we can breathe, we can enjoy all the gifts God has given us… being able to walk, see nature, to go out, to have a roof to live under, food. Most of all, to have our health because with it we can move about as we please.

Jackelín, a 40-year-old woman from Guatemala, considers herself Evangelical along with nine other women in the study (15.4 percent). A plurality of women identified as Catholics (47.7 percent), with varying degrees of involvement in religious activities. Two self-described their religion as Pentecostal and the remainder did not endorse any religion but believed in more personal and direct means of relating with the divine. Whether through prayer, listening to Christian music, reading the Bible, or speaking with family members—mothers and grandmothers in particular—about faith, religion
provided many women with forms of solace and a narrative architecture with which to understand their life experiences.

Medical anthropologist Helena Hansen, in her study of street ministries in Puerto Rico, identified the capacity of Pentecostalism to subvert social hierarchies for those positioned toward the bottom. The doctrine that any worshiper could “establish direct contact with the Holy Spirit and receive its gifts” re-imagined power relations by allowing marginalized individuals to experience “spiritual transcendence, self-transformation, and enchantment” (Hansen 2018, 20, 23). Such individual spiritual practices were more common among women who identified as “Christian” (i.e., Protestant), Evangelical, and Pentecostal and empowered them to find hope amid poverty, job loss, and stress about their pregnancies and immigration status.

For many women, believing in “God’s plan” and orienting themselves toward their understandings of that plan helped them make sense of moments of suffering and served as a guide for channeling their efforts.

When Jackelín endured harassment and intimidation from her coyote, her faith in God helped her endure. “As I say, I trust God and God’s work always comes through. And that was what gave me consolation, that although that person [the coyote] says that I did this or that, lying about me, God knows I did nothing wrong. And my conscience, my heart was clear.” For Jackelín, if she remained steadfast in her faith in God, the words and acts of this abusive man could not affect her.

This attitude also helped her cope with a diagnosis of gestational diabetes midway through her pregnancy. Although she initially felt frightened and overwhelmed by her
doctors’ assessment of her risk, and their intensive treatment program, Jackelín trusted that God would look out for her. She says,

> And well, so, I believe in God, and if God exists and He can perform any miracle, He can do everything! I believed in God, nothing more. There were times when I felt scared. What's going to happen? How is it going to be? How's everything going to go? Most of all, I trusted that God had everything, but there are times that I felt insecure. Always, I just thought that God could help me because there was nothing else to do other than trust the doctors.

Clinicians commonly characterize this attitude—of resignation to God’s plan and any the intercession He provides—as fatalism or fatalism, ascribing it to Latinxs as a cultural trait. The thinking goes something like, “Latin American migrants and Latinxs believe that the course of fate cannot be changed and exhibit pessimistic beliefs toward illness and treatment.” However, as psychologist Ana Abraído-Lanza and others have noted, treating fatalistic attitudes as a cultural characteristic overlooks the means by which institutional racism inhibits the ability of many Spanish-speaking Latinxs to advocate for themselves (Abraído-Lanza et al. 2007). Clinical scholar Rafael M. Díaz advances this interpretation a step further, noting how fatalism emerges as “a meaningful cognitive construction that emerges from specific experiences of social disempowerment” (1998, 137).

Studies of Muslims in the Middle East and in the U.S. similarly demonstrate beliefs in “God as the great decider.” This belief, rather than rendering spiritual subjects as passive and inert, provides a narrative arch with which to understand healthcare challenges like infertility and unsuccessful fertility treatment (Inhorn 2012). As such, “fatalistic” beliefs in God may buffer against harmful psychosocial conceptions of illness and healthcare that emphasize inherent fault or failure. In Jackelín’s case, her belief that
God “can do anything” increased her confidence in her obstetric care plan and reduced her anxiety.

**Intergenerational fortitude**

“My mother was always a hard worker,” Susana, a 31-year-old woman from Ecuador tells me. “She’s been working so hard, raising my brother and sister. And she raised me. I think the way she thinks made me think the same way, you know, focusing on studying, working hard, and keeping after the things that I want. She inspires me.”

Just as Susana’s mother inspired her, Susana hopes to inspire her daughter.

“This little thing [my baby girl] will be… my engine. My family will always be my inspiration, what pushes me forward. If I’m doing well, she will be well. If she’s good, I’m good. It’s a very tight connection.

“I want the best for her. I want her to be better than me. I want her to grow, to learn, to learn a lot of things—good things. I want to give her every blessing.”

Susana describes a bi-directional pull: Both her mother and the promise of her future daughter spur her forward, inspiring her to be her best self. She also relates an intergenerational transfer of wisdom and values that translates her mother’s work ethic and curiosity across to her daughter.

This narrative contrasts with the ones that first motivated this research, those of Eulalia and her peers enrolled in the behavioral health program at HAVEN Free Clinic. Rather than considering the ways their mothers’ adversities affected them—or the potential for their traumas to influence their children—the women in this study more
often focused on instances in which they or their mothers modeled positive behaviors that are (hopefully) taken up by their offspring.

Many women described deeply intimate relationships with their mothers that informed their goals, decisions, and approach to parenting.

“My mom is my best friend,” Elvira, a 30-year-old woman from the Dominican Republic says. “I am very attached to her. It’s been difficult because I don’t have the chance to visit her often, nor can she come here…” Elvira trails off. “There are days when I wake up and I just want to cry, wishing my mother ways here, but in the middle of all this [referring to immigration challenges and the pandemic], it is so difficult.

“But my mother believes in me. She always believed in herself, and she helps me find my own strength. She knows that I, we, are strong and we endure. Like her, I have been through a lot of things, too, and I have overcome them on my own. My mother always tells me that sooner or later, I will get out of any difficult situation, that everything will get better soon. This has always shaped my mind. I always try to stay positive.

“And so, I don’t only think about my future, I think about my mom and how I can help her. And I think about my prince charming.”

*Prince charming* was Elvira’s nickname for her soon-to-be baby boy, Jacob. She relates how her mother’s uplifting self-confidence, and belief in Elvira’s capacity to overcome, helped her in the early newborn period with Jacob.

“The first thing I did when Jacob came out of my womb was call my mother,” Elvira made clear. “I told her, ‘*Mami*, if at any time I have failed you, I apologize. Because now that I am a mother, I know what we go through—the pain, the struggle.’
“At first, I asked myself, ‘Am I really going to be a good mother to Jacob?’ I don’t know how to explain it, but I just saw this perfect boy and said, ‘Wow, is that really my son?’ I had always loved children and taken care of babies, but this felt different. I just wanted everything to be perfect.”

Elvira called her mother every day, who assured her that she was the perfect mother for her son.

“I love her so much more than I ever could, I value her so much more. She told me that the truth was that I was already a mother, that I already knew my baby. And gradually I saw that she was right. I got used to taking care of him, to see him, to know his needs. Little by little, I got used to it. Now I really know him, all his tricks!”

Elvira’s mother instilled in her a strong sense of self-worth and modeled unconditional love, which Elvira internalized and shared with her prince charming. Such attitudes, coping strategies, and adaptive capacities observed across generations have been described as “intergenerational resilience” (Atallah 2017; Schofield, Conger, and Neppl 2014; Denov et al. 2019). Given the limitations of the resilience concept, which I describe in the previous section, I instead name this process of transmitting self-preserving and adaptational practices across generations intergenerational fortitude. Just as mothers in this study recognized the ways their own mothers and grandmothers strengthened them, they, too, acknowledge their potential for positive impact on their children.

Almudena says, “I believe the mother’s mental health is passed on to her son or daughter. Because this way, the mother who is always happy—or courageous—well, the girl or boy will be like that.”
I had asked this question, about whether women believed their health or mental health could affect their children, with my mind fixed on the potential for adverse impacts of trauma on fetal development or developmental programming in young children. Most women, like Almudena, surprised me by emphasizing the positive.

Juana explained, “I believe that everything is transmitted. If I’m weak, she [my daughter] won’t have the tools, she won’t have someone to give her strength. I must be strong for her to give her strength. And she will be strong. Why? Because her mother is.”

This belief in the intergenerational commission of strength stems from Juana’s observations of her grandmother and her aunts and uncles. She explains,

My grandmother—my mother’s mother—was always a very good person. She taught us to work, she was kind to other people. When my mother had to go out to work, my grandmother would watch us. But she fell ill and my aunts and uncles treated her very badly. And we children saw how my uncles treated their own mother, and it upset us. No, we had to be different from them, to be the best children, and to treat her better. My grandmother instilled in us that lesson: Not to be like everyone else, but to be different, kinder. And that’s why I think we are like that. We now try to take care of my mother so that she’ll live longer. If she needs any medicine, whatever she needs, we children lend a hand and divide up her expenses so that she doesn’t have to worry.

And so, my grandmother and my mother affected me in a good way. I’m going to teach [my daughter] how much I learned from those two: To work, to study, to focus. Not to demand things from her but to give her the confidence so that, whether good or bad things happen to her, she does not dwell on them. I will listen to her, respect her—all the good things I got from my mom and grandmother.

Thus, intergenerational fortitude allows women to harness the wisdom, experience, and values of their maternal forbearers to better support their children.

**Conclusion**

In this chapter, I examine the ways women confront conditions of structural vulnerability—organized through immigration enforcement and the production of
‘illegality,’ experiences of racism, and economic inequality—and enact resistance to these oppressive structures through the psychological and social coping strategies of strategic coupling and imperative resilience. By selecting male partners who can provide financial, logistical, and legal support, women advance their pursuits of personal and familial goals, including continuing in or returning to the labor force and supporting their children’s social and academic formation.

In my development of the concept of imperative resilience, I highlight the limitations of current theories of resilience, specifically the interplay of obligatory, agentic responses to violence and the broader sociopolitical structures that engender such violence. Imperative resilience is more than “grit” or “toughness,” or a feature of culture; rather, just as medical anthropologist Nancy Scheper-Hughes understands illness as an expression of the “subversive body,” so, too, can we consider tactics of avoidance, repression, and problem-solving to be cognitive refusals to conform to rigidly oppositional social systems (1994). She writes:

For, while the body may be used to express a sense of belonging and affirmation (as symbolic anthropologists have long indicated), the body can also be used to express negative and conflictual sentiments, feelings of distress, alienation, frustration, anger, resentment, sadness, and loss… In social systems characterized by a great deal of institutionalized inequality (whether in the form of gender, racial, class, or caste hierarchies), feelings of oppression, frustration, and submerged rage are common, though disallowed, personal and social sentiments.

And so, in the highly inequitable social environment of the U.S., in which migrant women confront sexism, racism, xenophobia, and economic disadvantage, ‘submerged’ sentiments of frustration and rage manifest through psychological steeling, cognitive techniques that enable survival. Although psychologists might consider some of these techniques ‘negative’ or ‘maladaptive,’ this framing too narrowly focuses on the
individual rather than constituting the body as a rebellious actor against violent social and political systems.

In this last section, I described how women engage the empowered knowledge of their mothers and grandmothers to advance their hopes for their children, who often serve as their greatest sources of inspiration. The ‘transmission’ of these behaviors and traits— which women seek to pass on to their offspring—characterizes intergenerational fortitude. Together, the practices of imperative resilience and intergenerational fortitude enable women to seguir adelante or continue onward.
PART III: METAMORPHOSIS
Chapter 8: The Impact of COVID-19

When COVID-19 shook the U.S. in the spring of 2020, reports quickly emerged describing its disproportionate impacts on communities of color and other marginalized groups. Headlines like the ones below filled the pages of media outlets for months.

Growing Data Show Black and Latino Americans Bear the Brunt of COVID-19 (March 30, 2020)
Coronavirus may be hitting harder in Black and Latino communities (April 7, 2020)
NYC Blacks and Hispanics Dying of COVID-19 at Twice the Rate of Whites, Asians (April 8, 2020)
Coronavirus: Why some racial groups are more vulnerable (April 20, 2020)
Blacks, Hispanics Hit Harder by the Coronavirus, Early U.S. Data Show (May 8, 2020)
Black & Latino Communities More Likely to Contract COVID-19 (July 7, 2020)
Covid-19 is sending Black, Latino and Native American people to the hospital at about 4 times the rate of others (November 16, 2020)
Black, Hispanic children bear disproportionate burden of COVID-19 (December 2, 2020)

Immediately, studies emerged emphasizing potential genetic susceptibility of racialized minorities to infection with the SARS-CoV-2 virus, the causative agent of COVID-19. Particularly egregious reports attributed the emergence of SARS-CoV-2 in Asia to “an extremely large number” of angiotensin-converting enzyme 2 in “Asian” lungs or higher infection and death rates in Black individuals to “racial/ethnic variation” in the expression of transmembrane serine protease 2 in nasal and bronchial epithelium (Zhao et al. 2020; Bunyavanich, Do, and Vicencio 2020).

However, as medical anthropologist Lance Gravlee argues in Scientific American, “Racism, Not Genetics, Explains Why Black Americans Are Dying of COVID-19”
Gravlee criticizes baseless claims that “genetic” or “biological” factors explain racial disparities in COVID-19, noting how unequal exposures forged through structural racism contribute to varying phenotypes across racialized groups. Gravlee writes:

“... Our environments, experiences and exposures have profound impacts on how our bodies develop, turning genetic potential into whole beings. Most of us learned this lesson in high school—phenotype is the product of genotype and environment—but we tend to forget it when it comes to race. If we take the lesson seriously, it becomes clear that systemic racism is as much a part of biology as genomes are: The conditions in which we develop—including limited access to healthy food, exposure to toxic pollutants, the threat of police violence or the injurious stress of racial discrimination— influence the likelihood that any one of us will suffer from high blood pressure, diabetes or serious complications from COVID-19. Gravlee characterizes the confluence of structural racism, the inequities in chronic disease burden the latter produces, and the COVID-19 pandemic as a “syndemic,” or a synergy among epidemics occurring due to biological interactions between epidemics and overlap between the social conditions that shape them that result in poorer health outcomes (2020). This analysis is particularly applicable to Latin American migrant women, particularly those who are undocumented.

Women like those in my study confront vulnerabilities to the impacts of COVID-19. Many work low-wage “essential” jobs and lack the ability to work from home, increasing their risk of exposure to the virus (Stolberg 2020). Several have experienced unemployment but remain barred from collecting unemployment relief or stimulus payments proffered through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which compels them to engage in precarious work arrangements (Page et al. 2020). Due to lower incomes, many do not have the option to stock food and household supplies, requiring more frequent trips to stores, which also increases susceptibility to community transmission of COVID-19 (Jay et al. 2020). For economic...
and cultural reasons, many undocumented families live in larger, multigenerational households, which threatens older adults as younger family members work and attend school outside of the home (Clark et al. 2020). Immigration enforcement itself, through transmission by ICE agents, in crowded detention centers, and via deportation of migrants infected with COVID-19 pose enormous public health hazards (Erfani et al. 2020).

COVID-19 also visits a high emotional burden upon migrant communities. Grief from community members falling ill and dying from COVID-19—as well as loved ones in home countries highly impacted by COVID-19—confers a psychological toll that is difficult to quantify. Finally, given lack of healthcare access, undocumented migrants may be less likely to receive prompt evaluation for symptoms. Though testing for COVID-19 is free in most settings, evaluation and treatment often is not, which may deter low-income undocumented migrants from seeking necessary care and increase risk of mortality (Chua and Conti 2020).

In this chapter, I discuss the embodied effects of the COVID-19 pandemic on migrant women. I note the way COVID-19 has constrained mobility and social interaction, exacerbated economic precarity and psychosocial stress, and disproportionately afflicted the bodies of these migrant women and their loved ones. I further discuss how women make sense of racial and ethnic disparities in COVID-19, including the advancement of racial essentialist notions of disease as well as astute awareness of the structural barriers Latin American migrant women face. I also discuss attitudes toward vaccination, problematizing concerns of “vaccine hesitancy” among Black and Brown communities.
Embodied experiences of COVID-19

“I used to work at Amazon, scanning products,” Antoinetta, a 23-year-old from the Dominican Republic tells me. “I liked the work, but it was so long… eleven or twelve hours at a time. But I had to quit my job when I caught the coronavirus there. I got it there and I haven’t gone back, I’m too afraid. Especially now that I’m pregnant, I worry something will happen to me again.”

Antoinetta contracted COVID-19 in May 2020 at an Amazon distribution warehouse in North Haven, Connecticut. Just one month later, attacks on the company’s disregard for employee safety exploded throughout the news media. Warehouse workers criticized Amazon for failure to implement appropriate social distancing protocols, noting that the wearable devices used to signal proximity of less than six feet to other employees were useless because it was “impossible” to keep six feet apart. Others felt intimidated into showing up to work despite COVID-19 concerns or symptoms out of fear of losing their jobs. Many workers also felt that they did not receive enough time to properly wash their hands and disinfect workstations, and bemoaned delays—or nonpayment—of leave for quarantine or isolation following exposure or a confirmed infection (BBC News 2020). Particularly leading up to Prime Day in July, a large promotional sale for which increased demand dramatically taxes warehouse workers, employees stated that relentless hassling over productivity and unforgiving performance quotas forced them to prioritize profit over their own health. Amazon reported in October 2020, under pressure from thirteen attorneys general, that its COVID-19 infection rate was 42 percent below what would be expected based on national averages. However, multiple U.S. senators lambasted these claims, arguing that the lack of data for the entire Amazon workforce, on
trends in infection rates, for specific facilities, and on mortality undermined the company’s assertions and continued to raise concerns regarding worker endangerment (Brown 2020).

Amid this capitalist clash, Antoinetta suffered the consequences of her COVID-19 infection and her withdrawal from the workforce.

**Antoinetta:** It was like a week, two weeks I should say. My whole body ached. I couldn't even get out of bed. It had no taste, it did not smell. I couldn't eat much. Sometimes I felt like I couldn't breathe.

**Jes:** Did you ever go to the hospital?

**Antoinetta:** No, I never went to the hospital, I only went to get tested. I don’t know. I was scared. I just went out to get tested and went home. They called me after two days to tell me I had tested positive and to stay at home. If it got really bad, they said I could go to the emergency room or I could call and they would send an ambulance for me, but I was really scared.

Antoinetta’s fears were twofold. First, she feared that if she presented at the hospital with shortness of breath, then she might be admitted, and her condition would worsen. Her cousin in the Dominican Republic, just forty years old, had died in the hospital that had exceeded its capacity. “They did what they could,” she tells me, “But everything had collapsed because so many people had the coronavirus and my cousin just died.” Antoinetta feared a similar fate. Second, she worried that if she showed up at the emergency room, she would incur insurmountable debt from the expenses of her care. Although she now had HUSKY, state Medicaid, after acquiring residency through her U.S. citizen husband, Antoinetta felt scarred from prior incidences when dizzy spells from dehydration and overwork at Amazon landed her in the emergency room and accumulated enormous debts. “I got a big bill at Yale,” she tells me. “It’s still there. I have to agree to pay it little by little. It just added up.”
In my study, ten women had been personally infected with COVID-19; of those, half contracted the virus while pregnant. Cintia, a 36-year-old Dominican woman shared how she realized she had COVID-19 on Thanksgiving of 2020, at four months pregnant.

“At first, I just felt tired and uncomfortable and I had a headache, and that was it. I thought it was just the pregnancy,” Cintia told me. “But then my little boy [my son] took the test and he came out positive. I initially tested negative, but then as my son was getting better, I got sick.

“I tried to stay calm, but one day I felt awful. I was short of breath, and I worried about the baby. I figured, if I’m short of breath, she’ll be short of breath. So, I called the doctor and they just told me to wait it out. Eventually everything was okay.”

Still, Cintia worried about her daughter’s future.

“I’m scared because she will be such a defenseless creature and she could get infected with [coronavirus]. It worries me a lot. Also, the fact that we cannot have our freedom, that we must be so worried about our health.”

In response to pandemic conditions—and their own infections and pregnant status—both Antoinetta and Cintia avoided going out.

“I just stay here in the house, making sure that nothing happens to the baby or my son or me again,” Antoinetta explains. “It hit me hard because when that happened to me—the coronavirus—I didn’t know whether or not things would get better. So, we rarely go out. My husband is the one working but he comes into the house and immediately bathes, disinfects himself. I don’t let many visitors come.”

“I avoid going out unnecessarily,” Cintia says. “I don’t go to crowded places. I always wear a mask, although now it’s getting a bit difficult for me [with the
pregnancy] … I feel that I get a little more short of breath the more I walk with the mask. I try not to be afraid of the virus, but I respect it. I respect it and I give it its space and I do what I have to do so as not to contract it again.”

Staying at home and avoiding contact with others was the most common infection prevention precaution undertaken by women in this study, with more than two-thirds of interlocutors prioritizing this method even in the absence of locally mandated stay-at-home orders. However, this practice often exacerbated the social isolation and economic concerns many women endured as undocumented migrants and Spanish-speakers. Thirty-eight percent of women either left the workforce or chose not to return due to concerns of contracting COVID-19 while pregnant. This left many at home, alone, during the day, compounding dependence on partners and financial strain. Yet, women considered this choice a necessity. Jackelin explains,

> At first, before we were in the thick of it, just hearing about COVID-19 hit me, scared me. It was like a trauma. I didn’t ever want to leave the house. Suddenly, I was afraid of what would happen if I got sick—my children so young, me pregnant. That’s why for three months, I didn’t go out at all. Being at home, I felt safer. We kept hearing from our neighbors about people losing someone close or some pregnant people dying. We don’t live among other people so much anymore… we have to limit it. But now, it feels normal. Even if we don’t like it, it is necessary.

In the next section, I discuss the psychological and emotional impacts of losing loved ones and acquaintances to the pandemic, including members of home countries.

**Illness and death of loved ones**

> “We lost a bunch of residents,” Joyce, a hospice and home health aide shares, her tone somber. “In the assisted living part of the facility, they lost thirty-six residents. I lost seven of my home care patients.”
“I think that’s been the hardest one for me. I’d been going to one client for almost two years, she was 93. And, I mean, the moment I walked through the door, you know, you could just tell right up when they see you coming that they can’t wait to talk to you… they look forward to you coming. But then she got sick. And I was so scared. And even though she was dying, she was still able to talk and she told me, ‘It’s okay. When I’m dead, I won’t know what it’s like to be alive.’

“I was used to seeing people dying. There was this one client I went to where we would just talk and watch the news. Hospice. And, you know, very gradually he just died. But now there’s too much death that’s happening so rapidly. It was a lot of deaths. And so even though I was happy about the money I was making, I couldn’t handle the guilt of the loss of life. It wasn’t worth it.”

Joyce cut her hours dramatically in the first few months of the pandemic for her mental health, to reduce her exposure to the virus, and to allow more time to assist her son with virtual learning. Even though she has continued to work in hospice and elderly care, Joyce remains scarred from the profound loss of life she witnessed in her line of work.

For other women, like Antoinetta, the impact was more personal: Several related the passing of uncles, cousins, brothers, friends, in-laws, and grandparents who succumbed to the virus. The dual impact of living in a high-risk area—in the metropolitan region surrounding New York City, the original epicenter of the virus in the U.S.—and connecting to hard-hit relatives and friends in medically under resourced home countries took a profound toll on women’s lives and their apprehensions regarding the virus. Cintia—and Célia in the Introduction—describe it as “traumatic.”
Experiences of loss and grief or fear due to close proximity of COVID-19 infection, were nearly universal: Just two women in the study did not know anyone who had contracted the virus. Scholars at Harvard University found that Black and Latinx Americans experienced 6.7 and 5.4 times higher rates of years of potential life lost, respectively, relative to White people (Bassett, Chen, and Krieger 2020). Further, additional analysis has suggested that for every COVID-19 death, approximately nine surviving Americans will lose a grandparent, parent, sibling, spouse, or child (Verdery et al. 2020). This “bereavement multiplier” signals a dramatic psychological and emotional impact, particularly on communities of color, that bears heavily as grief and as fear.

Fears of contracting COVID-19 influenced women’s care-seeking behaviors, including during pregnancy. Jackelín told me that she did not attend her first prenatal appointment until she was almost eight months pregnant.

“I was afraid to go to the appointments,” she says. “I thought if I go, I could get [the coronavirus] or they would keep giving me more appointments and I could get it then. I think I went almost until I was eight months.”

Similarly, other women expressed fears of contracting COVID-19 in healthcare facilities. Juana worried about going to the hospital for prenatal visits and to give birth because “no one knows how many people enter the hospital, many people come in, and maybe they leave behind some of the virus.” Adelina, a 21-year-old from Puerto Rico, believed that healthcare workers were involved in a government plot to stymie population growth.

When it first started, I believed the coronavirus was like, that they [the government] trying to make the population smaller. I have a feeling like they was just killing people. Like with a vaccine or something. We have all these debts and people in the population just keep growing and growing and they just… they have no control over the world. So, I feel like this is a way of them trying to control the world, taking people away because
they know more people is coming into the world. I’ve seen a lot of videos of things where they was saying on Facebook, like, they work for the hospitals and they were like, ‘no, let people die’ and then ‘say that it’s just ‘cause of the coronavirus and when somebody need help, they would do a procedure wrong or something and they just blame it on the COVID… Maybe like whenever they get their blood drawn or get like a vaccine. But like, you know, how they put things in your IV, some type of liquids or something, ‘cause there’s a lot of cases that people went into the hospital and then some of them was being positive [afterward]. And there was just a lot of like, nurses and stuff, that was saying that, like, they killing people.

Adelina told me that she planned not to accept any intravenous medications or an epidural for pain relief during her labor out of fear they could infect her with COVID-19. Her belief in COVID-19 as a government conspiracy echoed common myths that circulated about the virus early in the pandemic: that COVID-19 is a biological weapon, that COVID-19 is a plot to control the population, that a “deep state” manipulated the pandemic, and that COVID-19 death rates are inflated (Lynas 2020). Adelina’s understanding of the pandemic echoes long-held attitudes of distrust toward government and healthcare systems, particularly among Black people. For her, the impacts of the pandemic were like those of her peers who fully believed in the virus. Adelina lost work, forced herself to stay at home, and minimized interaction with the healthcare system because of the virus.

In the next section, I focus on the economic impacts of COVID-19, which resulted in lost work and worsened financial insecurity for more than two-thirds of women.

**Social impacts**

In February 2020, immediately prior to the strike of the COVID-19 pandemic against the U.S., the U.S. economy and labor market enjoyed an unprecedented boom. Unemployment stood at 3.5 percent, a record low since December 1969. Yet, in the
following months, unemployment spiked to four times that rate, with 14.7 percent without work as of April 2020, though the level dropped to 6.7 percent by November. COVID-19 attacked the labor market in multipronged ways. First, consumer and business activities voluntarily decreased—particularly those that involved high contact with other individuals, such as restaurant work and retail shopping—due to fear of the infection. Second, government-imposed public health measures, including lockdowns or “stay-at-home” orders and requirements for social distancing shut down broad sectors of the “non-essential” economy. Given existing disparities in employment and wealth, scholars warned that women and racialized minorities were likely to be harder hit by the pandemic as they previously experienced lower wages, unpredictable and unstable work arrangements, and greater representation in high contact, which together reduced their potential to absorb and recover the large-scale economic shock imposed by the pandemic (B. L. Hardy and Logan 2020; S. Y. (Tim) Lee, Park, and Shin 2021). Thus, economic devastation due to the COVID-19 pandemic befell U.S. populations in harrowingly inequitable ways.

Latinxs experienced the fiercest blow to employment: among Latinxs who were previously engaged in the labor market, unemployment rose by 15.1 percentage points, a greater spike than for any other racial or ethnic group (S. Y. (Tim) Lee, Park, and Shin 2021). Intersectional analyses reveal that Latina women have been the most likely to be unemployed during COVID-19, followed by Black women who are still more likely to be unemployed relative to White women (Gezici and Ozay 2020). Overall, downturns in employment most severely affected women, Latinxs and Asians, those with lower educational attainment, and younger workers, controlling for all other factors. In addition,
Latinxs, despite greater increases in unemployment, were not significantly more likely to be unemployed than White people after accounting for industry, occupation, and other effects. This suggests that the economic impact for Latinxs struck hardest due to the types of jobs held, reflecting longstanding patterns of employment inequities.

Among my interlocutors, women most likely worked in housekeeping, caregiving (e.g., childcare, elderly care), and food service, all high-contact industries with elevated risk of exposure to the virus. Their partners most commonly worked in construction, landscaping, agriculture, manufacturing, and custodial or janitorial jobs, work characterized by instability, unpredictability, low wages, and amid pandemic closures, “essentiality.” The following table describes the economic impacts of COVID-19 on migrant families.

<table>
<thead>
<tr>
<th>Name</th>
<th>Home country/territory</th>
<th>Age</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ysabel</td>
<td>Ecuador</td>
<td>19</td>
<td>Because of the pandemic, my partner has not worked at all. We both lost our jobs. [My boyfriend] had lost his job as a waiter at a restaurant and bar for a few months. So he had to be on unemployment. When I first found out I was pregnant, it was like mid-pandemic and a lot of jobs wasn't hiring. I would've been working at the moment if the pandemic wasn't here. It's like you can't apply to a job right now because of the pandemic.</td>
</tr>
<tr>
<td>Adelina</td>
<td>Puerto Rico</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Célia</td>
<td>Ecuador</td>
<td>35</td>
<td>In the time of the pandemic, my husband stopped working and he is the one who supports the house. I went months without working. Everything stopped suddenly.</td>
</tr>
<tr>
<td>Nikki</td>
<td>Jamaica</td>
<td>33</td>
<td>My hours have come down, like during the pandemic, there were probably two, two and a half months when I was working 60 hours a week, but then things went down drastically where I was working like 12 hours a week, 16 hours.</td>
</tr>
<tr>
<td>Name</td>
<td>Country</td>
<td>Age</td>
<td>Statement</td>
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</tr>
<tr>
<td>Almudena</td>
<td>Mexico</td>
<td>34</td>
<td>Well, when this started, they canceled all [my husband’s] jobs. And then that money that we had, stopped coming in, right? They told my husband that there was no work. That extra money that came in was going into our savings and now we are without that savings.</td>
</tr>
<tr>
<td>Jackelín</td>
<td>Guatemala</td>
<td>40</td>
<td>They lowered my husband's work. There were fewer hours and people did not want to go in, out of fear, you see.</td>
</tr>
<tr>
<td>Marcela</td>
<td>Ecuador</td>
<td>34</td>
<td>My husband didn't have a job, he had a lot of work cut down, but things have improved a lot… we can recover.</td>
</tr>
<tr>
<td>Juana</td>
<td>Mexico</td>
<td>26</td>
<td>Before I was pregnant, I was working cleaning houses. But I got pregnant, and with everything with COVID, they didn’t allow me to come in.</td>
</tr>
<tr>
<td>Ascención</td>
<td>Guatemala</td>
<td>32</td>
<td>I used to work in the food carts but I'm out of work right now because of the current pandemic.</td>
</tr>
<tr>
<td>Camila</td>
<td>Mexico</td>
<td>36</td>
<td>Right now with everything going on, it's quite frustrating. Because we stopped working for three months. For three months we had no work.</td>
</tr>
<tr>
<td>Jeaneth</td>
<td>El Salvador</td>
<td>30</td>
<td>My baby’s father and I have a shared bank account, but he was let go from work. They only let him work twenty hours a week and [because he has TPS] he got the state to pay him the other twenty. But many months have passed now and he hasn’t been paid.</td>
</tr>
<tr>
<td>Karina</td>
<td>Ecuador</td>
<td>42</td>
<td>I don’t have any money. Because of the pregnancy and COVID, I can’t work. My partner didn’t work for like two months.</td>
</tr>
<tr>
<td>Mirelia</td>
<td>Dominican Republic</td>
<td>39</td>
<td>My love, I lost my job. Because of the pandemic, the business where I worked was sold.</td>
</tr>
<tr>
<td>Nieve</td>
<td>Ecuador</td>
<td>19</td>
<td>Work has gone down really, really badly. My husband’s job canceled a lot of work. We had to take out a loan in my home country so we can manage things here.</td>
</tr>
<tr>
<td>Ivette</td>
<td>Ecuador</td>
<td>24</td>
<td>We got the virus and my husband stopped working. The three of us [my husband, my son, and me] were in the house for about a month. There was no money. We had to borrow from our friends and we’re paying it back little by little.</td>
</tr>
</tbody>
</table>
| Raquel    | Chile         | 24  | Oh, for people like us, it's been very difficult. Sometimes, my husband has been left without a job. Sometimes only I had a job but my salary was lower than my husband’s. It’s affected us a lot. I spent a month longer without work. When all this started, my husband was instantly unemployed and I didn't have a job. While he
<table>
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<tr>
<th>Name</th>
<th>Country</th>
<th>Age</th>
<th>Text</th>
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</thead>
<tbody>
<tr>
<td>Anita</td>
<td>Puerto Rico</td>
<td>39</td>
<td>was still out of work, the people we were subletting from kept forcing us to pay and I couldn’t. They wanted to kick us out. Oh no, that was horrible.</td>
</tr>
<tr>
<td>Mildred</td>
<td>Mexico</td>
<td>33</td>
<td>When I got to Connecticut, they hadn’t closed everything down yet, but then two weeks later they closed and I couldn’t get a job.</td>
</tr>
<tr>
<td>Noelia</td>
<td>Mexico</td>
<td>40</td>
<td>Well, since everything started, I spent like three months out of work. I came back in late May, but the work has gone down. I’m just grateful to have a job right now.</td>
</tr>
<tr>
<td>Maribel</td>
<td>Ecuador</td>
<td>33</td>
<td>Well, when it all really started, my husband had all his jobs canceled. Because he works inside houses and you couldn’t go into houses to work. He was out of work for about two weeks.</td>
</tr>
<tr>
<td>Aida</td>
<td>Honduras</td>
<td>26</td>
<td>I mean, right now with this pandemic thing, I haven’t been working every day and so the rent is a struggle. There are some days that my partner has work and other days when he does not. He’s working here in Connecticut now but he used to work in New York and now, because of the pandemic, he can’t go there. He just gets work here for just days at a time.</td>
</tr>
<tr>
<td>Carmen</td>
<td>Ecuador</td>
<td>26</td>
<td>The pandemic has affected us so much because there is not a lot of work, not much opportunity.</td>
</tr>
<tr>
<td>Lidia</td>
<td>Mexico</td>
<td>25</td>
<td>Because of the pandemic, I couldn’t work.</td>
</tr>
<tr>
<td>Meri</td>
<td>Ecuador</td>
<td>26</td>
<td>I used to work, but when we got here, the virus started and unfortunately, no, I couldn't continue. I was cleaning houses and I lost my job. We live on what my husband brings in and sometimes it’s a little tight and we have to borrow.</td>
</tr>
<tr>
<td>Vanessa</td>
<td>Puerto Rico</td>
<td>39</td>
<td>Because of COVID, I haven’t been able to work as I normally would. I wanted to keep working in cleaning, but because of my pregnancy, I was told that it was better not to continue because I was going to be in contact with many people and could get infected with COVID at any time.</td>
</tr>
<tr>
<td>Cintia</td>
<td>Dominican Republic</td>
<td>36</td>
<td>Of course the pandemic affected my finances. My work stopped for like a month or two. My family had to help me.</td>
</tr>
<tr>
<td>Carla</td>
<td>Puerto Rico</td>
<td>21</td>
<td>Before COVID, I had three jobs and things were all right. I was caring for patients at home and I had time in a factory. But then when cases began rising in Connecticut, I was only allowed to work with one patient. And so now I’m trying to economize.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>When COVID happened, the manager cut hours so it’s been a struggle. At first, I was getting</td>
</tr>
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</table>
sixty hours, sometimes sixty-five. My paycheck was looking like around six hundred every week. But then COVID hit, and I’d get half of that, so like three hundred every week. I had to talk to my landlord to see if he could help me out with the rent.

<table>
<thead>
<tr>
<th>Name</th>
<th>Country</th>
<th>Age</th>
<th>Text</th>
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</thead>
<tbody>
<tr>
<td>Linette</td>
<td>Puerto Rico</td>
<td>26</td>
<td>I had just gotten a job, you know, a couple months before the pandemic started. And then the pandemic hit and I lost it, I had to go to unemployment. We had to quarantine and I was so stressed out, I got Bell’s palsy. COVID is horrible, horrible. It really takes a toll on you.</td>
</tr>
<tr>
<td>Gladys</td>
<td>Ecuador</td>
<td>41</td>
<td>Since all this COVID happened, all my work went down to fifty percent. I still haven’t gotten all my clients back.</td>
</tr>
<tr>
<td>Jenifer</td>
<td>Guatemala</td>
<td>32</td>
<td>My husband was furloughed from work for a while. We had to use up our little savings.</td>
</tr>
<tr>
<td>Amalia</td>
<td>Peru</td>
<td>37</td>
<td>Well, my husband lost work. And because of the pandemic, I don’t even dare to look for a job.</td>
</tr>
<tr>
<td>Kara</td>
<td>Guatemala</td>
<td>25</td>
<td>With the pandemic, work has gone down a lot. So now it’s a struggle to make rent, buy food.</td>
</tr>
<tr>
<td>Rosalia</td>
<td>Guatemala</td>
<td>27</td>
<td>At first, I didn’t work for like two weeks. And my husband has work some days, other days not. So because of this disease, we’ve been late on the rent.</td>
</tr>
<tr>
<td>Nely</td>
<td>Mexico</td>
<td>24</td>
<td>At first it was hard, I think for everyone. I stopped working because I have asthma and they said it was very dangerous for people with asthma and told us not to go in.</td>
</tr>
<tr>
<td>Meliza</td>
<td>Mexico</td>
<td>40</td>
<td>Since the pandemic started last March, I haven’t been working. Our savings are running out.</td>
</tr>
</tbody>
</table>

Importantly, just as with direct infection and grief over lost family members and friends, the economic toll of COVID-19 is also a psychological and emotional one. More than half of the women I interviewed cited pandemic-related concerns as a major source of stress in their lives. Comments along the lines of “I’m worried about losing my job,” “I’m worried that my husband won’t be able to bring enough money home,” and “I’m so stressed about not being able to work and being stuck at home all day” became refrains, repeated throughout the interviews. The patterns of anxiety changed over the duration of my interviews, from no pandemic concerns in the era before March 2020 to extreme
anxiety in the fall and winter of 2020 to optimism in the spring of 2021. However, as the Delta (and Lambda) variants of SARS-CoV-2 continue to increase spread, particularly among unvaccinated individuals, understanding pandemic-related stress remains an urgent priority.

In the next section, I discuss how women made sense of the high attack rate of COVID-19 among Latinxs, specifically pregnant Latina women. I discuss structural versus individualistic attributions of responsibility within a political economy of health and neoliberal pressures. In my review of geneticized explanations for racial disparities in COVID-19, I return to my examination of racial essentialism and race-based medicine. I further consider the meaning of ‘rational’ health beliefs and how intersubjectivity informs pattern analyses.

Political vs. genetic attributions

In August of 2020, The Washington Post reported that Latina mothers composed nearly half of the cases of COVID-19 among pregnant women in the U.S. (Schmidt and Tan 2020). That staggering statistic shocked me, but when my advisor Dr. Marcia C. Inhorn, shared the article, I thought that it might catalyze conversation regarding the disproportionate impact of COVID-19 on Latina women. This became a standard question in my semi-structured interview schedule and prompted a bifurcated pattern of response: Though many women understood the disparity to result from structural factors like racism, uninsurance, and disproportionate involvement in high-risk, “essential” work, even more considered the problem to be due to genetics, nutritional deficiencies, and individual irresponsibility. Jackelín tells me,
Yes, I’ve heard in the news that more Latinas get the disease. In the beginning, I would hear from people that so-and-so had gotten it. But the people around me were all fine. And so, we thought it was a conspiracy or something they had invented because everyone around me, the people I knew in the town, everyone was fine. We only ever heard of random people who had gotten it, not neighbors or acquaintances. And so, we did not believe.

Later, we started hearing of more people who had it and so we began to take more serious measures, to avoid going out a lot. But I have neighbors, acquaintances friends who continue to have their parties. My neighbors next door, I think they are from Santo Domingo, they just party, they don’t wear masks, they just play their… I don’t know what it’s called, some kind of board game every weekend and they’re not scared, they think they won’t get sick. My husband says they think the beer protects them.

Jackelin’s narrative echoes Adelina’s from earlier in this chapter, describing how the absence of direct experience of the pandemic—and its racial health inequities—eroded her trust. She and Adelina believed that the pandemic had been “invented” as a tactic of population control. Reports of adherence to conspiracy beliefs emphasized education, individual judgment, and choice of news media as contributors to uptake of misinformation; However, anthropological interpretations of health beliefs provide insights into their underpinnings and situatedness within paradigms of rationality and empiricism. Medical anthropologist Byron Good problematizes interpretations of health beliefs as “irrational” or “incoherent,” citing hierarchies of knowledge imposed by European thinkers (2010). Good notes distinctions between languages of “knowledge,” used to describe “ideas that accord with objective reality” and “beliefs” that do not, connoting “error and falsehood” or “culture” (Good 2010, 67, 71, 73). Medical anthropologists and scholars of science and technology recognize knowledge as “situated” and constituted relative to forms of social and political organization (Good 2010; Haraway 1988). As such, closer examination of Adelina and Jackelin’s narratives legitimates their claims. Adelina heard about nurses who intentionally killed hospital patients, or left them to die, blaming COVID-19. Jackelin initially did not know of any
direct contacts who had been infected with the virus. These are ‘true’ observations that support their hypotheses of conspiracy. Furthermore, longstanding trends of racial capitalism have dynamically transformed how racialized individuals affectively and cognitively express, understand, and remember their everyday experiences. As such, processes of medicalization and biopolitical governance of the body shape interpretations of public health crises as tools of population control (Biehl, Good, and Kleinman 2007).

Furthermore, Jackelín emphasizes individual behavior as a driver of disease comports with neoliberal discourses of health. Similar claims that Latinas suffered high rates of COVID-19 morbidity and mortality because “we don’t take care of ourselves,” “we go out too much,” “we have lots of parties,” “we don’t take things seriously,” “we ignore what we are told to do,” “we have little discipline and don’t like rules,” “we’re stubborn,” “we think everything is a matter of politics,” or “we don’t measure the consequences” reflect intersubjective knowledge and also uphold structural oppression, exculpating policymakers from addressing capitalist social stratifications that sanction health inequity.

Beyond individual social behavior, many women also understood the high COVID-19 attack rate in Latinas to be a consequence of inadequate nutrition. For instance, Maribel, a 33-year-old from Ecuador told me,

“I think it’s because of nutrition. Maybe we’re low on vitamins. It’s very necessary for the body so that we don’t have low defenses. I always know how to take vitamins. Whether it’s for the cold or for allergies in the summer, I always take vitamins.”

Similarly, Alejandra, a 34-year-old from Tlaxcala, Mexico, adds,
“I think it’s because of our bodies. We don’t have enough of… how do you say it? We’re kind of weak. We maybe lack healthy food. We don’t take care of ourselves.”

In fact, many of my interlocutors placed strong emphasis on proper nutrition and following a balanced diet. They described nutrient-dense, plant-based meal plans rich in fruits, vegetables, soups, salads, pulses and legumes, whole grains and starches (e.g., rice, yucca, plantain, corn tortillas, potatoes), alongside more occasional meats and dairy products (e.g., milk, yogurt). Medical anthropologist Anna Waldstein, in her study of Mexican migrants living in Athens, Georgia, found that they stressed the importance of nutritional balance, supporting diets abundant in “vegetables, fruits, plenty of water and perhaps some vitamin supplements (2017, 112). Similarly, Alyshia Gálvez noted that pregnancy care practices among Mexican women living in New York City centered around eating well and exercising (2011, 58). The women in these studies, like those in my own, held themselves accountable for their health by avoiding highly processed foods and excessive fats or meats, and by supplementing with vitamins, herbs, and spices as needed. In addition to their prenatal vitamins, women also took multivitamins, iron supplements, vitamin C, “peptides,” and herbal teas like hierbabuena (mint).

Understandably, these women understand nutritional imbalance to render people susceptible to infection.

Another explanation attributed ‘predisposition’ to developing COVID-19 to genetics or intrinsic features of “Latina” biology. Meliza, a 40-year-old from Mexico says,

I think it depends on our race… maybe our food, or sometimes because people don’t take the situation very seriously. I think, unfortunately, sometimes we Latinos don’t believe… they only began to believe when they saw many deaths of people they knew, sometimes their parents, their own families. Then they started to believe the situation. But to this day, many people go out and walk out without a mask. I think it also depends on your
immune system or your blood type, I don’t know. There are many, many question marks as well but they say that they also see that scientifically it depends on your DNA.

Here, Meliza connects Latinx “race” with diet, health attitudes and behaviors, “immune systems” and “blood types,” and “DNA.” This framing echoes biologized notions of race that are widespread in biomedicine. Authoritative regimes of biomedicine combine both ‘rational’ and ‘irrational’ elements: Racial essentialism, or theories that innate, genetic differences delineate members of racial groups, stands among the ‘irrational’ elements, exposing the origins of modern medicine at the intersection of European colonization and “Enlightenment” ideals (Tsai et al. 2020). Race-based medical practices, including racialized screening tools, treatment algorithms, and framings of pathology, become internalized to promote ideas that Latinas are biologically ‘different’ from women of other races. For instance, many interlocutors with histories of births by Cesarean section (C-section)—a common experience as Latin American and Caribbean countries have the highest C-section rate of anywhere in the world (Magne et al. 2017)—were told by their providers that they could not plan a vaginal birth for their current pregnancy. This warning likely emerges from the race-based clinical calculator for risk of vaginal birth after Cesarean section (VBAC). The VBAC calculator accounts for health data like age, body mass index, and prior obstetric history, the calculator also included two correction factors for “African American” and “Hispanic” race that reduce estimates for successful VBAC by 67 to 68 percent (Vyas et al. 2019). These race correction factors were only removed from the calculator, under intense pressure from scholars and activists, in May 2021.

Unsurprisingly, given personal experience and media narratives, some women attributed COVID-19 disparities to racism. Meri, a 26-year-old from Ecuador says,
It might be because of the fact that most Latina women are working in things like cleaning, in jobs that expose them to more people. But apart from that, it could be because of racism… You can get infected or even poisoned with all the fluids that are used for cleaning. Most of the time, when you want to look at it through the lens of racism, you see that most of us are more exposed to infection because we live in large groups and we have to get out to work.

Meri links the toxic exposures of housekeeping and custodial work, large social units in housing, and “essential” work to racism. In fact, as discussed earlier in this chapter, racial capitalism constructs inequities in employment and wealth accumulation, the latter of which—along with cultural reasons—contributes to the choice of many Black and Brown families to build households alongside multigenerational kin members (Keene and Batson 2010).

Several women expressed keen awareness of the structural constraints that rendered them more vulnerable to COVID-19 infection and death. Joyce says,

I think women like us, you know, we put on our makeup, we’re very hardworking. And, for example, I’m pregnant and I’m still working in that [healthcare] field. So sometimes, you know, we don’t have the ability to say, “Oh, I don’t want to work” or “I can just work from home, I don’t want to work in the situation where [I could get infected].” Some of us don’t have that choice. And we’re definitely on the front lines.

Célia also points out the exposure risk from the work many husbands undertake. She says, “I think it is because… that their husbands work in essential jobs. Farms. Cleaning. Construction. All those things. There’s more risk.”

Elvira, from the Dominican Republic, adds that “especially for those of us who do not have residence, we do not receive help from the government” and so “we must go out and expose ourselves, be at risk.”

Together, the “essential” work of both migrant women and their spouses, and the inability of undocumented or liminally legal women to benefit from government aid like
economic stimulus checks or unemployment assistance, demands increased infection exposure and leads to the staggering inequities in COVID-19.

All these interpretations—behavioral, nutritional, genetic, and structural—reflect women’s lived realities and experiences, their subjective knowledge. In the next section, I discuss how varying health attitudes shape openness to COVID-19 vaccination.

**Attitudes toward vaccination**

In the late fall of 2020 and spring of 2021, conversations regarding the COVID-19 pandemic centered on capacity and uptake of vaccines. In January 2021, incoming President Joseph R. Biden announced that he planned to administer 100 million shots in his first 100 days of office, a goal he met just 58 days into his presidency (Soucheray 2021; The White House 2021).

Quickly, attention turned to those Americans who planned to refuse the vaccine. A January 2021 report by the Kaiser Family Foundation found that Black (43 percent) and Latinx (37 percent) people were significantly more likely than White people (26 percent) to prefer to “wait and see” how the vaccine is working before pursuing it for themselves (Hamel et al. 2021). A follow-up report in August 2021 found that Black and Latinx Americans had received smaller shares of COVID-19 vaccinations relative to their shares of the total population in most states. For instance, in California, 30 percent of vaccinations reached Latinx people, even though they account for 63 percent of cases, 48 percent of deaths, and 40 percent of the population of the state (Ndugga, Hill, and Artiga 2021).
Many scholars and pundits attributed this racial variation in vaccine uptake to “vaccine hesitancy,” or delay in acceptance or refusal of vaccination despite availability. Google searches for the term “vaccine hesitancy” steadily rose in the U.S. beginning in August 2020, reaching a peak in April 2021. However, this framing misses important dimensions of power between government and healthcare institutions and people of color. Black and Latinx folks may be considered “hard-to-reach” populations due to governmental mistrust, language barriers, and limited healthcare access (Vlahov et al. 2007). Efforts to achieve herd immunity levels of vaccination in these communities require careful targeting and commitment to addressing outstanding concerns (Artiga and Kates 2020). As Tiffany Donelson, president of the Connecticut Health Foundation points out, “It’s not hesitancy. It’s access” (Brindley 2021).

In my study, women were fairly split between wanting the vaccine as soon as it was offered and preferring to hold out to see how vaccination played out among others. At the time I completed my fieldwork in May 2021, none of my interlocutors had been vaccinated. Among those women who eagerly awaited their chance at the shot, many told me that it simply had not been offered, or they did not know how to get it.

Newborns and children served as strong motivators for seeking vaccination. Although at the time of this writing, the various COVID-19 vaccines are not available for children under twelve years of age, women believed that they and their spouses should obtain the vaccine to protect their young children. Marta makes a careful calculation regarding the vaccine, ultimately prioritizing the health and safety of her newborn daughter.

**Marta:** “There are many myths about the vaccine. I have heard ugly things. They say the vaccine is dangerous, that they’re going to chip us. But no, I don’t think so. I have to think about the sake of my baby.”
**Jes:** So, for you, it would be more to protect your daughter, even though you would be the one to get the vaccine?

**Marta:** Well, of course, it is for my health, too. But when I think about the vaccine, when it comes to getting vaccinated, I think about her first.

Similarly, when I asked Ivette whether she would get the vaccine, she told me,

Yes. To take care of them [my two children]. It would be more of vaccine for them. They say that the first one [shot], those who have gotten it—residents and citizens—is rough, but it would be better to prevent the virus because even if it hits you, it would be much less severe. As a precaution, [the vaccine] would be everything.

Other women felt that vaccination was not such a big deal: They had received many vaccines throughout their lives, including the flu shot, and trusted the science. This also may reflect differences in policies surrounding vaccination in Latin America relative to the U.S. An analysis of vaccination legislation for forty-four countries Latin America and the Caribbean found that 96 percent mandated immunization (Trumbo et al. 2013). By contrast, although earlier in history compulsory vaccination constituted a staple of public health programming, these mandates have steadily eroded since the 1990s as individuals centered their freedoms to exemption from mandates (Salmon et al. 2006). States with more permissive exemption laws experience higher rates of infectious diseases, like pertussis (whooping cough) and measles (Bradford and Mandich 2015).

Célia and Ysabel shared similar thoughts on vaccination, believing concerns had been largely overblown.

“Many people area already doing it,” Célia said. “The time will come when I will be vaccinated, especially for the children. At school, they will require it. For now, they do not, but they will. I don’t think there are concerns. I mean, it’s really something that they
did that [developed the vaccine] so fast, but I have hope and faith in God that everything is fine.”

Ysabel echoed this sentiment.

You have to believe in science. I imagine when the flu thing [pandemic] happened, many people were in the same situation but they proved that it worked. I mean, it can help us. It’s the way to get out of this situation because we’ve been in it for a year already. So there may be some not-so-good side effects, but it might make the difference to change the situation.

Other women expressed doubts, adhering to the ‘myths’ to which Marta referred.

When I asked Jackelín if she would take the vaccine, she told me.

Well, I don’t know anymore. Because, sometimes I think that, how can I really know if it’s truly for coronavirus. Because… sometimes in the news, they say that there are so many negative [side effects]. Who can guarantee, or how can I tell if it’s true, that that’s what it’s for? Now that older people are getting it, some have gotten terrible fevers for three or four days and it makes me think, if the vaccine is supposed to take care of them, then why does it have to give you a fever?

Jackelin’s skepticism centered on the vaccine side effects and doubts as to whether the vaccine could truly protect against the coronavirus. Reports document that throughout Latin America—including Mexico, Colombia, Peru, Brazil, and Panama—citizens received vaccine knockoffs and counterfeits that, though likely harmless, offered no immunity against the virus (Shane Sullivan 2021; BBC News 2021). Delia, a 29-year-old from the Dominican Republic describes her own fears of the vaccine, which stem from experiences of peers in her home country.

“They’re all very scared,” she says of her family in the DR. “There, they don’t know if the vaccine you receive is the original. So, they’re scared not to get the vaccine and they’re scared to get it, as well.”
Careful probing into the thoughts and observations that inform women’s decisions regarding vaccination reveal thoughtful calculations of risk, uncertainty, and benefit. Women’s personal experiences, varying by home country or territory, time in the U.S., and media consumption—inform their opinions, revealing knowledgeable, ‘rational’ processes of deriving conclusions. Varying attitudes on vaccination thereby reflect women’s situations and intersubjective realities.

**Conclusion**

On one of his community tours for medical students, community leader Lee Cruz uses the metaphor of seagulls to impart a lesson to deconstruct hierarchies of knowledge. Walking on the river side of Criscuolo Park, a park that sits at the merger of the Quinnipiac and Mill Rivers, Lee calls attention of the tour-goers to the “white stuff” along the path. On a closer look, the “white stuff” takes the shape of seashell fragments.

“Now, how did they get there?” Lee asks, tilting his straw hat up.

“Seagulls,” a student answers tentatively.

“That’s right, seagulls. The seagulls have learned that if they drop their clams on this black stuff—the pavement—the shells will break. Now, people consider seagulls to be dumb animals, but they figured this out on their own and it helps them survive. The point is, just like we have our prejudices about what we believe intelligence is… we also have prejudices against each other, in terms of other people’s culture. ‘We know better than those people.’”

Lee then tells a story about when he worked in Nicaragua for twelve years and how the assumptions of public health interventionists and researchers caused them to
miss their targets by failing to truly pay attention and listen to the members of the community. In one example, attempts to prevent infant deaths to diarrheal diseases did not account for the local ecologies of caregiving and material access. The teams taught women to mix oral rehydration packets with water, overlooking the reality that these women worked while their young daughters cared for the babies and that water was not reliably clean. When they paid closer attention, and listened to community members, they focused their efforts on these young daughters and local bodega owners, who could sell these girls sanitary, bottled, carbonated beverages in which to mix the rehydration packets.

So again, this all started with the seagulls and dropping the shells, but all of this is part of a spectrum of “intelligence,” a spectrum of viewing the world, a spectrum of looking at the people that you’re going to be serving as not only people to be served, but as people with understanding of their own reality, of their own history, of their own culture. And when you do that, there will be times when what you know is better. That will actually be true most of the time. But if you make the assumption that because you know better, you will make things be better, then you are always going to lose. If you make the assumption that there’s someone here that has value to be respected, and you listen to them and try to understand them where they’re at, then when the right time comes and you have to say, “you should take this into account,” or “here’s a different way to do that,” there’ll be more of an openness to that. And that is a lesson that you’ll either trust me, or you’re going to learn it the hard way. And that can be here, it can be in a developing country, or it could be in Beverly Hills.

Ethnographers, just as much as clinical scientists, bear responsibility for thinking we “know better” than our interlocutors. This stems from the imperialist origins of anthropology. However, as Lee points out, this attitude of superiority, whether conscious or unconscious, impedes our ability to realize change in health outcomes.

On the issues of COVID-19 disparities and vaccine ‘hesitancy,’ many scholars and public health officials blamed genetics and unwillingness to participate in public health action to explain the high rates of morbidity and mortality from the virus and low rates of vaccination. Listening to the people most impacted reveals a different story:
Although few women in my study believed that Latinas were more susceptible to COVID-19 due to genetics or behavior, many others noted increased risks of exposure from working in high-contact settings outside the home and lacking the benefits of work-from-home flexibility, unemployment support, or economic stimulus checks. When I probed about willingness to receive the COVID-19 vaccine, women conveyed valid concerns based on the knowledge and information to which they had access. Those who wanted the vaccine simply did not know how to get it. This conflict between authoritative characterizations of two public health challenges and local, embodied renderings emphasizes the need, as Lee would say, to abandon our assumptions and attitudes of superiority to humble ourselves and to listen.

In this chapter, I described the impact of COVID-19 on the Latinx community, particularly undocumented migrant mothers. I discussed the embodied effects of the virus, as illness, grief, and anxiety. I examine ‘rational’ and ‘irrational’ ideas regarding racialized inequities in COVID-19, disrupting European-imposed hierarchies of knowledge. Extending this framing, I addressed issues of “vaccine hesitancy” and uptake, noting the unsuitability of the former term.
Chapter 9: Latina Reproductive Health and "Bureaucratic Disentitlement"

It is 8:08am, just about time for the morning “huddle,” when the providers, nurses, and medical assistants gather to review announcements and assignments for the day. Linda, a nurse and patient services manager who effectively manages the clinic, extends her ID badge and pings the door open. Her face is worn; her pale eyes—decorated with blue eyeshadow and eyeliner—hang heavy in her skull. As she chats with staff, her mood lightens. They discuss each other’s children and ask if anyone has news on a staff member who had called in sick. At that point, the head nurse Renee reads out the day’s assignments, or in which rooms the providers, medical assistants, and patient care attendants will work and with whom they’ll be paired.

The building is drab and worn. A gray facade with blue lettering announces its status as a primary care facility. Inside, it feels like a basement. Apart from the opening lobby, where patients funnel themselves toward pediatrics, adult medicine, or OB/Gyn, no windows brighten the building. I often entered the clinic from the medical school, passing through breezeways and descending shadowy staircases until I arrived at the Women’s Center.

At the time I worked there, all but two of the providers—including MDs, CNMs, and PAs—were White; the two people of color were South Asian. All the nurses were also White. The medical assistants (also called ambulatory care associates, or ACAs) and PCAs were all women of color—except for one White student from the University of Connecticut who filled in over the December to January holidays. The patients were nearly all women of color: In the several weeks I spent conducting fieldwork at the
Women’s Center prior to the COVID-19 pandemic, I encountered just two White women seeking care.

This racial dynamic of medical hierarchy—with White providers and nurses at the top and Black and Brown patients at the bottom—mirrors that of the “Alpha Clinic” in New York City, studied by anthropologist Khiara Bridges. Her description of the players at Alpha describes the dynamic of the Women’s Center exactly. She identifies an ancillary staff, composed primarily of first-generation immigrants of color, whose distrust and dislike of the patients they serve cause them to echo the arguments made by conservative pundits in favor of dismantling the existing welfare state; well-trained, elite physicians struggling to provide the most technologically sophisticated health care to society’s most destitute and most marginalized; patients, predominately poor persons of color, who are both the victims and the beneficiaries of Alpha’s underfunded, overburdened nature, struggling to receive that most technologically sophisticated health care; the thinly controlled chaos that threatens to burst forth—and, occasionally, does indeed do so—despite the best efforts of the staff, physicians, and administrators to prevent it (Bridges 2011, 21).

In this chapter, I examine care ‘kinetics’—the movements and orchestrations interplaying between patients and staff—at the Women’s Center. I discuss issues of racialization of Latina reproduction, challenging perceptions of migrant mothers as hyperfertile or “obstetrically hardy” birthers. I discuss challenges with pregnancy planning and birth control, broadening these observations beyond Latina women to emphasize their commonness across raced and classed strata of American women. I further discuss gaps in the healthcare system—and attempts to fill them—alongside experiences of “bureaucratic disentitlement,” which medical anthropologist Heide Castañeda defines as “the insidious process by which administrative agencies deprive individuals of their statutory entitlements and infringe on their constitutional rights” (2019, 3).
**Racialization of Latina birth**

In his book *The Latino Threat*, anthropologist Leo Chavez dedicates two chapters to characterizing the perceived demographic threat of Latina fertility and contrasting this with the reproductive realities of this group. Chavez argues that “race, immigration, and fertility have formed a fearsome trinity for much of U.S. history” (2013, 74). Sociologist and legal scholar Dorothy Roberts notes, in tracing the genesis of the reproductive justice movement, efforts to expand birth control served the eugenicist mission of curbing unwanted reproduction. In the early twentieth century, White Americans feared a “race suicide” due to perceptions of immigrant reproduction outpacing that of Anglo-Saxons (Roberts 1999, 99). Charles Davenport, a biologist and eugenicist influenced by social Darwinist Francis Galton, promoted restrictive immigration policies and selective marriages to ‘breed out’ the undesirable traits of newer immigrants, including Italians and Jews (Roberts 1999). Later, Chavez points out, declining fertility among U.S. born women coincided with changes in the demographic composition of U.S. immigrants following the Hart-Cellar Act of 1965 (2013, 74). Fears that ‘unworthy’ immigrant women would out-procreate ‘pure’ White women justified sterilization campaigns, reductions in social support for immigrants, and demonization of Black and Brown mothers.

Medical anthropologists Faye Ginsburg and Rayna Rapp advance the concept of “stratified reproduction,” originally proposed by Shellee Cohen to describe the way “some categories of people are empowered to nurture and reproduce, while others are disempowered… the arrangements by which some reproductive futures are valued while others are despised” (Ginsburg and Rapp 1995, 3). The state targets women’s bodies for
the purpose of producing “normative families” and building an “exclusive national collectivity” (Chavez 2013, 76; Gurr 2015, 32). Migrant women—whether Latin American, Middle Eastern, or African—as ‘foreigners’ racialized as non-White thereby threaten the implicitly “White” U.S. nation (Bridges 2011, 346).

These politics inform biases against Black and Brown women. At the clinic, I overheard providers making comments along the lines of “What’s the point in talking to them [Latinas] about birth control? They’re just going to be back here in a year,” suggesting that Latin American migrant women are ignorant of their bodies and irresponsible. I also heard one provider repeatedly speak of recipients of the privately funded “Me and My Baby” program—mostly undocumented immigrants—as “ungrateful,” mimicking racist tropes of Black and Brown women as undeserving and exploitative ‘welfare queens.’ Khiara Bridges concludes that “excessive medicalization” produces women, particularly poor women of color, as “possessors of ‘unruly bodies’… with the poor being treated as biological dangers within the body politic” (2011, 41).

In 2018, the year that the foreign-born population in the U.S. reached its peak, more immigrant women (7.5 percent) gave birth than U.S.-born women (5.7%) (Budiman 2020). In 2019, the fertility rate for Latina women was 1.94 whereas the rate for White women was 1.61 (Statista Research Department 2021). However, most American women desire between two and three children, with a growing number promoting “as many as you want,” suggesting that current fertility rates fall short of ideals (Stone 2018). In my study, 65 percent of women expressly wished for fewer than three children; those who had more often experienced reproductive coercion due to their inability to access birth control or abusive partners. Given that Latina reproduction rates more closely align with
expressed ideals, Chavez proposes considering White reproduction “abnormally low” rather than criticizing the supposed “hyperfertility” of Latina women (2013, 104).

Women deliberate thoughtfully over their desired family size and timing, considering familial goals and dynamics, gender balance, finances, and the potential to legitimate “strategic” relationships. Several women planned for tubal ligations or placement of intrauterine devices (IUDs) like the Mirena after birth. These findings echo those of medical anthropologist Alyshia Gálvez’s study of Mexican women in New York and social scientist Jennifer S. Hirsch’s work with Mexican immigrants in Atlanta, Georgia (Gálvez 2011; Hirsch 2003).

Just over forty percent of my interlocutors shared that their pregnancies had not been planned, a prevalence below the national average of 45 percent (Finer and Zolna 2016). Many referenced issues accessing, maintaining, and tolerating birth control.

Jackelín explains,

At first, this wasn’t in the plans. Because I’d had a previous C-section, I knew I would be at higher risk. After having my girls, I was no longer taking care of myself [using birth control]. I had gotten the injection before but it made me feel awful. I didn’t like it. My bones would hurt, my feet, too. It felt like one bone would separate from the other… So I got the one one you put in your arm [the implant]. I still don’t know why they gave that to me. It would move and it felt like having a needle in my hand. It felt like it would move at night and everything, and it hurt. I made an appointment to have it removed. They told me that everything was fine, that nothing was wrong, and that they didn’t have to remove it. I think I let another year pass and it still hurt and felt uncomfortable. So I decided not to keep it. I do try to be careful, but in this case, we didn’t take good enough care of ourselves. But I say anyway, he is a baby, he is a human being, he cannot determine his life and he must come to live in this world.

Jackelín calculated her risks with a future pregnancy, noting her susceptibility to complications like uterine rupture due to her prior C-sections. She tried to “take care of herself” by attempting multiple forms of contraception, but each provoked intolerable
side effects. Jackelín says that she and her husband still “try to be careful,” but she still got pregnant and believes it is the right of her future son to be brought into the world.

Women like Jackelín consider both the biological and social work of reproduction: Pregnancy is both a biological function that follows or rebels against attempts at control, while fulfilling social goals of supporting companionate marriage and strengthening familial love. These reflective and intentional approaches to family-building run directly counter to stereotypes of Latina women as ignorant, hyper fertile possessors of “unruly bodies” that undermine a White supremacist national collective.

The results of the 2020 Census revealed that, for the first time on record, the White population of the U.S. declined. At the same time, all population growth—an increase of roughly 23 million people—occurred among racially minoritized groups. Over the past decade, Latinxs accounted for half of the growth in the U.S. population (Tavernise and Gebeloff 2021). We are bound to see revival of racist tropes regarding the ‘threat’ Latina women—and other women of color—pose against essential ‘Americanness.’ Michael Rodríguez-Muñiz reminds us to consider the action of population politics: and the narratives of demographic change. Interpretations and projections of tabulated data achieve affective responses: Latinxs might view their “fast-growing” cohort as a sign of empowerment, whereas White people might consider the “shrinking” of their population an affront to their sense of selves and belonging. Rodríguez-Muñiz argues that these assessments “take for granted the existence of the ethnoracial populations they depict and frame the demographic future as more or less inevitable” (2021, 92). In other words, the forging and persistence of the racial categories
“Latinx” and “White” make these narratives possible and acts of forecasting imply teleology.

In the next section, I describe how Latin American migrant mothers become subjectivated as patients, attending to characterizations of deservingness and racialized judgments of reproductive capacity.

*Obstetrical hardiness and shared risk*

“Last Saturday, the pains started,” Célia told me. “In the morning, I went to the hospital, and they told me I was past my due date. They had already told me that if the pains did not start by Tuesday and they saw that I was not dilating, then they were going to induce labor. But then I started with pains on Saturday, and I went into the hospital, but there was no space for me yet.”

Célia relates the beginning of her traumatic birth story with calm resignation. With her older son, Alonso, she had undergone a C-section, and per her medical records, she had an “unknown” uterine scar, meaning she did not know—and her obstetricians in Ecuador had not documented—where her uterus had been cut to deliver her older son. Despite this, Célia consented to a trial of labor after Cesarean (TOLAC) three months prior to her delivery. In the morning Célia presented to the hospital, she had already begun bleeding.

“She was bleeding,” Marcelina, Célia’s sister-in-law, interjects.

“I had started bleeding. That’s why I went in. I was going to wait it out until the pains became stronger, but it was already too much. I went in that same day.”

Bleeding late in pregnancy raises concerns for several complications, including placenta previa (when the placenta partially or fully covers the mother’s cervix),
placental abruption (premature separation of the placenta from the uterine wall), vasa previa (when fetal blood vessels occur in the cervical opening), and most concerningly, uterine rupture (spontaneous tearing of the uterus). According to clinical guidelines:

In patients with vaginal bleeding and a previous cesarean birth or transmyometrial surgery, the possibility of uterine rupture should always be considered. It usually occurs during labor or as a result of abdominal trauma, but can rarely occur without an obvious precipitating cause. Abdominal pain, fetal heart rate abnormalities, and maternal hemodynamic instability due to intra-abdominal bleeding are likely and indicate an obstetric emergency (Norwitz and Shin Park 2021).

Despite these warning signs, the medical team at Yale-New Haven Hospital originally turned Célia away.

“They sent me back. They told me they would call me because there was still no bed at the hospital. They told me they would call that afternoon to try to check me in, but it wasn’t until Saturday night that they told me to come back.”

When she returned to the hospital, Célia received an infusion of pitocin, a synthetic form of the hormone oxytocin, to accelerate her labor.

“They began the induction on Saturday and from that night through the morning, the pains were very strong. In the morning, they gave me stuff for the pain. So, I had a lot of strong medicine in me, but I still could no longer bear the pain. I complained a lot and I told them I couldn’t take it anymore. The next step, they said, was to inject my back—the medicine they give you when you are going to have a C-section. It was only with that medicine that I was able to endure the pain.

“Then, around four in the afternoon, he [the baby, Gabriel] was still in there and he wasn’t coming. About four or six more hours passed, and it was now ten at night. It was time, but now many hours had passed, and I was not dilating normally.
“I tried pushing but now, the baby was not coming. There was no way for him to come down. And so, they realized this, but by that time it was too late. And the pains were so strong that I could no longer bear it. I was like, ‘I can’t take it anymore.’ I don’t remember very well but they were telling my husband that my pain could be because my wound was opening—or that’s what they were afraid of. I told them to please take care of it as soon as possible because the pain was very strong, and I had already pushed a lot but the baby was not coming down.

“So, they took me away to the operating room in about ten minutes. They gave me full anesthesia. And then they realized that it was the wound that had opened, which was why my belly had grown so much. That part became very difficult. I don’t know exactly what happened, but something was wrong with my uterus, I don’t quite remember what it was. But the operation was no longer a normal operation, a normal C-section. They had to reconstruct something, and it became much more tedious.”

Célia suffered a lateral extension of her original uterine incision, or a broad stretching of the scar that tore open her uterus. Not only this, but both of her uterine arteries, the major vessels that supply blood to the uterus, both ripped open. The obstetricians also noted that four centimeters of her uterus had thinned so much that her son could be seen through the tissue.

“I lost a lot of blood. It was not like a normal C-section… it was something else. It was because it was almost as if I had had like a double birth.”

Célia’s hematocrit—a measure of the volume percentage of red blood cells—dropped to a dangerously low level. She received two units of transfused blood.
“They injected me with a lot of things for the pain. I swelled up a lot—I was unrecognizable. The next day, after delivery, it was ugly. My entire body was swollen, from head to feet. My blood pressure went up. I got dizzy. They took a lot of blood out of me and then had to put blood back in me to be able to [recover].”

Multiple episodes of dizziness and severe fluctuations in blood pressure kept Célia under careful monitoring. The hospital eventually discharged her one week later.

Despite these harrowing events—including uterine rupture, postpartum hemorrhage, and postpartum pre-eclampsia—the attending physician described Célia’s C-section as “uncomplicated” in her discharge summary. This description, coupled with the possible medical blunders that occurred during Célia’s birth, raise issues regarding how Célia was subjectivated as a patient.

First, Célia was a “Women’s Center patient,” a label that patient care coordinator Dierdre notes is often assigned “in a derogatory tone.” In other words, Célia came from a safety net clinic and lacked insurance. This, coupled with her inability to speak English fluently, likely contributed to the delay in her admission for labor. Within the care model of the Women’s Center, as with many other ‘safety net’ prenatal clinics, patients see a variety of providers for their prenatal care, including midwives, physician assistants, and, rarely, obstetricians, and then give birth attended by whomever is on call at the time, usually a resident physician. Célia had no one who could advocate for her: When she called the hospital describing her early labor pains and bleeding, no dedicated provider could follow up and urge her admission. Célia lost precious hours, likely during which her lateral uterine excision extension worsened.
Second, at several points, providers underplayed and underreacted to Célia’s complaints of pain. Célia raised concerns of severe pain Saturday night and received no relief until the following morning. The American College of Obstetrics and Gynecology states that “maternal request is a sufficient medical indication for pain relief during labor,” yet Célia suffered hours of pain without relief (2019). Célia received butorphan, an opioid medication generally disfavored for labor pain given its lower effectiveness relative to neuraxial analgesia (i.e., epidural or spinal block) and associated risks of fetal heart rate and respiratory depression, and neurobehavioral changes in the newborn. Eventually, Célia received an epidural and her labor slowed.

Célia’s bleeding, severe pain, decrease in uterine tone, and history of prior C-section should have raised red flags for uterine rupture. Although it is impossible to know exactly how Célia set down the course of care she received, her experience raises concerns for racial biases in perceptions of pain and facility of childbirth.

A study of medical students and residents found that about 50 percent endorsed false beliefs about biological differences between Black and White patients, including that “Blacks’ nerve endings are less sensitive than whites’” and that “Blacks’ skin is thicker than whites;” those trainees who endorsed more false beliefs rated Black patients as feeling less pain than White patients and offered less accurate treatment recommendations in mock medical cases (Hoffman et al. 2016). Such racialized beliefs about pain sensitivity are evidenced in the lower likelihood of Black and Brown patients receiving adequate pain management. Patients of color, across care settings, consistently receive lower quality pain care and are less likely to receive opioid prescriptions for severe pain (Anderson, Green, and Payne 2009; C. R. Green et al. 2003; Pletcher et al.
2008). Specifically, a study of Medicaid beneficiaries in Georgia found that Black and Latina women were significantly less likely to receive epidural anesthesia relative to White women (Rust et al. 2004).

These findings invoke the myth of “obstetrical hardiness,” described by historian John Hoberman as the belief that socially and politically disempowered women—including Black and Latina women—are relatively unaffected by the pains of labor and childbirth (2005). This belief reflects hierarchical beliefs of biologized race by which Black people in particular are considered “a more primitive human type that is biologically and psychologically different from civilized man” (Hoberman 2005, 87). Physicians throughout the twentieth century considered “primitive” women—code for phenotypically darker, racialized women—to have “easy labors” that did not require pain relief.

In her examination of professional Black women who gave birth prematurely, cultural anthropologist Dána-Ain-Davis traces obstetric racism, and the traumatic birth experiences it produces, to historical patterns of exploitation, experimentation, and violation of Black bodies throughout U.S. history. Invasive examinations, diagnostic lapses, and characterizations of obstetrical hardiness derive from viewing Black bodies—particularly the bodies of Black women—as “hardy” producers and reproducers within a slave economy (D.-A. Davis 2019).

I often heard providers at the women’s center speak about how “healthy” Latin American patients were and how they rarely needed epidural anesthesia. Anthropologist Khiara Bridges sums up this bias as it applies specifically to the Mexican women she studied:
the assumption that Mexican women will have easy labors could have the same consequence for them as assumptions about Black women’s immunity to pain: the denial of analgesia and anesthesia or delay in administering them, the insistence that women undergo vaginal deliveries when a C-section may be indicated, or the failure to take the precautions to prevent trauma and infection that the physician might take with other racialized patients (Bridges 2011, 265)

Finally, Célia was constituted within a system of biomedicine that views women, particularly poor women, as pathological: possessors, as Bridges notes, of “unruly bodies.” In their medical notes, Célia’s providers state that she “failed TOLAC” and “did not labor,” characterizing Célia’s body as uncooperative and negating her experience of labor pains lasting more than twenty-four hours. The reason for her C-section was listed as “the head of the baby was big and it never fit,” disregarding the truth of her uterine abruption and the concerning clues of vaginal bleeding and prolonged labor. The medical team attributes the emergency surgery to the anatomy of Célia and her baby, rather than to an expected complication of birth following prior C-section.

Bridges theorizes the flattening of Célia’s distinctive medical history and presentation into assumptions about “obstetrically hardy” poor women of color using the concept of “shared risk.” Calculations of risk requires boundary-making around a supposed “population,” a political act as sociologist Michael Rodríguez-Muñiz reminds us (2021). This fabrication elides individual particularities to produce a homogenous group. According to Bridges, “shared risk makes poor, pregnant, uninsured women into a coherent population… eras[ing] the vast diversity—of health states, of relationships to biomedical discourse, of desire for the medicalization of their bodies and pregnancies, etc.—within this sizable and dissimilar group of individuals” (2011, 314). As such, presuppositions of “health,” or implicit minimization of risk, for Latin American mothers may contribute to harmful and even-life threatening biases in care practice.
In the next section, I discuss the mechanisms by which many interlocutors receive care and how they come to be constructed as a cohesive ‘population.’ I review the requirements for qualification for financial assistance for prenatal and intrapartum care, summoning anthropologist Heide Castañeda’s concept of “bureaucratic disentitlement,” or the manner by which institutional “red tape” may interfere with women’s receipt of services for which they are eligible.

The Me and My Baby Program and bureaucratic disentitlement

“So I have a pretty unique position,” Dierdre1 from the Women’s Center tells me. “People call it a hybrid job. I am trained as a family nurse practitioner. I am certified as a nurse case manager. And primarily my role is case management for the obstetrical patients in the clinic. I’m also in charge of the Me and My Baby program, which is a program that provides prenatal care for uninsured women. And initially it started in 1988. It was predominantly the working poor Americans before Medicaid was expanded. And then now, over time, it has evolved. It's become mostly a program for the undocumented.”

Dierdre then launched into a history of the Me and My Baby program.

The program was initially a grant that was provided for the Department of Public Health in the late 80s. The infant mortality rate was really high in New Haven and in Connecticut. And New Haven had really been ahead of the curve: They already had a consortium that works on it where all the providers in New Haven who normally were in competition sat at the same table and said, you know, ‘we have a problem here.’ So, when the RFP [Request for Proposals] came out, the consortium sat down and said, “okay, who's going to apply?” There were going to be seven sites throughout Connecticut.

1 A pseudonym. As with my interlocutors, the clinic staff interviewed here are described without their real names to protect confidentiality.
At the table, you had Planned Parenthood, Fair Haven [Community Health Center], the Hill Health Center [both federally qualified health centers in New Haven], housing...

And at the time, Yale didn’t own St. Raphael’s [a community hospital that Yale has since purchased]. They were two separate, competitive hospitals. So, the decision was made that St. Raphael’s would apply for one ant Yale-New Haven would apply for another. St. Raphael’s created the “MotherCare” van, which was a van that went around looking for women who were pregnant, trying to engage them in care, maybe doing some initial prenatal work but ultimately referring the patient to wherever she wanted to get care. It was decided that Yale would do more of the care because of our ability to have maternal-fetal medicine for patients with high-risk conditions. So, we set up the prenatal care program, and the MotherCare van would refer uninsured patients to us.

Our program was very big at the time. It was mostly the working poor… it was women who had to string together a bunch of part-time jobs, but none of them offered benefits. So that put them over the income limit for Medicaid, but they did not have insurance. Now, at that time, we had transportation, we had outreach workers, we had a part-time patient educator, we had a transportation coordinator and we paid for transportation, we had some social work and other free services. We had a lot. So, as things go, we were funded for three years and then we were re-funded for three more years. And at the end of that, the state said, “well you’re all doing a great job, it’s over.” And the other six sites closed down their programs. I’m proud that Yale made the decision to continue running the program, which costs about one million, two million [dollars] per year.

Dierdre then tells me how each year, the hospital pared down services. Now, the program covers prenatal care, including for high-risk mothers, prescriptions relating to pregnancy, and one postpartum visit. Women who earn up to 250 percent of the federal poverty level may qualify. The program does not cover contraception as the grant that previously provided this service expired and was not renewed.

Based on this description, the program seems like a godsend, a true blessing for uninsured women, particularly those who are undocumented. However, on closer examination, several concerning gaps emerge.

**Jes:** So, a question about contraception. If a woman wants to have an IUD placed, like if she has a C-section and wants to get her IUD while she’s in the hospital for her birth, it won’t be covered?

**Dierdre:** It will not in this state. Maybe a year and a half ago, the state finally started paying for immediate postpartum contraception for women on Medicaid. But they were very clear to say that patients who were receiving emergency Medicaid for their hospital...
stays would not be covered. We did have a grant for ten years for LARCs [long-acting reversible contraception], but it ended.

In other words, women in the Me and My Baby program or those who receive emergency Medicaid for their births, including many undocumented and “liminally legal” women like Joyce, a Jamaican immigrant and DACA recipient. Uninsured women thereby do not have the option to receive contraceptive support, preventing any unintended pregnancy.

“The decision was made that we can’t just, you know, cover thousands of women forever,” Dierdre explains. “We’re giving them a significant amount of care. And there has to be a cut-off at some point. ‘Cause if you gave someone an IUD or gave them depo (Depo-Provera, a hormonal contraceptive injection) and they wanted it again, you know, it’d be a lot—I have a few hundred patients a year on the program.”

Dierdre describes the failure to provide postpartum contraceptive care to women in the Me and My Baby program as a “cut-off,” admitting that while women deserve care for their pregnancies and births, their broader reproductive care and family planning fell beyond their scope. This attitude has two effects. First, it centers the child, rather than the mother, as the actual beneficiary of free care. The moral imaginary of pregnancy conceives of the women as a vessel for reproductive labor, fulfilling social and political obligations, rather than as an embodied subject herself (Mullin 2005). As medical historian Barbara Duden describes, the biomedical paradigm holds pregnant women hostage to their fetuses, “disembodying” the woman and subjecting her to calculations of need by healthcare professionals (1993). Second, it reinforces racialized conceptions of Latina women as “hyperfertile and ignorant baby machines” as it deprives them of resources to control and plan their reproductive effort (Gálvez 2011).
The narrow focus of the program on the ‘pathology’ of pregnancy also restricts receipt of care. Elyse, the project coordinator for the Me and My Baby program, who processes applications and reviews bills for potential or enrolled patients, explains:

I usually get a spreadsheet or an invoice, I guess you could say, with a list of charges for each patient. And, literally, you have to go through each charge to make sure that the ultrasound, you know, is appropriate, and that it was done in the hospital or here in the clinic… If the patient was seen in the emergency room for something that’s not pregnancy-related or they had another doctor visit or a dentist appointment or something, I will deduct those charges from the invoice… When the patients are approved for the program, we make it clear that the program only covers some of their medications and some of their doctor’s visits, because if you have a chronic condition, that’s something the program would not pay for. It has to be pregnancy-related.

The program dissects the gravid uterus from the remainder of the woman’s body, rationing care that Elyse or Dierdre consider “pregnancy-related.” To test the limits of eligible services, I proposed a hypothetical to Elyse.

**Jes:** I’m just curious, because this can get a bit sticky: One could argue that if a woman has untreated dental caries, that could lead to inflammation and preterm birth. How do you make the determination of what is pregnancy-related versus what’s not?

**Elyse:** So, it’s very strict. It’s usually just your visits here in the Women’s Center or your visit at maternal-fetal medicine.

**Jes:** What about a woman who has gestational diabetes and then gets referred to the Diabetes Center [a specialized endocrinology clinic dedicated to management of complex diabetes]?

**Elyse:** Well, maternal-fetal medicine has a diabetes education nurse… those are covered.

**Jes:** But if a woman is really, really struggling to manage her gestational diabetes and dose her insulin, and she needs an endocrinologist or an APRN who specializes in endocrinology, what then?

**Elyse:** No, to my knowledge they wouldn’t go. All of the patients with diabetes are managed by the high-risk group at MFM [maternal-fetal medicine].

Despite the increasing tendency of biomedicine to compartmentalize and molecularize health, pregnancy occurs as part of a complex physiological process, integrating endocrine, cardiovascular, neurologic, and genitourinary systems. Attempts to dissociate pregnancy from this dynamic system through restrictive care provision places
women at risk for obstetric complications like preterm birth and babies born small—or large—for gestational age. The Me and My Baby program justifies women’s entitlement to care through their reproductive labor.

Although the qualification standards for Me and My Baby recipients seem generous at 250 percent of the federal poverty level, the actual process of applying deters many women from accessing this benefit. First, women must verify their employment to ensure that they fall within the designated income bracket. Many working women, particularly undocumented women paid in cash, are not able to provide pay stubs. The program accepts a letter from an employer; however, this essentially requires employers to admit to breaking the law. Under the Immigration Reform and Control Act of 1986, employers are prohibited from knowingly hiring or continuing to employ undocumented workers. Acknowledgment of cash payments—especially to workers without work authorization—may place employers at risk of legal penalty. Women may forgo admission to Me and My Baby to avoid risk of employment termination on requesting verification of wages.

Second, women must apply for and receive a denial from Medicaid, or HUSKY in Connecticut. The HUSKY application requires women to provide their full names, social security numbers, citizenship status, and home address. For undocumented women, this means disclosing their unlawful presence in the country and providing the state with a means to find them. Many women fear that alerting the state to their ‘illegality’ renders them at risk of deportation.

Finally, eligible women do not automatically receive referrals to the program. Although the community health centers in New Haven know about the program and often
send uninsured women to the Women’s Center, women who do not access routine healthcare or prenatal care may fall through the cracks. Several of my interlocutors shared that they had heard about the program through friends or family members, leaving an unknown contingent of women who lack such social capital vulnerable to inadequate prenatal care or medical debt.

These barriers exemplify “bureaucratic disentitlement,” or “the insidious process by which administrative agencies deprive individuals of their statutory entitlements and infringe on their constitutional rights” (Castañeda 2019, 3). Medical anthropologist Heide Castañeda adds, “In everyday practice it takes the form of withholding information, providing misinformation, isolating applicants, and requiring extraordinary amounts of documentation for simple administrative procedures. In doing so, it inhibits the transformation of statutory rights into tangible benefits” (2019, 3). Although undocumented women are entitled to prenatal care through Me and My Baby, omission of information regarding the program and documentation requirements that may endanger women’s employment or safety strip them of their rights.

This practice is also racialized. When Me and My Baby primarily served White women, “women who worked in Dunkin Donuts and Wal-Mart here and there,” as Dierdre says, the program was more robust—including transportation and social services—and intensively sought out eligible applicants. However, now that the population is predominantly Latina, these services have eroded. The program no longer covers routine women’s health care or contraception and excludes transportation support and social services. In the past few years since I have collaborated with the Women’s Center, the clinic also lost its social worker, who previously helped with housing and
food insecurity and mental health care, and its coordinator for Head Start, a health and educational promotion program for low-income families. Lydia, the Head Start coordinator, used to wait outside of the examination rooms of the initial prenatal visits for every patient presumed to qualify—nearly everyone at the Women’s Center. She would meet women and help them receive services for their children. Now, women must navigate the bureaucracies of early childhood support, transportation, rental assistance, and other services on their own.

Melinda, an advanced nurse practitioner who worked at the Women’s Center two-and-a-half days a week also notes that, even when these services existed, they rarely benefited Latin American migrant women.

“Their target population is White and Black women,” Melinda complains, with a tone of exasperation. “They have a big, wide support network. But when asked very directly, like, ‘what about our patients who don’t fit that category or don’t speak English’—because neither of them speaks any other language—they’ll say ‘we welcome anyone’ but how welcoming can it be?”

Ethics of deservingness of prenatal care center around the unborn child but also perception of the mother’s ability to produce a “positive future” (Ginsburg and Rapp 1995). As such, poor Brown women become less ‘deserving’ than poor White women, an attitude reflected in the progressive cuts and barriers to enrollment in the Me and My Baby program as the demographics of its eligible population shifted from predominantly working-class White women to undocumented Latin American women. The barriers for Latina mothers constitute bureaucratic disentitlement, which strips away women’s rights to services by imposing logistical hurdles.
Conclusion

This chapter centered on reproductive healthcare for Latin American migrant women and their experiences of racialization and bureaucratic disentitlement. I related the traumatic birth of Célia, highlighting the ways in which her suboptimal care illustrated her subjectivation as an undeserving, poor, “obstetrically hardy” Latina woman, despite the particularities of her medical history. I then reviewed the history of the Me and My Baby program, a financial assistance program privately operated by Yale-New Haven Hospital that provides free prenatal and intrapartum care to uninsured women who earn less than 2.5 times the federal poverty level. I examined the ways the disintegration of the program over time reflects racialized attitudes toward healthcare deservingness and how barriers to enrollment (e.g., strict documentation requirements, requirement to apply and be denied from state insurance) deprive women of their right to care. Within the moral framework of healthcare deservingness, I emphasized prioritization of the fetus and the “disembodiment” of the uterus, noting how rigid restrictions on eligible healthcare services treat women as obstetric vessels rather than whole people.

In the next chapter, I discuss opportunities for policy advocacy, focusing on the social and political needs of migrant mothers.
Chapter 10: Policies to Move Onward

“You’re pretty for a Black girl.”

“You’re so articulate.”

“I thought you people like watermelon.”

“I’ve been so nice to your kind.”

“You Black [n-word] bitch.”

These comments punctuate the memories of Joyce Williams, a 33-year-old Jamaican immigrant living here in New Haven County. Words carry weight, but the textbooks from which they’re taught—of White supremacy as mass incarceration, redlining, and restrictive immigration policies—take lives.

Joyce’s brother Lloyd struggled growing up. Their father was always working, and their mother was back in Jamaica, so it was easy to get in trouble. He was handcuffed for the first time when he was nine. Then again at eleven. Then again and again until he dropped dead of a heart attack at age twenty-eight.

I cannot say for sure that racism killed Lloyd Williams. But racism does kill. Racism is linked to increased death rates due to cardiovascular disease, cancer, and more. It contributes to chronic stress that affects not only physical health but also mental health. Racism may also cause premature aging.

These adverse health effects also show up when racist immigration policies meet the healthcare system. Joyce has DACA and thereby cannot receive HUSKY. Currently pregnant, she relies on free care through Yale-New Haven Hospital for her prenatal health. Despite financial challenges, she worries that accepting WIC will affect her ability to obtain a green card.
So, what can the City of New Haven do to protect people like Joyce and Lloyd Williams, may he rest in peace?

First, we need to decriminalize petty crimes like drug use, sex work, loitering, sleeping in public, and minor traffic violations. We can look to our neighbor Massachusetts for their example of the Decriminalization of Misdemeanors Law.

Second, we need to increase investment in building healthy communities by supporting equity in education, affordable housing, and equal opportunity in employment. New Haven has a rich history of this but there is more to be done.

Third, we need to expand healthcare to all, including members of our undocumented community who have been systematically excluded from protections due to racist immigration policies. We can follow the example of New York City, which offers free care to all undocumented individuals at public hospitals.

As an MD/PhD Candidate in Medical Anthropology at Yale University, I am glad that we all agree that racism is a public health issue. With this knowledge, we must move forward together to build a healthier and safer city.

With permission and edits from Joyce (called Nikki elsewhere in this ethnography), I shared this testimony at the New Haven Board of Alders public hearing on racism as a public health issue in October 2020. I excerpted the experiences in Joyce’s life that most related to interpersonal and structural racism, including the untimely death of her younger brother. In that hearing, I listened to other residents protest food desert conditions in West River and West Rock and the high prices at Stop and Shop, mourn the loved ones who had died of COVID-19 after contracting the virus at their warehousing or
food service jobs, and decry the alders for just now acknowledging the health harms of racism.

Following the public hearing and further deliberation from the working group, the alders presented ten recommendations to the Health and Human Services committee, including revamping the city’s affirmative action program, expanding COVID-19 testing and vaccination outreach to communities of color, supporting state legislation for healthcare access for Black and Brown communities, expanding mental health outreach and trauma-informed care services, increasing economic development in Black and Brown neighborhoods and advocating for expansion of cash assistance, increasing affordable housing, strengthening accountability for racist policing, guaranteeing healthy food for all children and advocating for more robust food assistance programs, and supporting free public transportation for all residents (Brackeen et al. 2021). Many of these issues directly parallel the concerns and hopes raised by my interlocutors.

By studying trauma and structural vulnerability among migrant mothers, I knew I would inevitably run up against policy issues, particularly amid the COVID pandemic. In this chapter, I discuss the policy needs of the Latin American migrant community—particularly migrant mothers—and advocacy work emerging from this project, focusing on healthcare access, protection against intimate partner violence, support with necessities like food and housing, and immigration reform.

**Migrants and erosion of the social safety net**

More than one in seven Connecticut residents, or approximately 520,000 people, are migrants, a number that has increased by 30 percent over the past two decades
Migrants compose 17.6 percent of the Connecticut labor force and are numerous in the state’s healthcare, manufacturing, retail, and construction industries. In addition, one in four self-employed business owners in Connecticut is a migrant, responsible for over $1.8 billion in revenue. Collectively, immigrant households generate another $6.2 billion in state and local taxes (American Immigration Council 2020; New American Economy 2016). Despite these contributions, migrants remain excluded from several social programs, including food stamps (Supplemental Nutrition Assistance Program, SNAP) and cash assistance (Temporary Assistance for Needy Families, TANF).

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricted access of immigrants to health insurance, nutritional support, and cash assistance. PRWORA increased the proportion of uninsured migrants (see Table below). The act laid out a vision for a “successful society,” that included promoting sexual abstinence outside of marriage, supporting two-parent households, and discouraging welfare dependence. Specifically, the act established “self-sufficiency” as a standard of immigration policy, calling for “aliens within the Nation's borders not [to] depend on public resources to meet their needs, but rather rely on their own capabilities and the resources of their families, their sponsors, and private organizations” (Kasich 1996). By doing so, these ‘aliens’ would become “self-reliant” and no longer “burden the public benefits system” (Kasich 1996). Under the policy, one study found that single migrant women with limited education experienced a 12-percentage point drop in coverage following passage of the act (Kaushal and Kaestner 2005). A large sector of eligible migrants avoided these programs due to fear and stigma. As such, participation in
state insurance programs decreased for permanent residents and refugees at a rate three
and seven times greater than that of U.S. citizens (Fix and Passel 2002).

### Noncitizen Benefit Eligibility under PRWORA

#### Qualified Immigrants arriving on or before August 22, 1996 (preenactment)

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<tr>
<th>Qualified Immigrants</th>
<th>SSI</th>
<th>Food Stamps</th>
<th>Medicaid</th>
<th>TANF</th>
<th>State/Local Public Benefits</th>
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<td>Exempted Groups</td>
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<tr>
<td>With 40 quarters of work</td>
<td>Eligible</td>
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<td>State option</td>
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<td>Military personnel and their families</td>
<td>Eligible</td>
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<tr>
<td>Refugees/Asylees</td>
<td>Eligible for first 7 years</td>
<td>Eligible</td>
<td>Eligible for first 7 years; state option afterward</td>
<td>Eligible for first 5 years; state option afterward</td>
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#### Qualified Immigrants arriving after August 22, 1996 (postenactment)

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<th>Food Stamps</th>
<th>Medicaid</th>
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<th>State/Local Public Benefits</th>
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<td>Exempted Groups</td>
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<tr>
<td>With 40 quarters of work</td>
<td>Barred for first 5 years; eligible afterward</td>
<td>Barred for first 5 years</td>
<td>Barred for first 5 years; state option afterward</td>
<td>Eligible</td>
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<tr>
<td>Military personnel and their families</td>
<td>Eligible</td>
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<tr>
<td>Refugees/Asylees</td>
<td>Eligible for first 7 years</td>
<td>Eligible for first 7 years</td>
<td>Eligible for first 7 years; state option afterward</td>
<td>Eligible for first 5 years; state option afterward</td>
<td>Eligible for first 5 years; state option afterward</td>
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#### Unqualified Immigrants

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<th>SSI</th>
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<th>Medicaid</th>
<th>TANF</th>
<th>State/Local Public Benefits</th>
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<tr>
<td>Qualified Immigrants</td>
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**Notes:**

1. **SSI** = Supplemental Security Income
2. **TANF** = Temporary Assistance for Needy Families
3. Qualified immigrants receiving SSI on August 22, 1996, are eligible. All qualified immigrants
The Trump administration further restricted social protections for migrants. “Zero tolerance” policies justifying family separation at the border, an expanded “public charge” rule to further penalize migrants receiving public benefits, xenophobic rhetoric, and efforts to require collection of social security numbers for COVID-19 vaccine recipients prevent migrants from receiving asylum, necessary benefits like Medicaid, food stamps, or housing support, or life-saving immunization (Dickerson 2018; Parmet 2019; Ellis 2020; Stolberg 2020). As need for these services increased during COVID-19, this racist presidential administration further shattered the social welfare system available to immigrants.

**Healthcare access**

The COVID-19 pandemic exposed deeply racist fault lines in the American healthcare system that render undocumented and documented migrants particularly vulnerable. Despite longstanding recognition of the value of migrants, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 increased border enforcement and restrictions on public assistance for new permanent residents and unauthorized immigrants (Cohn 2015). Together, these policies demonstrate that the U.S. values migrants as instruments in a capitalist regime yet excludes them from citizenship as racialized entities; anthropologist Jason De León thus describes migrants as “excluded subjects,” upon which sovereign powers inflict violence “while simultaneously neutralizing their ability to resist or protest” (De León 2015).
This reality manifests clearly in debates over healthcare. The Affordable Care Act expressly left out undocumented migrants. In a joint congressional session on September 9, 2009, then President Obama felt compelled to provide reassurance: “There are also those who claim that our reform effort will insure illegal immigrants. This, too, is false—the reforms I’m proposing would not apply to those who are here illegally.” This promise prompted Republican Rep. Joe Wilson to shout, “You lie!” (Jackson 2009).

French anthropologist Didier Fassin noted the following of the exchange: “The soft—and discriminatory—position of the House bill implied that those not entitled to public social protection would still benefit from insurance if they could afford it” (2012).

Healthcare providers, and the broader public, persistently view migrants as undeserving of free care, considering healthcare a privilege rather than a right (Vanthuyne et al. 2013). Some particularly fear provision of pregnancy care to undocumented women due to racist and xenophobic concerns about “anchor babies” and the enduring politics of *jus soli* (“right of soil”) and birthright citizenship (Vanthuyne et al. 2013; Chavez 2013). The stratified system of healthcare provision renders those who are uninsurable—particularly those who are undocumented or “liminally legal”—as high-risk ‘drains’ on the system. Medical anthropologist Khiara Bridges notes that the absence of universal healthcare pathologizes poor people.

The production of the poor, PCAP-insured/uninsured pregnant women as exceptionally pathological would not necessarily occur if the United States actualized a system of unbounded, unlimited, and universal health care. Within a system of nationalized medicine, there would be no need to imagine a segment of society as somehow being more “at risk” for certain lamentable outcomes (and, therefore, uniquely deserving of the suspension of the system of privatized medicine) before health care is provided for them; the state’s subsidization of their health care would be the expectation, not the deviation (Bridges 2011, 36).
When I probed about policy needs—or the extant gaps in the social welfare system—with migrant women, affordable healthcare surfaced as the most common concern. Almudena, a 34-year-old from Tlaxcala Mexico says:

Well, right now, in my case, the support I need is insurance, healthcare. I applied [for free care] because I had received bills to pay. The worker told me that they had accepted me into the program but that I did not technically have insurance. She said that every time I receive a bill, I have to take it to her so that she can take care of it. It’s very stressful. For example, I got a bill for $750. Imagine. That’s the amount we earn in a week. Can you imagine paying each time you arrive or each time you have a visit with the doctor? The support I would like would be to not have to worry about that.

Even though Almudena qualified for free care, a private, unadvertised program of financial assistance for healthcare for uninsured individuals, she constantly received high bills for the services she received. One bill alone amounted to her family’s entire weekly earnings. Receiving these bills caused Almudena a huge amount of stress and added work: To ensure these bills would not go to collections, she had to present in person to a Yale administrator to present the charges and, later, receive confirmation that they would be covered.

Seventeen of my interlocutors (26.2 percent) reported outstanding medical debt. Most of these debts resulted from emergency care received when no free or sliding scale clinic was open. Other debts reflected accumulations of outstanding costs from routine healthcare. Ascención, from Guatemala tells me,

Sometimes, when I go to the clinic, I cannot pay. The last time I took my child in, they told me I owed forty dollars. I told them, “I don’t have it.” I asked them, “Don’t you understand? It’s expensive for me to take off [from work] and to come and bring in my child. I have to pay for a taxi to get here. I don’t have money to pay these clinics anymore.

Such seemingly small payments add up. Ascención, who previously worked in a food cart, likely earning ten dollars an hour or less, would need to leave her job—and
potential earnings—to bring her sick child in for evaluation. The ten to twelve dollars for a taxi ride plus the forty dollars for the clinic visit, minus her hourly earnings, would leave her with a deficit amounting to a full day’s pay. Although undocumented migrants like Ascención can apply for emergency Medicaid for situations that require immediate medical attention and severely jeopardize health, this provision does not cover necessary preventive and primary care (Edward 2014).

High costs prompt many migrants to avoid routine healthcare. Particularly in areas with more restrictive healthcare and immigration enforcement policies, migrants and their children have been shown to be less likely to seek and obtain routine services, an effect sociologist Meredith Van Natta refers to as “medical-legal violence” (Graefe et al. 2019; Rhodes et al. 2014; Van Natta 2019). This pattern is particularly concerning for pregnant women, for whom delayed or absent prenatal care increases the risk of newborn death by 40 percent (J. Rosenberg 2002). Raquel, from Chile says,

Recently, we had a very large debt. We were already in for five thousand dollars. My husband was very stressed about it. But he filled out some papers and it took a long, long, long time. It actually delayed me from going to the clinic in my first four months of pregnancy. Just yesterday, I saw that our application [was approved] and the debts were zero.

Raquel delayed receiving prenatal care out of concern for the mountain of debt she and her husband had already accumulated at the hospital. She told me she worried that if she went to the clinic, and kept receiving bills, her application for free care might not be approved and they would never be able to pay off their outstanding balance. Raquel went without care for almost half of her pregnancy due to concerns for healthcare costs, a calculated decision that unfortunately endangered her and her unborn child.
At the time I completed my fieldwork, the “HUSKY 4 Immigrants” movement engaged in strong efforts to advocate for expansion of Medicaid to undocumented immigrants. In July 2020, I collaborated with directors of the student-run HAVEN Free Clinic to generate letters and policy memos to key legislators—and the Connecticut governor—in support of this cause. We worked alongside the Mayor of New Haven, the city’s Health and Human Services director, and the Center for Children’s Advocacy to demonstrate the need for and interest in Medicaid expansion. In June 2021, State Senator Martin M. Looney, who represents New Haven, co-sponsored H.B. No. 6687, which proposed medical assistance to children and adults without health insurance. The amended version of the bill was signed into law on July 13, 2021 by Governor Ned Lamont, providing Medicaid coverage to children eight years old and younger and to pregnant women. The measure also called for development of plans to expand coverage to all children eighteen and under (Carlesso 2021). Presently, HUSKY 4 Immigrants has dedicated its efforts to expanding emergency Medicaid coverage to cover outpatient dialysis treatment, which traps dozens of uninsured individuals in hospitals throughout the state as these are the only sites at which they can receive life-saving renal replacement therapy (Rabe Thomas and Smith-Randolph 2021).

At present, most undocumented migrants in Connecticut remain without healthcare coverage, either rendering them susceptible to overwhelming medical debt or requiring them to overcome the bureaucratic disentitlement surrounding private charities like the Yale-New Haven free care and Me and My Baby programs. However, the state of California and New York City offer models for diversion of public funds to meet the health needs of the undocumented community. In July 2019, Governor Gavin Newsom
extended state Medicaid coverage to low-income, undocumented adults aged 25 and under (Allyn 2019). Similarly, local policy in New York City expands the MetroPlus Healthcare program, provided by the New York City hospital system, and invests 100 million dollars to ensure undocumented residents can access and receive necessary healthcare (Goodman 2019).

In the next section, I discuss the needs of migrant women for essential services like food, housing, and childcare supplies and the ways current social welfare policies intentionally fall short of meeting them.

**Essential services**

“I need both economic and emotional support,” Raquel tells me, her voice downcast. “If we could receive financial aid, it would be so welcome. It is very difficult when an immigrant arrives, and the situation is not the best [like during COVID-19]. I wouldn’t turn away that help. Emotionally, it would be so nice to be able to talk through things with someone… to not feel so invisible to society.”

Raquel and I spoke for over four hours together. I was the first person she had spoken to, other than her husband, in weeks. Isolation due to the pandemic, her immigration status, and her financial precarity prevented her from seeking out support or companionship. Nearly one-third of women in my study shared Raquel’s experience of social isolation, describing themselves as “alone” with limited social lives due to pandemic precautions and fear of exposure of their undocumented status. In addition to the psychological toll, this self-sequestration also removes women from sources of social and financial capital. Women with more robust social networks expressed greater
awareness of resources like Me and My Baby, food banks, diaper banks, and mutual aid funds that helped soften the blow of the COVID-19 pandemic. Those without felt they needed to handle things on their own, particularly mothering their newborns. Juana told me,

Everything is harder in this pandemic. Being a mother can be isolating enough when you don’t have the help of your family. But on top of that, when you’re not able to receive visitors, it’s harder. There is no one. I have to just learn to cope. Once my husband went back to work, I had to do everything on my own, with my baby. I could no longer ask anyone for help, like, “Oh, just put a blanket over her” or “check her diaper.” I have to do everything myself: Feed her, bathe her, change her diaper. I don’t have anyone to help me.

Juana and Raquel’s narratives elevate the importance of two policy interventions: to support behavioral health services and critical human services for migrants.

**Behavioral health services**

Social isolation and loneliness are associated with higher levels of depression, suicidality, psychoses, and personality disorders (Wang et al. 2017). Migrant women, who carry histories of trauma and confront social and economic disenfranchisement, experience increased risk for mental distress. Mental health care remains inaccessible to migrant communities, particularly undocumented communities, due to cost, availability, language, and educational barriers. Community health worker (CHW) or promotores de salud (PdS) programs, which have grown extensively over the past few decades, seek to mitigate these barriers by installing cultural brokers into high-need communities who can promote health and wellness among their peers (WestRasmus et al. 2012). CHW and PdS programs have demonstrated promise in improving health outcomes by increasing access to care, facilitating appropriate use of health resources, and providing health education
and screening (Witmer et al. 1995). States like Massachusetts and Minnesota have implemented CHW programs to overcome the challenges of healthcare shortages and diversifying populations (Citation). The success of these programs serves as models for more widespread implementation of CHW programs. To achieve this aim, such programs require sustainable financing, especially through services like Medicaid and the Children’s Health Insurance Program (CHIP), investment in workforce development, standards for training and certification, and guidelines for health impact evaluations.

The psychoeducation program I described in the Preface at HAVEN Free Clinic adapted a behavioral health *promotor* program for use among Spanish-speaking migrants. A study of the program found a significant decrease in depression symptoms among participants and increased interest among student facilitators in working with underserved populations (Rodriguez Guzman et al. 2018). Expansion of this program throughout New Haven county could harness existing resources at the Hispanic Clinic of the Connecticut Mental Health Center and the Connecticut Latino Behavioral Health System to protect the mental health of migrants experiencing social isolation and grappling with the sequelae of traumatic experiences.

**Food, housing, and financial support**

“With the pandemic, there is no work. You cannot pay your rent, buy food.

“Noelia, a 40-year-old woman from Mexico, lamented. “There are many places that provide help, like food pantries, but it’s not enough to survive.”

In Connecticut, residents can call 2-1-1 or visit 211ct.org to access critical human services. This is a common refrain among healthcare providers and non-profit workers throughout the state: “Just call 2-1-1.” However, many services and programs are not
accessible to undocumented migrants. Above all, my interlocutors expressed needs for food, housing security, and financial support. The corresponding programs—SNAP, Section 8, and TANF—do not cover undocumented migrants.

At the start of COVID-19, as a medical student and researcher barred from the clinic, I joined ContraCOVID, a healthcare navigation resource that provides educational and social service resources in multiple languages for migrant communities. As the Connecticut liaison, I pooled information on food, cash assistance, employment support, and COVID-19 testing services from a hodgepodge of sources, including the state government, local Facebook groups, immigrant rights organizations, and mutual aid networks. I learned that the resources available to migrants were sparse, fragmented, grassroots-developed, and temporary.

The devastation of COVID-19 adds pressure to reform policies that cast migrants as excluded subjects. In the absence of comprehensive immigration reform that provides pathways to legal status and possible citizenship for undocumented individuals, partial responses include improving wages and workplace conditions for undocumented workers, providing tuition support for higher education for undocumented youth, compensating communities that provide social services to migrants, and expanding rental assistance to migrant communities (Vazquez 2019; U.S. Department of Education 2015; Yoshikawa and Kholoptseva 2013). Broader improvements would reverse many of the restrictions imposed by PRWORA to allow migrants to access socioeconomically empowering services.
Intimate partner violence

Latina mothers confront specific vulnerabilities to intimate partner violence given barriers to escape from abusive relationships, including limited financial resources, inability to speak English, social isolation, and risks of deportation through exposure of undocumented status (Hass, Dutton, and Orloff 2000). Although prevalence of varied forms of violence may not occur more commonly among Latina migrants, research suggests that Latina migrants are significantly more likely to be killed by their partners (Runner, Yoshihama, and Novick 2009). A study of intimate partner violence in New York City found that 51 percent of intimate partner homicide victims were foreign-born (Futures without Violence 2021). As I previously noted, experiences of intimate partner violence and other forms of gender-based violence were particularly high among my interlocutors, highlighting opportunities for preventive policy reform.

PRWORA and the Illegal Immigration Reform and Immigration Responsibility Acts of 1996 (IIRIRA) exacerbated risk of intimate partner violence for migrant women by restricting access to benefits and imposing harsh penalties for undocumented residents. To receive exemption from these restrictions, women must demonstrate experiences of battering or “extreme cruelty,” per U.S. immigration laws. Similarly, provisions in the 1994 Violence Against Women Act for migrant women require evidence of physical or mental injuries, or threats to that effect. Broader patterns of psychological abuse translating to dominance and isolation may not fit criteria and remain difficult to prove before judges (Hass, Dutton, and Orloff 2000). As such, healthcare providers, community workers, lawyers, and judges should be trained to recognize abusive behavior that can lead to battering or homicide to advocate for women
trapped in controlling relationships and support their need for legal restitution, independence, and lawful residence. Screening should be universal at all sites of service provision, including healthcare and private charity (e.g., food and diaper banks), and effective tools should probe for more insidious forms of abuse like intimidation and coercive control (Rabin et al. 2009).

**Immigration policy**

Genuinely exhaustive remedies to the intense structural vulnerability encountered by migrant women requires reform to U.S. immigration policy. As I discussed in Chapter 10, pathways to legal residence are extremely limited and require accumulation of social and financial capital, along with some luck and patience.

“Comprehensive immigration reform,” a phrase that has circulated in U.S. political circles since the early 2000s and became a thoughtful point of debate during the 2020 elections. Former Secretary of Housing and Urban Development, Julián Castro, made headlines in 2019 when he proposed a repeal of Section 1325 of Title 8 of U.S. Code that criminalizes unlawful entry into the U.S. (Lind 2019). This spurred further debate among Democratic candidates, who also argued over whether to expand public healthcare to undocumented migrants, abolish or disband ICE, provide expanded services to migrant communities, and the timelines and requirements for legalizing undocumented migrants already present in the country (Mehta and Gomez 2019).

The Migration Policy Institute (MPI) highlights groups of undocumented migrants with “strong equities” for legalization, particularly amid the COVID-19 pandemic. These groups include DACA recipients and DREAMers, recipients of TPS, “essential workers,” farmworkers, migrants receiving family- or employment-based
sponsorship, and parents of U.S. citizens and permanent residents. The MPI encourages a broad legalization program for migrants present for three years or longer, paralleling the allowances of the 1986 Immigration Reform and Control Act. Alternatively, updating the dates from the 1929 Registry Act, which allowed migrants to apply for permanent residence if they had abided by U.S. laws and resided in the U.S. for a set length of time. The MPI estimates that revising the registry date would render between 2.8 and 8.0 million people eligible for green cards (Bolter, Chishti, and Meissner 2021).

In addition, legislative solutions could expand mechanisms for lawful presence short of permanent residence, including expanding the current DACA, TPS, and work visa programs; under the Trump administration, an estimated 1.3 million people were not able to access the DACA program (Beitsch 2021). The MPI also proposes eliminating the three- and ten-year bars to re-entry from abroad for migrants receiving family or employer sponsorship, a policy that would benefit nearly 2 million people (Bolter, Chishti, and Meissner 2021).

My interlocutors specifically articulated interests in expanding work visas, providing thoughtful legal and social services to support acquisition of citizen rights, and investing in the economic development of their home countries. As Almudena suggested,

Maybe with a permit you can travel to where you want to go and then return, right? Why not give us permits for a while so we can make the decision to stay or go back? Why don’t our presidents work on the economy, on employment, on creating more jobs? Maybe by giving us more jobs, people wouldn’t need to migrate to other places to look for something better, right?

Upon his inauguration in 2021, President Biden proposed a legalization framework to Congress that would make anyone unlawfully present in the country as of January 1, 2021 eligible to apply for adjustment of status (Bolter, Chishti, and Meissner...
The $3.5 trillion budget package includes $107 billion for the Senate Judiciary Committee to spend on charting pathways to citizenship and investing in border security (Beitsch 2021). The wheels are in motion to significantly improve the legal condition of many undocumented migrants; however, we remain far from full realization of this ideal.

**Conclusion**

In this chapter, I discussed the policy implications of this dissertation research, focusing on healthcare access, behavioral health support, and provision of essential human services like food and financial assistance, services that remain unattainable for many migrants due to restrictions of immigration laws enacted during the 1990s. I also consider ways that ethnographic narratives can—and already have—inform legislative action toward health equity.

In his original conception of structural violence, Norwegian sociologist Johan Galtung (1969) notes,

> It is difficult to compare the amount of suffering and harm that has been caused by personal or structural violence; they are both of such an order of magnitude that comparisons appear meaningless. Moreover, they seem often to be coupled in such a way that it is very difficult to get rid of both evils… there is no reason to believe that the future will not bring us richer concepts and more forms of social action that combine absence of personal violence with fight against social injustice once sufficient activity is put into research and practice.

Medical anthropologists have detailed across multiple volumes the human toll of structural violence. Importantly, these narratives have power to shape policy. The goal is to leverage our cultural capital to amplify the voices of vulnerable communities to reform the policies that disproportionately harm them.

Models of applied or engaged anthropology encourage scholars to collaborate with communities to generate actionable data that informs systems change (L. J. Hardy
and Hulen 2016). Decolonial methods necessitate community engagement prior to and during data collection, as well as in processes of dissemination (L. T. Smith 2012). Anthropologists should receive training in decolonizing methodologies and policy advocacy to ensure that our theories and practices achieve actionable change. As scholar and activist Angela Davis says, “You have to act as if it possible to radically transform the world. And you have to do it all the time.”
Conclusion: Following the Monarchs

In front of Lee Cruz’s home on Clinton Street, a beautiful Victorian-style home with a green-painted wood exterior, a post stands, calling attention to the surrounding milkweed.

Figure 15: Monarch Waystation sign on Clinton Street in Fair Haven.

Lee and his sons, along with other organizers and managers of local community gardens, have taken an interest in supporting the endangered population of monarch
butterflies that pass through Connecticut each year. Lee calls the milkweed planted throughout the neighborhood a “picnic” for the butterflies. Connecticut exists in the northern roosting territories for monarch butterflies. Each fall, the monarchs leave for their overwintering grounds in southwestern Mexico and send their descendants back to Connecticut.

“First they’ll go to Texas,” Diane St. John, the manager of a New Haven County garden center, says. “The milkweed is already coming out there. They’ll stop and lay eggs; those butterflies will die but their babies will be born and fly farther north. The great-great-grandchildren, the fourth generation, will come [back] to Connecticut” (Beach 2020).

“The butterflies have been migrating for ten thousand years,” Lee says, his voice raised in wonder. It was not until the 1970s that scientists began to ask where the monarchs go. Through crowd sourcing of monarch watchers throughout North America, they mapped the migration paths of the butterflies, which had previously been a mystery. We had to listen, observe, and learn to understand their truth.

Like the monarchs, humans have migrated across the Americas for tens of thousands of years. The process, previously just simple movement in search of resources, has become increasingly dangerous with the establishment of nation-states, borders, and policies that criminalize those seeking new terrain. In this dissertation, I have attempted to narrate the experiences of women who migrated from Latin America to New Haven, Connecticut, telling the stories of their predecessors, sharing circulating ideas about the transmission of their suffering, describing the violence and coping they experience on migration, and their production of futures through their children. These women are like
the female monarchs: intrepid travelers, gatherers, and bearers of life. Their journeys and triumphs shape the worlds of the generations that follow them. Like the monarchs, these women rely on their children to preserve their histories, carry their legacies, and continue to *seguir adelante*. As Ocean Vuong says, “only the future revisits the past.”

Through person-centered ethnography and oral history, I listened, observed, and learned. These women are the ultimate, authoritative narrators of their lives. Here, I merely share what they have taught me and what I have come to understand.

In Fair Haven, the youth have an ongoing project tracking the monarchs. Children like Lee’s son, Mateo, wait until the monarchs settle on a milkweed plant and then tag their left wing with a number.

“We’re waiting one day for our numbers to show up,” Lee says. “That will show me that a butterfly born in our backyard actually made it to Mexico.”
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