

NORTHWESTERN UNIVERSITY

**Foreclosing futures, enclosing lives: the performance of treating illicit substance use disorders during pregnancy**

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## Abstract

Anthropologists engaging with biopolitical theory have commonly assumed that biomedicine is a tool for enacting state-based policies to manage population health. Recent insights in medical anthropology have troubled this assumption, calling into question the role of physicians as “handmaidens” of state-based health policy. I use my position as a physician-anthropologist to critically engage with biopolitical theory as it relates to the issue of illicit substance use disorders diagnosed during pregnancy, a significant etiology for maternal morbidity and mortality in Illinois. Data informing my analysis are derived from a four-year ethnographic engagement with obstetrician/gynecologists and pregnant women using illicit substances at the John H. Stroger, Jr. Hospital of Cook County, the safety-net hospital for the Chicagoland area. I employ these data to elucidate an interpretation of biopolitical theory that centers biomedical practice not as a site of reproducing biopolitical paradigms, but as one where these paradigms may become contested as it relates to the health and well-being of pregnant women diagnosed with illicit substance use disorders. Through engaging with Foucault and his interlocutors, I use my perspective – grounded in the practice of maternal-fetal medicine and medical anthropology – to think critically about health and futurity among my pregnant interlocutors. I illustrate how state bureaucratic entities and biomedical practitioners practice *foreclosure*, rendering certain hopes, dreams, and health of pregnant women diagnosed with illicit substance use disorders as unlikely possibilities. I also elucidate how pregnant women diagnosed with illicit substance use disorders live *enclosed* lives, or how life is maintained and experienced once certain futures, possibilities of existing otherwise, are foreclosed. I refer to the relationship between foreclosing and enclosing practices as *the performance of treatment* for illicit substance use disorders. These findings break new ground in anthropological

interpretations of biopolitical theory by rethinking the role of biomedicine within biopolitical paradigms. My interpretation of biopolitics can be used in the future by medical social scientists interested in the relationship between the state, biomedical practice, and the health of marginalized individuals.

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## Glossary

ACOG: American College of Obstetricians and Gynecologists  
ARV: Antiretroviral  
CDC: Centers for Disease Control  
CDPH: Chicago Department of Public Health  
CMS: Centers for Medicare and Medicaid Services  
IDPH: Illinois Department of Public Health  
ILPQC: Illinois Perinatal Quality Collaboration  
IPV: Intimate Partner Violence  
MFM: Maternal-Fetal Medicine  
MNO: Mothers and Newborns affected by Opioids  
MOUD: Medications for Opioid Use Disorder  
MSM: Men who have Sex with Men  
OUD: Opioid Use Disorder  
PrEP: Preexposure Prophylaxis for HIV  
SMFM: Society for Maternal-Fetal Medicine  
SSHCO: South Side Health Community Organization



*This dissertation is dedicated to Natalie, my best friend, wife, and mother of my three children – James, Jude, and Ava. Without your support, guidance, and love, I would not have finished this arduous journey. I love you.*

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## Introduction

The hallways of John H. Stroger, Jr. Hospital of Cook County (“Stroger”), the safety-net hospital for the Chicagoland area, were usually bustling in the early morning. Staff crammed into the few working elevators to reach their respective floors. One morning in April 2021, I was running late to my shift as the attending physician on labor and delivery.<sup>1</sup> I edged through the mass of people to get to the labor and delivery unit. I made my way past multiple locked doors with my Stroger identification badge before I could enter. I walked past the triage nursing station, where patients needing urgent obstetrical evaluation checked in, and into a packed workroom. Inside, resident physicians were typing on desktop computers, lining the room's perimeter. The attending physicians for the day were sitting in two leather chairs in the middle of the room. Several nurses sitting in swivel chairs filled the limited space between desks and people. I made my way to the back of the room and stood, waiting to hear the overnight team’s “sign out,” when significant medical events and treatment plans for patients admitted to the unit would be reviewed with the incoming day team. Katie<sup>2</sup>, the senior resident who had been working the night shift, turned to address the wider group. She began telling the team about a

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<sup>1</sup> The medical hierarchy to an individual outside of biomedicine can be challenging to comprehend, as it varies depending on the training location (e.g., in the U.S. versus the United Kingdom) and specialty of choice. Generally, training to become a physician consists of four years of undergraduate training and four years of medical school. After graduating from medical school, an individual usually matches into a medical specialty, such as internal medicine or, for me, obstetrics and gynecology. Residency can last three to seven years, depending on the chosen specialty. After residency, individuals can stop training and go into practice or pursue subspecialty training, commonly termed a “fellowship.” During fellowship, they will focus on providing care within one specific domain of their larger field of training. Fellowships generally last between one and three years. After completing a fellowship, some physicians pursue additional fellowships, while others stop training and enter clinical practice. Once an individual leaves training and enters practice, they are called an “attending physician.” Throughout the dissertation, I categorize physicians based on their level of training.

<sup>2</sup> All names have been changed to protect the confidentiality of my interlocutors.

patient named Coralina, a young, homeless Latinx woman<sup>3</sup> who had delivered her baby a few days ago.

I knew Coralina well. I had met her almost a month before, when she was admitted to Stroger's antepartum unit<sup>4</sup> well into her third trimester. During that time, she had been diagnosed with opioid use disorder (OUD)<sup>5</sup> due to her chronic use of heroin throughout her pregnancy.<sup>6</sup> The obstetrical team had started Coralina on methadone, a medication commonly used to treat OUD.<sup>7</sup> I learned that Coralina's dependence on opioids had been going on for years. In fact, she

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<sup>3</sup> Throughout the dissertation, I utilize the term "pregnant woman," in lieu of "pregnant person." The latter term is commonly used to include pregnancy-capable individuals who may not identify as cisgender, or people whose gender identity generally aligns with the sex they were assigned at birth, women (American College of Obstetricians and Gynecologists (ACOG) 2021a). The reason for this choice is that all my pregnant interlocutors in this study self-identified as cisgendered women.

<sup>4</sup> The antepartum unit is pregnant women who are not about to give birth stay for a variety of medical reasons.

<sup>5</sup> The use of substances during pregnancy – whether prescribed by a physician or obtained through other means – has a particular history in the U.S. that takes into consideration questions of legality, morality, and risk. Many of the medications and substances discussed in my dissertation can be obtained through a physician (i.e., benzodiazepines, buprenorphine, methadone) or other means (i.e., purchasing them "off the street"). For the treatment of opioid use disorder, methadone can only be dispensed in the outpatient setting by federally-approved clinics (Kuehn 2005). During my fieldwork, formulations containing buprenorphine required additional clinical training and registration with the Drug Enforcement Agency to obtain a "x-waiver" to allow for outpatient prescription (American Society of Addiction Medicine (ASAM) 2020). Substances like crack/cocaine and heroin are not currently prescribed by physicians. For further discussion regarding the unique history of illicit and licit substance use in the U.S. among pregnant people, please see Armstrong (2003), Courtwright (2001 [1982]).

<sup>6</sup> In order to make a diagnosis of a substance use disorder, such as OUD, a clinician must be able to argue that an individual displays, "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (American Psychiatric Association (APA) 2013). For critiques focused on the diagnosis of substance use disorders, see Armstrong (2003), Carr (2011), Courtwright (2010), Lovell (2013).

<sup>7</sup> Based on recommendations from the American College of Obstetricians and Gynecologists (ACOG), as well as the Society for Maternal Fetal Medicine (SMFM), pharmacologic treatment for opioid use disorder during pregnancy (i.e., medications for opioid use disorder, or MOUD), by using opioid analogues like methadone or buprenorphine, are recommended. These medications are used to reduce the risk of adverse health outcomes for both the pregnant woman,

had conceived and delivered three other children while using heroin. However, she had not engaged with any psychiatric or behavioral health services during her other pregnancies, which led the Department of Children and Family Services (DCFS)<sup>8</sup>, a state<sup>9</sup> agency charged with guaranteeing the safety of children, to remove Coralina's legal ability to parent.

Describing the clinical events after this most recent delivery. Katie reported that Coralina's newborn was in the neonatal intensive care unit, being monitored by pediatricians for signs of withdrawal from opioids that Coralina had been using during pregnancy. Katie then turned to Coralina's course of events, which had been especially notable for a postpartum tubal

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such as fatal overdose, and her neonate, such as stillbirth associated with fatal overdose (American College of Obstetricians and Gynecologists (ACOG) 2017, Ecker, et al. 2019). Initiation and titration – or increasing from a low dose of medication to a higher, though more stable dose to combat symptoms of opioid withdrawal (e.g., jitteriness, gastrointestinal upset, myalgias) – is typically performed in the inpatient hospital setting. When clinically assessing an individual for a stable dose of either MOUD, cessation of cravings for other opioids and lack of withdrawal symptoms demonstrates a successful dose of medication. Recidivism, or the use of non-prescribed opioids (e.g., heroin), while simultaneously using MOUD is traditionally a clinical situation wherein the treating physician must reevaluate the utility of the clinical treatment plan and potentially switch the type of MOUD being used (American Society of Addiction Medicine (ASAM) 2020). For a historical overview of MOUD, see Kuehn (2005) & Hansen and Skinner (2012).

<sup>8</sup> Throughout the text, I use the term DCFS to describe state-level bureaucracies aimed at surveilling appropriate modalities of family construction and parenting. Activists, critical legal scholars, and social scientists have utilized the term the “family regulation system” to describe this apparatus, emphasizing its relationship with wider policies of settler colonialism, apartheid, and extractive capitalism (Fong 2019, Fong 2020, Reich 2005, Roberts 2002). I choose to use DCFS, rather than family regulation system, given that the term is used by my interlocutors.

<sup>9</sup> While the concept of the “state” within political and legal anthropology has historically engaged with the national-level policies and practices (e.g., Scott 1998), I deploy the term to focus specifically on the state government of Illinois. However, my privileging of a geospatial definition of the state is complicated by the role the Illinois government plays in interpreting federal legislation on illicit substance use disorders diagnosed during pregnancy (see Chapter 3). Further, the Illinois state legislature has its own sets of laws and legislation that are pertinent to the problems of pregnancy and illicit substance use. Therefore, I believe that the state is a dynamic, multifaceted entity. For a discussion of the theoretical ramifications of conceiving the state as an intricate network of multiple, oftentimes contradictory, bureaucracies, see Ferguson and Gupta (2002), Graeber (2012), Gupta (2012).

ligation, which she had asked the obstetrical team to perform. A few days before her delivery, Katie reported that she had signed the required state consent forms for the sterilization to take place. Katie then moved from reviewing Coralina's otherwise-straightforward postpartum recovery and stated that Coralina had abruptly left the hospital "against medical advice" overnight.<sup>10</sup> I spoke up, asking Katie to elaborate on the circumstances that led to Coralina leaving the hospital. "She just got anxious and didn't want to stay anymore," Katie replied. I knew Coralina struggled with anxiety from her past admission. However, this explanation for Coralina's behavior did not fully explain why she would leave in the middle of the night, let alone without her child. I asked Katie if DCFS had been notified to put a legal hold on Coralina's newborn, which would begin DCFS's investigation of Coralina's ability to parent legally. Without missing a beat, Katie replied, "Yes, obviously."

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After Coralina left Stroger, I lost contact with her. I tried calling her cell phone multiple times, only to be met with a disconnection notice.<sup>11</sup> Reflecting on the brief time I knew her, I kept coming back to the fact that the birth of her child and subsequent departure from Stroger were among the least tumultuous things that occurred during her pregnancy. Coralina had been

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<sup>10</sup> Leaving the hospital against medical advice (AMA) is when a patient leaves the hospital before a physician recommends discharge. Prior to leaving the hospital, a patient is asked to sign a document stating that they are leaving against the recommendations of their clinical team and that they acknowledge the health-related risks of leaving the hospital. The presumed logic behind this documentation is to protect the hospital system against potential legal action if an adverse event were to occur. However, what constitutes leaving AMA is not defined by any particular physician organization, and there are scant data to suggest a legal ramification for healthcare systems if an individual leaves AMA without signing appropriate documentation (Alfandre and Schumann 2013).

<sup>11</sup> Many of my pregnant interlocutors had "burner" phones, or cheap cell phones that come with prepaid time allotted to make calls. If someone did not pay for additional time, the number is disconnected from service.

incarcerated during a significant portion of her pregnancy, and this had caused several problems for her and her overall health.

When I first met her at Stroger a month before her most recent delivery, she had been transferred from Cook County Jail, where she was being held for various misdemeanor charges related to her drug use, for medical management of her OUD. As part of the jail's protocol, any pregnant detainee diagnosed with OUD would need to be transferred to Stroger to initiate medication treatment, as historical data demonstrated an increased risk for miscarriage or stillbirth if withdrawal, or abrupt cessation of opioids, occurred.<sup>12</sup> Once a stable dose is achieved, the detainee would be transferred back to jail, as the theoretical risk for adverse outcomes would be minimal. Clinicians working at the jail would then dispense methadone at the appropriate dose, as they provide this service for non-pregnant incarcerated individuals every day.

As I realized later, the paramount issue for Coralina was her sustained access to methadone after leaving the prison-carceral system. Traditionally, individuals diagnosed with OUD who are decarcerated from Cook County Jail are supposed to be connected with behavioral health services and residential treatment programs, inclusive of outpatient methadone clinics.<sup>13</sup> Dramatically complicating Coralina's case, however, were outstanding arrest warrants in two other Illinois counties: Kane and DeKalb. Because of these warrants, she could not be released

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<sup>12</sup> Data suggesting that opioid withdrawal, or detoxification, during pregnancy is associated with a higher risk for miscarriage and stillbirth have been called into question (Terplan, et al. 2018).

<sup>13</sup> Residential treatment programs are coordinated health services that offer housing, behavioral health services, social services, and case management. Critically, they also offer the ability to house children, many for up to 2 years' time. Due to their popularity, accessing residential treatment services can be difficult. However, having OUD during pregnancy increases one's likelihood for obtaining a spot in a residential treatment program. Statewide mandates emphasize the prioritization of pregnant people with OUD as a mechanism to offset the morbidity and mortality associated with untreated OUD (Guttmacher Institute 2021).



from Cook County Jail after posting bail.<sup>14</sup> Instead, she would have to be transferred to Kane County's jail and have the legal case that led to the warrant for her arrest be re-reviewed by a Kane County judge. The same thing would have to occur in DeKalb County once she posted bail in Kane County. Only after posting bail in the last county, DeKalb, could Coralina finally be released back into the community.

During Coralina's cycles of posting bail and being extradited to different counties, she encountered yet another problem with her access to methadone: the jail in Kane County could not administer methadone, forcing her to undergo the trauma of opioid withdrawal.<sup>15</sup> The result: she spent another two weeks between Kane County and DeKalb County jails without access to methadone before being released. During this time, I suspect she may have received little to no evaluation of her withdrawal symptoms or pregnancy by a trained medical provider. My opinion was influenced by the scant amount of information provided to the obstetrical team at Stroger of any healthcare services provided at either jail.<sup>16</sup> The lack of medical evaluation over weeks could

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<sup>14</sup> In the American legal system, "posting bail" refers to the act of paying a local legal system, such as the Cook County Sheriff's Office, a fee to be released from jail after charges are filed against an individual. Eligibility for bail depends on the severity of the charges being filed, though the detainee's ability to post bail is not traditionally assessed during court hearings. For critiques of posting bail from a racial and economic justice perspective, see Anonymous (2018) and Van Cleve (2017).

<sup>15</sup> Withdrawing from opioids not a recommended approach to management of OUD, as this can lead to higher rates of recurrent opioid misuse, fatal and nonfatal overdose, and increase in frequency of behaviors associated with acquiring HIV (e.g., needle sharing) (Premkumar, et al. 2019a, Sees, et al. 2000). However, data suggest that only a minority of jail and prison systems in the U.S. provide MOUD (Scott, et al. 2021). Further, data suggest that approximately 45% of jail facilities in the U.S. use withdrawal as a method of management of OUD for pregnant women (Kelsey, et al. 2017).

<sup>16</sup> Based on ethnographic data from medical anthropologist and obstetrician/gynecologist Carolyn Sufrin (Kuhlik and Sufrin 2020, Sufrin 2017), the method in which an incarcerated person who is pregnant receives medical attention is first by alerting a custody officer. Though the officer has the privilege of contacting a trained medical professional, they often use their own opinions about whether a pregnant detainee's reported concerns constitute a medical problem. While the American College of Obstetricians and Gynecologists, as well as various state and

have put Coralina and her pregnancy at risk for adverse outcomes, such as a stillbirth. By the time Coralina had finished posting bail in DeKalb County, she was over fifty miles from Chicago. Moreover, she had no access to medical care or housing. Coralina somehow returned to Chicago but, unsurprisingly, used heroin again.

Coralina's trek through multiple Illinois counties' legal and public health systems demonstrates that providing prenatal care and treatment for OUD are not as simple as they may seem. The prison-carceral system, DCFS, and the accessibility of medications for opioid use disorder put different pressures on Coralina, leading to withdrawal, recurrent illicit opioid use, and the need to be hospitalized. However, the overarching issue that drives this cacophony of different systems that bear on Coralina's life – the thing that I believe most dictates how she was treated, both in jail and at Stroger, and the reason that DCFS became involved in her life – is her pregnancy and her potential ability to parent a child legally. More specifically, it is that different groups, each affiliated with the state, came to understand Coralina's pregnancy and her diagnosed OUD as problems requiring identification and treatment.

The problem I am most interested in unpacking is how we, anthropologically, can situate her predicaments and actions concerning state bureaucratic practices, including biomedical care. What do they tell us about ways of being and projections about future health and life as a socioeconomically-marginalized individual with a stigmatizing, chronic medical condition?

### *The scope of the problem*

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federal laws, note the need for pregnant detainees to obtain prenatal care while incarcerated (American College of Obstetricians and Gynecologists (ACOG) 2021b), Kuhlik and Sufrin (2020) demonstrate that the gatekeeping practices of custody officers impede access.

Coralina's story points to more essential questions about multiple state-based institutions - legal, juridical, public health, and biomedical – and their competing logics. Each set of logics claim to focus on a particular form of regulating care for her health, her pregnancy, the safety of her children, and her legitimacy as a parent. Specifically, Coralina's story, as a pregnant woman diagnosed with OUD, demonstrates that systems of so-called “care” can be socially, medically, and legally punitive.

My contentions sit alongside common anthropological critiques of public healthcare systems within the U.S. (Bourgois and Schonberg 2009, Bridges 2011, Stonington, et al. 2018) and elsewhere (Farmer, et al. 2013, Fassin 2011, Keshavjee 2014, Ticktin 2011). These critiques demonstrate that state-based bureaucratic agencies can contribute to harm to people seeking healthcare (Bourdieu 1999, Bourdieu 2020, Bourdieu 1997, Bourdieu 1994, Weber 2002). Anthropologists of the state have historically been interested in how violence or indifference towards human suffering is explicitly or implicitly maintained (Berlin, et al. 2019, Bourdieu 1998). They traditionally attend to bureaucratic (Graeber 2012, Gupta 2012, Hertzfeld 1992) and other state-making practices, such as urban and agricultural planning (Ferguson and Gupta 2002, Scott 1998). Specifically, anthropologists working within this school of thought demonstrate how well-intentioned goals, such as the building of a dam to improve the electrical supply for a given area, may perpetuate marginalization and harm, such as forced resettlement of groups living in the area of the dam due to flooding from the redistribution of water (Farmer 1992, Farmer 1999, Farmer 2010, Farmer 2003).

Within this broad concept of the state as potentially generative of logics that may cause harm and marginalization towards people, I return to the case of Coralina. Despite the limited vision within which I could understand her case, I could tell she was not simply manipulated by

state practices, such as undergoing forced opioid withdrawal in the Kane County Jail. She acted in response to situations structured by state policy and procedures, managing to hedge her bets on her precarious future. She decided to undergo sterilization after the birth of her fourth child. Afterward, she left the hospital against medical advice, her newborn still in the neonatal intensive care unit. Her actions stand out for an anthropologist precisely because they conceptually demonstrate how individual behavior may simultaneously fall in and out of line with state-based bureaucratic expectations, with social, legal, and health ramifications.

Rereading Coralina's activities from a bureaucratic standpoint illuminate these contradictions. Coralina did not simply undergo a tubal ligation; she had to voice her desire and sign state-required consent forms for the procedure at least 72 hours before delivery, as the Illinois Department of Healthcare and Family Services required. Her access to surgical sterilization, that is, to a life without the possibility of becoming pregnant, *depended* on acquiescing, partly, to bureaucratic activities required by Stroger. Coralina also did not just leave Stroger after delivery and her tubal ligation: she had to do so under the quasi-legal, but bureaucratically-sanctioned, label of "against medical advice." Yet DCFS's legally-required involvement with Coralina's newborn, jeopardizing her capacity to parent, may have likely motivated Coralina to leave Stroger far before her recommended discharge date. In both instances, understanding Coralina's story, and her problems related to childbirth and OUD, require attention to bureaucratic institutions and practices. However, attention must also be paid to how Coralina colludes with and eludes these institutions and practices and what this means for her health and her precarious future.

Especially in the past fifteen years, cultural and medical anthropologists have focused on understanding human behavior and activities at the intersection of clinical medicine and state

bureaucratic activities (Crowley-Matoka 2014, Knight 2015, Mattingly 2010, Singer 2022, Sufrin 2017). These works are often categorized as forms of “hospital ethnography” (Anspach 1988, Bosk 2003 [1979], Fox 1988, Kaufman 2015, Livingston 2012, Prentice 2012), wherein the environment which the ethnographer conducts research is confined to the hospital. While this may pose limitations in traditional ethnographic inquiries, particularly related to how patients and staff live outside of the hospital, it allows for a unique way to think about thorny anthropological questions filtered through the unique blend of scientific research, biomedical practice, juridicolegal requirements, and economic reasoning that make up the American healthcare system (Starr 2017 [1982]). Specifically, the clinical encounter, or when a patient speaks with and is treated by a clinician, nurse, or another member of a healthcare team, can be used as an entry point to think about the nexus of health, debility, bureaucracy, and the state. Like other hospital-based ethnographers, I draw upon the clinical encounter to think more deeply about Coralina’s story and clinicians as actors in the milieu of agencies that interact with women diagnosed with OUD during pregnancy. However, I do so from a unique vantage point: as a practicing clinician and an anthropologist. My reasoning is partially borne out of convenience, as I work in a hospital, but also deeply personal: I am entangled in the innumerable complexities of prescribing and coordinating treatment while adhering to a variety of complex and, at times, contradictory sets of rules and regulations.

To illustrate this point, I turn to Katie, the senior resident physician who disclosed Coralina’s sudden departure from the hospital during morning “sign out” with the next shift of attending and resident physicians. I too was a resident physician in obstetrics and gynecology. I had been in her position: taking care of a postpartum patient with multiple medical, legal, and social needs, only to have the patient leave in the middle of the night against medical advice. In

such situations, how do you provide clinical care to someone who seems determined to avoid it? How do you have any meaningful, positive impact on a chronic, possibly deadly condition, like OUD, when multiple other bureaucratic groups work on the same health conditions, albeit in ways that may undermine your own?

Social scientists working in the fields of the anthropology of medicine and reproduction commonly draw upon a biopolitical framework, initially elucidated by philosopher Michel Foucault (Foucault 2010, Foucault 1978, Foucault 2007, Foucault 2003c), to capture the tensions that physicians like Katie and I have experienced in providing treatment and adhering to bureaucratic requirements (e.g., Knight 2015, Singer 2020, Sufrin 2017). Biopolitics focuses on state-based social, economic, and political activities that may lead to undue harm, suffering, and death, especially among people like Coralina. In a classic Foucauldian biopolitical conceptualization, physicians, especially obstetricians Field (Arney 1982), are one of the key groups who enact state policies that categorize appropriate behavior and expected health outcomes for pregnant women diagnosed with OUD. With the widespread application of state-based health policies through biomedical practices, some pregnant women diagnosed with OUD are helped, and their health is improved, while others are harmed (Canguilhem 1991, Foucault 1978).

However, a common limitation of anthropological analyses that use biopolitics as a guiding theory is a simplification of physicians' complex role in regulating and managing human health and illness. In a Foucauldian interpretation of biopolitics, physicians are theorized as the handmaidens of biopolitical regimes (Foucault 2010, Foucault 1975, Foucault 1977, Foucault 2007, Hacking 1982). Physicians are described as tools for enacting biopolitical paradigms, such as prescribing medications or recommending lifestyle changes to improve the population's

health. Obstetricians are no different. Whether through the process of examining a cervix (Smith-Oka 2013, Underman 2020) or discussing reproductive options, such as contraception or abortion (Singer 2022), they are theorized by social scientists as enacting forms of normalization that unduly reify inequities that lead to harm in the name of health (Arney 1982, Weir 2006).

However, recent insights from medical and cultural anthropologists trouble this assumption. Physicians are increasingly seen to manage competing, and sometimes divergent, goals of different state-based bureaucratic agencies and those of the pregnant woman, all the while trying to deploy the tools they are licensed to use to keep the patient and her fetus healthy (Buchbinder 2022, Singer 2022, Smith-Oka 2013, Sufrin 2017).<sup>17</sup> Managing this convoluted framework of risks and benefits is critical for any clinician working with pregnant women diagnosed with OUD. However, what do these competing goals mean for biopolitical theory, specifically those tasked with understanding issues of reproduction and parenting?

For my dissertation, I use cases like Coralina's as a jumping-off point to think through recent innovations in biopolitical theory and the physician's role. I show how information from clinical experiences with pregnant women diagnosed with OUD is made legible (Biruk 2018, Scott 1998) to the state to create data, legislation, and policy. I argue that this discourse creates a subject: a pregnant woman diagnosed with OUD for whom certain futures have been *foreclosed* – those futures deemed unattainable but carry differential risks for morbidity and mortality – and certain forms of existence *enclosed* – ways of life that are maintained after the possibility of alternative futures disappear, which may lead to harm or death.

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<sup>17</sup> This dichotomy is not to overstate the possibility that physicians may provide healthcare services but, in fact, not actually *care*, in the emotional sense, about the well-being of a pregnant woman. Further, a physician's actions, which may spring from intentions to avoid harm to a pregnant woman or her fetus, may lead to harm. See Goodwin (2020) for details.

*The problem of OUD in the U.S.*

Before delving further into foreclosure and enclosure, it is critical to contextualize Coralina's story within the broader problem of OUD in the U.S. In 2017, the Acting Secretary of the U.S. Health and Human Services (HHS) Eric D. Hargan declared a nationwide public health emergency<sup>18</sup> regarding the misuse of opioids in the U.S. (U.S. Health and Human Services 2017). This emergency was driven, in part, by the overprescription of opioids in the early 2000s, as demonstrated in recent television series like *Dopesick* (2021) and documentaries like *The Crime of the Century* (2021). Overusing prescribed opioids was posited to lead to subsequent misuse of nonprescribed opioids, such as heroin. Specifically, Secretary Hargan emphasized the risk of untreated OUD, which can lead to deaths from overdose, or excessive ingestion of opioids. Opioids affect the brain's respiratory drive, or the ability of the brain to stimulate the diaphragm to move for breathing to occur. By depressing the respiratory drive, opioids, in high quantities, can lead to asphyxia and death. Also complicating the diagnosis of OUD are coexisting, often untreated, psychiatric diseases and risk behaviors, such as injection drug practices, that increase the likelihood of an individual acquiring HIV.

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<sup>18</sup> Invoking an "emergency" by the state, particularly as it relates to an alleged public health dilemma, is laden with political, economic, and historical considerations. Janet Roitman (2016) notes that the use of crisis, a synonym for emergency, has moved from the concept of a "critical, decisive moment" to one that demonstrates a "protracted historical and experiential condition" (ibid, p. 18). She argues that crisis marks time by hearkening to a non-crisis period. Crisis defines what counts as "history" (i.e., the time absent of crisis) and demands a moral rectification of events that have caused them to occur. Invoking crisis does not merely create an object to observe (e.g., the opioid epidemic), but is "an observation that produces meaning" (ibid, p. 27). My point in hearkening to Roitman is to destabilize the notion of emergency within public health, and to actively question why, at certain points in time, issues like opioid use are deemed an emergency and what the epistemological limitations might be when the term is deployed.



In the most recently-available nationwide data from 2017, analyzed by Hirai and colleagues in 2021, OUD was stated to be present in approximately 8.2 per 1000 delivery hospitalizations; however, when looking at state-level data, the reported frequency of OUD varied to a peak of 47.3 per 1000 delivery hospitalizations. Similar to the problem of fatal overdose among nonpregnant individuals, OUD ranked as the leading cause of maternal mortality in Illinois in the most recent report released by the Illinois Department of Public Health (Illinois Perinatal Quality Collaborative (ILPQC) 2019). In addition, OUD during pregnancy is associated with neonatal opioid withdrawal syndrome (NOWS), wherein a newborn child exhibits signs and symptoms consistent with opioid withdrawal, such as jitteriness and, rarely, seizure activity (Ecker, et al. 2019, Reddy, et al. 2017, Schiff, et al. 2018). NOWS commonly requires monitoring in a hospital setting and, at times, treatment with medications.

However, providing medical services for a mother and their child for OUD and NOWS is not as simple as diagnosing the problem and providing treatment options. Depending on the state where a clinician is practicing medicine, they may be legally required to report people who give birth who were diagnosed with OUD but did not receive appropriate treatment to DCFS. In certain circumstances, this may lead termination of parental custody of a newborn by DCFS. (Briggs 2021, Falletta, et al. 2018, Goodwin 2020, Knight 2015, Meinhofer and Anglero-Diaz 2019, Premkumar, et al. 2019b, Roberts 1999, Roberts 2002, Roberts 2022, Sanmartin, et al. 2020).

Like any significant public health issue, there are gendered, racialized, economic, and sexualized dimensions to the problem of OUD diagnosed during pregnancy. To set the stage for the current opioid epidemic, it is essential to examine these issues during the 1980s, with the rise

of crack/cocaine use and a public health interest in perinatal outcomes associated with illicit substance use during pregnancy. An important character in this narrative is the “welfare queen”: A politized trope of a poor, hypersexualized, hyperfecund, minoritized woman who misuses federal government benefits to purchase illicit substances instead of supporting her family (Glenn 2014, Morgen and Maskovsky 2003, Murphy and Sales 2001, Note 1994, Roberts 1999, Spillers 1987). Further complicating this picture was preliminary data demonstrating an association between crack/cocaine use during pregnancy and adverse neurodevelopmental outcomes in children (Chasnoff, et al. 1985). Though these associations were later found to be erroneous, they nevertheless captured the imagination of the American public (Buckingham-Howes, et al. 2013). Critics and lay media specialists heralded the rise of a “bio underclass” (Krauthammer 1989) of children who were neurodevelopmentally delayed and would sap needed healthcare and social support resources from “more deserving” children (Glenn 2014). They would be the bane of the taxpayer, who, under policies of social retrenchment enacted by President Reagan, would be less sympathetic to providing funds to support the social safety net (Morgen and Maskovsky 2003).

What resulted from this confluence of economic, public health, and social policies? Namely, a punitive approach was taken towards illicit substance use diagnosed during pregnancy. Hospitals commonly tested the urine of pregnant women for illicit substances without consent and were more likely to test minoritized women (Chasnoff, et al. 1990). Further, legislators and clinicians treated illicit substance use during pregnancy as a form of “child” abuse, given its preliminary associations with adverse neurodevelopmental outcomes (Amnesty International 2017). Given state and national laws focused on standardizing reporting of child abuse to DCFS through the creation of “mandated reporting” (Lloyd Sieger, et al. 2021), many

pregnant women were reported to the police, which led to instances of incarceration and forced separation from their children (Annas 2001, Goodwin 2020, Roberts 1999, Roberts 2002, Roberts 2022).

These elements of the crack/cocaine epidemic find themselves reproduced in the current opioid epidemic. Treatment for OUD commonly involves opioid analogues, such as methadone, a medication that must be dosed daily at an outpatient clinic, or buprenorphine, which can be prescribed for use in private (Kuehn 2005, valentine 2007).<sup>19</sup> Medical anthropologists have demonstrated that the rhythm of life associated with attending a methadone clinic can be disruptive to other activities, such as having a job or being able to attend to the needs of family members (Knight 2015, Premkumar, et al. 2019b). Accessing buprenorphine, especially in pregnancy, is also riddled with issues. During my fieldwork, physicians had to apply for a special waiver from the Drug Enforcement Agency. This federal organization regulates who can prescribe “controlled” substances, such as methadone.<sup>20</sup> Medical anthropologist Helena Hansen and sociologist Julie Netherland illustrate that the specific dispensing requirements of buprenorphine and methadone, coupled with data demonstrating disparate access and use of either drug among minoritized groups, lead to the crafting of OUD as a “White” problem (Hansen 2017, Hansen and Netherland 2016, Hansen, et al. 2020, Hansen and Skinner 2012, Netherland and Hansen 2016, Netherland and Hansen 2017). OUD is an illness that is treated

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<sup>19</sup> Most clinics will offer “take home” doses of methadone – or methadone that may be consumed in private – after individuals have demonstrated retention in care over the course of months.

<sup>20</sup> A controlled substance is defined through the Controlled Substances Act of 1971, which classifies substances based on s medical use, potential for abuse, and safety (Drug Enforcement Agency (DEA) 2023). Since January 2023, a waiver is no longer required to prescribe buprenorphine (Substance Abuse and Mental Health Services Administration (SAMHSA) 2023).

differently – in private – and has different social ramifications if one is White compared to minoritized individuals.

Medical anthropologist and lawyer Khiara Bridges argues that the category of White is policed through state-based practices and policies. Though an individual may identify as White, if their behaviors around illicit substance use slip into the stereotypes of minoritized individuals, punitive state-sponsored interventions (e.g., termination of parental custody, incarceration) are employed (Bridges 2020, Netherland and Hansen 2016). More concerning, minoritized individuals are also less likely to be offered treatment for OUD during pregnancy (Peeler, et al. 2020). Finally, though a diagnosis of OUD has been associated with self-identifying as White, the frequency of harm associated with OUD, such as fatal overdose, is more likely among Black and indigenous individuals (Kariisa, et al. 2022).

Coralina's story reflects these epidemiological and racialized patterns of OUD diagnosed during pregnancy: her newborn child, admitted to the intensive care unit at Stroger to manage NOWS, and her history with DCFS. All these issues hinge on Coralina's interactions with multiple bureaucracies purporting to focus on her health and that of her newborn child. I use Coralina's story to think about what I call "foreclosing" and "enclosing" practices related to her future and her precarious existence as a "mother," a person with a diagnosed illicit substance use disorder, and an individual labeled as a "criminal" by the juridico-legal system. I organize the relationship of these practices under the guise of what I describe as *the performance of treatment*: the deployment of specific actions by clinicians and other state-affiliated groups focused on health that attend to bureaucratic rules and regulations but leads to forms of harm, foreclosed futures and enclosed lives, among marginalized people, such as Coralina.

### *Summarizing the problem*

Thinking about reproductive health and biopolitics, I return to Coralina's trek through multiple bureaucratic groups throughout the perinatal period. I argue that the performance of treatment – that is, the way certain futures for Coralina are foreclosed and ways of living become enclosed – in Coralina's story is multifaceted, a combination of biomedical, public health, and juridico-legal actions at the state, local, and interpersonal levels. The harm that Coralina experienced was multifaceted: her forced withdrawal in a jail cell in Kane County, her recidivism to opioid use, and her motivation, whatever it may have been, to leave the hospital against medical advice almost immediately after the birth of her child. I argue that the impetus for performing treatment rests on the state's interpretation of illicit substance use disorders diagnosed during pregnancy. More significantly, I submit that it is the state's projection of ontologies and futures that people like Caroline are made to experience that allows for the performance of treatment to occur.

For people like Coralina, the foreclosed possibilities of a life that involves ongoing treatment of OUD and subsequently enclosed precarity constitute the way treatment is performed (Premkumar, et al. 2019b). The job of my dissertation is to unveil and describe these acts of foreclosing and enclosing, thereby decomposing the performance of treatment into its constituent parts. Through this process, I critically engage with biopolitical theory and its shortcomings, providing novel insights into future directions for biopolitical thought within the anthropology of reproduction from the vantage point of clinical medical practice.

### *Methods*

To evaluate the performance of treatment, I conducted my fieldwork in a large, urban healthcare system in Chicago, Illinois. Specifically, I worked at Cook County Health's (CCH's) flagship hospital, the John H. Stroger, Jr. Hospital of Cook County (Stroger). CCH is one of the largest public integrated healthcare delivery systems in the U.S., serving the 132 contiguous urban and suburban municipalities of Cook County, including Chicago. CCH acts as the "safety net" healthcare system for Cook County – namely, it is supposed to provide healthcare services to people regardless of the ability of an individual to pay. CCH operates sixteen community health centers, as well as correctional healthcare services for the county jail (Cermak Health Services, or, as clinicians at CCH colloquially called it, "Cermak"), a juvenile detention center, and a comprehensive medical home for people living with HIV. Given the multiple forms of marginalization faced by pregnant women diagnosed with substance use disorders, CCH is one of Illinois's few public healthcare systems to engage this group in longitudinal care, including psychiatric, behavioral health, and obstetrical services.

Data informing my dissertation are drawn from a four-year engagement at Stroger (2018-2022) as a participant observer and a practicing physician-anthropologist. Institutional review board approval was given by CCH to all study activities (IRB#18-089). I conducted formal, lengthy interviews with 22 pregnant or postpartum women with OUD (Table 1) and 11 clinical staff members (social workers, resident physicians in obstetrics and gynecology) throughout this period. In addition, I spent countless hours on the labor and delivery and antepartum floors, caring for women diagnosed with OUD. I worked closely with the hospital's "Screening, Brief Intervention, and Referral to Treatment" (SBIRT) team – composed of social workers, peer support specialists, nursing staff, and physicians trained in both family medicine and obstetrics and gynecology – which helped connect pregnant women diagnosed with OUD to behavioral

health services and MOUD. Alongside an obstetrician/gynecologist colleague Dr. Cam, I coordinated care services for pregnant women diagnosed with OUD who were incarcerated at Cook County Jail with physicians working at Cermak. I also participated in state-level and national discussions on clinical management and policy surrounding OUD diagnosed during pregnancy through the Illinois Perinatal Quality Collaborative, the Society for Maternal-Fetal Medicine, and the National Academy of Medicine.

My position during my fieldwork changed over the course of four years. I started as a researcher during the early parts of my fieldwork, providing no clinical care to patients at Stroger. In late 2020, I transitioned to a clinician-researcher, working simultaneously as a maternal-fetal medicine (MFM) subspecialist and an anthropological researcher at Stroger. Autoethnographic data, derived from my clinical practice melding with my fieldwork during the latter years of my time at Stroger, is unavoidably a core component of my dissertation.<sup>21</sup> My autoethnographic perspective offers a unique vantage point to evaluate how clinical policies and practices, derived from state-based initiatives, contribute to the performance of treatment.

As compelling as autoethnographic data became for my study, my positionality as a clinician also foreclosed certain areas where I could not engage in ethnographic evaluation. For example, due to my status as an attending physician and multiple issues within the nursing union during my tenure at Stroger, I felt uncomfortable ethnographically engaging with the nursing staff. I felt that, within the clinical hierarchy, I would be seen as exerting undue pressure on them to participate. Further, they might feel pressured to provide me with the information I wanted

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<sup>21</sup> Autoethnography is defined as an “autobiographical genre of academic writing that draws on and analyzes or interprets the lived experience of the author and connects researcher insights to self-identity, cultural rules and resources, communication practices, traditions, premises, symbols, rules, shared meanings, emotions, values, and larger social, cultural, and political issues” (Polous 2021).

rather than accurate information. I would also be remiss not to emphasize how much the COVID-19 pandemic affected my ability to conduct fieldwork. My role as a clinician required me to care for pregnant people during the Omicron variant surge in 2020-2021, sometimes taking away time I could have spent performing additional key informant interviews. On the other hand, I believe that it is precisely because of my clinical duties, with all their challenges, that I was able to complete two essential tasks: 1) To obtain information about how patients navigate the convoluted public healthcare system in Cook County and 2) To foster solidarity with my clinician interlocutors.

The latter conclusion foregrounds an ongoing ethical dilemma common to clinician-researchers: how does one separate “clinical work,” such as seeing patients in the clinic or attending births on the labor and delivery unit, from “research”? What if you cannot? Could this make one’s findings less reproducible, therefore less credible? Throughout my fieldwork, I have attempted to maintain some level of separation between my clinical and anthropological roles while acknowledging that a clean split between the two is neither possible nor fully desired. During fieldwork, I tried to reflect critically on my positions and ethical stakes as a clinician. Throughout my dissertation, I try to put as many assumptions I have made about OUD during pregnancy, DCFS, and maternal morbidity and mortality up for debate while contextualizing my position on these issues from a clinical standpoint (Kierans and Bell 2017).

Data collection was one of the first places I began to run into the thorny problems associated with being both an active clinician and a research anthropologist whose field of study included my clinical role. I tried to institute concrete practices that might help to clarify the split between both identities, such as pursuing recruitment of and interviews with other clinicians when I was not clinically active (i.e., not directly overseeing patient care) and specifically



interviewing pregnant women diagnosed with OUD if I was not providing clinical services to them. As much as I tried to solidify the barrier between being a clinician and an anthropologist, I could not fully dissociate the two identities. From a pragmatic standpoint, participating in fieldwork during the COVID-19 pandemic would have been next to impossible had it not been for my clinical practice. As physician-anthropologist Carolyn Sufrin (2017, pp. 18-19) describes her experience of investigating reproductive health practices in the prison-carceral system:

My status as a doctor gave me access to sites and situations that would have been off-limits if I were “just an anthropologist” – and had I not had history there, for the staff had come to trust me. I also knew how to navigate the rules and spaces of the institution [...] [I]t was impossible to distinguish my roles and insights gained from being a doctor and an ethnographer.

Sufrin’s discussion of the “insider” perspective garnered from being a physician-anthropologist elides the effort needed to maintain the divide. In my fieldwork, and primarily as my research protocol was being evaluated by the Institutional Review Board (IRB) at CCH, I had to consistently use my clinical expertise to justify my research questions and methodologies. Indeed, IRB staff told me on more than one occasion that my research proposal would have been dead in the water without my clinical background. Like Sufrin’s claims regarding staff trust, I, too, had social capital to spend with the IRB. Because of my background as a MFM and my employment through CCH, I was not perceived as an “outside” researcher preying upon the marginalized individuals who seek care at Stroger.<sup>22</sup> I suspect that because I was providing

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<sup>22</sup> During my time at Stroger, I was attempting to start to approach pregnant people for a large National Institutes of Health-funded study focused on investigating whether maternal stress during pregnancy was associated with offspring neurodevelopmental outcomes. The study’s primary investigators were housed at a large academic institution in Illinois. As I tried to get the study protocol through the CCH IRB, one of the committee members relayed that they were

clinical care – that I was not just “taking” data without any benefit to the institution – my IRB protocol, which would have otherwise not gotten past full board review, was ultimately accepted.

Being a physician-anthropologist also had ramifications for my interaction with resident physicians. I was privileged enough to be in a unique situation that does not commonly occur among physician-anthropologists: I was a medical trainee – as a fellow in MFM – with many of my resident physician interlocutors. We worked together in the operating room on complex obstetrical cases, cracked jokes on rounds on the antepartum unit, and decompressed over drinks at a local bar to process the stress of working almost 100 hours a week. Because of these experiences I had before my fieldwork, the power dynamic that is traditionally at work between an attending physician and a resident physician – one that is infused with austerity from the former and obedience from the latter – was not present in the same degree while I was at Stroger (Becker 1961, Bosk 2003 [1979], Fox 1988). While the power within the medical hierarchy can be an issue in any examination of biomedical care, the collegiality afforded to me by resident physicians was forged not through wielding power over the powerless but through working side-by-side.

#### *A note on being an MFM*

Before discussing the organization of my dissertation, I want to highlight the perspective I bring to the data at hand and biopolitical theory. My position prioritizes some aspects of

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particularly concerned about the politics of large academic centers using safety-net hospital systems for data collection. This individual implied that because the academic center funded to do the study did not contribute to the clinical service provision of CCH, the feasibility of the study was under question. This sentiment – that academic centers are predatory towards people receiving care at Stroger for research purposes – was also voiced to me by other clinician-researchers at Stroger, even though many of them did hold academic appointments at research institutes across Chicago and conducted research at Stroger.

pregnancy – namely, the pregnant woman, as opposed to her family, partner, other children, and the newborn child. This orientation is familiar to most MFMs and is replicated throughout our pedagogy and practice (D'Alton 2010, D'Alton, et al. 2013). Further, my position also focuses on specific spaces where healthcare is provided, such as during an inpatient admission to the hospital as opposed to outpatient prenatal care in a clinic.

What is the reason for emphasizing these aspects, as opposed to a more global view of pregnancy, kinship, and healthcare service provision? Due to my clinical activity as an MFM, I primarily saw poor pregnant women diagnosed with OUD during their antepartum hospitalizations. Often, my pregnant interlocutors were away from family and support systems, as they had traveled long distances to obtain MOUD because their local clinician did not undergo appropriate training to treat their diagnosed OUD. Some were incarcerated and were separated from their loved ones. Others would be admitted to the antepartum unit at Stroger early in their pregnancies, stabilized on MOUD, discharged, and subsequently delivered their babies at other hospitals. These fleeting moments spent in the confines of a hospital – often on the order of days – are the basis of my analysis. On the surface, these data could be seen to lack the *longue durée* traditionally associated with ethnographic inquiries. However, my longitudinal presence as a clinician at Stroger and the highly-constructed circumstances in which pregnant women diagnosed with OUD find themselves at Stroger are rich with details for my analysis.

To further delineate my perspective, I propose a thought experiment: imagine, for a moment, that you are an obstetrician in the contemporary U.S. Your job, day in and day out, is to provide care for pregnant women, either in an outpatient clinical visit or during time spent on a labor and delivery unit. You work with a team of nurses and other physicians from multiple specialties – like anesthesiology, pediatrics, and family medicine – and in different levels of

training (some are newly-minted intern physicians, others are seasoned attending physicians).

Every day, you spend your time in one of three places:

- a) In the clinic<sup>23</sup>, listening to pregnant women discuss issues associated with their pregnancies, measuring their abdomens to detect any issues with fetal growth, and auscultating the soft *thock-thock* – the sound akin to a tennis ball hitting a concrete wall – of the fetal heart with a handheld Doppler machine;
- b) In the hospital’s “labor and delivery” unit, helping birthing women through their labor course by attempting to evaluate their overall well-being and that of the fetus through modes of surveillance, such as serial pelvic examinations and electronic fetal monitoring; and
- c) In the operating room, working with a larger group of individuals to safely and swiftly perform cesarean births, deliver twin pregnancies, and, in the rare circumstance of unmitigated hemorrhage, emergency hysterectomies to save the life of a newly-postpartum woman.

Couple this overarching view of obstetrical practice by inserting any form of illness or debility – whether brought about by the pregnancy, injury, or a chronic condition that a woman had before getting pregnant – and the job becomes even more complicated. Helping a pregnant woman understand the risks of an illness for a developing pregnancy, the options for treatment (inclusive of abortion), and the need to coordinate longitudinal care – including care after

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<sup>23</sup> Outpatient prenatal clinics can be located both within a hospital complex or as “freestanding” buildings located away from a hospital. The clinic where I provided prenatal care was located within Stroger, on the same floor as the labor and delivery unit. It was made up of a small waiting room, with about 20 chairs lining the perimeter. Through a locked door was a series of clinic rooms, each filled with an examination table, sink, and a stack of drawers with assorted tools to aid in obstetric and gynecological examinations, such as speculums and Pap smear brushes and spatulas. One room had a large ultrasound machine to help physicians confirm fetal heart activity in case a standard evaluation with a handheld Doppler machine was not useful. Medical assistants and nurses sat in two rooms nearest to the entrance to the clinic, while the physicians sat in a central workroom of about 10 computers, nestled in an area just adjacent to the clinic rooms.

delivery with a primary care physician – is critical (American College of Obstetricians and Gynecologists (ACOG) 2018a, Kaimal and Norton 2021).

Certain obstetricians see people afflicted with one or more illnesses during the pregnancy, for whom the risk of morbidity and mortality is substantially higher for the pregnant woman and/or the fetus. These are people who specialize in MFM. Commonly, MFMs serve multiple roles within hospitals and health systems. They act as “pregnancy experts” based on their education in the pathophysiology of maternal and fetal conditions that lead to morbidity and mortality. They review adverse obstetrical outcomes at the hospital level and provide knowledge to identify missed opportunities that may have led to an adverse event. They also serve as public health practitioners on state-level maternal morbidity and mortality committees. In their public health role, MFMs advocate for policy changes that could improve the health and care of pregnancy-capable people and assist in creating state-level interventions focused on reducing frequencies of maternal morbidity and mortality.

This is the vantage point from where I write my dissertation. I vacillate between analyses of data derived from “the bedside” – or clinical encounters between a physician and a patient – and epidemiological data. The movement between different data and spaces may sometimes seem unfocused and unwieldy. But for those of us who work as MFMs, these wildly different positions are all home to us. Many of us participate in state or national conferences focused on reducing maternal morbidity and mortality during our lunch breaks during a busy day seeing patients in the clinic or between attending births on labor and delivery. We edit and review manuscripts focused on interventions to reduce the frequency of maternal morbidity and mortality on call overnight at the hospital. We submit grants to the National Institutes of Health before we run to consult on people with potentially life-altering diagnoses. To critically engage

in questions surrounding morbidity and mortality during pregnancy, I must offer critique and analysis in each of these spaces because, as a clinician, I constantly move through them.

*An overview of the dissertation*

The dissertation contains five chapters, linked through different critiques of biopolitical theory through illustrations of the performance of treatment, from healthcare policy to the clinical bedside. Out of the gargantuan amount of data I derived from four years of research, I have chosen to focus on four topics: Illinois-specific maternal morbidity and mortality statistics focused on OUD; the affective role of DCFS in the clinical encounter with pregnant women diagnosed with OUD; how pregnant women diagnosed with OUD discuss their risk of acquiring HIV; and the role of an opioid-related overdose in fostering social and institutional relationships between pregnant women diagnosed with OUD and healthcare services. I have intentionally chosen these topics from a clinical perspective, as they are relevant to the counseling and recommendations I provide pregnant women diagnosed with OUD. These topics also reflect my anxieties about what can go wrong with people diagnosed with OUD and the harm that substance use disorders can do to the health and well-being of an individual that extends beyond pregnancy and into the rest of their lives.

I begin my dissertation by defining what performing treatment for illicit substance use disorders diagnosed during pregnancy looks like by critiquing Foucauldian iterations of biopolitical theory and theories of the state. I outline how certain futures of pregnant women diagnosed with OUD are foreclosed, and their lives and those of the physicians who care for them are enclosed. By having different groups (e.g., physicians, public health departments) attend to bureaucratic rules and regulations related to healthcare, namely *performing* forms of

treatment, certain temporalities and ontologies for patients and the physicians who care for them are created and maintained, leading to potential forms of harm towards pregnant women diagnosed with illicit substance use disorders.

In Chapter 2, I examine one aspect of the performance of treatment by attending to the logic of foreclosure. I critically evaluate the etiologies and strategies for managing maternal morbidity and mortality related to OUD in Illinois and Chicago. I delineate the logic of foreclosure present in proposed solutions to the high frequency of maternal morbidity and mortality among people of color in the predominantly-marginalized South and Westsides of Chicago – areas within the catchment area of CCH. By analyzing state-proposed solutions to the issue of high maternal morbidity and mortality, I posit that, in Illinois, the state is privileging public discourse that appears to be aimed at reducing geospatial and racial disparities in maternal morbidity and mortality. However, I believe the state’s proposed solutions seldom seem to go beyond the reification of inequities along racial and class lines in Chicago. I argue that the state perception of maternal morbidity and mortality forecloses solutions that might radically alter the lives of pregnant women living on the South and Westsides. By foreclosing certain solutions – performing specific “treatments” to reduce excess morbidity and mortality – demonstrate that the goals of state-based programs may be to “soften injustice” (Singer 2021, p. 198), rather than ameliorate it.

These findings add to biopolitical approaches to reproduction and the state by complicating epidemiological strategies to understand maternal morbidity and mortality. My findings, alongside insights from anthropologists working in science-and-technology studies and critical global health, suggest how data on maternal morbidity and mortality do not simply record the world as it exists or a version of the world as it is thought to exist. Instead, these data exist in

discourse with other groups – policymakers, clinical practitioners, and the very people who are being measured. Further, strategic selections of measures shape views of who is included in a population, what problems exist for a population, what interventions should be used to reduce the harm associated with a particular problem, and, importantly to my argument, exclude alternative forms of conceiving problems and solutions that may exist (Adams 2016, Biruk 2018, Storeng and Béhague 2017, Storeng and Béhague 2014). In line with anthropologist David Reubi’s (2020) insight, my data demonstrate how epidemiological data can “articulate complex and normatively loaded visions of social life that both enable and constrain action” (ibid, p. 2). For me, the “action” can be “the lack of action,” the foreclosing of possibility for policies and practices that could exist but do not currently (and, perhaps, will not in the future).

Chapter 3 evaluates the process of enclosing – how particular forms of existence are policed through different policies and practices – through a meditation on DCFS’s legal role in the biomedical care of pregnant women diagnosed with OUD who receive prenatal and postpartum care at Stroger. Illinois state law mandates that substance use during pregnancy is reportable to DCFS (Guttmacher Institute 2021). Critics of DCFS, such as sociologist Dorothy Roberts (1997, 2002, 2022), argue that the logic for surveilling the behavior of pregnant women lies in the false assumption that certain behaviors, which can potentially be identified before childbirth, can either predict child abuse, or, in the setting of substance use during pregnancy, be construed as a form of child abuse by equating the fetus as morally and biologically equivalent to a child. Harkening to critiques of neoliberalism and tenants of critical race theory, Roberts nuances her argument by suggesting that individuals who are poor, minoritized, and/or engage in illicit substance use during pregnancy are morally inferior to others. The attribution of moral inferiority rests upon a historical assumption that addiction is a matter of choice, indicating a



defective will to improve one's condition (Carr 2011, Gershon 2011). The remedy to a defective will is ultimately thought to be within the purview of the state. In the most extreme of state actions, a child born to a woman who was using illicit substances during her pregnancy may be placed on a "police hold" by DCFS, barred by law enforcement from being discharged from the hospital with their mother. A police hold may culminate in eventual reunification between the woman and her child. Still, it can also lead to the termination of parental custody and the child being placed in the care of relatives or within the foster care system (Knight 2015, Meinhofer and Anglero-Diaz 2019, Reich 2005, Roberts 2002).

Using case studies of physician and patient interactions, I trouble the assumption that biomedical practice and state-based policies focused on regulating families and parenting are inextricable from one another (Feder 2007, Foucault 1978, Knowles 1997, Taylor 2012, Wells 2011). In contrast to traditional biopolitical interpretations of clinicians as handmaidens of state interests in surveilling and reporting behavior, I demonstrate that these roles are *negotiated* within the clinical encounter through interpersonal interactions, such as between a patient and their clinician (Goodwin 2020). Thus, the process of enclosure is not wholly implemented hierarchically – from the state, on high, down to the individual. Instead, I argue that, in the clinical encounter, enclosure is instigated through the management of different affects, or a pre-social, pre-linguistic, and, thus, pre-cognizant state of being which can become an emotion through a sociolinguistic utterance (Massumi 2021, Underman 2020). Therefore, my data contribute to the burgeoning literature focused on affect theory and biopolitics by thinking about the affective dimensions of enclosure not as a process that is *imposed* upon pregnant women diagnosed with OUD but *managed* in the patient-clinician encounter (e.g., Schuller 2018, Underman 2020).

In the final two chapters of my dissertation, I investigate how the performance of treatment associated with OUD diagnosed during pregnancy *categorizes* specific future-related health events. My motivation for thinking about how actors envision alternative futures beyond the pregnancy at hand stems from my clinical practice. I have been inculcated to counsel pregnant people about their health and lives *beyond* the immediate pregnancy. This may take the form of discussing how to prepare for a subsequent pregnancy or consider long-term risks for developing chronic medical conditions after pregnancy, or both.<sup>24</sup> I specifically analyze the risks of acquiring HIV and dying from an opioid-related overdose, as these reflect my anxieties for my patients diagnosed with illicit substance use disorders during pregnancy.

In Chapter 4, I tackle what I believe are the public health attempts to foreclose access to pharmaceutical technologies aimed at reducing the risk of acquiring HIV among pregnant women diagnosed with OUD. Epidemiological data from the U.S. demonstrate that pregnant and postpartum women diagnosed with OUD are one of the highest risk groups for acquiring HIV; this is theorized to be due to practices associated with drug use, such as transactional sex work and sharing injection equipment with others (American College of Obstetricians and Gynecologists (ACOG) 2014). As part of a statewide endeavor to reduce the number of people who are acquiring HIV, the Getting to Zero-Illinois program aimed to increase the percentage of

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<sup>24</sup> Researchers in the past ten years have sought to evaluate how pregnancy-related health complications may serve as a “window” to depict future morbidity and early mortality. For example, researchers have demonstrated that developing preeclampsia during pregnancy has been associated with a higher risk for developing cardiovascular disease later in life, when compared to people who do not develop preeclampsia (Brown, et al. 2013). I use this concept as an entry point to think about future morbidity and mortality among pregnant women diagnosed with illicit substance use disorders, and what this, anthropologically, tells us about biopolitical theory, individual agency, and the performance of treatment.

people using pre-exposure prophylaxis (PrEP), a daily oral medication used to reduce the risk of acquiring HIV (Getting to Zero Illinois (GTZ-IL) 2019).

Based on ethnographic data from pregnant women diagnosed with OUD receiving prenatal care at Stroger and an evaluation of public health messaging on HIV risk and PrEP, I demonstrate a conflicting biopolitical focus on population health. I show how PrEP-specific public health messaging emphasizes the risk for HIV acquisition among transgender women and men who have sex with men. However, it fails to acknowledge the risk of acquiring HIV among cisgendered women, especially those who are pregnant or using illicit substances. The practice of foreclosing the possibility of acquiring HIV in the future among cisgendered women continues a longstanding biopolitical framing of HIV as an event that either does not occur or occurs so infrequently as to lack importance for state-based organizations (Treichler 1999, Watkins-Hayes 2014).

The possibility of acquiring HIV predicted in epidemiological analyses, I believe, is virtually ignored in public health messaging for PrEP for pregnant women diagnosed with OUD. My data demonstrate that most individuals describe their risk of acquiring HIV in the future as unlikely. While a minority of individuals describe the desire to start PrEP in the present (e.g., Groves, et al. 2022), a critical finding from my data is that individuals specifically describe the desire to *have been offered PrEP in the past*. The shift in temporality – running back to a time where, for a variety of reasons, the risk of acquiring HIV was much higher than what it was at the time of my interview with a pregnant interlocutor – offers a novel opportunity to consider how the foreclosure of risk by pregnant women diagnosed with OUD is temporally constrained. My data expand on these topics by helping me to critique *anticipation*, a biopolitical approach to understanding modes of being and thinking in the present that prepare someone for a future

situation, whether likely or unlikely (Adams, et al. 2009, Johnson-Hanks 2002). I think about how an individual reckons with past behaviors, which may have increased their risks of acquiring HIV in an alternative future. In contrast to biopolitically-informed theories of temporality and its relationship to preventative health, I draw attention to the role of self-perception of past behaviors and the construction of futures that may not be likely but must be reconsidered in the light of PrEP (Adams, et al. 2009, Clarke, et al. 2003).

In Chapter 5, I focus on the enclosing practices of interpreting fatal and nonfatal opioid-related overdose during pregnancy and the postpartum period by the state. I counter this interpretation, heavily reliant on biomedical and public health goals of preventing mortality, with my interlocutors' experiences of nonfatal opioid-related overdose and deaths of interlocutor's friends or family members due to opioid-related overdose. Harkening to Chapter 2, fatal and nonfatal opioid-related overdose constitutes one of the significant contributors to maternal morbidity and mortality in Illinois (Illinois Department of Public Health (IDPH) 2021). The Mothers and Newborns affected by Opioids initiative – a statewide initiative aimed at reducing morbidity and mortality associated with OUD during pregnancy - emphasizes the need to reduce the risk of fatal overdose during pregnancy and postpartum. Utilizing biopolitical theories that focus on the activities of the state that “*disallow* [life] to the point of death” (Foucault 1978a, p. 113), such as necropolitics and thanatopolitics (Esposito 1998, Mbembe 2019), I examine how my pregnant interlocutors describe opioid-related overdose, either as an inevitability for themselves (Garcia 2010, López 2020) or as a way to facilitate engagement in behavioral health and psychiatric services, such as initiating MOUD during pregnancy.

I coin the phrase *the social context of overdose* to describe what connections appear to be created and lost between pregnant women diagnosed with OUD and their wider community of

family and friends and how these connections act as motivation for engaging or disengaging in long-term healthcare use. I argue that the social context of overdose complicates current anthropological applications of biopolitical theory to understanding overdose, as it deemphasizes the inevitability of or the consistent production of death (Garcia 2010, López 2020, Stevenson 2014). I argue that the social context of overdose indicates a particular configuration of how pregnant women diagnosed with OUD try to adjudicate their own risk for death or harm in a highly marginalized environment: they entertain certain futures, foreclose others, and enclose particular ways of living that acknowledge death yet simultaneously strive to avoid it.

I conclude my dissertation with a coda, situating my findings and the performance of treatment in a reproductive healthcare landscape after *Dobbs v. Jackson Women's Health* in June 2022. I utilize data demonstrating similarities between the criminalization of pregnancy associated with substance use and those against pregnant women seeking or undergoing an abortion. I specifically think about abortion as a form of “treatment,” in line with advocacy from the American College of Obstetricians and Gynecologists (2020a) to categorize abortion as a form of healthcare. I take up Roberto Esposito’s call for affirmative biopolitics –a move away from the governance *over* life and towards the governance *of* life (Tierney 2016) – to pivot towards understanding attempts to manage reproductive harm by different actors through fostering community. I use the case of Lizelle Herrera, a woman jailed in Starr County, Texas, in April 2022 for a self-managed abortion, and subsequent support for her from national, nongovernmental reproductive justice organizations, like If/When/How and the Frontera Fund to think critically about how affirmative biopolitics may look in a deeply punitive legal environment. In this way, I contend that such an approach to the issue of abortion access in the

U.S. can shed light on areas where enclosing and foreclosing practices are managed by different actors and what those managing skills may look like in practice.

## Chapter 1. Foreclosing futures, enclosing lives: on the performance of treatment

In this chapter, I situate my theoretical basis for understanding foreclosure and enclosure as a form of *performance*, requiring efforts by multiple groups across different hierarchical levels, from the clinical encounter to state policy and legislation. To fully elucidate these concepts, I draw upon theoretical guidance from anthropologies of the state and biopolitical theory because of my interest in how state policy and legislation interact with the ability to provide healthcare services, such as prenatal care, to highly-marginalized people, such as pregnant women diagnosed with illicit substance use disorders. My dissertation critiques certain iterations of and rejoinders to Foucauldian biopolitical theory, specifically the embodied tensions that physicians experience when simultaneously attempting to provide healthcare services while adhering to complex regulatory schemes laid out by the state. These tensions are critical to understanding how and under what conditions biopolitical regimes may be enacted through biomedical practices and how they are negotiated between a patient and physician and inconsistently applied.

### *On the state and bureaucracy*

Before diving into my conceptualization of the performance of treatment, I want to illustrate what I mean when I invoke “the state” and “bureaucracy.” The state is a key player in my dissertation, given my assertion that foreclosing acts emanate, in part, from bureaucratic groups – or agencies, departments, and other organizations that form parts of the government which are created mainly by appointment, rather than through a mechanism like a general election (Graeber 2012, Gupta 2012, Hertzfeld 1992). For my dissertation, bureaucracies are critical to the way the state enacts forms of power through surveillance and intervention. From a

pragmatic standpoint, as my data are derived from Illinois, I use “the state” as a stand-in for “the state of Illinois.” However, my theoretical construction of the state and its activities draw from political anthropological and sociological examinations of the state. Specifically, I think about the state as a set of bureaucracies that render certain parts of a given environment as natural and measurable, such as the annual rate of maternal morbidity and mortality (Hacking 1982). Further, the state is also defined by its ability to intervene upon these measurable events, attempting to govern the frequency of their occurrence among its constituents (Annavarapu and Levenson 2021, Foucault 1977, Scott 1998).

Using the framework created by James C. Scott (1998), social actions such as a pregnant woman dying after ingesting heroin are uninterpretable to the state in a “raw” form. The act must be “cooked” to distill enough information to guide policy, such as having a coroner rule that the cause of death for the woman was due to heroin and producing appropriate documentation. Insofar as the state’s existence is presupposed on fulfilling objectives, such as promoting the health and welfare of its constituents, the state’s interpretation of social phenomena inherently supersedes local knowledges and practices instead of standardization. Therefore, what the state may consider to be phenomena worth evaluating, such as an apparent rise in the annual frequency of fatal overdose due to opioid use disorder (OUD) diagnosed during pregnancy, and appropriate solutions to the issue, such as public health messaging on the use of harm reduction tactics for curbing the risk of opioid-related overdose, may not be incongruent with the experiences of individuals themselves.

The potential for contradictory perceptions of illicit substance use disorders by the state and pregnant women requires attention to conflict, negotiation, and resolution among multiple stakeholders. Pierre Bourdieu's theories of the state are helpful to consider in this regard. He



situates his analysis by defining the state through its actions (Bourdieu 1994; 2020), namely its ability to name and reify social categories and elevate them to unquestioned social truths (e.g., Bourdieu 2020, p. 28). To attend to different actors and their role in state creation and maintenance, Bourdieu conceives the state as a field: a “network, or a configuration, of objective relations between positions” (Bourdieu and Wacquant 1992, p. 97). He likens the field to a game, wherein different agents and institutions struggle within states for the collection, control, and manipulation of multiple forms of capital (e.g., economic, political, cultural, symbolic); the assumptions and regularities associated with interactions between agents and institutions are constantly renegotiated. Therefore, to conceive of the state as a field – one in which forms of capital are centralized, controlled, and unevenly distributed among its population – is to open a possibility of analysis that takes into consideration struggles for power between institutions and agents as well as attention to networks of alliance, collusion, and conflict (Bourdieu 1994; Bourdieu and Wacquant 1992). Further, it considers the ramifications of the state's power to name, and thus define and legitimate, particular populations, problems, and solutions (Bourdieu 2020, p. 9).

With this overarching perspective on the state and bureaucracy, I turn to how the state is conceived in relation to monitoring and intervening upon the health of certain individuals through an exegesis of Foucauldian biopolitical theory. Given my focus throughout the dissertation on pregnant women, I specifically engage with biopolitical theory pertaining to reproduction. Through this evaluation of biopolitics, I lay the groundwork for my critique of Foucauldian biopolitics through an elucidation of foreclosure, enclosure, and the performance of treatment.

*Clinical practice, biopolitics, and reproduction: limitations and a path forward*

My dissertation examines health, illness, and death. The primary ways in which foreclosure and enclosure exist in the lives of my pregnant interlocutors, the clinicians working with them, and the state-based bureaucratic activities that affect them can be understood through the lens of what has been called “biopolitics.” I begin from the Foucauldian perspective on biopolitics but utilize much of my dissertation to critically engage with some of his interlocutors who have focused on reproductive health – particularly during pregnancy. I turn to rejoinders to Foucault’s iteration of biopolitics via theories of stratified and distributed reproduction (e.g., Colen 1995, Murphy 2017), as well as reproductive governance (Morgan and Roberts 2012). These theories offer a backdrop for my engagement with biopolitics, serving as a map for key sites of interrogation that I will discuss in further detail in each of the chapters.

In *The History of Sexuality, Volume I*, Foucault (1978) elucidates his theory of biopower, or the “power to *foster* life or *disallow* it to the point of death” (ibid, p. 138, italics in primary text) as the primary means in which a population – or a group of people that come to be surveilled and intervened upon by the state – is created. Foucault describes biopower using a bipolar model, vacillating between what he terms an “anatamopolitics,” the individual physical body as the site of discipline, and “biopolitics,” state efforts to measure biological processes (e.g., frequencies of birth and death) and to intervene in them (ibid, p. 139). The purpose of state-based interventions focused on biological processes, he argues, is critical to creating and maintaining a population (Curtis 2002). For this to occur, the state must also have deemed

biological functioning to be superfluous or harmful among other segments of the population (Foucault 1977, Foucault 1980).<sup>25</sup>

Multiple scholars in the social sciences have engaged with Foucault's initial iteration of biopolitics as it relates to the state's alleged preoccupation with health and reproduction among certain groups.<sup>26</sup> A key insight into the conception of biopolitical activity in this domain was provided by Shelee Colen in her Marxist-influenced elucidation of *stratified reproduction* (Colen 1995). Colen sought to delineate whom the state saw as being compelled to reproduce – in effect, who bore the brunt of “bearing, raising, and socializing children and of creating and maintaining households” (ibid, p. 78). She described stratified reproduction as a phenomenon that emphasized how:

[...] physical and social reproductive tasks are accomplished differently according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in a global economy, and migration status and that are structured by social, economic, and political forces” (ibid).

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<sup>25</sup> For example, in “The Politics of Health in the Eighteenth Century,” Foucault (1980, p. 169) argues that the state created the categories of the “good poor” and the “bad poor,” the “involuntarily unemployed” and the “willfully idle,” respectfully. He notes that during the eighteenth century, the state begins to privilege non-disabled poor individuals to work while attempting to limit the stress the “willfully idle” place on the rest of society by forcing them to support themselves without governmental assistance, leading to sickness and incapacitation (ibid). See Chapter 3 for a further discussion of this phenomenon in relation to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

<sup>26</sup> The use of biopolitical theory as a distinct approach in the social sciences, particularly anthropology, began with Paul Rabinow's initial work with Foucault, stemming from Foucault's residency at University of California Berkeley in the 1980s (Rabinow and Rose 2006). Within the anthropology of reproduction, William Arney's ethnography of obstetrical practices in the U.S. (1982) was one of the first works which relied heavily upon Foucauldian iterations of biopower.

Though Colen's work focused on childcare, the concept of stratified reproduction has been extended to engage more specifically with questions of pregnancy and childbearing. Researchers in the U.S. and globally have utilized the theory of stratified reproduction to ask critical questions about topics as diverse as prenatal care, genetic testing, abortion, maternal-fetal surgery, contraception, and the politics of reproduction among marginalized groups (e.g., Andaya 2018, Bridges 2011, Casper 1998, Ginsburg and Rapp 1995, Kanaaneh 2002, Knight 2015, Knight, et al. 2019, Singer 2022, Theobald 2019, Wahlberg and Gammeltoft 2018, Weir 2006). However, an important question thinly addressed by Colen and her interlocutors: *why* certain populations are considered to be compelled to reproduce? To address this question, scholars within science-and-technology studies proposed the concept of distributed reproduction (Haraway 2016, Murphy 2017). Historian Michelle Murphy argues that the biopolitical concept of a population has an *a priori* set of expected probabilities for life, death, and reproduction baked into it. She posits that by asking *what* gets reproduced (i.e., institutions and behaviors, see *ibid*, p. 141), instead of *who* gets to reproduce, social scientists can expand their analytic purview to ask why practices and policies nurture reproduction for some and not others. Anthropologists Lynn Morgan and Elizabeth Roberts take up this focus on practices and policies in their theory of *reproductive governance*, or how state-based groups may use legal, economic, moral, and ethical activities to “produce, monitor, and control reproductive behaviors and practices” (Morgan and Roberts 2012, p. 243). Anthropologists have sought to trouble the hierarchical approach to understanding reproductive governance – that is, policies emanating from the state that impinge

on an individual's desire to be pregnant or not, and to parent in a safe environment (Ross and Solinger 2017).<sup>27</sup>

A significant limitation to the extant interpretations of Foucauldian biopolitics that draws attention to monitoring and intervening in pregnancy and motherhood lies in the role of the physician. In the past decade, medical anthropologists have sought to trouble the Foucauldian notion of the physician, especially that of obstetricians (Arney 1982), as an instrument of biopolitics (Foucault 1980). In attempting to provide healthcare services to patients, physicians must deal with contradictions imposed by bureaucratic rules and state legislation (Buchbinder 2022, Singer 2022, Smith-Oka 2013, Sufrin 2017). However, these anthropologists focused primarily on bureaucratic policies, practices, and rules which impact pregnant women's health and clinicians' ability to provide healthcare services. I argue that this is only one part of the story.

What gap in biopolitical theory does a perspective like mine, derived from simultaneous clinical practice and critical anthropological research, fill? What novel perspective might it provide? My contribution begins from a struggle I have faced throughout my formal training in cultural anthropology. It boils down to these two questions: if physicians and the biomedical system are thought to be harmful, “handmaidens” of a larger biopolitical paradigm that inevitably reinforces inequity, how do I understand the meaning of my actions as a clinician? And if I think my clinical activities ultimately do more help my patients heal and improve their health, how do I demonstrate this, and what does this mean for anthropological critiques of biomedicine, public health, and the state?

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<sup>27</sup> Scholars focusing on the anthropology of the state have critiqued the concept of the state as a monolith, or a unified structure with similar goals and practices that can be evaluated from the local to the national levels. See Ferguson and Gupta (2002), Gupta (2012), Buchbinder (2022).

My data suggest that there is a critical interplay between bureaucratic policies, practices, and rules and the provision of healthcare services that do not necessarily hamper pregnant women and their physicians from working together to potentially achieve a healthy pregnancy and childbirth. Instead, I argue that this interplay is a *performative* act insofar that it communicates that rules and policies are being followed, thereby achieving an illusion of treating illicit substance use disorders during pregnancy. The performance of treatment necessitates *foreclosing* certain futures and actions and *enclosing* specific ways of existence and ways of practicing medicine, for pregnant women and their physicians respectively.

Wrangling with the performance of treatment lies at the heart of my analysis of biopolitical theory. Indeed, my anthropological critiques cannot solely lie outside of actual biomedical practice insofar as I must reckon with their clinical implications. In the next section, I elucidate the theories of foreclosure, enclosure, and the performance of treatment in the setting of illicit substance use diagnosed during pregnancy. My dissertation will use these terms to critique perspectives on Foucauldian biopolitical theory that do not center on the contradictions inherent in providing healthcare services to highly-marginalized individuals, such as pregnant women diagnosed with illicit substance use disorders.

### *On foreclosing and enclosing: the performance of treatment*

The term foreclosure has been used in various ways in the 20<sup>th</sup> century by social scientists and humanities scholars investigating questions of temporality and the self.<sup>28</sup> Anthropologist

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<sup>28</sup> French psychiatrist and psychoanalyst Jacques Lacan employed the term to evaluate identity formation and consolidation. He posited that a key component of childhood development was exposure to the depth and breadth of societal activities, such as the arts, through a father. Without this crucial activity performed by the father, a child would not fully extricate themselves from their mother, leaving them unable to gain independence. Lacan posits that psychosis stems

Elizabeth Povinelli (2001) uses the term foreclosure, in concert with the term emergence, to describe how people may communicate with one another. Povinelli couches the ability to communicate in the rendering of different social worlds as *commensurate*, or able to be compared with one another. Therefore, individuals sharing some aspects of different social worlds will have a commonality between them, a sense of shared ontologies and epistemologies. Without commensurability, Povinelli argues that the ability to communicate is diminished, and opportunities for collaboration are foreclosed. If social words can be made commensurate, communication is successful and can potentially lead to the emergence of novel forms of community building. A philosophical conceptualization of foreclosure like Povinelli's – as affecting potential futures, communicative or otherwise – is one that I lean upon throughout my dissertation.

From my perspective, as someone who attended high school and college in the early 2000s, the term *foreclosure* has an association with the American financial crisis of 2008 and the massive loss of home ownership that resulted among the general population. In her analysis of the housing market crisis of the early 2010s in California, anthropologist Noelle Stout (2019) argues that foreclosure changed the concept of what was obtainable in the future. She argues that through a legal agreement between an individual in search of money to pay for a place to live and an institution that would lend money to the individual, potentialities, futures, and desires were being crafted, supported, and curtailed (ibid, p. 14). Importantly, ways of being were *foreclosed*, placed out of reach. When I hearken to foreclosure within my dissertation, it is to

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from the inability to connect broader concepts around sociality with the self; therefore, if the father is *foreclosed* from activity with a child, the groundwork is laid for psychosis to occur (Lacan 2007).

indicate health-related acts (e.g., taking medications, attending prenatal care visits) that render hopes, dreams, and health in the future as unlikely possibilities, and possibly contribute to excess morbidity and mortality.

Once certain futures are foreclosed, modes of existence become *enclosed*. In archeology, enclosure traditionally refers to a closed-off space for a specific purpose, such as protecting a grazing area for livestock or isolating infected crops to prevent the disease from spreading to the rest of the farmland. To enclose, then, is also to signal the importance – good or bad – of a given material space for the way of life of an individual. I employ enclosure to indicate modes of being that are encircled and policed through different policies and practices. My use of enclosure explicitly foregrounds how temporality, ontology, and social interactions are created and reproduced through bureaucratic activity. I use the term in a similar vein as anthropologist Damien Sojoyner (2017, p. 521), who describes enclosure as: 1) the capacity to foreclose particular forms of futurity and 2) activities that decrease the ability of groups to resist the process of foreclosure, primarily by refashioning forms of futurity as irrelevant. In my dissertation, the outcome of enclosure I am most concerned with is an individual's health, which may be altered through racialized, gendered, political, and economic practices.

Through my explication of foreclosure and enclosure, I think about futures and ways of being that lead to harm towards highly-marginalized individuals, like pregnant women diagnosed with illicit substance use disorders. But how does someone respond to these actions? How can I theorize the ability of my pregnant interlocutors to *work against* foreclosure and enclosure, render them less harmful, or exploit them to improve their own health?

Drawing from other medical anthropologists interested in health and marginalization (Bourgois and Schonberg 2009, Farmer 2010, Gupta 2012, Scheper-Hughes 1992, Stonington, et



al. 2018), I think about how people exert forms of agency – or the ability to complete an act – in the face of constraint from factors like poverty, racism, and misogyny. Drawing from critical theorist Lauren Berlant (2011, p. 117) and anthropologists Caroline Bledsoe (2002) and Jennifer Johnson-Hanks (2002), I think about agency among my pregnant interlocutors diagnosed with illicit substance use disorders as a set of geospatially and temporally *contextualized activities*, borne out of uncertainty about the future. They argue that individual actions must, in part, deal with the ambiguity of what is to come. For example, my pregnant interlocutors often described how childbirth would raise questions about whether they could legally parent. In some instances, their request for methadone or buprenorphine seemed to be motivated by a desire to avoid DCFS oversight; this was because DCFS was thought to be less likely to start an investigation into their legal capacity to parent if an individual demonstrated that they were in treatment for OUD (see Chapter 3). Therefore, a request to start treatment for OUD may harbor broader implications beyond the illness in question. Instead, it may demonstrate a form of mitigating uncertainty about the future – in this case, whether DCFS may begin an investigation into their legal capacity to parent.

I also think about individual action within the frame of “structured possibilities” (Johnson-Hanks 2002, p. 872, see Farmer 2010), or the idea that there are limited available opportunities to act due to constraints placed by poverty, racism, and misogyny. Therefore, the choice to perform a certain act may not be a “choice” from a cornucopia of possibilities, but a choice among a limited set of options. I argue that the decisions and actions that my pregnant interlocutors undertake, such as continuing to live with an emotionally-abusive partner, may lead to constraints in other areas of their lives, such as the ability to adhere to daily doses of

methadone (see Chapter 5). Enclosure becomes a way to evaluate the effects of foreclosed possibilities, of interrogating constrained agency and existence predicated upon inequity.

Despite my separation of foreclosure and enclosure for analytic purposes, these concepts are not independent of one another. The coordination between foreclosure and enclosure rests on communication, regulation, and organization between different bureaucratic groups and individuals. Further, I argue that each bureaucratic group is attempting to enact forms of *treatment* – actions that aim to change behaviors among pregnant women diagnosed with OUD, either directly or through healthcare systems, to purportedly improve their health and/or the safety of their children. I think about how these different groups enact treatment through the theory of *performance*. Specifically, I draw from performance studies scholar Diana Taylor (2003), description of performance as both an object of analysis and a way of illustrating forms of knowledge.<sup>29</sup> In Taylor’s analysis, she notes that any performance, whether a dance or a political protest, rests upon a repertoire – a set of skills and behaviors someone or a group regularly uses. A performance is communicative, transmitting interpretations of history and moral and ethical values of the performer(s) (ibid, pp. 20-21). Further, performances in discourse with other performances, moving along different “circuits and economies” (ibid p. 27) to potentially alter the interpretation of a performance in the past or conducting a performance in the future.

I draw from Taylor to illustrate how the performance of treatment occurs at different levels, from the medical clinical encounter to statewide public health mandates. I posit that

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<sup>29</sup> My use of the term “performance” extends a lineage within medical anthropology of ethnographers who situate their analyses at the nexus of performance arts and the social sciences (Bridges 2011, Livingston 2012, Prentice 2012). I thank Adia Benton her suggestion to think about my analysis in the context of performance arts theory.

performances of treatment between a patient and a physician interact with other performances at the state level. Further, these different performances of treatment may simultaneously align and be in opposition to one another. These opportunities for friction – when the performance of treatment at different levels may not work fully in concert with one another – are spaces that I am the most interested in delineating. These are moments where I can theorize how foreclosure and enclosure may not be teleological, shaping the conditions for an almost predictable outcome. Further, it allows me to consider when the reaction to forms of foreclosure and enclosure by pregnant women diagnosed with illicit substance use disorders, their clinicians, and public health officials provokes a change in the performance of treatment, and what harms or benefits may occur.

In Part I, I take up the concepts of foreclosure and enclosure from a critical stance towards Foucauldian biopolitical theory to illustrate the performance of treatment. I turn towards state-based endeavors focused on reducing maternal morbidity and mortality in Chicago and the role of DCFS in relationship to illicit substance use diagnosed during pregnancy to think critically about the health ramifications of the performance of treatment for pregnant women diagnosed with illicit substance use disorders at the level of public health and clinical practice, respectively.

## PART I: Interpreting statistics, engaging in bureaucracy

Creating statistics from existing data through morbidity and mortality review committee meetings is central to the life of a maternal-fetal medicine (MFM) subspecialist. While working as a physician-anthropologist at Stroger, I served every few weeks on review committees that evaluated cases of maternal morbidity and mortality throughout our network of affiliated hospitals. Sitting in on video calls with perinatal nurses, other obstetricians, and representatives from various state agencies, my colleagues and I would painstakingly review charts of cases where patients had to get transferred from one facility to Stroger to obtain higher levels of care. For example, a woman in preterm labor at 24 weeks' gestation – a time currently considered to be at the threshold of fetal viability, albeit with a high risk of long-term multiorgan system dysfunction – would need to be transferred to a facility capable of resuscitating her newborn if she gave birth. If she delivered at a hospital that did not have the appropriate equipment or skilled staff, there was serious risk of adverse events, including neonatal death. We discussed these cases in detail, as doing so was thought to improve lines of communication, care provision, and reporting of adverse outcomes directly to the Illinois Department of Public Health (IDPH). The work of creating statistics through morbidity and mortality review committee meetings, therefore, is considered to be central to being an MFM, especially at Stroger.

My focus on the performance of treatment – or how state-based bureaucratic policies foreclose certain futures and enclose ways of life that may lead to harm for pregnant women diagnosed with illicit substance use disorders – prioritizes a clinical perspective in the next two chapters. Partially, this is an act borne out of convenience, given my position as a practicing physician-anthropologist. However, I argue that my close entanglement in the clinical setting and different bureaucracies, with their endless rules, provides a different vantage point to rethink Foucault's iteration of biopolitics. As described in Chapter 1, Foucault's initial elucidation of

biopolitics emphasizes the importance of bureaucratic functioning, especially the collection of statistics, in constructing and managing populations (Foucault 2007, Foucault 2003c). Foucault's arguments surrounding statistics, bureaucracy, and governmentality in relation to health are rooted in what he terms a "genealogy" – a broad attempt to understand how we ("we" in the Western world, mainly Europe and North America) came to see biological activities (e.g., death, reproduction) as worthy of state concern and intervention.<sup>30</sup>

Whether considering expectations of the state's role in claiming to ameliorate maternal morbidity and mortality associated with illicit substance use (Chapter 2), or the affective contours of the Department of Children and Family Services (DCFS) within biomedical care for pregnant and postpartum women diagnosed with illicit substance use (Chapter 3), I want to stress that clinical medicine cannot be divorced from the state-based bureaucratic practices. Put another way, the concept that clinical medicine would be "better" if the state's conflicting bureaucratic agencies stayed out of the exam room is a shortsighted, superficial conclusion. Indeed, as Foucault and others reminds us, the practice of biomedicine is imbricated within modern statecraft and must be situated alongside any critique of state-based endeavors (Canguilhem 1991, Foucault 1975, Foucault 2003b, Wahlberg and Rose 2015). However, this conclusion does not mean that physicians support or follow a unified biopolitical paradigm in a predictable, blind fashion. Instead, as I illustrate in the Introduction and Chapter 1, these arenas can be heavily

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<sup>30</sup> The creation of biopolitical paradigms in the West should not discredit the role of the (post)colony as a testing ground (e.g., use of concentration camps during the Second Anglo-Boer War in South Africa by the British) or active site of biopolitical activities (e.g., spatial segregation, enforced by threat of violence or death, in the Occupied Territories). Scholars argue that biopolitical activities in these arenas reverberate into governmentalities in the Global North (Mbembe 2008, Mbembe 2019, Murray 2006, Povinelli 2011, Povinelli 2016, Puar 2017, Stoler 1995, Valencia 2018).

contested and, as I describe in the following two chapters, ripe for further analyses to act as a rejoinder to classical Foucauldian biopolitical theory.

## Chapter 2. The logic of foreclosure: state strategies purporting to reduce the rate of maternal mortality in Chicago

In this chapter, I begin to define the performance of treatment by evaluating *foreclosure*: bureaucratic acts that effectively render certain hopes, dreams, health, and harms about the future as impossibilities. In particular, I am interested in the *logic* of foreclosure, or the rationalizing processes by clinicians and bureaucratic agents that purport to reveal certain ontologies of maternal morbidity and mortality as visible and controllable (Collier and Lakoff 2008, Foucault 2002 [1970]) and others as invisible and uncontrollable. My analytic framework stems from physician-anthropologist Paul Farmer's (2010) description of alternative futures for public health interventions that question assumptions about what is deemed possible and acceptable in caring for marginalized groups of individuals.<sup>31</sup>

Maternal morbidity and mortality have specific definitions based on requirements from the Centers for Disease Control (CDC) and regional public health departments (Illinois Department of Public Health (IDPH) 2021). I choose to think about both morbidity and mortality as events that occur during pregnancy or the postpartum setting<sup>32</sup> that cause disability or death. I

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<sup>31</sup> Farmer's critique of public health as suffering from "a failure of imagination" has reinvigorated debates on standards of biomedical care and the flow of material goods, services, and funds to the global South. However, activists and scholars argue that with the rise of health endeavors emanating from the global North comes simultaneous defunding of state-based public health initiatives in lieu of private, non-governmental organizations; ongoing neocolonial, racist, misogynistic, and paternalistic tropes in epidemiological ascertainment of morbidity and mortality; and the heavy imbalance of knowledge production on global health issues which disadvantage scholars in the global South. For further information, see Benton (2015), Biehl and Petryna (2013), Farmer, et al. (2013), Fassin (2011), Krause (2014), Naidu (2021), Richardson (2020).

<sup>32</sup> Historical definitions for maternal mortality were any pregnancy-attributable death that occurred during pregnancy or up to 42 days after delivery. However, due to concerns for misclassification, the CDC recommended changes to the standard U.S. death certificate in 2003 that extended the time frame from the start of a pregnancy to 1 year after delivery. See MacDorman, et al. (2016), St. Pierre, et al. (2018).



use vignettes – culled from participant observation, evaluation of IDPH data on maternal morbidity and mortality, and grant proposals to the state from non-governmental organizations aimed to improve obstetrical care in Chicago – to describe the logic of foreclosure.

I contend that the logic of foreclosure is critical for understanding both the performance of treatment of illicit substance use disorders diagnosed during pregnancy and, more generally, maternal morbidity and mortality within the racially and economically-segregated landscape of Chicago (Moore 2016, Ralph 2014, Wacquant 2015, Wilson 1990). In the following sections, I take up theories on the state’s generative capacity to name problems and create interventions through the logic of foreclosure. The following data will contextualize the public health environment where maternal morbidity and mortality become a problem worthy of the state’s attention. I begin by evaluating the genealogy of the healthcare system in Chicago focused on maternity care, with due attention to fiscal remuneration and provision of labor and delivery services for pregnant women, as a starting point to consider the logic of foreclosure.

### *The limitations of postpartum Medicaid expansion*

It is critical to consider the role of sociohistorical inequity in perpetuating excess morbidity and mortality in the U.S., especially among people of color. While multiple studies demonstrate an association between maternal race/ethnicity and maternal morbidity (e.g., Bryant, et al. 2010), one key area that has been the subject of investigation has been the mediating role of the hospital system in which a pregnant woman receives care. This topic is particularly relevant to my interpretation of maternal morbidity and mortality statistics and the logic of foreclosure because of the geospatial, economic, and racially-segregated nature of providing obstetrical services in Chicago.

Clinician-researchers, such as obstetrician-gynecologist Elizabeth Howell (2016b, 2020), have evaluated the relationship between the hospital where an individual gives birth and maternal morbidity. In a retrospective analysis of the National Inpatient Sample – a curated dataset of a representative sample of 20% of hospitalizations sponsored by the Agency for Healthcare Quality and Safety through the U.S. Department of Health and Human Services – Howell and colleagues demonstrated that disparities in severe maternal morbidity between self-identified Black and White pregnant women were associated with the percentage of deliveries attributable to Black women at a hospital (Howell, et al. 2016b). Unpacking this association further, the authors demonstrated that this association persisted after controlling for multiple confounding variables, such as the insurance payor mix (e.g., the percentage of all healthcare services paid for by private payor insurance in a fiscal year). Howell’s findings have been replicated utilizing other datasets, particularly in large metropolitan areas like New York City (Howell, et al. 2016b, Howell, et al. 2020).

I want to pause on this finding: where someone receives obstetrical care, particularly whether that hospital services primarily Black people, is associated with the likelihood of experiencing maternal morbidity. While startling, these data suffer from what critical public health scholars term *structural confounding* (Messer, et al. 2010). Namely, the distribution of people for a given exposure (i.e., the site where someone receives obstetrical care) will not be random and cannot be overcome by accumulating more data. Issues as varied as redlining policies, underdevelopment of healthcare systems in minoritized areas of major cities, an individual’s distance from a labor and delivery unit, and insurance acceptability (or lack thereof)

in a health system<sup>33</sup> may be so strongly associated with someone's site of delivery that an acceptable control group for comparison may be impossible. Thus, an epidemiological finding may not mirror the reality of what it means to seek intrapartum healthcare services in the U.S.

Based on the issue of structural confounding, I ask: Is it the hospital itself or the health system – made up of physical spaces (e.g., hospitals, clinics), philosophies, and practices – that is associated with severe maternal morbidity? In line with critical medical anthropologists (Baer, et al. 1986), I posit that the healthcare system is associated with maternal morbidity and mortality, not merely the specific location in which someone undergoes childbirth. This conclusion necessitates an unpacking of how health systems are maintained and reproduced, which I argue begins with the issue of remuneration to healthcare systems for services rendered by a hospital.

Currently, in the U.S., a major insurance payor for pregnant women of limited economic means is Medicaid. With the creation of the Centers for Medicare and Medicaid Services (CMS) in 1965, the U.S. government entered the healthcare financing sector by offering insurance for low-income groups, funded by a federal matching program (Centers for Medicare & Medicaid Services 2017, Iglehart 2007). Over the past twenty years, the U.S. government has granted more power to state-level governments in setting stipulations of access to Medicaid, such as the type of medical services covered. For example, in 2019, Illinois enacted the Reproductive Health Act, which allowed for the coverage of abortion-related services by Medicaid (Illinois General Assembly 2019). However, the reimbursement allocated to healthcare systems through Medicaid

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<sup>33</sup> Due to the Emergency Medical Treatment and Labor Act (EMTALA), passed by the U.S. Congress in 1986, individuals cannot be turned away from hospitals if emergency care is required, regardless of ability to pay (Centers for Medicare & Medicaid Services 2021). Therefore, a pregnant individual may present to a facility that would otherwise not accept their insurance and receive care if they were in labor or had an extenuating circumstance requiring delivery for maternal and/or fetal safety.

is a fraction of that for Medicare and private health insurers, leading to competition among healthcare systems for patients not insured by Medicaid (Reich 2014, Starr 2017 [1982]).

While the prospect of reimbursement plays a role in how health systems target pregnant women to receive prenatal care and undergo childbirth at their facilities, the very ability of an individual to obtain health insurance is fraught with difficulty. As part of the Medicaid program in Illinois, pregnant people are deemed “presumptively eligible” due to their pregnancy and household income. As a result, they may get “immediate coverage” for outpatient medical services, meaning that while an individual may not have insurance at the time of a prenatal visit, they will be “retroactively covered” once the person’s application for Medicaid is processed by the state (Illinois Department of Healthcare and Family Services 2022). However, the Medicaid Presumptive Eligibility (MPE) program must be converted to another program – Moms and Babies – through a separate application process – either via phone or in person at a clinician’s office – to allow for extended coverage of perinatal and neonatal healthcare services after delivery. Traditionally, postpartum care services under Moms and Babies were limited to 60 days postpartum, whereas neonatal care services were up to 1 year after birth.

Given increasing evidence of the need for continued engagement in maternal healthcare services well after the six-week postpartum mark to improve overall health, clinicians and policymakers have argued for the need to expand the duration of Medicaid insurance coverage (American College of Obstetricians and Gynecologists (ACOG) 2018a, Schiff, et al. 2018). In April 2021, Illinois Governor J.B. Pritzker announced that CMS would grant a request to expand postpartum insurance coverage from 60 days to 365 days after delivery until December 2025 (Cirruzzo 2021). This expansion would occur among postpartum women with household

incomes up to 208% of the federal poverty line, thereby impacting individuals at the highest risk for adverse postpartum health outcomes.<sup>34</sup>

In Illinois, expanding the Moms and Babies program to 1 year postpartum allows more time for people to obtain other forms of health insurance and a longer period of follow-up with primary healthcare services aimed at preventative health interventions. The state's proposed solution to the issue of maternal morbidity and mortality emphasizes an approach that attempts to reduce barriers to engagement in primary healthcare services in the postpartum period by dichotomizing the barrier as the presence or absence of health insurance. It does not engage in the issue of reimbursement rates associated with Medicaid, which are set at the state level and are subject to wide variations (Medicaid and CHIP Payment and Access Commission 2022, Zuckerman, et al. 2009). Therefore, the competition among healthcare systems for privately-insured people and those who receive insurance through Medicare is left untouched, leaving healthcare systems disincentivized to serve individuals insured by Medicaid.

### *Considering race, class, and location of residence*

To contextualize the economic backdrop of the archeology of the healthcare system in Chicago, I turn to the physical healthcare landscape, or the location of hospitals and the types of healthcare services they provide. Any investigation into the healthcare landscape in Chicago,

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<sup>34</sup> The U.S. Government's Office of the Assistant Secretary for Planning and Evaluation annually sets the federal poverty level (FPL), which is the household income cutoff at which individuals would be eligible for financial benefits from the U.S. government, based on the state of residence and the number of members in the household (Office of the Assistant Secretary for Planning and Evaluation 2020). Commonly, these cutoffs are translated into percentages (e.g., below 138% of FPL), which states can use to render eligibility for support services like income-based Medicaid.

particularly related to obstetrical care, necessitates an evaluation of the longstanding issues of inequity related to the geospatial location of hospitals and the types of services they provide.

Chicago's history has been marked by segregation along race and class, with the South and Westsides historically populated by individuals hailing from racialized backgrounds (Moore 2016, Ralph 2014, Wacquant 1998, Wilson 1990). Notwithstanding neighborhoods like Bronzeville and Hyde Park, located on the near-Southside of Chicago – where many individuals who would identify as middle- or upper-class members of racialized groups would historically reside (Drake and Cayton 2015 [1945]) – social scientists argue that the “‘stitching together’ of color, class, and race” (Wacquant 1996, p. 122) occurs through multiple mechanisms. Sociologist Loïc Wacquant identifies territorial stigmatization, or “well-identified, bounded, and increasingly isolated territories viewed [...] as social purgatories” (ibid, p. 125), and retrenchment policies, replete with socioeconomic isolation of social and economic services, as key factors. The importance of Wacquant's insights to my analysis rests upon its emphasis on the relationship among color, class, and place in dictating what services – such as healthcare – are economically supported by the state.

Data derived from the Chicago Department of Public Health (CDPH) demonstrate a higher frequency of severe maternal morbidity in areas more likely to be populated by racialized minorities and those who face higher odds of economic hardship ([Figure 1](#)). Significantly, over the past five years, multiple hospitals providing inpatient obstetrical services in these neighborhoods – such as Jackson Park Hospital, St. Bernard's Hospital, and Mercy Hospital – have curtailed services to only outpatient prenatal care. Hospitals that continue to provide labor and delivery services in these neighborhoods – such as the University of Chicago, Advocate Trinity, Advocate Christ, Silver Cross, and Roseland – have multiple institutional and service

limitations to provision of care throughout the perinatal period, inclusive of outpatient prenatal care services and access to subspecialty care. As a result, federally-qualified health centers – or clinics that receive special funding through the U.S. Department of Health and Human Services’ Health Services & Resources Administration to provide primary healthcare services to marginalized and vulnerable communities (Health Resources and Services Administration (HRSA) 2021) – take up the task of providing prenatal care services. Yet they must rely upon larger healthcare systems to accept their referred patients for subspecialty care, if needed; further, they also rely upon larger systems to provide a labor and delivery unit capable of caring for a woman and her newborn.

The complexity of the healthcare systems dedicated to providing obstetrical care in Chicago can leave most individuals unfamiliar with reproductive health (and many who are) confused and unequipped to examine it thoroughly. My goal with my overarching introduction to the economic and structural provision of obstetrical healthcare services is to provide a backdrop for evaluating the logic of foreclosure. Even at the outset, the possibility of reducing the rate of maternal morbidity and mortality seems insurmountable, given the multiple obstacles on the path towards healthcare access, let alone provision and quality.

To complicate the genealogy of the healthcare system I have described, I will now turn to different vignettes to illustrate the logic of foreclosure. Through this exercise, I delineate the state’s role in perinatal health as one that is not uniform in its execution but contradictory and, at times, self-defeating.

*The potential closure of Mercy Hospital and the alleged need for a “universal” electronic medical record*

In the winter of 2020, I was part of a conference, instituted at the request of the CDPH among different healthcare systems and community stakeholders focused on coordinating safe maternity care in the wake of a proposed closure of Mercy Hospital (Mercy), one of the oldest hospitals catering to the near-South and South side of Chicago (Chase 2020, Glass 2020).<sup>35</sup> Due to the COVID-19 pandemic and financial stresses associated with keeping hospitals open which catered to largely underinsured<sup>36</sup> or uninsured people, multiple hospitals across Chicago were permanently closing their doors to patients. Mercy was among them.

The shuttering of hospital doors that were predominantly located in socioeconomically- and racialized areas of Chicago came at a time when CDPH was placing intense focus on the inequitable distribution of maternal morbidity and mortality in these same neighborhoods ([Figure 1](#)). Given the previously-described association between maternal race/ethnicity and maternal morbidity and mortality, alongside prominent media coverage of deaths of women of color during childbirth (ProPublica 2017), CDPH's focus on rectifying disparities in maternal morbidity and mortality also hinged on rectifying *racial* disparities (Howell, et al. 2016a, Illinois Department of Public Health (IDPH) 2021, Joseph, et al. 2021, MacDorman, et al. 2021, St. Pierre, et al. 2018). Therefore, the task of the conference was not only to consider how accessing

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<sup>35</sup> Mercy Hospital has since been bought from Trinity Health by the nonprofit group Insight Chicago (Associated Press 2021) and renamed Insight Hospital & Medical Center (Reel 2021). Based on conversations with other healthcare providers across the southside of Chicago, the provision of perinatal health services is unclear. Reel (2021) notes that Insight Hospital has resumed outpatient obstetrical services. However, on a review of Insight Hospital's website in March 2023 ([www.insightchicago.com](http://www.insightchicago.com)), I can find no listing for obstetrics or gynecology under "Programs and Services." Further, under "Careers," there is no active employment request for obstetricians or gynecologists.

<sup>36</sup> Individuals are categorized as "underinsured" if their health insurance plan has an out-of-pocket or deductible cost which is high relative to their income. See Schoen, et al. (2005)



obstetrical services among marginalized women was feasible on the Southside as Mercy was shutting down, but how this related to problems of equity.

Participating in this call as a MFM and anthropologist, I was struck by a conversation between members of a hospital system's leadership located on the far Southside and CDPH representatives on the issue of pregnant women receiving care at multiple hospitals across the city. The argument put forth by hospital leadership was that due to the closures of multiple labor and delivery units between downtown Chicago and the far Southside, people had limited choices as to where they could receive prenatal care *and* give birth. The problem this disaggregated model of obstetrical care posed was the ability to swiftly transfer medical records from the healthcare system that provided prenatal care to another healthcare system tasked with providing labor and delivery services.

The ability to access medical records can be time-consuming and onerous to a labor and delivery medical team, who may need to obtain them rapidly because of an urgent clinical issue. Not only must the labor and delivery team obtain a pregnant woman's approval to release her medical information from her prenatal clinic, but they must also then send a signed release form to her clinic and await the clinic to approve the release and send the requested medical records. Limited working hours for many clinics and lack of well-organized clinical documentation can all lead to the inability to access medical records in a timely fashion. Preexisting medical conditions and/or fetal anomalies can complicate an otherwise-straightforward birth, potentially putting the pregnant woman in harm's way. Despite changes in certain electronic medical

record<sup>37</sup> software that allow for access to records across institutions, significant limitations still do not allow for the seamless sharing of medical information.

Not surprisingly, the hospital leadership of a healthcare system located in the far Southside perceived the limitations of knowledge transference between healthcare systems as one that could influence the rate of maternal morbidity and mortality. The bulk of the conversation over the next 40 minutes centered around the need for labor and delivery units across the city to share information on individuals presenting for care easily. Multiple clinicians brought up an idea to create a CDPH-specific electronic medical record (a “universal” electronic medical record) for all pregnant women in Chicago. Clinicians stressed that the universal electronic medical record must integrate with all forms of existing electronic medical record software for it to be useful. Given the relationship people on the call drew between lack of timely knowledge transference and the risk of increasing maternal morbidity and mortality, multiple clinicians brought up the time-sensitive nature of trying to get a project of this magnitude off the ground. As previously discussed, Mercy’s closure was one in a rapid string of closures of labor and delivery units and one that was making headlines in major news outlets (Associated Press 2021, Chase 2020, Podmolik, et al. 2021, Reel 2021, Schorsch 2020). Therefore, with the public’s eye on providing obstetrical care on the Southside, clinicians on the call emphasized the concern that pregnant women had to travel significant distances from their site of prenatal care to access an available labor and delivery unit. They were proposing a solution that, on face value, seemed relatively straightforward but was the furthest thing from operational.

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<sup>37</sup> As opposed to paper charts, filled with handwritten notes and printed copies of laboratory and imaging results, the electronic medical record is a software system for a given medical network that allows for notes, laboratory results, vital signs, imaging studies, and other information to be housed.

A few days after the meeting, I sat down with one of my colleagues in obstetrics and gynecology at Stroger to review the meeting's agenda and any actionable steps we could take to contribute to CDPH's preparatory work as Mercy was about to close. When I causally brought up the discussion surrounding the universal electronic medical record, my colleague stared back at me, silent. When I asked them what their thoughts were about the idea, they remarked that the entire conversation was nothing more than "a pipe dream." one that sounded rich during the discussion among representatives from different hospital systems and CDPH but would ultimately go nowhere. Since that meeting with CDPH, neither I nor my clinician interlocutors have heard of any action from CDPH or other public health agencies to create a universal electronic medical record.

*Mercy Hospital's closure stalled, the birth of the South Side Health Community Organization*

Shortly after the citywide meeting on the closure of Mercy, the Illinois Health Facilities and Services Review Board denied an application from Trinity Health – the owners of Mercy – to shut down the hospital after filing for bankruptcy (Schorsch 2020). Though the hospital was technically open, physicians and other healthcare staff were leaving in droves to other hospital systems throughout the city, rendering Mercy a shell of its former self (Podmolik, et al. 2021). Labor and delivery services were no exception, and the obstetrics and gynecology department quickly folded.

In early 2021, a group of healthcare organizations and community groups rooted in the Southside, and independent of Trinity Health, put forth an application to the Illinois Department of Family and Healthcare Services (2021) to create a not-for-profit organization – the South Side Health Community Organization (SSHCO). The goal of the SSHCO was "primary and specialty

care access, preventive and chronic care management, care coordination and management, provider collaboration, community engagement, and a connected digital and technological infrastructure” (ibid, [Figure 2](#)). While noting the “growing desert of OB [obstetric] programs” (ibid) with closure of four out of seven hospitals providing labor and delivery services on the Southside, the authors of the grant emphasized the need to strengthen the obstetric workforce across the Southside. Specifically, hiring additional clinicians to staff outpatient prenatal clinics would increase the ability of health centers to funnel pregnant women to active labor and delivery units for appropriate care. The grant was ultimately funded, with \$30 million USD invested into the SSHCO over five years.

On the surface, the SSHCO seems to cover one of the key themes that were brought up by clinicians in conversation with CDPH on the phone call about the potential closure of Mercy: the limitations in transferring both pregnant women and information about them to existing labor and delivery units. A “connected digital and technological infrastructure” played prominently in the SSHCO’s grant proposal, as well as the strengthening of the outpatient clinical provider workforce trained to provide prenatal care. However, two issues bear mentioning at this point. First, the proposal for the SSHCO does not rectify the issue of the lack of labor and delivery units on the Southside. Instead, the SSHCO offers to enhance the workflow for pregnant women receiving prenatal care in outpatient clinics by improving accessibility to existing labor and delivery units. Second, the SSHCO, a non-governmental agency, proposes to do the work that the CDPH and other public health agencies have previously voiced an interest in accomplishing, such as a well-connected digital infrastructure for medical information.

Ultimately, the success of the SSHCO in achieving funding directly from a state-based organization emphasizes the political legitimacy of the concept of a parallel bureaucracy (Biehl

and Petryna 2013, Farmer, et al. 2013, Fassin 2011, Packard 2016). This demonstrates a prioritization of enhancement of an existing, inequitable health system for pregnancy-related care, rather than a radical reimagination. Further, it demonstrates the legibility of certain rhetorical devices employed in healthcare grants of this fiscal magnitude, such as the promise of technology to reduce racial inequities in maternal morbidity (Benjamin 2019).

The claim of incrementally enhancing, rather than rebuilding, public health infrastructure, prevalent in the debacle surrounding the proposed closure of Mercy and the formation of the SSHCO, is a vital logic to follow as I turn my attention away from the public health landscape of Chicago and towards illicit substance use disorders during pregnancy in Chicago. My prolonged discussion of Chicago's recent public health history sets the stage for understanding issues about obstetrical care and the inequitable distribution of maternal morbidity and mortality on the South and Westside. It also allows me to demonstrate, more clearly, the logic of foreclosure at the heart of thinking about ways to reduce maternal morbidity and mortality.

*“I’m just assuming fentanyl<sup>38</sup> is everywhere”*

Every day during my fieldwork, I would drive along I-290 – a large highway cutting longitudinally between Chicago and the western suburbs – between my home and Stroger. Though the drive is largely unremarkable, save for views of the Chicago skyline in the distance and the intermittent rumbling of the Blue Line “el” trains running parallel to the highway, I usually found myself staring off at billboards. During one of my commutes in the spring of 2021,

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<sup>38</sup> Fentanyl, a synthetic opioid, has been noted to be increasing in frequency of use, either as a standalone drug or laced within other substances (e.g., heroin, crack/cocaine). However, fentanyl and a synthetic analogue, carfentanyl, have been implicated as the etiology in many fatal opioid overdoses over the last five years (National Institute on Drug Abuse (NIDA) 2021).

I looked up from my dashboard to see a billboard depicting two hands – one, visibly White, hand holding a packet of white powder while another hand, visibly Brown, joins it in what appears to be a subtle handshake ([Figure 3](#)). The handshake is depicted as a covert way of distributing illicit opioids. The billboard warned that “The drugs in Illinois are different now,” emphasizing the concern that fentanyl-laced heroin was becoming more prevalent.<sup>39</sup>

That same week, a commercial depicting the same scene I saw on the billboard on the way to Stroger was playing on my Instagram feed. Warning that “fentanyl is so strong that just two grains are enough to turn a typical night out fatal,” the video depicts a presumably-White man, clad in black, handing a packet of white powder to a presumably-Brown man, wearing an apron and a white collared shirt, likely a cook, in an alleyway at night. When this commercial ran, I assumed that I was spending too much time searching on my phone for relevant research on opioid use disorder (OUD) and that the application’s algorithm was tracking my search history, presenting me with information tailored to my interests. More concerning to me as a clinician was the thought that fentanyl had become such a problem in Illinois that public health organizations were turning to social media to promote awareness of the issue. Indeed, even the CDPH had promoted self-testing kits for fentanyl on its Twitter feed ([Figure 4](#)). The use of social media as an outlet for public health messaging appeared to signal the gravity of the situation, as the CDC was using social media outlets to raise public awareness about COVID-19 vaccine availability and quarantining protocols during the same period. Fentanyl was apparently a major issue in Chicago, on par with a global pandemic.

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<sup>39</sup> An accompanying report from the CDPH released a few months before this vignette demonstrated that 90% of drug-related deaths in Chicago involved fentanyl or heroin, and that the majority of opioid-related deaths involved more than one type of opioid (e.g., heroin laced with fentanyl) (Turner, et al. 2020).

Later that year, I was working with one of my colleagues, Dr. Cam, at Stroger. We discussed a case of a pregnant woman, Emily, who came to Stroger for management of OUD, diagnosed late in her third trimester. We chatted about something Emily had mentioned when I met her. Before being admitted to Stroger, Emily had been at a residential treatment facility in Chicago. She told me that when she was first enrolled in the facility, she provided a urine sample for laboratory-based toxicology testing, so that the staff could see what substances she had been recently using to guide their clinical recommendations. Emily described that her urine was tested for fentanyl, which is usually done as a separate, point-of-care test by dipping a small strip of treated paper into her urine. She described feeling shocked when the test strip displayed two lines, rather than only one “control” line, indicating that she had recently ingested fentanyl. She told me she was using heroin and crack/cocaine, not fentanyl. “I can’t believe it was there!” she exclaimed. When I specifically asked her if the presence of fentanyl worried her, she replied in the affirmative, explicitly acknowledging that fentanyl was associated with a higher risk of fatally overdosing when compared to the heroin she was used to using.

I was initially surprised when I heard Emily’s story. Beyond the public health messaging I described earlier and CDPH (2020) data demonstrating a rise in fentanyl-associated mortality in Chicago, I never heard clinicians at Stroger discuss fentanyl as a significant issue among pregnant women. The only clinicians I had ever heard speak about fentanyl use among pregnant women diagnosed with OUD were my MFM colleagues in western Pennsylvania or Utah. My MFM colleagues working in these areas served a large rural, population. I assumed fentanyl was not a problem I would face in Chicago, let alone at Stroger, for pregnant women. I thought of it as a problem confined to life outside of a major city, in a similar way methamphetamine had been associated in the lay media with people residing in a rural area (Garriott 2011). A part of

me also thought that fentanyl use might be a gendered and age-related issue in Chicago, partly because of the CDPH data demonstrating that fatal fentanyl-related overdoses had a higher prevalence among older individuals identified as male in Chicago (CDPH 2020). Emily was the first person I had seen during my fieldwork with some evidence of fentanyl exposure, which upended many of my presumptions about who is exposed to fentanyl in Chicago.

I mentioned my surprise to Dr. Cam, and she almost instantaneously replied in a deadpan voice: “I just assume fentanyl is everywhere” ([Figure 5](#)).

### *Who is dying, and where?*

What do these vignettes – focused on topics as varied as the epidemiology of maternal mortality, medical communication, hospital closures, outpatient obstetrical services, and fatal opioid-related overdoses – tell us about maternal morbidity and mortality in Chicago? What opportunities for reimagining programs and tactics to reduce maternal morbidity and mortality are cut short, left unrealized – in short, foreclosed?

At first glance, these vignettes seem superficially connected as they deal broadly with maternal morbidity and mortality. I argue, however, that the narratives I have provided demonstrate key components of the logic of foreclosure. They signal hypothetical “solutions” to the problem of maternal morbidity and mortality – such as the promise of a universal electronic medical record for health providers or self-test kits to evaluate for fentanyl. At the same time, they also signal knowledge among clinicians that the proposed “solutions” are problematic to operationalize, as seen with the “pipe dream” of creating a universal electronic medical record.

How the state offers and seeks to legitimate solutions to the disproportionate amount of maternal morbidity and mortality occurs in different ways. The state may hearken to traditional



methods, such as proposing to use money to improve healthcare access through the creation of public-private partnerships on the Southside (e.g., SSHCO) or to expand the duration of insurance coverage in the postpartum period to promote longitudinal engagement in preventative health services. It also may emphasize technological solutions, such as a universal electronic medical record or public health messaging on social media. Yet, none of these practices and policies engage with the needed structural changes required for meaningful, sustained improvement in health outcomes, such as a re-envisioning of reimbursement schemes based on the type of health insurance payor to support healthcare systems in prioritizing services for the poor and marginalized (Chenhall and Senior 2018, Underman 2020, Yates-Doerr 2020). Therefore, the logic of foreclosure is present from the outset with any proposed solutions to a health issue.

Understood through its biopolitical underpinnings, the logic of foreclosure is not just a way of understanding state activities or particularities of maintaining the health of a population (Adams 2016, Biruk 2018, Storeng and Béhague 2017, Storeng and Béhague 2014). I propose that by promoting certain solutions to the problem of maternal morbidity and mortality, the state demonstrates how it conceives of the problem itself. In line with anthropologist David Reubi's (2020) insight, my data demonstrate how state-sponsored solutions to maternal morbidity and mortality "articulate complex and normatively loaded visions of social life that both enable and constrain action" (ibid, p. 2). For me, the "action" is "the lack of action," the foreclosing of possibility for policies and practices that *could* exist, but likely will not in the future.

Proposing solutions like a universal electronic medical record, public health messaging on social media, or expanded government payor insurance does little to address the barriers to operationalizing these recommendations. Solutions such as improving reimbursement rates for

Medicaid to incentivize health systems to serve highly-marginalized individuals or financially sponsoring the construction and provision of labor and delivery services throughout the South and Westsides were never discussed by my interlocutors during my fieldwork. This may be because these strategies were deemed outside of the scope of a state-based bureaucracy or simply unfeasible. Therefore, the state emphasizes technologies and practices that keep untoward health events within “socially and economically acceptable limits” (Rabinow and Rose 2006, p. 5), rather than employing new logics that question what the “acceptable limit” of morbidity and mortality is.

In the next chapter, I deepen my examination of the performance of treatment associated with illicit substance use disorders diagnosed during pregnancy by moving from the logic of foreclosure to the process of enclosure – how particular forms of existence are brought into view and policed through different policies and practices. Moving from large-scale epidemiological data towards granular, (auto)ethnographic data derived from clinical encounters with pregnant women diagnosed with OUD receiving care at Stroger, I describe the convoluted, and oftentimes fractured, relationship between state-based perceptions of illicit substance use in pregnancy, understood through the state’s preoccupation with fitness to parent, and the clinical management of OUD diagnosed during pregnancy.

### Chapter 3. State power and the family: the enclosure of parenthood

Daphne, a young White woman, was sitting in a beige hospital gown in her bed in one of the postpartum rooms at Stroger late in 2019. Her new daughter, Libby, was nursing between the folds of the gown. With the blinds open to let the weak, overcast winter light, I could make out a pink knitted hat covering Libby's head, a white onesie and a blanket covering her little body. I was not expecting the scene to be so calm and quiet. Before walking into the room, I met with Samira, one of the resident physicians who knew Daphne well, in the resident physician workroom on labor and delivery. She prefaced Daphne's recent birth with her 10-day admission during the second trimester of her pregnancy with Libby, when she was being treated for benzodiazepine and opioid use disorders. Samira recounted how she would often catch Daphne irritably pacing the halls to deal with the side effects of withdrawal, making her way to the vending machines to purchase cookies and other snacks.

One of my colleagues, Dr. Cam, chimed in: "I'm not sure how she was walking," referring to the high dose of benzodiazepine she had been using. Daphne described using 4 bars of "xannies"<sup>40</sup> daily, along with heroin and methadone, to cope with her ongoing anxiety: "I was initially getting them [the xannies] prescribed, but then my doctor lost his license [...] and then I was forced to buy them on the street." Daphne had used both xannies and heroin during her previous pregnancies and had two of her previous children removed by the Illinois Department of Children and Family Services (DCFS) shortly after birth and placed in the care of her family outside of Chicago due to her substance use disorders. She told me that these experiences – of

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<sup>40</sup> Alprazolam, known by its trademark name of Xanax® and colloquially as "xannies," is a short-acting benzodiazepine used to treat various mental health conditions. Due to their rapid onset of action and relaxing effect profile, xannies are known to be at high risk for abuse (Ait-Daoud, et al. 2018). A "bar" of xannie is used colloquially to describe a 2-milligram pill, which is in the shape of a small rectangle.

having her ability to parent called into question, and ultimately legally removed – motivated her to think about her polysubstance use disorder and need for treatment during this pregnancy:

“When I found out I was pregnant with Libby, I was five months [along and] I’d already been using. I just decided [...] the least I could do is bring her into the world clean and healthy as can be. So, I went to Roosevelt [an inpatient residential treatment program]<sup>41</sup> and cleaned up. I changed my goal.”

This time, when Libby was born, Daphne had been off xannies and heroin for four months and had been on a stable dose of methadone. Libby had been doing well postpartum and had shown no signs of neonatal opioid withdrawal syndrome (NOWS) – or when a neonate displays signs and symptoms consistent with opioid withdrawal, such as irritability and diarrhea, due to previous exposure to opioids in utero (McQueen and Murphy-Oikonen 2016, Patrick, et al. 2020). Indeed, Daphne noted that her last two children did not display any signs of NOWS and were subsequently discharged into her care a few days after her delivery. As in her other postpartum experiences, Daphne was visited by a DCFS case worker shortly after Libby’s birth. “I was surprised that DCFS came by,” she said, especially since she had stopped using xannies and heroin for some time. “I thought I would be able to take Libby back to Roosevelt [with me],” implying that, as with her other children, DCFS may have been in the process of placing a “police hold” – or a legal injunction that does not allow a newborn to leave the hospital.

I use Daphne’s story to explicate a larger trend in America focused on the intersection of state interest in parental capacity and illicit substance use disorders during pregnancy (Knight 2015, Rosenbaum and Murphy 1998). I think about the state’s preoccupation with parental

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<sup>41</sup> Due to the limited number of residential treatment facilities in Chicago that accept pregnant or newly-postpartum people, I have chosen to anonymize the name of the facility that Daphne ultimately attended to preserve confidentiality.

behavior – here, understood through the role DCFS plays in the lives of people diagnosed with OUD after delivery – to understand the process of enclosure: how particular forms of existence (here, the ability to legally parent) are identified and policed through different policies and practices. Though the broader policy of evaluating and, at times, investigating postpartum women diagnosed with OUD for fitness to parent by DCFS is the backdrop to my analysis, I am particularly interested in the ways people participate in or resist the process of enclosure.

To evaluate enclosure, I draw from Michel Foucault's and his interlocutors' discussions of power and the family (Feder 2007, Foucault 2003a, Foucault 1977, Foucault 1978, Foucault 2003b, Taylor 2012, Wells 2011). I illustrate situations in which the performance of treatment demonstrates a unique discourse, played out at the clinical level, that demonstrates the contradictory ways in which patients and clinicians resist the process of enclosure related to parenting among postpartum women with OUD.<sup>42</sup>

The process of enclosure is predicated upon a relationship between state-based agencies, such as DCFS, and healthcare providers. However, these two entities are not mutually exclusive, nor does one necessarily impinge on the autonomy of the other. While other state-based agencies, such as medical licensing boards and departments of public health, help to create and maintain entire healthcare systems, I submit that in the case of DCFS and healthcare providers, the relationship does not originate at the state level and trickles down to the clinician. It is dynamic and, critically, one that renders practices germane to DCFS and clinical medicine as intertwined – they inform each other, move together, and, sometimes, split apart. Therefore,

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<sup>42</sup> While other scholars, such as Michele Goodwin (2020) and Dorothy Roberts (1997, 2002, 2022), have provided a macro- and meso-level evaluation of the relationship between biomedical practice and the juridico-legal system, these are largely confined to legal analyses without the opportunity to engage in deep, ethnographic evaluation of *how* clinical interactions are structured and interpreted by both clinicians and patients.

enclosure needs to be investigated through attention to local practices performed by people working for DCFS and clinicians.

I consider the relationship between DCFS and biomedical practice in two specific ways. First, I highlight how clinicians discuss and follow state-mandated reporting guidelines pertaining to a diagnosis of an illicit substance use disorder during pregnancy. Second, I examine how certain clinical recommendations, such as the need to observe a newborn for signs of NOWS can be reinterpreted as the state, vis-à-vis DCFS, speaking through clinical interlocutors (Chandler, et al. 2020). These two scenarios provide opportunities to examine how clinicians and patients “speak back” to the state through their discussions of their opinions of DCFS and subtle negotiations over medical surveillance practices that diverge from state-based perceptions of parenting among women with an illicit substance use disorder diagnosed during pregnancy. I conclude that these dimensions of biopolitics, co-constituted through clinical medicine, are critical avenues to consider when theorizing about enclosure and the performance of treatment.

*The state’s preoccupation with care: the family as a focus*

Throughout my dissertation, I explicitly hearken to a biopolitical approach to understanding the role of reproduction and the state. Thus, it is fitting that I turn to Foucault’s interpretation and use of the familial structure in his exegesis of contemporary institutional systems and forms of governance. I attend to his theories of power as they undergird his conceptualizations of the role of the family and the state. His analysis is critical for understanding rejoinders to the state’s involvement in parenting in relation to DCFS involvement in cases of illicit substance use diagnosed during pregnancy.

In his early works, Foucault theorizes power in two broad ways: as sovereign or disciplinary in nature (Foucault 1977, Foucault 1978). As described in *Discipline and Punish* (Foucault 1977), the exercise of power by a sovereign is commonly targeted upon a given individual's life, such as through the spectacle of public execution. Foucault eruditely demonstrates a shift from sovereign power to disciplinary power over the 17<sup>th</sup> and 18<sup>th</sup> centuries, or a transition towards using power to craft an idealized subject. The future-oriented nature of disciplinary power – namely, its move away from outrightly causing death and towards a form of “rehabilitation,” is critical to understand why the state and other actors come to be preoccupied with the family itself (Foucault 1978).

In *A History of Madness* (Foucault 2006), Foucault argues that the bourgeoisie family fell within the purview of the state because of its symbolic importance as a site of rationality: “The institution of the family traced the circle of reason, and outside it lurked all the perils of insanity” (ibid, p. 90). Therefore, the “irrational” family member becomes the subject of state-based interventions, such as forced incarceration, to ensure familial stability. Even within the state-sponsored asylum or prison, the family becomes reimagined through each institution's daily, normalizing practices (Canguilhem 1991). Social organization of patients or inmates is described in hierarchical, familial terms (i.e., inmates referred to as “brothers,” see Foucault 1977, p. 293), while the “family” is overseen by physicians or wardens, respectively.

However, Foucault's later works, such as his Collège de France lectures between 1973 and 1975 and the *History of Sexuality*, demonstrate how disciplinary power resides *within* the family (Foucault 2003a, Foucault 1978, Foucault 2003b, Wells 2011). Families were to bear children that would enter disciplinary institutions (e.g., schools), and, if they could not fully be disciplined into upstanding citizens, other institutions would be utilized for rectification (e.g.,

prisons). Parents were charged with closely monitoring their children to correct aberrant behavior to improve the health of the next generation (Foucault 1978a). Thus, the home became a clinical space, wherein parents acted as surrogate medical professionals aimed at instituting normalizing practices (Canguilhem 1991, Donzelot 1979, Taylor 2012). The reciprocal relationship between disciplinary institutions and the family is critical for Foucault's theories of power and for my ethnography precisely because "[a] family that fails to produce well-disciplined and normal subjects may lose its authority over its members through the interventions of state and disciplinary agents" (Taylor 2012, p. 205).

Other interlocutors with Foucault – such as Jacques Donzelot (1979), Ann Stoler (1994), and Ellen Feder (2007) – have similarly evaluated the state's perception of the etiology of abnormal subjects through the family. For example, through an exegesis of the American concept of the "welfare queen"<sup>43</sup>, Feder (2007) argues that the supposed failure of the mother within the family unit breeds social dysregulation, a "bio underclass" (Krauthammer 1989). Harkening to the Moynihan Report (1965) – wherein sociologist Daniel Patrick Moynihan argued that the rise of the single-family, female-headed household among Black Americans was one of the primary factors leading to poverty and need for governmental assistance – Feder traces the linkage between motherhood, class, and race in rejoinder to Moynihan's thesis. She specifically notes Hortense Spillers's (1987) classic discussion on the affective and biopolitical stakes of reproduction and the Black family in the U.S. Spillers meditates on how the erasure of the texture of the lives of Black individuals in the U.S. is imbricated into a state-level view of the

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<sup>43</sup> "If one takes a serious moment to envisage what the 'typical' welfare recipient looks like, perhaps the image is one of an urban, black teenage mother, who continually has children to increase her benefits and who just lies around all day in public housing waiting for her check to come" (Note 1994, p. 2019; cited by Bridges, 2011, p. 211).



household and kinship. Indeed, the work done through the disaggregation of motherhood, gender, and reproduction renders the pathologizing factor contributing to poverty to sit squarely at the foot of the mother. The corrective factor – good parenting – is within the purview of the state. Thus, biopolitical “child saving” via raced, gendered, and classed understandings of motherhood become the standard to which the family regulation system, like DCFS, is understood in the U.S.

Given the interpersonal and intrapersonal ramifications of state perceptions of the family, I turn towards the relationship between affect theory and biopolitics to specifically interrogate the affective dimensions of enclosure of parenthood and the performance of treatment. Similar to other social scientists drawing upon affect theory (e.g., Clough 2008), I utilize Brian Massumi’s (2021) rendition of the concept of affect as a pre-social, pre-linguistic, and, thus, pre-cognizant, state of being; only through a sociolinguistic turn does affect transform into emotion, which becomes fixed in an individual. The role of the Other – another person, another institution – in performing the transformation between affect and emotion is critical, as it necessitates a traffic or circulation in affect:

Unlike emotion, affect is not fixed or contained inside one body of one individual.

Instead, it circulates between bodies, between signs, between material objects and discourses. Because of this inability to fully capture and contain affect, affect has the property of a verb: it *does* things. It moves, it connects, it severs (Underman 2020, p. 16).

Feminist scholar Kyla Schuller (2018) posits, through an evaluation of 18<sup>th</sup> and 19<sup>th</sup> century American texts and media, that cultivating the ability of an individual to be sympathetic towards others (i.e., sentimentality) and to be impressed upon by others in their environment (i.e., impressibility) is a key strategy under a biopolitical regime. These qualities of individuals

separate the human from the less-than-human, the “welfare queen,” the “bio underclass” (Ahmed 2004, Mbembe 2019, Puar 2017).

As affect is theorized to be both constitutive of and targeted by biopolitical regimes, the influx and maintenance of normative affective states helps to reify racist, classist ideologies that seek to separate the human from the non-human (Weheliye 2014). Thus, it is critical to unveil how affective states circulate; how they create and interpellate particular subjects (Althusser 1971, Butler 1997); and what forms of life they allow and enclose (see Anderson 2012). Scholars have evaluated the family as a site of affective governance in multiple dimensions: from meditations on the role of native servants in the colonial household as harbingers of sexual deviance to Western European children (Stoler 1995) to the role of settler colonial policies in devaluating and violently policing reproduction and parenting among First Nations and Native American populations (Schuller 2018, Stevenson 2014, Theobald 2019). However, less attention has been placed on how apparatuses like DCFS target particular affective dimensions of the “ideal” family (Roberts 2002, Roberts 2022) and the role of ancillary agencies – such as those within the purview of biomedicine – in perpetuating or resisting a normative affective dimension of mothering and parenthood (Goodwin 2020, McCabe 2016).

### *The family regulation system and illicit substance use during pregnancy*

Moving from a Foucauldian approach to the family, I now turn to the application of motherhood in the setting of illicit substance use diagnosed during pregnancy. Importantly, when

pregnant people who use illicit substances seek medical care, the criminalized trope of the “drug-addicted” – and, hence, unqualified and dangerous – mother becomes visible in multiple ways.<sup>44</sup>

One way the criminalization of illicit substance use during pregnancy manifests itself is through mandated reporting, or the communication of concerns for child abuse to DCFS and the Department of Public Health, by medical personnel. The Child Abuse Prevention and Treatment Act (CAPTA), passed in 1974, formalized mandated reporting (Hoerr, et al. 2018, Lloyd Sieger, et al. 2021). CAPTA also created the role of a mandated reporter, someone in charge of communicating concerns for child abuse, and linked it to certain professional categories, such as clinicians. While there are clear instances where DCFS’s involvement is critical to ensure the safety of a child, as has been described by multiple organizations (American Academy of Pediatrics (AAP) 2021), it is important to note that the role of DCFS in the setting of parental illicit substance use is heavily debated by scholars and activists, particularly centering around illicit substance use disorders during pregnancy. Specifically, multiple amendments to CAPTA over the past fifty years have created the concept of chemical endangerment, or the idea that fetal exposure to illicit substances constitutes child abuse (Amnesty International 2017, Carroll, et al. 2021). However, as Leiner, et al. (2021) note, there is wide geographic interpretation and

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<sup>44</sup> This statement contradicts the attribution of a neurobiologically-driven approach to understanding substance use, which is heavily driven by both gender and race (Campbell 2013, Courtwright 2010, Hansen and Skinner 2012). I specifically use the term “addiction”, rather than “substance use”, in the text to highlight the underlying assumptions surrounding moral will, choice, and freedom that are traditionally associated with American notions of addiction (Armstrong 2003). From a clinical perspective, the American Psychiatric Association, in their Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> edition (DSM-5), specifically note that addiction is no longer the preferred nomenclature due to stigmatizing connotations of the word itself (American Psychiatric Association (APA) 2013).

enforcement of CAPTA in both what constitutes “exposure” to a given substance and the subsequent response from DCFS.<sup>45</sup>

Exactly who is evaluated by DCFS in the setting of illicit substance use during pregnancy has been the subject of critique over the past thirty years. Sociologist Dorothy Roberts (Roberts 1999, Roberts 2002, Roberts 2022) has demonstrated two differing systems for evaluation and management of so-called child abuse: one – primarily catering to White, upper-class individuals – where suspected child abuse is not within the purview of the state and handled privately, and the other – focused on low-income, minority households – where suspected child abuse becomes an opportunity to intervene publicly through DCFS. Inherent to Roberts’ argument is the ongoing pathologization of poverty in American politics, accelerated over the past forty years with the dismantling of what has been called the social safety net, or governmental programs aimed at providing fiscal and material benefits to low-income families. Initiated under President Ronald Reagan and culminating with President William J. Clinton’s Personal Responsibility and Work Opportunity Reconciliation Act, the loss of the social safety net specifically exploited a classist, racist, and misogynistic stereotype of the “welfare queen.” Further, the connection between being a “welfare queen” and using illicit substances during pregnancy was solidified by both Reagan and Clinton (Bridges 2011, Goodwin 2020, Morgen and Maskovsky 2003). Therefore, the state perceives someone who uses illicit substances during pregnancy in a predefined way that immediately classes and races the individual.

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<sup>45</sup> Furthermore, with the passage of the Comprehensive Addiction and Recovery Act (CARA) in 2016, the focus on the newborn was broadened to encompass parent(s) with illicit substance use disorder, emphasizing need for engagement in treatment and ongoing behavioral health support. Despite this shift in focus, CARA was not accompanied by increase in grant funding for states to prioritize the expansion of psychiatric and behavioral health services geared towards illicit substance use (Lloyd Sieger, et al. 2021).

The philosophy undergirding the dismantling of the social safety net have also been at work in Chicago for decades, structuring inequities in access to basic governmental services, such as housing and medical care, among racialized minorities on the South and Westsides (e.g., Ansell 2011, Kleinberg 2015, Moore 2016, Wacquant 2015, Wilson 1990). Scholars argue that coupling neoliberal perspectives on social support (Harvey 2007) with non-neurobiological theories of addiction lead to policies aimed at punishment, rather than treatment, of illicit substance use (Amnesty International 2017, Bridges 2011, Goodwin 2020, Thomas, et al. 2018). In Illinois, illicit substance use diagnosed during pregnancy is a mandated, reportable instance to DCFS (Guttmacher Institute 2021) In most cases, the individual who is reported to DCFS is notified that DCFS will be contacted, though the person who specifically reports the individual to DCFS is often not known. In the most extreme of circumstances, DCFS can place a newborn on a “police hold,” barring them from being discharged from the hospital with the mother. A police hold may end with the child placed in foster care with termination of parental custody (Reich 2005, Roberts 2002).

The cessation of parental custody by state agents resonates throughout the lives of a woman and her family members. Academic and community-derived research demonstrates that cessation of parental custody can affect relationships with caregivers and subsequent reproductive choices (Dewey, et al. 2018, Knight 2015, Movement for Family Power 2021, Wall-Wieler, et al. 2018). Data from pregnant and postpartum people with substance use disorders demonstrate that they endorse a high level of concern for DCFS involvement (Howard, et al. 2019, Leiner, et al. 2021). My previous work on pregnant women in San Francisco who cease use of illicit substances during pregnancy demonstrates that engagement with the medical system – through attendance of prenatal visits and undergoing urine toxicology screening to

detect illicit substance use – can create a medical record that a woman can use as a “résumé for a take-home baby,” legible to case workers from DCFS (Premkumar, et al. 2019b). Sociologist Kelley Fong (2019) demonstrates how mothers engaged with the family regulation system must demonstrate “ideal” parenting practices to case workers. These data demonstrate how DCFS and clinical practices build upon each other to enclose forms of being that, juridicolegally, do not allow for parenting. Only through extraordinary measures on the part of the pregnant or postpartum woman – through creating and controlling a narrative of an idealized parent – do I believe that DCFS can be kept at bay.

One might construe the previously-described data as indicative of a colluding relationship between DCFS and clinical medicine – that they might universally share a similar goal of regulating parental capacity through racialized and classed practices directly targeting people who use illicit substances while pregnant. However, my ethnographic data, drawn from clinical encounters between physicians and pregnant or postpartum women diagnosed with illicit substance use disorders, demonstrates moments where there is a conflicting relationship between those who clinically practice medicine and those working for DCFS.

To illustrate my argument, I will analyze two instances in which DCFS works within the hospital setting to theorize the relationship between state-based bureaucracies and the enactment of biomedical care: one focusing on the relationship of an obstetrics and gynecology resident with a pregnant woman who was using illicit substances, and the other on an interaction between Daphne, introduced in the beginning of the chapter, and a pediatrician taking care of her newborn. I will focus not just on clinical practices, but their affective dimensions to consider their biopolitical ramifications within the performance of treatment.

*The physical presence of DCFS case workers in the hospital*

Billy, a second-year obstetrics and gynecology resident physician, was discussing his experiences as a mandated reporter during an interview with me in early 2019, before my work as a clinician at Stroger. He brought up Annie, a Black woman living with HIV who recently was admitted for delivery while incarcerated at Cook County Jail. She had a history of crack/cocaine use in prior pregnancies and her current pregnancy. DCFS had investigated her previously, and they had terminated parental custody over all her children, turning custody over to other family members in Cook County.<sup>46</sup>

Billy knew Annie from prior admissions to Stroger when she was undergoing inpatient stabilization after using crack/cocaine. He told me had become close with her, sneaking her bags of Doritos from the vending machine – food she may not have necessarily gotten while incarcerated. Despite her relationship with Billy, other resident physicians relayed that she was deeply distrustful toward anyone purporting to care for her in the hospital. Billy described Annie’s tenuousness to engage with members of the clinical team in this way:

She’s been living on the streets for fifteen years and she’s a “user” [of crack/cocaine] on and off. I think she’s learned how to survive in her own way [...] She’s put up walls and barriers and maybe it’s not always been beneficial for her to be straightforward with people [...] So I think it’s challenging sometimes to convince people that you’re not working an angle. You’re just really trying to help them.

As Billy hints at in the last sentence, Annie’s way of life, her ability to survive in a difficult situation, is predicated on her distrust of people she suspects are “working an angle.” One could

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<sup>46</sup> For a further discussion regarding how pregnant women who use illicit substances rely on kin, whether fictive or consanguineal, to care for children after termination of parental custody, see Knight (2015).

posit that providing people with *too much* information, such as in the case of her clinical staff, might lead to undue harm. Annie's precarious state – both as a person involved in the criminal justice system and someone who has previously had her parental custody terminated by DCFS – may lead her to withhold information, as it may be unclear what the motivations are behind certain questions (what angle is being “worked”) and, ultimately, what the information Annie would provide could be used to achieve.

While Billy was describing his relationship with Annie, I could not help but wonder about the complex ethical problems that structure his interactions with her, specifically surrounding the role of mandated reporting. The whole concept of mandated reporting revolves around anonymity: an individual reported to DCFS will not be told who reported them. However, the legal requirement to be a mandated reporter injects an uneasy secret into an already-tenuous clinical relationship, wherein trust between patient and physician needs to be built. I have been in Billy's shoes before with other patients diagnosed with illicit substance use disorders with whom I became emotionally close with during their pregnancies. I never knew how much the concern for mandated reporting impacted what information they wanted to divulge to me. While I might have thought the information would be useful to structure a clinical treatment plan, I suspect that they thought DCFS could use it to place a police hold on their child. I always felt that I was straddling two roles that did not correspond with one another: a caregiver and an investigator for a state-based agency (Goodwin 2020).

I wondered if Billy felt similarly, given his relationship with Annie. I pushed Billy to elaborate on his interactions with DCFS as a mandated reporter, particularly in the case of Annie. In the workflow at Stroger, one member of the social work team primarily deals with mandated reporting, while another member coordinates services for any pregnant or postpartum person



diagnosed with illicit substance use, such as connecting them with a methadone clinic.

According to one of my interlocutors who works as a member of the substance use outreach team, the separation of activities among team members is to avoid the problems that I struggle with as a clinician and a mandated reporter: being a caregiver and performing a legally-required activity that has drastic implications for a person's way of life. As my interlocutor described, if a patient is unable to get access to a residential treatment facility and has a case reported to DCFS by the same social worker, the argument could be made that the social worker is unfairly biased against a patient and is actively undermining their ability to engage in treatment and family reunification.

Despite these proposed safeguards for dealing with mandated reporting of pregnant women diagnosed with illicit substance use, Billy's experience is unique in that he had to directly call DCFS, as Annie delivered her baby later in the evening. "The social worker works from 8 [AM] to 4 [PM]. We work 24/7 [24 hours a day, 7 days a week]. Patients are here 24/7. Their questions don't stop at 4 PM when the social worker goes home," Billy said. As this was the first time I had heard of a resident physician calling DCFS directly, I asked Billy about the steps it took to contact a member of DCFS. "I paged them, I called them, I didn't get through to them – it was after hours. But I'm sure today it'll be the same thing," he said. Given the constant presence of resident physicians in the hospital, I asked Billy if he had ever seen a DCFS case worker in person, on the floor or interacting with a patient. He told me no – the rare times he had spoken with a member of DCFS, it was always through the telephone or reading notes written by a social worker who reported a case to DCFS in the electronic medical records.

This lack of a physical presence of DCFS in the hospital, noted by Billy, is particularly illuminating, when compared with the overwhelming presence of other members of state-based

organizations, namely the carceral system, during Annie's admission to the hospital. Two guards from the sheriff's department maintained security either directly inside or adjacent to Annie's room – both during her labor course and after delivery.<sup>47</sup> The constant physical presence of guards can be imposing for patients and their physicians, particularly when clinicians are attempting to provide care or perform clinical examinations (see Sufrin 2017). Having guards in uniform, carrying firearms, in the room of a pregnant or postpartum person demonstrates a brute physicality to the state that is incongruent with the expectations of medical treatment, and especially with the issues that are causing Annie to be admitted to the hospital: managing her diagnosed illicit substance use disorder and giving birth to her child. In comparison, Annie's DCFS case worker, one of the most crucial figures in determining her trajectory as a legal parent, is hard to reach and unable to be physically identified. However abstract Annie's DCFS case worker was, they, as well as the legal need for mandated reporting, exerted a significant effect on both Billy and Annie. However, the effect was distanced – physically and temporally – from the clinical environment where Billy and Annie interacted.

As someone who previously was a resident in obstetrics and gynecology, I cannot stress enough how mundane activities, such as Billy's attempt to call DCFS, can be made more frustrating because you are tasked to do innumerable other activities simultaneously. It is not simply that Billy has one task to do with his day: to contact DCFS. He needs to attend to the needs of people in labor, operate at a moment's notice, or simply catch up on medical record documentation. Therefore, trying, in vain, to contact DCFS repeatedly is one more inane task to add to an already overwhelming schedule of things that need to get done. Further, Billy's future

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<sup>47</sup> “Upon the pregnant prisoner's entry into a hospital room [...] a corrections official shall be posted immediately outside the hospital room, unless request to be in the room by medical personnel attending to the prisoner's medical needs” (Illinois General Assembly 2018).

days will also be impacted by knowledge that “it’ll be the same thing” – that Billy will try again and again to call DCFS to no avail. The affective state of repetition and futility (Camus 1955) is further described by Billy’s elaboration of his previous experiences with DCFS: “It just hasn’t gone smoothly with any of these patients.” Therefore, not only will Billy be unsuccessful in contacting DCFS, but if DCFS is notified, the result will lead to further complications, ostensibly involving Billy and other resident physicians further as they “work 24/7.”

For Annie, her affective stance towards the entire clinical team caring for her is theorized to be due, in part, to her previous experiences with DCFS, alongside her ongoing use of crack/cocaine, unstable housing, and involvement in the criminal justice system. Her ability to “survive in her own way,” as Billy describes it, is partly predicated on a form of informational opacity. She does not respond to direct questions, posed by clinicians at Stroger, about her life; this act is categorized by those same clinicians as indicative of a distrust of the healthcare system in which she is currently admitted. I argue that DCFS’s role in Annie’s reported behavior towards the clinical staff works on a different temporal and physical scale. It is both retrospective, emanating from her past experiences with losing custody over her children, and prospective, running ahead towards the possibility of losing custody of her child resulting from her current pregnancy. Therefore, DCFS exerts a physically-distant, but temporally-complex, effect on Annie’s affect towards the clinical care team.

The enclosure of giving birth without the legal ability to parent is experienced, in part, through the cultivation of affective states by both pregnant women diagnosed with illicit substance use and the clinicians caring for them. These affects are not easily predictable and are heavily contextualized by past experiences and subsequent prognostication into the future. Further, the process of enclosure does not presuppose total compliance on the part of the

mandated reporter; as Billy's comments about the process of contacting DCFS and his relationship with Annie demonstrate, the tension between "trying to help" Annie and the poor outcomes Billy states he has experienced when reporting patients to DCFS define the clinical environment in which pregnant women diagnosed with illicit substance use disorders receive care. Pushing this analysis further, one could say Billy obeys the "letter of the law" – he structures part of his day around repetitively attempting to fulfill the legal needs of a mandated reporter – but resists its' "spirit," acknowledging the problems DCFS has had in Annie's life and the likely harm it will continue to perpetuate.

While Billy's comments offer one perspective on DCFS's activities in the clinical space, and how enclosure of the ability to parent is structured through clinical activities, I turn towards the patient experience. I reintroduce Daphne, described earlier as a newly postpartum woman diagnosed with opioid use disorder (OUD), to elucidate how the process of enclosure is resisted in multiple linguistic and affective ways in a clinical encounter.

*"I'll make sure she has good nutrition": rethinking discharge times with Daphne*

At the outset of this chapter, I described how I had initially walked into Daphne's postpartum room as she was feeding Libby. During this encounter, she also spoke with one of the pediatricians on call that day. He had just finished examining Libby and was talking to Daphne about the planned discharge time for her baby. Daphne had finished breastfeeding and put Libby back into her crib, a clear plastic tub sitting atop a wheelable stack of wooden drawers filled with diapers, blankets, and wipes. Daphne was scheduled to be discharged the next day, but Libby was to be held in the hospital to watch for any signs of NOWS and monitor her weight, which had dropped outside the expected range after birth. The pediatrician kept emphasizing the need

to keep Libby in the hospital, stating multiple times that he had no intention of keeping Daphne from her baby. “We never want to separate a mom and her new baby, but sometimes we need to make sure the baby is safe,” he said. I could imagine that this statement from the pediatrician might implicitly assume that Daphne was somehow *not* keeping Libby safe; that Daphne’s use of methadone and Libby’s limited weight gain after birth were indicative, both biologically and morally, of faulty motherhood (McCabe 2016). The pediatrician tried to temper his stated perspective on ensuring Libby’s safety through monitoring in the hospital by emphasizing how well Daphne was doing as a mother.

Daphne was visibly annoyed that the pediatrician would suggest she could not go home with Libby. “I’ve had two other daughters exposed to methadone, and they went home on day three [after birth]!” she exclaimed to the pediatrician, leaning forward in bed. The pediatrician looked uncomfortable with the situation, darting his eyes away from Daphne when she would speak and trying to look both at me and Libby instead. However, Daphne persisted: “I feel like everything going on with my baby is because I am on methadone,” she explained. They continued back and forth in a calm, sometimes raised, pitch. Finally, Daphne and the pediatrician came to an agreement: Libby would be discharged tomorrow, alongside Daphne, pending any development of symptoms consistent with NOWS. “I’ll be watchful,” she reassured the pediatrician. “I’ll make sure she has good nutrition.” The pediatrician promptly nodded, said goodbye, and left the room.

After he left, Daphne and I began discussing the issues she had faced since she delivered. Beyond the issue of the pediatrics team wanting to monitor Libby for NOWS after Daphne was discharged, she emphasized her overall distrust and dislike of DCFS. A DCFS worker had already come by her room shortly after delivery, which, as described in the introduction, was

stated to be unusual by Daphne. She contextualized her suspicion of DCFS's intentions with Libby by describing her relationship with her case workers. Daphne was concerned that her previous experiences would jeopardize her ability to continue parenting Libby with a case worker who had been part of legally terminating custody of her other children. Her prior case worker had risen in the ranks at DCFS and was now a manager. She expressed that her previous case manager might be able to put pressure on her current case manager, thereby voiding any "objective" evaluation of her parenting capabilities with Libby.

Imposing any barrier to taking Libby back to Roosevelt with her – such as the need to monitor Libby for NOWS and weight loss after Daphne was discharged from the hospital – could be interpreted as early actions towards termination of parental custody. The tension between the presence of DCFS and the pediatrician's recommendation for inpatient monitoring for NOWS is highlighted in one of the last statements made by Daphne to the pediatrician: "I'll be watchful. I'll make sure she has good nutrition." Her apparent need to emphasize parental vigilance and responsibility to ensure that Libby did not lose more weight works in two different ways. It can be understood as a sign of a supportive and caring mother to the pediatrician; it also attempts to undermine the assumption already paved by DCFS and other bureaucratic institutions regarding pregnant women who use illicit substances as lacking a maternal instinct, as a less-than-human individual, to care for their children (Murphy and Sales 2001, Schuller 2018, Weheliye 2014).

Here, as seen with Annie, the specter of an enclosed life –potentially being *without* Libby, without parenting – is at the cusp of her conversation with Libby's pediatrician. Even though no direct actions are being taken to curtail her custody of Libby, Daphne's substance use during pregnancy is, in part, being used to justify ongoing in-hospital monitoring of Libby.

Further, though Daphne's parental capacity is not being questioned by the pediatrician – in contrast, he emphasizes explicitly Daphne's qualities as a good mother – her need to justify her parenting capabilities can be read, in a sense, as a resistance to the possibility of a (re)enclosed life, away from her children, unable to parent. Daphne had to describe her prior experiences with her two other children after delivery, specifically the fact that they did not develop Nows and were safely discharged home with her; further, she had to verbally emphasize her qualities of vigilance and support of Libby through providing “good nutrition.” Critical to both of these attempted acts of resistance to an enclosed life, Daphne had to avoid mentioning her previously-enclosed life: the fact that her two other children were removed from her custody by DCFS. Though Daphne described her concern that her past experiences with DCFS may impact her current parental capacity with Libby to me, she did not endorse this to her pediatrician.

DCFS contextualizes the interaction between Daphne and Libby's pediatrician, defining the contours of a potentially-enclosed life for Daphne, in which her parenting capabilities are questioned and legally removed by the state. Via Schuller (2018) and Donzelot (1979), Daphne's attempts at conveying her vigilance towards Libby's weight loss and potential development of Nows can be understood to identify herself as mother, capable of sentimentality (an affect not traditionally afforded to people with illicit substance use disorders, see Glenn 2014, Murphy and Sales 2001). Suspicion and unease, on the part of Daphne, enter the affective framework of a routine discussion of discharge time for her daughter. Such a space exposes the discourse between biomedical care and the state, attending to questions of societal worth, risk, and responsibility enshrined in DCFS.

*Affect and enclosure*

In this chapter, I demonstrate the affective dimensions of clinical encounters wherein DCFS is foregrounded among pregnant women with illicit substance use disorders. Through understanding the affective dimensions of mandated reporting or conveying certain qualities indicative of responsible motherhood by Daphne towards her daughter's pediatrician, I demonstrate the consequences of DCFS's legacy and the laws and logics which inform their attempted interventions. Second, by focusing on turns of speech, deployments of phrase, and translations of affect, I demonstrate how the care provided in a hospital setting exists as a discourse between state-based agencies and biomedical practice. This finding exposes the duality inherent in situations like Daphne's and Annie's, where punitive legal consequences and biomedical risk meld (Goodwin 2020, Mulla 2014, Sufrin 2017). Finally, my analysis demonstrates how the performance of treatment – specifically the enclosure of a life without the ability to parent – is deployed and resisted, historically and coeval with my time as a participant observer. Further, resistance to an enclosed life is not performed solely by individuals whose life may be enclosed, but by those who are legally obliged to partake in the process of enclosure: members of their clinical care team, such as physicians.

What does using the theory of enclosure, including its affective dimensions and resistances, tell us about creating a biopolitical subject? How can it help us better understand the issues of legal parenting faced by Annie and Daphne? What about the clinical practices of Billy and Libby's pediatrician? I argue that by attending to the performance of treatment, the creation of subjects of interest to the state is not wholly a problem of *categorization* – of who can be seen and who cannot (Biruk 2018; Scott 1998). Instead, creating a subject whose lack of parental capacity is legally enclosed is rendered a *potentiality*. There are moments where this potential can be realized, based on a perfect storm of clinical surveillance strategies, legal requirements for



mandated reporting, and an individual's substance use history. But my data demonstrate that people involved in the performance of treatment may try to render the process of categorization as contingent, rather than universal.

The affective dimension is one among many where resistance to enclosure can occur; in the following chapters of my dissertation, I consider how the performance of treatment can be understood and resisted on a different temporal scale than the one dictated by pregnancy. Instead, I focus my interrogation on the performance of treatment towards the future, using pregnancy as a “window” to consider problems associated with long-term harms from illicit substance use diagnosed during pregnancy: HIV and the risk of fatal overdose, respectively.

PART II: Hailing disability and death, from the bedside

It might seem odd to the reader why HIV and fatal opioid-related overdoses during pregnancy and the postpartum period are paired together in my dissertation. In the U.S., HIV is no longer the death sentence that it was thirty years ago. With the advent of universal treatment with antiretrovirals (ARVs), HIV has changed from a disease that people were “dying from” to something people are “living with” (Watkins-Hayes 2019). Indeed, HIV has now become a chronic medical condition with a negligible risk of sexual transmission if an individual living with HIV continues to use ARVs (Eisinger, et al. 2019). And, as described in Chapter 2, opioid-related fatal overdoses are *the* leading cause of maternal mortality in Illinois, particularly in Cook County. How do these seemingly disparate issues connect with each other, particularly under the overarching theoretical framework of the performance of treatment?

First, I see both issues along a clinical spectrum of morbidity and mortality. I emphasize *clinical* in the previous sentence because, as a clinician, my job is to reduce the likelihood of either outcome. Second, I am biased in how I think about HIV as a life-limiting condition. Though this is no longer the case in much of the U.S., it continues to be a contributor to mortality worldwide, particularly in the global South (GBD 2017 Disease and Injury Incidence and Prevalence Collaborators 2018). Further, my own experiences growing up during the second and third decades of the HIV pandemic, when HIV was all-too-commonly thought to be a deadly disease due to a lack of available treatments, have weighed heavily on my own ethical decision to pursue medicine.

I distinctly remember viewing an episode of “Bill Nye the Science Guy” – a popular television series that aired on the Public Broadcasting Service in the 1990s – as a young child that specifically focused on HIV acquisition and, for a few, brief moments, children who were living with HIV. Re-viewing the episode on YouTube in 2022, I was struck with what Bill Nye

(1995) says about HIV and AIDS. Staring at the screen, wearing a blue lab coat, Bill Nye states, “Right now, there is no vaccine or medicine you can take that fights the HIV [sic]”. The scene then cuts to a few kids entering a carnival, with one girl, Amelia, stating to the camera that she is 11 years old and living with AIDS. Despite the scientific advancements in treating HIV, I still think about HIV as I did as a kid, through Amelia’s image: a skinny kid, wearing thick, blue rimmed glasses, destined to die.

Those feelings about 11-year-old Amelia and her inevitable death, all these years later, bubble to the surface every time I think about my training in MFM and perinatal HIV care at Northwestern. I am still processing the emotional gravity of the stories my attending – a senior MFM physician who specifically focused on perinatal HIV – would tell me during my fellowship. As I rotated through the joint obstetrics-infectious disease clinic, where we would take care of pregnant people living with HIV, I would get bits and pieces of the historical impetus for the clinic's foundation in the early 1990s. My attending would tell me the purpose of the clinic was to help people cope with the idea that they not only would succumb to a deadly disease, but that they would likely pass this disease on to their child (Connor, et al. 1994, Garcia, et al. 1999). She would tell stories about how she and other clinicians would work with pregnant women to create journals they could pass along to their children. In these journals, my attending would tell me about the stories women wrote to be remembered by their children, the apologies they sometimes gave to them for transmitting a disease for which there was no cure.

Because HIV holds such a deep grip on my perception of morbidity and mortality during pregnancy, I can’t avoid thinking about OUD in a similar fashion. Like HIV – which, left untreated with daily medications, can lead to severe morbidity and mortality – OUD can, too, lead to adverse health outcomes and early mortality if left untreated (Schiff, et al. 2018). Though

the public health ramifications of OUD are substantially different than those of HIV in the U.S., the way pregnant women diagnosed with both conditions are treated, socially, and the clinical methods to deal with each problem are similar. In both circumstances, pregnant women are putting their fetuses “at risk,” whether through a potential exposure to HIV and subsequent perinatal transmission, or opioids and the risk of neonatal opioid withdrawal syndrome (NOWS) or, legally, “chemical endangerment” (see Chapter 3). Clinically, the goal for both sets of people is to try and keep them in the healthcare system beyond the window of pregnancy; this optimizes the chance that they stay on medication treatment for their disease, whether antiretrovirals or MOUD, to reduce the risk of harm or death.

The latter topic – the risk of death – philosophically preoccupies me the most. Clinically, I speak frankly about the possibility of early death with people diagnosed with OUD during pregnancy. I don’t usually discuss this possibility with pregnant women living with HIV. Why? Pregnant women living with HIV have many resources to keep them engaged in healthcare – case managers, social workers, and dedicated centers in Chicago focused solely on comprehensive healthcare services. People diagnosed with OUD during pregnancy have similar resources, but due to co-occurring structural vulnerabilities, such as housing instability, and oftentimes-undertreated psychiatric conditions, these resources often are limited in their effectiveness (Knight 2015). The possibility of death for pregnant women diagnosed with OUD, particularly in the postpartum period (Schiff, et al. 2018), is a source of anxiety for me, both clinically and anthropologically. Even when I am not outrightly discussing the risk of fatal overdose, I find myself contemplating the possibility of death during discussions of medication adherence, attending prenatal care visits, and continuing in care after delivery.

For both pregnant women living with HIV and those diagnosed with OUD, the temporal space after pregnancy is where my anxiety heightens. As a clinician, this is when I say my goodbyes, as my services as a MFM are no longer needed because the person is no longer pregnant. Clinical care is handed off to another physician in a different subspecialty, such as internal or family medicine. I acknowledge that the anxiety I experience stems from my inability to exert some level of surveillance over an individual's disease course. After about 6 weeks after delivery, I will not write prescriptions for medications to manage their chronic medical condition or be the person to help connect them with different resources to improve their health. Therefore, the level of clinical concern I can relate to a patient diminishes as time passes between us.

The potential for death undergirds every conversation I've had, both clinically and through this project, about pregnant women with OUD. Dr. Cam, my obstetrician/gynecologist colleague, and I would sit down with me every month to review a list we kept of pregnant women diagnosed with OUD. Part of the purpose of this list was to ensure people were connected with MOUD, behavioral health, and psychiatric services, both during pregnancy and after birth. For me, there was a sense of relief when discussing people on this list. We reviewed the brief moments these women would contact us by phone after giving birth, either for birth control refills or for questions about getting into primary care. When Dr. Cam and I spoke to each other about these people, I inadvertently thought: yes, thank God they're still alive. It's a little win, a small good in the world.

I take up my anxiety about harm and death in temporal spaces connected to, but wholly outside of, pregnancy to critically investigate the performance of treatment. The following two chapters extend the ramifications of HIV acquisition and overdose to consider the incursion of morbidity or outright mortality. I foreground these discussions by reconsidering temporality

(Chapter 4), the social context of overdose, and its relationship to engagement in clinical care (Chapter 5). Each chapter focuses on limitations within current biopolitical theories and contributes ethnographic data to understanding enclosing and foreclosing practices that may lead to undue morbidity and mortality. Importantly, my data privilege both the clinical encounter, especially the interactions between a physician and their patient, and public health messaging as critical avenues to investigate the performance of treatment more thoroughly.

The tension I feel when writing these chapters, simultaneously weaving my role as an anthropologist and a physician, feels messy. I acknowledge I cannot separate my deeply-held perceptions of the goals of medical practice to better the lives of the people who come to see me as patients and the inquisitive, critical perspective I bring as an ethnographer (Kierans and Bell 2017). However, evaluating the performance of treatment with a foot firmly planted in the clinical space *feels right*, philosophically and morally. Because, after all, medical practice is where I feel the most comfortable, day in and day out as a clinically-active MFM. It is where I feel at home.

## Chapter 4. Reconsidering risk, reevaluating the past: the temporal redistribution of the risk of HIV acquisition

(Fieldnotes, 9/2021). *Before rounding on the inpatient antepartum service today, one of the resident physicians in obstetrics and gynecology wanted to discuss a pregnant patient in her third trimester and admitted to the antepartum unit to manage cocaine use disorder. She had disclosed that she engaged in frequent transactional sex work to obtain money and cocaine. I asked the resident if they had discussed the option of preexposure prophylaxis, or PrEP, with the patient, as transactional sex work and substance use disorders are major risk factors for acquiring HIV (American College of Obstetricians and Gynecologists (ACOG) 2014). The resident told me they hadn't discussed it with the patient, but wanted to talk about it with her when we went to see her together.*

*When we walked into the patient's room, I sat near her bedside and briefly talked about how things were going with the pregnancy. I knew I had to broach the topic of HIV, but I was nervous about it. Every time I've had to talk about the risk of HIV with a patient, it's almost as if a bomb goes off in the room. They usually are caught off guard – some have even asked me why I would bring up this topic, as if it was an insult. They would then withdraw from the conversation or become suspicious of follow-up questions. No matter how much I try to normalize it in the moment ("I ask everyone these questions" is my go-to phrase when discussing anything about the risk for acquiring HIV), discussing this topic with a patient is challenging.<sup>48</sup>*

*This is why it was surprising that when I began to talk to the patient about her risk of acquiring HIV – "So, I always talk about this with my patients, but have you heard about ways to reduce your chance of getting HIV?" – she immediately interrupted me. She said "Oh, is this about PrEP?" I looked at the resident and asked if she had brought up PrEP, to which the resident physician said no. I looked back at the patient, shocked. In the year I had been at Stroger, no patient had ever brought up PrEP – a clinician always was the one starting the conversation.*

*She immediately gave me a deadpan look and said, "Look, I know about my options. I sell pussy, you know?"*

Nineteen percent of all new HIV diagnoses in the U.S. are among women, most of whom are between 13 and 44 (Centers for Disease Control (CDC) 2019). Among new diagnoses of HIV among women, 11% were attributable to practices associated with illicit substance use disorders (SUD) – such as injection drug use (Centers for Disease Control (CDC) 2019). Further data suggest that risk for HIV among women with illicit substance use disorders can be linked to

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<sup>48</sup> See Smith, et al. (2022) for an evaluation of the affective dimensions of counseling about PrEP within sexual health encounters.



other high-risk practices associated with drug use, such as heterosexual transactional sex work (American College of Obstetricians and Gynecologists (ACOG) 2014).

PrEP, formulated as a daily tablet of two antiretroviral medications (tenofovir and emtricitabine) or a monthly injection of a single antiretroviral medication (cabotegravir), has been demonstrated to reduce the risk of acquiring HIV among cisgender women (Baeten, et al. 2012, Bradley, et al. 2019, Delany-Moretlwe, et al. 2022, Moodley, et al. 2023, Mugo, et al. 2014). It has been approved for use by the Food and Drug Administration since 2012. In Illinois, most new HIV diagnoses occur in the Chicagoland area. The “Getting to Zero-Illinois” program, sponsored by the Illinois Department of Public Health (IDPH), aims to end the HIV epidemic in Illinois by 2030 by increasing the percentage of people using PrEP (Getting to Zero Illinois (GTZ-IL) 2019). Though legislative endeavors – such as Illinois House Bill 4430, allowing for pharmacists to dispense PrEP without need for a prescription (Illinois General Assembly 2022) – as well as public health campaigns aimed at improving PrEP awareness across Illinois (Dehlin, et al. 2019), PrEP has come into the public eye in Chicago.<sup>49</sup>

In the U.S., PrEP has almost been exclusively promoted as an option suitable for non-pregnant individuals. For example, as part of the Illinois Perinatal Quality Collaborative’s Mothers and Newborns affected by Opioids (ILPQC MNO) initiative, focused on reducing the morbidity and mortality associated with OUD during pregnancy, clinicians are urged to complete an OUD Clinical Care Checklist ([Figure 7](#)). The checklist highlights routine preventative health services done by prenatal health providers, such as discussion of contraception and screening for

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<sup>49</sup> Between 2017 and 2020, I consistently could see billboards in the “el” trains or buses I would take across the city or, during my tenure at Stroger, on banners fluttering on streetlights along Harrison Avenue – the main thoroughfare of the Illinois Medical District – focused on HIV testing and initiation of PrEP ([Figure 6](#)).

sexually-transmitted infections (American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG) 2017). It also emphasizes assessment of OUD-specific comorbidities, such as HIV, and implementation of strategies to reduce the morbidity and mortality associated with OUD, such as naloxone. However, the problem I note is the *absence* of linking screening for HIV to PrEP in the OUD Clinical Care Checklist. I argue that this finding reflects an ongoing issue within prenatal care: PrEP, and the risk of acquiring HIV, is a preventative health service that is rarely discussed by clinicians who work with reproductively-capable people or acknowledged by pregnant women (Butler, et al. 2022, Fruhauf and Coleman 2017, Henny, et al. 2020, Seidman and Weber 2016).

However, my interlocutor, introduced in the epigraph to the chapter, not only voiced knowing about PrEP, but she was able to verbally assess her risk for acquiring HIV. At first glance, it seems she does not fit the picture painted by epidemiological data or my critiques of the ILPQC MNO initiative. She appears to be one of the few exceptions to the trend I noticed while at Stroger. I posit that state-based public health programming has a conflicting biopolitical focus on HIV acquisition as it relates to pregnancy: in short, clinicians are recommended by public health agencies to screen for HIV, but not necessarily doing anything to inform pregnant women about options for preventing the acquisition of HIV. This disconnection between screening and prevention efforts requires me to investigate the concept of being “at risk” for acquiring HIV more thoroughly, especially during pregnancy.

I unpack the concept of risk in the context of the performance of treatment, specifically how alternative temporalities and futures – ones that may include the possibility of acquiring HIV – are expressed, foreclosed, and reimagined by my pregnant interlocutors. Through evaluation of public health messaging focused on PrEP and ethnographic data derived from key

informant interviews with pregnant women diagnosed with OUD, I describe how futurity, anticipation, and opportunity costs<sup>50</sup> are used in different, incongruent ways. I show how PrEP-specific public health messaging, targeting men who have sex with men (MSM), neglects the concerns for HIV risk acquisition among cisgendered women.<sup>51</sup> However, for the pregnant women diagnosed with OUD in my ethnography, most of them describe the risk of acquiring HIV as negligible. Further, my pregnant interlocutors rarely describe being aware that PrEP exists or experience with using PrEP.

While these findings roughly support much of the biomedical and public health literature focused on HIV in the U.S., some of my interlocutors express their concerns about acquiring HIV in different ways that trouble the future-oriented goals of PrEP. While a minority of individuals describe the desire to start PrEP, a finding like other data derived from pregnant women (e.g., Groves, et al. 2022), they specifically describe the desire to *have been offered PrEP in the past*. The shift in temporality and futurity – running back to a time where, for a variety of reasons, the risk of acquiring HIV was much higher – through a discussion of a prophylactic medication offers a novel opportunity to think more critically about biopolitical interpretations of time (Adams, et al. 2009). I ask: how do these alternative futures, where the risk of acquiring HIV is thought to be higher than what is endorsed by a person in the present, become constructed? How were they foreclosed to begin with? And what are the public health and biomedical ramifications of reevaluating these foreclosed futures?

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<sup>50</sup> “[T]he world as being *capable of being otherwise* than we believe it to be” (Gell 1992, p. 217)

<sup>51</sup> The relegation of the risk of acquiring HIV to people other than cisgendered women is a common theme in the history of HIV (Cohen 1999, Treichler 1999, Watkins-Hayes 2014). By rendering the risk of acquiring HIV among cisgendered women as minimal, at best, by public health agencies, PrEP is, by definition, a gendered technology (Davis 2020).

*Temporality, biopolitics, and the risk of acquiring HIV: on anticipation and abduction*

Before considering both the perspectives of the state and my interlocutors, I want to situate my analysis from the perspective of anthropological engagements with time. Time is a critical factor in how people consider when a potential adverse event will occur: will I get HIV today, five years from now, or never? Furthermore, how assumptions about time – such as the philosophical transition from determinism (i.e., I will get HIV) to probabilism (i.e., I have a chance that I will get HIV, see Hacking [1990]) – are wedded to public health programming is critical to my analysis of the foreclosure of the risk of acquiring HIV. As anthropologist Nancy Munn describes the relationship: “Control over time is not just a strategy of interaction; it is also a medium of hierarchic power and governance” (Munn 1992, p. 109). *Whose time* is seen by the state as opportune for management is inherent in the concepts of population and normalization, projects inherent to public health and biomedical practice (see Chapter 1, Braun [2007]).

The perception and management of time by public health groups and biomedical practice require a shared understanding of how events are organized in relation to others. Anthropologist Alfred Gell (1992, pp. 150-2) describes the organization of time by hearkening to metaphysician J.M.E. McTaggart in two steps: 1) A key event, such as a birthday, is identified and 2) Other events are ordered as before, coeval, or after a key event, delineating a past, present, and future. Gell jumps from this rudimentary evaluation of time to reconsider the notion of opportunity costs and, with it, the future:

Once we start to judge actions and outcomes in the actual world against the imaginary standard of alternative scenarios stemming from once open but subsequently closed possibilities, we enter an arena of radical uncertainty (ibid, p. 219).

How the “radical uncertainty” of an alternative history – such as the possibility of acquiring HIV in the past, expressed by my interlocutors – becomes managed through public health and biomedical practices is of great concern to me.

However, to understand how time and risk are coordinated, I turn to scholars influenced by Foucault’s iteration of biopolitics. Sociologist David Armstrong (1995) argues that if risk of acquiring a disease is to be operationalized into actions performed by public health and biomedical practitioners, the concept of disease needs to be decomposed. No longer should there be “the well” and “the sick,” but there needs to be a way to separate “a precarious normality from a threat of illness” (ibid, p. 403). Using the example of HIV, the pre-disease state is not a series of laboratory values, signs, or symptoms (see Foucault 1975) but risk behaviors.<sup>52</sup> From a public health standpoint, assessing who is at risk of acquiring HIV is not necessarily understood through a person’s own ascertainment of their risks for HIV. It requires an orientation of an individual towards the risk of HIV through public health messaging. Or information must be drawn out by clinicians and translated back to the patient to orient them towards a future risk of acquiring HIV. Thus, time becomes clinically rendered, via ascertainment of risk behaviors, into a future where HIV acquisition may be on the horizon to a meaningful degree.

The moral work of mitigating one’s own risk of morbidity – whether through lifestyle modifications or use of pharmaceutical interventions like PrEP – is at the heart of what sociologists have termed *biomedicalization* (Clarke, et al. 2003). How affective, ethical, and

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<sup>52</sup> What specific behaviors indicate a “threat of illness” (e.g., the risk of acquiring HIV) vary (Table 2). In June of 2022, ACOG, in line with the CDC, expanded its recommendations for discussing PrEP with any sexually-active individual, instead of only those who were deemed high risk for acquiring HIV (American College of Obstetricians and Gynecologists (ACOG) 2022). During my fieldwork, these changes for PrEP eligibility were not yet implemented. Therefore, my analysis may not be relevant to current discussions of PrEP eligibility among pregnant women diagnosed with illicit substance use disorders.

temporal dimensions of biomedicalization are enacted by an individual have been theorized by anthropologist Vincanne Adams and colleagues (Adams, et al. 2009) as *anticipatory* practices.

[...] [A]nticipation now names a particular self-evident ‘futurism’ in which our ‘presents’ are necessarily understood as contingent upon an ever-changing astral future that may or may not be known for certain, but still must be acted on nonetheless. (p. 247)

Adams and colleagues draw from Foucault’s interlocutors interested in the role that biotechnologies aimed at disease identification have on identity formation (e.g., Rose 2006) and affect theory (see Chapter 3). They argue that anticipation is a “moral economy in which the future sets the conditions of possibility for action in the present, in which the future is inhabited in the present” (ibid, p. 249). Therefore, how time – particularly the uncertain way in which past behaviors weigh on the potential for acquiring HIV in the future – is manipulated by someone is both intensely personal and deeply political.

For Adams and colleagues, how individuals frame events by toggling between the past, present, and future is termed *abduction*. As a method of working with and shaping time, the future “[...] not only gives meaning to the past, but conjures new temporalized domains, versions of the present as sites of *contingent and malleable action*” (ibid, pp. 250-1, italics added). Here, the future of a life with a chronic, infectious co-morbidity – laden with historical, racialized, sexualized, gendered, and classed tropes (Benton, et al. 2017, Farmer 1992, Treichler 1999, Watkins-Hayes 2014) – can be intervened upon to reduce its likelihood. Preparing oneself for avoiding this future state is “legitimately infinite in its scope and always ongoing” (ibid, p. 256). How individuals become aware, perceive, and organize their lives around a particular future

(e.g., one wherein HIV is present) is situated<sup>53</sup> by multiple intersecting factors that may render a future state as (im)plausible.

However, Adams and colleagues place their emphasis on decision making in the present. Specifically, they are interested in how an individual uses historical data to predict certain futures, which must be attended to in the present (ibid, p. 255). I think about problem of past, present, and future differently: rather than focusing on a future that must be attended to in the present, I use data from my interlocutors to demonstrate how certain forms of medical technology require people to reevaluate the past, to reconsider risks. I demonstrate that it is not only the future risk for acquiring HIV that inhabits the present, but past activities which trickle into the present and move an individual to consider *alternative futures*. Therefore, there is more to be unpacked than how an individual cultivates proactive stance towards the future; it is how someone might toggle between the past and present to envision certain futures that may need attention.

*Who constitutes an “at risk” population: clinical guidelines, expert opinion, and public health messaging*

To invoke the futurity of acquiring HIV, public health messaging and clinical protocols must interpellate the appropriate subject for PrEP, thereby bringing into consideration the question of *who* is eligible through exculpation of past or current behaviors (see [Table 2](#)).

Organizations formulating recommendations for PrEP eligibility, such as ACOG and the CDC,

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<sup>53</sup> In contrast to Adele Clarke and colleagues’ use of “stratified,” hearkening to work done by Faye Ginsburg and Rayna Rapp (1995) emphasizing “who” is allowed to do a certain activity, I hearken to Michele Murphy’s rejoinder to entertain the use of the word “situated” to foreground the “why” and “how” social activities, like reproduction, occur (Murphy 2017).

have differing opinions on what information is needed from an individual to assess the risk of acquiring HIV in the future. For example, ACOG recommends assessing if a someone is having sex with someone living with HIV. However, this is incredibly difficult, as few individuals know whether their sexual partner has tested positive for HIV (e.g., Conserve, et al. 2015).

Furthermore, the interpersonal moral, affective, economic, and social ramifications of inquiring about a sexual partner's HIV status may preclude accurately knowledge. My pregnant interlocutors would describe suspecting a sexual partner of being at risk for acquiring HIV in opaque ways: they would state that knew that their partner was not “faithful” or was the source of a recently-diagnosed sexually-transmitted infection.<sup>54</sup> However, many would endorse that they did not know for certain. Among a subset of pregnant women diagnosed with OUD explicitly queried about HIV status of their primary sexual partner (n=10) at Stroger, 30% endorsed that they did not know. Digging deeper into the issue, I performed retrospective chart review of all pregnant people with OUD receiving care at Stroger from 2013 to 2022. Out of 132 pregnant women diagnosed with OUD, there was no documentation of a patient's knowledge of the HIV status of sexual partners during prenatal, intrapartum, or postpartum care visits.

Further complicating the guidelines created by ACOG and CDC is pregnancy: neither guideline explicitly links pregnancy with other risk factors for acquiring HIV. For example, one of my clinical interlocutors – a prominent infectious disease clinician-scientist – informed me that, by definition, women who are pregnant had unprotected sex. Therefore, they are at risk for acquiring HIV, as heterosexual intercourse is the main risk factor for acquiring HIV among cisgendered women (Centers for Disease Control (CDC) 2019). With this rather humorous take

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<sup>54</sup> It is also possible that my pregnant interlocutors do not want to disclose that their partner(s) may be living with HIV for a variety of reasons, such as the social stigma associated with people living with HIV.



on pregnancy, my interlocutor found a narrow gap between what ACOG and the CDC purport as risk factors for acquiring HIV and how someone becomes pregnant. Just because the ACOG and CDC guidelines on PrEP do not acknowledge pregnancy as a risk of HIV does not mean that the risk of acquiring HIV is negligible during pregnancy. Illinois legally mandates HIV screening at least twice during pregnancy (American College of Obstetricians and Gynecologists (ACOG) 2018b).<sup>55</sup> Further, data suggest that the risk of acquiring HIV is higher during pregnancy when compared to not being pregnant (Thomson, et al. 2018). If pregnancy is deemed a high-risk time for acquiring HIV, why does PrEP-specific public health messaging *not* focus on pregnancy?

Public health messaging focused on PrEP is meant to target individuals who, epidemiologically, fall into predefined sociodemographic categories wherein HIV incidence is the highest. In the city of Chicago, most new HIV diagnoses occurred among individuals who identify as MSM and those who self-identify as non-Hispanic Black (Chicago Department of Public Health (CDPH) 2020). Public health resources through the Illinois Department of Public Health (IDPH) specifically identify these groups as potentially benefitting from PrEP:

- MSM who engage in condomless receptive anal sex
- MSM with multiple anal sex partners
- MSM with syphilis or rectal STDs (for example, rectal gonorrhea or chlamydia)
- MSM with one or more HIV-positive sex partners, particularly if the HIV-positive partner is not in care or does not have an undetectable viral load
- Heterosexual men and women with one or more HIV-positive sex partners

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<sup>55</sup> In areas with a high incidence of HIV, ACOG recommends that HIV screening occur in the first and third trimesters (American College of Obstetricians and Gynecologists (ACOG) 2018b). Illinois has mandated third trimester HIV testing since 2003 with the Perinatal HIV Prevention Act (Illinois General Assembly 2003) and has supported implementation via the Perinatal Rapid Testing Initiative (Wong, et al. 2012, Yee, et al. 2018).

- Injection drug users (Illinois Department of Public Health (IDPH) 2022)

Noting the list of proposed risk categories, pregnant or pregnancy-capable individuals are not explicitly acknowledged. They may be implicitly understood in the term “heterosexual women.” They could be categorized under “injection drug users,” if they are diagnosed with OUD during pregnancy and engage in injection drug practices. However, pregnancy as a health state is not outrightly mentioned.

The effacement of pregnant women from public health messaging focused on PrEP is also felt outside of guidelines. Turning to visual public health messaging, the #PrEP4Love campaign was one of the most notable displays of PrEP messaging in Chicago ([Figure 5](#)). Importantly, the creators of #PrEP4Love made a conscious decision to foreground displays of queer intimacy and racialized groups to “celebrate non-normative gender expressions and sexualities that are often stigmatized and marginalized” (Dehlin, et al. 2019). Like other forms of public health messaging, #PrEP4Love does not explicitly acknowledge pregnancy as an opportunity for PrEP. Inferring the potential for reproduction through intimacy, as depicted in panels 1 (furthest left) and 3 (last to the right) in [Figure 5](#), with visually-appearing cisgendered male and female models<sup>56</sup>, is as close as an observer may get to the prospect of pregnancy.

Through this frame, HIV continues to be understood as a problem affecting individuals engaging in sexual practices traditionally associated with “homosexuality” (e.g., MSM). PrEP is marketed, for all intents and purposes, *for use outside of pregnancy* (Butler, et al. 2022, p. 767). Therefore, PrEP becomes a gendered and sexualized technology, replete with particular biopolitical ramifications for thinking about the risk of acquiring HIV in the future and behaviors

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<sup>56</sup> This conclusion is not to discredit the possibility that the individuals depicted in [Figure 5](#) may identify as another gender (e.g., transgender man and transgender woman; two gender fluid individuals).

in the present and past (Davis 2020). I turn to this problem and the issue of reevaluating the past and reconsidering risks among pregnant women diagnosed with OUD, as these individuals demonstrate multiple, unique behaviors that place them at high risk for acquiring HIV (e.g., transactional sex work, intravenous drug use).

### *Foreclosing the risk for HIV*

My ethnographic engagement with pregnant women diagnosed with OUD complicate the arguments about anticipation and abduction proffered by Adams and colleagues (2009). Many of my interlocutors would toggle between their past behaviors; their current engagement in healthcare services, which may lessen their risk for acquiring HIV; and their projections of a desired future abstaining from illicit substance use and, therefore, activities that increase the risk of acquiring HIV. Instead of using the past to think about anticipated futures, my interlocutors would use the concept of HIV prevention to think about past behavioral risks and alternative futures where the risk of HIV might be more substantial. My interlocutors created an assemblage of risk that kept PrEP as a tool that could be used if things did not go as planned, if problems arose, if situations changed.

Among a subset of my interlocutors who participated in surveys<sup>57</sup> and interviews focused on knowledge, attitudes, and practices for HIV prevention<sup>58</sup> (n=10), most interlocutors met one or more criteria that would place them at high risk for acquiring HIV ([Table 2](#)). 80% endorsed

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<sup>57</sup> These surveys were adapted from Ralph, et al. (2021).

<sup>58</sup> Knowledge, attitudes, and practices is a common theoretical framework utilized in implementation science, a burgeoning field of study that sits at the intersection of the biomedical (e.g., preventative medicine), behavioral (e.g., psychology), and social sciences (e.g., anthropology) (Brownson, et al. 2017). One of the goals of implementation science is to understand barriers and facilitators to using interventions to reduce adverse health outcomes.

intermittent or no condom use when engaging in vaginal or anal intercourse, 30% endorsed transactional sex work in the past six months, and 40% tested positive for one or more sexually-transmitted infections during their pregnancy. Among all pregnant participants in the study, I specifically asked if they had ever heard about PrEP. 10% affirmed knowledge about PrEP or prior use of PrEP. One individual stated they had used PrEP in the past, while another stated they had seen commercials on television that advertised PrEP. Despite the large-scale public health messaging for PrEP through IDPH and #PrEP4Love, none of the participants specifically acknowledged these venues as ways in which they were exposed to the possibility of PrEP. However, during semi-structured key interviews focused on HIV prevention, 50% of participants described that they wished they had been offered PrEP by a clinician or started PrEP in the past.

Olivia, a young Latinx woman who came to Chicago to be closer to her partner's family while seeking care for her OUD, described to me her wish to have been offered PrEP when she was actively using heroin in Texas during a pregnancy four years prior:

They [her clinical team] didn't think about it or something. Maybe I wasn't even paying attention. I'm not sure, but I know that my sister has [been offered PrEP in the past]. I would assume that they would because I feel like they should have, because, you know, my sister's ex, he's got hepatitis C and my brother's got hepatitis C from sharing needles. So, you know, at one point in time, I thought I had hep[atitis] C too as well, and I found out I didn't have it when I got pregnant with my son. And then I got chlamydia multiple times while I was pregnant. So, I feel like just the fact that it was some kind of STD [sexually transmitted disease, sic] going on, they knew I'd share needles. I feel like they should have mentioned it [...]

The contextualization of Olivia's risk for acquiring HIV is manifold: sharing needles and affirmation of one or more sexually-transmitted infections (e.g., hepatitis C, chlamydia) all constitute risks that, in her words, "should have" triggered a discussion about PrEP. Though she prefaces her discussion by stating that perhaps it was her lack of awareness – perhaps about the existence of PrEP, her risk for acquiring HIV, or both – that caused her clinician to not engage in a discussion about PrEP, the issue that Oliva brings up remains: there were multiple signs pointing towards an elevated risk for acquiring HIV that Oliva affirms should have been attended to, which were only highlighted *in retrospect*. Though Oliva declined PrEP initiation during her current pregnancy at Stroger – as she was stabilized on buprenorphine and felt that she would not engage in intravenous drug use if she were to have an episode of recidivism – discussing the possibility of PrEP helped to reformulate her experiences of her past behaviors and the potential for her future risk of acquiring HIV based on changes in the way she used heroin.

Like Olivia, Evelyn, a young Latinx pregnant woman admitted to Stroger for management of her diagnosed OUD, endorsed how discussing PrEP with me made her rethink her past behaviors related to acquiring and ingesting illicit substances. Evelyn had always lived in the Chicagoland area and had sought assistance for multiple psychiatric and substance use conditions over the past fifteen years. She had struggled with OUD, benzodiazepine, and crack/cocaine use over the past decade, reporting a history of intravenous drug use and a non-fatal overdose a few years ago. She also endorsed that she intermittently would engage in transactional sex work for money and illicit substances, though this had not occurred in some time. Unlike Olivia, Evelyn struggled to stop using both cocaine and heroin during her pregnancy, even while in treatment at an outpatient treatment facility and while using methadone. She was admitted to Stroger multiple times to treat her illicit substance use disorders,

and it was during one of her hospitalizations I was able to speak with her. While she ultimately declined initiating PrEP, she endorsed that she would have like to have been offered PrEP in the past. When I asked her why, she responded that it was because she was deeply involved with “unsafe behavior,” alluding to her history of intravenous drug use and transactional sex work.

I argue that most of my pregnant interlocutors described their own future risk of acquiring HIV in a manner that is not necessarily as straightforward as state-based public health messaging and clinical guidelines would describe. A minority of individuals identified their risk factors for acquiring HIV and demonstrated some level of knowledge about HIV prevention methods, including PrEP. For most of my pregnant interlocutors, they endorsed that their own perceived risk of acquiring HIV was low. However, by interpreting past behaviors as associated with a high risk of acquiring HIV and projecting them into an alternative future, my pregnant interlocutors concluded that they should have been offered PrEP in the past. Inherent in these topics is how we think about foreclosing and enclosing practices germane to the performance of treatment that focus on a life led by pregnant women diagnosed with OUD without the specter of HIV. I turn to these problems in the next section.

### *The temporal redistribution of risk for HIV*

PrEP became how my pregnant interlocutors understood past experiences with biomedical care, their own risks for HIV acquisition, and the futures they voiced that they were avoiding through engagement in treatment for illicit substance use disorders. Though many of my interlocutors declined to start PrEP, my data demonstrate that they had multiple risk factors that put them at a high risk for acquiring HIV. Further, when my pregnant interlocutors were invited to reminisce, they excavated practices and behaviors that would have put them at high

risk for acquiring HIV, thereby bringing an alternative future – one that was previously foreclosed – into view. I argue that my interlocutors hearkened to a past wherein acquiring HIV was at a high enough concern for them that they voiced that they would have liked to have been offered PrEP, with some individuals going so far as to describe it in terms of a medical oversight.

However, the interpretation of HIV risk and preventative strategies elucidated by my interlocutors contrasts with the state-sponsored clinical criteria and public health messaging on PrEP. The possibility of acquiring HIV is foreclosed from groups that policymakers, state officials, public health organizations, and physician-led bodies deem “low risk” or, in the case of pregnancy, “not risky enough” to warrant a discussion about PrEP. Thus, state-sponsored clinical criteria and public health messaging do not offer the possibility of a health strategy aimed at preventing morbidity.

If one takes seriously sociologist’s Nikolas Rose’s assertion that the “vital politics of our own century [...] is concerned with our growing capacities to control, manage, engineer, reshape, and modulate the very vital capacities of human beings as living creatures” (ibid 2006, p. 3), then my data demonstrate an ambiguity in what are “vital capacities,” as defined by the state and endorsed by pregnant women. A personal evaluation of the risk of acquiring HIV, and subsequent emphasis placed on that risk, is not a resistance nor acquiescence to a dominant biomedicalized paradigm of risk. I posit that it manipulates forms of time – moving among the past, present, and alternative futures, once foreclosed and possibly could be reopened, to assess whether the risk of acquiring HIV has substantially changed. In this way, state perceptions of public health issues and requisite solutions demand an evaluation of how time is marked, as it underpins how risk is constructed and interventions are structured.

The final chapter of my dissertation builds on these insights into temporality, biopolitics, and risk by focusing on how ways of being among pregnant women diagnosed with OUD become enclosed by the state through public health messaging focused on opioid-related overdose. I pivot my focus from ambiguous futures, fraught with the possibility of acquiring HIV, towards enclosed lives, where the risk of harm or death due to opioid-related overdose is palpable. In both circumstances, the temporal aspects of the performance of treatment are critical to note.



## Chapter 5. On the social context of overdose

I was on call at Stroger one Friday afternoon in late 2021, when my partner, Dr. Cam, alerted me that a pregnant woman in her third trimester, with suspected OUD, had been brought in from a referring hospital. Dr. Cam was told that emergency medical services found her unconscious on the streets of the southside of Chicago. The paramedic had administered naloxone, after which she had woken up and become extremely agitated. Because of the referring hospital's limitations in caring for sick pregnant individuals, as they had no MFMs on staff, she was immediately transferred to Stroger for further evaluation.

When she first arrived at Stroger, she was awake and was wheeled into a room on the labor and delivery unit. I walked by, and from the hallway, I could see a flurry of nurses trying to start intravenous (IV) fluids, obtain bloodwork, and perform electronic fetal monitoring by placing small, hockey-puck-shaped objects over her pregnant abdomen to measure the fetal heart rate and ascertain evidence of uterine contractions. However, when Dr. Cam and I went back in to see her, not even an hour later, she was barely awake and breathing. We suspected that her naloxone had worn off, and that she likely needed another dose. However, she did not immediately awaken after another dose of naloxone, as she had previously with the paramedic. As she could not control her ability to breathe and was at risk for asphyxiation, she was rapidly intubated, sedated, and sent to the intensive care unit (ICU).

Only after this dramatic event were we able to parse her history from different documents in the electronic medical record. She had been in and out of Cook County Jail multiple times over the past few years. Documentation from various nurses and social workers noted a history of exchanging sex for illicit substances and money, while others hinted at the possibility of

multiple psychiatric conditions.<sup>59</sup> From the medical record, she had come to Stroger's emergency room a few months earlier complaining of being "dope sick," or withdrawing from opioids, and was started on buprenorphine. However, she had not attended any subsequent outpatient prenatal visits.

Dr. Cam and I discussed what we thought would happen in this situation. "Ten bucks says that after they extubate her in the ICU, she pulls out her IV lines and walks out the door," I said, somewhat jokingly, as people admitted to the ICU commonly have a prolonged hospital stay and do not usually immediately leave the hospital. Dr. Cam dryly replied "Yeah, probably."

When I returned to Stroger the following Monday, I asked the resident physicians what happened to the patient. When they replied that she had pulled out her IV lines and left after being extubated, against medical advice, I already knew the answer to my next set of questions: no, there was no way to contact her, as she didn't leave a phone number or a stable address; yes, she had a scheduled appointment with us in our prenatal clinic; and no, she did not confirm that she would attend before leaving Stroger.

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In this chapter, I want to unpack the problem of opioid-related overdose. Fatal and nonfatal opioid overdose constitute one of the major causes of maternal morbidity and mortality in Illinois (Illinois Department of Public Health (IDPH) 2021). I examine how my pregnant interlocutors contradictorily describe death due to opioid overdose as both an inevitable (Garcia 2010, López 2020) and motivating event. I use the term "motivating" to indicate how my

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<sup>59</sup> A significant clinical conundrum is parsing out whether an individual's erratic behavior or thought process is due to an underlying psychiatric diagnosis or is induced by using substances. Therefore, psychiatric disorders may be suspected among individuals using substances, whether illicit or licit, but sometimes may be challenging to confirm.

pregnant interlocutors describe opioid-related overdoses as a motivation to engage with behavioral health and psychiatric services, including starting methadone or buprenorphine.

I demonstrate that public health messaging and programming from state-based bureaucratic agencies, such as the Illinois Perinatal Quality Collaborative (ILPQC) and Illinois Department of Public Health (IDPH) privilege a narrative focused on preventing opioid-related fatal overdoses, emphasizing the use of naloxone, an opioid antagonist, to immediately reduce the risk of death. Yet, I argue the state upholds a biopolitical paradigm in which the state “sees” death as only something to be avoided (Kaufman 2015, Kaufman and Morgan 2005, Scott 1998). Importantly, it cannot “see” that, for some pregnant women diagnosed with OUD, death due to opioid use is described as inevitable. It is also, paradoxically, motivational: it can spur engagement in healthcare services that can subsequently help to lessen the risk of harm or death among the same people.

I term this phenomenon the *social context of overdose*, or what connections are created and lost between pregnant women diagnosed with OUD and their wider community of family and friends, and how these connections act as motivation for engaging or disengaging in long-term healthcare service use. I am concerned with how individuals shift into alternative futures and careen into different interpretations of the past, and how these activities can alter how overdose, as a concept, is interpreted.

I argue that the social context of overdose is one way of thinking about potential futures that state-based bureaucracies may foreclose. I further posit that current public health and biomedical messaging do not address the paradoxical possibility that opioid-related overdose may be an unavoidable event but may also be the impetus to engage with healthcare services to reduce someone’s future risk for fatal overdose. Current trends in biopolitical thought focus on

how current state policies may be cursorily interested in reducing morbidity and mortality associated with illicit substance use. Instead, by continuing to uphold forms of sociopolitical, racialized, gendered, and economic forms of marginalization, state policies inherently support a unique form of biopolitics: namely, thanatopolitics or necropolitics (Esposito 1998, Mbembe 2019), regimes which generates an excess of death among marginalized people in pursuit of health for a larger segment of the population (e.g., López 2020, Stevenson 2014).

My data demonstrate that state-based bureaucratic agencies fail to ascertain the work that opioid-related overdose does outside of solely producing death. Importantly, my interlocutors description of the social context of overdose – particularly the concept that fatal opioid-related overdose of a loved one may motivate someone to engage in healthcare services – does not easily reflect either biopolitical paradigm in the Illinois context. Instead, the social context of overdose indicates a particular configuration of how pregnant women diagnosed with OUD adjudicate their own risk for death or harm: they entertain certain futures, foreclose others, and enclose particular ways of living that acknowledge death yet simultaneously strive to avoid it.

### *The work that death does*

Before presenting my data, it is important to situate how death relates to a biopolitical analysis of state-based public health endeavors. A genealogy of inquiry into “letting die” – or how biopolitical strategies lead to death among certain segments of the population (Foucault 1978) – can heuristically be considered to start with philosopher Giorgio Agamben’s initial rejoinder to Foucault. Agamben described the *homo sacer* – or an individual who has been stripped of their social life (*zoë*) and left as pure biological life (*bios*) (Agamben 1998). Through different juridico-legal and political practices, these individuals were left biologically alive, but

unable to meaningfully engage in societal activities. Though *homo sacer* has enjoyed a wide applicability within the social sciences, particularly in canonical texts in medical anthropology (e.g., Biehl 2001, Fassin 2009, Ticktin 2005), anthropologists over the past ten years have begun to engage with other interlocutors of Foucault, particularly Achille Mbembe and Roberto Esposito, to critically consider the ramifications of death, politics, and the state beyond *homo sacer*.

Mbembe's formulation of necropolitics starts with, and radically reconsiders, the role of sovereign power. As elucidated in Chapter 1, Foucault's genealogy of power is characterized by a shift from sovereign power towards disciplinary power and biopower – namely, from “letting live” to “making live”. Mbembe centers postcolonial and apartheid states as key to his elucidation of necropower, or the “subjugation of life to the power of death” (2008, p. 39). The state accomplishes this subjugation through different techniques: geospatially segregating and surveilling minoritized groups and creating spaces for state-sponsored violence against these individuals (*ibid*, pp. 34-35). Esposito, in contrast to Mbembe's distinctly postcolonial lens, seeks to privilege the Foucauldian biopolitical focus on vitality, or the state of being healthy, in relation to death. He begins, *contra* Mbembe, by conceptualizing death as a byproduct of current biopolitical regimes, rather than its sole focus. However, by bringing up the example of the Nazi regime – where vitality was of the utmost political concern, but genocide of certain “undesirable” groups became the method of ensuring the health of the Germanic population – Esposito asks a provocative question: “Why does a politics of life always risk being reversed into a work of death?” (*ibid* p. 8) As opposed to Mbembe's description of necropolitics as a state of near-total war, Esposito focuses on the thanatopolitical, or state practices which aim for vitality but are, instead, caught up in producing death.

Esposito builds on the concept of autoimmunity – proposed by individuals like Donna Haraway, Jean Baudrillard, and Jacques Derrida (Campbell 2006) – to conceptualize “that strange behavior where a living being, in quasi-*suicidal* fashion, “itself” works to destroy its own protection, to immunize itself *against* its “own” immunity” (Derrida 2003, p. 94). Esposito argues for an immunitary focus within biopolitics by reconsidering the relationship between the individual and the community. He argues that eschewing reciprocal “concrete obligations or responsibilities” (1998, p. 45) between an individual and the community to, theoretically, preserve an individual’s well-being:

[...] subjects the organism to a condition that simultaneously negates or reduces its power to expand. Just as in the medical practice of vaccinating the individual body, so the immunization of the political body functions similarly, introducing within it a fragment of the same pathogen from which it wants to protect itself, by blocking and contradicting natural development (ibid, p. 46)<sup>60</sup>

Though he sees the lack of reciprocating social responsibilities as one of the etiologies for the transformation from a politics of life towards a politics of death, I want to think more critically about the formation of different bonds – both social and institutional – and how those are facilitated or hindered by state-based perceptions of death and harm at the level of a population.

Scholars like Stuart Murray (2016, Murray 2022, 2006, 2008) have engaged with Mbembe and Esposito to evaluate the work death does at the level of the individual and their larger community. He considers how death can exist as a “*community ethic that is more than the negation of life or the moral failure to live*, more than the production of biopolitical life that is

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<sup>60</sup> Esposito engages directly with Marcel Mauss’ canonical text, *The Gift* (2002 [1950]), and situates his analysis in the vein of refusing the gift.

presumed to be foundational” (Murray 2008, p. 205, *italics added*). This intriguing premise – that death can be a uniting factor “to bind together or to sustain a living community in friendship and shared beliefs and values” (ibid, p. 206) – stands in contrast to Mbembe’s elucidation of necropolitics or Esposito’s own take on the immunitary paradigm within thanatopolitics: that, in today’s current biopolitical landscape, one must either reckon with the shortcomings of the “letting die” aspect of biopolitics and seek an “affirmative biopolitics” (i.e., modes of living that actively resist domination) or succumb to the immunitary paradigm and descend into totalitarianism (Esposito 2013 [2008], Murray 2016, Murray 2022).

It is between Esposito’s deft elucidation of the breakdown between the self and community, which he posits to sit at the heart of thanatopolitical regimes, and Murray’s interest in the productive work of death in fostering community where I enter the conversation. As I will illustrate, death due to opioid-related overdose is an event that the state is preoccupied with preventing; however, its inevitability, described by my pregnant interlocutors, is also met with a need to engage in healthcare services aimed at reducing its inevitability. The state’s inability to see the paradox at the heart of the social context of overdose has ramifications for thinking about public health messaging and building healthcare infrastructure. Anthropologically, I believe it tells us more about how pregnant people diagnosed with OUD structure their own lives – both in the present, but also, looking towards the future and back to the past – related to the prospect of opioid-related overdose and death.

### *Ethnographic engagements with overdose and death*

Anthropological engagements with death and dying have traditionally looked at forms of community building through rites of passage, such as funerary practices (Durkheim 1995, Evans-

Pritchard 1949, Malinowski 1948). In the past thirty years, medical anthropologists have expanded upon these inquiries, turning towards the role of medical technologies and biomedical practices that trouble the notions of the end of life (Kaufman 2015, Kaufman and Morgan 2005). Importantly, ethnographies focused on substance use and death over the past decade have privileged the lives of individuals marginalized through settler colonialism and social retrenchment. While these data shed light on the provocative questions raised by Mbembe, Esposito, and Murray as to the future of biopolitics, necropolitics, and thanatopolitics, they leave much unanswered.

Specifically, I argue that current anthropological evaluations of death specifically related to illicit substance use disorders do not attend deeply enough to the role of the healthcare system. Many cultural and medical anthropologists critique the role of public health institutions in actively stigmatizing and harming marginalized people (e.g., Berlin, et al. 2019, Bourgois and Schonberg 2009, Messac, et al. 2013, Mulligan and Castañeda 2017, Stonington and Coffa 2019). However, a significant limitation of these analyses has to do with the way the healthcare system is theorized. Though the prevailing philosophy is that hospitals and clinics provide care to improve the health of patients, they are posited to be ironically-harmful bureaucracies. My data, and those of other cultural and medical anthropologists, trouble this approach to thinking about public health and biomedical healthcare systems solely as a source of harm. Instead, I want to reconsider how these systems work to foreclose certain futures and enclose ways of existing in relation to the prospect of opioid-related overdose.

Andrea López's (2020) ethnography of homeless women who use illicit substances in San Francisco focuses on how adverse health outcomes are bred through social retrenchment and neoliberal economic policies. She argues that healthcare is only provided through the infliction



of harm, understood as institutional neglect leading to development of other complex medical conditions. Applying necropolitical theory to her analysis, López argues that women with illicit substance use disorders live with, anticipate, and manage death in an environment that allegedly is driven to help promote a reduction in morbidity and mortality.<sup>61</sup> The healthcare system exists in the lives of her interlocutors as both the source of care and harm; further, it becomes a tool in which women diagnosed with illicit substance use disorders use to understand the possibility of harm and death.

Angela Garcia's ethnographic evaluation of illicit substance use among indigenous and Latinx individuals living in the American southwest also troubles the healthcare system's role in relation to opioid-related overdose (Garcia 2008, 2010). Garcia theorizes OUD as a chronic disease, but one that does not vacillate between periods of abstention and use (Courtwright 2010, Leshner 1997). Instead, a life without heroin does not necessarily exist. She eruditely posits that opioid use and misuse, overdose and death, exist for her interlocutors as experiences that align with other forms of loss: loss of autonomy over land ownership, economic freedom, and social mobility. Therefore, in a landscape affected by the vestiges of settler colonialism and continued sociopolitical and economic marginalization, the possibility of dying from using opioids is part of life. The healthcare system may provide opportunities for people to engage in behavioral health services – as one of Garcia's interlocutors, a young woman named Alma, did after a nonfatal opioid overdose. However, the healthcare services she received did not stop her death due to OUD. Indeed, as Garcia reminds the reader, Alma's fatal opioid-related overdose almost

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<sup>61</sup> Interlocutors of Mbembe's work emphasize that necropolitical theory traditionally uses the spectacle of violence – rather than forms of slow death (i.e., instances of morbidity that, over time, culminate into mortality, see Berlant (2007)) – as its frame of reference. See Povinelli (2011).

two years after entering a rehabilitation program was structured, in part, by the ongoing loss felt at the level of her community, reinforced through generations affected by opioid use disorder.

Anthropologist Lisa Stevenson's (2012, 2014) analysis of suicide among the Canadian Inuit – framed, like OUD, as a public health crisis – works in the same vein as Garcia: focusing on the issue of death in the wake of settler colonialism. She proposes that to understand death among her interlocutors, it must not only be situated as a biopolitical project – replete with ethics of governmentality and how subjects are constituted in the eyes of the state – but it must be acknowledged as a mode of being that forges community. Stevenson describes the “life of a name,” or engaging in meaning-making through invocation of the names of the deceased in everyday practices among friends and family. Thus, life is constituted for her interlocutors through direct engagement with the living and the dead. Subsequently, death holds a different value than it does under a clinical or biopolitical framework. Death, then, becomes part of life, and becomes an ethical task for building community, rather than an affliction to be stopped through public health and biomedical bureaucratic agencies.

In these examples, death exists beyond a statistic or an adverse outcome. It is acknowledged, lived with, anticipated – used to forge relationships and break them apart. It is imbued within healthcare systems which seek to provide care and becomes the focus of governmental policies aimed at reducing deaths to the detriment of forms of community. While these data are compelling, they largely treat the role of public health and the biomedical systems as biopolitical tools of the state. They “disallow life unto death” (Foucault 1978) through a variety of mechanisms: they are underfunded to provide needed resources to help reduce harm, their clinical staff behave in a way that stigmatizes people diagnosed with illicit substance use disorders, or, more concerningly, do not act to provide health services in a timely fashion,

leading to further harm. Extant anthropological engagements with overdose fundamentally misread the public health and biomedical care system's relationship with pregnant women diagnosed with OUD. Through the social context of overdose, I argue that the relationship between public health and biomedical systems with pregnant women diagnosed with OUD is more complex, requiring attention to how people both engage in care to reduce the likelihood of fatally overdosing from opioids and continue to engage in opioid use and other self-harming practices.

In the following sections, I describe three vignettes of my pregnant interlocutors diagnosed with illicit substance use. Within each of them, I highlight a component of the social context of overdose. I specifically attend to how forms of being and ways of thinking about the future, including using healthcare services to treat their diagnosed OUD, nestle closely with the prospect of fatally overdosing from opioids.

### *Sienna*

Out of the blue, Sienna called me eight months after she delivered a healthy baby girl in late 2020, asking for a refill of her birth control. Had this been any other person, I would have simply clicked a few buttons in the electronic medical record and sent a prescription to a local pharmacy. However, Sienna's call from a women's shelter almost two hours away from Chicago was markedly different: she had just left her emotionally-abusive partner. She told me that though they had been living together, her partner had restricted her ability to see her child. She could move through the house that they shared, but her baby was kept in another room, with the door shut. Frustrated and angry with her inability to care for her baby, she took her daughter and left.

During this conversation, I remembered how difficult it was to talk to Sienna during her pregnancy, unless it was a rare occasion that she was alone. Her partner, a short pudgy man who almost universally wore t-shirts and baggy shorts, would always be by her side. Sienna was admitted to the hospital multiple times during her pregnancy to treat her diagnosed OUD and benzodiazepine use disorder. Every time she was admitted, the resident physician rounding with me in the hospital would try to speak with Sienna quietly in the morning, when we knew her partner would be most likely asleep. Sienna would only answer in terse, short sentences if he were awake. He would answer every question we posed. Everything we proposed to try and help Sienna, from going to an inpatient residential treatment to trying a new medication to ease her anxiety, would be met with resistance from her partner. He always suggested that any plan we tried to enact “hurt his baby girl.” It was only after a few times going through similar conversations with her partner that we realized that the “baby girl” he was referring to was *not* Sienna, but rather the fetus.

It was only during those rare occasions when Sienna was alone that she would discuss the problems she faced when she was living at his house with his mother: the verbal abuse she heard from his family, accusing her of hurting her pregnancy by using heroin “on top” of her methadone. She would endorse feeling isolated from her family, who lived in Tennessee. She even tried to stay with them during the early part of her pregnancy, but found it too challenging due to the lack of obstetricians willing to provide prenatal care to a pregnant woman with OUD. (Ecker, et al. 2019). Further adding to this problem was the high dose of methadone she required to treat her OUD. As her dose was above the Tennessee state maximum limit for methadone, she was unable to receive a therapeutic dose of her needed medication.

After moving back to Chicago to restart prenatal care and her methadone treatment, she told me about the emotional manipulation she faced from her partner and his family. Sitting alone in a clinic room after a routine prenatal visit, she disclosed how she had been snorting heroin and using her mother-in-law's benzodiazepines every day after receiving her methadone. When I pressed her to understand why, thinking that she may be potentially underdosed and was using these substances to curb symptoms associated with withdrawal, she disclosed something more sinister. She told me that her partner would verbally harass her every day, telling her that her substance use was harming the pregnancy. He would make her "sign a contract" stating that she would not use heroin or benzodiazepines again. He would then take the signed contract and hand her both substances to use or drive her to her drug dealer. She would relate how her partner's mother would consistently accuse her of hurting her pregnancy by continuing to use heroin. Still, she would, according to Sienna, turn a blind eye towards her son's own continued use of heroin.

I became increasingly concerned about these instances of outright intimate partner violence (IPV) – or the "a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion" (American College of Obstetricians and Gynecologists (ACOG) 2012). Indeed, the impetus for Sienna's call to me, months after delivering her daughter, was yet another instance of IPV – this time, her partner trying to police her ability to parent and be with her child. However, during one of the few moments I had alone with her during her pregnancy, I broached the concerns I had about her partner and her substance use. I outrightly asked Sienna if she thought she would die from her OUD, to which she shrugged and nonchalantly replied in the affirmative.

She disclosed an episode of overdosing on heroin seven months before becoming pregnant. In her words, “I flatlined [i.e., the heart lost electrical activity and the ability to pump blood] and they [the doctors in the emergency room] brought me back to life.” She then stated, somewhat brashly, that after she regained consciousness and left the emergency room, “I went out and snorted two bags [of heroin].” It was hard for me to not have my mind immediately begin to race, thinking about what she was doing to reduce her risk for another overdose, such as always having a prescription of naloxone with her ([Figure 6](#)). But, looking at her during this moment, she didn’t seem concerned about her history of overdose or my concerns that she could overdose again. Indeed, the way she was talking about her past and her possibility of dying from OUD, she seemed, at best, neutral about the whole idea.

Sienna had a family history that was notable for illicit substance use among multiple family members. She disclosed that her sister fatally overdosed using opioids in 2010; further, she also lost her mother to an opioid-related overdose in 2015. Maybe to Sienna, dying from opioids was an event that she had already survived – after all, she flatlined, regained consciousness, and immediately went out and used again. Was Sienna untouchable by death, able to have an almost-otherworldly capacity to continue using heroin? Or, maybe, overdosing was just the path others in her family had walked before her – and it was the path that Sienna was bound to go down?

In that moment, I felt too uncomfortable to press her about which possibility it was – why she seemed almost nonchalant about the possibility of dying. I was preoccupied with the possibility that there was nothing I could do – that no amount of counseling or linking her to different psychiatric and behavioral health services would deter her from the path that she was on. As a clinician, I couldn’t accept that possibility. But part of me thinks that one day, I’ll

receive a phone call from her grandmother, who she was close with, to inform me she stopped breathing after using too much heroin, her naloxone just out of reach.

### *Eliza*

Eliza was too incapacitated from withdrawing from heroin to talk to me much when she came to Stroger in early 2021. Burying her head under the thin white hospital blankets, she barely acknowledged my presence when I walked into her room to check on her. It was only after a few days – after multiple doses of methadone and medications to ease her muscle aches and diarrhea – that she was able to be conversant for more than a few jolted sentences. She had described her recent episode of using heroin in the setting of “going cold turkey” for three months after a stint in a rehabilitation center, shortly after the death of her best friend, Cooper.

As Eliza described, Cooper had a known history of OUD but had been attending outpatient behavioral health visits – “working in the program and everything” – and was “doing good for almost six months.” However, he began to have kidney problems and had to start dialysis for kidney failure. A few weeks into dialysis, Eliza and Cooper went costume shopping for a Halloween party thrown by Eliza’s brother:

After we separated [for the night], I guess he went out because I live close to one of the biggest drug spots in Chicago [...] And he ended up OD’ing [overdosing] that night and smacking his head on a dresser.

Eliza’s roommate found Cooper unconscious, almost an hour later. Despite being put in the intensive care unit and placed back on dialysis, “[the doctors] decided, after all the tests came back, that pretty much there was nothing going on there,” likely referring to absence of brain activity.

She told me that after Cooper's death, she no longer wanted to use heroin. She decided to go a rehabilitation center in Indiana, closer to her family. However, instead of being provided with methadone or buprenorphine, she told me that she underwent detoxification, or withdrawal of all opioids (i.e., "going cold turkey"). After returning to Chicago from her stay in Indiana, Eliza was around all her old friends and in the general environment where heroin was regularly used. It was no surprise to either her or me that she began using again. Only after finding out she was pregnant did she immediately come to Stroger for treatment for her diagnosed OUD.

In her quiet hospital room, Eliza and I began speaking about her recent heroin use and thoughts on overdose. Though she described never experiencing an overdose, she described her future risk for overdose in this way:

I like to say I know my limits. I mean, you never know what you're truly getting, but I try to be as safe as possible, especially if it would be some new stuff I've never tried before.

I only do a tiny bit and wait a significant amount of time before I do more. And, you know, I try to be as safe as I possibly can.

When I spoke with Eliza, there were multiple public health alerts throughout Chicago warning residents about the increasing frequency of fentanyl-related deaths (see Chapter 2). Many of these deaths were partly attributable to heroin being "cut," or mixed, with lethal amounts of fentanyl. The critical problem with fentanyl was that even very minute amounts could lead to fatal overdose, as it is an extremely potent type of opioid. Indeed, Cooper's death may have been due to fentanyl present in the heroin he used. Eliza voiced that she was using "test and see" approach to avoid overdosing, but she did not endorse using other approaches, such as fentanyl test strips. These strips, which could be dipped into any substance and would change color in the



presence of fentanyl ([Figure 7](#)), were being distributed by the Chicago Department of Public Health at the time to try and reduce the likelihood of people ingesting fentanyl unsuspectingly.

In one biopolitical reading of Eliza's narrative, she anticipated the possibility of dying by projecting practices she had used in the past, such as a "test and see" approach to using heroin, towards a possible future (Adams, et al. 2009). Though fentanyl test strips did not figure into the approach she wanted to use to avoid fatally overdosing from opioids that she voiced to me, there could have been multiple reasons. Perhaps Eliza did not know about the increased frequency of fentanyl-related deaths in Chicago or fentanyl test strips. Or maybe she knew and did not feel that being exposed to fentanyl was of sufficient concern to her to incorporate fentanyl test strips into her practice of using heroin.

Nevertheless, one can begin to see multiple alternative futures arising for Eliza. Her initial reason for her coming to Stroger for her diagnosed OUD during pregnancy was Cooper's fatal overdose. Yet, despite starting methadone, Eliza acknowledged a future that continued to have heroin and the prospect of fatally overdosing. To a clinician, this bleak prospect can be read alongside recent neurobiological insights that consider substance use disorders to be "relapsing and remitting": illnesses that do not have a cure, but may flare throughout someone's lifetime, requiring treatment with behavioral health and psychiatric health services (Leshner 1997). However, I posit that Eliza's motivation for seeking treatment for diagnosed OUD and her perspective that she may use heroin again, possibly leading to death, sits uneasily with public health and biomedical perspectives on OUD. At the heart of this issue is the way she decides to live in relation to heroin, particularly the techniques she might use to reduce the likelihood of death.

*Joan*

I met Joan shortly after she had been arrested for buying heroin with her boyfriend in K-Town, an area in west Chicago known for its open-air drug markets (Ali and Charles 2018). She was admitted to Stroger on transfer from Cook County Jail, as she was in the second trimester of her pregnancy and needed to be started on buprenorphine as she was actively withdrawing from opioids. Joan found out she was pregnant only three weeks before she was arrested. After discovering she was pregnant, Joan decided to stop using heroin. She and her boyfriend had met with a clinician willing to prescribe her buprenorphine provider a few hours before their arrest:

I got myself into a clinic. I made the appointment. I got the money rounded up. I spent the money on the appointment, which was six-hundred dollars that I could have used for drugs. Yeah, you know, I was focused on getting clean. I paid two-hundred-and-fifty dollars for the medicine [buprenorphine] at the pharmacy because I have no insurance. Despite using a significant amount of money to both see a clinician and to obtain buprenorphine, she told me that she wanted to “use one last time”:

I made a bad decision. I was deciding, “Well, we’ve got our medicine, so today will be the last day we’ll get high and then tomorrow we’ll start on our Subutex [buprenorphine]. And we got to the Westside and we got it [heroin]. But they [the police] saw us buying it. Her use of heroin and subsequent involvement with state-based agencies were not new events for Joan. She told me that her last pregnancy was marked with intermittent intravenous heroin use, though she was able to stop using heroin in the last few months of her pregnancy. However, she began using heroin again postpartum, and DCFS terminated her parental custody of her children. When I asked her what prompted her loss of parental custody, she described the day in question as “the worst experience in my life.”

I had got some heroin that day [two months after giving birth] and decided to use it in the bathroom. I thought that my body could take what I was using.<sup>62</sup> You know, I thought I could do what I've used before and that no one would notice. And then I woke up to the ambulance there and my children are in the home at the time that I overdosed. Just them seeing all that and doing that in front of them, [I was] just humiliated. I was devastated that I would even choose to do that.

Joan's speech slowed during these moments, her Southern accent coming out more intently when she described the shame she felt, as a mother, after her overdose. I asked her what went through her head that morning, what prompted her to use that day:

It was honestly just this: I just put this idea in my head like, "You know what? I just want to get high today." [...] I felt I was getting everything back in my life [...] I mean, everything was going really well. I, you know, had a good job and it was *that quick of a decision*.

I was struck by the phrase "that quick of a decision." Joan survived a brush with death, overdosing in front of her children and being revived by paramedics. She also quickly decided that she wanted to use heroin one more time before starting buprenorphine in her current pregnancy, only to be arrested. In both cases, what centers Joan's relationship among death, opioid use, pregnancy, and parenting is a series of choices that are, from a cursory glance, impulsive – that is, non-future oriented, grounded in an immediacy to satiate one's desires. Yet Joan *did plan* to start using buprenorphine in her most recent pregnancy, going so far as to pay

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<sup>62</sup> Schiff, et al. (2018) demonstrate that the highest risk of fatal and nonfatal opioid-related overdose occurs in the postpartum setting. Multiple theories abound as to why this is more likely, ranging from changes in use during pregnancy, leading to mistaken overdose, to changes in metabolism due to a significant drop in estrogen and progesterone after delivery.

hundreds of dollars to see a clinician and obtain a prescription for buprenorphine. To an extent, she had planned to stop using heroin before she overdosed after the birth of her last child.

Though the goals of impulsivity and careful coordination seem to contradict one another in Joan's life, they nevertheless represent ways that Joan exists in relation to possible alternative futures as a parent and as someone with diagnosed OUD.

### *Dissecting Sienna, Eliza, and Joan's histories*

What do Sienna, Eliza, and Joan's histories of overdose – experience both individually and among their friends and family – tell us about the social context of overdose? To answer this question, I believe it is useful to begin with the issue of how overdose is understood and translated into action, at both the state and individual level.

As illustrated in Chapter 2, opioid-related overdoses are thought to be the main contributor to maternal mortality in Illinois. As described in Chapter 3, the state's response – seen through the ILPQC MNO initiative's checklist ([Figure 6](#)) and messaging from departments of public health and other groups ([Figure 2](#), [Figure 7](#)) – has been to emphasize harm reduction strategies, such as naloxone or fentanyl test strips. However, I argue that state-based bureaucratic agencies charged with reducing the likelihood of opioid-related overdose among pregnant women diagnosed with OUD interpret overdose as a binary event: either someone experiences an overdose or they do not.

I argue that the way the state interprets opioid-related overdoses sits uneasily with the narratives of pregnant women diagnosed with OUD that I've presented. One key area where this is demonstrated is through understanding the role harm reduction strategies play in the lives of my pregnant interlocutors. Few individuals I encountered during my fieldwork at Stroger found

either naloxone or fentanyl test strips readily useful. My interlocutors acknowledged that they were aware of naloxone and how to use it. Indeed, many – like Joan and Sienna – were saved from dying from an opioid-related overdose because of it. Most people verbalized that they had filled a prescription for the medication, but it was rare for someone to endorse that they carried naloxone with them, in case of an overdose. Indeed, only one person I interviewed described using it to resuscitate one of their friends, who had overdosed in front of them when they were both using heroin. None of my interlocutors discussed using fentanyl test strips, let alone specifically acknowledging that fentanyl was a significant issue in Chicago. Some were even shocked to find that they tested positive for fentanyl when they consented to a urine drug toxicology screen (see Chapter 2).

These data could simply be interpreted as a lack of awareness of basic tools and information disseminated by the state to reduce the likelihood of harm associated with OUD. Or, like conclusions drawn from other medical and cultural anthropologists using biopolitical theory (e.g., López 2020), a sign of a necropolitical public health strategy: a “caring” state is providing solutions to a problem that they have no intention of solving, especially for a stigmatized, minoritized population, like pregnant women diagnosed with OUD. However, I believe that the work opioid-related overdose does in the narratives I’ve presented is indicative of a more complex relationship between the state; public and biomedical health systems; and how an individual structures their way of life and possible futures in relation to OUD and pregnancy.

I turn to a meditation on the role of hope fostered by clinicians caring for a pregnant woman diagnosed with OUD. I believe that this perspective will shed light on the complex role of the social context of overdose and the role of the biomedical system, commonly critiqued in anthropological evaluations of death due to illicit substance use disorders. Further, it will

demonstrate that the process of foreclosing futures and enclosing ways of living leaves room for forms of hope for alternative futures fostered by clinical practitioners.

*On hope: thinking through the social context of overdose*

The obstetrical team was discussing the overnight events of a homeless pregnant woman with OUD, in her third trimester, during morning “sign out” in the workroom of labor and delivery at Stroger in the summer of 2022.<sup>63</sup> She was admitted for management of a severe skin infection over her hand, likely due to “skin popping.”<sup>64</sup>

Before coming to Stroger, she was admitted to another hospital, where she received methadone and was diagnosed with an abscess on her hand. The abscess was incised, drained, and catheterized to allow pus and blood to drain from the area. She left the other hospital only after staying for two days. I suspected she likely left against medical advice as the severity of her infection would likely have required a longer course of intravenous antibiotics and clinical observation to ensure that her abscess was improving. She immediately began to use heroin again. She came to Stroger to manage her withdrawal symptoms, after she could not obtain another dose of heroin. We gave her a dose of methadone and recommended that she stay in the hospital for intravenous antibiotics, given the high likelihood of progression of the infection to other parts of her hand, like her bone, or into her bloodstream, which could threaten her life and her pregnancy.

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<sup>63</sup> Shifts on the labor and delivery unit are traditionally 12 hours long. At the beginning and end of each shift, the oncoming team of physicians and nurses is given report by the team leaving the hospital.

<sup>64</sup> Skin popping is a method of drug administration when substances are injected just below the skin, as opposed to into a blood vessel.

However, barely 12 hours into her admission, she decided that she needed to leave Stroger. She walked off the labor and delivery unit after being extensively counseled by the obstetrical team about the risks of leaving the hospital with an undertreated infection and the lack of achieving a therapeutic dose of methadone. The patient had told the team that she needed to get her personal life “in order” and would return to the hospital as soon as possible.

“I know she’ll come back,” concluded the resident physician, who gave the morning obstetrical team “sign out” about the patient. The resident physician’s confidence that this person would come back almost made me chuckle. I politely chided the resident physician for being so naïve. After all, this patient had already left one institution incompletely treated for her hand infection and her diagnosed OUD; why would she decide to return to Stroger? As I demonstrated in the beginning of this chapter, experiences derived from practicing clinical medicine have heavily shaped what I think will likely happen. I’m not proud of my kneejerk response to my colleagues when I expect a pregnant woman will pull out her IV lines and walk out of the intensive care unit, or, in this case, a patient with life-threatening infection will leave Stroger against medical advice.

Despite my past experiences with pregnant women diagnosed with OUD, I hoped she would return to Stroger. However, I felt that my hope differed from the confidence of the resident physician. Perhaps the resident physician was considering how severe the patient’s illnesses were. Her hand, after all, was undertreated. Maybe the pain would become so severe that she would need to come back to the hospital for care? Or maybe the infection would seed to another part of her body, causing her to become so unwell that she would need to come back? Regardless of the circumstance, the resident physician’s confidence that the patient would return to Stroger signaled a level of *hope*. However, her hope was focused on the patient coming back

to get treatment for her multiple illnesses so that she would not become sicker or die from her medical conditions. My hope was that the patient was *alive*, given the high risk she had for sepsis and fatally overdosing from opioids. My hope was temporally situated in the here-and-now, not resting on a future possibility of coming back to Stroger.

These two types of hope reflect different positions, derived from years in medical practice and experience with pregnant women diagnosed with OUD. I believe they shed light on the scope of the social context of overdose and the performance of treatment from the perspective of physicians working in a public healthcare system. Going to one hospital for treatment for diagnosed OUD and an abscess, only to leave the same hospital against medical advice and use heroin again, is expected for someone diagnosed with an illicit substance use disorder (American Psychiatric Association (APA) 2013). Hope in both the survival of this patient and for her to come back to Stroger to start methadone and antibiotics rest, in part, on willful ignorance: we tamed our superficial assumptions about a predictable course of events based on the patient's past behavior and overarching psychiatric categorization of what is to be expected in the setting of an illicit substance use disorder (Premkumar 2015, Premkumar and Gates 2016).

Both the resident physician and I embraced the contradictions inherent in the patient's past behavior; we acknowledged her risk for harm and death due to multiple undertreated conditions; and we *chose to hope that she would come back to Stroger, alive*. This affective stance towards the patient's future, and potential ways we project that the patient should live in relation to the healthcare system and her opioid use, could be categorized by some medical anthropologists as humanistic (Farmer 2003, Farmer, et al. 2013, Kleinman 2017, Kleinman 1995). I find this term too broad and nondescript to capture the essence of what I believe is going



on between myself and the resident physician. Instead, I choose to think of it as somewhere between the state's interpretation of opioid-related overdose, preoccupied with preventing death, and the patient's behaviors, which careen towards harm and aim to reduce its likelihood. Our hope leaves open the possibility of alternative futures and different ways of being for the patient, albeit ones that may never actualize. Our interpretation of the performance of treatment that the patient experienced while receiving care and her risk of death allows us to position ourselves as ready, even desiring, the counterfactual.

### CODA. An affirmative biopolitics? Some thoughts from a post-Roe landscape

An analysis of court records and medical-examiner data over the past 23 years found at least 20 felony cases in Alabama, 13 in South Carolina and 10 in Oklahoma, as well as nine in other states, where prosecutors have embraced some form of “fetal personhood” in bringing criminal charges after miscarriage or stillbirth [...] Prosecutors who bring these cases say they see them as a deterrent, or a way to help women get drug treatment. “It stops the cycle, it stops them getting pregnant again and using drugs and trying to get around it,” said Brian Hermanson, district attorney for two small counties north of Oklahoma City. (Aspinwall, et al. 2022)

Contrary to what one might imagine, the emergence of life within the apparatuses of power signals the eclipse of democracy, at least of the kind of democracy that we have imagined up to this point. Naturally, this doesn’t mean that another kind of democracy is impossible [...] But where to look for, how to think, what a biopolitical democracy, or a democratic biopolitics, that is capable of exercising itself not *on bodies but in favor of them* might mean today is quite difficult to identify [...] (Esposito 2013 [2008], pp. 110-111, italics added)

The Supreme Court of the United States’ (SCOTUS) ruling on *Dobbs v. Jackson’s Women’s Health Organization* in June 2022, dealing with the passage of an abortion ban after 15 weeks of gestation in Mississippi (Supreme Court of the United States 2022), signaled two radical changes to reproductive healthcare: 1) The federal juridico-legal system effectively ceded the decision to legally permit abortion to the states, triggering a wave of increasingly-restrictive bans (Center for Reproductive Rights 2022) and 2) The question of who is being protected by the state moves away from people capable of pregnancy and towards the fetus (Premkumar and Wendland 2022). Scholars working with the issue of illicit substance use during pregnancy have had much to add to the latter finding, as connections between abortion restrictions, criminalization of pregnancy, and fetal personhood have dogged the topic since the 1970s (Amnesty International 2017, Flavin and Paltrow 2010, Goodwin 2020, Roberts 1999, Roberts 2002, Roberts 2022).

As I illustrated in Chapter 3, by conflating the fetus with a child, legislators have been able to pass a series of punitive laws aimed at pregnant women (particularly poor women of

color) who use illicit substances due to issues as varied as chemical endangerment and the assumption that ongoing substance use is a marker of unsafe parenting. Indeed, the legislative imagination surrounding illicit substance use during pregnancy is one of the reasons I became interested in the topic as a medical student; pursued research and advocacy as a resident and fellow physician; and made it the focus of my dissertation. The motivation for much of my work has been on how illicit substance use renders the pregnant body as a site of risk – and how that risk becomes interpreted, problematized, and worked on by different groups. In the “post-Dobbs” reproductive health landscape, the “god trick” – to quote Donna Haraway (1988) – of turning fetuses into children (i.e., fetal personhood) through juridico-legal interpretations of clinical, biological, and neuroscientific research<sup>65</sup> has its roots in illicit substance use diagnosed during pregnancy.

As evidenced in the epigraph, women have been brought into the prison-carceral system through charges of manslaughter and murder for stillbirths and miscarriages “attributable” to illicit substance use.<sup>66</sup> A similar set of principles were used to justify the arrest and incarceration of Lizelle Herrera, a young Latinx woman, who was charged in Starr County, Texas in April 2022 for a self-managed abortion with medications obtained through the mail (Heyward and

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<sup>65</sup> One of the key arguments within *Dobbs v. Jackson Women’s Health* was the supposed biological plausibility of fetal pain in the “pre-viable” stage of development, roughly understood to be before 24 weeks’ gestation. These findings were driven by testimony from individuals like Dr. Maureen Condic, Associate Professor of Neurobiology and Adjunct Associate Professor of Pediatrics at the University of Utah. As a result, the Society for Maternal Fetal Medicine (SMFM) filed an amicus brief in *Dobbs v. Jackson Women’s Health* (Society for Maternal-Fetal Medicine (SMFM), et al. 2021) and published a clinical practice document, alongside the Society for Family Planning, focused on the biological implausibility of fetal pain as understood in the context of maternal-fetal surgery (Norton, et al. 2021).

<sup>66</sup> Data do not exist to definitively associate ongoing illicit substance use disorders with increased risks for stillbirth or miscarriage outside of rare circumstances. However, licit substance use (e.g., alcohol, tobacco) during pregnancy have been associated with higher risks for stillbirth (Jones and Prasad 2014).

Kasakove 2022). In both instances, particular futures – such as legal freedom or the ability to not be pregnant – are foreclosed and ways of being are, both legally and physically, enclosed through state-based interpretations about bodily autonomy, reproduction, and fetal personhood.

As an anthropologist writing about biopolitics, what can the performance of treatment, initially elucidated through an exegesis on illicit substance use disorders diagnosed during pregnancy, tell us about the issue of abortion in a post-Dobbs world? Other anthropologists working within this space hearken to notions of stratified or situated reproduction (Ginsburg and Rapp 1995, Murphy 2017) – thinking about who and under what conditions reproduction or abortion can occur. They consider the style of governmentality used to facilitate access to care, be it methadone or abortifacients (Morgan and Roberts 2012). However, both biopolitical interpretations privilege the link between biopolitics and practices of alterity – namely, that governmental policies focused on health necessitate certain forms of harm towards minoritized communities (Foucault 2010, Foucault 1978, Foucault 2007). I want to trouble this assumption by taking up Roberto Esposito’s call for an affirmative biopolitics – understood as a move away of governance *over* life and towards a governance *of life* (Tierney 2016).

As described in Chapter 5, Esposito has come to terms with the pervasiveness of biopolitics within modern forms of governmentality. While criticizing the 20<sup>th</sup> century iterations of biopolitics via thanatopolitics in Nazi Germany, Esposito seeks to critically undo the links between liberalism (i.e., a focus on individuality, using the self as the ethical and moral object of governance) and democracy (i.e., a focus on community, or a group which is completely immunized<sup>67</sup>, see Esposito 2013 [2008], pp. 37-46), which he describes as philosophically

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<sup>67</sup> To turn the immunitary paradigm on its head, Esposito asks, “What if we tried to rethink community beginning by completing the process of immunization? After all, a world without an outside – that is, a world completely immunized – is by definition without an inside.” (Esposito

antithetical to one another. In his elucidation of the immunitary paradigm, he specifically states that the transformation of biopolitics from a politics of life into management of death starts when governments “protect life from the risks that inhere in the relationship among men and women even at the cost of ending communitarian bonds” (Esposito 2013 [2008], p. 71). Thus, the undermining of *community* is what pushes forward the immunitary paradigm, and, ultimately, the homicidal and suicidal nature of thanatopolitics in general (Esposito 1998).

Indeed, the “god trick” of fetal personhood is replete with legal and political ramifications, which deal with problems related to the formation of community.

For example, fetal personhood laws have led to legislation that allows for tax credits up to \$3,000 in Georgia; proposed federal legislation, currently in the U.S. House of Representatives, would mandate child support payments to “unborn children” from the time of conception (Zernike 2022). As a significant number of people undergoing abortions in the U.S. are parents (Jones and Jerman 2017) and financial issues are commonly cited as reasons to undergo an abortion (Foster 2020), antiabortion activists argue that social investments in subsidized childcare could lead to a reduction in the number of annual abortions (Bachiochi 2022).<sup>68</sup>

As interesting as these possibilities are for reversing inequity and improving community, the documented violence ensuing through this calculus is manifold. The removal of bodily autonomy for pregnancy-capable people and the health risks associated with carrying a pregnancy – ranging from life-threatening hypertension to hemorrhage – cannot be swept aside

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2013 [2008], p. 46). Therefore, the thanatopolitical need to protect the community through perpetuating death is rendered obsolete.

<sup>68</sup> The practice of offering subsidies to sway individuals away from abortion has been used by crisis pregnancy centers (CPCs) – or centers which falsely advertises themselves as abortion care facilities, but in reality attempt to counsel pregnant people away from abortion. See Holland (2020) for a critical genealogy of CPCs.

(Raymond and Grimes 2012). But what can the messiness of fetal personhood, antiabortion legislation, and the criminalization of pregnancy tell us about the usefulness of affirmative biopolitics as an analytical tool, particularly in elucidating foreclosing and enclosing practices?

I want to return to the case of Lizelle Herrera to explicate the utility of an approach that includes attention to affirmative biopolitics. Prior to Herrera's arrest, the state of Texas passed a series of laws focused on severely curtailing legal access to abortion: Texas Senate Bills 4, effective December 2021, and 8, effective September 2021 (Arey, et al. 2022, Zettler and Sarpatwari 2022). Before fully dissecting Herrera's case, it is important to provide the legislative background in which the case occurred to grasp why Herrera's imprisonment was unique, both from a legal and a biopolitical framework.

Under Texas Senate Bill 4, physicians can no longer prescribe misoprostol and mifepristone, the medications used to complete an abortion, after 7 weeks of gestation.<sup>69</sup> Further, a physician must physically see a patient seeking abortion and document that a pregnancy has not proceeded beyond 7 weeks of gestation before administering medications to induce an abortion. A physician who fails to comply with these requirements is charged with a civil felony, which could lead to the loss of a medical license (American College of Obstetricians and Gynecologists (ACOG) 2023).

Texas Senate Bill 8 banned the provision of abortion after the detection of fetal cardiac activity through ultrasound, which is commonly seen after 7 weeks of gestation. Though

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<sup>69</sup> In contrast, ACOG (American College of Obstetricians and Gynecologists (ACOG) 2020b) supports use of medications to complete an abortion up to 10 weeks of gestation. Further, many individuals with an unintended and undesired pregnancy do not detect a pregnancy until the second trimester, when medication abortion regimens are not commonly used (Drey, et al. 2006). Taken together, Texas Senate Bill 4 drastically decreases the accessibility of abortion for a significant number of individuals.

legislators made provisions to allow for abortions in the case of “medical emergencies,” data demonstrate that a combination of local, institutional barriers and physician fears of legal repercussions significantly affected the provision of abortion services (Arey, et al. 2023). Physicians suspected of “aiding and abetting” an individual seeking an abortion or providing an abortion beyond 7 weeks outside of a medical emergency could face a civil lawsuit and monetary penalties.

When Herrera was jailed in April 2022, Texas Senate Bills 4 and 8 were in effect for a few months. Investigative journalists and Texas-based abortion advocates suspect that the District Attorney’s office became aware of the case from staff at a local hospital, where Herrera sought care for a “miscarriage” in January 2022. She disclosed to a clinical staff member that her miscarriage was due to medications she used to cause an abortion (Nowell 2022, Stanton 2022). After receiving information about Herrera’s abortion, the Starr County Clerk’s Office’s chose to proceed with indicting her for “intentionally and knowingly caus[ing] the death of an individual” through a self-managed abortion (McCullough 2022, Vásquez 2022). Herrera was arrested and imprisoned for two days, with her bail set at \$500,000; she was eventually released after If/When/How, a national legal defense fund focused on reproductive health, paid her bail and the Frontera Fund, a national abortion fund, organized protests at the Starr County Jail (Baker 2022).

Upon reviewing the case within a day of release, the District Attorney for Starr County, Gocha Allen Ramirez, dropped the charges. He stated that there was a fundamental misreading of the law, which mistakenly led to Herrera’s arrest. In no case is self-managed abortion an indication to pursue an arrest for murder in Texas. As previously discussed, Texas Senate Bills 4 and 8 specifically criminalize those who either are physicians providing an abortion or those who

“aid and abet” people seeking an abortion; they do not deem obtaining an abortion as an illegal act.

There are multiple questions, informed by a biopolitical approach, that can be asked to interpret the series of events that led to Herrera's wrongful imprisonment and psychological harm. Did an “aura of illegality,” sparked by Texas Senate Bills 4 and 8, lead hospital staff to report Herrera to the District Attorney’s office (Goodwin 2020, Vásquez 2020)? Did it also influence incompetence at the level of the District Attorney’s office and the local juridical system (Graeber 2012)? Both questions implicate multiple bureaucratic structures – the biomedical care and juridico-legal systems – leading to Herrera’s literal physical enclosure in the Starr County Jail.

However, other groups worked to undo parts of the performance of treatment, namely national, non-governmental activist groups like If/When/How and the Frontera Fund. Not only did they pay her bail, but they held a series of protests and started a social media campaign to highlight issues that I would categorize as foreclosing and enclosing practices. During press conferences, they specifically discussed the potential violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), protecting the disclosure of personal health information, by healthcare workers who likely reported Herrera to the District Attorney’s office. Second, they critiqued the scant amount of public information provided in the Herrera’s indictment, implicitly suggesting that the grand jury decision to support Herrera’s arrest was founded on, at best, a misreading of Texas law and, at worst, implicit biases towards abortion and reproduction among minoritized populations in the U.S. (Bridges 2011, Grand Jury of Starr County (Texas) 2022). District Attorney Ramirez stated that the interpretation of extant Texas legislation was inappropriate, and that the grand jury’s request to indict Herrera was legally



unfounded. However, this conclusion brought into stark relief the slippage between fetal personhood laws and laws criminalizing the provision of, but not the act of obtaining, an abortion – a fact acknowledged by If/When/How and the Frontera Fund (Baker 2022).

I want to consider what these activities from nonstate-affiliated organizations lend towards a theory of affirmative biopolitics. The actions of the local hospital system, District Attorney's office, and local juridical system signal the fetus, and its requisite legal personhood, as an object needing protection from the state. However, the impetus for Herrera's legal troubles began with hospital staff disclosing privileged, confidential information to the District Attorney's office, potentially due to concerns that they were legally required to do so in the wake of Texas Senate Bills 4 and 8 (McCullough 2022, Vásquez 2022). Hospital staff members eschewed "concrete obligations or responsibilities" (Esposito 1998, p. 45) to Herrera in the name of a quasi-legal concern for fetal personhood, leading to Herrera's imprisonment.

However, using Esposito's approach to community and biopolitics, both If/When/How and the Frontera Fund took on responsibilities towards Herrera: they paid her bail and organized protests and social media campaigns to advocate for her charges to be dropped. They sought, in part, to create alternative futures and ways of existing for Herrera through countering state-based bureaucratic activities. These activities emanated from both organizations' commitment to reproductive justice – in this circumstance, the right to not be pregnant (Ross and Solinger 2017). This principle contrasts the slippage between the legal requirements posited through state-based antiabortion legislation and fetal personhood. These actions are epitomized through the local hospital staff's disclosure of Herrera's self-managed abortion to the District Attorney's office, and the subsequent inditement of Herrera on "intentionally and knowingly caus[ing] the death of an individual" (McCullough 2022, Vásquez 2022).

Anthropologists, sociologists, and historians have historically been interested in the role of social organizations in impacting biomedical practice, public health policy, and clinical research (Epstein 1996, Fassin 2007, Ginsburg 1998 [1989], Holland 2020, Ticktin 2011). My cursory analysis of Herrera's case in the context of antiabortion legislation in Texas suggest that anthropologists should consider how state-based interest in health may not only cause friction with social organizations, but how those organizations may cause us to rethink dominant biopolitical paradigms in reproductive health. Further, Herrera's case helps us think through the consequences of upholding or ignoring obligations and responsibilities towards individuals by different groups affiliated with the state, inclusive of the biomedical care system.

The latter topic will ultimately serve as a base for my future inquiries at the nexus of biopolitical theory, reproductive health, and clinical medicine. The stakes are not simply theoretical, but directly bear how the healthcare system plays a role in community formation or dissolution. Critically, this approach can further trouble the status of clinical medicine in current biopolitical theory as a "handmaiden" of state control over health.

## References

- 1995 Bill Nye the Science Guy. Germs. Pp. 23 mins, Vol. 3: Public Broadcasting Service.
- A Dose of Truth
- 2021 The Usual. <https://www.youtube.com/watch?v=EmaaYbeuXZg>, accessed 20 October 2021.
- Adams, Vincanne, ed.
- 2016 Metrics: What Counts in Global Health. Durham, NC: Duke University Press.
- Adams, Vincanne, Michelle Murphy, and Adele E. Clarke
- 2009 Anticipation: technoscience, life, affect, temporality. *Subjectivity* 28(1):246.
- Agamben, Giorgio
- 1998 Homo Sacer: Sovereign Power and Bare Life. Stanford, CA: Stanford University Press.
- Ahmed, Sara
- 2004 Affective Economies. *Social Text* 22(2):117-139.
- Ait-Daoud, Nassima, et al.
- 2018 A Review of Alprazolam Use, Misuse, and Withdrawal. *Journal of Addiction Medicine* 12(1):4-10.
- Alfandre, D., and J. H. Schumann
- 2013 What is wrong with discharges against medical advice (and how to fix them). *Journal of the American Medical Association* 310(22):2393-4.
- Ali, Tanveer, and Sam Charles

2018 A 4-block radius on the West Side is at the heart of Chicago's opioid epidemic.

Chicago Sun-Times, 25 May.

Althusser, Louis

1971 Ideology and ideological state apparatuses (Notes towards an investigation). *In*

Lenin and Philosophy and Other Essays. B. Brewster, ed. Pp. 142-7, 166-76. New York:

Monthly Review Press.

American Academy of Pediatrics (AAP)

2021 Reimagining Child Welfare: Recommendations for Public Policy Change.

<https://www.aap.org/en/advocacy/child-welfare-report/>, accessed 20 June 2023.

American Academy of Pediatrics (AAP), and American College of Obstetricians and

Gynecologists (ACOG)

2017 Guidelines for Perinatal Care. Elk Grove, IL: American Academy of Pediatrics.

American College of Obstetricians and Gynecologists (ACOG)

2012 Committee Opinion No. 518: Intimate Partner Violence. *Obstetrics &*

*Gynecology* 119:412-7.

—

2014 Committee Opinion No. 595: Preexposure prophylaxis for the prevention of

human immunodeficiency virus. *Obstetrics & Gynecology* 123(5):1133-1136.

—

2017 Committee Opinion No. 711: Opioid use and opioid use disorder in pregnancy.

*Obstetrics & Gynecology*. 130(2):e81-94.

—

2018a Committee Opinion No. 736: Optimizing Postpartum Care. Obstetrics & Gynecology 131(5):e140-e150.

---

2018b Committee Opinion No. 752: Prenatal and Perinatal Human Immunodeficiency Virus Testing. Obstetrics & Gynecology 132(3):e138-e142.

---

2020a Committee Opinion No. 815: Increasing Access to Abortion. Obstetrics & Gynecology 136(6):e107-e115.

---

2020b Practice Bulletin No. 225: Medication Abortion Up to 70 Days of Gestation. Obstetrics & Gynecology 136(4):e31-e47.

---

2021a Committee Opinion No. 823: Health care for transgender individuals. Obstetrics & Gynecology 137:e75-88.

---

2021b Committee Opinion No. 830: Reproductive Health Care for Incarcerated Pregnant, Postpartum, and Nonpregnant Individuals. Obstetrics & Gynecology 138(1):164-165.

---

2022 Practice Advisory: Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus. <https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2022/06/preexposure-prophylaxis-for-the-prevention-of-human-immunodeficiency-virus>, accessed 12 July 2022.

---

2023 Texas Senate Bill 4. <https://www.acog.org/community/districts-and-sections/district-xi/advocacy/texas-sb4>, accessed 11 April 2023.

American Psychiatric Association (APA)

2013 Substance-Related and Addictive Disorders. *In* Diagnostic and Statistical Manual of Mental Disorders. 5th edition. Arlington, VA: American Psychiatric Association.

American Society of Addiction Medicine (ASAM)

2020 The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder: 2020 Focused Update. Rockville, MD: American Society of Addiction Medicine (ASAM).

Amnesty International

2017 Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA. London, UK: Amnesty International Ltd.

Andaya, Elise

2018 Stratification through Medicaid: Public Prenatal Care in New York City. *In* Unequal Coverage: The Experience of Health Care Reform in the United States. J.M. Mulligan and H. Castañeda, eds. Pp. 102-126. New York City, NY: New York University Press.

Annas, George J.

2001 Testing poor pregnant women for cocaine--physicians as police investigators. *The New England Journal of Medicine* 344(22):1729-32.

Annavarapu, Sneha, and Zachary Levenson

2021 The Social Life of the State: Relational Ethnography and Political Sociology.  
Qualitative Sociology 44:337-48.

Anonymous

2018 Bail Reform and Risk Assessment: The Cautionary Tale of Federal Sentencing.  
Harvard Law Review 131(4):1125-1146.

Ansell, David A.

2011 County: Life, Death, and Politics at Chicago's Public Hospital. Chicago, IL:  
Academy Chicago Publishers.

Anspach, Renee R.

1988 Notes on the Sociology of Medical Discourse: The Language of Case  
Presentation. Journal of Health and Social Behavior 29(4):357-375.

Arey, Whitney, et al.

2022 A Preview of the Dangerous Future of Abortion Bans - Texas Senate Bill 8. The  
New England Journal of Medicine 387(5):388-390.

Arey, Whitney, et al.

2023 Abortion Access and Medically Complex Pregnancies Before and After Texas  
Senate Bill 8. Obstetrics & Gynecology 141(5):995-1003.

Armstrong, David

1995 The rise of surveillance medicine. Sociology of Health & Illness 17(3):393-404.

Armstrong, Elizabeth M.

2003 Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome & the  
Diagnosis of Moral Disorder. Baltimore, MD: Johns Hopkins University Press.

Arney, William Ray

1982 Power and the Profession of Obstetrics. Chicago, IL: University of Chicago Press.

Aspinwall, Cary, Brianna Bailey, and Amy Yurkanin

2022 They lost pregnancies for unclear reasons. Then they were prosecuted. The Washington Post.

Associated Press

2021 New Mercy Hospital Owner Vows Full Service Until 2029.

<https://www.nbcchicago.com/news/local/new-mercy-hospital-owner-vows-full-service-until-2029/2523544/>, accessed 12 October 2021.

Bachiochi, Erika

2022 What Makes a Fetus a Person? The New York Times, 1 July 2022.

Baeten, Jared M., et al.

2012 Antiretroviral prophylaxis for HIV prevention in heterosexual men and women. The New England Journal of Medicine 367(5):399-410.

Baker, Carrie N.

2022 Texas Woman Lizelle Herrera's Arrest Foreshadows Post-Roe Future.

<https://msmagazine.com/2022/04/16/texas-woman-lizelle-herrera-arrest-murder-roe-v-wade-abortion/>, accessed 11 April 2023.

Becker, Howard Saul

1961 Boys in White: Student Culture in Medical School. Chicago, IL: University of Chicago Press.

Benjamin, Ruha

2019 Race after Technology: Abolitionist Tools for the New Jim Code. Cambridge, UK: Polity.



Benton, Adia

2015 HIV Exceptionalism: Development through Disease in Sierra Leone.

Minneapolis, MN: University of Minnesota Press.

Benton, Adia, Thurka Sangaramoorthy, and Ippolytos Kalofonos

2017 Temporality and Positive Living in the Age of HIV/AIDS--A Multi-Sited  
Ethnography. *Current Anthropology* 58(4):454-476.

Berlant, Lauren

2007 Slow Death (Sovereignty, Obesity, Lateral Agency). *Critical Inquiry* 33(4):754-  
780.

Berlin, Anita, et al.

2019 The Right and Left Hands of the State — Two Patients at Risk of Deportation.  
*The New England Journal of Medicine* 381(3):197-201.

Biehl, João

2001 Vita: Life in a Zone of Social Abandonment. *Social Text* 19(3):131-49.

Biehl, João, and Adriana Petryna, eds.

2013 When People Come First: Critical Studies in Global Health. Princeton, NJ:  
Princeton University Press.

Biruk, Crystal

2018 Cooking Data: Culture & Politics in an African Research World. Durham, NC:  
Duke University Press.

Bledsoe, Caroline

2002 Contingent Lives: Fertility, Time, and Aging in West Africa. Chicago, IL:  
University of Chicago Press.

Bosk, Charles L.

2003 [1979] Forgive and Remember: Managing Medical Failure. Chicago, IL:  
University of Chicago Press.

Bourdieu, Pierre

1994 Rethinking the State: Genesis and Structure of the Bureaucratic Field.  
Sociological Theory 12(1):1-18.

—

1997 Pascalian Meditations. Stanford, CA: Stanford University Press.

—

1998 The Left Hand and the Right Hand of the State. *In* Acts of Resistance: Against the  
New Myths of our Time. Cambridge, UK: Polity Press.

—

1999 The Abdication of the State. *In* The Weight of the World. Pp. 181-188. Stanford,  
CA: Stanford University Press.

—

2020 On the State: Lectures at the Collège de France 1989-1992. Medford, MA: Polity  
Press.

Bourgois, Philippe, and Jeff Schonberg

2009 Righteous Dopefiend. Berkeley, CA: University of California Press.

Bradley, Erin, et al.

2019 Factors Affecting Pre-Exposure Prophylaxis Implementation for Women in the  
United States: A Systematic Review. Journal of Women's Health 28(9):1272-1285.

Braun, Kathrin

2007 Biopolitics and Temporality in Arendt and Foucault. *Time & Society* 16(1):1-19.

Bridges, Khiara

2011 *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization*.

Berkeley, CA: University of California Press.

Bridges, Khiara M.

2020 Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy. *Harvard Law Review* 133(133):771-851.

Briggs, Laura

2021 *Taking Children: A History of American Terror*. Oakland, CA: University of California Press.

Brown, Morven Caroline, et al.

2013 Cardiovascular disease risk in women with pre-eclampsia: systematic review and meta-analysis. *European Journal of Epidemiology* 28(1):1-19.

Brownson, Ross C., Graham A. Colditz, and Enola K. Proctor, eds.

2017 *Dissemination and Implementation Research in Health: Translating Science to Practice*. New York, NY: Oxford University Press.

Bryant, Allison S., et al.

2010 Racial/ethnic disparities in obstetric outcomes and care: prevalence and determinants. *American Journal of Obstetrics & Gynecology* 202(4):335.

Buchbinder, Mara

2022 Dirty Work in Medicine: Understanding U.S. Physicians' Agency in Contested Medical Practices. *Medical Anthropology Quarterly* 36(4):534-551.

Buckingham-Howes, Stacy, et al.

2013 Systematic Review of Prenatal Cocaine Exposure and Adolescent Development.  
Pediatrics 131(6):E1917.

Butler, Judith

1997 The Psychic Life of Power: Theories in Subjection. Stanford, CA: Stanford  
University Press.

Butler, Sharlay K., et al.

2022 Implementing pre-exposure prophylaxis for HIV prevention in women: the role of  
the obstetrician-gynecologist. American Journal of Obstetrics & Gynecology 226(6):764-  
772.

Campbell, Nancy D

2013 “Why Can’t They Stop?” A Highly Public Misunderstanding of Science. *In*  
Addiction Trajectories. E. Raikhel and W. Garriott, eds. Pp. 238-282. Durham, NC: Duke  
University Press.

Campbell, Timothy

2006 “Bios,” Immunity, Life: The Thought of Roberto Esposito. *Diacritics* 36(2):2-22.

Camus, Albert

1955 The Myth of Sisyphus. J. O’Brien, transl. New York, NY: Vintage.

Canguilhem, Georges

1991 The Normal and the Pathological. C.R. Fawcett and R.S. Cohen, transl. New York  
City, NY: Zone Books.

Carr, E. Summerson

2011 Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety:  
Princeton University Press.

Carroll, Jennifer J., Taleed El-Sabawi, and Bayla Ostrach

2021 The harms of punishing substance use during pregnancy. *International Journal of Drug Policy* 98:103433.

Casper, Monica J.

1998 The Making of the Unborn Patient: A Social Anatomy of Fetal Surgery.  
Piscataway, NJ: Rutgers University Press.

Center for Reproductive Rights

2022 After Roe Fell: Abortion Laws by State.  
<https://reproductiverights.org/maps/abortion-laws-by-state/>, accessed 28 August 2022.

Centers for Disease Control (CDC)

2019 HIV and Women. <https://www.cdc.gov/hiv/pdf/group/gender/women/cdc-hiv-women.pdf>, accessed 1 Feb 2020.

—

2021 Deciding to Take PrEP. <https://www.cdc.gov/hiv/basics/prep/prep-decision.html>,  
2022

Centers for Medicare & Medicaid Services

2017 Program History. <https://www.medicaid.gov/about-us/program-history/index.html>.

—

2021 Emergency Medical Treatment & Labor Act (EMTALA).

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA>, accessed 1

February 2022.

Chandler, Amy, et al.

2020 Diagnosing uncertainty, producing neonatal abstinence syndrome. *Sociology of Health & Illness* [ePub ahead of print].

Chase, Brett

2020 With no state help forthcoming, 4 South Side hospitals call off merger, predict service cuts. <https://chicago.suntimes.com/2020/5/26/21271216/hospitals-merger-advocate-trinity-mercy-south-shore-st-bernard-health>, accessed 4 October 2020.

Chasnoff, Ira J., et al.

1985 Cocaine Use in Pregnancy. *The New England Journal of Medicine* 313(11):666-669.

Chasnoff, Ira J., Harvey J. Landress, and Mark E. Barrett

1990 The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida. *The New England Journal of Medicine* 322(17):1202-1206.

Chenhall, Richard D., and Kate Senior

2018 Living the Social Determinants of Health: Assemblages in a Remote Aboriginal Community. *Medical Anthropology Quarterly* 32(2):177-195.

Chicago Department of Public Health (CDPH)

2019 Maternal Morbidity & Mortality in Chicago. Chicago Department of Public Health. [https://www.chicago.gov/dam/city/depts/cdph/statistics\\_and\\_reports/CDPH-002\\_MaternalMortality\\_Databook\\_r4c\\_DIGITAL.pdf](https://www.chicago.gov/dam/city/depts/cdph/statistics_and_reports/CDPH-002_MaternalMortality_Databook_r4c_DIGITAL.pdf)

---

2020 HIV STI Surveillance Report 2020.  
[https://www.chicago.gov/content/dam/city/depts/cdph/statistics\\_and\\_reports/CDPH-HIV-STI-REPORT-2020.pdf](https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/CDPH-HIV-STI-REPORT-2020.pdf), accessed 1 June 2022 2022.

---

2021 Tweet.  
[https://twitter.com/ChiPublicHealth/status/1466505043532652544?ref\\_src=twsrc%5Etfw%7Ctwcamp%5Etweetembed%7Ctwterm%5E1466505043532652544%7Ctwgr%5E%7Ctwcon%5Es1\\_&ref\\_url=https%3A%2F%2Fwww.chicagotribune.com%2Fnews%2Fbreaking%2Fct-fentanyl-test-strips-chicago-department-public-health-20211213-kq47omauzfcn5omf64xjhc7pki-story.html](https://twitter.com/ChiPublicHealth/status/1466505043532652544?ref_src=twsrc%5Etfw%7Ctwcamp%5Etweetembed%7Ctwterm%5E1466505043532652544%7Ctwgr%5E%7Ctwcon%5Es1_&ref_url=https%3A%2F%2Fwww.chicagotribune.com%2Fnews%2Fbreaking%2Fct-fentanyl-test-strips-chicago-department-public-health-20211213-kq47omauzfcn5omf64xjhc7pki-story.html), accessed 1 July 2022.

Cirruzzo, Chelsea

2021 Illinois Gains Approval for Postpartum Coverage Extension.  
<https://www.usnews.com/news/best-states/articles/2021-04-12/illinois-gets-ok-for-first-in-nation-extension-of-medicaid-for-postpartum-mothers>, accessed 22 February 2022.

Clarke, Adele E., et al.

2003 Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine. *American Sociological Review* 68(2):161-194.

Cohen, Cathy J.

1999 The Boundaries of Blackness: AIDS and the Breakdown of Black Politics.  
Chicago, IL: University of Chicago Press.

Colen, Shellee

1995 “Like a Mother to Them”: Stratified Reproduction and West Indian Childcare Workers and Employers in New York. *In* *Conceiving the New World Order: The Global Politics of Reproduction*. F.D. Ginsburg and R. Rapp, eds. Pp. 78-102. Berkeley, CA: University of California Press.

Collier, Stephen J., and Andrew Lakoff

2008 The Problem of Securing Health. *In* *Biosecurity Interventions: Global Health & Security in Question*. A. Lakoff and S.J. Collier, eds. New York City, NY: Columbia University Press.

Connor, Edward M., et al.

1994 Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. Pediatric AIDS Clinical Trials Group Protocol 076 Study Group. *The New England Journal of Medicine* 331(18):1173-80.

Conserve, Donaldson F., Allison K. Groves, and Suzanne Maman

2015 Effectiveness of interventions promoting HIV serostatus disclosure to sexual partners: a systematic review. *AIDS and Behavior* 19(10):1763-1772.

Courtwright, David T.

2001 [1982] *Dark Paradise: A History of Opiate Addiction in America*. Boston, MA: Harvard University Press.

—



2010 The NIDA brain disease paradigm: History, resistance and spinoffs. *BioSocieties* 5:137-147.

Crowley-Matoka, Megan

2014 *Domesticating Organ Transplant: Familial Sacrifice and National Aspiration in Mexico*. Durham, NC: Duke University Press.

Curtis, Bruce

2002 Foucault on Governmentality and Population: The Impossible Discovery. *Canadian Journal of Sociology* 27(4):505-33.

D'Alton, Mary E.

2010 Where Is the "M" in Maternal–Fetal Medicine? *Obstetrics & Gynecology* 116(6):1401-1404.

D'Alton, Mary E., et al.

2013 Putting the "M" back in maternal-fetal medicine. *American Journal of Obstetrics & Gynecology* 208(6):442-448.

Davis, Clay

2020 Homo adhaerens: Risk and adherence in biomedical HIV prevention research. *Social Studies of Science* 50(6):860-80.

Dehlin, J. M., et al.

2019 #PrEP4Love: An Evaluation of a Sex-Positive HIV Prevention Campaign. *JMIR Public Health and Surveillance* 5(2):e12822.

Delany-Moretlwe, S., et al.

2022 Cabotegravir for the prevention of HIV-1 in women: results from HPTN 084, a phase 3, randomised clinical trial. *The Lancet* 399(10337):1779-1789.

Derrida, Jacques

2003 Autommunity: Real and Symbolic Suicides. *In* Philosophy in a Time of Terror: Dialogues with Jürgen Habermas and Jacques Derrida. Pp. 85-136. Chicago, IL: University of Chicago Press.

Dewey, Susan, Treena Orchard, and Kyria Brown

2018 Shared Precarities and Maternal Subjectivities: Navigating Motherhood and Child Custody Loss Among North American Women in Street-Based Sex Work. *Ethos* 46(1):27-48.

Donzelot, Jacques

1979 The Policing of Families. R. Hurley, transl. New York, NY: Pantheon.

Drake, St. Clair, and Horace R. Cayton

2015 [1945] Black Metropolis: A Study of Negro Life in a Northern City. Chicago, IL: University of Chicago Press.

Drey, Eleanor A., et al.

2006 Risk factors associated with presenting for abortion in the second trimester. *Obstetrics & Gynecology* 107(1):128-35.

Drug Enforcement Agency (DEA)

2023 Controlled Substances Act. [https://www.dea.gov/drug-information/csa#:~:text=The%20Controlled%20Substances%20Act%20\(CSA,and%20safety%20or%20dependence%20liability](https://www.dea.gov/drug-information/csa#:~:text=The%20Controlled%20Substances%20Act%20(CSA,and%20safety%20or%20dependence%20liability)., accessed 11 April 2023.

Durkheim, Emile

1995 The Elementary Forms of the Religious Life. K.E. Fields, transl. New York, NY: The Free Press.

Ecker, Jeffrey L., et al.

2019 Substance Use Disorders in Pregnancy: Clinical, Ethical, and Research Imperatives of the Opioid Epidemic: A report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. *American Journal of Obstetrics and Gynecology*. 221(1):B5-28.

Eisinger, R. W., C. W. Dieffenbach, and A. S. Fauci

2019 HIV Viral Load and Transmissibility of HIV Infection: Undetectable Equals Untransmittable. *Journal of the American Medical Association* 321(5):451-452.

Epstein, Steven

1996 *Impure Science: AIDS, Activism, and the Politics of Knowledge*. Oakland, CA: University of California Press.

Esposito, Roberto

1998 *Bios: Biopolitics and Philosophy*. Minneapolis, MN: University of Minnesota Press.

—

2013 [2008] *Terms of the Political: Community, Immunity, Biopolitics*. R.N. Welch, transl. New York, NY: Fordham University Press.

Evans-Pritchard, E.E.

1949 Burial and Mortuary Rites of the Nuer. *African Affairs* 48(190):56-63.

Falletta, Lynn, et al.

2018 Perceptions of child protective services among pregnant or recently pregnant, opioid-using women in substance abuse treatment. *Child Abuse & Neglect* 79:125-135.

Farmer, Paul E.

1992 AIDS and Accusations: Haiti and the Geography of Blame. Oakland, CA:

University of California Press.

—

1999 Infectious and Inequalities: The Modern Plagues. Oakland, CA: University of

California Press.

—

2003 Pathologies of Power: Health, Human Rights, and the New War on the Poor.

Oakland, CA: University of California Press.

—

2010 Partner to the Poor: A Paul Farmer Reader. Oakland, CA: University of California

Press.

Farmer, Paul E., et al.

2013 Reimagining Global Health : An Introduction. Oakland, CA: University of

California Press.

Fassin, Didier

2007 When Bodies Remember: Experiences and Politics of AIDS in South Africa.

Oakland, CA: University of California Press.

—

2009 Another Politics of Life is Possible. *Theory, Culture & Society* 26(5):44-60.

—

2011 Humanitarian Reason: A Moral History of the Present. Oakland, CA: University

of California Press.

Feder, Ellen K.

2007 The Dangeous Individual('s) Mother: Biopower, Family, and the Production of Race. *Hypatia* 22(2):60-78.

Ferguson, James, and Akhil Gupta

2002 Spatializing States: Toward an Ethnography of Neoliberal Governmentality. *American Ethnologist* 29(4):981-1002.

Flavin, Jeanne, and Lynn M. Paltrow

2010 Punishing pregnant drug-using women: Defying law, medicine, and common sense. *Journal of Addictive Diseases* 29(2):231.

Fong, Kelley

2019 Concealment and Constraint: Child Protective Services Fears and Poor Mothers' Institutional Engagement. *Social Forces* 97(4):1785-1810.

—

2020 Getting Eyes in the Home: Child Protective Services Investigations and State Surveillance of Family Life. *American Sociological Review* 85(4):610-38.

Foster, Diane Greene

2020 The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having - or Being Denied - an Abortion. New York, NY: Simon and Schuster.

Foucault, Michel

1975 The Birth of the Clinic: an Archaeology of Medical Perception. A. Sheridan, transl. New York, NY: Vintage Books.

—

1977 *Discipline and Punish: The Birth of the Prison*. A. Sheridan, transl. New York, NY: Vintage Books.

---

1978 *The History of Sexuality: An Introduction*. R. Hurley, transl. Volume I. New York, NY: Pantheon Books.

---

1980 *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*. New York, NY: Vintage.

---

2002 [1970] *The Order of Things: An Archeology of the Human Sciences*. New York, NY: Routledge.

---

2003a *Abnormal: Lectures at the Collège de France 1974-1975*. G. Burchell, transl. New York, NY: Verso.

---

2003b *Psychiatric Power: Lectures at the Collège de France 1973-74*. G. Burchell, transl. New York, NY: Palgrave Macmillan.

---

2003c *"Society Must Be Defended": Lectures at the Collège de France 1975-1976*. D. Macey, transl. New York, NY: Picador.

---

2006 *A History of Madness*. New York, NY: Routledge.

---

2007 Security, Territory, Population: Lectures at the Collège de France 1977-1978. G. Burchell, transl. New York: Picador.

—

2010 The Birth of Biopolitics: Lectures at the Collège de France, 1978. G. Burchell, transl. New York, NY: Picador.

Fox, Renée C.

1988 Essays in Medical Sociology: Journeys Into the Field. New Brunswick, NJ: Transaction Books.

Fruhauf, Timothee, and Jenell S. Coleman

2017 A Missed Opportunity for U.S. Perinatal Human Immunodeficiency Virus Elimination: Pre-exposure Prophylaxis During Pregnancy. *Obstetrics & Gynecology* 130(4):703-709.

Garcia, Angela

2008 The Elegiac Addict: History, Chronicity, and the Melancholic Subject. *Current Anthropology* 23(4):718-46.

—

2010 The Pastoral Clinic: Addiction and Dispossession Along the Rio Grande. Berkeley, CA: University of California Press.

Garcia, Patricia M., et al.

1999 Maternal levels of plasma human immunodeficiency virus type 1 RNA and the risk of perinatal transmission. Women and Infants Transmission Study Group. *The New England Journal of Medicine* 341(6):394-402.

Garriott, William Campbell

2011 Policing Methamphetamine: Narcopolitics in Rural America. New York, NY: New York University Press.

GBD 2017 Disease and Injury Incidence and Prevalence Collaborators

2018 Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990-2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet* 392(10159):1789-1858.

Gell, Alfred

1992 The Anthropology of Time: Cultural Constructions of Temporal Maps and Images. Washington, D.C.: Berg.

Gershon, Ilana

2011 "Neoliberal Agency". *Current Anthropology* 52(4):537-555.

Getting to Zero Illinois (GTZ-IL)

2019 Getting to Zero Illinois: Executive Summary. [https://gtzillinois.hiv/wp-content/uploads/2019/08/GTZ\\_ExecPlan\\_EN-081619.pdf](https://gtzillinois.hiv/wp-content/uploads/2019/08/GTZ_ExecPlan_EN-081619.pdf), 2022

Ginsburg, Faye D, and Rayna Rapp

1995 Introduction: Conceiving the New World Order. *In* Conceiving the New World Order: The Global Politics of Reproduction. F.D. Ginsburg and R. Rapp, eds. Berkeley, CA: University of California Press.

Ginsburg, Faye D.

1998 [1989] Contested Lives: The Abortion Debate in an American Community. Berkeley, CA: University of California Press.

Glass, Kelly



2020 When Maternity Wards in Black Neighborhoods Disappear. *New York Times*, 5 May.

Glenn, Jason E.

2014 Making Crack Babies: Race Discourse and the Biologization of Behavior. *In* *Precarious Prescriptions: Contested Histories of Race and Health in North America*. L.B. Green, J. McKiernan-González, and M. Summers, eds. Pp. 237-260. Minneapolis, MN: University of Minnesota Press.

Goodwin, Michele

2020 *Policing the Womb: Invisible Women and the Criminalization of Motherhood*. Cambridge, UK: Cambridge University Press.

Graeber, David

2012 Dead zones of the imagination: On violence, bureaucracy, and interpretative labor—The Malinowski Memorial Lecture, 2006. *HAU: Journal of Ethnographic Theory* 2(2):105-28.

Grand Jury of Starr County (Texas)

2022 Indictment of Lizelle Herrea. <https://reason.com/wp-content/uploads/2022/04/Herrera-indictment-3-30-22.pdf>.

Gupta, Akhil

2012 *Red Tape: Bureaucracy, Structural Violence, and Poverty in India*. Durham, NC: Duke University Press.

Guttmacher Institute

2021 Substance Use During Pregnancy. <https://www.guttmacher.org/state-policy/explore/substance-use-during-pregnancy>, accessed 14 September 2021.

Hacking, Ian

1982 Biopower and the avalanche of printed numbers. *Humanities in Society* 5:279-95.

Hansen, Helena

2017 Assisted Technologies of Social Reproduction: Pharmaceutical Prosthesis for Gender, Race, and Class in the White Opioid “Crisis”. *Contemporary Drug Problems* 44(4):321-338.

Hansen, Helena, and Julie Netherland

2016 Is the Prescription Opioid Epidemic a White Problem? *American Journal of Public Health* 106(12):2127.

Hansen, Helena, Caroline Parker, and Julie Netherland

2020 Race as a Ghost Variable in (White) Opioid Research. *Science, Technology, & Human Values* 45(5):848-76.

Hansen, Helena, and Mary E. Skinner

2012 From White Bullets to Black Markets and Greened Medicine: The Neuroeconomics and Neuroracial Politics of Opioid Pharmaceuticals. *Annals of Anthropological Practice* 36(1):167-182.

Haraway, Donna

1988 Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies* 14(3):575-599.

—

2016 *Staying with the Trouble: Making Kin in the Chthulucene*. Durham, NC: Duke University Press.

Harvey, David

2007 A Brief History of Neoliberalism. New York, NY: OUP Oxford.

Health Resources and Services Administration (HRSA)

2021 What is a Health Center? <https://bphc.hrsa.gov/about/what-is-a-health-center/index.html>, 2022

Henny, Kenny D., Ya-lin A. Huang, and Karen W. Hoover

2020 Low Human Immunodeficiency Virus (HIV) Testing Rates and No HIV Preexposure Prophylaxis Prescribed Among Female Patients Diagnosed With a Sexually Transmitted Infection, 2017-2018. *Obstetrics & Gynecology* 136(6):1083-1085.

Hertzfeld, Michael

1992 The Social Production of Indifference: Exploring the Symbolic Roots of Western Bureaucracy. Chicago, IL: University of Chicago Press.

Heyward, Giulia, and Sophie Kasakove

2022 Texas Will Dismiss Murder Charge Against Woman Connected to ‘Self-Induced Abortion’. *New York Times*, 10 April 2022.

Hirai, Ashley H., et al.

2021 Neonatal Abstinence Syndrome and Maternal Opioid-Related Diagnoses in the US, 2010-2017. *Journal of the American Medical Association* 325(2):146-155.

Hoerr, Jordan J., et al.

2018 Substance-exposed newborn infants and public health law: Differences in addressing the legal mandate to report. *Child Abuse & Neglect* 81:206-213.

Holland, Jennifer L.

2020 Tiny You: A Western History of the Anti-Abortion Movement. Oakland, CA: University of California Press.

Howard, Heather F., Katherine; Freeman, and Katie Clark

2019 U.S. Survey of Shared Decision Making Use for Treating Pregnant Women Presenting with Opioid Use Disorder. *Substance Use & Misuse* 54(13):2241-2250.

Howell, E. A., et al.

2020 Race and Ethnicity, Medical Insurance, and Within-Hospital Severe Maternal Morbidity Disparities. *Obstetrics & Gynecology* 135(2):285-93.

Howell, Elizabeth A., et al.

2016a Black-White Differences in Severe Maternal Morbidity and Site of Care. *American Journal of Obstetrics & Gynecology* 214(1):122.e1-122.e7.

Howell, Elizabeth A., et al.

2016b Site of delivery contribution to black-white severe maternal morbidity disparity. *American Journal of Obstetrics & Gynecology* 215(2):143.

Iglehart, John K.

2007 Medicaid Revisited - Skirmishes over a Vast Public Enterprise. *The New England Journal of Medicine* 356(7):734-40.

Illinois Department of Healthcare and Family Services

2021 Application for Funding: Healthcare Transformation Collaboratives. Illinois Department of Healthcare and Family Services.

[https://www2.illinois.gov/hfs/Documents/South%20Side%20Healthy%20Community%20Organization\\_Application.pdf](https://www2.illinois.gov/hfs/Documents/South%20Side%20Healthy%20Community%20Organization_Application.pdf)

—

2022 Medicaid Presumptive Eligibility.

<https://www2.illinois.gov/hfs/MedicalProviders/ProviderPrograms/Pages/MedicaidPresu>

[mptiveEligibility.aspx#:~:text=The%20Medicaid%20Presumptive%20Eligibility%20\(MPE,her%20family's%20gross%20monthly%20income.>, accessed February 1 2022.](#)

#### Illinois Department of Public Health (IDPH)

2021 Illinois Maternal Morbidity and Mortality Report: 2016-2017. Illinois Department of Public Health.

---

2022 Pre-Exposure Prophylaxis (PrEP). <https://dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/pre-exposure-prophylaxis-prep.html>, accessed 1 June 2022.

#### Illinois General Assembly

2003 410 ILCS 335: Perinatal HIV Prevention Act.<https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2483&ChapterID=35#:~:text=The%20health%20care%20professional%20providing,current%20pregnancy%2C%20or%20is%20already>

---

2018 ILCS 5/3-15003: Pregnant female prisoners.Springfield, IL: Illinois General Assembly.<https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=005500050K3-15003.6>

---

2019 Reproductive Health Act.Springfield, IL: Illinois General Assembly.<https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=3987&ChapterID=64>

---

2022 HB 4430: Pharmacy-HIV Patient Care.Springfield,

IL.<https://www.ilga.gov/legislation/BillStatus.asp?DocNum=4430&GAID=16&DocTypeID=HB&SessionID=110&GA=102>

Illinois Perinatal Quality Collaborative (ILPQC)

2019 Mothers and Newborns affected by Opioids (MNO)-OB Initiative.

<http://ilpqc.org/?q=MNO-OB>.

Johnson-Hanks, Jennifer

2002 On the Limits of Life Stages in Ethnography: Toward a Theory of Vital  
Conjunctures. *American Anthropologist* 104(3):865-80.

Jones, Hendrée E., and Mona R. Prasad

2014 Substance Abuse in Pregnancy. *In* Creasy and Resnik's *Maternal-Fetal Medicine: Principles and Practices*. Seventh Edition edition. R.K. Creasy, R. Resnik, J.D. Iams, C.J. Lockwood, T.R. Moore, and M.F. Greene, eds. Philadelphia, PA: Elsevier.

Jones, Rachel K., and Jenna Jerman

2017 Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014. *American Journal of Public Health* 107(12):1904-1909.

Joseph, K.S., et al.

2021 Maternal Mortality in the United States: Recent Trends, Current Status, and Future Considerations. *Obstetrics & Gynecology* 137(5):763-771.

Kaimal, Anjali, and Mary E. Norton

2021 Society for Maternal-Fetal Medicine Consult Series #55: Counseling women at increased risk of maternal morbidity and mortality. *American Journal of Obstetrics & Gynecology* 224(4):B16-b23.

Kanaaneh, Rhoda Ann

2002 *Birthing the Nation: Strategies of Palestinian Women in Israel*. Oakland, CA: University of California Press.

Kariisa, Mbabzi, et al.

2022 *Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics - 25 States and the District of Columbia, 2019-2020*. *Morbidity and Mortality Weekly Report* 71(29):940-947.

Kaufman, Sharon R.

2015 *Ordinary Medicine: Extraordinary Treatments, Longer Lives, and Where to Draw the Line*. Durham, NC: Duke University Press.

Kaufman, Sharon R., and Lynn M. Morgan

2005 *The Anthropology of the Beginnings and Ends of Life*. *Annual Review of Anthropology* 34:317-41.

Kelsey, C. M., et al.

2017 *An Examination of Care Practices of Pregnant Women Incarcerated in Jail Facilities in the United States*. *Maternal And Child Health Journal* 21(6):1260-1266.

Keshavjee, Salman

2014 *Blind Spot: How Neoliberalism Infiltrated Global Health*. Berkeley, CA: University of California Press.

Kierans, Ciara, and Kirsten Bell

2017 *Cultivating ambivalence: Methodological considerations for anthropology*. *HAU: Journal of Ethnographic Theory* 7(2):23-44.

Kleinberg, Eric

2015 Heat Wave: A Social Autopsy of Disaster in Chicago. Chicago, IL: University of Chicago Press.

Kleinman, Arthur

1995 Writing at the Margin: Discourse Between Anthropology and Medicine. Berkeley, CA: University of California Press.

—

2017 Presence. The Lancet 389(10088):2466-2467.

Knight, Kelly R.

2015 addicted.pregnant.poor. Durham, NC: Duke University Press.

Knight, Kelly R., et al.

2019 Reproductive (In)justice - Two Patients with Avoidable Poor Reproductive Outcomes. The New England Journal of Medicine 381(7):593-596.

Knowles, Caroline

1997 Family Boundaries: The Invention of Normality & Dangerousness. Toronto, CA: University of Toronto Press.

Krause, Monika

2014 The Good Project: Humanitarian Relief NGOs and the Fragmentation of Reason. Chicago, IL: University of Chicago Press.

Krauthammer, Charles

1989 Children of Cocaine. Washington Post, July 30.

Kuehn, Bridget M.

2005 Methadone treatment marks 40 years. Journal of the American Medical Association 294(8):887-889.



Kuhlik, Lauren, and Carolyn Sufrin

2020 Pregnancy, Systematic Disregard and Degradation, and Carceral Institutions.  
Harvard Law Review 14:418-466.

Lacan, Jacques

2007 Écrits. B. Fink, transl. New York, NY: W.W. Norton & Company.

Leiner, Catherine;, et al.

2021 "The elephant in the room;" a qualitative study of perinatal fears in opioid use  
disorder treatment in Southern Appalachia. BMC Pregnancy & Childbirth 21(1):143.

Leshner, Alan I

1997 Addiction is a brain disease, and it matters. Science 278(5335):45-7.

Livingston, Julie

2012 Improvising Medicine: An African Oncology Ward in an Emerging Cancer  
Epidemic. Durham, NC: Duke University Press.

Lloyd Sieger, Margaret H., Rebecca Rebbe, and Stephen W. Patrick

2021 The 2021 Reauthorization of CAPTA - Letting Public Health Lead. The New  
England Journal of Medicine 385(18):1636-1639.

López, Andrea M.

2020 Necropolitics in the "Compassionate" City: Care/ Brutality in San Francisco.  
Medical Anthropology 39(8):751-64.

Lovell, Anne M.

2013 Elusive Travelers: Russian Narcology, Transnational Toxicomanias, and the Great  
French Ecological Experiment. *In* Addiction Trajectories. E. Raikhel and W. Garriott,  
eds. Pp. 126-159. Durham, NC: Duke University Press.

MacDorman, Marian F., et al.

2016 Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. *Obstetrics & Gynecology* 128(3):447-455.

MacDorman, Marian F., et al.

2021 Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016–2017. *American Journal Of Public Health*:e1-e9.

Malinowski, Bronislaw

1948 *Magic, Science, and Religion and Other Essays*. Boston, MA: Beacon Press.

Massumi, Brian

2021 *Parables for the Virtual: Movement, Affect, Sensation*. Durham, NC: Duke University Press.

Mattingly, Cheryl

2010 *The Paradox of Hope: Journeys through a Clinical Borderland*. Oakland, CA: University of California Press.

Mauss, Marcel

2002 [1950] *The Gift: The form and reason for exchange in archaic societies*. New York, NY: Routledge.

Mbembe, Achille

2008 Necropolitics. *In Foucault in an Age of Terror: Essays on Biopolitics and the Defence of Society*. S. Morton and S. Bygrave, eds. Pp. 152-182. London: Palgrave Macmillan UK.

—

2019 *Necropolitics*. Durham, NC: Duke University Press.

McCabe, Katharine

2016 Mothercraft: Birth work and the making of neoliberal mothers. *Soc Sci Med.* 162:177.

McCullough, Jolie

2022 After pursuing an indictment, Starr County district attorney drops murder charge over self-induced abortion. <https://www.texastribune.org/2022/04/10/starr-county-murder-charge/>, accessed 11 April 2023.

McQueen, Karen, and Jodie Murphy-Oikonen

2016 Neonatal Abstinence Syndrome. *The New England Journal of Medicine* 375(25):2468-2479.

Medicaid and CHIP Payment and Access Commission

2022 Directed Payments in Medicaid Managed Care. <https://www.macpac.gov/wp-content/uploads/2022/06/June-2022-Directed-Payments-Issue-Brief-FINAL.pdf>, accessed 30 December 2022.

Meinhofer, Angélica, and Yohanis Anglero-Diaz

2019 Trends in Foster Care Entry Among Children Removed From Their Homes Because of Parental Drug Use, 2000 to 2017. *JAMA Pediatrics.* 173(9):881-3.

Messac, Luke, et al.

2013 The good-enough science-and-politics of anthropological collaboration with evidence-based clinical research: Four ethnographic case studies. *Social Science & Medicine* 99:176-86.

Messer, L. C., J. M. Oakes, and S. Mason

2010 Effects of socioeconomic and racial residential segregation on preterm birth: a cautionary tale of structural confounding. *American Journal Of Epidemiology* 171(6):664-73.

Moodley, Dhayendre, et al.

2023 Pregnancy and neonatal safety outcomes of timing of initiation of daily oral tenofovir disoproxil fumarate and emtricitabine pre-exposure prophylaxis for HIV prevention (CAP016): an open-label, randomised, non-inferiority trial. *The Lancet HIV*.

Moore, Natalie Y.

2016 *The South Side: a Portrait of Chicago and American Segregation*. New York, NY: St. Martin's Press.

Morgan, Lynn M., and Elizabeth F.S. Roberts

2012 Reproductive governance in Latin America. *Anthropology & Medicine* 19(2):241-54.

Morgen, Sandra, and Jeff Maskovsky

2003 The Anthropology of Welfare "Reform": New Perspectives on U.S. Urban Poverty in the Post-Welfare Era. *Annual Review of Anthropology* 32:315-338.

Movement for Family Power

2021 <https://www.movementforfamilypower.org/>, 2022

Moynihan, Daniel Patrick

1965 *The Negro Family: The Case for National Action*. Washington, D.C.: United States Department of Labor.

Mugo, Nelly R., et al.

2014 Pregnancy incidence and outcomes among women receiving preexposure prophylaxis for HIV prevention: a randomized clinical trial. *Journal of the American Medical Association* 312(4):362-71.

Mulla, Sameera

2014 *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention*. New York, NY: New York University Press.

Mulligan, Jessica M., and Heide Castañeda, eds.

2017 *Unequal Coverage: The Experience of Health Care Reform in the United States*. New York City: NYU Press.

Munn, Nancy D.

1992 The Cultural Anthropology of Time: A Critical Essay. *Annual Review of Anthropology* 21:93-123.

Murphy, Michelle

2017 *The Economization of Life*. Durham, NC: Duke University Press.

Murphy, Sheigla, and Paloma Sales

2001 Pregnant drug users: Scapegoats of Reagan/Bush and Clinton-era economics. *Social Justice* 28(4):72.

Murray, Stuart J

2006 *Thanatopolitics: On the Use of Death for Mobilizing Political Life*. *Polygraph* 18:191-215.

—

2008 *Thanatopolitics: Reading in Agamben a Rejoinder to Biopolitical Life*. *Communication and Critical/Cultural Studies* 5(2):203-7.

---

2016 Affirming the Human? The Question of Biopolitics. *Law, Culture, and the Humanities* 12(3):485-95.

---

2022 *The Living from the Dead: Disaffirming Biopolitics*. University Park, PA: The Pennsylvania State University Press.

Naidu, Thirusha

2021 Says who? Northern ventriloquism, or epistemic disobedience in global health scholarship. *The Lancet Global Health* 9(9):e1332-e1335.

National Institute on Drug Abuse (NIDA)

2021 Overdose Death Rates. <https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates>, accessed 20 October 2021.

Netherland, Julie, and Helena B. Hansen

2016 The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse. *Culture, Medicine and Psychiatry* 40(4):664-686.

---

2017 White opioids: Pharmaceutical race and the war on drugs that wasn't. *BioSocieties* 12(2):217-238.

Norton, Mary E., et al.

2021 Society for Maternal-Fetal Medicine Consult Series #59: The use of analgesia and anesthesia for maternal-fetal procedures. *American Journal of Obstetrics & Gynecology* 225(6):B2-8.

## Note

1994 Dethroning the Welfare Queen: The Rhetoric of Reform. *Harvard Law Review* 107(8):2013-2030.

## Nowell, Ceclia

2022 The Long, Scary History of Doctors Reporting Pregnant People to the Cops.  
<https://www.motherjones.com/crime-justice/2022/04/self-induced-abortion-herrera-texas-murder-hospital/>, accessed 11 April 2023.

## Office of the Assistant Secretary for Planning and Evaluation

2020 Prior HHS Poverty Guidelines and Federal Register References.  
<https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references>,  
 accessed 3 January 2021.

## Packard, Randall

2016 A History of Global Health: Interventions into the Lives of Other Peoples.  
 Baltimore, MD: Johns Hopkins University Press.

## Patrick, Stephen W., Wanda D. Barfield, and Brenda B. Poindexter

2020 Neonatal Opioid Withdrawal Syndrome. *Pediatrics* 146(5):e2020029074.

## Peeler, Mary, et al.

2020 Racial and Ethnic Disparities in Maternal and Infant Outcomes Among Opioid-Exposed Mother-Infant Dyads in Massachusetts (2017-2019). *American Journal of Public Health* 110(12):1828-1836.

## Podmolik, Mary Ellen, Alexia Elejalde-Ruiz, and Gregory Pratt

2021 Mercy Hospital, denied approval to close in Bronzeville, files for bankruptcy.  
 Mayor Lightfoot calls it ‘devastating for that community.’

<https://www.chicagotribune.com/business/ct-biz-mercy-hospital-bankruptcy-closure-20210211-au7d6ys62zhyxa537eywigreb4-story.html>, 2022

Polous, Christopher N

2021 Essentials of Autoethnography. Washington, D.C.: American Psychological Association.

Povinelli, Elizabeth A.

2001 Radical Worlds: The Anthropology of Incommensurability and Inconceivability. Annual Review of Anthropology 30:319-34.

—

2011 Economies of Abandonment: Social Belonging and Endurance in Late Liberalism. Durham, NC: Duke University Press.

—

2016 Geontologies: A Requiem to Late Liberalism. Durham, NC: Duke University Press.

Premkumar, Ashish

2015 ‘The opposite of a history’: What substance use in pregnancy can lend to an ethics of accompaniment. Medicine Anthropology Theory 2(2):28-53.

Premkumar, Ashish, and Elena Gates

2016 Rethinking the Bioethics of Pregnancy: Time for a New Perspective? Obstetrics & Gynecology 128(2):396-9.

Premkumar, Ashish, et al.



2019a Methadone, Buprenorphine, or Detoxification for Management of Perinatal Opioid Use Disorder: A Cost-Effectiveness Analysis. *Obstetrics & Gynecology* 134(5):921-931.

Premkumar, Ashish, Jennifer Kerns, and Megan J. Huchko

2019b "A Resume for the Baby": Biosocial Precarity and Care of Substance-Using, Pregnant Women in San Francisco.

Premkumar, Ashish, and Claire L. Wendland

2022 Tracing the life of evidence: Abortion and maternal mortality in the post-Dobbs era. <https://culanth.org/fieldsights/tracing-the-life-of-evidence-abortion-and-maternal-mortality-in-the-post-dobbs-era>, accessed 6 June 2023.

Prentice, Rachel

2012 *Bodies in Formation: An Ethnography of Anatomy and Surgery Education*. Durham, NC: Duke University Press.

ProPublica

2017 Lost Mothers. <https://www.propublica.org/article/lost-mothers-maternal-health-died-childbirth-pregnancy>, accessed 14 March 2019.

Puar, Jasbir Kaur

2017 *Terrorist Assemblages: Homonationalism in Queer Times*. Durham, NC: Duke University Press.

Rabinow, Paul, and Nikolas Rose

2006 Biopower Today. *BioSocieties* 1(2):195-217.

Ralph, Jessika A., et al.

2021 Get PrEPPT (pre-exposure prophylaxis and pregnancy termination): an exploration of the values, attitudes and preferences regarding HIV and PrEP among women seeking abortion. *BMJ Sexual & Reproductive Health* 47(3):e6.

Ralph, Laurence

2014 *Renegade Dreams: Living through Injury in Gangland Chicago*: University of Chicago Press.

Raymond, Elizabeth G., and David A. Grimes

2012 The comparative safety of legal induced abortion and childbirth in the United States. *Obstetrics & Gynecology* 119(2):215-9.

Reddy, Uma. M., et al.

2017 Opioid Use in Pregnancy, Neonatal Abstinence Syndrome, and Childhood Outcomes: Executive Summary of a Joint Workshop by the Eunice Kennedy Shriver National Institute of Child Health and Human Development, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, Society for Maternal-Fetal Medicine, Centers for Disease Control and Prevention, and the March of Dimes Foundation. *Obstetrics & Gynecology* 130(1):10-28.

Reel, Monte

2021 The Left-for-Dead Hospital That Got a Second Chance for \$1.  
<https://www.bloomberg.com/news/features/2021-10-01/mercy-hospital-gets-second-chance-to-provide-health-care-to-chicago-s-poor>, accessed 20 October 2021.

Reich, Adam D.

2014 *Selling Our Souls: The Commodification of Hospital Care in the United States*. Princeton, NJ: Princeton University Press.

Reich, Jennifer A.

2005 *Fixing Families: Parents, Power, and the Child Welfare System*. New York, NY: Routledge.

Reubi, David

2020 Epidemiological Imaginaries of the Social: Epidemiologists and Pathologies of Modernization in Postcolonial Africa. *Medical Anthropology Quarterly* 34(3):438-455.

Richardson, Eugene T.

2020 *Epidemic Illusions: On the Coloniality of Global Public Health*. Cambridge, MA: MIT Press.

Roberts, Dorothy E.

1999 *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. New York City, NY: Vintage.

—

2002 *Shattered Bonds: The Color of Child Welfare*. New York, NY: Basic Books.

—

2022 *Torn Apart: How the Child Welfare System Destroys Black Families--and How Abolition Can Build a Safer World*. New York, NY: Basic Books.

Roitman, Janet

2016 The States of Crisis. *In Critical Theories of Crisis in Europe*. P. Kjaer and O. N, eds. Pp. 17-34: Rowman & Littlefield International.

Rose, Nikolas S.

2006 *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton, NJ: Princeton University Press.

Rosenbaum, Marsha, and Sheigla Murphy

1998 Pregnant Women on Drugs: Combating Stereotypes and Stigma. Piscataway, NJ: Rutgers University Press.

Ross, Loretta J., and Rickie Solinger

2017 Reproductive Justice: An Introduction. Berkeley, CA: University of California Press.

Sanmartin, Maria X., et al.

2020 Association Between State-Level Criminal Justice-Focused Prenatal Substance Use Policies in the US and Substance Use-Related Foster Care Admissions and Family Reunification. JAMA Pediatrics 174(8):782-788.

Scheper-Hughes, Nancy

1992 Death Without Weeping: The Violence of Everyday Life in Brazil. Oakland, CA: University of California Press.

Schiff, Davida M., et al.

2018 Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts. Obstetrics & Gynecology 132(2):466-474.

Schoen, Cathy, et al.

2005 Insured but not protected: how many adults are underinsured? Health Affairs Suppl Web Exclusives:W5-289-w5-302.

Schorsch, Kristen

2020 Illinois Regulators Say Mercy Hospital Must Stay Open for Now.

<https://www.wbez.org/stories/state-regulators-say-mercy-hospital-must-stay-open-for-now/3c010952-0855-4551-ac5a-33e31599daf5>, 2022

Schuller, Kyla

2018    *The Biopolitics of Feeling: Race, Sex, and Science in the Nineteenth Century.*

Durham, NC: Duke University Press.

Scott, Christy K., et al.

2021    The impact of the opioid crisis on U.S. state prison systems. *Health & Justice* 9(1):17.

Scott, James C.

1998    *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed.* New Haven, CT: Yale University Press.

Sees, Karen L., et al.

2000    Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence: a randomized controlled trial. *Journal of the American Medical Association* 283(10):1303-10.

Seidman, Dominika, and Shannon Weber

2016    Integrating Preexposure Prophylaxis for Human Immunodeficiency Virus Prevention Into Women's Health Care in the United States. *Obstetrics & Gynecology* 128(1):37-43.

Singer, Elyse Ona

2022    *Lawful Sins: Abortion Rights and Reproductive Governance in Mexico.* Stanford, CA: Stanford University Press.

Smith, Anthony K.J., et al.

2022 Prescribing as affective clinical practice: Transformations in sexual health consultations through HIV pre-exposure prophylaxis. *Sociology of Health & Illness* 44(7):1182-1200.

Smith-Oka, Vania

2013 Managing Labor and Delivery among Impoverished Populations in Mexico: Cervical Examinations as Bureaucratic Practice. *American Anthropologist* 115(4):595-607.

Society for Maternal-Fetal Medicine (SMFM), et al.

2021 19-1392: On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit re: Thomas E. Dobbs, M.D., M.P.H. et al. v. Jackson Women's Health Organization et al. New York, NY. [https://www.supremecourt.gov/DocketPDF/19/19-1392/192912/20210920115339758\\_210193a%20Amicus%20Brief%20for%20efiling.pdf](https://www.supremecourt.gov/DocketPDF/19/19-1392/192912/20210920115339758_210193a%20Amicus%20Brief%20for%20efiling.pdf)

Sojoyner, Damien M

2017 Another Life is Possible: Black Fugivity and Enclosed Places. *Cultural Anthropology* 32(4):514-36.

Spillers, Hortense J.

1987 Mama's Baby, Papa's Maybe: An American Grammar Book. *diacritics* 17(2):65-81.

St. Pierre, Amy, et al.

2018 Challenges and Opportunities in Identifying, Reviewing, and Preventing Maternal Deaths. *Obstetrics & Gynecology* 131(1):138-42.

Stanton, Andrew

2022 Abortion-Murder Charge Against Texas Woman Spurs Calls for HIPAA Lawsuit.

<https://www.newsweek.com/calls-hipaa-lawsuit-follow-dismissal-charges-against-lizelle-herrera-1696757>, accessed 11 April 2023.

Starr, Paul

2017 [1982] The Social Transformation of American Medicine. New York, NY: Basic Books.

Stevenson, Lisa

2014 Life Beside Itself: Imagining Care in the Canadian Arctic. Oakland, CA: University of California Press.

Stoler, Ann Laura

1995 Race and the Education of Desire: Foucault's *History of Sexuality* and the Colonial Order of Things. Durham, NC: Duke University Press.

Stonington, Scott D., and Diana Coffa

2019 Structural Iatrogenesis — A 43-Year-Old Man with “Opioid Misuse”. The New England Journal of Medicine 380(8):701-704.

Stonington, Scott D., et al.

2018 Case Studies in Social Medicine — Attending to Structural Forces in Clinical Practice. The New England Journal of Medicine 379(20):1958-1961.

Storeng, Katerini T., and Dominique P. Béhague

2014 “Playing the Numbers Game”: Evidence-based Advocacy and the Technocratic Narrowing of the Safe Motherhood Initiative. Medical Anthropology Quarterly 28(2):260-279.

—

2017 "Guilty until proven innocent": the contested use of maternal mortality indicators in global health. *Critical Public Health* 27(2):163-176.

Stout, Noelle

2019 *Dispossessed: How Predatory Bureaucracy Foreclosed on the American Middle Class*. Oakland, CA: University of California Press.

Substance Abuse and Mental Health Services Administration (SAMHSA)

2023 Removal of DATA Waiver (X-Waiver) Requirements.

<https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement>, accessed 11 April 2023.

Sufrin, Carolyn

2017 *Jailcare: Finding the Safety Net for Women Behind Bars*. Oakland, CA: University of California Press.

Supreme Court of the United States

2022 *Dobbs, State Health Officer of the Mississippi Department of Health et al. v. Jackson Women's Health Organization et al.* Washington, DC. [https://www.supremecourt.gov/opinions/21pdf/19-1392\\_6j37.pdf](https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf)

Taylor, Chloë

2012 Foucault and Familial Power. *Hypatia* 27(1):201-18.

Taylor, Diana

2003 *The Archive and the Repertoire: Performing Cultural Memory in the Americas*. Durham, NC: Duke University Press.

Theobald, Brianna



2019    Reproduction on the Reservation: Pregnancy, Childbirth, and Colonialism in the Long Twentieth Century. Chapel Hill, NC: University of North Carolina Press.

Thomas, Sue, et al.

2018    Drug Use During Pregnancy Policies in the United States From 1970 to 2016. Contemporary Drug Problems 45(4):441-459.

Thomson, Kerry A., et al.

2018    Increased Risk of HIV Acquisition Among Women Throughout Pregnancy and During the Postpartum Period: A Prospective Per-Coital-Act Analysis Among Women With HIV-Infected Partners. Journal of Infectious Diseases 218(1):16-25.

Ticktin, Miriam

2005    Where ethics and politics meet: The violence of humanitarianism in France. American Ethnologist 33(1):33-49.

—

2011    Casualties of Care: Immigration and the Politics of Humanitarianism in France. Oakland, CA: University of California Press.

Tierney, Thomas F

2016    Towards an Affirmative Biopolitics. Sociological Theory 34(4):358-81.

Treichler, Paula

1999    The Burdens of History: Gender and Representation in AIDS Discourse, 1981-1988. *In* How to Have Theory in An Epidemic: Cultural Chronicles of AIDS. Pp. 42-98. Durham, NC: Duke University Press.

Turner, Blair, et al.

2020 Opioid Overdose Surveillance Report—Chicago 2018. City of Chicago.

[https://www.chicago.gov/content/dam/city/depts/cdph/statistics\\_and\\_reports/CDPH-005\\_OpioidReport\\_Final.pdf](https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/CDPH-005_OpioidReport_Final.pdf)

U.S. Health and Human Services

2017 HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis. <https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html>, accessed 1 November 2020.

Underman, Kelly

2020 Feeling Medicine: How the Pelvic Exam Shapes Medical Training. New York, NY: New York University Press.

Valencia, Sayak

2018 Gore Capitalism. J. Pluecker, transl. Cambridge, MA: The MIT Press.

valentine, kylie

2007 Methadone Maintenance Treatment and Making Up People. *Sociology* 41(3):497.

Van Cleve, Nicole Gonzalez

2017 Crook County: Racism and Injustice in America's Largest Criminal Court. Stanford, CA: Stanford Law Books.

Vásquez, Tina

2020 How an 'aura of illegality' stigmatizes self-managed abortion in Louisiana. <https://prismreports.org/2020/02/13/how-an-aura-of-illegality-stigmatizes-selfmanaged-abortion-in-louisiana/>, accessed 11 April 2023.

2022 How misinformation about medical reporting requirements fueled Lizelle Herrera's criminalization for abortion.

<https://prismreports.org/2022/04/21/misinformation-fueled-lizelle-herrera-criminalization-abortion/>, accessed 11 April 2023.

Wacquant, Loïc

1996 The Rise of Advanced Marginality: Notes on Its Nature and Implications. *Acta Sociologica* 39(2):121-139.

—

1998 Inside the Zone: The Social Art of the Hustler in the Black American Ghetto. *Theory, Culture & Society* 15(2):1-36.

—

2015 Revisiting territories of relegation: Class, ethnicity and state in the making of advanced marginality. *Urban Studies* 53(6):1077-1088.

Wahlberg, Ayo, and Tine M. Gammeltoft

2018 Introduction: Kinds of Children. *In* *Selective Reproduction in the 21st Century*. A. Wahlberg and T.M. Gammeltoft, eds. Pp. 1-24. Cham, Switzerland: Palgrave Macmillan.

Wahlberg, Ayo, and Nikolas Rose

2015 The governmentalization of living: calculating global health. *Economy and Society* 44(1):60-90.

Wall-Wieler, Elizabeth, et al.

2018 Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling Analysis. *American Journal Of Epidemiology* 187(6):1182-1188.

Watkins-Hayes, Celestine

2014 Intesectionality and the Sociology of HIV/AIDS: Past, Present, and Future Research Directions. *Annual Review of Sociology* 40:431-57.

—

2019 *Remaking a Life: How Women Living with HIV/AIDS Confront Inequality*. Oakland, CA: University of California Press.

Weber, Max

2002 The Profession and Vocation of Politics. *In* *Political Writings*. P. Lassman and R. Speirs, eds. Pp. 309-369. Cambridge, UK: Cambridge University Press.

Weheliye, Alexander G.

2014 *Habeas Viscus: Racializing Assemblages, Biopolitics, and Black Feminist Theories of the Human*. Durham, NC: Duke University Press.

Weir, Lorna

2006 *Pregnancy, Risk and Biopolitics: On the Threshold of the Living Subject*. London, UK: Taylor & Francis.

Wells, Karen

2011 The Politics of Life: Governing Childhood. *Global Studies of Childhood* 1(1):15-25.

Wilson, William Julius

1990 *The Truly Disadvantaged: The Inner City, the Underclass, and Public Policy*. University of Chicago Press.

Wong, Amy E., et al.

2012 Perinatal HIV testing and diagnosis in Illinois after implementation of the Perinatal Rapid Testing Initiative. *American Journal of Obstetrics & Gynecology* 207(5):401.e1-6.

Yates-Doerr, Emily

2020 Reworking the Social Determinants of Health: Responding to Material-Semiotic Indeterminacy in Public Health Interventions. *Medical Anthropology Quarterly* 34(3):378-397.

Yee, Lynn M., et al.

2018 Sustainability of Statewide Rapid HIV Testing in Labor and Delivery. *AIDS and Behavior* 22(2):538-544.

Zernike, Kate

2022 Is a Fetus a Person? An Anti-Abortion Strategy Says Yes. *The New York Times*, 21 August 2022.

Zettler, Patricia J., and Ameet Sarpatwari

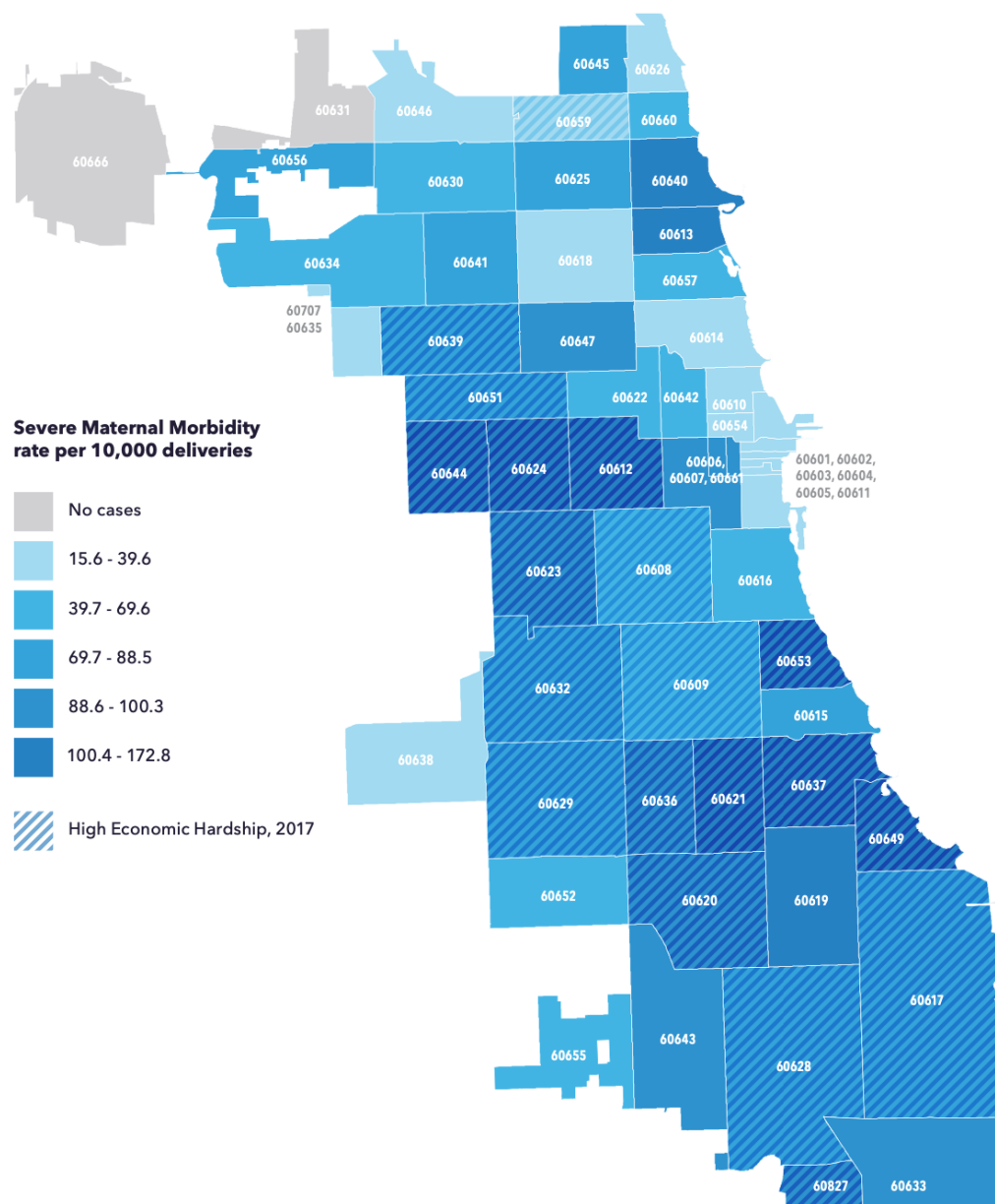
2022 State Restrictions on Mifepristone Access - The Case for Federal Preemption. *The New England Journal of Medicine* 386(8):705-707.

Zuckerman, Stephen, Aimee F. Williams, and Karen E. Stockley

2009 Trends in Medicaid physician fees, 2003-2008. *Health Affairs* 28(3):w510-9.

## Figures

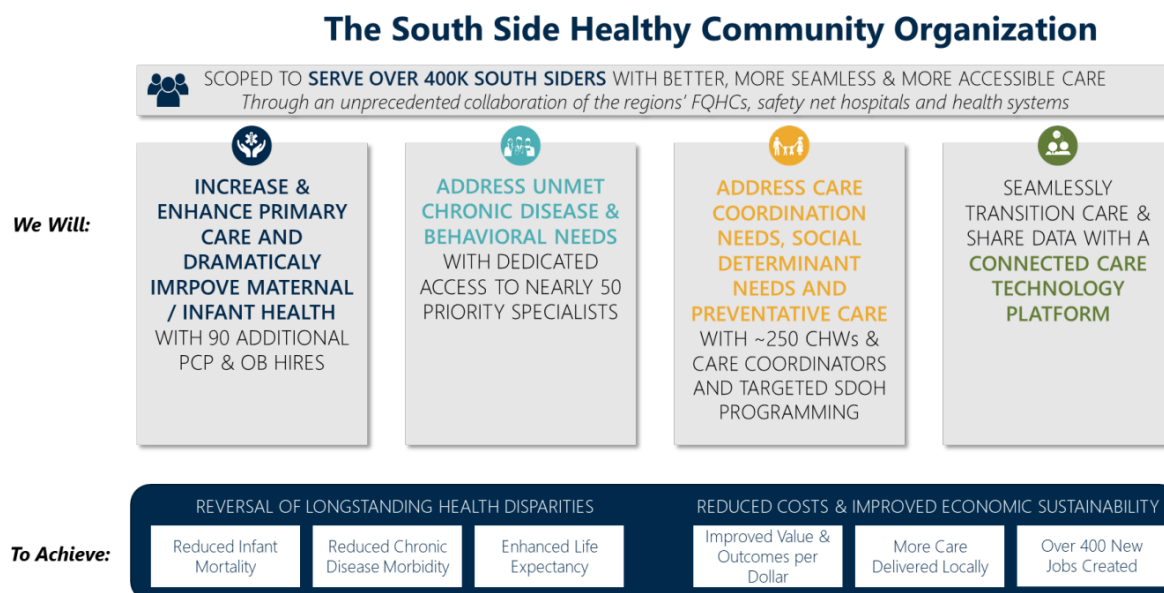
Figure 1. Severe Maternal Morbidity by Zip Code and High Economic Hardship, Chicago 2016-2017



*Hospitals that have ceased offering inpatient obstetrical services since 2017: Jackson Park Hospital (zip code 60649), St. Bernard's Hospital (zip code 60621), and Mercy Hospital (zip code 60616)*

*Citation: Chicago Department of Public Health (CDPH) (2019)*

Figure 2. South Side Healthy Community Organization

**Figure 1: Components of The South Side Healthy Community Organization**

*CHW = community health workers; OB = obstetrician; PCP = primary care physician; SDOH = social determinants of health*

*Citation Illinois Department of Healthcare and Family Services (2021)*



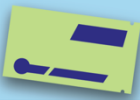
Figure 3. A scene from “The Usual” from the public health campaign “A Dose of Truth”




*Citation: A Dose of Truth (2021)*

Figure 4. Chicago Department of Public Health (CDPH) fentanyl test strips tweets

Fentanyl test strips are an easy to use tool that can detect the presence of fentanyl in substances in a few minutes

**This is a fentanyl test strip** 


To request test strips, email [OSU.CDPH@cityofchicago.org](mailto:OSU.CDPH@cityofchicago.org)




**A five step guide**  
**How to use a fentanyl test strip**

**1** Add a tiny amount of substance (about the size of a half grain of rice) to a half shot glass of water (about 15ml).

*If you are testing meth, cocaine, MDMA or another stimulant, use a full shot glass of water (30ml)*

 You can use a 30ml ketchup cup like the one in this kit.


**A five step guide**  
**How to use a fentanyl test strip**

**4** Take the strip out of the water and lay it on a flat surface. Wait 60 seconds. 

**5** Look at the strip under bright light. Even very light red lines count!

**ONE (1) red line = FENTANYL PRESENT**


**TWO (2) red lines = NO fentanyl present**

Check the strip within 10 minutes of testing. Throw the strip away when done. 


Fentanyl test strips only tell you if fentanyl is present in the sample tested. They do not tell you how much fentanyl is present.


A negative test result does not mean the substance is safe. Fentanyl test strips are not 100% accurate.

If you think someone is overdosing, call 911 immediately and administer naloxone if available.


 Call the Illinois Opioid Helpline at: **1-833-2-FINDHELP**


**A five step guide**  
**How to use a fentanyl test strip**


**2** Mix the powder into the water until it is completely dissolved.   
*If you are testing something that is not powder, crush it first.*

**3** Hold the solid blue end of the test strip and dip the other end in the water for about 10-15 seconds.   
*Keep the water below this line*

**Interpreting the results**

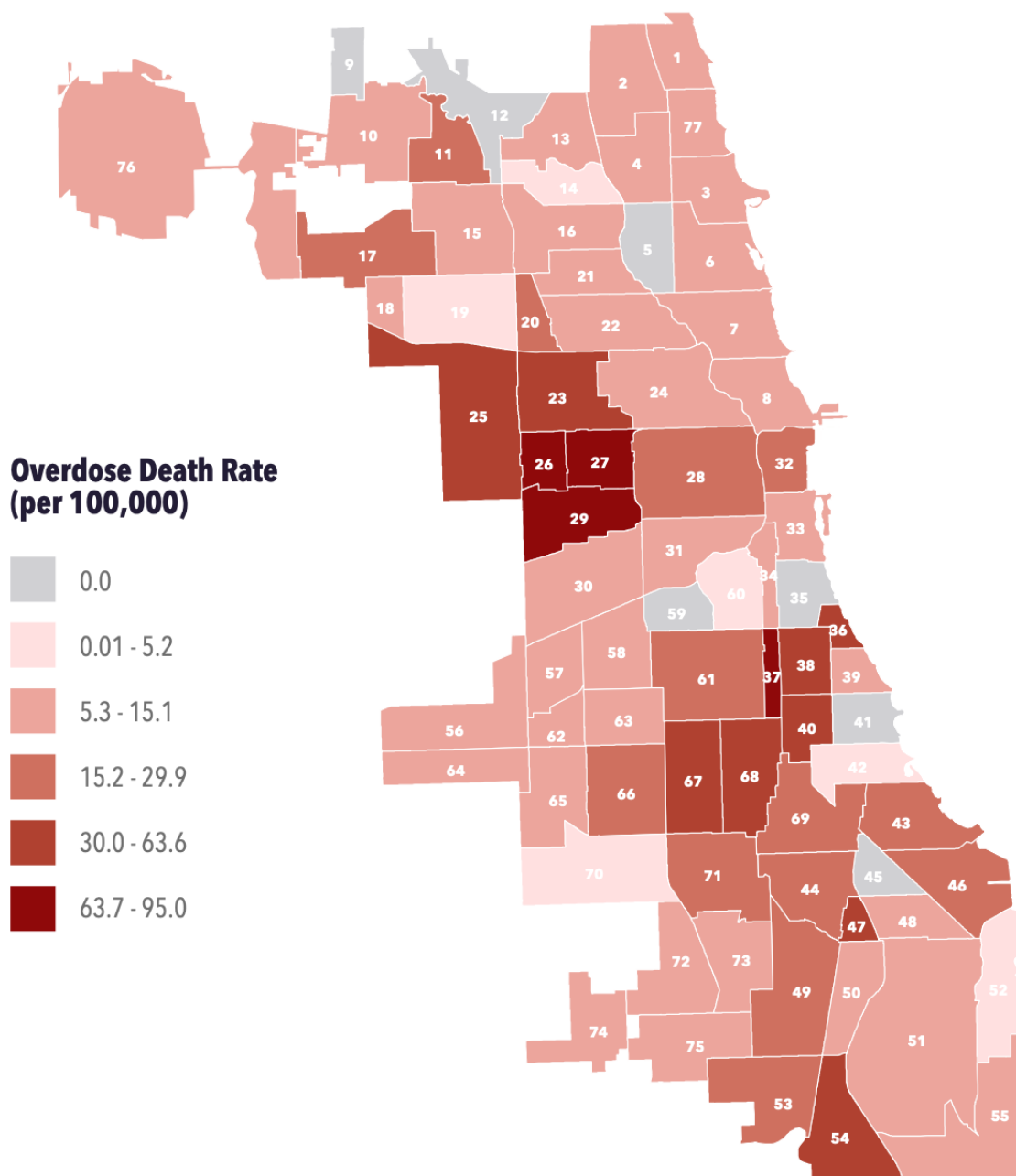
**+ Positive test**  
  
One line means fentanyl detected.

**- Negative test**  
  
Two lines means no fentanyl detected.

**? Inconclusive / Invalid test**  
  
The top red line (closest to the solid blue) should always show up on the strip. If it doesn't, the test is invalid. Stirring or wetting above the solid line may result in an invalid test.

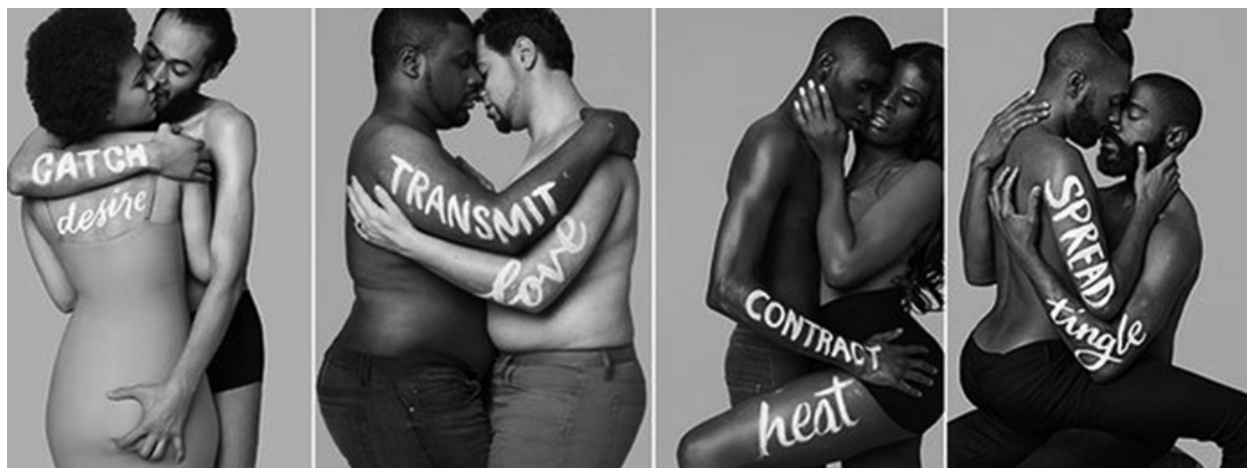
Citation: Chicago Department of Public Health (CDPH) (2021)

Figure 5. Fentanyl-related lethal overdoses, Chicago 2018

**4c FENTANYL-INVOLVED (n=486)**

*Citation: Turner, et al. (2020)*

Figure 6. #PrEP4Love Public Health Campaign




*Citation: Keene, et al. (2021)*

Figure 7. Illinois Perinatal Quality Collaborative (ILPQC) Mothers and Newborns affected by Opioids (MNO) Initiative Opioid Use Disorder (OUD) Clinical Care Checklist

Illinois Referral Helpline  
 Opioids & other substances:  
 1-833-2FINDHELP Helpline.IL.org

**ILPQC OUD Clinical Care Checklist**



Checklist Element	Date	Comments
<b>Antepartum Care</b>		
Counsel on MAT for OUD and arrange appropriate referrals		
Counsel and link to behavioral health counseling /recovery support services		
Social work <u>consult</u> or navigator who will link patient to care and follow up		
Obtain recommended lab testing- <ul style="list-style-type: none"> <li>HIV / <u>Hep B</u> / <u>Hep C</u> (if positive viral load &amp; genotype)</li> <li>Serum Creatinine/ Hepatic Function Panel</li> </ul>		
Institutional drug testing policies and plan for testing reviewed		
Urine toxicology testing for confirmation and follow up (consent required)		
Discuss Narcan as a lifesaving strategy and prescribe for patient / family		
Neonatology/Pediatric consult provided, discuss NAS, engaging mom in non-pharmacologic care of opioid exposed newborn, and plan of safe care.		
DCFS Reporting system reviewed, discuss safe discharge plan for mom/baby		
Screen for alcohol/tobacco/non-prescribed drugs and provide cessation counseling		
Screen for co-morbidities ( <u>ie</u> : mental health & domestic violence)		
Consent for obstetric team to communicate with MAT treatment providers		
Consider anesthesia consult to discuss pain control, L&D and postpartum		
<b>Third Trimester</b>		
Repeat recommended labs (HIV/ <u>HbsAg</u> /Gc/CT/RPR)		
Ultrasound (Fluid/Growth)		
Urine toxicology with confirmation (consent required), and review policy		
Review safe discharge care plan and DCFS process		
Patient Education: OUD/NAS, participating in non-pharmacologic care of the opioid exposed newborn, including breastfeeding, and rooming in.		
Comprehensive contraceptive counseling provided and documented		
<b>During Delivery Admission</b>		
Social work consult, peds/neonatology consult, (consider) anesthesia consult		
Verify appointments for support services (MAT/BH / Recovery Services)		
Confirm Hep C, HIV, Hep B screening completed		
Discuss Narcan as a lifesaving strategy and prescribe for patient / family		
Provide patient education & support for non-pharmacologic care of newborn		
Review plan of safe care including discharge plans for mom/infant		
Schedule early postpartum follow-up visit (within 2 weeks pp)		
Provide contraception or confirm contraception plan		

**SBIRT Billing Codes:**

**G0396:** Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30min

**G0397:** Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30min

**BOLD** Text = elements tracked with monthly data collection for all women with OUD. Also track completion of checklist for all women with OUD.

*BH = behavioral health; DCFS = Department of Child and Family Services; GC/CT = gonorrhea and chlamydia; HbsAg = Hepatitis B surface antigen; Hep B = hepatitis B; Hep C =*

*hepatitis C; MAT = medication-assisted treatment; OUD = opioid use disorder; RPR = rapid plasma reagin (i.e., non-treponemal test for presence of syphilis)*

*Citation: Illinois Perinatal Quality Collaborative (ILPQC) (2019)*

Table 1. Pregnant participant information

Age	Gravida	Para	GA	Incarcerated	Homeless	Race/ethnicity	Substance use	IVDU	Transactional sex work	History of DCFS experience in prior pregnancy
36	6	4	37	Y	Y	White	Opioids, tobacco	Y	N	N
35	5	5	postpartum	N	N	White	Opioids, tobacco	N	Y	Y
32	8	4	21	Y	N	Other	Opioids, crack/cocaine, benzodiazepines	N	N	Y
33	1	0	8	N	N	White	Opioids, tobacco, marijuana	N	N	.
26	7	6	16	N	N	White	Opioids, marijuana	Y	N	Y
36	2	0	33	Y	N	Native American	Opioids, tobacco	N	N	.
31	5	3	18	Y	.	White	Opioids, crack/cocaine	Y	N	Y
31	1	1	postpartum	N	N	White	Opioids, crack/cocaine	N	N	.
26	6	5	postpartum	N	N	Other	Opioids, tobacco, alcohol, marijuana, crack/cocaine	N	Y	Y
30	5	3	5	Y	.	Hispanic/Latinx	Opioids, tobacco, crack/cocaine, methamphetamine	Y	Y	Y
36	1	0	20	Y	N	White	Opioids, crack/cocaine, methamphetamine	N	N	.
38	5	4	15	Y	N	Black	Opioids, tobacco	N	N	N
39	1	1	postpartum	N	Y	White	Opioids, tobacco, marijuana	N	Y	.
30	4	1	15	N	N	Hispanic/Latinx	Opioids	N	N	Y
32	4	2	26	N	N	Hispanic/Latinx	Opioids, crack/cocaine	N	Y	Y
33	4	3	27	Y	N	White	Opioids	Y	N	Y
26	2	1	35	N	N	Hispanic/Latinx	Opioids	N	N	N

22	2	1	37	N	N	Hispanic/Latinx	Opioids, benzodiazepines, tobacco	N	N	Y
27	3	1	27	N	N	White	Opioids, tobacco, marijuana, crack/cocaine, methamphetamine	Y	Y	N
20	1	0	24	N	N	Hispanic/Latinx	Opioids	N	Y	.
39	2	1	29	N	N	Hispanic/Latinx	Opioids	N	Y	Y
29	2	1	26	N	N	White	Opioids	N	N	N

*DCFS = Department of Children and Family Services; GA = gestational age; IVDU = intravenous drug use; N = no; Y = Yes; . = not able to be reported or inapplicable*



Table 2. Centers for Disease Control (CDC) and American College of Obstetricians and Gynecologists (ACOG) risk factors for acquiring HIV

Centers for Disease Control criteria (Centers for Disease Control (CDC) 2021)	American College of Obstetrician and Gynecologists' criteria (American College of Obstetricians and Gynecologists (ACOG) 2014)
Anal or vaginal sex in the past 6 months with: <ul style="list-style-type: none"> <li>a) A partner living with HIV or;</li> <li>b) Inconsistent condom use or;</li> <li>c) Diagnosis of a sexually-transmitted infection (STI)</li> </ul>	Sexual partner living with HIV
Injection drug use and: <ul style="list-style-type: none"> <li>a) An injection partner with HIV or</li> <li>b) Share injection equipment</li> </ul>	Engaging in sexual activity in a high HIV-prevalence area or social network with: <ul style="list-style-type: none"> <li>a) Inconsistent or no condom use or;</li> <li>b) Diagnosis of a STI or;</li> <li>c) Transactional sex work or;</li> <li>d) Use of intravenous drugs or alcohol dependence (or both) or;</li> <li>e) Incarceration or;</li> <li>f) Partner(s) without known HIV status and who have risk factors a-e.</li> </ul>
Receipt of post-exposure prophylaxis (PEP) and: <ul style="list-style-type: none"> <li>a) Continued risk behavior for HIV acquisition or;</li> <li>b) Multiple courses of PEP</li> </ul>	