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“A Matter of Life and Death”: Biocitizenship and (In)Voluntary Reproductive
Sterilization of Hmong Refugee Women in California (Post-1979)

A thesis submitted in partial satisfaction
of the requirements for the degree Master of Arts
in Asian American Studies

by

Ger Xiong

2013

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ABSTRACT OF THE THESIS

“A Matter of Life and Death”: Biocitizenship and (In)Voluntary Reproductive
Sterilization of Hmong Refugee Women in California (Post 1979)

by

Ger Xiong

Master of Arts in Asian American Studies
University of California, Los Angeles, 2013
Professor Thu-Huong Nguyen-Vo, Chair

This thesis explores how women’s reproductive choices and capacities are regulated through state apparatuses and medical processes in the optimization of life. In particular, I examine reproductive sterilizations of six Hmong refugee women in California, even after the sterilization legislation was legally repealed. These women’s voices and critical contestations make visible the racialization and pathologization of female bodies within biopolitical order.

The thesis of Ger Xiong is approved.

King-Kok Cheung

Purnima Mankekar

Thu-Huong Nguyen-Vo, Committee Chair

University of California, Los Angeles

2013

Dedication

I dedicate this thesis to the Hmong women who shared their stories and wisdom with me.

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Introduction

In 1994, Lee Lor went to the Valley Children's Hospital complaining of severe abdominal pain and was diagnosed with appendicitis. During an appendectomy procedure, the doctors found cancer in her body, and decided to remove a tumor, an ovary and an adjoining fallopian tube. Lor's family say they were not told about the cancer or the extensive sterilization until three days later ("Girl Flees After Clash Of Cultures On Illness," 1994). A *Los Angeles Times* article entitled, "Cancer Case Ignites Culture Clash: Medicine: Hmong Parents Refuse To Agree To Court-ordered Chemotherapy for Teen-age Daughter. They Fear Treatment by Doctors Will Make Her Infertile and Unmarriageable," highlights how Lor and her family feared that the effects of chemotherapy might cause her to lose her hair-- and by extension her marriageability. According to the article, once Lee Lor's doctors had discovered cancer in surgery, the doctors had "*no choice*" but to perform the operation. The hospital's doctor explained, "*It was a matter of life and death. To do otherwise would have been malpractice*" (Arax, 1994). I will come back to this issue of 'life and death.'

In discussing another related case involving a Hmong woman who underwent surgical sterilization, researchers Rita A. Sperstad and Joan S. Werner demonstrate how cultural conflict occurs when traditional Hmong beliefs and Western health care ideologies are misunderstood. A 34-year old Hmong woman experienced uncontrolled hemorrhaging after delivering her infant in a

hospital. The researchers note that this pregnancy would be her ninth with six living children and a history of two miscarriages. The woman's condition deteriorated rapidly, prompting the obstetrician to perform a hysterectomy with the signed consent of the patient's husband. It was noted that the patient's husband appeared to understand English. After the surgery, the woman's physical condition improved but she became severely depressed and expressed this to the nurse who then communicated this to the primary physician. Subsequently, a meeting was arranged with the patient, husband, nurse and all physicians involved. The Hmong woman and her husband both felt that it would have been better for her to have died, rather than to have had a hysterectomy. Now that she was physically unable to work, she was unable to provide for the family. The obstetrician explained that even without the husband's consent, he would have proceeded with the surgery anyway – for it was medically necessary in order to save his patient's life (Sperstad & Werner, 2005).

While these two better publicized cases concerning Hmong female patients' confrontation with Western medical practices have predominately been framed around a culture-clash narrative, this depiction may not necessarily shed light on this conflict. The debate of life and death, divergent perspectives that emerge as a "culture clash," will be a central theme of this paper. *I would argue that these instances exemplify matters of 'life and death' as the medical professionals claim, but that these matters are not just vital to the patients.* Rather, this popular narrative re-asserts the discourse of care and of medical help to maximize the wellbeing of the patient-subject in order to uphold a

particular kind of socio-political order. The maximizing of life through regulatory apparatuses is part of what French philosopher Michel Foucault would call biopolitics.

Framework & Literature Review

I draw on Foucault's notion of biopolitics to demonstrate the distinctive techniques of government/institutional apparatuses and politics to regulate the biological health of populations through "biopower." My study uses this conceptualization to explore the power domains within the culture clash paradigm and critique how women's *choice* to be fertile or infertile is taken away. I illustrate the modes of objectification that turn persons into subjects, rather than persons who have distinct values and identities. According to Foucault, biopolitics offers the opportunity for resistance because it manifestly produces subjects of agency and of choice. As he puts it,

[T]he subject constitutes himself [sic] in an active fashion, by the practices of the self, these practices are nevertheless not something that the individual invents by himself. They are patterns that he finds in his culture and which are proposed, suggested and imposed on him by his culture, his society and his social group. (Foucault, 1987, p. 122)

Sociologists Nickolas Rose and Carlos Novas use Foucault's conceptualization to forward their neoliberal concept of biocitizenship to demonstrate how citizens become subjects of choice. Biocitizens (according to Rose and Novas) are able to deconstruct their subjectivity by taking personal responsibility for their own biological bodies, health and recovery. My study will critique how this Foucauldian model of biopolitics and biocitizenship discounts the racialization,

gendering and class demarcation of persons – in this case Hmong refugee patient-subject.

As doctors and news coverage of Hmong women's sterilization repeatedly refer to their high fertility, the practice is evocative of eugenics, which Foucault also discusses as a phenomenon part and parcel of biopolitics (Foucault, 1990). I place the sterilization of my participants in the history of race-based eugenics in the US, and situate my study within the existing literature that critiques modern day sterilization. The history of reproductive sterilization abuse dates back to the eugenics movement that began around 1850 and ended by the turn of the twentieth century in the United States (Largent, 2011). Eugenic sterilization sought to eliminate the genetic reproduction of those who were deemed feebleminded and undesirable: the deaf, blind, criminal, drug addicted, and the poor (Kendregan, 1966; Silver, 2003). By the turn of the twentieth century, the discourse appropriating reproductive control changed with the panic of new immigrant arrivals and overpopulation. Reproductive control embodied an economic solution in ending these concerns and reducing social burdens on the state. State institutions systematically targeted women of African, American Indian, Mexican and Puerto Rican descent through the 1970's, as chronicled in the works of Angela Davis (1981), Jane Lawrence (2000), Sally Torpy (2000), Jennifer Nelson (2003) and Virginia Espino (2007). Although eugenic sterilization is primarily thought of as something in the past, or has ended by the 1970's, author Mark Largent makes the assertion that it reemerged through the 1980's, where legislatures and courts again began

employing sexual surgeries to punish welfare recipients, rapists, and child molesters (2011). He states, “As was the case a hundred years earlier, many government officials believed that the source of complex social problems was located within the genitals of certain citizens” (Largent, 2011, p. 7). My study is a continuation and contribution to the contemporary works on eugenic sterilization. In my study, I focus specifically on Hmong refugee women who underwent sterilizations in the late 1980’s and 1990’s (including one in 2001) in California. Hmong immigrant cases have gained a high profile because Hmong women have resisted; their resistance in turn has excited the response of the medical professionals and other authorities involved. In my research, I rely on these women’s voices to critique the politics of medical personnel (doctors, nurses, health educators and psychiatrists) and federal policy, in particular Temporary Assistance for Needy Families (TANF), in regulating Hmong refugee women’s higher-than-average fertility rates through disciplinary and coercive forms. Hmong women’s voices are alternative sites that make visible the upholding of the biopolitical order. Their voices prompt a critique of Rose and Nova’s conceptualization of biological citizenship. I argue that the construction of the biocitizen others groups whose practices and ideologies of self-care do not accord with neoliberal notions of personal and reproductive responsibility. Biocitizenship is also a mode of pathologization and racialization. I use the concept ‘racialization’ defined by sociologists Michael Omi and Howard Winant as “the extension of racial meaning to a previously racially unclassified relationships, social practice or group,” to examine how racial meanings are

assigned to raced bodies (Omi & Winant, 1994). In her ethnography of Southeast Asian refugees, Aiwah Ong studies how racial meanings merge with discourses of health, morality, welfare and citizenship in conceptualizing the refugee (Ong, 2003). I draw on these analyses to critique how state institutions reproduce essentialist notions of race that perpetuate the subjugation of Hmong women's choices and pathologization of cultural practice involving reproduction.

I focus on Hmong women in California because it is the most populated state of resettlement for the refugee group. Based on census analysis, the growth rate of the U.S. Hmong population in the 1990-2000 period was 97%. (Pfeifer, Sullivan, Yang, & Yang, 2012). A second important consideration is that California is home to an extensive eugenics movement, which has carried out the highest number of eugenic sterilizations nationally (Espino, 2000; A. M. Stern, 2005). Although California repealed their state's force-sterilization law in 1979, it does not mean that sterilization abuse and its eugenic ideologies have ended; in fact, it may very well obscure them. In his recent work, *Breeding Contempt: The history of coerced sterilization in the United States*, author Mark Largent asserts:

Imagining that American advocates of coerced sterilization were Nazi-like distorts both their activities and our ability to recognize contemporary authoritarian tendencies and the enduring influence of biological determinism in American culture. (2011; p. 117)

In my research, I found that if and when patients demonstrate critical resistance to sterilization, they are conditioned to meet opposition. My

research suggests that these undesired surgical sterilizations largely go unchallenged because sterilization has become normalized as a preventative method for female genetic diseases and/or a necessary method to save the patient's life. The benefits of sterilization, it seems, would outweigh the negatives. The racialization of Hmong women's bodies, medicalization of their multiparity and maternal ages render them vulnerable to pressures of "personal responsibility." This neoliberal principle of self-reliance pathologizes Hmong women. Overall, I am interested in looking through the lenses of affected persons at how medical/state personnel, policy and politics of "reproductive responsibility" administrate Hmong women's procreative capacities,

Method

The goal of my research is not to treat these women as subjects of study. Rather, because of their resistance to sterilization practices, their voices enable me to analyze how Western medical practices and ideologies to exercise "reproductive responsibility" via sterilization pathologize these women. My treatment of these women's voices as a site of critique is also a response to literary theorist Gayatri Spivak's essay, "Can the Subaltern Speak?" Spivak questions if those who are marginalized and silenced in the hegemonic discourse can speak autonomously. She argues that by speaking out, subalterns reinscribe their subordinate position in society, for there are merely Western essentialist representations. Spivak concludes that the subaltern cannot speak (Spivak, 1988). However, my study illustrates that these women are able to

articulate their discontent and resistance to their subjugation. It is not impossible for these women to mount a resistance against biopolitical governance. I find that as the Hmong women are othered by medical practices that construct the mainstream biocitizen, these women are able to mount a critique in their refusal of the practices or in voicing their unhappiness after the fact. It is this resistance that has been generally cast as the language of ‘culture clash.’

As mentioned, I think this culture clash narrative focuses on cultural difference and fails to explain the workings of biopolitical governance in the US. It is not my intention to show how the Hmong culture and its difference allow women to mount this resistance to the biopolitical order in this country. Neither is it my intention to demonstrate that Hmong cultural practices of fertility offer these women a good alternative set of ideas to biopolitics. Rather, I am more concerned with how their voices present us with a site that enables an alternative reading of biopolitical normativity.

My research draws from qualitative interviews conducted with six Hmong American women who have undergone sterilization, and interviews with two family members. Over the course of six months, I completed preliminary and full interviews with eight participants in total. I used interviews as a method to appropriately register these women’s and their family members’ voices. My interview questions were designed to be as open and adaptable as possible to the participants’ priorities.

Through word of mouth, I relied primarily on snowballing in recruiting participants for my research. I conducted interviews at the participant's home in an enclosed area, where third parties were unable to overhear/witness our conversation. Follow-up interviews were conducted over a secured telephone line. As I conducted my interviews, I used a voice recorder device when permitted by my participant. The purpose of the device was for my own personal use to re-examine my participants' responses and data I may have missed. I audio recorded, transcribed and coded all interviews, observational data, field notes, and written materials. All participants are given pseudonyms to protect their identities given the level of high sensitivity of my research topic.

Profile of Participants

All of my participants reside in Northern and Central California. All six of these first generation refugee women are now in their fifties and sixties. These women resettled with their families in the United States after the Vietnam War.

Blia is a mother of five children. She was relatively young when she arrived in the United States in her mid-thirties. She was able to take a small English course and learn the language well enough to obtain a part time job. She is proud of her contribution to her family and supports her children whole heartedly to seek higher education. She rents a small plot of land in her local community to plant vegetables as a source of food supplement for her family.

Ying first arrived in Oregon from the Thai refugee camps. She now resides in Northern California. Ying is an active participant in her church. In her leisure time, she sews traditional clothes for her children. Her husband recently passed away and she now depends on her eldest son for support. She lives with her son and enjoys caring for her grandchildren.

Vue is a beautiful woman in her sixties. She is well known within her clan community for her skills in cooking delicious dishes and for her stern character. She used to work as a seasonal farm worker. She now resides within the home to look after her grandchildren. On most days she enjoys listening to and participating in Hmong radio channels that connect with the Hmong diasporic community.

Lia is mother of nine children. Lia is an active participant in her church and she enjoys singing. She regularly reads the Bible for spiritual healing. She enjoys sewing clothing for her children. Her daughter Treng also participated in the interview.

Chung is a mother of nine children. She is lively with a great sense of humor and is incredibly intelligent. She enjoys visiting her sister who lives across town. She also enjoys walking to the local farmers market weekly.

Pang is a mother of twelve children and a sister of seven siblings. She enjoys sewing Hmong traditional outfits for her children. Like many of the women in my study, Pang enjoys gardening. Pang's daughter also contributed to my study.

Organization

In Chapter 1, I introduce Hmong's family structure and their resettlement in the United States and I analyze the ethnic reproductive practices. I argue that the racialization of Hmong refugee immigrants deploys the medicalization of Hmong women's high fertility. I analyze how this appropriation informs federal policy in administering women's reproductive capacities and biopolitics.

Chapter 2 utilizes Foucault's concept of biopolitics as an analytical tool to study fertility control. It examines the trajectory of reproductive sterilization within the United States. Utilizing individual experiences of Hmong women in my study, I demonstrate that sterilization practices were steered through the use of expert knowledge and coercive methods in the purpose of maximizing life.

In Chapter 3, I analyze sociologists Nickolas Rose and Carlos Nova's concept of biological citizenship. I argue that biocitizenship excludes groups and persons like Hmong women. Not only is it exclusive, it actively others Hmong women's autonomous practices of "personal responsibility." I situate Hmong women's voices as epistemological alternative sites that make visible the biopolitical order.

I conclude that sterilization essentially devalues Hmong women's reproduction. The neo-liberal emphasis on self-sufficiency is a form of government that marginalizes the group. Hmong women's course of action resists the imposition of a normative process that does not necessarily speak to their desires and reproductive freedom.

CHAPTER I: Regulation of Hmong Refugee Women's Reproductive Choices & National Inclusion

This chapter provides a background of Hmong's family structure and practices of fertility. I examine the biopolitical administration of Hmong women's reproductive practices prior to and after their resettlement in the United States. I argue that the dissolution of polygamous marriages prior to immigration, the scattering of refugee families across the United States and state policies that impede welfare mother's procreation are examples of how state biopolitical power regulate the reproductive capacities of Hmong refugee women.

Hmong Family Structure

Hmong are an ethnic group from the Southeast Asian countries of Laos, Thailand, and Vietnam; their ancestors originated from southwestern China (Chan, 2010). Within Southeast Asia, the average size of Hmong (and other Southeast Asian) families and households is typically much larger than the average size of American families or households. Hmong married couples choose to have more children compared to American couples, largely because infant mortality was and still is much higher in their Southeast Asian countries than in the more economically and technologically developed United States. Given the almost complete absence of professional health and medical care services in the mountainous regions of Laos before the 1960s, Hmong (as well as other Laotian) couples were well aware of the real possibility that not all of

their children would survive past childhood or adolescence.

Secondly, Hmong's traditional norm and value of having large nuclear families is associated with their material and economic conditions. In Laos, Hmong's basic means of survival depended on slash and burn farming. Within this agrarian economy, children are considered an economic asset; a large family unit is useful in terms of the source of labor power that family members provided (Watson, 2001). Furthermore, given their agrarian economy, there was no such thing as retirement for the aged or social security for the old and disabled. Hmong seniors who are no longer able to work rely almost entirely on their adult children for social and economic support. This means that having children was necessary for adults' basic survival during old age.

Finally, Hmong's large households is due in part to their residential lifestyle—a lifestyle that provides social support to family members and to emergent nuclear families. Within Hmong's patrilineal society, fathers and their married sons typically share the same roof. This means that it is common to find Hmong households that include paternal grandparents, parents, parents' non-married children and married sons and daughters-in-law along with their grandchildren. In other words, multiple nuclear families may share the same roof. As the nuclear families of sons expand (i.e., as more grandchildren are born), sons and daughters-in-law typically move out but remain in the same region.

During the Second Indochina War, the United States Central Intelligence Agency (CIA) recruited a major segment the Laotian Hmong society to fight in

covert operations against the anti-U.S. forces in Laos. This segment of Hmong society fought from the early 1960s until the U.S. withdrew in 1974 (Chan, 2010; Hamilton-Merritt, 1993). In the aftermath of the civil war in Laos, tens of thousands of Hmong became refugees in Thailand. Most Hmong refugees would spend several years or decades in Thailand before they were admitted to the United States as refugees. Since 1975, Hmong refugees have resettled in the United States, France, Australia and Canada (Chan, 2010).

Within the United States, Hmong former refugees are concentrated in a few states such as California, Minnesota, and Wisconsin. For the most part, their family size post-resettlement remains large. According to U.S. census, Hmong's average family size was 7.57 persons compared to the U.S. general population's 3.70 in 1990. By 2000, Hmong's average family size was 6.34 compared to the U.S.'s 3.14.¹ We see a gradual decrease in fertility post-resettlement, yet they are still twice the size of the U.S. general population's family size. Many Hmong families understand the financial challenges of having large family sizes; therefore, this may explain the decreased family size. Despite the decrease in family sizes that may lighten financial challenges, Southeast Asians like the Hmong still need to rely primarily on government welfare and aid because of various barriers such as language, skills, education, racism and discrimination (Hing, 1993). Their dependency on government assistance, like other racialized groups, has led to social stigmatization.

¹ U.S. Census Bureau. 2004. We the People: Asians in the United States, Census 2000 Special Reports, December Issue.

Sociologist Jeremy Hein looks at how Southeast Asian refugees, particularly the Hmong, became the 'new racial minorities' in the United States. His study suggests that the newly arrived group faced extensive interpersonal discrimination parallel to the experience of African Americans. In the height of the anti-welfare campaigns in the 1990s, numerous newspapers perpetuated public opinions about immigrant and refugee groups who were large beneficiaries of California's welfare benefits. Similar to how poor African American and Mexican American immigrants who were received and portrayed as "hyperfertile," this new group from Southeast Asia was characterized as undeserving welfare recipients. How the Hmong had been perceived socially and economically is illustrated in a piece in *New York Times*:

Officials in many parts of California are complaining with increasing sharpness that refugees are causing a serious strain on local welfare budgets, schools and medical facilities. The complaints have been particularly vocal here in the San Joaquin Valley, which suffers from chronic high unemployment and other economic difficulties despite its fertile soil and fame as a farming center (1993).

The classic perception that immigrants are a fiscal burden to the host society is especially stigmatizing towards welfare mothers. Hmong women's reliance on welfare is symptomatically attributed to their rate of fertility. In an article by the *Los Angeles Times* states:

Early marriage has helped make Hmong mothers among the most prolific in the world--with an average fertility rate of 9.5 children per woman, according to studies--and has fed what U.S. authorities say is the highest welfare rate of any refugee group in this country. Of the 125,000 Hmong in the United States, more than 62% rely on public assistance. The rate is higher in the Fresno and Merced areas, where 45,000 Hmong have been drawn by the bountiful soil and generous welfare checks (Arax, 1993).

The Hmong ethnic group does not fit into the Asian American ‘model minority’ image. As historian Gary Okihiro illustrates, Asians in America fit two sides of the same coin: the model minority or the yellow peril (Okihiro, 2001). In the host society, the Hmong were predominately portrayed and seen as belonging into the latter, not only in public media but also in literary texts. For example in Anne Fadiman’s *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, a canonized work within the medical school curricula, Hmong patients are portrayed in similar vein:

[T]he Hmong do not like to take orders; they do not like to lose...that they are rarely persuaded that the customs of the other cultures, even more powerful than their own, are superior...Those who have tried to defeat, deceive, govern, regulate, constrain, assimilate, intimidate, or patronize the Hmong have, as a rule, disliked them intensely (Fadiman, 2012, p. 17).

The inability or ‘unwillingness’ of the ethnic group to assimilate is somewhat accepted and even expected in these researchers’ perception and depiction of the Hmong. The cultural construction of the noncompliant refugee became a national narrative, becoming what Monica Chiu observes as, “symptomatic of a history in which ‘unassimilable’ and ‘inscrutable’ Asian Americans have been posed as perils to national health and welfare, demanding forms of domestication and management” (Chiu, 2004). In general, Hmong patients have been perceived and portrayed as most difficult or deviant; in similar vein,

Hmong women's procreative practices have been perceived alike. In one study² that assessed health professionals' perceptions of the problems associated with pregnancy for Hmong women, the researcher found that they were most concerned with Hmong women's multiparity and the need for contraception compliancy (Faller, 1992). According to the researcher, statements such as: "*They have a baby every year*" was a resounding theme; and statements such as, "*They refuse to take the pill, but are willing to have an abortion,*" was also vocalized by the health care professionals (Faller, 1992, p. 146).

Hmong Refugee Families: Scattered Settlements

The control of Hmong women's reproductive practices and capacities has been administered at the very beginning and before their arrival to the United States. Due to U.S. law, polygamous unions were dissolved prior to entry, forcing many women to face resettlement apart from husbands and sometimes their children (Walter, 1981). Researcher Miriam Kockvedgaard Zeitzen explains:

When talks began over the fate of more than 14,000 Hmong living in camps in Thailand, polygamy became a stumbling block in the negotiations. Men would only be allowed to bring one wife to the USA, but, as many Hmong have several wives, the authorities would be forced to separate family members. In practice, however, they could all move to the USA and stay together as a family group, though for some second

² This study was based on immigrant Hmong women from a small town in southeastern United States.

wives it involved a forcible divorce from their husband in order to enter the USA. (Zeitzen, 2008, p. 166)

The dissolution of Hmong polygamous marriages imposes regulations for the group to conform to heteronormative family norms. The dissolution of polygamous unions implemented by U.S. provisions may in part impede women's reproductive capacities.

Upon their arrival to the United States, they were displaced throughout the country. Government placement policies favored the dispersion of Southeast Asian refugees throughout the country in order to facilitate assimilation and to lessen the impact on American communities of large groups arriving at one time (Fadiman, 2012; Gordon, 1987). As researcher Joseph Westermeyer explains,

[F]amilies were scattered randomly to locations at considerable distances from each other which prevented a re-grouping of extended families immediately after arrival in the U.S. This policy was antithetical to Hmong village social organization, in which several households lived in close approximation to one another, providing both social and economic support for each other" (Westermeyer, 1987, p. 942).

Federal provisions to disperse the Hmong across the nation can implicate their desire to place Hmong families and bodies in physical isolation (at precisely the time of immense changes in their lives) in order to render their greater dependency on the state. Despite government provisions to geographically scatter Hmong refugees across the nation, many eventually moved away from their sponsoring communities (known as the secondary migration) and resettled in California, Minnesota and Wisconsin (Cha, 2003; Gordon, 1987). Prior to and

immediately after their arrival to the United States, we see how Hmong refugee families are already regulated at the federal level.

Administration of Public Assistance to Practice Biopolitics & Hmong Women's Responses

Economic assistance to Southeast Asian refugees to the US has been channeled primarily through the government assistance since 1975. These new Southeast Asian groups were deemed as “social failures” due to their agrarian backgrounds, poor performance in school, poverty, and dependence on government welfare (Ong, 2003). California's program for public assistance program provided one of the highest levels of assistance to refugees in the nation (Fadiman, 2012; Habarad, 1987). According to a 1987 study which surveyed 2,773 Southeast Asians in California, the percentage of families dependent on public assistance was 79.3% for Cambodians, 76.3% for Chinese-Vietnamese, 49.7% for Vietnamese, and 81.1% for Hmong and for Lao (Gong-Guy, 1987). Public assistance purportedly promotes self-sufficiency by compelling women to practice fertility control. In examining stratified reproduction within the United States, researchers found that marginalized women are more likely to receive medical care that impedes fertility, such as sterilization, and less likely to receive care that facilitates fertility (as cited in Greil). In the interviews that I've conducted, many of the women were well aware of how the combination of their imposed identities – female, refugee,

“hyper-fertile”, noncompliant patient, and welfare-mother – stigmatized and constrained them to undergo reproductive sterilization.

As California’s “new racial minorities,” Hmong refugees were subjected to the same ideologies and legislations as other historically discriminated immigrants and poor women of color on welfare. Bill Ong Hing illustrates that groups were portrayed by the media as “undeserving” and allegedly abusing the system by refusing to work and continuing to have children. He argues that images upon which welfare reform was founded are erroneous, relying more upon public opinion than the realities of individual and group experience or economic fact (Hing, 1998). According to Hing and Lynn Fujiwara, the negative perceptions of immigrant/refugee groups contributed significantly to the enactment of the 1996 welfare reform legislation. As Fujiwara elucidates,

Backlash against Asian refugees' use of public assistance escalated during the 1980s as many "Americans" felt that public assistance should not be spent on "foreigners." Despite mass trauma and dislocation caused by the U.S. involvement in the Vietnam War and the participation of Hmong men and boys on the U.S. side, Asian refugees and immigrants were demonized as culturally inassimilable and overdependent on welfare (Fujiwara, 1998).

The correlation between poverty, welfare dependency and large families is the same rhetoric that stigmatizes black mothers as “welfare queens” for their own socioeconomic position. Hing asserts that in effect, immigrants had their own “welfare queen” (1998). Stigmatization is highly influential in how public policies are constructed. Historian Jennifer Nelson in her study of sterilization of Mexican women states, “There holds the belief that poor women of color should not reproduce in large numbers because they and their children are

considered ‘dangerous’ and ‘burdensome’ to society – this is the same ideology that motivated the anti-welfare campaigns in the 1980s and 1990s” (Nelson, 2003, p. 185).

The sexual reproduction among women of low-income and of color is controlled through legislations that implement the family cap provisions or child exclusions in welfare programs such as the Temporary Assistance for Needy Families (TANF). Under the welfare reform in 1996, TANF replaced the old welfare program known as the Aid to Families with Dependent Children (AFDC), the Job Opportunities and Basic Skills Training (JOBS) program, and the Emergency Assistance (EA) program. This welfare reform was enacted to curtail the reproductive capacity of its recipients. Under TANF, women were not expected to increase the size of their families after they’ve started receiving public assistance (Hirsch, 2001). The intention is to curb and limit the number of children welfare recipients may desire to have; in specific, these programs effectively prevent children born to a woman, after she has begun to receive assistance, from receiving the same benefits their older siblings receive (Hirsch, 2001; Kearney, 2004; Peters, Plotnick, & Jeong, 2003). Author Carole Hirsch posits,

[TANF] sends a ‘moral message’ about responsibilities of procreation and parenting, procreation within marriage and financial resources, and the limits of governmental responsibility for such procreation, thus ensuring fairness to the taxpaying working families. Through family cap legislation the government in effect steps in to control women who, presumably, have no other controls on their procreative habits. The family cap was the solution to what many people saw as a widespread problem: lazy welfare recipients willing to live off the welfare state (Hirsch, 2001, p. 345)

TANF speaks to politics of who is “fit” and “unfit” to be a mother. Welfare recipients appear to embody the latter. This is a political process that may be characterized as a residual form of sterilization – for it legally restricts or discourages women to procreate more because her ‘surplus’ children would not be able to receive the same benefits their older siblings receive.

Not only does this state policy financially discourage women from having more children, it also promotes contraception for its recipients. King and Meyer (1997) analyze how recent state infertility mandates extend infertility services for people who can afford them, but Medicaid covers only contraception (as cited by Greil, 2011). For example, one woman felt the threat of welfare cuts to raise future children she would desire to have. With the sway of her caseworker, Vue decided to undergo sterilization. She provides insight into her reasoning,

I hear lots of different things [about new policies]. Some people say our welfare will get cut off completely, some say something else. What would I do if one month my benefits suddenly stop? You know that living in someone else’s country, if they don’t want to support us anymore, we can’t do anything about it. They wouldn’t want to support our own children even if born Americans. Of course it worries me because I do not understand it completely. I regret it [sterilization] because I live like a man now. But I should be prepared and it probably was the best for me.

Vue’s body tenses up as she speaks. She then leans back into her couch.

Yes, because I do need to be prepared. If they cut my benefits tomorrow, at least I won’t have to worry about feeding anymore little ones (X. Vue, personal communication, December 28, 2012).

Understanding that the implementation of new welfare policies meant Vue’s future children would not be able to qualify for the same benefits as her older

children, Vue underwent surgical sterilization “voluntarily”. Her gripping assertion, “...*living in someone else’s country, if they don’t want to support us anymore, we can’t do anything about it. They wouldn’t want to support our own children even if born Americans,*” describes a racial outcast perceived by Vue. This demonstrates how state institutions like the welfare system play a role in the control of women’s reproductive choices; furthermore, her assertion demonstrates how she is marginalized and racialized.

The welfare reform provoked mixed rumors within the community. Because of this uncertainty Vue decided to see her caseworker with her daughter to learn more about the exact policy changes. In their meeting, Vue was told by her case-worker that her welfare benefits cannot support her family if it continues to increase in size. In addition to her case-worker helping Vue to understanding the policies, she also encouraged Vue to seek effective methods of birth control. Vue describes,

I think she [caseworker] looked down on us that I was having more children and I was afraid she’ll cut our welfare. She gave us information about the procedure to tie your tubes. She said it was just temporary and reversible. I didn’t want it, but I was very scared she really will cut our benefits if we kept having children. But I think now it was for the best for me and my family. (X. Vue, personal communication, December 28, 2012)

Vue expresses regret for undergoing the procedure; however, she consistently reiterated that the procedure was “for the best” for her and her family. It is apparent that Vue’s decision to undergo sterilization is influenced by state policies that financially limited Vue’s desire to procreate. I argue that state policy is an appropriation of a continuum in the eugenic thinking of who is “fit”

or “unfit” to procreate. Not only does state policy financially restrict women from having more children, it also pressures women to undergo measures to better prevent reproduction. In this coercive form, the biopolitical governing of the self is achieved as in the case of Vue.

In this chapter, I have tried to show historical Hmong reproductive practices are disciplined through government policies, particularly through the administration of public assistance. The arguments put forth for controlling fertility change, but the application of medical and policy measures remains on poor women and women of color. In the next chapter, I seek to explain the reasons for state institutions’ involvement in discipline of the female body through a discussion of eugenics and medical practices of sterilization.

CHAPTER II: The Biopolitics of Sterilization: Eugenics and the Racialization of Hmong Women

I'm sure your mother knows this from her doctors too. Because we are covered by Medi-Cal, I feel that doctors don't treat us fairly. The clinic that I go to, the doctor thinks that Hmong women have too many babies. He thinks it's not a good thing because it's bad for our bodies and also because we are on welfare. I don't know English well, but I know enough to understand. He always tells me to avoid sleeping with my husband or to consider surgery to prevent me from having more children. (X. Vue, personal communication, December 28, 2012)

In contemporary practices of fertility control, the discourse of reasoning is oriented toward the biopolitical good of society and the bio-citizen's responsibility. However, I argue, the resulting recommendations can be eugenic in nature when it necessitates the limiting of procreation of a particular group of people. In this chapter, I will first provide an overview of the literature on eugenic reproductive sterilizations in Native American, African American, and Mexican immigrant communities. I will then examine sterilization practices post-1979 in the experiences of Hmong refugee women. These women's experiences and interpretations of their surgical procedure reveals that sterilization practices were steered through both disciplinary and coercive forms. Utilizing Foucault's conceptualization of biopolitics, I examine how disciplinary power operates through expert knowledge as a mode of subjectification. Sterilization practices today are based on the same premises underlying eugenics rhetoric –to “improve” life by restricting certain types of women from reproducing. Drawing from Foucault, I argue that eugenics is

essentially biopolitics. As coercion becomes apparent in these sterilization practices, I argue against neo-Foucauldian's explanation of biocitizenship based on choice and responsibility.

History of American Eugenic Sterilization in the Construction of Bio-Ethnic Class

Eugenics is the science for biological improvement of human race particularly through the control of hereditary factors. It targets groups for mass experimentation and controls procreation through sterilizations of deviant, poor and undesired subpopulations. The American eugenic movement had professional ties with the German Nazi racial hygiene program in controlling the reproduction of undesired groups (Garver & Garver, 1991; Kuhl, 1994).

Kenneth Garver and Bettylee Garver inform us of the rationales that emerged in the early 1920's in America:

[T]he increasing unemployment and increasing immigration of unskilled workers made it possible for a group of dedicated eugenicists to promulgate the unfounded claim that people from southern and eastern Europe, Jews, Negroes, and Asiatics were inferior and would dilute the Anglo-Saxon stock in the United States (Garver & Garver, 1991, p. 1114)

Scientific intervention was the perceived solution to resolve social and population issues by reducing or curbing the reproduction of these undesired groups. Eugenic sterilization laws galvanized in the United States and targeted marginalized groups for the first half of the twentieth century.

The language of Anglo purity eugenics eventually faded – or rather masqueraded once the United States tried to disassociate with Germany's eugenic program. However, scientific racism underlying eugenics provided

legitimacy to compulsory reproductive sterilizations of groups deemed “unfit” prolonged through the 1970’s. The large numbers of American Natives, African American and Mexican migrant women who underwent coercive sterilization through the 1970’s speaks to the continuation of eugenic practices. An estimation of at least 25 percent of Native American women during the 1970’s were sterilized by the Indian Health Service (Lawrence, 2000; Robison, 1977). Researcher Sally Torpy examines how American Native women were most vulnerable to reproductive control due to their tribal dependency on federal government through the Indian Health Service (IHS), the Department of Health, Education, and Welfare (HEW), and the Bureau of Indian Affairs (BIA) (Torpy, 2000). African American women were also targets of eugenic agendas. Political activist and scholar Angela Davis uses the example of Nail Ruth Cox [1965], a black woman who was threatened that her family’s welfare payments would be discontinued if she refused to submit to surgical sterilization. Cox consented to the surgery, after being deceived that the sterilization would be temporary and reversible (A. Davis, 2003). The historical construction of Black women’s “hyper-fertility” has attributed to their inherent “hyper-sexuality.” Eugenicists further associated Black women’s “hyper-fertility” with intellectual inferiority, which has driven the legitimacy and longevity of coercive sterilization in the United States (Snyder, 2002). During the birth control movement, that era stirred the ideology that “poor women, Black and immigrant alike, had a ‘moral’ obligation to restrict the size of their families” (A. Y. Davis, 1990).

In the 1970's the language of population control, family planning, reproductive rights and the "culture of poverty" paradigm dominated the discourse of reproductive control according to historian Virginia Espino in her study of Mexican migrant women who was sterilized in that era (2007). Population growth became a danger to the host society and immigrants were conveniently scapegoat as responsible for communities' changing social and economic conditions. Anti-immigrant "activists" claimed that immigrant population growth is a major cause of environmental deterioration and drain on public resources, and reducing the immigrant population was seen as a solution (Huang, 2008). The compulsory sterilizations of marginalized women resurfaced as community activism rallied around a major landmark lawsuit (*Madrigal v Quilligan 1978*) against the Los Angeles County Hospital-USC Medical Center. The plaintiffs claimed they were misinformed and coerced by their doctors into consenting sterilization, even though they did not understand the medical language and consent forms (Stern, 2005). Many were forced to give consent while in the throes of active labor (Espino, 2007). Espino found that public hospital patients, in particular impoverished women patients of color, were used as surgical practice and "training material for young and inexperienced doctors who would later use those experiences to better serve paying middle class and well-to-do patients" (Espino, 2007; 171). In crude, Mexican immigrant women were systematically subjected to coercive sterilization and utilized for the "greater good." In her article, "Sterilized in the Name of Public Health," Stern finds that the plaintiffs in *Madrigal v Quilligan*

were neither welfare recipients nor on trial for illegitimacy. She writes, “Instead, they were working-class migrant women sterilized in a county hospital where obstetric residents were pressured to meet a quota of tubal ligations and where the physicians at the top of command were partisan to *racially slanted ideas about population control*” (Stern, 2005; own emphasis).

Population control is based on the premise that the world is overpopulated and it is causing hunger, famine and resource depletion; thus, overpopulation renders various practices to alter the rate of population growth. These practices include the advancement of reproductive technology, abortion policies, etc. to curve human reproduction. Population control movements and debates in the 1960’s and thereafter shed light to the new form of language and techniques used to manage the reproductive capabilities of the population. However, communities of color in the United States were disproportionately favored for reproduction control compared to their Anglo counterparts (Huang, 2008). At the same time that the 'implicit fertility policy,' of the United States discourages births among poor women and women of color, it promotes births among white and middle-class women (Bell 2010, as cited in Greil 2011).

In general, Asian American women’s experiences are rarely visible within discussions of population control and reproductive sterilization confronting women of color. Popular discourses around fertility control and welfare debates infrequently included Asian American women within the white-black paradigm. It is important to keep in mind that by the end of the 1970’s, Southeast Asian refugees began entering the United States. It was not until the increased entry

of Southeast Asian refugees through the 1980's did we see their visibility in public, policy and medical discussions about fertility control.

Bio/Disciplinary Power Through Use of Expert Knowledge

The Hmong's resettlement in central California stirred deep-rooted fears about the growth of immigrant populations on American soil and they too became scapegoats for the deteriorating economy. I show that the discourse around reproductive control from the 1970's shifted. There is an emergence of pathologization and medicalization of women's bodies through the use of expert knowledge that compel women to undergo sterilization due to: cervical cancers/diseases, menopause, birth defects/birth complications, "advanced" maternal age, and perceived mental/physical dangers of women who have "too many children too soon." As could be seen in my personal interviews with Hmong American women, the medicalization of personal choice to procreate has become a reoccurring theme.

Women of "advanced" age who have a desire to reproduce goes against western obstetric standards and medical recommendations, for childbearing at such an age is associated with increased risks of fetal complications and genetic disorders/diseases. In general, women should only procreate within their "biological clock" timeframe to avoid these risks. However, contrary findings to this correlation have been studied within the Hmong community. It is common that women traditionally procreate at an early age and continue to bear children well into their forties and beyond age fifty (Culhane-Pera, 2003; Yang, Mills, &

Dodge, 2006). One comparative study sampled 1937 Hmong childbirth cases from 1985 through 1988 in the central valley of California found that 0.8% of white mothers compared to 4.8% of Hmong mothers were over age 40. The study found that overall complication rates are higher among White mothers than among Hmong mothers (Helsel, Petitti, & Kunstadter, 1992). Likewise, in an earlier study of the pregnancies outcome among Hmong adults to non-Hmong adults, based in a Minnesota medical center within a seven year period, researchers Edwards, Rautio and Hakanson found that despite existing numerous high-risk factors such as short stature, advanced maternal age, grand multiparity, late prenatal care, and poor nutrition, Hmong pregnancies outcomes are surprisingly good (Edwards, Rautio, & Hakanson, 1987). However, although existing research demonstrate that Hmong pregnancy outcomes are healthy which dispels the correlation of advanced maternal age with birth complications, their behaviors and practices are still perceived as irresponsible when compared to that of the 'average' population as the standard.

Researcher Barbara Hanson posits that the social construction of maternal age over 35 as a major fertility problem with adverse consequences does not fully reflect available medical evidence. She asserts that this dominant social construction stays alive even in the existence of contradictory scientific evidence, because it “taps into existing beliefs about women’s aging as negative” (Hanson, 2003). She states, “Women experience levels of intervention that are tied to belief in the age-related pathology of their bodies” (2003, p. 172). This dominant social construction discriminates groups that do

not consider or *experience* pregnancies at ages 35 years or over to be “at risk”. This dominant social/medical construction also actively others and stigmatizes groups who deviate from these norms. As many of my participants were told by their doctors and nurses that they are “too old” to be having children and/or it was dangerous to “having too many children too soon.” The stigmatization of Hmong women’s fertility is instrumental to the same discourse that informs public policy in appropriating control over fertility rates and mother’s “self-sufficiency.”

Due to Hmong women’s social and economic position in the United States, many mothers face very real maternal discrimination and this renders them most vulnerable to sterilization, as did African American and Mexican American women in the 1970’s. Apparatuses to curb poor and racialized women’s reproductive capacity are implemented in various subtle and disciplinary forms. These disciplinary forms come in the name of moral and reproductive care to “protect” their bodies. As I will discuss further using individual narratives, disciplinary power is about training the actions of bodies and operates through the utilization of expert knowledge.

What was once considered a normal human condition—menopause and “advanced” maternal age – is now viewed as a medical disease/problem that can and *should* be treated. Expert knowledge poses as a mechanism of control doctors/clinicians exercise over their patients. According to Foucault, knowledge as linked to power not only assumes the authority of ‘the truth’ but has the power to make itself true (Hall, 2001). There is a moral code placed

upon women to take “personal responsibility” for their health after their caregivers have provided them with expert knowledge. Blia, who was in her mid-thirties when she arrived to the United States, underwent a hysterectomy under apprehensive conditions. Prior to her surgery, she received an overwhelming amount of medical information about cervical diseases and advice to take responsibility of her reproductive health. Her freedom to “voluntarily” choose sterilization, however, becomes unclear as her narrative unfolds. She initially objected her doctors’ recommendations to get sterilized; however, after several months learning about the types of cervical diseases and cancers that existed. She finally agreed to her doctors’ recommendation Blia received an abundant of information and participated in several health education workshops to learn about reproductive health and risk behaviors. She was encouraged to take responsibility for her own reproductive health, and one of the ways she can be responsible was by considering undergoing sterilization to prevent age-related diseases. She recalls her experience:

They showed us this film about all the dangers and pelvic diseases you can get at old age. They showed us these horrific pictures of cancers within your body that can develop, which I have never seen or heard of before coming here [to the United States]. It terrified me so much, that I was convinced. There was nothing wrong with me, but I decided to undergo a hysterectomy because they said it was the best one... I am so angry... so angry to have been so frightened. (X. Blia, personal communication, October 13, 2012)

Blia’s account speaks to how biopolitics produces compliancy and self-regulating subjects. Biopower, as Foucault examines, is the process of producing ‘docile’ bodies and it is “seductive because its logic, technologies, and experts offer, or

at least purport to offer, tools for societal self-government” (Nadesan, 2008). Blia’s internalization of reproductive health diseases risks and the exacerbated probability of developing them in old age provoked her to conform to medical recommendations. This use of expert knowledge is a form of coercion that eventually compelled her to “choose” sterilization even though she had initially refused it. This begs the question that to what extent is “self-government” autonomous? Based on Blia’s re-evaluation of her decision to undergo hysterectomy, she was unmistakably pressured to yield her healthcare providers’ recommendations. A hysterectomy would be the “best one” in preventing possible pelvic diseases, as she was told (X. Blia, personal communication, October 13, 2012). The means to be “responsible” for her own health was instilled by medical personnel she saw and believed to be state authorities. This is illustrative of biopolitics, in what Nadesan explains as, “implicated in the development of indices of knowledge about populations by expert authorities acting within both public (i.e., state) and private institutions (e.g., hospitals)” (Nadesan, 2008). Disciplinary power operates through patients, and they internalize appropriate discourses on how they should know and experience, behave, monitor and regulate themselves (Jaye, Egan, & Parker, 2006). Blia’s “choice” to undergo sterilization is an example of how social control is achieved through disciplinary subjectification.

The probabilities of risks, genetic diseases, birth complications and so forth as associated with advanced maternal age are commonly accepted medical expert knowledge for women to undergo surgical sterilization. In a study

conducted in 1980-1993, researchers found that women between the ages of 40-44 are most likely to undergo this procedure (Lepine et al., 1997). Elective sterilization poses as a solution to self-control one's fertility and to prevent probabilities of diseases that are supposedly out of control. Hysterectomy remains the second most frequently performed major operation next to caesarean section; approximately 600,000 hysterectomies are performed annually (Keshavarz, Hillis, Kieke, & Marchbanks, 2002; Pokras & Hufnagel, 1988). According to research, one reason why many women have chosen hysterectomy, even though there is no life threatening reason to do so, is advice they receive from their clinicians (Voda cites Coffey, 1994). This is demonstrative of how influential expert knowledge is aligned to power. Women are encouraged to surgically remove the organ to eliminate the bleeding because they will function "better" if they eliminate that monthly nuisance (Voda, 1994). According to Coffey, "This is the theory of the defective woman; that is, if women had been made right to begin with, they would not have been born with these useless, bleeding, potentially dangerous sex organs" (as cited in Voda, 1994, p. 211).

Use of Coercion and Hmong Women's Responses

In exploring the conditions under which these Hmong women underwent sterilization, I find that sterilizations operate through coercive forms such as misinformation, threat of "life or death" condition, lack of information, and the threat of economic disincentive in welfare reform. By coercion, I do not mean

the physical and brute coercion of their bodies, but rather the more subtle levels of coercion. At age 35, Ying was two months pregnant with her daughter when she arrived in Oregon. Two months after delivering birth to her daughter, Ying was scheduled to go meet her doctor, which resulted in her receiving a hysterectomy on that same day. Ying was told that there was a lump on her womb, which needed to be surgically removed. Ying refused the surgery on the basis that her doctors had not even performed any electronic (ultrasound, radiologic) or physical pelvic examination on her yet. As a patient, Ying was expected to accept or consider the validity of her doctor's medical recommendations; however, Ying's initial decision prompted an angry reaction from her doctor. As she described,

When my husband and I went in for the first examination appointment, the doctors said they wanted to do the surgery on me. I refused it. And when I said no, the doctors' face became very red. Maybe because I had rejected their recommendations, that's why their faces got very red. But how can I believe them? They would not show me any proof [of lump]. (X. Ying, personal communication, October 27, 2012)

According to Ying, her doctors told her, "*We have to remove the lump. If you don't let us do it today, it will eventually increase in size and then it will explode in your womb. This will kill you.*" (X. Ying, personal communication, October 27, 2012). She finally succumbed to the surgery through pressure and a tragic misunderstanding (if not misinformation) that she was only having the small lump removed from her uterus, *not* the entire organ. Shortly after she underwent the procedure, she moved to California. In California, she found a new doctor and had her first checkup five months after the surgery. It was

only then when she finally discovered she had received a hysterectomy. There was a strong sense of loss as she describes her experience and at times she would chuckle halfheartedly to lighten up the mood,

Maybe it is because we are not American and we don't know English. We are Hmong and so very poor. We had no car, so we had to bike to the hospital!

[She chuckles]

That's why they [doctors] look down on us and know that they can do what they think is best for us (X. Ying, personal communication, October 27, 2012).

Ying is aware of the social construction of doctors knowing and holding expert knowledge of her body, more than the Ying herself. Moreover, Ying is aware that her ethnic, class and citizenship status as a refugee – as attached to her body, is subjected to the Western medical gaze. Ying's experience suggests how sterilization is carried out through coercion. Her hysterectomy was scheduled on the same day on her first checkup appointment. Ying was not given adequate time and/or choice (or at least the impression of choice) to learn more about the supposed lump and the procedure. Like many of the women in my research, consent was attained under questionable methods by the doctors and/or nurses.

In Pang's experience undergoing a hysterectomy, consent was obtained under a life or death threat. Pang's daughter explained the traumatic experience she faced during her mother's stay at the hospital. After a few hours delivering birth to her infant, Pang experienced hemorrhaging. According to Pang's daughter (sixteen years old at the time) who was present to

translate, the doctors needed to “check” and seal any open wounds that may have resulted from labor. I interviewed Pang’s daughter who described in detail,

[T]he doctors told us *“If we let her lose more blood, she may even die from this.”* I just remember that we didn’t want Mom to undergo surgery and we were scared to death since the doctor’s kept telling us we were losing time and every minute... We didn’t know what the outcome would be, but we were assured by the doctors that if we let them do the surgery, if they find any open wounds, they can seal it and it would stop the bleeding, and it could save Mom’s life.

After surgery, they said they couldn’t find anything wrong with her bleeding. There were no open wounds or whatever, but they had to perform hysterectomy “just” to be sure the bleeding would stop and wouldn’t put her life in danger. If I remember correctly, we were never told of the hysterectomy, it was supposed to be a simple surgery to find out what was causing the bleeding. I saw her in so much pain, and she was telling me, *“The doctors are so mean I do not know how I will come out of this.”* A daughter [16 years old then] recalls her mother’s experience undergoing involuntary sterilization. (M. Xue, personal communication, January 19, 2013)

Ying and Pang’s experiences demonstrate how biopolitics is practiced through coercive forms and how Hmong women are turned into subjects. Here, we see how sterilization is compulsory when she is constrained to a life or death situation.

Although Foucault’s theory of disciplinary power is useful in understanding how women and their bodies are rendered docile, many feminists have argued that Foucault’s account of power strips women of self-determination and autonomy. Through a feminist perspective, Lois McNay challenges Foucault’s account of power. She writes, “What Foucault’s account of power does not explain is how, even within the intensified process of the hysterization of the female body, women did not simply slip easily and passively

into socially prescribed feminine roles” (McNay, 1992, p. 41). Women’s determination to self-govern outside disciplinary power is evident within my research. It is in their critical resistance that manifests further disciplinary control. I find that if and when women demonstrate resistance to disciplinary power, they are conditioned to meet overwhelming opposition. As we see in these women’s experiences, their initial resistance to undergo sterilization was opposed by their physicians/health care providers.

Although not all patients slip easily and passively into their roles and subjugation, there exist medical norm/standards that demarcate them as atypical. Women’s reproductive health and behaviors are evaluated on a health standard based on an “average” population that is white and middle class, which inevitably position the Hmong women as ‘abnormal.’ A group’s “abnormality” then renders medical intervention to make normal their practices. This is distinctive of how biopolitics functions. As according to Foucault,

The mechanisms introduced by biopolitics include forecasts, statistical estimates, and overall measures. And their purpose is not to modify any given phenomenon as such, or to modify a given individual insofar as he is an individual, but, essentially to intervene at the level at which these general phenomena are determined, to intervene at the level of their generality. The morality rate has to be modified or lowered; life expectancy has to be increased; the birth rate has to be stimulated. And most important of all, regulatory mechanism must be established to establish an equilibrium, maintain an average, establish a sort of homeostasis, and compensate for variations within this general population and its aleatory field. (Foucault, 2003, p. 246)

Not only are Hmong female patients’ higher-than-average fertility rates and maternal age constructed as non-normative, their opposition to conform to certain medical recommendations to control their sexual reproduction are also

constructed as non-normative and irresponsible. Despite her doctor's recommendations to discontinue having children at an "advanced" age, Lia conceived the following year. At age 43, Lia conceived her ninth child and went into labor at her county hospital when she started experiencing abdominal pains. In her interpretation, her amnion ruptured at the hospital but she had not contracted yet after twenty-two hours. Her doctors recommended that Lia must undergo a C-section due to her unstable condition. Lia's daughter, Treng (who acted as a translator at the hospital) participated in her mother's interview with me. Treng explained that her mother did not want to undergo a caesarean section. In response to Lia's refusal, as Treng explained, the nurses exerted more pressure on Lia to consent to a C-section. The nurses also exerted pressure on Lia's husband and Treng to persuade Lia into consenting. After 36 hours Lia still had not contracted and she became distressed with her nurses' growing frustration and her family's anxieties. One of her nurses told her, *"Your body cannot push this baby. We have to perform a c-section."* After a thorough discussion with her husband, Lia consented to the C-section. Lia had also received a hysterectomy due to complications during the surgery. However, Lia expresses doubt that there were actual complications during her C-section. Lia described,

In all of my past times in labor, I know it takes longer than usual to start contracting. I didn't want to undergo C-section because I believe it was unnecessary. The doctors rushed me. I feel that they purposely did it while I my stomach started hurting. I did not want them to do the surgery and wanted to give birth naturally as I always had in the past. They used the C-section as a convenient way to take out my womb." (X. Lia, personal communication, December 27, 2012)

Lia's narrative parallels that of Mexican migrant women in the *Madrigal* case. Many of the plaintiffs were subjected to sterilization shortly after giving births. The conditions that have allowed for their sterilization are involuntary and suggest that sterilizations are steered through eugenic thought.

Eugenics is a part of biopolitics that rely on disciplinary power continuous with coercion as a mode subjectification. In the experiences of Blia, Ying, Vue and Lia, it is important to point out the utilization of expert knowledge and pressures under the language of "self-care." Such mode of subjectification is not only unique to Hmong women but to all other marginalized women in history. As Rose and Novas admit, "Emphasis on the need to educate individuals so that they will take personal responsibility for the genetic implications of their reproductive decisions is not new: the genetic education of the citizen was a constant theme in the eugenic period" (Rose & Novas, 2004, p. 9). Yet, Rose and Novas forward their concept of biocitizenship utilizing Foucault's conceptualization of biopolitics in reproducing subjects of will and of choice. However, in the next chapter, I will question *what* choices are produced and available for these women? I will also examine how these women embody and understand their experiences in the discourses they use.

Chapter III: Hmong Women's Critique of Biocitizenship as Method for Modification of Behavior

Sociologists Nikolas Rose and Carlos Novas demonstrate that in the age of biomedicine and biotechnology, a new kind of citizenship is emerging – *biocitizenship*. Biocitizenship emphasizes human agency, defining the way patients have “become active and responsible consumers of medical services and products ranging from pharmaceuticals to reproductive technologies and genetic tests” (Rose, 2006). In this chapter, I analyze biocitizenship and how it is a form of neoliberal governance strategy for an active citizen-individual to practice ‘personal responsibility’. I argue that biocitizenship practices exclude and marginalize patients/citizens such as the Hmong women in my study. Biocitizenship only apply to certain demographics of women, and depends on the marginalization/other of some as deviant.

Rose and Novas call attention to the individual citizen and collective groups who have mobilized to claim self-responsibility over their own bodies and health. Biocitizens, using the authors’ definition, are individuals who are taking responsibility for their own health by learning and understanding their own diseases and/or possible diseases their bodies may develop. In doing so, citizens have learned to take measures to prevent or alleviate medical disorders/sufferings. Rose and Novas describes the way in which active biocitizens are enhancing their own scientific and biomedical literacy, through media, support groups and cyberspace. Through a collective effort as

individuals, their practices are empowering themselves and the greater society to claim self-responsibility for their health and to maximize the conditions for it rather than waiting to be disciplined by experts. They make the argument that biomedical authority no longer encourages the passive and compliant patient-hood of the previous form of medical citizenship. As they clarify:

Citizenship, here as elsewhere, is to be active. Thus the actual or potential patient must try to understand their depression, to work with their doctor to obtain the best programme of medical care, to engage in self-techniques to speed the process of recovery – and, of course, to ask his or her doctor to prescribe Prozac by name. (Rose & Novas, 2004, p. 17)

Rose and Novas' argue that biocitizens' civic participation to form communities that share the same health suffering/experience and attain medical literacy about their diseases/suffering opens up a new "economy of hope." Rose and Novas use Prozac's website to exemplify an "element in the 'political economy of hope,' in which it sutures together hopeful beliefs that one can recover from depression if one knows how to recognise and deal with it and the marketing of the drug Prozac itself" (Rose & Novas, 2004, p. 16).

Neoliberal Self-Reliance

Rose and Nova's use of biocitizenship reaffirms neoliberal ideas of "personal responsibility" and the optimization of life. It requires that the biocitizen operates within this framework of responsibility for the maximization of life. It requires that the biocitizen has a high level of education, cultural and material resources such as money and time to become actively involved either in seeking

better treatment or pushing for public policy that addresses her bio-concerns. Rose and Novas uses the profile of Carmen Leal whose ex-husband suffers from Huntington's disease. Leal is able to form a support community via a website that provides an education and literacy project in assisting individuals educate themselves on the various aspects of disease. She also encourages visitors to the website to financially contribute to the cure and raise awareness of the diseases. Her active participation contributes to what Rose and Novas describe as an "economy of hope":

In this political economy of hope, citizenship is enacted through ethical self-formation, through personal economising, and through activism. It thus tries to constitute a public arena in which responsibility for the cure is not merely attributed to scientists and doctors, but is embraced by those who have a stake in the suffering wrought by a disease such as Huntington's. (Rose & Novas, 2004, p. 26)

Clearly, the Hmong women do not fit this profile. Biocitizenship racializes patients and subjects them to undesired medical norms and practices. It attributes those who resist or do not partake in this citizenry as racially other and as irresponsible. To exemplify how biocitizenship racializes persons who do not partake in this biocitizenry, in the 1994 case of Lee Lor mentioned, her resistance (supported by her family) to undergo further treatment after involuntary sterilization, was portrayed as culturally backwards in the media. It was not the initial misdiagnosis of appendicitis and non-consensual sterilization conducted by the doctors, but the family's refusal to admit their daughter into chemotherapy and the ethnic group's "problems" that subsequently were highlighted in national and international newspaper publications. *A Los Angeles*

Times article makes it very clear to the public, “The unusual case has unleashed passionate feelings among the tens of thousands of Hmong refugees who have settled in the San Joaquin valley, and pitted their 16th-century tribal customs against modern American medicine” (Arax, 1994). The association of Western/white with authoritative knowledge is a prevailing ideology that devalues the practices and medicine of non-western/non-white cultures. The type of language the article used, “*pitted their 16th-century tribal customs against modern American medicine*” connotes the classic East vs. West dichotomy, racializing and portraying the former as backwards.

Although biocitizenship may be useful in understanding how citizens are no longer passive by taking personal responsibility for their own biological bodies, health and recovery, I argue that this is not suitable to characterize and/or value how the women in my study have coped (or cannot cope) with their experiences. Ying, the woman who found out she underwent a hysterectomy five months later, opened a dialogue with Pang to share her experience. The two women are companions and relatives within the same clan. In this instance, a collective effort to understand their experiences is present. The language coming from these women’s responses to these expectations does not constitute hope but of despair. Ying and Pang conversed at length about their misery and regret for undergoing involuntary sterilization. Ying expressed in a dejected tone:

We can’t do anything because I already signed the consent forms. But I don’t even read or understand what I consented to. I never thought the doctors would have any bad intention, but now I know that there are

doctors out there with cruel intentions. I suffered for so long. Every time I do work around the house, like vacuum or do the laundry, I would feel as if my body has been beaten up to a pulp. (X. Ying, Personal Communication, October 2012)

When asking the women if they would now consider seeking legal redress after their physical recoveries, Ying responded:

This happened to me more than twenty years ago. How will anyone believe me or want to help me now? I don't have the energy to fight it anymore. As much as I want to seek the court, I know there is no one reliable to take on the case whole-heartedly. I don't have the money for that kind of support. (X. Ying, Personal Communication, October 2012)

There was a strong sense of despair as Ying and Pang talked to each other about their experiences undergoing involuntary sterilization. Ying's assertion, "*I don't have the money for that kind of support,*" speaks to biocitizenship's exclusion of women from low socioeconomic class.

While biocitizenship highlights how individuals are learning to resist totalizing disciplinary power, to foster empowerment of his/her community and claim "self-responsibility," biocitizenship excludes certain segments of the populations who do not have access to these domains. These individual cases demonstrate that these women do not have the privilege to access biocitizenship. Like the national standard for health measurement based on an "average" population that is white and middle class, biocitizenship is also facilitated by this prototypical population who has access and resources to claim membership. Refugees occupy a liminal space between national and cultural borders. Biocitizenship, I posit, excludes minoritized women such as Hmong female refugees who are English illiterate and unable to access these

social mediums. Many Hmong women simply *cannot* partake in biocitizenship practices. There are financial, linguistic and structural barriers that prevent Hmong refugee women from these sorts of activities such as organizing support groups, seeking legal aide, using the internet to gain better understanding of the disease process, enhancing their own biomedical literacy, and/or negotiating with the doctor about a range of therapeutic possibilities—activities Rose and Novas associate with biocitizenship. How they are able (or unable) to negotiate their experiences are within the limits of structural and class constraints.

Biocitizenship is also a process of othering that is essential in drawing the parameters of the mainstream by establishing the binary of proper and improper behavior. Defining a racialized other is essential to drawing discernible parameters of mainstream America, a space that privileges white middle class. The language used by these Hmong women show that they are being produced as other. Their othering is evident through public narratives about their foreign culture and resistance.

Some women critically contest biocitizenship practices which makes visible the coercive forms of medical practices. As evident in my interviews, Hmong women are constantly urged by their doctors, mental health therapists, and caseworkers to learn practices of self-care and reproductive responsibility. After learning these practices, they are expected to comply with medical recommendations. Pang who is a mother of twelve children, recalls how she often felt stigmatized by her health care educator's recommendations. Pang has been told to be more responsible and practice abstinence, because it would be

“dangerous” for her and her infant if she conceived at such an “old age.” In 2001, Pang had her last child after undergoing an uninformed hysterectomy. She explained what happened to her body hours after giving a healthy birth,

This female nurse came in and gave me a vaccination. She said it is routine and it is suppose to rid the “bad blood” that can clot my system. After they gave me that shot, I felt the body’s blood melted immediately.

[Pang puts down her sewing and motions her hands, sweeping them from her shoulders to feet]

The body started bleeding profusely so the doctors said that it was an emergency. They said that, “your body will run out of blood.” That’s when they said they needed to take me into the emergency room to examine it. They need to examine it if in case its womb has a damaged opening or whatever was wrong. I tried to tell them it was the shot that caused the bleeding, but no one listened. So they just took the body. But the doctors lied. They took it to the other room and they just did the hysterectomy. No one knew they were going to do a hysterectomy. I found out after I woke. (X. Pang, Personal Communication, September 2012)

When Pang referred to her body, she rarely used first person form, rather in third person perspective. Whether consciously or unconsciously, Pang rarely used “my body,” signaling a lack of biological sovereignty. I judge that she uses this type of language to illustrate the severe violation and the resulting sense of disassociation from her body. It may be her way to disassociate herself from the horrific experience. Her heavy expressions entail a physical and mental coercion over her body against her will. There is an extreme sense of violation, for she firmly believes the cause of her body’s uncontrolled hemorrhage was not due to her “damaged” womb (as her doctors’ had attributed to her old age), but what she described as an unacknowledged vaccine injected into her body.

After Pang received a vaccination from her nurse, her body immediately experienced hemorrhage. A hysterectomy was performed consequently. Pang's narrative illustrates how the body is acted upon on, rather than maintained at the patient's discretion. Pang expressed,

I had a normal and perfectly healthy delivery. Hours later when the female nurse came into my room, she gave me that vaccination. The vaccination was the immediate cause of the heavy bleeding. The doctors say the hemorrhage was possibly caused by an open wound in my uterus because I was too old. But that's all false. See, even after the surgery they claim they didn't know what caused it. (X. Pang, Personal Communication, October 2012)

Pang's experience in the hospital starkly links to the experiences of Mexican immigrant women who were sterilized shortly after birth, as analyzed in the works of Virginia Espino (2007). Although the women refused to undergo surgery, doctors pressured their family members to give consent. Pang expressed emotions of desolation not only towards the doctors but also towards her husband who had signed the consent form, giving doctors full control of Pang's body and life while in surgery. After the hysterectomy was performed, Pang and her husband were notified about the extensive surgery. The couple was devastated to learn that although the doctors were unable to find the cause of the hemorrhage, a hysterectomy was performed "*just to be sure the bleeding would stop*" as their daughter explained. Pang and her husband tried to seek an attorney to represent her case; however, her attorney was reluctant to take on the case due to the reasoning that her doctors had a legitimate right to perform the surgery in order to save her life. Therefore, it

would be difficult and costly to make a case based on a “my word against yours” battle, according to what the attorney had told a family member. Pang was unable to obtain legal help for her case, causing her to suffer for many years.

According to expert knowledge, there are risks of birth defects, labor complications, or even maternal/infant mortality that are attributed to higher-than-average maternal age. But I should point out again that research showing Hmong women’s healthy pregnancy outcomes dispute the correlation between “advanced” maternal age and birth complications.

Chung, a Hmong woman, recalls being told by her mental health specialist, *“You are old now and you’ve had enough children – eight already! Wow! In America, there isn’t really anymore use for the uterus when a woman reach menopause* (X. Chung, Personal Communication, October 2012). As interpreted by Chung, there is a real stigma placed upon women have who had “enough” children and thus ought to control or correct their sexual procreation behaviors. This is the same eugenic argument around the sterilization of African American/Mexican immigrant women in the 1970’s who were perceived as “hyper fertile.” However, these arguments are not the immediate rationales given to Hmong women to undergo sterilization. Rather, the emphasis is on the “protection” from pelvic diseases and/or birth defects associated with advanced age. As Chung’s doctor had told her, *“You should remove it [uterus] because there are advantages in preventing serious diseases”* (X. Chung, Personal Communication, October 2012).

Rose and Novas' concept of biocitizenship connotes a form of belonging that individuals should aim to practice. They authors assert:

We think, in an comparable way, the new biosocial communities forming on the Web and outside it are moral pioneers - we would prefer to say 'ethical pioneers' - of a new kind of active biomedical citizenship. They are pioneering of a new informed ethics of the self - a set of techniques for managing everyday life in relation to a condition, and in relation to expert knowledge. (Rose & Novas, 2004, p. 21)

Despite this form of pioneering activism that work towards the good of the community, this biomedical citizenry is contingent on the person's actions (or inaction). For example, when Chung's doctor told her, "*In America*, there isn't really anymore use for the uterus when a woman reaches menopause" [own emphasis], the doctor hints at a place of belonging that is accessible or welcoming to citizens who follow American practices. Patients are obliged to follow normalized practices of sterilization to 'protect' their bodies; however, the Hmong women in my research perceive these recommendation and/or pressures to rid their organs not as a protection, but rather a social *devaluation* of their reproductive and biological bodies.

Hmong Women's Response: Alterity as Site of Understanding

If biocitizenship allows individuals to take personal responsibility for their own health and behavior, what happens to persons who are unable or *reluctant* to partake in bio-normativity? Biocitizenship goals to practice and promote individual and collective reproductive responsibility are subjective, and it demarcates non-participatory groups as other. Because many Hmong refugee women do not conform to the same ideas of what "personal responsibility"

entails in accordance to Western health care providers and biocitizenship, this creates a dilemma. I argue that biocitizenship become a standard of comparison which actively others and thus modify Hmong women and/or group's reproductive practices. Biocitizenship renders these Hmong women's active resistance as irresponsibility. For example, when Ying had initially rejected her doctors' recommendations to undergo surgery to remove a lump on her uterus, her doctors became angry with her decision. Ying's doctors then eventually compelled her to undergo the surgery after forewarning if she should refuse to do the surgery, she would eventually die from the disorder developing on her uterus. In another example, Chung was told she has had "enough" children because at such an age she continued to have children. Or in the public case of Lee Lor and her family whose resistance to follow medical procedures was seen as "irresponsible". Most of these Hmong women who had these supposed reproductive disorders/risks and/or underwent undesired sterilization have been constrained to a life or death option. When a woman is constrained under a life or death situation, to what extent is sterilization voluntary?

As if responding to the exhortation to be actively engaged in the maximization of their well-being, Chung explained,

If my body still has the capacity to reproduce, why would I want to alter this natural thing just because I'm old? I want to have a large family as I see fit. I shouldn't be looked down about it. Isn't family supposed to be important in America? Why don't I deserve to have large families? (X. Chung, Personal Communication, December 2012)

Chung's question, "*Why isn't my family seen as deserving,*" speaks to the politics of "deserving" and "undeserving" mother. Racialized mothers are often placed in the category of the undeserving not necessarily because of their deprived resources/access to embody a biocitizen but because of their reluctance to "benefit" from biocitizenship. Hmong mothers in my study are critically resistant to reproductive sterilization because their means to "protect" their bodies is to keep their organs intact and to maintain their reproductive choice, not eradicate it. Women's personal choice to maintain a reproductive choice/ability should not be perceived as irresponsibility, but as a form of resistance against the biopolitical subjectification of their health and bodies. As found in my preliminary research and other works such as *Healing by Heart: clinical and ethical case stories of Hmong families and Western providers (2003)*, according to many Hmong women's perspective, ridding of your organs disrupts or even jeopardizes the body's health. The abrupt stop in menstruation is considered unsafe for uterine health (Culhane-Pera 2003).

Chung explains further,

"We do not want to get rid of our uterus because there is nothing wrong with it. How else will the body cleanse itself? Even after menopause, I want to keep my uterus even if it has risks. But my mental health doctor doesn't agree." (X. Chung, Personal Communication, October 2012)

Chung's desire to self-govern her reproductive health (keeping her uterus and continuing to have another child at forty-two years of age despite learned risks) was opposed by her mental health specialist who continually urged Chung to take "responsibility" by doing the opposite. Along with her doctor, Chung's

mental health provider also had a role in enforcing or normalizing expert knowledge. Chung underwent a hysterectomy under a tragic misunderstanding that it would be temporary. She suffered physically for many months and psychologically for many years consequently. Like many of the women in my study, Chung cannot actively participate in community support groups to share her experience undergoing undesired sterilization. She is not able to demand particular rights, protections or recognition as biocitizens should and are able to partake in. Chung is unable to fully emotionally recover from her experience and carries a deep distrust towards the medical system. What Chung's narrative demonstrates is not irresponsibility, but an understanding of why and how women like her are prevented from exercising their choice and their will. She actively contests the devaluation of her body and her ability to create life.

Hmong women's discontent allows me to have an alternative way to rethink biopolitical order. I am not arguing that the preference on the part of these women to have as many children as they can epitomizes freedom alternatively conceived. I am well aware that the notions of freedom and individual choice are highly problematic. I am also aware an argument could be made that these women had subjected to patriarchal norms in the Hmong culture to value their fertility. My intent is not to uphold an alternative autonomy, but to see the ways in which this biopolitical order subjects them. Their voices make visible the ways in which this biopolitical order pathologizes and racializes their reproductive bodies

Conclusion

We want to name the doctors that did this to us. We haven't done anything wrong for this treatment. We have the rights to name and shame these people. (X. Ying and X. Pang, personal communication October 27, 2012)

There is something extremely powerful in the way these women want to make visible the individual actors responsible by naming doctors as arbitrators of institutional inequalities. This research urges the need to go beyond the cultural clash narrative which simplifies how minoritized women are subjected undesired medical processes. My study suggests that involuntary reproductive sterilization goes largely unchallenged because it has become a normalized method for women to practice “personal responsibility.” We ought to challenge the neoliberal assumption of medical practices that actively pathologizes the women. There is a pathologization of women's bodies in the drive to maximize care. The discourse of care and medical help to maximize the life of the patient-subject through regulatory apparatuses is demonstrative of biopolitics. However, biopolitics purportedly produces subjects of choice and this allows for the practice of biocitizenship, as Rose and Novas develop from Foucault. Foucault's conceptualization of biopolitics is useful in understanding how subjectivity is produced and at the same time how agency is produced from within; however, it is limited in explaining how the construction of agency simultaneously produces the other. While Foucault's framework of biopolitics have been useful in understanding how state institutions simultaneously

produce disciplined bodies and subjects of choice and will, it is also limited in understanding how race and class demarcate minoritized groups like the Hmong.

My study demonstrates that the practice of biocitizenship is exclusive and actively others minoritized women. Rose and Nova's conceptualization of biocitizenship is insufficient as a framework to assess how persons navigate biopolitical processes. My research is not necessarily concerned about making biocitizenship accessible, but about listening to Hmong women's voices as an alternative site that makes visible the biopolitical discourse and processes of medical procedures that pathologizes and racializes them. The hegemony of medical expert knowledge in standardizing the female body is a process of social control that deepens inequalities of race and class. The contemporary practices of biocitizenship are essentially biopolitical, in its emphasis on maximizing life. In this particular context, state institutions try to construct its own biopolitics and its own model of biocitizenship. This necessitates a kind of negative example of the other as deviant. My study validates the voices of these women not as alternative practices of choice and will, but as the prism through which we could understand the workings of biopolitics and now its attendant biocitizenship. I argue that neo-liberal emphasis on self-sufficiency is a form of government that marginalizes this group. Hmong women's course of action resists the imposition of a normative process that does not necessarily speak to their desires and reproductive freedom. Their voices can be an epistemological alternative to rethink and question the biopolitical conceptual framework itself. Hmong women's practices deviating from biomedicine and reproductive control should

be viewed as critical resistance against very real racialization and biopolitical subjectification of their bodies.

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