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# "Stains" on their self-discipline: Public health, hygiene, and the disciplining of undocumented immigrant parents in the nation's internal borderlands

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## Abstract

Histories of the role of public health in nation building have revealed the centrality of hygiene to eugenic mechanisms of racial exclusion in the turn-of-the-20th-century United States, yet little scholarship has examined its role in the present day. Through ethnography in a Mexican migrant farmworking community in California's Central Valley, we explore the role of oral-hygiene campaigns in racializing Mexican immigrant parents and shaping the substance of their citizenship. Public health officials perceive migrant farmworkers' children's oral disease as a "stain of backwardness," amplifying Mexican immigrants' status as "aliens." We suggest, however, that the recent concern with Mexican immigrant children's oral health blends classic eugenic concerns in public health with neoliberal concerns regarding different immigrant groups' capacity for self-governance.

### Keywords

governmentality; citizenship; public health; eugenics; Mexican immigrants; hygiene; United States

Hygiene, with its connotations of civilization and morality, has long served as a yardstick against which nonwhites' "fitness" for citizenship has been assessed. Judgments about a group's capacity for self-governance are often based on assessments of proper family governance, and, thus, negative portrayals of minority women's caregiving practices have long assumed a central place in both nativist and colonial discourses. During the early 20th century, for example, the high infant mortality rate of Mexican-origin children in southern California generated stereotypes of Mexican immigrant women as "bad mothers" (Molina 2006). These concerns, in turn, cast public health departments as Mexican immigrants' legitimate "stewards," portraying them as what Natalia Molina calls "stubborn children—a whole population who needed to be overseen, trained, controlled" (2006:74). Meanwhile, in the colonial Philippines, public health officials' portrayals of women's unhygienic caregiving practices justified Filipinos' continued status as wards of the state. As Bonnie McElhinny (2005) writes, a purportedly "benevolent" campaign against high rates of infant morality in the early 20th century strategically transformed Filipinas' mothering strategies into an argument for the continuation of the United States' "civilizing influence." In short, just like

gender and sexuality (Stoler 1991, 2002, 2006), childhood has long been the subject of national and imperial reforms that aim not only to restructure subaltern practices of mothering but also to legitimize the racial and imperial projects of which they are part.

New social histories of public health in the western United States have revealed the centrality of hygiene to eugenic mechanisms of racial exclusion during the nation's first major wave of immigration between 1880 and 1920.[1] These histories show that the rise of regional public health authorities was in part predicated on the assumed hygienic threat immigrant groups posed to the dominant population, and the growing medical authority of public health lent scientific credence to racial claims (Kraut 1994). Because of the challenge the state's high proportion of non-European immigrants posed to binary schemes of racial classification, the relationship between public health promotion and nation building may have been particularly virulent in California. On San Francisco's Angel Island, medical screenings more intensive than those to which southern and eastern European immigrants were subjected examined Chinese, Filipino, and South Indian immigrants for the “eugenic criteria of fitness” (Shah 2001:186). Steerage passengers were rigorously screened for conditions that would interfere with their productivity as laborers—such as trachoma and hookworm, known as the “germ of laziness”—and medical certification became the dominant ground for deportation. Meanwhile, at the U.S.–Mexican border, the convergence of medicalization and militarization created a regime of “eugenic gatekeeping,” as sanitation plants that outlasted the threat of the typhus that had initially spawned them enforced views of Mexicans as biologically inferior (Stern 2005:58–59). As Alexandra Stern writes, such medical inspection plants, the predecessors of the modern Border Patrol, helped to mark Mexicans as outsiders who could be admitted to the United States “only if sanitized by the methods of modern science” (2005:71). Thus, early in the 20th century, public health authorities were central in lending a scientific basis to exclusive immigration policies and in racializing different immigrant groups.

Public health discourses and practices have remained central to racialization processes in the 21st century, figuring prominently in the debates currently underway about the proper boundaries of the body politic and about who deserves citizenship. Hygiene remains a potent symbolic marker of racial difference, and public health has continued to justify the exclusion of certain groups on eugenic grounds (see Bashford 2004:11; Molina 2006). Yet scholars argue that the “new public health” entails a fundamental revision of the relationship between the state and its citizens. The focus of public health promotion, they suggest, has increasingly shifted from coercive quarantines to individual self-governance, and from eugenic concerns with safeguarding the “germ plasm” to neoliberal reforms instilling techniques of the self (Lupton 1995; Rose 1999, 2007). In an era in which immigrant groups are judged “worthy” or “unworthy” of public benefits on the basis of assessments of their self-reliance and individual responsibility, personal hygiene perhaps bears an even greater symbolic load as a marker of capacity for self-governance. For these reasons, public health campaigns focused around personal hygiene serve as fertile ground for an exploration of the shape of this new “sanitary contract” between state and citizen.

[1]Contemporary historical scholarship on the modern U.S. West has increasingly pointed to the connections between coercive public health measures in the metropole and those in the colony, as quarantines first deployed in the latter were then used to manage the medical menace of nonwhite others in the former. For example, Alexandra Minna Stern shows that public health measures used to defuse the hygienic threat posed by Mexican immigrants in the early 20th-century Southwest were initially designed in the colonies of the Philippines, Cuba, and Puerto Rico. She argues that the racial assumptions behind colonial medicine themselves became domesticated, and practices such as quarantine and prophylaxis “became entwined in the American public health mentality” (Stern 2005:21). Meanwhile, Nayan Shah shows that the medical exams of the early 20th-century Angel Island, California, immigration and quarantine station were part of a “world-wide emerging network of quarantine and health inspection that served as ‘imperial defense’ against the potential invasion of epidemic diseases into metropolitan ports in North America and Europe” (2001:180). These histories are part of a growing trend in critical scholarship that examines the way racialized assumptions that informed public health measures aimed at minority populations in the metropole were themselves forged in part through colonial histories (see also Anderson 2006).

A variety of scholars have explored the critical role of public health workers—as influential intermediaries between the state and its new citizens—in instilling immigrant newcomers with U.S. norms (Horton 2004; Molina 2006; Ong 1995, 1996, 2003; Shah 2001). Yet analyses of public health as a vehicle of Americanization often neglect the way disciplinary power works through the very medium of caregiving. As the state teaches citizenship through the family, immigrant parents and children are charged with fundamentally distinct civic roles. The immigrant family is enlisted as an instrument of governance, with proper parenting reflecting on capacity for responsible citizenship (see Lupton 1995; Rose 1999, 2007). Meanwhile, public health anxieties about immigrants' "fitness" as parents serve as thinly veiled arguments for minority populations' sustained dependency (McElhinny 2005; Molina 2006). Just as hygiene serves as a rich symbolic register in which to discuss national purity and pollution, parenting practices are similarly made to reflect on broader civic issues of responsible conduct. Yet, despite the rich literature on the relationship between public health and citizenship in the turn-of-the-20th-century U.S. West, little scholarship has examined the contemporary role of public health in shaping the substance of citizenship for Mexican immigrants during the current, second, major wave of immigration to the United States.

In this article, we explore the way that public health campaigns' anxieties about Mexican immigrant mothers' caregiving practices have served as a potent site for constructions of Mexicans' "deservingness" of citizenship during this second wave of immigration. To do so, we focus in particular on a topic that has generated increased public health concern in the past decade—that of Latino children's oral hygiene. Public health officials have historically fixated on the hygienic threats posed by different groups at different historical moments, each one conjuring up a specific public anxiety—whether the fear of contagion, race suicide for "whites," or hope for race uplift for "minorities" (McElhinny 2005; Shah 2001). The reduction of oral disease in developed nations through the fluoridation of public water systems and the promotion of preventive oral hygiene practices is viewed as one of the major public health triumphs of the past century (U.S. Department of Health and Human Services [USDHHS] 2000). Yet children from minority groups—Latinos, in particular—have not benefited from these scientific advances, and recent oral-hygiene campaigns have attempted to instill in such groups "American" norms of health and hygiene. What specific public anxieties do contemporary concerns about immigrant children's oral hygiene speak to, and to what racialization projects do they contribute? How do current public health campaigns focusing on immigrant families' hygiene illustrate the social contract proposed by the "new public health" (Petersen and Lupton 1996) during this second major wave of immigration? In addressing these questions, we attend to public health not only as discourse about citizenship but also as practice, examining how a range of educational, public health, and public welfare programs exert a disciplining function that differentially positions immigrant families in the body politic.

## The Central Valley: A racialized space internal to the nation

To examine how oral hygiene campaigns construct Mexican immigrant families' "deservingness" of citizenship, the first author conducted nine months of ethnographic research in Mendota, a predominantly immigrant farmworking community in the heart of the fertile San Joaquin Valley, the southern part of California's Central Valley. Between 2005 and 2006, she conducted interviews with a range of actors involved in farmworker children's oral health. She conducted 18 interviews with the area's public health and social service professionals—including doctors, dentists, and school nurses. She also conducted 12 interviews with early childhood educators in the federal Head Start and Women, Infants, and Children (WIC) nutritional programs who serve as influential "agents of Americanization."

An examination of the role of public health officials in crafting discourses about immigrants' proper place in the polity must be complemented by an analysis of such discourses' practical effects. To understand immigrant mothers' interpretations of and responses to the discourses of these citizen-making agencies, the first author conducted multiple interviews with 26 Mexican immigrant mothers about their interactions with the health care and welfare bureaucracies in the area. Mothers were randomly selected from a list of addresses and names generated by a partner study of farmworker occupational health; women were eligible for inclusion in the study if they were Latina and had a child under the age of five (see Barker and Horton 2008). Primarily undocumented, these immigrant mothers had been in the United States a mean of nine years; their children had variable citizenship status. To fully capture the experiences of immigrant parents and children in the public health and welfare systems as they shuttled between dentists, school nurses, and migrant program liaisons, the first author also contacted the parents of five children whom elementary school nurses deemed to be “problem children” because of their persistent and untreated oral disease. She interviewed these parents as well as the health and school officials who interacted with them. To gather firsthand data on their interactions, she accompanied parents and children to dental appointments while providing transportation. Together with her interviews, these observations of the interactions between immigrant mothers and public health officials yielded a complex portrait of the way oral hygiene has become a new site for the elaboration of racial distinctions.

California's Central Valley provides the nation with one-quarter of all its food (Gonzales and McChesney 2002); major crops in Mendota, the “Cantaloupe Capital of the World,” include cantaloupes, broccoli, almonds, peaches, and grapes. Yet, despite being the nation's fruit basket, agricultural communities in California's Central Valley compose part of an “other California,” one far-removed from the state's general economic prosperity. Scholars have noted that farmworking communities exhibit a stark polarization along lines of race and class, divided between poor agricultural laborers of Mexican origin and a white agribusiness elite (Griffith et al. 1995; Palerm 1991, 1992). California's agribusiness industry grosses $27 billion a year (Gonzales and McChesney 2002), but farmworkers receive average annual salaries of only between $7,500 and $10,000 (Villarejo et al. 2000). Agribusiness companies typically do not offer farmworkers employment benefits such as child care, pension plans, or health care. Thus, to supplement their meager incomes, eligible farmworkers depend on public agencies that provide food coupons, food stamps, preschool, medical care, and unemployment insurance. As farmworking families are dependent on the state to survive, the state, ironically, wields considerable influence in the daily conduct of undocumented immigrants and their families. Thus, public health and social service agencies play a major role in shaping the sense of civic membership of immigrants in farmworking communities and in incorporating them as “new Americans.”

Because they are racially segregated and rely on the labor of undocumented immigrants, farmworking communities in the Central Valley constitute an internal borderland of sorts. The town of Mendota is 95 percent Latino (U.S. Census 2000), primarily of Mexican and Central American origins. Mendota has long been a destination point for Mexican immigrants, who have migrated to the area from central Mexico since at least the late 19th century. The federal Bracero Program, which directly imported 4.6 million agricultural laborers to work in U.S. agriculture between 1942 and 1964, even more tightly linked migration networks in the classic sending areas in Mexico to the region. The small town is now a first destination point for many new arrivals, many of them undocumented. Thus, health professionals and social service workers commonly speak of Mendota as a liminal space between Mexico and the United States—an internal borderland of sorts. Whereas some call it a “migrant labor camp,” others refer to it as a “port of entry” for Mexican immigrants.

Historian Mae Ngai argues that the production of racialized spaces such as the Central Valley arose from the advent of the legal practice of deportation, coinciding with the creation of the illegal alien as a "new legal and political subject" (2004:4). She shows that the nation's first comprehensive immigration reform, the Johnson-Reed Act of 1924, introduced the precedent of numerical restriction of immigration along with a new system of visa controls and border surveillance, generating what Americans know as "illegal immigration" for the first time in U.S. history. "Unauthorized entry," a wholly 20th-century invention, soon became the main reason for deportation (Ngai 2004:59–60). The act enshrined territoriality as the engine of immigration policy, and the nation's borders were deemed unstable because of the challenge presented by the undocumented, seen as "invisible enemies in America's midst" (Ngai 2004:62–63). The coding of the undocumented as "Mexican" meant that persons of Mexican origin—immigrant and citizen alike—were soon perceived as internal "foreigners." Thus, Ngai argues that the concept of "illegal" immigration "generated racial ideas and practices that, in turn, produced different racialized spaces internal to the nation" (2004:64).

Although Ngai does not explore the role of public health in creating such internal borderland spaces, public health practices such as mass vaccination and medical deportation (Horton 2004) are central to the continued production of such "alien spaces." To control the flow of disease, goods, and bodies through these internal borderlands, public health officials and educators in the Central Valley employ public health policing measures in the form of health screenings and quarantines. As Molina (2006:17–45) has shown for the selective enforcement of sanitary codes in Los Angeles' Chinatown in the early 20th century, parents in largely migrant areas are held to a higher standard of healthiness than those in other California communities. For instance, children must present proof of a negative TB test only upon entering kindergarten in most California schools, but in Mendota, children must present proof of a negative TB test at the beginning of each school year and following trips out of the country.[2] The school district holds medical and dental screenings for its migrant children at the beginning of the school year, and schools often exclude children with health conditions deemed persistent or contagious, including severe oral disease. Children's oral disease may be legally prosecuted as a form of child neglect, and, thus, school officials assign a Child Protective Services (CPS) worker to monitor parents who are seen as refusing to comply with standards of health or hygiene.[3] Thus, the policing of this internal borderland has generated racialized public health practices that constitute the Central Valley as a space of potential contagion.

In Mendota, public health professionals and educators evinced a border mentality, perceiving themselves as literally besieged by foreign health behaviors among a transient, rapidly changing population. At a time when a 2005 U.S. House of Representatives bill would have made all undocumented immigrants felons, public perceptions of migrant spaces such as Mendota are mixed with suspicion and fear. The conjoining of the threat of disease and criminality may be seen in the city's WIC office, on the wall of which hangs a poster—akin to a police suspect profile—with pictures of various "wanted" Mexican-origin tamarind

[2]The state mandates all childhood vaccinations for children, at varying age levels. The requirement of proof of a negative TB test, however, varies from county to county. Counties with high immigrant populations, such as Fresno County, where Mendota is located, require proof of a negative TB test before a child may enter kindergarten. In the Mendota Unified School District, however, school officials have adopted stricter policies, requiring that a negative TB test be presented each year before enrollment. In addition, teachers are requested to notify the school nurse when children leave the country—mostly to visit Mexico—and a child must be retested after each trip before he or she is readmitted to school.

[3]Some dental clinics in the Central Valley also alert CPS when children repeatedly present with oral disease, as their parents are deemed to be refusing to adopt a regimen of proper oral hygiene. The clerk in one clinic explained, "We've called CPS many times. Because dental neglect is child abuse. If a child comes in and eight teeth are bombed out, and we fix them, and they come back, guess what, they have another eight bombed out, and if they make that second appointment for treatment and don't show up—then we do, we call CPS. Because that child is suffering!"

candies with high lead content. Explaining the poster, a WIC worker said that she had attended a WIC meeting in San Diego during which the group took a field trip across the border to see the substandard plants where these candies were manufactured. “Those kids they run around eating them all the time. And then they come over here and bring them over here,” she said, shaking her head. Her coworker, standing nearby, affirmed, “These kids eat a lot of candies from Mexico. Sometimes they buy them in the stores, sometimes their relatives send them as a gift. And parents dole them out when they've done something good. The problem is they easily come across the border, and they're made in plants where they don't have the regulations we have. So that poses a health risk.” Thus, despite its interior location, health professionals portray the Valley as a borderland—a space invaded by alien products, where the presence of internal “foreigners” places national, social, and hygienic boundaries at constant risk.

Concerns about contagion, and particularly about the role of children's mouths in spreading contagion, are common among health professionals in this “port of entry.” As the mouth itself is the “port of entry” to the body, children's mouths become the first line of defense in educators' strategies to combat the spread of germs and disease. The elementary school nurse, for example, excludes from school children who present with large cavities—as well as with pink eye, lice, chicken pox, and strep throat—until parents can provide proof of treatment. The Head Start programs routinely sanitize their schoolrooms, toys, beds, and countertops to prevent the spread of germs due to children's oral fixations. Although these are not unusual measures for schools to take, educators remain particularly alert to the potential for migrant children to spread contagious diseases of exotic origins. One teacher at the Migrant Head Start, for example, recalled an instance in which a child showed up with his mouth pockmarked by an unusual form of blisters—what she described as “white blisters that erupt.” “It wasn't cold sores, it was some kind of virus,” she remembered.

> I spotted it because he was crying and when he opened his mouth I saw these blisters all along his lower gum. They were erupting and one had already popped and his whole mouth was red. So we called his mom and had her pick him up. … When we talked to grandma, it turns out that her two-year-old grandchild also had the blisters. This little boy had put her bottle in his mouth and had caught whatever it was.

Thus, in this “port of entry,” the “port of entry” to children's bodies in turn becomes a suspected harbor of germs and disease, and children are viewed as the vector by which harmful microbes may be spread.

## Public health, governance, and the “sanitary contract”

Scholars have long noted that the development of the discipline of public health went hand in hand with the rise of the modern, liberal state (Foucault 1991; Lupton 1995). Deborah Lupton (1995:18), for example, shows that the epidemics of 17th- and 18th-century Europe left an enduring legacy of the state being considered responsible for the public's welfare. Until the early 19th century, the emerging discipline of public health relied primarily on emergency measures such as quarantines to address periodic outbreaks of epidemic disease. The success of public health in eliminating these major epidemics was considered “a triumph of technological and scientific innovation” and evidence of the salvific potential of science (Shah 2001:3). The state's success in combating such epidemics ushered in a public health “social contract” between states and their citizens: The modern state would protect the health of its population in exchange for the public's ceding authority in matters of health to official expertise (Lupton 1995:24; see also Briggs 2003:288).

Yet, with concerns mounting over the health of a growing labor force because of industrialization and urbanization, the focus of this new public health apparatus shifted from contagious epidemics to endemic diseases and the hygiene of the masses (Lupton 1995:22). The doctrine of “hygienism” that accompanied this concern with the effects of industrialization attributed disease among the urban proletariat to their immediate environment (Lupton 1995:29). Conjoining medical and moral concerns, hygienists attempted to “civilize” laborers' domestic lives and reform their intimate conduct. Local and state public health authorities that originally arose to address the epidemics—the “medical police” (Foucault 1984)—turned their disciplinary attention to enforcing urban sanitation. By the 19th century, authorities' public health concerns had shifted from emergency quarantines to preventive measures, and sanitation had become a principle of local government (Lupton 1995:30).

The discovery of the microbe in the late 19th century gave scientific credence to the hygienists' concerns about contagion, ushering in a new era of a “sanitary contract.” Disease had once been held to reside in visible disorder in the general environment, but now public health officials increasingly scrutinized the invisible disorder that could inhabit the individual body. Public health concerns shifted to education around proper bodily deportment in an attempt to discipline the interpersonal contacts through which contagion spread (Lupton 1995:16). This renewed attention to interpersonal hygiene was reinforced in the United States by a virulent eugenic concern about the fitness, “cleanliness,” and domestic environment of nonwhite, immigrant Others (Molina 2006; Shah 2001; Stern 2005). Armed with scientific evidence, public health workers inspected and meticulously documented the “hygienic threat” assumed to be posed by the nation's first wave of immigrants.

In the United States, middle-class women reformers associated with settlement houses and public schools scrutinized the domestic life of immigrants, evaluating both their living arrangements (Shah 2001) and the details of their child-rearing practices (Ehrenreich and English 1979:153–160). Reforming immigrant women's conduct and domestic practices was viewed as crucial to ensuring their children's “physical and moral fitness” for citizenship (Shah 2001:215). A new “sanitary contract” had emerged between the state and the public, one that exalted domestic cleanliness as a supreme moral virtue (Lupton 1995:38). Because women were held responsible for the proper conduct of domestic life, immigrant mothers' caregiving practices emerged as a primary focus of public health scrutiny (Porter 2005:174–179).

This increased concern for domestic hygiene around the turn-of-the-20th-century coincided with the drive in the United States toward the professionalization of public health as a form of expertise that could guide public policy (Porter 2005:156–160). The public's health was no longer managed by a coercive centralized state authority; instead, myriad forms of professional expertise allowed the state to govern at arm's length. As Nikolas Rose argues, under this new model of governance, “political rule would not itself set out the norms of individual conduct, but would install and empower a variety of ‘professionals’ who would, investing them with authority to act as experts in the devices of social rule” (1993:285). Vested with the authority and objectivity of science, experts in human conduct, such as social workers and health professionals, urged members of society deemed aberrant or unfit to take it on themselves to assume the responsibilities of self-governance.

Rose (1999, 2007) argues that a shift in biopolitics has ushered in a new era of public health—one concerned with encouraging individual self-governance and self-responsibility rather than with policing public health through coercive eugenic measures. As the more stringent monitoring of the health of migrant children in Mendota suggests, coercive public health

measures have by no means disappeared. Instead, they exist side by side with neoliberal strategies to instill individual self-discipline (see Bashford 2004). Yet in the contemporary era of advanced liberal rule, Rose argues, the burden of responsibility has increasingly shifted from the shoulders of health officials to those of the individual. As expertise is now viewed with suspicion, each citizen is, instead, enjoined to become an “active agent in his or her government” (Rose 1993:296). “Good citizenship” in a neoliberal era is increasingly based on the individual's capacity for autonomous self-mastery and self-discipline, qualities that constitute a new “moral code” (Porter 2005:297).

## Hygiene, foreign bodies, and governance

One form of the “capacity to exercise citizenship” (Rose 1993:291) valorized by advanced liberal societies is the daily attention to the minutiae of personal hygiene. The upholding of U.S. standards of personal health and hygiene as a measure of one's citizenship draws attention to new arrivals whose norms of hygiene are perceived to be different. In her study of immigration authorities' reception of Cambodian refugees, for example, Aihwa Ong (1995:1245–1246) shows that the Department of State's “Facts of Life in the United States” handbook inordinately stresses personal hygiene, including the elimination of “personal body odors” through practices such as bathing, the use of deodorant and mouthwash, and the brushing of teeth. Adherence to modern norms of hygiene has thus become a central criterion in health professionals' assessments of immigrant groups' “fitness” for citizenship and in the demarcation between “sanitary citizens” and “unsanitary subjects” (Briggs 2003; Briggs with Mantini-Briggs 2003).

Yet a series of structural obstacles militated against farmworker families' ability to meet the hygienic ideals of sanitary citizenship. Their low incomes prevented regular and preventive dental checkups, and the seasonal nature of their work led to fluctuating eligibility for California's state-subsidized dental care program (Denti-Cal). The organization of the dental public health care system itself discouraged access, as Denti-Cal reimbursements made it more profitable for area dentists to encourage families to bring children back for multiple dental visits rather than to perform all treatment at once (see Barker and Horton 2008). Finally, many immigrant parents came to the United States from rural areas with economies based on subsistence farming and thus enjoyed a low incidence of oral disease despite few preventive oral health behaviors (see Horton and Barker 2009). As a result, they were unprepared for the oral health implications of the more cariogenic diet they encountered in the United States.

In discussing the practices of farmworker parents, health educators engaged in a “geography of blame” (Farmer 1993) that downplayed such structural obstacles while pinpointing Mexico as the source of unhealthy behaviors. Nutritional educators in the WIC program, for example, spoke disparagingly about what they called the “deficits of knowledge” they encountered among their Mexico-born food-coupon recipients. As one WIC educator said, “Our job is to do a lot of educating because the immigrants from Mexico don't know this stuff.” Another explained, “We have to spend a lot of time educating, a lot of time dealing with foreign beliefs. …The Hispanic ones, they make a shake with a raw egg in it. I think it has Nesquik, a raw egg, and a banana. And you explain that it could have bacteria and hurt them and they say, ‘Well I did it with my five kids and I never had any problems.’ Like that means it's fine!” Many of the public health professionals in the area are themselves second- or third-generation Mexican Americans; thus, such professionals draw on hygienic hierarchy to enforce social distance between themselves and the “recent arrivals.” In pointing south, this “geography of blame” obscured the U.S. origins of the cariogenic diet of farmworker children by fingering Mexican practices as the culprit.

Health educators drew on norms of hygiene as an “index of civilization” (McElhinny 2005:185) that perceptibly demarcated the boundary between Mexico and the United States, between “internal foreigner” and “American.” Aware of their evaluation according to these norms of personal hygiene, immigrant parents were often quick to assert their “Americanness” by prominently displaying their very modern cleanliness. Coached by Head Start to wean their children from their baby bottles, some mothers commented disparagingly to health professionals about specific children who had not moved on from the *teta* (baby bottle). One mother remarked on a friend's child who had a “mouth full of cavities” because he drank soda from his baby bottle, and another was aghast that a neighborhood child “drank from the teta until he was five.” Yet not all parents subscribed to this new gospel of hygiene. One immigrant mother, for example, resisted subsequent dental visits for her children as a form of imposed state discipline because one child's first trip to the dentist—required by Head Start—had been traumatic and had resulted in a swelling inside his cheek. Immigrant mothers were clearly taught to perform their very civility by displaying modern hygienic competence, as the language of hygiene became a language of modernity. The statements quoted above illustrate immigrant mothers' acute awareness that public health officials judge their parenting skills—and their “fitness” for consideration as “Americans”—by the proper hygienic care of their children.

## Oral disease as a “stain of backwardness”

Oral disease assumed a prominent place in health professionals' discourses in signifying immigrant parents' nonmodernness and, thus, incapacity for self-governance. The most common childhood illness, oral disease is disproportionately concentrated among low-income children (USDHHS 2000). Latinos have higher rates of oral disease than any other ethnic group, and farmworker children, as a group, have rates of early childhood caries that reach five times those for Latino children in general (Nurko et al. 1998; Weinstein et al. 1992). Indeed, local health officials named oral disease—along with anemia and obesity—as one of the three top health issues affecting farmworker children. Health professionals in Mendota encountered severe oral decay in their everyday contact with farmworker children, offending their senses of smell and sight. One Head Start teacher said, “You see kids with all sorts of dental problems—with huge holes, or you can smell it when they open their mouth.” And the elementary school's nurse observed, “You see kids with big holes in their mouths. Or sometimes the ones who just came in from Mexico they just have pointed jags from the decay. I don't even know how they eat.”

To health professionals in Mendota, then, Mexican immigrant children's high rates of oral disease amplified their status as “aliens,” serving as a particularly visible sign of this population's “foreignness.” Educators viewed children's early childhood caries as a sign of their parents' lack of familiarity with modern caregiving practices—such as oral hygiene and proper infant feeding techniques. One WIC educator said, “The problem is that parents don't brush their [kids'] teeth. And they fill their bottles with juice—and a lot of times it's Tampico, Kool-Aid, Sunny Delight, sometimes soda. It's crazy the things they put in there.” Whereas this WIC educator suggested that parents' irresponsibility and ignorance of proper child-feeding habits was the cause of their children's oral disease, others directly implicated products brought from Mexico. “My concerns are that they put a lot of juice in their kids' bottle and the kids have it all day long. Or they have them on those honey-filled pacifiers that they bring from Mexico,” one WIC worker said. These statements portray Mexican immigrants as unschooled in modern hygienic practices, targeting Mexico in particular as the source of such “backward” practices. They point to the way that a Mexican origin itself is perceived as unmodern and unhygienic, as hygienic competence becomes a proxy for immigrant status. To public health officials, then, Mexican immigrants' lack of familiarity

with preventive oral hygiene practices and their children's decayed teeth visibly symbolize this population's "foreignness."

Unlike complex childhood illnesses such as anemia, obesity, and diabetes, then, oral disease carries with it what we call a "stain of backwardness" because it is imagined as easily preventable with modern scientific methods. The first-ever surgeon general's report on oral health, released in 2000, is illuminating in this regard. The report frames its call for eliminating oral health disparities in terms of biomedicine's legacy of "extraordinary advances in the health and well-being of the American people" (USDHHS 2000:v). As the report describes, the discovery of fluoride as an effective preventive measure after World War II and the understanding of dental caries and periodontal diseases as preventable bacterial infections have "allowed most middle-aged and younger Americans [to] expect to retain their natural teeth over their lifetime" (USDHHS 2000:1). Yet, against this triumphal narrative of scientific progress, the authors state, "*not all* Americans are achieving the same degree of health" (USDHHS 2000:1). The stated goal in reducing disparities in oral health is the intention to render the "American dream" of "liv[ing] well into old age … with a high quality of life" (USDHHS 2000:4) available to the marginal populations overlooked by advances in modern science.

Like other diseases related to a modern diet and lifestyle, oral disease may be viewed as a "disease of civilization" (Bodley 2008). Yet, because of advancements in modern science and the promotion of oral hygiene and health behaviors, "modern" societies such as the United States have witnessed a decline in oral disease in recent years. The pronounced oral disease among minority populations in the United States signals their adoption of a "modern" diet without a correspondingly rapid uptake of "modern" health behaviors. The high rate of oral disease among Latino farmworker children appears as a "stain of backwardness," a haunting reminder of uncivilized health behaviors in an otherwise "civilized" environment. As the surgeon general's report implies, the persistence of oral disease is a blight on the promise of medicine—a sign of deplorable retrogression in an otherwise modern society.

The report singles out one particular form of early childhood caries—baby bottle tooth decay (BBTD)—as an especially egregious example of such populations' defiance of modern hygienic standards. Unlike other common childhood illnesses, such as asthma, obesity, and anemia, BBTD is perceived to reflect more strongly on one's parenting skills. A syndrome coined by the dental public health community to describe the severe decay caused by prolonged bottle feeding, BBTD is commonly blamed on improperly vigilant or poorly educated caregivers. Because it is treatable with fillings and restorations, untreated BBTD may be construed as a form of child neglect and constitute grounds for a child's removal from the home. In contrast, other childhood farmworker illnesses—which often strike later in childhood and have more complex etiologies—cannot be so easily chalked up to a failure in proper parenting.

In keeping with this view of children's oral disease as an atavistic and unnecessary affliction in a modern society, health officials in Mendota spoke of children's high rates of early childhood caries with particular emotion and vehemence. As one Head Start educator said with dismay, "The thing that really gets you is seeing those kids who have their front teeth falling off in pieces or who can barely talk because of their problems. And you wonder, how can that parent go to sleep at night knowing that their kid is in pain and it could be avoided?" As farmworker children were perceived as not benefiting from the advances of public health promotion achieved during the past half century, their dental decay was viewed as a visible sign of backwardness. In particular, as this educator's quote indicates, the

oral disease of Mexican-origin children is viewed as a “stain” on their parents' caregiving skills, signaling the unfitness for citizenship of such newly arrived “foreigners.”

Just as children's poor diet and oral hygiene reflected on their parents' poor governance, the capacity for self-governance was similarly signaled by a mother's adoption of the norms of oral hygiene. During one interview, for example, one mother demonstrated her son's new implements of personal hygiene to explain why she thought Head Start was helping him adjust to life in the United States. Trotting out the toothbrush, cup, and hourglass she had received at a lecture at the local Head Start, she said, beaming, “You see, they give him his little brush and cup and an hourglass *(reloj de arena)* so he knows exactly how long to brush.” To this mother, then, such hygienic accoutrements were a sign of the better life opportunities afforded her son in the United States and a visible symbol of “Americanness.” Thus, as proper personal hygiene is viewed as a marker of good citizenship, immigrant mothers too draw on this hygienic hierarchy to contest officials' portrayals of them as “backward” and to assert their worthiness for inclusion in the body politic.

## Making sanitary citizens and “citizen consangines”

Not only do public health professionals attempt to instill in immigrants the “self-mastery” necessary for participation in liberal governance but they also help adapt immigrant newcomers to the racial hierarchies of the nation. Experts in human conduct—WIC educators, Head Start teachers, and health care professionals—play a crucial role in educating new immigrants about their “place” in U.S. society. As Ong argues, biomedicine not only reforms immigrant bodies but also “is constitutive of the social, economic and juridical practices that socialize biopolitical subjects of the modern welfare state” (1995:1244). Although Ong (1995, 1996, 2003) pays attention to the internal differentiation among immigrant groups according to nationality, class, and gender, little scholarship to date has examined the differential disciplining of immigrants according to generation. The family is one key institution through which expertise operates—through which individuals are governed and learn the norms of citizenship. As Rose writes of the technologies of liberal rule, “The family, then, is to be instrumentalized as a *social machine*—both *made* social and utilised to *create* sociality—implanting the techniques of responsible citizenship under the tutelage of experts and in relation to a variety of sanctions and rewards” (1993:293–294).

Yet the immigrant family does not enter the U.S. imagination as a monolithic entity; instead, concerns about nation building interpellate immigrant parents and children into different roles. Domestic hygiene has historically served as a domain in which immigrant parents and children have been differentially disciplined, and to different ends. The different “place” of parents and children in Americanization projects at different historical epochs reveals much about the politics of incorporation of different immigrant groups. Turn-of-the-20th-century social workers, for example, often taught classes in “home economics” to children of immigrants because they feared that their southern and eastern European parents were unassimilable (Ehrenreich and English 1979:188). In the 1930s, social workers attempting to address high infant mortality rates in a rapidly acculturating and domesticating Chinatown revealed a more optimistic view of the capabilities of Chinese immigrant parents, focusing primarily on the immigrant mother as the “key” to the family's acculturation. Thus, we explore how such institutions position immigrant parents and children differently and what this illustrates about the contemporary politics of incorporation of Mexican-origin immigrants.

Whereas legal status played a relatively little role in the first major wave of immigration around the turn-of-the-20th-century, its “invention” with the Johnson-Reed Act in 1924

(Ngai 2004) has greatly shaped the role of the immigrant family as an instrument of governance. Latino families in particular are fractured along the lines of legal status (Fix and Zimmerman 2001), differentially shaping the access of immigrant children and parents to the benefits of the state. Although legal status should not be viewed as a primary determinant of identity (Coutin 2000), it plays a large role in shaping an individual's—and indeed a family's—relationship to the state. Therefore, along with generation, race, and class attributes (Ong 1995, 1996), legal status helps influence health professionals' assessment of immigrant parents' and children's "place" in society.

As Ngai argues (2004:6), the line between "legal alien" and "citizen" in the United States has historically been soft; access to naturalization has meant that "legal aliens" may eventually benefit from the same rights as citizens. However, a series of legislative acts passed during the 1990s served to harden the distinction between "citizens" and "legal aliens," ossifying the distinction between the categories "citizen" and "immigrant." The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, for example, barred all legal immigrant entries from receiving food stamps and cash assistance and allowed states to render legal immigrants ineligible for Medicaid for five years after their arrival. The category of "citizen" has been recently thrown into sharp relief by the gradation of legal and illegal statuses whose associated rights have been abridged, even as the distinction between "legal" and "illegal" immigrant has grown less stark. Moreover, the increase in families that include individuals of different legal statuses (Fix and Zimmerman 2001) complicates the notion of citizenship as an individual status. Although "illegal aliens" stand at "the outermost point of exclusion from national membership" (Ngai 2004:6), the practicalities of life in mixed-status families situate undocumented parents of citizen children in a unique relationship to the state. We show below that although the primary goal of health professionals is to transform immigrant children into U.S. citizens, they attempt to enlist undocumented immigrant parents as supporting actors in this drama, as "proxies for the state."

## Differential disciplining by generation: Enlisting parents as proxies for the state

An examination of the interactions between educators from early-childhood development programs and immigrant parents reveals the role of such experts in teaching immigrant parents and children about their different places in U.S. society. Many families in the Central Valley include undocumented parents and citizen children because increased border enforcement in the past decade has led many formerly migrant families to settle permanently in the United States (Cornelius 2001). Families with mixed legal status are quite common. Thus, analysis of how health officials interact with undocumented parents and their children reveals the way the family members' incorporation into the social body is influenced by the fault lines of both generation and legal status.

Organizations such as WIC and Head Start devote a great deal of their time to instructing parents in the U.S. norms of child rearing. These organizations utilize the family as an instrument for teaching self-governance, encouraging parents' assumption of the responsibility of parenthood as a form of "active citizenship" (Rose 1993:296). Immigrant parents are asked to subject their feeding and hygienic practices to WIC's scrutiny in exchange for monthly food coupons; WIC educators and nutritionists examine children's height, weight, and hemoglobin levels as well as their diet and toothbrushing habits. At monthly parent meetings, Head Start educators host lectures on child development, the nutritional content of meals, and proper individual hygiene. During one parent meeting, for example, the Head Start program director exhorted a room full of immigrant mothers, many of whom work part- to full-time in the fields, to assume full responsibility for their children's

educational development. She remonstrated, “This month we are talking about important people—the president, the governor, and you. Because you are the most important person for your child.” Through WIC and Head Start, then, the state governs at a distance, utilizing educators' expertise to scrutinize and normalize immigrants' child-rearing practices and to instill norms of self-discipline.

As during the first major wave of immigration, personal health and hygiene, the “yardsticks of Americanization” (Molina 2006:45), play a large role in these organizations' socialization of new immigrant families. WIC educators inquire about parents' child-related oral hygiene and feeding practices, and they teach parents to clean infants' baby teeth with a clean wet rag when they first emerge. They urge parents to “find a dental home” for their child by the age of one. Meanwhile, Head Start requires that parents secure a medical and dental screening for each child before he or she is enrolled in the program. Children “dry-brush” their teeth with a fluoride spray after each Head Start meal to encourage tooth care as an everyday routine. Head Start bars children from bringing their baby bottles to program activities, to encourage weaning. Finally, to teach parents proper nutrition, parents—under the supervision of Head Start educators—are put in charge of designing the program's “healthy” lunch menu. Such organizations thus attempt to normalize the domestic space immigrant families inhabit, focusing on domestic hygiene as an “index of civilization” (McElhinny 2005).

Although both WIC and Head Start attempt to instill the norms of self-discipline in young citizens through the institution of the family, they simultaneously inculcate different expectations of citizenship among parents and children. On the one hand, undocumented parents gain access to limited services through such programs because of their status as parents of citizen children. For example, citizen children are eligible for Medi-Cal, California's public health insurance program, and their undocumented immediate family members are eligible for emergency Medi-Cal because of their relation to the children.[4] Although undocumented parents gain limited benefits through their citizen children, their value to the state is solely relational. As programs such as WIC and Head Start prepare immigrant children to assume the rights and responsibilities of citizenship, they simultaneously remind immigrant parents of their provisional and limited membership in the social body. Undocumented parents live the contradiction in social rights open to themselves and their citizen children every day. The majority of the parents we interviewed suffered from dental pain or visibly rotten teeth for which they were ineligible for treatment, but they took their citizen children for dental visits covered through Denti-Cal at the behest of Head Start or the school system. This example illustrates that one's relationship to the state is not determined by individual citizenship status alone; instead, what we call their “citizen consanguinity” placed undocumented immigrants in a unique relationship to the state.

By emphasizing parents' importance in raising the next generation of Americans, agencies such as WIC and Head Start differentially produce parents and children as U.S. citizens. Through meetings with schoolteachers and Head Start and WIC educators, parents are taught that their value to the state lies in their relationship to their children. At the elementary school's “parents' night,” for example, parents were taught the English names of colors, shapes, and numbers with the express purpose of enabling them to help their children with homework. As one parent explained, “They teach us this so we don't fight with our kids over how to say *blue*.” Thus, undocumented parents' relationship to the nation-state is

[4]The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which barred all legal noncitizen immigrants who arrived in the country that year and afterward from receiving Medicaid, also decreed that qualified noncitizen immigrants may receive emergency Medicaid. Such qualified immigrants include pregnant women, minors, the disabled, the elderly, and parents taking care of minor children.

mediated through their offspring; they gain membership in the polity only as guardians of citizen children. In this way, parents are incorporated into the social body indirectly as "proxies for the state," asked to lend their caregiving assistance to the state in raising its next generation of new citizens.

Although parents are reminded of their own meager claims on the polity, such programs also instill pride in them in the promise of their citizen children. In this farmworking community, for example, the photos Head Start takes of its four- and five-year-old "graduates" were a source of considerable distinction, displayed prominently in living rooms. These photos of young children in blue and red caps and gowns—foreshadowing children's high school graduations in families in which few parents had had the opportunity to complete secondary schooling—testified to families' hopes that their children would secure a better life in the United States. One farmworking mother, for example, who was ashamed that she had only completed schooling through the eighth grade in Mexico, proudly showed off the monthly calendar Head Start had given her to record the daily educational activities she did with her children at home. The previous year, she explained, she had been one of three mothers awarded a prize for having amassed the most points for doing such activities with her child. "When they called my name to get the prize, I was so nervous, so excited" she remembered. "I do all the activities I can with [my kids] so that they get the opportunity to learn the things I didn't get to learn." Governing at a distance through Head Start and WIC, then, the state's emphasis on creating a "fit" generation of young citizens thus dovetails with immigrant parents' own hopes. Such programs teach parents the value of their children as U.S. citizens as well as their own indirect value to the state through their proper guardianship of such children.

## Differential disciplining by family's legal status: Creating sanitary citizens and unsanitary subjects

Scholarship on the history of public health interventions in California has examined the way that public health, ironically, helped erect racialized legal barriers to immigrants' enterprise and sanitary living conditions. Members of minority groups were held to standards of hygiene and healthfulness precluded by their unequal living conditions, which public health officials either ignored or overlooked (Molina 2006; Shah 2001). Yet, along with racial and class hierarchies, illegal status shapes immigrants' access to both employment and state-provided benefits and, thus, their ability to comply with standards of healthiness. Little scholarship examines public health officials' differential disciplining of immigrants according to legal status. Below, we suggest that public health officials participate in the creation of ideals of sanitary citizenship from which "illegal" immigrants are excluded because of their lack of access to medical insurance. Unable to comply with medical standards of hygiene, noncitizen children and their parents are more likely to draw the medical gaze and become the subjects of the school district's disciplinary attention.

We begin with the example of one family legally in the United States who were able to comply with their preschool's requirement that their child receive dental care. The Ortiz family, composed of parents who were legal permanent residents and two citizen children, reside in the more comfortable neighborhood of Mendota. Having lived in the area for 15 years, and having bought their own home, the Ortizes are among the more established immigrant families in the area. They enjoy a comfortable annual income based on their relatively well-paying jobs in a tomato processing plant in the area. Mr. Ortiz has an interest in U.S. history and takes English classes at the local adult school. The Ortizes are clearly attempting to put down permanent roots in the United States and to claim for themselves a place in the social body.

As part of the process of transforming themselves into “Americans,” the Ortizes have been subjected to rigorous enforcement of U.S. norms of hygiene and child rearing through the local social service agencies. When their son, Oscar, entered Head Start at the age of three, the Ortizes were required to present proof of Oscar's having had a physical and a dental exam and of having fixed all problems discovered in the course of these screenings. Although the physical screening disclosed that Oscar was a normal, healthy toddler, the dental screening posed a difficult challenge. A series of radiographs revealed that the child's upper front teeth had severe decay, and the dentist told Mrs. Ortiz that her son would need to be given general anesthesia to allow for his dental treatment. A few weeks later, Oscar was sedated, and the dentist placed four stainless-steel crowns on his upper front teeth.[5]

When Oscar first emerged from the operating room, his parents were aghast at the visibility of his crowns and were concerned about this obvious mark of what others might perceive as their poor parenting. They were relieved to learn through a translator that his crowns would fall out along with his baby teeth. As they told me later,[6] they felt chastised yet again when the dentist reiterated what they had heard several times from educators at WIC and Head Start—that they should make sure to brush Oscar's teeth before he fell asleep and to feed him with a cup with a spout rather than a bottle with a nipple. “And we told the dentist that Oscar no longer used a bottle; that he was well beyond that,” Mrs. Ortiz asserted. Adapting the language of hygiene as an “index of civilization,” then, the Ortizes attempted to assert their “fitness” for the task of governance. The Ortizes were well aware that their son's poor oral hygiene and bottle-feeding habits were viewed as evidence of their own irresponsible caregiving; his having visible decay attested to their “failure” as “sanitary citizens.”

Oscar's stainless-steel crowns continue to serve as a source of embarrassment for his parents, who view them as something like a blight on their claims to middle-class civility and “Americanness.” Two years after Oscar received his first four stainless-steel crowns, another dental visit landed him with an additional three crowns on his lower front teeth. By the age of five, Oscar's smile had become a blur of grayish silver. Discussing his crowns one afternoon, his parents joked anxiously about the visibility of Oscar's oral disease at such an early age. “Almost all of Oscar's teeth are now silver,” his father laughed. “See, open your mouth, Oscar. Which ones *aren't* silver?” Incensed at being the butt of his father's humor, Oscar turned around his father's use of the word *silver (de plata)*. “Well, almost all yours are of *bananas (de plátanos)*,” he retorted, using the false cognate. “And you have holes,” he told his older brother, who recently had had four incisors extracted. Then he turned to his five-month-old sister, with the crowning slight: “Well, you don't have *any* teeth. You're going to get older and say, ‘I want my *bibi* (baby bottle)!’” He whined. Then he finally hit on the solution of transforming his visible difference into a form of distinction. “My teeth aren't silver, they're *iron*!” Oscar proclaimed proudly.

In fact, Oscar's stainless-steel crowns were a sign of status among his peers in Head Start, some of whom had little or no access to oral health care. Three other children in his class also had stainless-steel crowns on their front teeth because of BBTD, but others had extractions or, worse, visibly rotten teeth. To his peers, then, Oscar's crowns were known as “silver teeth” and were viewed as a charming fad, a distinctive sign of social status. In our interviews, children without such “silver teeth” often spoke enviously about them, as they would an expensive toy. “He tells me, ‘Take me to the dentist so they can put those silver teeth on me,’” laughed one immigrant mother, while her son enumerated the children who

[5]Like mercury amalgam for fillings, stainless steel is the cheapest material available for making crowns. As Denti-Cal charges parents extra for porcelain crowns, it is common to see children like Oscar with front teeth capped in stainless steel in the Central Valley. In fact, local children have devised their own term for such crowns, calling them “the silver teeth.”

[6]For the purposes of clarity and simplicity, we use the first person in the next two case studies to refer to the first author, who conducted the fieldwork.

have them: “Luisa has them, Oscar has them, and Mariela has them,” he said eagerly. Thus, whereas Oscar's parents viewed the stainless-steel crowns as a visible reminder of their temporary lapse in proper parenting, the crowns appeared as a luxury to noncitizen children without access to Denti-Cal. Simply put, Oscar's silver teeth were the visible mark of his relative advantage in a hierarchy of legal statuses. Most importantly, Oscar's legal status, and access to Denti-Cal, facilitated his family's compliance with Head Start agency directives. His parents were relieved of the stigma of having a child with noticeable and persistent oral disease, and the visible stain of Oscar's decay was replaced by slightly more prestigious stainless-steel fillings.

## Unsanitary subjects: Illegality and public health

Not all children were fortunate enough to have access to the resources necessary for such “sanitary citizenship.” Undocumented children were not eligible for state-provided health care, and undocumented siblings of citizens were limited to emergency Denti-Cal, which only covers the extractions rather than restorations of decayed teeth. Undocumented siblings thus gain a modicum of care because of their citizen consanguinity—but it is bare-bones care limited to emergency treatment. The parents of undocumented children often find themselves in a double bind when the school district's annual dental screening reveals the severe oral health needs of their uninsured children. Because parents of undocumented children often wish to avoid the premature extractions the dentists suggest to resolve their children's oral disease, they postpone treatment, hoping they will be able to eventually pay for restorations. In the meantime, they and their children continue to draw the disciplinary gaze of the school district, labeled “unsanitary subjects” because of their “noncompliance” with hygienic standards.[7]

Mrs. Madrigal was one such “unsanitary subject” referred to me by the elementary school nurse because of her son's extensive and untreated oral disease. The school nurse called in six of the school's “hard-luck cases” from their classes and had them open their mouths for my benefit; Mrs. Madrigal's child had what the nurse called “the worst teeth in King Elementary School.” Roberto, then six years old, had been born in Mexico and had arrived in Mendota at the age of one. When he entered kindergarten in Mendota, he received a dental and physical screening by health care workers in a county mobile van. The county dentist had marked Roberto's teeth a “1,” meaning he required “very urgent treatment” because of oral disease that could cause permanent physical or developmental effects. The school nurse kept a list of these cases; she sent a note home to Roberto's mother. That was the beginning of a long history of headaches for both the school nurses and Mrs. Madrigal, mutual frustration caused by the simple fact of Roberto's lack of eligibility for health care.

Mrs. Madrigal recalls the relationship she's developed with the many officials assigned to her case over the past year, summing it up with a nervous laugh and the phrase “they call me all the time.” She receives weekly notes from the school and county nurse about Roberto's teeth and phone calls from the social worker with the school district's migrant program. Sometimes, Roberto's teeth begin to hurt when he eats his lunch, and a trip to the school nurse will trigger another call to Mrs. Madrigal. But mostly, says Roberto, a shy child with a sheepish grin, he just eats quietly because he knows that—as he puts it—“they can't treat me.”

[7]This section is drawn in particular from observations of the journeys of the five children deemed to have the worst oral health in the local elementary school as they navigated the dental public health safety net. With their parents' permission, I obtained children's dental records and discussed their treatment with their dentists. These observations and discussions allowed insight into the way “unsanitary subjects” are created through systemic obstacles and public health officials' expectations.

By the time I met Roberto, he was on his second round of antibiotics to treat the infection in his gums—an anodyne to salve his lack of treatment. His front teeth had rotted to become flush with his gum line. He had two permanent molars scooped out by oral disease, and one canine tooth was verging on black. He did not like to smile for his school photograph and had difficulty pronouncing certain words. During his first year of school, he was found to be “slow in language acquisition” and was made to repeat kindergarten.

When Roberto first entered kindergarten, Mrs. Madrigal had a brief glimmer of hope he might be treated. The county migrant program had a small amount of funds to pay for dental treatment, so it covered Roberto's examination by a local dental specialist. Roberto's chart at the time of his visit to the dental specialist, in November 2003, reveals that he required the following treatment: “three therapeutic pulpotomies;[8] five prefabricated stainless steel crowns on primary teeth; two two-surface amalgam crowns; one resin filling on two surfaces; one extraction of an erupted tooth; and one space maintainer.” Yet, in looking back at Roberto's file, the specialist notes the biggest obstacle to Roberto's treatment: “Those were all from the visual exam; we couldn't even get him to keep his mouth open for the Xrays.” Because of Roberto's “lack of cooperation,” the most expensive aspect of his care would have been the general anesthesia necessary to perform extensive treatment on such a young child—an $8,000 price tag that the county program could not afford. As a result, Roberto went home without treatment, and the school nurse and the migrant program continued sending notes home to Mrs. Madrigal. The severe extent of Roberto's decay had placed him and the school district at square one again, and Mrs. Madrigal bore the brunt of school officials' frustrations. Roberto's lack of access to insurance made Mrs. Madrigal appear an “unsanitary subject” unconcerned with the health of her child.

By the end of Roberto's first year in kindergarten, school officials were threatening legal action. The school nurse had talked to the migrant program's parent liaison, who had intimated that a CPS worker could be assigned to Mrs. Madrigal's case. Mrs. Madrigal got Roberto an appointment with the local dentist—who had been unable to treat him earlier that year—but he was only able to do a cleaning. She would take Roberto to two more dentists in the area within the year, paying a neighbor for the ride each time. By the winter, she had grown desperate. She took him to a fourth dentist in the area, who was unable to do more than a general exam. Speaking to me in English, he said Roberto was a “clear referral case”; he would need a specialist because “his mouth is totally bombed out.” Exiting the clinic, Mrs. Madrigal said she felt she had hit a brick wall: “Now he's going to go back to school [after break] and we won't have anything to show for all this. It's going to call attention to me again.”

Trapped between Roberto's lack of access to Denti-Cal and her family's lack of income, Mrs. Madrigal served as a lightning rod for the pent-up frustration of the school nurse and migrant program liaison. The school nurse confided to me about farmworking families such as Mrs. Madrigal, “I have to say that I don't really understand that thing about not having the money. Because when you have five families sharing a house and sharing the rent, then how can you not have the money to pay for dental care? I think what they mean by that is that it's just not a priority.” Similarly, the county migrant nurse, who had been followed Roberto's case for three years, blamed Mrs. Madrigal for not having successfully disciplined Roberto to make him behave during dental visits. She snapped, “One thing you might ask Mrs. Madrigal is whether oral health is a priority for her. You might ask her, ‘What do you expect out of your child's health?’ Do you expect that it can be made better? The kids are so young, so it's really up to the parents to make them comply.” The complex chain of structural obstacles to Roberto's treatment had disappeared in the revelatory judgment of Mrs.

[8]Pulpotomy is a child's version of a root canal.

Madrigal as an “unsanitary subject.” In the end, Mrs. Madrigal was held responsible for Roberto's inability to receive dental treatment. Thus, not only children's oral disease but also their behavioral issues are chalked up to farmworker parents' improper caregiving.

In the eyes of health officials, then, Roberto's lack of insurance and his family's lack of income ultimately prevented the Madrigals from meeting the norms of “sanitary citizenship.” Although Roberto's severe oral disease attested to Mrs. Madrigal's low rating on a hygienic scale of “civilized conduct” (Ong 1996:738), the Madrigals' lack of insurance and income precluded their ability to have his teeth restored. As public health officials deduce Mrs. Madrigal's improper caregiving from Roberto's poor oral health, her parenting skills become the focus of both medical and legal scrutiny. In short, public health officials' constant disciplining of Mrs. Madrigal indicate her and her husband's “unfitness” for the task of self-governance, as their perceived inability to care for Roberto reflects on their proper place in the polity.

## Conclusion

Public health officials have historically fixated on different health issues among minority populations at different historical moments, each one speaking to a specific racial anxiety. During the Great Depression, for example, public health officials no longer attended to the high infant mortality rates among Mexicans but, rather, to their high birth rates, playing into white anxieties about the possibility of whites' “race suicide” (Molina 2006:116–141). Meanwhile, during the first two decades of the 20th century, the quarantining procedures for Asian immigrants at Angel Island gave way to exams for “hookworm” and “trachoma,” screening specifically for diseases that might affect immigrants' workforce productivity (Shah 2001:179–203). This is not to dismiss the reality of the incidence and prevalence of such diseases but, rather, to suggest that particular diseases may receive greater attention when they speak to the racial concerns of the day. We note, for example, that despite the U.S. Department of Health and Human Services' issuance of the first-ever “Surgeon General's Report on Oral Health Disparities” in 2000, which proclaimed a “silent epidemic” of oral disease in the United States, high rates of oral disease have long existed among certain subgroups of the population.

We have focused on public health campaigns targeting the oral disease of children of Mexican immigrants as a means of examining what they illustrate about conceptions of immigrant parents' capacity for self-governance. The reduction of oral disease in developed nations is viewed as one of the major public health triumphs of the past century, yet one that has been compromised by persistently high rates of oral caries among certain low-income populations. In public health circles, the persistence of poor oral health among these groups is perceived as what we call a “stain of backwardness,” a deplorable sign of retrogression in an otherwise modern society. More than other common childhood illnesses, early childhood caries is perceived as directly implicating immigrant caregivers as ignorant, lazy, and unhygienic. To public health officials, then, Mexican immigrants' lack of familiarity with preventive oral hygiene practices and their children's decayed teeth amplify their status as “aliens” and visibly symbolize their “foreignness.” This focus on hygiene recalls public health concerns regnant during the first great wave of immigration, when cleanliness was infused with morality and patriotism and served as a yardstick of Americanization (Molina 2006; Shah 2001). Deployed by public health educators in a neoliberal era, proper personal and familial hygiene carries a new moral significance—that of capacity for self-governance. As the welfare state makes the family an instrument of governance (Rose 1993, 1999), the high rates of oral disease among Mexican-origin children reflect poorly on their parents. The oral disease of children of Mexican farmworkers is viewed as a “stain” on their parents' self-discipline, indicating their “unfitness” for inclusion in the body politic.

Health educators' concerns about foreigners' hygiene, and their portrayal of immigrants as vectors of disease, speak to current concerns about self-governance while recalling old concerns, such as popular eugenics. Summoning contrasting images of purity and pollution, hygiene as a public health concern evokes the specter of connected universes of microbial and racial contamination. As hygiene focuses on removing “matter out of place” (Douglas 2002), it maps structural concepts about the social order onto the human body. The concept of hygiene invokes an entity with carefully defined borders that must be preserved from invading foreign bodies, much like the notion of the nation itself. In the discourse of racial hygienists, the nation is but the human body writ large. Public health campaigns that fixate on the hygiene of specific racial groups in turn raise public anxiety about such groups' pollutant effects on the general population. Thus, the study of oral hygiene campaigns illustrates the convergence of eugenic and neoliberal discourse, opening a window onto the haunting of neoliberal governmentality by the old ghosts of experiments in racial hygiene and concerns with racial pollution.

Reports of the declining fertility of white middle-class women early in the 20th century, for example, evoked the specter of the possibility of whites' “race suicide.” To some extent, these old racial concerns have been revived by current anxieties over a new demographic transition, as aging white baby boomers will be replaced by younger, largely Mexican immigrants (Myers 2007). This demographic reality has birthed a new, and equally virulent, eugenic discourse about the physical, moral, and cultural “fitness” of this second wave of immigrants for full social membership (see Huntington 2005). Thus, current demographic shifts in the United States have led to a renewal of concern with the “fitness” of immigrant populations; public health campaigns targeting immigrant hygiene exhibit old-fashioned concerns about “fitness” tinged with a new neoliberal hue.

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