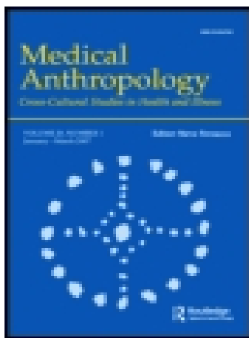

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Transnational Mother Blame: Protecting and Caring in a Globalized Context

Alyshia Gálvez

Food Studies, The New School, New York, New York, USA

ABSTRACT
Mexican women in both the United States and Mexico face uneven landscapes of benefits and discourses as they negotiate family members' health. Building on two decades of ethnographic research, I explore how Mexican mothers navigate social and medical services, food provision, food preparation and health, and describe some of the ways that governments in each country abdicate responsibility for shaping structural constraints on citizens' health. Transnational "mother blame" is a pattern that builds on tropes about the simultaneous responsibility and incapacity of women to ensure their family's health, while offering new articulations of responsibility in neoliberal, globalized, transnational contexts in which flexible care arrangements are both necessary and denigrated.

KEYWORDS
Mexico; chronic disease; gender; immigration; structural violence; transnationalism

PALABRAS CLAVE
México; enfermedades crónicas; género; inmigración; violencia estructural; transnacionalismo

SPANISH ABSTRACT
Las mujeres mexicanas en México tanto como en los Estados Unidos enfrentan una compleja gama de riesgos, beneficios y discursos al navegar la salud de sus familias. En base de dos décadas de investigación etnográfica, exploro las maneras en que las madres mexicanas navegan servicios sociales y médicos, provisión y preparación de alimentos, y la salud, y las maneras en que los estados de cada país niegan su responsabilidad al influir en los factores estructurales que afectan la salud de sus ciudadanos. "La culpa de la madre" es un patrón transnacional que descansa en ideas antiguas sobre la simultánea responsabilidad e incapacidad de las mujeres por asegurar la salud de sus familias, mientras se articulan nuevas formas de responsabilizar y promover el auto-cuidado en contextos transnacionales, globalizados, en los cuales los arreglos flexibles para cuidar a los miembros de las familias se ven a la vez necesarios y denigrados.

At the public elementary school in the rural community of Santo Tomás Tlalpa,[1] in the state of Puebla, Mexico, on a weekday in January 2015, I was handed a paper plate with three *memelas* (thick, round discs of corn masa with raised edges) dressed with red and green salsa, some cotija cheese, and a drizzle of sour cream. I was sitting on a low wall, watching as five women whose children attended the school prepared the food. Working smoothly and cooperatively, one woman patted the memelas into shape, another tended the *comal* (the clay griddle), and another – Irma – raised the edges of the memelas with her fingers as they came off the fire, then dressed and served them. Warm, filling, and labor-intensive, the memelas were much enjoyed by those of us lucky enough to eat them that day. But, according to officials I interviewed in the federal health ministry, foods like the memelas the women made are a stark emblem of the need for nutrition education and intervention to reduce the noncommunicable diet-related diseases that claim more than 80,000 lives each year in Mexico.

CONTACT Alyshia Gálvez galveza@newschool.edu Food Studies, The New School, 66 West 12th St., Rm. 913, New York, NY 10011, USA

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A few months later, in March 2015, I sat at the table of Irma's sister-in-law, María, in the Bronx, as she too made memelas and explained to me the difficulty of preparing the food she grew up eating in Santo Tomás Tlalpa. Ingredients can be hard to come by: she can buy dried, industrial corn masa flour at the supermarket, but she can't get fresh ground corn masa, and the cheeses and chiles available in her hometown are not always available in the Bronx. María said she has to be careful to eat a healthy diet to prevent weight gain and diabetes. She had suffered gestational diabetes in both her pregnancies, and diabetes had recently claimed her mother's life. Years before, a hospital nutritionist had explained to her how to eat a low-fat diet and told her that corn tortillas were not really part of a healthy diet – they were "just carbs" (interview, July 2006). María received the message that her traditional foods were inadequate for preventing chronic disease. In this article, I argue that being a low-income Mexican mother in the early twenty-first century, whether a migrant in the United States or living in Mexico, means being both charged with responsibility to prevent family members from contracting noncommunicable chronic illnesses, and yet being viewed as incapable of this task and thus blamed for "failure" to keep family members healthy.

In many countries, as the welfare state has shrunk and neoliberalism dominates as a governing logic of economic and social policy, citizenship demands a willingness and ability to care for oneself. Full social citizenship with minimal or no scrutiny or intrusion is only given to those who ask nothing[2] of the state (Gálvez 2011; Berlant 2007; Bridges 2010; Davis 2006). Those who receive assistance must agree to surveillance and demonstrate adherence to specific sets of values and behaviors that index achievement of or aspiration to self-sufficiency, compliance, fiscal conservatism, credit-worthiness and capable personhood. Mexican mothers' responsibility for the well-being of the family – day-to-day and in the long term – decenters the role of the state[3] to support citizens amid shifting economic and social tides. In this article, I examine the exclusion of low-income and immigrant people from the rights and benefits of citizenship, with particular attention to how exclusion is gendered and to the relationship between reproduction, race and gender.

Literature

I focus on Mexican mothers in both Mexico and the United States because my interlocutors and their kin navigate both systems as they seek to protect the health of their family members and prevent chronic disease. Migration is a key way that many families in rural Puebla and elsewhere in Mexico have sought economic stability over the last 25 years, and many of the women I interviewed participated in the programs I describe, in both Mexico and the United States, which link women and their family members in transnational networks of social services and care arrangements.

Historically, eligibility for the benefits of the commons is based on belonging, i.e., residency in a territory as customarily determined (Parker 2001). Following this logic, immigrants are always already excluded from the capacity to request assistance. But citizenship has also historically distinguished between "contributors" and "takers" implicitly and explicitly, so justifying de facto the denial of citizenship rights and heightened state surveillance and intervention. I trace these ideas in Mexico and the United States, both of which assign the primary responsibility for health to mothers in a manner that presents particular challenges and contradictions for low-income and migrant families.

Mother blame

Many Mexican families navigate more than one national context in their pursuit of stability, safety and opportunity. Both sending and receiving governments treat the reproductive futures of migrant and low-income women, and the care of their children, as a relevant area for intervention. In Mexico, eligibility for means-tested poverty remediation and nutritional support programs varies with each presidential administration, but after historically favoring mothers and children for nutritional and economic support, the most recent administration (Peña Nieto 2012–2018) reduced eligibility to exclude most able-bodied adults.[4] In the United States, the 1996 Illegal Immigration

Reform and Immigrant Responsibility Act made undocumented immigrants, and authorized immigrants with permanent residency of under five years, ineligible for federal benefits except in cases of emergency medical care. But when migrants settle in New York State, the main destination for migrants from the state of Puebla since the 1990s, they encounter a very different landscape of services, structural constraints and opportunities than those they knew in Mexico. In New York State, pregnant women are eligible for state-subsidized prenatal care and nutritional benefits, irrespective of immigration status. Outside of pregnancy, only US citizens and permanent residents of more than five years can access nutritional and health care benefits. Thus becoming a mother confers a different eligibility and official consideration than that afforded adults without children, even for those who are undocumented.

While the act of migrating often bars one from benefits in home and host countries, some nevertheless accuse immigrants of stealing benefits, rights, wealth and jobs from citizens. While unauthorized migrant men and women who are not parents might have the ability to "live in the shadows," neither served nor scrutinized by the state, migrant mothers, especially those of US-citizen children, are always vulnerable to state surveillance and interference (Gálvez 2011). Immigrants are as susceptible as any other parents to charges of neglect or abuse, if not more so (Applied Research Center 2011; Treviso 2011). But in addition, when classified as low-income or undocumented, many migrant mothers must continually demonstrate capacity for care to evade additional state intrusions, which constitutes a de facto severance of privacy rights (Bridges 2017). This susceptibility to scrutiny is a result of the racialization experienced when immigrant families are incorporated into public welfare systems.

To consume public benefits, Dana-Aín Davis (2006) argues, marks one as Black. In the context of public prenatal care, Mexican immigrant women are made structurally Black by a system that seeks to discipline and surveil in exchange for health care benefits and services. Simone Browne calls this "racializing surveillance … when enactments of surveillance reify boundaries along racial lines, thereby reifiying race, and where the outcome of this is often discriminatory and violent treatment" (2015:8). Low-income parents must simultaneously demonstrate care by consuming all benefits to which their children are entitled, while they must, impossibly, consume no benefits because their immigration status conceptually, if not juridically, precludes them from the benefits reserved for citizens (Gálvez 2011). Conceptual projects racializing African-Americans as "deserving poor," morally culpable for material disadvantage, worked over decades to shape narratives about public assistance in the United States for citizens and also for immigrants of color (Marchevsky and Theoharis 2000). For immigrants to seek and to consume benefits is to mark them as racialized and inadequate protocitizens, while to refuse benefits – even when eligible and when needed – is to participate in a larger white supremacist project in which immigrants imagine they might more likely be accepted if they refuse similitude or solidarity with other low-income people of color. Recent proposals by the Trump administration take this predicament even further, by disqualifying immigrants from food and other government benefits if they wish to adjust their status or naturalize.

In Mexico, neoliberal models of social and economic policy also denigrate the abilities of families to care for their members in ways shaped by ideas about gender, class and race. While the language utilized is framed as empowering, discourses of "coresponsibility" construct and legitimize behavioral mandates and surveillance in exchange for benefits (Saldaña-Tejeda 2012). Surveillance is essential in order to access means-tested benefits from the state in the form of poverty remediation or nutritional support. Mothers must provide proof of their family members' immunizations and school enrollments to maintain eligibility for benefits, and, in the last two presidential administrations, demonstrate a trajectory of empowerment, entrepreneurship, self-sufficiency or *capacidad* ("capacity"). A neoliberal notion related to an intersection of knowledge, skills, and most importantly, affective disposition toward productivity, capacidad structures interactions between the state and poor citizens. Further, while in Mexico racialization takes a different form than in the United States, to consume benefits nonetheless racializes people as poor, non-white, rural and indigenous. Capacidad frequently means aspiring to or demonstrating the habits, behaviors and affective disposition of the middle and upper class, highly educated elites, or the policy makers who design these programs.

The habits, caregiving and health of low-income families are the state's business, and the state's nosiness in these domains is viewed in both countries as appropriate, legitimate and benevolent. The welfare state in its most progressive expression depends on ensuring the well-being of the most vulnerable, and in exchange for the state's largesse, the poor must give up, or never enjoy, privacy rights (Bridges 2017). Poor families must rigorously demonstrate continuing need and worthiness via performances of productivity and compliance.

When people migrate, in many ways they demonstrate maximal self-care. Tropes about immigrant entrepreneurialism, flexibility and innovation are ubiquitous. Historically, some immigrant-sending countries shunned migrants for abandoning the nation and its projects, but in the last 30 years, many sending nations have begun to frame migrants as "national heroes,"[5] and developed creative programs to capture and maximize migrant remittances, political activism and business enterprises (Délano 2011, 2018; Iskander 2010). While migrants lose some benefits when leaving their home country (Délano 2018), and are excluded from others in host countries (Galarneau 2011; Park 2011; Viladrich 2012, 2019), their willingness to get up and go in circumstances of hardship and lack of opportunity fits neoliberal notions of flexibility and self-sufficiency. In both sending and receiving contexts, migrants often consume fewer benefits than those to which they are entitled (Park 2011), and they sometimes echo neoliberal discourses about merit, dignity and self-reliance.

But heightened globalization and migration are not without health consequences, and massive out-migration and destabilization of the Mexican countryside have been accompanied by a precipitous rise in noncommunicable chronic diseases among migrants and in their communities of origin. Today, non-communicable diseases – sometimes known as "prosperity" or "diet-related" diseases – pose the major threat to the health and well-being of people in the United States and Mexico. Diabetes was the top cause of mortality in Mexico in 2016, claiming 87,000 deaths, with an additional 110,700 deaths attributable to high blood glucose in the latest year of available data (WHO 2016). Noncommunicable chronic diseases claim more lives than all other causes combined, and have risen precipitously in recent decades, coinciding with the industrialization of the continent's food systems and Mexico's decisive shift toward globalization with NAFTA (Gálvez 2018).

In the United States, Hispanics of Mexican origin confront a diabetes prevalence rate of 13.8 percent, second highest among ethnic groups after Native Americans (Centers for Disease Control 2017; Schneiderman et al. 2014). Mexican mothers are consequently subjected to a great deal of intervention, nutrition education and surveillance regarding their own and their children's weight, diet, exercise and perceived propensity for obesity and diabetes (Tuñón-Pablos and Dreby 2016; D'Alonzo, Johnson and Fanfan 2012; Gálvez 2011; Handley et al. 2013; Greder, Romero Slowing and Doudna 2012). While obesity is a poorly defined and understood health indicator, it is commonly referenced as a risk factor for diabetes and other noncommunicable diseases (Boero 2009; Carney 2015; Greenhalgh 2015; Greenhalgh and Carney 2014; Guthman 2011; Rothblum and Solovay 2009; Wann 2009; Yates-Doerr 2012, 2015).

Despite structural shifts, neoliberal states frame health as belonging to the domain of personal responsibility rather than a right. Noncommunicable diseases, insofar as they are classified as "diet-related," are particularly susceptible to neoliberal etiologies and prescriptions for self-care: moderation in diet and exercise, and proactive, responsible management of one's consumption of foods and beverages, are posed as solutions to an epidemic that is, arguably, systemic in nature and reflects as a kind of structural violence caused by and contributing to the heightened vulnerability of certain marginalized populations (Farmer 2004; Povinelli 2011). Structural violence frames a way to critique the blame assigned to individuals, especially women, for their own and their families' health concerns.

Methods

I conducted the research on which this article is based over several years in New York City and in Puebla and Oaxaca States since 2000, although I collected the data in this article between 2006 and 2016. I began studying diabetes and the health consequences of the North American Free Trade Agreement (NAFTA) in 2014, and pursued new ethnographic research in multiple sites, including in Mexico City, the Mexican

states of Puebla and Quintana Roo, and in New York City. Policies aimed at poverty remediation, health services, prevention of obesity and diabetes, and more are discussed in detail below. While the migration trajectories of the individuals and families with whom I worked vary, the policies I address were relevant to people living in Mexico and in the United States throughout the research period, although any individual's migration trajectory could make certain policies more or less relevant depending on where they were residing at different moments and when policies were initiated, amended or discontinued. In addition to participant observation and informal interviews with people in communities impacted by chronic illnesses and public health interventions to prevent and treat them, I conducted formal and informal interviews with health care providers, government officials in the Mexican ministries of health, social welfare and education, as well as scholars, advocates, and activists working on public health and consumer protection. My access to government officials was aided by my role as director of a university institute for Mexican Studies from 2012–2016.

Of the extended family I describe in this article, María Pacheco and her husband Raúl live in the Bronx. María's sister-in-law, Irma, migrated to the Bronx then returned to Mexico with her child, while her partner remained in the Bronx. María's brother Samuel and his partner Elena never migrated, but continued to live in the same house with their children – a relative luxury. Nonetheless, migration permeated every aspect of the lives of all family members in both countries, from the ways they made a living (for example, transporting goods to and from migrants in the Bronx) to the ways they ate (relying more on prepared foods as migration and chronic disease have emptied their house of extended family). Like many others, although each woman was still charged with ensuring the well-being and health of her children, partner, and herself, their lifestyles were radically different from those of previous generations.

Findings

Ideologies of self-care inherent to neoliberal governance confer attribution of responsibility for health to individuals, and to mothers for their families, while simultaneously destabilizing structural supports and programs to protect health. Linking women to the domestic domain is typical of patriarchal social structures, but contemporary social and economic arrangements give new shape to old patterns. Women must simultaneously provide economically and emotionally to their families, be responsible for their home and the well-being of their families, and participate in the public sphere. This is amid destabilization of the patriarchal economic and domestic models. These discursive moves simultaneously charge women with responsibility for their family's health while disrupting the resources they need to do so, setting them up in advance for failure and deflecting the blame for massive public health issues from the architects of economic and health policy.

Migration and anti-poverty policy: Mexico

In the early 1980s, following a massive currency devaluation that depleted much of Mexico's wealth, and the pivot by its political leaders toward foreign direct investment and globalization, there was a massive wave of migration from rural Mexico to cities and to the United States, peaking between 1995 and 2005 (Passel 2012). Following the implementation of NAFTA, massive numbers left, even from regions with no prior history of migration, resulting in one in 10 Mexicans residing in the United States. Whether they migrated internally or transnationally, the living arrangements of many families were permanently disrupted. Men led the initial wave of migration, leaving women as heads of households; eventually, women numbered nearly half of migrants. Even when separated by physical distance, many mothers continued to view themselves and be viewed as the primary caregivers charged with their children's health and education, and found creative ways to respond to this role through phone calls and Facebook messages, Facetime, WhatsApp, and care packages (Boehm 2012; Hannaford 2015; Hondagneu-Sotelo and Avila 1997; Oliveira 2018; Parreñas 2005). This often involved the careful negotiation of care arrangements with "other mothers" providing day

to day care. Many migrant women had children in their place of origin and in the place to which they migrated, often unable to be united because of immigration status issues. Many migrant women also cared for other people's children, raising complications for care that must be navigated near and far.

The flexibility and creativity inherent in crafting and maintaining binational care arrangements is not always acknowledged in home or host societies. At times, care is framed as an innate or obligatory function of mothers, even when care requires elaborate efforts in transformed transnational contexts. Other times, women who have migrated are viewed as having abandoned their families, with their financial contributions not reckoned as worthy or equivalent to the sacrifice of separation. Mothers who stay behind sometimes describe themselves as having to play the role of "mother" *and* "father," caring in the domestic sphere, nurturing children, earning a living and navigating what are in many communities traditionally male public spheres (Pauli 2008). In these contexts, the widening of opportunities for women to occupy roles that break with long-standing gender norms are often framed not as liberation but as survival, in a context where the still ideologically dominant patriarchal system is too weak to sustain families.

In Mexico and in the United States, where many Mexican people have relocated in response to a lack of economic or social opportunities, families navigate patchy social safety nets. Their pursuit of benefits in both places often subjects them to discipline and surveillance that shapes how their economic circumstances, citizenship and social responsibility are framed. In the following, I analyze Mexico's massive national campaign, *Estrategia Nacional Para La Prevención Del Sobrepeso, La Obesidad y La Diabetes* [National strategy to prevent overweight, obesity and diabetes] implemented in 2013 (Salud/Secretaría de la Salud 2013), as well as the poverty and hunger remediation campaigns intertwined with it. In interviews, the architects of the national strategy and its accompanying policies in the health ministry and in the ministry of social development, referred to as Sedesol, told me that noncommunicable disease was "multifactorial," thus necessitating a multisectoral response. I then describe the context in which Mexican immigrant women receive health and nutritional services in New York City. I analyze how poverty remediation programs and government programs and strategies to address diabetes and obesity contain implicit judgments about poor families, and especially mothers in those families, and assign them disproportionate responsibilities.

Despite NAFTA's promises of prosperity, some 56 percent of the population of Mexico live in poverty, making tens of millions of people eligible for federally sponsored assistance programs (The World Bank Group 2016). For a decade, conditional cash transfers (a program now known as Prospera, previously Oportunidades and Progresa) provided assistance to mothers in exchange for complying with guidelines, including immunization regimens, well-child visits, parent-teacher conferences, and more. In 2012, government administrators in the offices of Sedesol revamped Oportunidades and renamed it Prospera in order to center "personal responsibility," making cash benefits available only to people who were disabled or ill, and instead offering to everyone else scholarships and loans to incentivize "responsible" financial citizenship, entrepreneurship and use of credit.

In the wake of this retrenchment of benefits, another program, *La Cruzada contra el Hambre* (Crusade against Hunger) stepped in to provide extremely poor households with subsidized food baskets, largely of processed foods like soy protein, lacking traditional nonperishable foods like corn for making tortillas, beans and dried chiles, and without fresh foods like eggs, nopales, chiles, herbs and tomatoes. An administrator of the program explained to me that the program was designed to prevent graft, address hunger, disincentivize dependency and be efficient (interview, January 2015). Being efficient meant, in part, shelf-stable processed foods such as soy protein, easily reconstituted with water, as opposed to perishable fresh foods. Concerned that desirable foods might be resold or hoarded from the most vulnerable members of families by higher status adults, officials intended the foods to provide high nutritional value, but be of low market value and appeal.

Interviewed by a reporter, a recipient of the food benefit in the mountainous region of Guerrero state, one of the most economically marginalized areas in the country, commented: "We are not used to eating this way. If we eat eggs, it's from the hen, not from powder. This soy protein, what is it called? We are not used to that" (Montalvo 2016). When asked about the rationale for providing

processed foods higher in sodium, sugar and fat than that recommended by the national strategy for minimizing risk of chronic disease and obesity, Omar Garfias, charged with implementing the Crusade, said, "Well, it's a problem we must try to solve by giving information to the cooks so they can make the necessary changes in their food behavior." He continued: "It's all about culture. The home cook [*cocinera*] is accustomed to cooking with too much fat and salt." Garfias used the term cocinera, a female cook, not male, *cocinero*, or the plural and gender non-specific *cocineros*. He blamed the home cooks' culture as lacking while he exculpated the nutritional quality of the food provided to them. An evaluation team has criticized the Crusade for associating hunger with "women's affairs" (Montalvo 2016). Here, although gender is not a component of determining eligibility for means-tested benefits, women face specific expectations in receiving and administering the benefits, and ensuring that they fulfill their intended purpose, including redeeming low-quality food ingredients through vaguely defined improvements in the healthfulness of their cooking.

Meanwhile, the health ministry reduced basic publicly subsidized health services while increasing "preventative" care and publicly subsidizing yoga, Zumba and running clubs (Maldonado 2014). Framed around logics of self-sufficiency and self-care, these programs accompany an austerity-oriented scaling back of health care services and represent a shift toward a more consumer-oriented model of care in which the citizen-consumer navigates a landscape of "choices," incentives and counter-incentives, that are envisioned to foster self-sufficiency and prevent *asistencialismo* or over-reliance on public benefits (Molyneux 2006).

Another part of the national strategy was Mexico's implementation in 2013 of the world's first national sugar-sweetened beverage tax. Taxes are a mechanism that global public health advocates argue addresses structural issues, like the affordability of soda, to incentivize reduced consumption. The tax appears to have reduced soda consumption (Colchero et al. 2016; Colchero et al. 2017). However, critics argue that the tax's implementation was weakened by including industry representatives and excluding nutritionists at the negotiating table, by conflicts of interest in the health ministry, and by a failure to consider the multiple reasons that people might continue to drink soda even when aware of its deleterious health effects (Gálvez 2018; Roberts 2015).

Another part of the *Strategy* was a national ban on kiosks and carts selling processed foods outside public schools. Based on the rationale that kiosks make snack foods high in sugar and fats overly accessible, the assumption was that their elimination would lead families to provide higher quality food for children to eat during the day. In December 2014, when I interviewed the second in command at the ministry of health, I asked whether it was safe to assume that with the ban, children would bring food from home instead. The confident response: "There's always a mom." Perhaps in reaction to a skeptical expression on my face, she added, "or another woman." Regardless of whether mothers are employed outside of the home or are the primary caregivers or cooks, they – or other women assumed to be their proxies – are expected to provide affordable and healthy food to school children during the day.

In the same interview, she recounted to me a failed pilot program in which, in the wake of the elimination of kiosks, mothers were directly asked to prepare hot food for a school's pupils. They prepared an offering very like the memelas with which I began this article. The vice minister of health told me,"*¡era peor!* [it was worse!]" – the mothers' offerings were worse than the kiosk food. She assumed that the school's parents lacked the nutritional education to prepare a better offering than processed packaged snacks, without saying if or how the hot foods they prepared were nutritionally inadequate. It seems to me that a homemade, unprocessed corn-masa-based dish with salsas of freshly made vegetables and herbs, and high-protein fresh cheese are likely to be nutritious and health-promoting. But more importantly, although several members of the health ministry told me that foods like memelas were "peor," worse than the food on offer in the kiosks, I was never offered evidence of the nutritional inferiority of this food. In other words, while nutritional health, and by extension prevention and maintenance of chronic illness in Mexico, are in the hands of women, women are not seen as adequate to this task without elaborate training, nutrition education, and their availability during school hours.

As I interviewed others who constructed and were charged with implementing the Mexican government's *Strategy*, despite their acknowledgment of the complexity of diabetes and obesity, government officials fell back on speculations about what they perceived to be the root causes and obstacles to health – mothers. No-one in the government appeared willing to attribute some of the blame to shifts in food systems, economic policy or trade. This was despite the fact that many analysts and consumer advocates in the civil sector pointed to NAFTA and the globalization of the food economy as central to shifts toward an industrialized food system, cheap, processed foods, and the decline of small-scale agriculture and traditional ways of eating.

Even the policies most inherently structural in nature, like the soda tax, are premised on incentivizing household-level behavioral change and ultimately rely on the keeper of the household purse strings to change their decisions at the check-out counter. Thus, aspects of the *Strategy* array around government assessments of how trustworthy, informed, reliable and energetic the female head of household is or can be with greater education and training. Boero writes:

> One does not have to dig far below the surface to find a distinct trend of 'mother blame' in common sense and professional understandings of both the causes of and interventions into this 'epidemic of childhood obesity.' As they are usually charged with the preparation, regulation, and purchase of food for their children, mothers – working mothers in particular – are held responsible for children's 'poor' eating patterns and their assumed-to-be related 'obesity' (2009:113).

Mother blame is not a new concept in Mexican health interventions (Molyneux 2006, quoting Rose and Miller, 430; Farnsworth 2009; Hershfield 2008; Pilcher 1998, 62; Pollard and Haney 2003). Even so, today, as part of a larger shift away from comprehensive social programs, greater expectations are placed on individuals to ensure their family's well-being in a manner that relieves the state of its failure to provide equitable and empowering services for all citizens. Low-income women are framed as both responsible for and incapable of protecting their family members' health. Within this model, currently driven by market logics and neoliberal economic and social policy, citizens are imagined to be empowered and capable (both economically and in terms of skills) to choose the best solutions to their health, social, economic, and other challenges and risks.

Migration and anti-poverty policy: United States

The framing of chronic disease in Mexico as simultaneously women's responsibility and beyond their capacity is echoed in the ways that public benefits are delivered to low-income women in the United States. Women are obliged to navigate programs for public health and poverty remediation. In my research on public prenatal care in New York City (Gálvez 2011), I found that women were asked to demonstrate that they were not only needy but also "worthy" of care and the resources assigned to them, through their diligence and compliance with a range of often opaque, arbitrary and intrusive metrics and interventions (cf. Bridges in the same clinic, 2010 and 2017). Women were concurrently classified as being "at risk" because of low income, low average levels of educational attainment, and what were often problematically assigned measures of household stability. Ironically, recently-arrived Mexican immigrant women in New York City illustrate the so-called "immigrant paradox" of "better than expected" health outcomes, with rates of infant mortality and low birth-weight on a par with non-Hispanic white women, whose average levels of income, education level, etc., are higher.

Given these facts, health care providers might celebrate Mexican immigrant women's defiance of the usual linkage between wealth and health in achieving better than expected health outcomes with worse than average circumstances, or mine their knowledge and practices to see what resources they bring that might inform the care of other women in resource-scarce environments. Instead, women were subjected to a subtractive model of health care that displaced their orientations, knowledge and practices with demeaning and disempowering clinical encounters. For many women, enrolling in public prenatal care became tantamount to a socialization into the expected behaviors and affective

demeanor that simultaneously demonstrated need for services and worthiness to receive them. While some of these dynamics are common to other racialized and low-income groups (Bridges 2017), immigrant women might feel it especially necessary to distance themselves from public charge accusations.

Receipt of nutritional support during pregnancy and for children up to age five in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program requires weigh-ins. Historically, inquiries about the weight of children receiving nutritional benefits were intended to assess whether the benefits were sufficient, resulting in children's developmentally appropriate physical growth. Today, families report that WIC weigh-ins center largely on preventing overweight.

María Pacheco's gestational diabetes led her to be subjected to an elaborate series of interventions, mainly focused on weight control, including mandatory visits with nutritionists and social workers, in which she was counseled to eat a diet low in fat, sugar and sodium, neither adapted to or incorporating her preferred way of eating. Other mothers told me they found the kinds of foods provided with WIC or authorized for purchase with food stamps to be unfamiliar and not particularly "healthy" by their own definitions ("cornflakes, cornflakes, cornflakes," one mother complained, interview, July 2006). Non-Mexican care providers demonstrated their lack of familiarity with the foodways of many Mexican people by telling them simply to avoid tortillas to control weight gain, rather than offering culturally sensitive nutrition advice that acknowledged the centrality of corn to many Mexicans' ways of eating.[6]

Consumption of benefits obliges recipients to perform neediness even when by many families' estimations, they had been doing quite well since migrating compared to Mexico. They were required to demonstrate compliance with directives: to show up for appointments, take vitamins, eat "properly," learn about contraception, take parenting and nutrition classes, and participate in WIC counseling and nutrition education. Women able to effectively achieve the right balance of receptivity to being "taught" how to be good parents, adhere to expectations, and remain cheerfully docile and compliant, were rewarded. More than once, health care providers I interviewed exclaimed Mexican patients in their sites were "our favorite patients!" (Interviews, 2006–07). These kinds of characterizations contrast and assign value to certain kinds of stereotypical expectations about relative docility, behavior and social norms (Gálvez 2011).

Many women understood that receipt of public prenatal care required various trade-offs, making them more susceptible to scrutiny and surveillance while providing benefits that they wanted or needed.[7] Prenatal care required them to undergo a complex, multi-agency battery of psycho-social and economic assessments, mandatory physical and educational interventions. One woman noted that she sometimes wished she could refuse to answer intrusive questions or openly express her disagreement:

> *Pues yo tengo la forma de pensar en este sentido si no quiero decir nada puedo tener o sí, si sí creo que en algún lugar por quedarme callada voy a recibir más apoyo o algo a mí en ese sentido a mí no me afecta.*

> Well, my way of thinking is that if I don't want to say anything maybe I'll receive [what I'm asking for], or maybe not, and yes, if I believe that I'm going to receive more support being quiet or something, then I put up with it (April 2006).

As a strategy for upward mobility and assimilation, other women felt it necessary to distance themselves from those who they saw as less self-sufficient in ways that echoed nativist discourses about immigrants and other low-income people as "takers." In a planning meeting for an imminent action, a leader of one immigrant rights group reminded everyone, *Es importante acordar que si te preguntan los medios, que estés preparado … Porque nosotros no nos sentamos a pedir* welfare, *sino trabajamos y exigimos* [It is important to remember that if the media asks you, you are prepared … Because we are not sitting here asking for welfare. We work and that is why we demand rights] (October 2003). Rather than finding sisterhood in a shared experience of struggling in low-wage, often exploitative work, many women in the prenatal clinic tried to distance themselves from other

women who they saw as less productive or less meritorious of public benefits. One woman said, "I only use the benefits my child is eligible for, because he is a US citizen, and it is his right" (May 2006). In these framings, immigrant women reproduce anti-immigrant sentiments and discourses that divide low-income women along racial and citizenship lines, distinguishing between legitimate and illegitimate uses of public benefits. In this way, they not only assume responsibility for protecting the health and well-being of their children, but also the public image of immigrants and the state's purse.

Conclusion

As the sun rose on Santo Tomás Tlalpa, Elena, María's sister-in-law, could sometimes be found having breakfast at a truck stop in northern Mexico, Texas, or Louisiana. Other times, she might be at her sister-in-law's apartment in New York, or rushing around at home to get her younger children off to school. Elena and her husband Samuel possessed visas enabling them to routinely enter the United States. The visas enabled them to enjoy a degree of mobility relatively unparalleled in their rural community, and to make a living with a *paquetería* business, delivering goods between families that have migrated and families that have remained at home.

Samuel and María's mother passed away in 2014 due to diabetes-related kidney failure, but when she was well, she did most of the food preparation. Years before, I sat in her kitchen and watched her roast chiles and tomatoes over an open flame, smash them in a stone molcajete, and serve the freshly made salsa with a delicious assortment of meat, beans, vegetables, tortillas, and cheese. Elena told me that unlike her mother-in-law, she was not a good cook (I begged to differ) and that she avoided cooking when possible. As her marriage was based on rather egalitarian values of shared labor, her reluctance to cook was not an issue in their relationship. When Samuel traveled for work, Elena managed the store and workshop, and took care of their five children. Like a growing number of mothers in Mexico, she did not spend every day at the stove, although when she was able, she made a hot meal of stewed zucchini and tortillas for her youngest children to eat as their mid-morning meal at the primary school. Utilitarian in her cooking, she told me it did not give her much enjoyment. As a family, they enjoyed driving to Tehuacán to do their weekly shopping, stopping for a meal at a restaurant on the way home. Like many Mexican families today, the older model of a multigenerational extended family living under one roof was no longer their reality. And as a result, what constituted a meal for them was not especially "traditional."

With more money than time, they often relied on prepared foods. The children grabbed milk and cereal or a granola bar on their way to school. This family devised a routine and division of responsibilities that worked for them and was based on mutual respect and commitment, as opposed to patriarchal divisions of labor. Still, according to ideas prevalent in Mexican policy and public discourses, Elena was the one who determined the health and well-being of her family. Whether or not she liked cooking or her schedule permitted the time to do it, it was her responsibility to make sure her children and husband were well-nourished, healthy and avoided chronic disease. Placing the responsibility for the well-being of the family on the shoulders of Mexican mothers decenters the historically expected role of the state to support citizens amid shifting economic and social tides.

Whether remaining in Mexico, or having migrated to the United States, neoliberal political and economic formations, and an emphasis on "self-care" as a key requisite in navigating public and primary resources, hand to Mexican women the bulk of responsibility for the health and well-being of themselves and their families. Yet many women see the structural contexts in which they make their lives utterly transformed by globalized economic patterns that increasingly oblige transnational migration, precarious employment and flexible navigation of ever leaner landscapes of public services and benefits. The dynamics of migration which divide many families by distance and borders has reduced the number of multigenerational extended families in which caregiving roles and responsibilities are shared. Employment opportunities and immigration laws conspire to divide families, sometimes for decades, but retain the responsibility on mothers to manage family well-

being. At the same time, the landscapes they navigate to provide for their families – the social assistance, health care and poverty-remediation programs in both Mexico and the United States – while specific to state and federal jurisdictions, take on transnational scope. In their pursuit of economic stability and well-being, families are characterized and given responsibility by them in similar ways across national borders, despite very different policy environments. At the same time, the decline of subsistence agriculture and proliferation of hyperindustrialized food are not recognized officially as major drivers of the public health care crisis of rising noncommunicable diseases. Rather, in official responses to the health crisis, women in Mexico must monitor their family's diet and activity levels, moderate the consumption of sweets and starches, and make healthier meals, through education rather than structural change. After migrating, Mexican families are classified as at high risk of overweight, obesity, and noncommunicable diseases, often beginning during pregnancy with profiles of risk for gestational diabetes, and continuing with metrics designed to monitor and treat them. In both places, health and nutrition education, campaigns for "active lifestyles," and individual management of the responsibility of health are advanced by governments to address epidemics that are systemic in nature and require structural solutions. The state interacts with low-income families in ways that racialize immigrant families, inserting them into historically discriminatory and abusive systems of social control and surveillance. In Mexico, racialization is not mainly about black and white racial categories, but rather historical categories linking indigenous and rural communities to poverty and need; it is a virulent kind of structural violence. While the architects of the public health campaigns and providers of services in both countries may not intentionally "mother blame," they set women up for failure by placing on them an inappropriate level of responsibility for care. Enduring patriarchal tropes surround women's paradoxical responsibility for and supposed incapacity to properly steward their family's health. Taking seriously the maxim that all politics is reproductive politics (Briggs 2017), we are able to note that the public health response continues to place blame and responsibility for health risk on women by centering maternal responsibility and personal behavior.

Notes

1. The name of the town and my interlocutors are pseudonyms.
2. All citizens receive a wealth of benefits and services from the state. Even those who receive no welfare "benefits" such as subsidized medical care or insurance, public education or food stamps, benefit from the state in the form of roads, bridges, 911services, use of a national currency, fire and police departments, and so on. But often only benefits that are means-tested are categorized as benefits, per se.
3. Since the Mexican Revolution, the state had assumed a robust role in ensuring its population's well-being.
4. It is so far unclear how the new administration of Andrés Manuel López Obrador, of the left-leaning PRD party, will amend the government's anti-poverty programs.
5. Former Mexican president Vicente Fox (2000–2006) used this wording in his campaign in 2000.
6. It is also important to note that consumption of corn tortillas is not historically associated with adiposity.
7. Bridges (2017) describes enrolling in public benefits as coerced, not a choice, for low-income mothers. Lacking private health insurance and private means essentially obliges women to enroll in benefits for which they are eligible because "failure" to enroll can be grounds for charges of neglect and further, often more destructive, scrutiny and interventions by the state for "neglect." While many participants in my study found these benefits to be generous, some also noted the constraints they entailed.

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Notes on contributor

Alyshia Gálvez is a cultural and medical anthropologist and is a professor of food studies and anthropology at The New School in New York City. She is the author of a recent book entitled *Eating NAFTA: Trade, Food Policies and the Destruction of Mexico* (UC Press, 2018) as well as two previous books on Mexican migration, *Patient Citizens, Immigrant Mothers: Mexican Women, Public Prenatal Care and the Birth Weight Paradox* and *Guadalupe in New York: Devotion and the Struggle for Citizenship Rights among Mexican Immigrants*

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