

[PRESENTLY UNTITLED]

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Overview of the Manuscript

Like death and taxes, the denunciation of the fertility of poor black and Latina women seems certain. Indeed, one need not listen especially closely on any given day in order to hear someone condemn the reproduction of poor women of color. At present, all we need to do is to pay attention to the campaign for the 2016 Republican presidential nomination. Throughout the campaign, GOP presidential hopefuls Jeb Bush and Donald Trump have taken turns vilifying noncitizen women who would give birth to their children within the United States. They have told us that the procreation of noncitizen women is for the sole purpose of producing “anchor babies”—children whose birthright citizenship will not only enable their mothers to remain within the terrifyingly porous borders of the country, but will also enable these problematically fertile women to drain state coffers through their inevitable use and abuse of public resources.

The rhetoric about “anchor babies” is just the newest iteration of an old trope that understands the reproduction of poor women of color to be a social problem. In the 1980’s, then-President Ronald Reagan warned hardworking taxpayers that the money that they had rightfully earned was being used to finance the lavish lifestyle of implicitly black “welfare queens” all over the country. In the 1990s, then-President Clinton “ended welfare as we kn[e]w it” by helming the passage of the Personal Responsibility and Work Opportunity Reconciliation Act. The very title of this legislation insisted upon the “personal responsibility” of the implicitly black and Latina mothers who turn to the state for financial assistance—implying, of course, that these same mothers would be *irresponsible* in their personal lives in the absence of the law. And now, in the teenage years of the 2000s, we have the “crisis” of the “anchor baby.”

In essence, hegemonic discourses understand as deviant the procreation of poor black and Latina women. Instead of having children for all of the virtuous reasons why wealthier women are thought to elect to become mothers, poor women of color are imagined to reproduce for decidedly un-virtuous reasons. They become mothers because they have failed to exercise care—because they did not use contraception during their sexual encounters and have found themselves with an unintended pregnancy (for which the state ultimately must pay). Alternately, when poor women of color are imagined to become mothers *intentionally*, they are thought to do so for the sole purpose of making demands upon the state—in the form of citizenship or welfare assistance. Within extant political and cultural narratives, the fertility of poor women of color is either careless and accidental or pragmatic and exploitative. Either way, it is pathological.

In such a context, the reproduction of the *wealthier* black and Latina woman is intensely fraught. The class privilege enjoyed by the middle- and upper middle-class woman of color who desires motherhood allows her an exit from the discourses that would pathologize her fertility. However, while a person’s race tends to be conceptualized as difference one can see, socioeconomic status is not always a visible phenomenon. That is, class is not located in the economy of the visible in

the way that race is. Accordingly, a woman's class privilege is not something that is inevitably discernable on or in her skin. The result is that the pregnant body of the wealthier woman of color is one that ricochets between being censurable (when its class privilege is not detected) and being laudable (when the woman's economic self-sufficiency is detected and her body becomes understood within cultural and political discourses as one that "rightfully" reproduces).

And there remains the question of how much privilege the class privileged racial minority can actually access—even when her elevated socioeconomic status is detected or otherwise apprehended. Racial disparities in health are well known, and it is well documented that racial minorities, especially black people, are sicker and die earlier than white people *even when one controls for class*.¹ Thus, class privilege does not necessarily immunize racial minorities against the structures and processes that produce excess morbidity and mortality in people, communities, and populations without racial privilege. An ethnographic interrogation of this fact is long overdue.

[PRESENTLY UNTITLED BOOK] is an ethnography of the fraught reproduction of middle- and upper middle-class black and Latina women in the United States. The central preoccupation that motivates this study is the complex relationship between race and class. The proposed book interrogates how class privilege inflects upon, and alters, the experience of race in the United States. Many scholars of race recognize that class privilege saves racial minorities from some of the deleterious effects that the absence of race privilege would otherwise effect. The proposed book examines that intuition during the racially salient event of pregnancy—investigating whether, how, and to what extent class privilege changes the meanings that attach to the reproductive body of color.

Further, while the proposed book interrogates how class privilege impacts the experience of race in the United States, it simultaneously interrogates how race impacts the experience of class privilege. It is a mistake to believe that all those with private insurance have a common experience when navigating healthcare systems and receiving medical care. The proposed book investigates the racially-inflected heterogeneity within the fact of class privilege during the event of pregnancy.

Like my first book, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization*, the proposed ethnography is a description of race as it is remade, reaffirmed, reiterated, and reconsolidated on the bodies of pregnant women seeking prenatal care in the United States. Unlike my first book, the proposed project trains its focus on a group that is frequently overlooked in studies of race and racialization: those who are not poor.

While the proposed book builds upon a wide body of recent theoretical and empirical work in anthropology and critical studies of race and racialization, it is singular in the empirical data it will analyze. Beginning in May 2017, I will engage in twelve months of fieldwork research in an obstetrics clinic of a private hospital in [Boston] that accepts Medicaid insurance and, consequently, serves a wealthier clientele alongside low-income seekers of healthcare. Fieldwork will consist of daily participant-observation. Sites of participant-observation will include the

¹ Institute of Medicine, *Addressing Racial and Ethnic Health Care Disparities: Where Do We Go From Here?* (2005), available at http://www.iom.edu/Object.File/Master/33/249/BROCHURE_disparities.pdf.

clinic's waiting room, the front desk (where intake work is performed), and nurses' triage rooms (where patients are prepared for their medical examinations). Over time, I expect to be able to observe the examinations that women receive from their providers. I will also observe patients' consultations with other healthcare workers and professionals who work in and out of the obstetrics clinic. Further, I expect to create relationships with women who receive their care in private doctor's offices, and I intend to accompany them as they receive that care—allowing me access to medical spaces that will serve as a counterpoint to the primary site of the ethnography's fieldwork. Additionally, I will conduct several hundred hours of in-depth interviews with patients, providers, and staff during my year of fieldwork. Finally, I expect that my research will lead me outside of institution walls—to attend baby showers held in honor of the women who I meet during my fieldwork, to audit birthing classes offered by non-hospital-affiliated organizations, and to interview women inside of their homes or offices.

My location in spaces within which healthcare is dispensed will give me access to stories that have not frequently been told in the medical anthropology literature. The proposed book will tell those stories and use them to answer questions about race, class, and the complicated relationship between the two in the contemporary United States. The project's aspiration is to make critical theoretical interventions in several fields of intellectual inquiry and, simultaneously, to contribute an original ethnography that is substantial, innovative, conceptually sophisticated, and self-reflexive.

It is the premier goal that the book that emerges is accessible to the general public, yet also makes for engaging and provocative reading for both undergraduate and graduate classrooms. In addition to being timely and relevant to lay readers, it is a work of innovative and challenging research that contributes to the reconceptualization of paradigms among scholars in several areas of inquiry, including Anthropology, Sociology, "American" (U.S.) Studies, Critical Studies of Race and Racialization, Critical Studies of Science and Medicine, and Women and Gender Studies. My first book, *Reproducing Race*, has been used in introductory level sociology and anthropology courses as well as in courses such as Gender and Health Policy, Critical Race Theory, Dilemmas in Biomedical Ethics, Field Research/Ethnographic Methods, and Sexual Health and Reproductive Justice. I expect that [PRESENTLY UNTITLED BOOK] will find similar uses.

Significance and Contributions of the Study

The proposed book belongs to the literature composed of critical studies of race and racialization. It asks *how* race is socially constructed, by what processes, and to what effects. Further, it weds "race studies" to "science studies" by inquiring into how race threatens (or reinvigorates) the hegemony of biomedicine while simultaneously inquiring into how biomedicine threatens (or reinvigorates) race. Moreover, this project is unique inasmuch as it studies processes of racialization through examining the experiences of wealthier persons. Studies of marginalized subjects compose the majority of the literature that investigates race and racialization. This creates a gap in the literature and in our knowledge about race and racialization. This study endeavors to fill that gap and, in so doing, to answer questions about whether and how racialization processes are different for wealthier racial minorities and whether and how race *means* different things to and for racial minorities with class privilege.

Further, this study's interest in physicians, nurses, and hospital staff also represents a shift in focus away from marginalized subjects. In this respect, the proposed book contributes to a subject that is still fairly undertheorized and not frequently discussed within the medical anthropology that explores the relationship between race and medical disenfranchisement: physicians' and other healthcare providers' beliefs about race and racial difference. I will be well situated to contribute to this literature, as I will be privy to physicians and healthcare providers as they provide care to racial minorities and manage a highly racially-salient event, pregnancy. Importantly, I will take advantage of my location and ask physicians and healthcare providers questions about their personal understandings of race. The result is that I will be able to derive insights that might help to explain racial health disparities and the persistence of racial inequality in the contemporary United States

Methodologically speaking, while the crux of the fieldwork will take place inside of an institution, the pursuit of answers to the research questions will lead me outside of the facility walls and into unexpected sites—like childbirth education classes, baby showers, and women's homes. Pregnancy is certainly a “multiply inflected cultural object” and, as such, the study of it necessarily strains the boundaries of traditional anthropological method. Yet, the strain is welcomed, as it demonstrates the adaptability of the discipline of anthropology to the complexity that ensues when one studies multifaceted processes.

Description of Chapters

Introduction

This chapter provides the reader with a concise overview of the work as a whole. It stages the central arguments and gives an overview of each chapter's content. This chapter also gives a descriptive composite of the fieldwork: relating the length of time of participant-observation, the total number of interviews conducted, the categories of persons interviewed, etc.

Further this chapter situates the proposed study within a reproductive justice framework—a perspective and movement that contends that there are significant limitations to conceptualizing reproductive “rights” as the answer to the subordination of women and girls through their bodies, sexualities, and reproduction. Reproductive justice understands that “rights”—i.e., the right to an abortion, the right to contraceptives, the right to family autonomy, the right to privacy—are given meaning and lose meaning according to the attributes of the purported rights-bearer. Thus, a woman's race, class, age, sexual orientation, immigration status, and physical and mental ability impact the efficacy and meaning of any reproductive right that she is imagined to bear. Accordingly, a reproductive justice paradigm analyzes reproductive issues through an intersectional lens that considers the simultaneous operation of a person's statuses, and it notes that the remedy to reproductive oppression may frequently lie outside of the realm of the strictly legal. Now, studies deploying a reproductive justice framework tend to focus on marginalized individuals and populations. However, the experiences of individuals with some degree of privilege—like the women who are the subjects of the proposed study—are appropriately analyzed through a reproductive justice lens. That is, reproductive justice theorizes the political, social, and cultural experiences of all those who would reproduce—not just the disenfranchised. By situating the proposed study within the reproductive justice framework, the proposed book illustrates the basic premises of the paradigm and extends them.

Chapter One: Navigating Knotty Spaces

Because of the censure levied against poor women of color who insist upon becoming mothers, it may be important for wealthier pregnant women of color to disavow that they are poor and/or are “on Medicaid.” These disavowals—verbal and nonverbal declarations that a woman is not a bearer of problematic fertility—allow wealthier women of color to deny the relevance of discourses that would otherwise proclaim the pathological nature of their fertility. These disavowals may simultaneously allow women entrance into discourses that affirm that their reproduction is *good*—for themselves, for their families, and for society. In terms of medical care, when a woman possesses private health insurance, establishing this possession affords women an expanded array of options regarding the healthcare that they can receive. Thus, how a woman is *treated*, in multiple senses of the word, may turn on whether she is apprehended as poor or as a member of the middle-class. This chapter takes up the question of how wealthier women of color navigate medical spaces that accept both private insurance and Medicaid and, consequently, serve both poor and nonpoor patients. It asks whether and how wealthier women of color attempt to perform their class privilege in these knotty spaces, and it interrogates their appreciation of the import of their performances.

This investigation will move outside of hospital, clinic, and doctor’s office walls to examine whether and how wealthier women of color perform class privilege in *nonmedical spaces*—when they are simply going about their lives outside in the world. Insofar as the healthcare that a woman receives is not implicated in her encounters with people in nonmedical spaces, the stakes of such disavowals in these spaces may not be as high; the quality of the healthcare that she will receive is not at issue at all. Nevertheless, these disavowals may still be significant to wealthier women of color. It may be important to a woman that her material body be understood as one that ought not to be aligned with discourses that maintain that it is a social problem. She may insist that her material body be appreciated as one that makes no demands on state coffers and that performs a function that is good for the nation, more generally.

Chapter Two: Choosing Care

This chapter investigates the choices that wealthier women of color make around prenatal care, and it asks about how the simultaneity of women’s class privilege and lack of race privilege affects those choices. To date, no study has interrogated how class privilege, when it is enjoyed by black and Latina women, impacts their healthcare decisions.

In Gertrude Fraser’s study of obstetric and midwifery practices in the South, she found that intensely medically-managed pregnancies and childbirths were largely coveted in the impoverished, predominately African American community in which she did her fieldwork.² This was a community that, due to classism and racism, historically had been ignored by the medical establishment. That the women in this community now had the choice of receiving their prenatal care from obstetricians and delivering their babies in hospitals with the aid of anesthesia “signaled a symbolic if not fully realized inclusion in the field of vision of a health-care bureaucracy that had until then largely ignored the health needs of African Americans.”³ In

² Gertrude J. Fraser, *AFRICAN AMERICAN MIDWIFERY IN THE SOUTH: DIALOGUES OF BIRTH, RACE, AND MEMORY* (Harvard University Press 1998).

³ *Id.* at 57.

Reproducing Race, I observed a similar phenomenon in the obstetrics clinic of the large, public hospital in New York City in which I conducted my fieldwork. Many of the women with whom I spoke chose to receive their care from this hospital—as opposed to hospitals that were located closer to their homes—because they had heard that it offers the “best” [read: most technologically intense and scientifically advanced] prenatal care.

This chapter asks: what kinds of relationships do wealthier women of color have to biomedicine and biomedical discourse? How might those relationships be explained or interpreted in light of these women’s racial identities and socioeconomic statuses?

When wealthier women of color choose to have their pregnancies administered in line with what we might call a “technocratic model of pregnancy,” these choices might be understood similarly to those made by the poor women of color who were the subjects of Fraser’s study. That is, wealthier women of color might seek a pregnancy that is intensely medically-managed because, like their poorer counterparts, they might experience it as symbolic of their “inclusion in a field of vision of a health-care bureaucracy” that, historically, has ignored the needs of people of color. Which is to say: the class privilege enjoyed by wealthier women of color might not rid them of the racialized sense that accessing technology and biomedicine is something that historically has been denied to those who they consider “like” them, something that is “new,” and something that is desirable for that very reason.

Alternately, when wealthier women of color choose to have pregnancies that are less intensely medically-managed—when they choose to receive their prenatal care from a midwife instead of an obstetrician, or when they attempt to have a homebirth instead of giving birth in a hospital—these choices might be understood as products of their class privilege and as opportunities to demonstrate that privilege. Indeed, electing out of the technocratic model of pregnancy and childbirth might be an occasion for wealthier women of color to align themselves with a movement that has criticized this model—a movement that Fraser describes as “consumerist” and “influenced in large part by middle-class (white) feminist theory and praxis.”⁴ In aligning themselves with this movement, wealthier black and Latina women might be simultaneously aligning themselves with those who have enjoyed race and class privilege and distancing themselves from their poorer counterparts without class privilege.

Part of the import of this chapter is that it ethnographically documents just how choices and “wants” are born out of particular socio-political milieus. Like all desires, the desires that wealthier women of color have regarding pregnancy and birth are products of a social context that is stratified by class and within which race has remained powerfully significant.

Chapter Three: Explaining Pathology

As mentioned above, racial disparities in health in the United States are well documented. The rate at which black women die during or shortly after childbirth is three to four times the rate at which white women die. The rate at which black infants die during or shortly after childbirth is twice the rate at which white infants die. Now, it is tempting to explain these disparities in terms of class. That is, it is tempting to imagine that the reason why there are increased levels of

⁴ Id. at 55.

morbidity and mortality in black women and children is because black people tend to be poorer than their white counterparts; thus, we can imagine that these racial disparities in health are a function of black people's poverty-induced lack of health insurance or the inferior quality of the healthcare that poor people manage to receive. However, as discussed above, racial disparities in health persist even when one controls for class. Thus, black people are sicker and die earlier than their white counterparts not because they are poor; rather, they are sicker and die earlier than their white counterparts because they are black. With this context, this chapter turns its attention to healthcare providers, asking how they explain the pathology and risk that they encounter in their wealthier patients of color.

This chapter asks whether healthcare providers insist upon explaining the pathology and risk that they manage in their wealthier black and Latina patients in terms of a lack of health insurance and inferior healthcare—despite the fact that the class privilege that these patients enjoy should afford them quality health insurance and superior healthcare. To the extent that providers recognize their patients' class privilege, how then do they explain pathology and risk? What explanatory force do providers give to ideas about biological race? That is, do they understand the pathology and risk that they encounter in their wealthier patients of color to be a function of the imagined “bad” genes or “bad” biology that biological race asserts that black and Latino people possess? Moreover, what explanatory force do providers give to ideas about culture? In *Reproducing Race*, I offered that the concept of culture can be as deterministic as biological-race determinism. “Culture” frequently does the work of race, oftentimes invoked to signify radical otherness in ways that “race” has been invoked to signify radical otherness. Indeed, cultural stereotypes and beliefs about the way people from certain cultures “just are” can be just as racist as racism. This chapter examines whether and how healthcare providers allow “culture” to do similar work when explaining pathology and risk in wealthier black and Latina women.

This chapter will also explore how wealthier black and Latina women explain pathology and risk in their own bodies, asking about the extent to which these women offer “culture” and biological notions of race in this regard. With respect to biological notions of race, paying attention to women's acceptance of these ideas allows for this chapter to interrogate why the myth of racial biology is attractive to some racial minorities. Racial biology posits that there is an essence to race—a racial truth that is fixed, enduring, and not in any way contingent. Accordingly, racial biology assures people of color that, despite cultural appropriation and the fact that black and Latino cultural traditions tend to be valued more highly when those with racial privilege perform or exhibit them, their race is something that that can not be taken away from them. In this way, the attraction of biological race to racial minorities, ironically, may serve to reveal the actual contingent nature of race.

Chapter Four: Enjoying Privilege

The existing literature has explored quite extensively the surveillance and regulation that poor pregnant women and poor mothers must endure. For one, *Reproducing Race* discusses the elaborate bureaucratic apparatus into which poor pregnant women are inserted when they attempt to receive Medicaid-subsidized prenatal care. This study and others have remarked on the fact that the law, through the Medicaid program, compels poor pregnant women to confess their “sins” to the state. As a condition of their receipt of Medicaid-subsidized prenatal care, poor pregnant women must provide the state with a dossier of information regarding their sexual histories,

histories with domestic violence, histories of contact with the welfare state and the child protective state, and histories with drug use and abuse. However, to date, no legal regime has been erected that compels wealthier women with private insurance to perform similar confessions. This is true despite the reality that wealthier women frequently have the same “problematic” histories as their poorer counterparts and have engaged in many of the same “problematic” behaviors. Indeed, no legal regime exists that compels healthcare providers and the professionals that work within medical spaces to create as an object of inquiry the social and historical context in which a wealthier woman’s current pregnancy is situated. Consequently, the assumption is that wealthier pregnant women, unlike their poorer counterparts, enjoy the privilege of having their healthcare providers focus their attentions on the immediate pregnancy. The assumption is that wealthier women, unlike their poorer counterparts, can avoid the possibility that they will become the subject of state surveillance, regulation, and/or punishment by virtue of simply receiving prenatal care. This chapter asks whether *all* wealthier women are similarly situated in that regard, exploring the ability of wealthier women of color to access this privilege. This chapter investigates whether these women enjoy the benefit of having their healthcare providers conceptualize their sexual, romantic, domestic, social, and financial lives as an irrelevancy. This chapter asks about the extent to which the lack of race privilege that these women embody functions to negate the class privilege that they otherwise would enjoy. To what extent do their private lives, like their pregnancies, become understood as an object for which healthcare providers need to provide “care”?

Many scholars have theorized that healthcare providers view wealthier patients and poorer patients through different lenses—lenses that are informed and constituted by extant cultural and political discourses. The lens through which providers view poorer patients lead providers to “see” abnormality and dysfunction, while the lens through which they view wealthier patients allow them to see no similar pathology. For example, one research study “found child maltreatment to be reported more often for low-income than middle- and upper-income families with similar presenting circumstances.... [R]esearch has revealed that doctors are more likely to diagnose physical injuries among poor families as ‘abuse’ and to diagnose them as ‘accidents’ among affluent families.”⁵ Essentially, providers tend to presuppose the dysfunction of poor mothers and poor parents while making no similar presupposition about their wealthier counterparts; these presuppositions, these lenses, lead a provider to see “abuse” in a poor child’s arm fracture while seeing “accident” in the arm fracture of his wealthier equivalent. This chapter seeks to explore ethnographically the lenses that providers use when perceiving wealthier women of color. That exploration will allow for a simultaneous interrogation of the cultural and political discourses that have constituted those lenses, providing insight into how race, class, and gender inflect upon one another in our sociopolitical present.

Conclusion

The conclusion offers a forceful synthesis of the arguments that have been developed across the preceding chapters of the book. Moreover, it reflects on how the findings and interpretations offered in the book might enrich the reproductive justice perspective, going on to contemplate

⁵ Robert B. Hill, “Synthesis of Research on Disproportionality in Child Welfare: An Update,” Casey-CSSP Alliance for Racial Equity in the Child Welfare System, page 18, published October 2006, <http://www.cssp.org/reform/child-welfare/other-resources/synthesis-of-research-on-disproportionality-robert-hill.pdf>.

how ethnography might be used to understand and illuminate the claims of the reproductive justice framework and movement.

Further, it muses on the possibility that Foucauldian theory ought to be revised in light of the experiences of wealthier black and Latina pregnant women. To explain: in *Discipline and Punish*, Foucault contends that the disciplinary work that the prison accomplishes has been disseminated to a range of institutions. The result of this dissemination is the creation of a “carceral archipelago,” which “transport[s] [the technique of the prison] from the penal institution to the entire social body.”⁶ Thus, at present, bodies incarcerated in penal institutions are not the only bodies subjected to constant surveillance and management; rather, all bodies caught within the “carceral net” are thus subjected.

However, it is likely that Foucauldian notions of “discipline,” and even “power,” need to be productively revised. Foucauldian theory arguably speaks at a broad societal and historical level without concerning itself too much with social distinctions. However, the experience of the poor pregnant women who were the subjects of *Reproducing Race* suggests that the bodies that tend to be caught within “carceral nets” have specific racial, class, and gender ascriptions. That is, power and the promise/possibility of discipline might not be as ubiquitous and random as Foucault suggests. There might be an intentionality to discipline that would allow it to be directed towards certain subjects thought *worthy* of discipline. Which is to say: discipline, power, and all of the conceptual tools that Foucault presciently described take place within a world shot through with stratifications in the name of nation, citizenship, class, race, gender, disability, sexuality, etc. As such, it may be wrong to expect that poor expectant mothers who are forced to rely on Medicaid if they hope to receive prenatal care are disciplined in the same way as are their privately-insured counterparts. It may be a mistake to insist that those with race, class, and gender privilege will be caught up within “carceral nets”—within the regulatory reach of the biopolitical state—to the same extent as those who lack such privilege. The conclusion proposes this amendment to Foucauldian theory. Moreover, it reflects on the extent to which the class privilege that wealthier women of color enjoy allows them to escape the reaches of the biopolitical state, yet how their lack of race privilege foils those opportunities for escape.

Competing Volumes

- Rachel Chapman, *FAMILY SECRETS, RISKING REPRODUCTION IN CENTRAL MOZAMBIQUE* (Vanderbilt University Press 2010).

Chapman’s ethnography poses the question of why women in Mozambique do not use the prenatal and maternity services that are available to them. She answers this question by looking to the social, political, and economic forces that influence women’s choices around healthcare, explaining and documenting how these macro forces impact upon women’s intimate reproductive experiences. Chapman’s project is similar to the proposed project in that it is also an ethnography that interrogates women’s relationships with the healthcare systems that would care for them during their pregnancies, and it also explores how large-scale forces come to bear on the most intimate of an individual’s experience. However, that Chapman’s book is an ethnography of Mozambique makes it a substantially different book

⁶ Michel Foucault, *Discipline and Punish: The Birth of the Prison* 298 (1975).

than the one that is proposed, which will focus entirely on the United States. Moreover, Chapman's book does not ask questions about how racial meanings come to be attached to particular bodies—questions that constitute the central preoccupation of the proposed study.

- Gertrude J. Fraser, *AFRICAN AMERICAN MIDWIFERY IN THE SOUTH: DIALOGUES OF BIRTH, RACE, AND MEMORY* (Harvard University Press 1998).

Fraser's ethnography uses data gathered during fourteen months of fieldwork in the pseudonymous Green River County in rural Virginia to explore the changing performance of pregnancy and birth. The book explores how most African American midwives in the South were gradually excluded from reproductive healthcare systems and how members of an African American community affected by that exclusion now conceptualize midwives' roles. Fraser's study is similar to the proposed volume because, like the proposed volume, it is an ethnography that asks questions about the relationships that women of color have to healthcare care systems that would provide them with care during their pregnancies and the births of their children. However, Fraser's volume focuses on the experiences of poor black women. This disallows her from asking questions about how class privilege may alter the experience of the lack of race privilege in the United States. Moreover, Fraser's volume was published more than fifteen years old. The proposed volume will be able to explore the vastly transformed technology that has come to manage pregnant bodies and the relationships that black and Latina women have to that technology.

- Alyshia Gálvez, *PATIENT CITIZENS, IMMIGRANT MOTHERS: MEXICAN WOMEN, PUBLIC PRENATAL CARE, AND THE BIRTH WEIGHT PARADOX* (Rutgers University Press 2011).

Gálvez's ethnography examines the "Latina health paradox," a term that references the fact that, despite their socioeconomic disadvantage, Mexican immigrant women have less complicated pregnancies and more favorable birth outcomes than many other groups. In order to explore this paradox, Gálvez conducted fieldwork in the obstetrics clinic of a large public hospital in New York City as well as in communities in Oaxaca and Puebla in Mexico. The proposed volume differs from Gálvez's volume because, while the former trains its focus on middle- and upper middle-class women, the latter focuses on poor women—specifically Mexican and Mexican-American women. Moreover, Gálvez ultimately tells a story about migration, focusing her inquiry on how immigrants are received by medical institutions in the United States and by the United States more broadly. The proposed volume endeavors to tell a story about women whose sense on "belonging" to the United States is not complicated by the fact of recent immigration to the country, but rather by racial discourses that vex racial minorities' sense of inclusion in the nation.

- Ann Oakley, *THE CAPTURED WOMB: HISTORY OF THE MEDICAL CARE OF PREGNANT WOMEN* (Basil Blackwell Publisher 1984).

This seminal tome critiques the medical technology that has come to be *de rigueur* in the provision of healthcare to pregnant women. In this volume, Oakley traces the history of how pregnancy became "a distinct type of social behaviour falling under the jurisdiction of the medical profession." There are substantial differences between Oakley's book and the proposed volume. Oakley's book is a study of the United Kingdom; the proposed book is a

study of the United States. Oakley's book is uninterested in questions around race and class; exploring those questions is the primary motivation of the proposed book. Moreover, Oakley's book was published over twenty years ago. The technologies that have come to manage pregnancy and childbirth have changed significantly in these two decades. The proposed book endeavors to explore women's relationships to these changed technologies.

- LISA PAISLEY-CLEVELAND, *BLACK MIDDLE-CLASS WOMEN AND PREGNANCY LOSS: A QUALITATIVE INQUIRY* (Lexington Books 2013)

This volume is a case study on infant mortality, and it focuses on eight black, American-born, middle-class, professional, married women who have experienced the loss of an infant. By investigating the lives of black middle-class women who have had experiences with infant mortality, this volume is able to explore the phenomenon outside of the poverty paradigm. While the volume centers women's personal experiences with the loss of an infant, it links those experiences with clinical and psychosocial factors that lead to infant mortality. Paisley-Cleveland's project is similar to the proposed project inasmuch as it is a study of middle-class women of color during their pregnancies, and it seeks to explore how the lack of racial privilege can diminish, in the most devastating of ways, the privilege that a middle-class racial minority might have by virtue of her elevated socioeconomic status. However, the proposed volume differs significantly from Paisley-Cleveland's book inasmuch as the former is an ethnography that will be product of a year of fieldwork, while the investigatory tool that the latter study primarily uses is the semi-structured interview instrument. Further, the proposed volume turns its attention to healthcare providers—actors who are omitted from Paisley-Cleveland's investigation, but who nevertheless have profound impacts on women's experiences of pregnancy and childbirth and the outcomes of both.

- Marsden Wagner, *BORN IN THE USA: HOW A BROKEN MATERNITY SYSTEM MUST BE FIXED TO PUT WOMEN AND CHILDREN FIRST* (University of California Press 2008).

This study examines flaws in the American maternity care system and argues that the system fails to deliver safe, effective care for both mothers and babies. This volume explores many issues surrounding pregnancy and childbirth in the United States, including the relative dearth of midwifery care and out-of-hospital births as well as increases in the number of risky, but doctor-friendly, interventions. The primary goal of Wagner's volume is critique. Thus, it differs substantially from the proposed volume, which has as its primary goal an analysis of discourses regarding race, class, and biomedicine. Moreover, Wagner's book is not an ethnography, whereas ethnographic fieldwork is the methodology that will produce the proposed volume.

Author Qualifications and Relevant Background

Khiara M. Bridges is a Professor of Law and a Professor of Anthropology at Boston University. She is the author of *REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION* (University of California Press 2011), which explores poor pregnant women's experiences with Medicaid-subsidized prenatal care in an obstetrics clinic of a large public hospital in Manhattan. Her second book, *THE POVERTY OF PRIVACY RIGHTS*, is under contract with Stanford University Press, and it examines the constitutional issues around Medicaid that

her first book examines ethnographically. Her scholarship – which explores reproduction, race, class, and the intersection of the three – has appeared in the *Stanford Law Review*, the *Columbia Law Review*, the *California Law Review*, and the *Harvard Journal of Gender and Law*, among many others. She is a member of the Academic Advisory Council for Law Students for Reproductive Justice, and she is a faculty advisor for the Boston University School of Law chapter of the organization. She is also a co-editor of a book series titled REPRODUCTIVE JUSTICE: A NEW VISION FOR THE 21ST CENTURY, published by the University of California Press.