HERE AND AWAY: MOTHERHOOD AND BELONGING AMONG EXPAT WOMEN IN GENEVA, SWITZERLAND

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ABSTRACT

Lindsey Marie West Wallace: Here and Away: Motherhood and Belonging among Expat Women in Geneva, Switzerland
(Under the direction of Michele Rivkin-Fish and Peter Redfield)

The transient space of Geneva hosts a cosmopolitan and mobile population that challenges anthropological understandings of culture, community, and kinship in everyday life. Shrouded in privilege, the world of international expats operated almost invisibly in Geneva. When I asked doctors or midwives questions about them, I heard a dismissive message: "expat women do not have any problems." However, the transition to parenthood is a rite of passage that involved navigating physical, medical, emotional, and social challenges. This dissertation follows a cohort of first-time mothers through pregnancy and birth to explore how their position as expats shaped their prenatal education, care-seeking strategies, experiences, and birth narratives.

Expat mothers built narratives of self and networks of support to manage their experiences of pregnancy and birth in Geneva that redefined their relationships to the local and the global, home and away, and the meaning of citizenship. These communities and identities viewed citizenship as strategic rather than as a mode of belonging rooted in local communities. They turned to each other and the internet for guidance and information about health care during pregnancy and birth. Because they often had private health insurance and economic capital, they looked for care in private clinics, trusting the market-based model of care presented. They wanted the ability to choose providers who would work with them for both pregnancy and birth and speak their language with them. However, Geneva has a robust public health system, and

women faced fewer unnecessary interventions in the public hospital, so choosing private care in this context carried added risk. I argue that expat women were unable to make informed choices about medical care because their privilege created assumptions of competence which led to blind spots in their understanding of Swiss medical culture and systems of care. These elisions left them unable to advocate for themselves during birth.

To my family, without whom this wouldn’t exist.

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LIST OF ABBREVIATIONS

CHF	Switzerland Franc
HUG	*Hopitaux Universitaires de Genève*
ICT	internet and communication technologies
MMG	Mommy Meetup Group
MMO	Major Midwife Organization
Ngos	non-governmental organizations
UK	United Kingdom
UN	United Nations
USD	United States Dollar

INTRODUCTION

This study explores the disjunctures between expat communities and models of belonging built on a transactional model of citizenship and the Swiss model, which centers on integration and focuses on citizenship as a core aspect of membership in a national community, entailing obligations of care. In Geneva, the relative visibility of different groups of foreignness gets created and reified through state categories and policies of health access: migrants, asylum seekers, and undocumented workers are covered under distinct programs that offer different degrees of access to reproductive health care and support for integration into Swiss society. Expatriate communities of highly educated Francophone or Anglophone women "elite migrants" (Coles and Fechter 2008:5) are rendered relatively invisible in this context. The state and medical apparatus consider them part of the general patient population of the city. These women have health insurance or pay for care out of pocket, navigating the health system on their own.

This introduction situates my research at the intersection of anthropological work on gender, reproduction, and mobility. I provide an overview of my research in Geneva, including the methods I used, how I came to study expats and focus on pregnancy, and how I conducted this study.

Dynamics of identity and belonging play out in how expat women seek and receive care during pregnancy and birth. Expat women's status as outsiders who don't need or want to integrate into Swiss society creates a paradox in which these highly-privileged women get less information to prepare them to give birth in Switzerland than more vulnerable migrant women because they are interpellated (Althusser 1971) as highly-functioning mobile outsiders. This

mutual blindness results in expat women often seeking out expensive and riskier private medical care during birth. Looking at expat women's birth narratives reveals the importance they place on finding providers who will speak to them in their own languages and give them personalized attention. However, this strategy ends up posing unanticipated risks because the women end up seeking care in private clinics and relying on individual relationships with their providers to navigate pregnancy and birth.

Studying expat communities is often challenging for anthropologists, as expats are defined by their mobility and their quintessential outsiderness (Redfield 2012). Whereas anthropologists since Malinowsky have been hurling themselves “off the veranda” (Malinowski 1989), studying expats entails embracing and turning towards the people who inhabit and define themselves on the veranda. This dissertation is in conversation with anthropological works that place expats in the context of global migration. This study focuses on the concrete ways that expats positions in the global economy challenges and reshapes ideals of citizenship in the Swiss context, building on insights and questions raised by literature exploring the expat as neo-liberal subject and the messy intimacies of neoliberalism and global migration(Ong 2007: 88, Hannaford 2017).

Why Expats?

While I use the terms "expat" and "international" throughout this dissertation. I do not mean to imply that "expats" are a homogenous or bounded group. In fact, quite the opposite. So then what do we mean when we talk about "expats"? In the anthropological literature, expats are often categorized as people who live outside their home countries for extended periods of time because of their careers.

In contrast to the term migrant laborer, expat implies a high level of socioeconomic status and a professional level job. Anthropologists of migration use terms like "astronaut families"

(Ong 1999) to discuss expats, terms that convey a sense of frictionless motion, of floating above the local context, having no problems, that elide the messy and complicated ways that expats interact with and live in their local contexts in their day to day lives. It might be a coincidence that "expat" and "expert" are so close in sound, but it is an apt pairing. When anthropologists write about expats, they are writing about elite businessmen sent abroad by their corporations or pursuing entrepreneurial opportunities (Ong 2006), humanitarian aid workers with specialized skill sets (Redfield 2012) and diplomats who represent their countries abroad. In contrast, much research on migrants outside of this narrow group focuses on the bonds of kinship and responsibility linking them to their home country, exploring the ways they remain grounded and tethered (Hannaford 2017). In Geneva, while these people indeed are part of the expat community, the term has a particular local meaning.

Studying the ways expats made lives in their communities meant confronting how the systems of inequality and privilege that minimized problems for expat families, that allowed them to overcome the inevitable shocks and difficulties of living in a new place, also made my work possible and propped me up as a participant-observer in that community. As an anthropologist, engaging with my position as a privileged sojourner in the city of Geneva and as a pregnant and mothering researcher became imperative.

Looking at the way expat women navigate becoming mothers and handle the stress of mobility offers a possibility for understanding stratified reproduction (Ginsburg and Rapp 1995) and the ways it creates opportunities and eases reproduction for women at the top. As anthropologists, we can turn our analytical tools to understand the experiences of the privileged, which are hidden and black-boxed. Examining these experiences both allows us to understand the subjectivities of those making the rules and also how people benefit both knowingly and

unknowingly from their social position. Expat models of belonging challenge the universalizing project of democratic citizenship, which is depersonalized and universal (Ong 2007:88). For expat women, successfully navigating becoming mothers was not easy and did not happen just by their social status, but these women through their experiences, background, and habitus possessed tools they used to make sense of their experiences and craft their subjectivities as mothers. One of my informants, Becky, summed up a lot of the themes that came up during this research as women navigated the transition to motherhood.

> As you become a mother, I think, especially while you're at home, however long you're at home with the child, whether it's 3 months or um, 6 weeks or a year, you, your identity changes as you become a mother and you become the caretaker of a small being. And sometimes I think, more so than a man feels as a father, because they're a man and it is not expected of them, you wonder if, you know, you care about them and you love them and everything, but if by giving everything to them, by taking care of them, that you are like, not a modern woman sometimes? You feel a little bit like, "am I like selling out into this retro gender role?" and especially if you're home for a longer time, and you do things around the house, so I think that's probably the biggest challenge, how you view yourself. And I honestly think that by moving and doing it in a city that's new to you, I think it's probably easier. Because, um, you aren't stepping away from something you used to do or how you used to view yourself in the same environment. So you, you have to re-create your identity a little bit so you might as well throw the baby in with it. (Becky, American)

Why Reproduction?

As I developed my project, motherhood became the central focus and lens through which I approached understanding women's lives. Motherhood links women's physical, affective, familial, economic and social experience (Maher 2010). At the same time, "professional nomads are at once situated and circulating, and they embody a kind of market citizenship - occupation-driven, mobile, temporary residence, here today, gone next year - bodies that express the sign value and extraterrestrial reach of the global city itself" (Ong 2007:89).

Pregnancy, birth, and parenting are possibly the most physically and emotionally fraught transitions many women will experience during their lives. I argue that in contrast to being

frictionless for expat families, the physical coming and going of an expat life are complicated and full of friction. This research shows that women, particularly mothers, face the downsides of mobility immediately and struggle with loneliness, dislocation, dependence, and adjustment as they work to build families and identities in Geneva.

The woman as a maternal citizen (Arextaga 2003, Gal and Kligman 2000, Krauss 2004, Rivkin-Fish 2010) is in some ways problematically positioned within the male-gendered realm of the state, even as women are central to the nation. "Whether to treat women as producers or reproducers has been a perennial dilemma, differently handled in different historical moments and systems" (Gal and Kligman 2000:32, Berdahl 2003, Paxson 2004). Reproduction and health emerged as essential sites of contested discourse over gender, family, and citizenship even in the privileged expat world. Examining prenatal education and birth care revealed the ways that contests over desirable personhood and gender performance influenced aspects of teaching and medicine that seemed on the surface to be merely biological or scientific (Martin 1987) Delvecchio-Good 2007).

As many anthropologists have noted (Maher 2010, Cheney 2011, Davis-Floyd 1994, 2003, Rivkin-Fish 2007), birth is a social rite of passage that creates new subjectivities for women as mothers in particular cultural contexts. Robbie Davis Floyd's (1994, 2003) research revealed how numerous rituals in American hospital births have emphasized the central importance of scientific authority and medical power over women's bodies and practices, a topic I will elaborate on in later sections of this dissertation.

The Field

Geneva, Switzerland sits in a small valley, hemmed in by the Alps on one side and the Jura mountains on the other. Its position at the end of Lac Leman and the junction of the Rhone and the Arve rivers has made it a hub of trade since at the Roman occupation of the area.

Politically, Geneva's history is one of a city-state, and although it joined the Swiss Confederation in 1815, before that time, it existed as an independent republic. Since the early middle ages and the end of Roman occupation it was first ruled by the bishops of the Catholic church, and then after the Calvinist reformation by a council of citizens, In fact, it is still officially known as "The Republic and Canton of Geneva" despite being a part of the Swiss nation-State (Zimmer 2003). In addition to the topographical boundaries, the city is geopolitically bounded. Surrounded on three sides by France, it is a little point of Switzerland, more border than interior. Geneva has been the center of an international community at least since the founding of the League of Nations in 1924. Before that, Geneva was the site of the founding of the International Red Cross and our modern idea of humanitarianism. Going back even further, Geneva's history as a center of new ideas and trade dates back to the Renaissance and its role as the birthplace of Calvinism. Rousseau and Voltaire also frequented Geneva and its surrounding areas.

The geography of Geneva is complicated and made more complex by the scarcity of housing and the ways the city spills across the border with France. The ever-increasing influx of international workers strains the city's housing supply and contributes to the "*crise du logement*," an ongoing housing crisis of escalating costs and diminishing supply of housing in the city. The cost and shortage of housing in the city shape everyday life for expats and locals, and families and the state adopt various strategies to deal with it. Housing in Geneva is incredibly expensive, but this on its own is not noteworthy: everything in Geneva is expensive. Geneva was ranked the third most expensive city in the world to live in in the year 2012 and money is discreet yet pervasive in shaping the social life of the city. When international workers come to Geneva, they are paid salaries that keep up with, and arguably raise, the cost of living in the city. In addition to generous salaries, workers often receive apartment subsidies and

relocation assistance to locate appropriate housing and navigate the complicated Swiss housing laws and rental process. Landlords (*régies*) take advantage of the transient international labor force through charging more for short-term leases and turning a blind eye to the subletting economy, through which rooms and apartments are rented for short periods of time to people in Geneva for internships or short-term contracts, undocumented laborers, or other temporary appointments, at many times their original rental cost. The people subletting are transient and cannot meet or do not know the requirements to rent an apartment concerning income, documentation, and stability. Besides, the influx of well-heeled workers and families competing for apartments in the city keeps the demand for flats exceedingly high and allows the *régies* to basically do what they want regarding charging fees, making income restrictions, and selecting tenants.

To talk about Geneva is to talk about both the relatively compact urban core of the city itself, and the broader reaches of the community that spill into neighboring France and are linked by a complex system of trains, buses, and trams, in addition to roads and bicycle infrastructure. "*Le Grand Genève*" is the official name for an ongoing project of coordination between France, the Canton of Vaud, and the Canton of Geneva to integrate public services and transportation. The goal is to increase infrastructure in the larger Geneva metropolitan area across France and Switzerland. Many families, both Swiss and expat, live well outside the city. The neighboring sleepy little villages are now increasingly clogged with traffic and new buildings to house workers for Geneva. While conducting my research between 2011 and 2013, I lived in the town of Prévessin-Moëns and commuted into the city daily for research. I've marked my location with a star on the map of the Canton of Geneva below.

Figure 1. Maps of the city and Canton of Geneva

Geneva is a special place to study both expats and families. Situated on the border between Switzerland and France, it is both a place of frequent coming and going and a city that is very concerned with place-making and community. Geneva is perhaps best known globally as the home of the UN and a representation of Swiss neutrality. Heads of state routinely fly in and out of the city to discuss the important matters of the day, and the city is often in the world-wide news as the site of international declarations and negotiations. However, when we talk about this Geneva, the city itself is erased and denationalized (Ong, 2007:84) and becomes just a backdrop to the comings and goings of the very important foreigners in the city.

> The tendency has been to consider the big city as a denationalized space, a site of universal rights for all newcomers. I propose an alternate concept of the city as a national site that activates neoliberal desires for foreign experts whose presence puts into question equality of access to rights and entitlements. As an interstitial space between nation and the world, the megacity becomes a zone of mutating citizenship, as different categories of migrants are differentiated according to the kinds of tangible or intangible assets they bring to the urban economy. The pied-a-terre is the hinge between a global meritocracy and the megacity. The talented expatriate, poised between staying and going, participates in a kind of dysfunctional marriage that destabilizes notions of permanent belonging. (Ong 2007: 84)

While Geneva is in some ways emblematic of a global city, that does not tell the whole story. In contrast to many cities we think of as being cosmopolitan and representing the jet-setting dynamism of fast capitalism, Geneva is not a mega-city. It is not even a particularly big city. The population of the city of Geneva is just about 200,000 people, and the Canton of Geneva doubles that. In interviews and discussions with people working in the city's government and Swiss friends, they stressed that Geneva was still a "village."

As I'll discuss at length in this dissertation, the value of "integration" - helping immigrants become part of Swiss, and more particularly Genevan, society through learning French and accepting Swiss social practices and values - undergirded a well-developed and complex network of social services provided by the city, canton, and NGOs for migrants in Geneva. This value of integration also came to bear in the efforts that the city made to foster civil society and public life for families. In addition to numerous impeccably maintained parks, public pools, and beaches, the city also funded public spaces specifically for families with babies and small children. Although not explicitly "women only" these public play-spaces and toy libraries were heavily gendered female. The unspoken presumption in Geneva is that when women have children, they don't work, or at least not full time while the children are young. This assumption underlays a strong commitment to fostering inclusion and "integration" for women with young children into public life by providing indoor playspaces and toy libraries as well as other events.

Expat mothers living in Geneva found themselves engaging with these local institutions much more intensely then they did before they had children, or than men. I argue that while these spaces helped them build networks and a sense of community and belonging, women used them to make expat communities based on shared identity, experience, and life-stage, rather than integrating into Swiss communities.

Although the elite UN and diplomatic communities in Geneva were a part of the expat community, it would be a mistake to assume that it was made up uniformly of the elites. Much of the expat community consisted of students and jobseekers drawn to Geneva by the lure of landing a job with the UN or a large multinational corporation. Looking for a job or pursuing an internship or education in Geneva was precarious and offers no guarantees of success. Also, even "securely employed" foreign workers faced high levels of precarity. My interviews were littered with stories of spouses being laid off after the family had moved to Geneva, divorces pushing women out of the city, and sudden moves because of job changes. Studying expats also offered the opportunity to look at a different aspect of mobility. In contrast to refugees and asylum seekers who are forced to flee their home countries, and also to undocumented migrants who often migrate in circumstances that make the concept of "choice" irrelevant, the mobility of expats was often desired mobility, attained through careful effort and strategic use of papers and citizenships. "A popular view of the city stresses its internationalized role in converting immigrants into citizens, if not of the country, then of the city itself." (Ong 2007:84).

Research Phases

I conducted this research in three phases, and my fieldwork approach shifted over time. I centered each phase around discussions with distinct groups of interlocutors, each conducted in different social spaces. I performed this research over a period of four years between 2009 and 2013. Over the course of the project, I used four main strategies to learn about the world of expat women in Geneva: interviews, participant-observation, observation, and embodied auto-ethnography. Each of these strategies allowed me to understand a different aspect of what people say, what they do, and what they say about what they do, and how these core elements of experience relate to and inform each other. I used each method in different ways and with

differing intensity over the course of the research, which I've represented visually at the start of each section.

My perspective over the course of my research was shaped by growing familiarity with the city and by my transition from being a single person in the summer of 2009, to the married mother of a 1-year-old son when I left in 2013. Writing about the experiences of the women I met while becoming a mother in Geneva provided me with many opportunities as an ethnographer, while my own experience inevitably shaped my preoccupations, focuses, and biases. Pregnancy and parenthood indelibly shaped this research. I fought nausea during a lengthy interview in French with a city functionary about integration early in my first trimester. I also learned the ways that people interacted with visibly pregnant women, shielding them from stories of unhappy outcomes in birth, asking "why are you still here?" when I showed up to observe an event close to the end of pregnancy. I experienced the constraints and opportunities of researching while invariably accompanied by an infant.

On the one hand, these experiences offered challenges and constrained the scope of what I was able to study, but in many ways, pregnancy and parenthood made the research possible. I conducted almost all the interviews in phase three of the research with other mothers while our babies played on the floor, napped, or nursed. In addition to the direct experience of fieldwork, living my research showed me that having a child changes everything about the ways women move around the city and interact with others. I could not have foreseen the ways that my pregnancy and birth experience would frame and inform my research, and the degree to which I would become enmeshed and complicit in the world I studied. My experience as an ethnographer was undoubtedly one of fully embodied participant-observation, having a child affected and shaped every aspect of my fieldwork in positive, negative, and unpredictable ways.

This research is an in-depth look at a small population of expat parents in Geneva and explores one kind of mothering and parenting experience. Taking seriously Haraway's (1991) view of bodies as socially constructed rather than biological and "natural" illuminates the limits of this research and what is outside the scope of this project. Haraway is part of a tradition of feminist scholars who speak to the problematic equation of sex and gender and point out that biology is not destiny (Butler 1990, Fausto-Sterling 1992, Oudshoorn 1994, Martin 1996, among others). The population I spoke with was limited to female-identified, cis-gendered pregnant people, but not all pregnant people identify as women. Though this research focuses specifically on pregnancy and birth as rites of passage into parenthood, I do not intend to reify biological reproduction as the only or best way to define motherhood or parenthood, which includes a range of relationships, identities, and activities.

When invoking women's activities as mothers, we recognize the multiple layers of identity, action, and meaning that common conceptualizations of motherhood contain. Motherhood refers to an identified relationship between a woman and her child, but the term simultaneously evokes interactions between women, children, and society more broadly, and encompasses a range of physical, emotional, social and care activities. These activities, which include the biological labor of reproduction, and the cultural and social works of provisioning, care, and emotional relations, contribute value beyond the child and the family to broader social and national goals (Ginsberg and Rapp 1995).

There are many ways to become a parent, and the family itself needs to be defined beyond biological models to include the many ways people build kinship ties beyond biological models of family. Extensive anthropological and feminist scholarship (Emilio and Freedman

1988, Weston 1991, Bowie ed. 2004, Howell 2009, among others) give us tools and models for broadening our understanding of family and parenting.

During the initial phase of this project, I worked as an observer, gathering necessary information on migration and health practices and organizations. Later, my role shifted to become a participant-observer, as I inhabited an identity similar to the women I studied. I conducted the first phase of research over the summer of 2009. The second and third phases of the project happened over the two years I spent in Geneva from 2011 to 2013, separated by the birth of my son, Victor. I became pregnant shortly after arriving in Geneva in the fall of 2011. My pregnancy ended up determining the course of my research in phase two, granting me default access to the social world of expat parents and access to midwifery organizations, but curtailing possibilities for studying aspects of reproduction such as abortion and contraception. In phase three, after I had my son, my ability to participate in structured ethnographic work such as observing prenatal classes and hanging out in clinics declined dramatically. However, I was welcomed to expat playgroups and was quickly able to recruit other mothers and conduct interviews with them about their experiences living and giving birth in the city. Having "been there, done that" gave me a level of credibility and trust that would have been difficult to obtain otherwise.

Becoming a mother during my research also made my research almost excruciatingly intimate, enabling a depth of empathy and identification with my subject I may not have achieved otherwise, and giving me a deeply-felt perspective and insight into the rite of passage I studied. However, this closeness also created particular demands for taking a reflexive approach and thinking through the extent of my auto-ethnographic practice, to avoid generalizing and universalizing my own experience and challenges and respect the limits of my perspective.

Phase 1 (Summer of 2009)

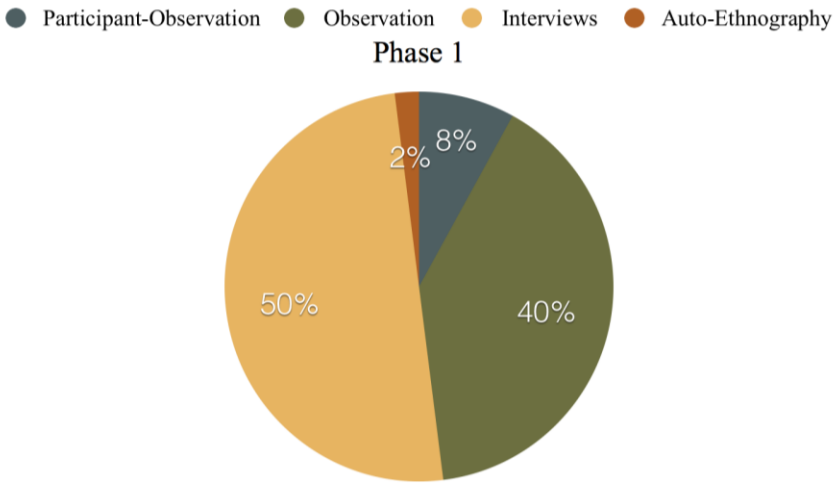

Figure 1. Breakdown of research activities during phase 1 of project

I undertook the first phase of this research during the summer of 2009 with pre-doctoral funding from the Mellon Foundation and Council for European Studies.

My husband's family lives in Geneva, and I had lived there for six months before starting graduate school, but at that time I'd stayed firmly in the anglophone world of the United Nations community while doing an internship at the World Health Organization. My summer research in 2009 was my first engagement with the Swiss community and institutions in Geneva. Instead of staying with my in-laws, I rented a room with a Swiss graduate student. We lived in Carouge, a diverse neighborhood across the city from the UN near the main research hospital. Being physically and culturally removed from the Geneva I knew, I struggled with unexpected culture shock and depression, which Irwin (2007) attributes to the loss of meaning-defining symbols and defines as "the anxiety and emotional disturbance experienced by people when two sets of realities and conceptualizations meet" (Irwin 2007). Since I had lived in Geneva and thought I "knew" the city, when I moved out of the expat bubble, I was surprised to learn how little I knew, and how far I felt from my familiar cultural context. When I returned in 2009, I realized

most of the people I'd socialized with the first time had moved away (my first lesson in the fragility of expat social life). I learned that trying to gain access to the Swiss life of the city and learn about migration and health as an ethnographer was a completely different experience than staying in the comfort of the UN community.

That first summer in Geneva I barely spoke French, as I found out that despite achieving "fluency" in the classroom, I was nowhere near able to discuss anything meaningful or understand the level of French used in everyday interactions. My level of comprehension grew over the summer, and more importantly, I learned how to express a willingness to speak French that allowed me to begin interactions and build trust with interlocutors who then usually talked to me in English or a mix of English and French. Although my French was never excellent, I learned that beginning conversations in French was essential to build rapport and gain access into the professional worlds of Geneva. I also learned that a poorly written email in French asking for a meeting was a lot better than a well-written one in English.

The importance of beginning in French was my first lesson in the tensions and divides between anglophone and francophone Geneva. The people I spoke with over that early summer taught me in no uncertain terms that refusing to try French or insisting on English was unacceptable and disrespectful. However, as I interacted with anglophone acquaintances in the city, I realized they had no concept that speaking English was insulting or anything other than practical. All of these challenges and personal experiences shaped my understanding of the difficulties faced by foreigners living in the city and interacting with local institutions, as well as the social segregation between the Swiss and expat communities and the kinds of efforts needed to bridge those divides.

I focused my fieldwork on interviews with people in the fields of migration and health. I wanted to learn about the Swiss cultures of medicine and understand the lived practices of migration policy to deepen my understanding of the relationships between migration and healthcare. This early fieldwork is where the theme of integration emerged in discourses across movement and health, and when I first began to see the invisibility of the expat communities to the Swiss experts in these fields. My interlocutors did not include the expat populations as people for whom migration posed a health risk, or who may view health through different cultural lenses. I carried out some limited observation in clinical settings as a volunteer with the *Hopitaux Universitaires de Genève* (HUG). Asking for interviews allowed me to build relationships with critical cultural gatekeepers and was often the first step in gaining entry to the organizations and communities where I worked. I conducted three main types of interviews with different groups during my time in Geneva.

My early research efforts hinged on obtaining conversations with people in Geneva working in the fields of migration, government, and healthcare. During my first summer in Geneva and my time living in the city, I was able to meet with key stakeholders, policymakers, and front-line workers in the fields of immigration policymaking at the cantonal and municipal level, immigrant support and advocacy, and health care policy and delivery. These professional interviews broke into three categories outlined below: policy experts, immigrant advocates and front-line supporters, and clinical experts.

Policy experts**:** To learn about the ways that cantonal and city officials thought about and managed the diverse population of non-Swiss residents, I conducted interviews with policymakers and bureaucrats at the *Centre de Contact Suisses-Immigrés*, the cantonal *Bureau de l'Integration* and the Federal Office for Migration.

Immigrant advocates and front-line supporters: In Geneva, there is a robust community of over 460 non-governmental organizations (ngos) working in the areas of migration, health and integration. During my first summer in Geneva, I conducted interviews and built relationships with staff and managers at some of them. I spoke with teachers at the Worker's University of Geneva, a non-profit offering French courses and job training to low-income people and immigrants, where I learned about how they were trying to help their students manage precarity and navigate social services in the city. I interviewed the director of Camarada, a venerable organization run by Swiss feminists whose mission was to help migrant women integrate into Geneva. Our conversations led to my volunteering with them during stage two of my research and also profoundly influenced my understanding of how the value of integration translates into care, services, and support for migrant women in Switzerland. I also spoke with counselors at Appartenances, a small six-person community psychiatry practice funded through grants from the city and the university that worked extensively with patients dealing with psychological problems from their experiences migrating to and living in Geneva as foreigners. At Appartenances I learned that despite the many languages spoken in Geneva and the robust infrastructure to support migrants and help them integrate, they were unable to access interpreter services for their patients due to cost and had to send away anyone who needed an interpreter. This restriction primarily affected patients who spoke indigenous and non-European languages, as they had staff conversant in most languages spoken in Western Europe, as well as some Slavic languages. The providers I spoke with were passionate about helping their patients. They expressed a sense of injustice at the tightening of migration laws, particularly around asylum and refugee status, and the financial constraints that prevented them from serving their patients as

well as they wanted to and allowed them to accept only a third of the patients who came to them seeking care.

Clinical experts: My understanding of the health care system came from extensive interviews with health care providers in three main sites that taught me about different kinds of care: The HUG, offsite programs for migrant health, and the Major Midwife Organization (MMO).

The MMO was the central organization for midwifery care in Geneva. I conducted interviews with senior midwives who focused their practice on non-Swiss populations, including the midwife who founded and taught the migrant prenatal course "*Maman à Genève*," and midwives who specialized in caring for anglophone and hispanic women before and after birth, and who taught antenatal courses targeting these groups. My interviews at the MMO were the beginning of a long and fruitful practice of participant-observation in the prenatal classes they offered and at the MMO itself. My conversations with midwives taught me about the role of midwifery in pregnancy and birth in Geneva, as well as the ways that midwives conceptualized birth as a rite of passage and problem of integration.

At the HUG I interviewed gynecologists and administrators, particularly in the maternity and family planning clinics, as well as the UMSCO clinic which provided outreach care to underserved populations on a sliding scale from the hospital and offsite. My interviews with doctors and health care providers at the hospital allowed me to understand the ways the public hospital worked. These conversations revealed the ways doctors experienced migrant women as particularly vulnerable and problematic patients but positioned expat women entirely outside the scope of those facing problems of migration and health. Since HUG is a teaching hospital, the doctors I spoke with who worked extensively with migrant patients were actively shifting the

medical training they provided to include issues of intercultural communication and difference and the specific problems caused by the intersectional stressors of gender, culture, and migration for their patients. The doctors I spoke with helped me understand a Swiss medical culture that they thought was shifting from a paternalistic culture of medical authority to one that was more patient-centered.

I also conducted interviews at offsite clinics affiliated with the hospital serving exclusively migrant populations. At the *Programme Santé Migrants* I interviewed nurses and observed visits, and at the *foyer d'asile* (detention center for asylum seekers), I conducted interviews with nurses and doctors and shadowed a nurse visiting residents for health checks. Interviewing staff and observing interactions with patients at these locations provided insight into the everyday interactions through which they provided care to the city's most vulnerable residents. Through spending days shadowing nurses and doctors as they worked with patients, I observed the things that went unspoken in conversations about care and integration of immigrants. The *foyer d'asile* changed my perspective on Geneva's migration policy and revealed the limitations of Geneva's willingness to invest in care for asylum seekers.

From field notes:

> We walked down the hall full of gear, strollers and car seats, and walked into the basic industrial looking kitchen where a woman offered us rolls she had just baked. This woman had just made these rolls in this dirty, hectic kitchen and was living in this loud, oppressive, claustrophobic place and she offered us her food. Following the nurse's lead, I thanked her and politely refused. 60 people lived on this floor and shared this kitchen. Residents had lockers to store their food, one resident a month was responsible for cleaning the kitchen. It had two stove/ovens and metal sinks and refrigerators. Outside of the kitchen, the nurse insisted I had to see the shared bathroom to understand the hardship of the people living there. It was horrific. Dirty and overwhelmingly stinking of urine. There were five stalls, a mix of Turkish and Western toilets, all disgusting. Here, there was another group of African men giving each other haircuts. One addressed us over and over again, but I could not understand him. We went into a woman's room. She looked like she was in her late 30s. She had high blood-pressure though on this visit it was

> better than it had been the last time the nurse visited. Earlier she had grabbed her 2-year-old daughter and dragged her off from where she stood with us. The nurse explained that the woman was terrified for her daughter and worried about keeping her safe from groups of men. As the nurse took her blood pressure and we chatted, another woman washed her son and made him ready to take a nap. After the appointment, we walked out, and I thanked E. for allowing me to come with her. It has taken me a few days to write these notes. The building was by FAR the worst place I have seen in the entire city of Geneva, a town that maintains perfect floral arrangements in every public park. It is true that asylum seekers have access to medical care and counseling provided by the state, but there is a lack of political will to give them better conditions or help them leave the *foyer*.

I learned through my conversations with the nurse and with others in Geneva that the state of the *foyer* was deliberate, both a response to anti-immigrant political pressure against spending money on housing migrants, and a conscious effort not to make their accommodations "too nice" to discourage them from returning to their home countries.

My experience being in these places and talking to the providers who ran them and the researchers they worked with began to seed my discomfort with the ways that vulnerability and poverty shaped the populations available to study. The regular exchange of services or privacy and information led me to question the ethics of observing these settings as an anthropologist. I felt like an additional pair of eyes who could offer no immediate benefit to these patients through my presence. It also revealed the ways that the expat community existed outside of the conversations about migration and health happening among experts in Geneva because expat women were defined by their position of privileged outsiderness and independence.

Phase 2: Fall 2011- July 30th 20

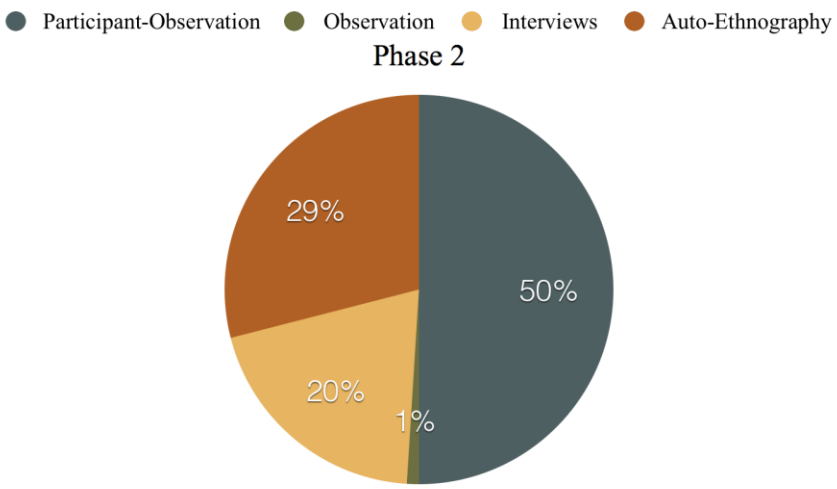

Figure 2. Breakdown of research activities during phase 2 of project

The second phase of this research began when I returned to Geneva with my husband in the fall of 2011 as a visiting doctoral fellow at the Graduate Institute of Geneva and continued until July 2012. I initially focused my efforts on reconnecting with the NGOs and midwives I met during phase one. On returning to Geneva, I enrolled in a 2-month long intensive French course and began volunteering in the *crèche* (daycare) at Comarada, which I did until June 2012, when they told me I was too pregnant to keep coming in. Upon returning to Geneva, I reconnected with some of the doctors I'd met during the first phase of the project to discuss a more in-depth ethnography. The harder I worked trying to gain access to "migrant women" in Geneva, the more discomfort I felt with the ways they were available to study because of their social position. The poor, the undocumented, the marginalized, the refugees and asylum seekers were the focus of extensive scholarly research and targeted by the harsh glare of multiple levels of state-surveillance. Social programs and interventions structured their lives and came with research studies that obligated them to share more of their stories, tell more about themselves to the scholars and officials running the programs they relied on to navigate the city.

As I worked to re-establish connections and gain access to the multiple organizations focused on researching and aiding these women, building up networks with the scholars building their careers on their stories, I felt a mounting sense of discomfort. My pregnancy and the contrasts I started to observe in the kinds of care deemed appropriate for expat and migrant women heightened my unease. I was able to attend prenatal classes for migrant women as a participant observer and get to know some of the women and the people running the program.

I learned I was pregnant a month after returning to Geneva, which shaped the trajectory of my research. I quickly learned there were some topics of conversation that no-one was willing to discuss with a pregnant person in Switzerland[1]. I also learned that pregnancy inspired people to spontaneously share their thoughts, memories, and feelings about the process of giving birth and transitioning into parenthood. These stories and conversations contributed to my interest in examining birth as a social rite of passage. My pregnancy eased my experience as an ethnographer working with the midwives and observing prenatal classes, and it allowed me entrance into private and digital communities of expat mothers and expectant parents in Geneva.

This phase of research centered around participant-observation work with the MMO, including six weeks of antenatal classes for migrant women (from April 20th-May 26th, 2012 and June 8th-July 10th, 2012) and a session of the English language prenatal course (May 5th-June 12th, 2012). The first course was taught in French and translated. Women from diverse linguistic backgrounds, ranging in age from fifteen to their early forties participated. No men were

[1] A prevailing view in Switzerland is that stress in pregnancy is hazardous for both maternal and fetal health, and people actively try to avoid upsetting and scaring pregnant people by giving them information that might make them worry about their health. Therefore adverse reproductive events such as abortion and miscarriage were taboo topics of conversation during my pregnancy. Preventing stress on the pregnant body informs Swiss parental leave practices: women are expected to stop working and rest for the eight weeks before birth unless explicitly cleared by a medical provider.

allowed, including male partners, but some women attended with female relatives. The instructors were two senior midwives from the MMO.

The second course was taught in English and attended by a small group of couples. To try and address the ambiguity inherent in being visibly a participant and also a researcher in these courses, at the beginning of each session I identified myself as an anthropologist, and briefly explained my research interests in French or English. I'd ask for permission from the group to observe and take notes and show my notebook. As I discuss in chapter three, I wound up providing ad-hoc translation during the migrant course, because when a translator was absent, many of the women participants were more comfortable in English than French. As I also discuss in more depth later, I had very different kinds of permission to record in these two courses, an experience which informed the line of questioning I pursued in phase three of this research. In the English language course, the instructor welcomed my participation and permitted for me to conduct my research there and discuss the course, but in the interest of protecting participant confidentiality and creating a safe space, she asked I not record any specifics of individual participation in the class, people's questions or concerns. Because of that, the participants in the course I describe are the ones who became vital informants and whose stories and experiences I learned about during one on one conversations outside of the course setting.

Experiencing the differences between these two courses, their goals, and approaches informed my perceptions about diverse women's experiences in Geneva, and contributed to shifting my focus to the carefully guarded experiences of expat women. I was also living this experience first-hand as I chose medical care and experienced all of the medical care needed during a relatively straightforward pregnancy.

During this phase of the research, I continued conducting interviews with policymakers in the fields of migration, gender, and health in Geneva. I also joined some online parenting groups which hosted events to help expectant and new expat parents connect with others in the city. As I continued in my research, I began to implicitly compare my experience as an anglophone, white, pregnant foreign women to the experiences of the pregnant "migrant" women I was meeting through my research, and "unofficially" to the expat anglophone community. This perspective brought into relief the ways that class and identity shaped the kinds of care women received and the different extents to which they were expected to integrate into Swiss society.

As my pregnancy progressed and I met more and more English-speaking expats in Geneva, the contrasts in the experiences of the two groups of women I was moving between as I did my research and prepared for my son's arrival stood out to me. I was struck not merely by the sharp contrasts of wealth, education, and status, but also by the disparities in the degree of privacy these distinct groups enjoyed, and in the extent to which scholars and officials were interested in what these respective groups of women were doing vis-à-vis their health and family practices. As I worked with migrant women and the complex structure of NGOs and official offices that served and researched them, I felt increasingly intrusive. I could neither help migrant women in any meaningful way nor contribute anything to scholarship on their experiences in Geneva. There was already a thriving community of intercultural psychologists, anthropologists, sociologists, public health researchers, and medical doctors interviewing them about every aspect of their experiences as migrants and with pregnancy, birth, and motherhood. As an anthropologist, I represented just one more level of surveillance, not necessarily welcome, that they tolerated as the price of accessing health care and social and educational resources.

The course for migrant women and the English prenatal course differed significantly, which I explore in chapter two. While the class for migrant women had multiple researchers in the room, on the first day of the course for Anglophone women, the midwife asked us to not speak of what happened in class to the outside and to preserve the confidentiality of our classmates, to create a safe space for people to discuss their experiences. I realized that in stark contrast to the women who relied on the state to provide them with healthcare, the experiences of expats, who operated in a privatized system outside of the scope of "interventions," was completely opaque. Because of my connections and position in the city, I had access to this community that was unusual and provided an opportunity to “study up” (Nader 1972) and investigate the ways that stratified reproduction (Colen 1984) shaped the experiences of elite expat women in Geneva.

Studying the ways expats make lives in their communities means understanding digital as well as physical community spaces. As an anthropologist, engaging with my position as a privileged sojourner in the village of Geneva and as a pregnant and mothering researcher made me uncomfortable but became increasingly urgent as I continued to structure my project.

As anthropologists, we have the opportunity to show how structures of inequality shape the lives not just of the marginalized, but also of the privileged. Anthropology of privilege, studying up (Nader 1972) allows us to understand how some people benefit from structures of inequality that constrain others. Also, it seems that an aspect to highlight (which could fall under "benefit" but seems to be worthwhile to emphasize separately, as it is not experienced directly as "benefit") is that those with privilege are shielded from and unaware of the inequalities that exist and therefore of their relatively privileged status.

Phase 3: July 30th, 2012 - Fall 2013

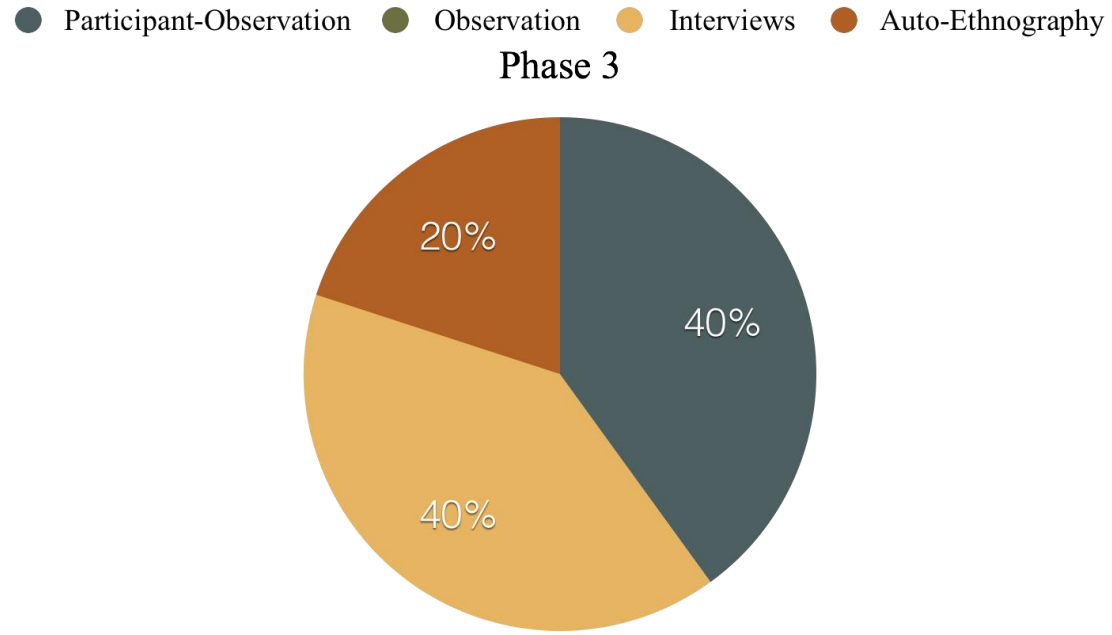

Figure 4. Breakdown of research activities during phase 3 of project

In phase three of my research, I left behind researching the systems that structured migration and health in Geneva. I shifted my focus to understanding the private worlds of the individual pregnant and parenting people living in and navigating these systems. During this phase of the project, I gathered most of my data through a mix of interviews, participant observation, and reflecting on my own experiences. When I started my research among privileged expat women having babies in Geneva, I expected to run into the types of stories and experiences chronicled by Betty Friedan in The Feminine Mystique (1963) with an added dash of culture-shock (Irwin 2007) and homesickness. On the surface, the situation in Geneva for many expat women resembled the context of mid-century middle-class America. Swiss social structures assumed a single-income patriarchal family resulted in, among other things, inadequate resources for early childcare in Geneva. The difficulty many expat women found in finding work both because of visa restrictions and language and cultural barriers meant women

were often at home or working part-time while their children were young and as their husbands or partners pursued demanding full-time careers.

Social activities for expat women in Geneva were almost entirely sex-segregated and most mothers' days revolved around childcare. As I began my interviews and spent more time in the expat community, I was surprised to see that my expectations of quiet desperation were often wrong. In the course of my research on mothers, I came to know women from many backgrounds, and a few, such as Ruby, Clarissa, Eliza, and Diana became key interlocutors, and their voices appear throughout these chapters. Women often talked about how they loved living in Geneva, the unique opportunities they seized living away from home, and the sense of adventure and excitement that they felt learning to manage a strange city. They were actively building social worlds in the city, and their inability to work was as often a welcome break as a stifling loss. I also heard many narratives of moments of feeling scared, unsafe, alone, isolated and adrift. Women relied on community resources both online, such as the online "expat mommy's group" and "expat site" as well as physical community spaces such as parks, city-run play-spaces, the midwives' organization, and private department stores as meeting spaces. Children's classes were essential sources of support and networking to maintain dynamic social lives and make mothering in Geneva enjoyable.

In addition to many informal chats and conversations, I conducted twenty-five semi-structured interviews with pregnant and parenting women in Geneva. Each meeting lasted between one and three hours, and focused on the women's lives, migration history, move to Geneva and community there, as well as their pregnancy and birth experiences and lives as parents in Geneva.

These interviews captured women's histories and travel to Geneva, family structure, and professional status. I asked them about how they found medical care before, during, and after their pregnancies for themselves and their children, focusing on how they found information about providers and how they chose who to see. These questions illuminated the importance of shared language to building trust with medical providers and pointed to the significance of the figure of the physician guide during pregnancy and birth, as outlined in chapter three.

During the interviews, we discussed the participant's experience giving birth, which often became a detailed story. The women I spoke with loved telling their birth-stories. These stories were meaningful to them, capturing their experience of physical pain, joy, fear, and transition. Women framed these narratives in terms of their sense of agency through the process, medical complications, and degree of happiness with the outcome. I discuss these narratives in depth in chapter three. I built my understanding of how these women viewed their relationship to the Swiss state and integration into Swiss society through our conversations about childcare, plans to stay in Geneva, and the regimes of paperwork involved in navigating questions of citizenship and residence in Switzerland.

The women I spoke with included friends and acquaintances I met during phase two and through parent-focused events, women I met through personal connections and referrals, and women I recruited through internet forums aimed at both the general expat population and at targeting expat mothers in particular. In the course of my interviews, I found that expat women viewed managing mobility and distance as a central problem and preoccupation as they became mothers. Far from being something frictionless or smooth, they devoted vast amounts of time, resources, and energy into managing their dislocation.

I conducted participant-observation fieldwork in many settings both physical and virtual during this phase of the project. Since I had a baby with me at all times, I socialized with new expat mothers and their children daily through informal playdates, interview sessions, walks around the city, and visits to the indoor play-areas and parks. I also participated in a few types of formal events for mothers. The digital expat parents' group in Geneva discussed in chapter two ran many activities such as lunches, dinners, and structured coffee and play-dates. There were English-language baby-friendly exercise classes for moms run by a Scottish expat where the participants brought babies who rolled around on the floor. I attended events like this at least weekly.

Conducting this fieldwork while pregnant and parenting as an anglophone person in Geneva positioned me in very defined ways while creating many opportunities. Following Haraway in thinking of the scientific (anthropological) gaze as embodied, grounded in an individual perspective, reveals that knowledge is always partial and situated. Far from discounting the anthropological endeavor, Haraway claims that viewing knowledge as situated "allows us to become answerable for what we learn how to see" (Haraway 1988:183). This view of reality and knowledge as situated and partial, positions actions born from situated knowledge as fundamentally interactional rather than dominating.

My relationships with the people I talked to and the city I studied were inescapably shaped by my social position and physical reality, in ways that were impossible to ignore or discount. These factors inform any anthropological inquiry, but the constraints of parenting made it explicit for me. Moving around Geneva with an infant in a stroller showed me barriers to mobility, experiences that shaped my understandings profoundly but would not rise to the level of explicit conversation or discussion in interviews. Navigating the social isolation and

emotional and physical turmoil of new parenthood with my research participants changed the way I researched by positioning me within the study as a participant as well as an observer.

Haraway's image of people as enmeshed in complex networks of connection, inequality, technology and sociality offered a way to think about embodied experience and culture. Haraway views bodies as more than material, not coterminous with singular biological entities. Bodies are both biologically and subjectively created, historically through structures of domination, semiotics, and meaning. To her, feminist consciousness involves painful awareness of how history constructs our bodies through forces partially beyond our control that are nonetheless part of us and implicated in our being (Haraway 1988). Understanding people as interconnected, involved in global structures and networks of circulation of power and capital, engaged in the semiotics of self-presentation, while negotiating identity and the limits of their bodily possibilities, provided guidance in thinking through the complex social worlds and experience of expat mothering in Geneva.

Through these three phases of research, I built an understanding of the social worlds of expat mothers in Geneva, and how they created communities through their identities as outsiders, living in Geneva but never calling it home.

Overview of Chapters

I begin Chapter One by exploring the communities that expat mothers build through virtual and physical gatherings and how they form identities outside of the framework of citizenship and belonging, based on mobility. I examine the place of internet and communication technologies, (ICTs) in expat mothers' lives and the digital spaces which provide frameworks of information and belonging as they navigate the gendered space-time of Geneva. I look at how these sites offer spaces for women to make local connections with other women based on shared experiences, and how women use them to seek information and reassurance from global

communities of parents through international websites, as well as maintain ties with their home countries and extended families. While scholarship often focuses on the ways immigrants and migrants use Internet and Communication Technologies to maintain ties with their home countries, this study focuses on how women used these technologies to create communities in their local context with others in similar situations and life stages. For expat mothers in Geneva, there was no clear line between the digital and real community spaces they built in the city as they navigated their cities with their phones in hand. Conversations, relationships, and events moved seamlessly between the two. I argue that through the communities they built online and in real life, and their work building families in Geneva, expat women made an understanding of citizenship as a personal form of capital. In this model citizenship is valued primarily for the possibilities it opens up for future mobility, and the locus of value is identity documents. These communities and this way of engaging with Geneva and Switzerland shaped the ways that women found medical care during their pregnancies, normalizing and promoting care in private clinics while positioning the public hospital outside of the scope of desired birth locations.

Chapter Two delves into Swiss conceptions of citizenship, belonging, and family. I begin the chapter by looking into the ways that Swiss bureaucracy around birth certificates enforces Swiss gender norms. Women managed the constant and mundane demands for paperwork from the bureaucratic bodies that regulated mobility both on an international scale and on the level of daily life. The bureaucracy of everyday life is exceptionally intense in the context of Geneva, Switzerland. This bureaucracy rewards integration and conformity with Swiss social norms of gender performance and family formation, norms that fell unevenly on women. I then examine how Swiss values of integration inform prenatal education for migrant women, and how the

private courses attended by expat parents focus on personal relationships and market-based healthcare rather than encouraging integration.

In Chapter Three I examine how expat women navigated and narrated birth as a rite of passage and the specific kind of relationships they developed with their physicians and hospitals. My research examines how women navigated becoming mothers in what are often extremely uncertain situations in the city through embracing a consumer identity and placing their trust in private doctors. I discuss the contrasting approaches to prenatal education offered to migrant and expat women, and the strategies expat women used to limit their engagement with the Swiss medical system during birth. This chapter reveals the ways expat women stood outside of Swiss concepts of "integration" and were not often encouraged to learn about Swiss practices during their transitions to parenthood. For many expat women, this resulted in a sense of safety and control that was illusory during labor and delivery. Because they often did not understand how to interact effectively with healthcare personnel in the Swiss hospitals and clinics and did not realize how Swiss medical practice differed from other localized versions of biomedicine, they were unable to question their provider's decisions. For many women, this resulted in the sense of lost agency and failure that was traumatic. Expat women did not make stupid or careless choices around care, but their strategies for navigating Geneva and forming communities of support created blind spots in their understanding of Swiss medical culture. They searched for information to make birth decisions through English-language websites and forums, they often interacted with and sought advice from other expat mothers, and when they took prenatal education courses, they worked with instructors who viewed them as highly informed and competent subjects who needed support during the social transition to parenthood rather than information about how to find quality healthcare.

In my conclusion, I discuss possible implications of this research, as well as raise questions that lay outside the scope of this dissertation but warrant further study about how expat women's models of belonging might shift over time as their children grow up and start negotiating their own identities and needs for communities.

CHAPTER 1: GENDERED SPACE-TIME AND MOBILITY AS IDENTITY

Introduction

The expat women I studied managed mobility always only contingently at home in Geneva. I argue that being an expat and being "away from home" became integral parts of these women's subjectivities. I examine how they defined their identities as parents and created communities of support. From looking at movement in the broader sense, I review how being expat informed the daily lives of women in Geneva and the communities they formed to manage the particular challenges of this kind of "frictionless" mobility. I argue the communities that these women formed, while offering valuable support and reassurance, inhibited their ability and desire to learn how to navigate Swiss social life and norms. These isolated communities shaped the ways women viewed the Swiss healthcare system, encouraging them to value market-based relationships and shared language, and avoid the public hospital.

The mobility women experienced was often tenuous, tense, and the product of untold hours of women's invisible intimate labor. Anthropologists think of expats as an easily mobile group. "One of the starkest divides falls between people who travel easily and people who do not. At the most literal level, those equipped with funds and the right documents pass lightly over borders, whereas the poor and undocumented incite security concerns. […] With a few exceptions (e.g., Fechter 2007) the easy passage of the privileged largely escapes notice." (Redfield 2012:358). Delving into the experience of these expat communities reveals the ways that mobility is uneven and gendered within expat communities, as well as the behind-the-scenes work to maintain and manage movement and family life. Women's mobility is historically

problematic and viewed with official suspicion (Salter 2003:95). The women in my study engaged deeply in administrative, organizational, and care-work to create communities around mobility and manage questions about citizenship and belonging.

This experience provided them opportunities to construct creative identities and communities apart from both the local Swiss community in Geneva and what would be expected of them in their home countries. In this chapter I draw from work in feminist geography on the gendered ways space is coded and created and the ways that power and identity shape possibilities for mobility. This work shows us that "place itself is a process that makes and is made by migration" (Silvey 2006: 71). Expat women I spoke to were preoccupied with managing mobility, and it was often their full-time occupation. Their invisible labor made mobility look effortless. I argue that the communities mothers built became critical sites for producing belonging outside of citizenship, which the women viewed as social capital to be strategically acquired, rather than a mark of belonging.

> Whereas earlier anthropological approaches to reproduction tended to focus on how reproductive practices and beliefs *reflected* social and cultural systems, scholars now argue that anthropology can benefit from viewing reproduction itself as a key site for understanding the ways in which people *re*conceptualize and *re*organize the world in which they live (Van Hollen 2003, p. 5; emphasis in original, in Kaufman & Morgan 2005:322).

The expat community in Geneva maintains a scaffolding of resources that help people meet each other, find housing, learn about the city, and navigate the various institutions and bureaucracies that regulate Swiss social life. The primary sources expats use to navigate the city are websites including groups organized through meetup.org and forum sites like Glocals. In addition, there is an ecosystem of services and businesses that cater to and are often run by expats such as a groupon-like discount site and a constellation of entrepreneurs catering to various needs within the community. All of the expat mother's groups I worked with were

founded and maintained by expat women and mothers who used their own experiences and needs to inform their business and community building endeavors.

Expat Strategic Citizenship

High-status migrant (expat) women living in Geneva, Switzerland thought strategically about citizenship for themselves and their children. I argue that for the multi-national and highly mobile group of women I interviewed, citizenship carried little to no sentimental meaning and was instead primarily a form of expensive social capital (Bourdieu 1986, Hannaford 2017). The legal and bureaucratic structures that shape possibilities for movement provide the framework for understanding how being away from home shapes women's lives in Geneva. Even for families planning to live indefinitely in Switzerland, the desirability of Swiss citizenship rested on whether or not they already possessed a passport that would allow work and residence in the Schengen area, rather than an interest in integration or participation in Swiss political and civil life. This strategic approach to citizenship conflicts with the emphasis in Swiss law on integration, following Swiss norms of behavior, and engagement with the Swiss political system. Ever-tightening restrictions on claiming citizenship in Switzerland reinforced the divide between the expat community and Swiss civil society.

For international families in Geneva where the parents possessed different citizenships, only those that were advantageous and high-status were passed down to children. These women pursued citizenship status based on ensuring or improving future mobility, work, and educational prospects for them and their children. Expat mobility is comparatively “frictionless," and expats move over borders more easily than most migrants (Ong 2007:98, Redfield: 2012:358). However, for the women in my study managing regimes of citizenship to create and preserve their families’ possibilities for mobility was a central problem. Citizenship became strategic and fraught, in the context of reproduction and parenting. Correctly managing newborns' documents

influenced their options for movement around the world. Strategically managing citizenship and identity documents was an integral part of becoming a parent, a shared rite of passage in the expat community. Examining how expat mothers strategized citizenship and mobility provides a space to explore the changing and stratified relationships between the individual, family, state, and nation.

Expat women in Geneva often discussed citizenship decisions in our conversations about their experiences forming families. In her book, Flexible Citizenship (1999), Aiwha Ong explained the changing value of mobility in the current globalized moment: "Flexibility, migration, and relocations, instead of being coerced or resisted, have become practices to strive for rather than stability" (Ong 1999:19). In her book on Senegalese migration and marriages, Hannaford (2017) positions migration as a signature way of belonging and navigating the global inequalities of neoliberalism. In this moment, state power and citizenship become another form of symbolic capital (Bourdieu 1989) strategically deployed by transnational people in the pursuit of liquid wealth. Indeed, the expat women I interviewed in Geneva spoke of citizenship in nearly exclusively practical terms. During my interview with Diana, a Columbian woman who had left Columbia as a young person and been living abroad in Spain and England since she was in college, I asked her where she got citizenship for her daughter.

> Diana: It was, we have to register here in our nationalities, but I decided I don't want her to have the Columbian nationality. She only has the British one. Because for me, it's not that I don't like Columbian stuff, but for me, it's been a problem. It's always like, 85 countries ask a visa for you to enter, so it's like, why am I going to do that to my daughter? You know? So no, I decided I did not want her to have that passport. So, she has a British one.

Diana viewed her Columbian citizenship as a burden, and something that would dis-advantage her daughter in the life she wanted for her spent in Europe and hopefully in Geneva, rather than in Columbia or with strong connections to Latin America. Since Switzerland joined the

Schengen zone for the free movement of people within the EU, having a western European passport entitles the bearer to live and work indefinitely in Switzerland[2]. In addition to the freedom to move around Western Europe, Diana chose her daughter's nationality to ensure she had maximum flexibility and access to mobility and travel in her life. Similarly, Samantha was not interested in Swiss citizenship for herself but considered it to solve a problem for her son caused by the restrictive residency requirements of the UK.

> Samantha: I'd have to do some more research to see what the benefits (of Swiss Citizenship) would be. I can't see any benefit. I think for Robert though it is important. I mean he was born here, and also if we did stay here long term, one thing I learned recently is he would not be able to count on British or Irish nationality unless he lived for some significant, like 5-year period in those countries. So, we have a few friends who now are caught in between or else if they have Swissness that they have to pass on, so if it would help him to be Swiss, but I don't think so. So more, I think I'd want it for Robert than for us. (Samantha, UK expat)

Performing for Papers

Swiss expectations about gender and family infuse the processes for obtaining any Swiss identity documents for newborns, from a birth certificate to citizenship. Expat families must navigate multiple systems of bureaucracy to obtain first a Swiss birth certificate, then the identity papers they need to establish citizenship for their children in their home countries. Although children born in Switzerland have no right to Swiss citizenship, obtaining a simple birth certificate means performing Swiss family life. In Rites of Passage: The Passport in International Relations Mark Salter traces the history of the passport, and how it assumed its position of prominence. He makes the case that the inspection of papers stands in for the inspection of

[2] Although, since the referendum on the 9th of February 2014 instilling quotas for foreigners passed, Switzerland's continued participation in the Schengen accord is unlikely and the value of Western European passport will shift, though likely not diminish.

bodies to determine the legitimacy of traveling people at border crossings and that the two are intimately bound (Salter 2003:95). He contends that:

> The modern passport does not certify the "security" or even "identity" of the bearer; the passport certifies only that the document of the passport is identical to other documents. The accumulation of papers and documents creates the identity. (Salter 2003:93)

If birth certificates are foundational papers that create personhood and identity for states, then Swiss requirements for documentation and family naming regulate not just the personhood of citizens, but also exert control over the personhood of infants born in the country. Families having infants in Switzerland do not receive citizenship for their child, yet they must submit to the inspection of the state and conform to its expectations. Expat families juggle multiple requirements as they strategically pursue passports and papers, performing different norms of family and personhood simultaneously for different official gazes. In this context, “The passport becomes a solution to the problem of nationality and the problem of porous borders” (Salter 2003:96).

At the time of my research, women in Switzerland were legally obligated to take their husband's last names when they got married, and children could only be given their father's last names in married couples. These rules caused many problems for families and particularly women. Although a benefit of giving birth at a private hospital was that they registered the birth, this did not work in the many cases that families did not conform to Swiss expectations. My experience illustrates the conflicts and performative requirements to obtain an identity for a baby born in Switzerland.

Although my husband and I had been married for years when our child was born, and I had his last name (conforming to Swiss law) it took us six months and many visits to the municipal hall of the suburb where he was born to obtain a birth certificate for our child. As

anxious first-time parents, we researched the requirements for obtaining a Swiss birth certificate online and made sure we had the correct documents. We entered the hospital prepared with original copies of our marriage certificate and both of our birth certificates. We also brought our passports and visas for good measure. The woman at the hospital took all of our documents and told us we'd get a birth certificate in a few weeks. Instead, we were called and summoned to the municipal hall to discuss our papers. There was a problem with our marriage certificate. The clerk had been researching and had learned that there was no "Boston County," which was what the clerk in North Carolina had listed as my husband's county of birth since he didn't know the name of the county where he was born.[3] The clerk needed us to obtain a new marriage certificate and correct the error. Besides, I only had an American Certificate of Birth Abroad (I was born in Germany), and they needed an original birth certificate from Germany. I explained I'd never had one, and pointed out that the baby's birth certificate would not entitle him to any legal status in Switzerland, asking, "is this necessary?" The clerk coldly informed me that if they were not confident we were who we said we were, they could not determine that the baby was who we said he was, or that we were his parents. This logic didn't make much sense to me, but I knew better than to argue. I went home and found one English-speaking person in the Frankfurt city hall on the telephone then asked them to send me a copy of my original birth certificate. That was the moment I learned that American military hospitals in the 1980s were somewhat lax on record-keeping procedures, and in fact, neither my parents nor the hospital had not registered me in the Frankfurt town hall. To obtain a birth certificate, I'd need to send my parents' marriage certificate, birth certificates, and divorce certificates to Germany. Eventually, I tracked

[3] In Massachusetts, where my husband was born, official documents expressed location by township, and the county is irrelevant. In North Carolina, where we were married, the county was the crucial geographic distinction.

everything down and sent it off with the help of family around the globe. During this time, the clerk had decided that Alex's birth certificate was not good enough and we'd need to present a more recent original, which he began working on getting from Massachusetts. Finally, we triumphantly returned to the town hall with all of our expensive and hard-earned documents, only to be told that since I'd kept my maiden name as a second middle name, I'd need an affidavit from the American embassy stating that this was allowed under US law. The clerk said there was no way she could prove this was my official name as this naming practice was not permitted under Swiss law. I showed her my passport with my name on it and the American seal: "Look, it is on my passport." "Ah, but passports are not official documents that prove identity," she responded. I stopped arguing. I booked an appointment at the "America Center" in Geneva and paid 50 CHF to have a confused American official put a stamp on a handwritten note that said, "I, Lindsey Marie West Wallace, certify that my legal name is Lindsey Marie West Wallace and that this name conforms with American laws and regulations." I returned the stamped note to the municipal hall, and they said they'd send the file off to Bern for approval. A few weeks later we received Victor's birth certificate and began the comparatively lax process of getting his American passport and Certificate of Birth Abroad. After six months of living in a foreign country with our child a non-person and eight months of him living without any proof of citizenship, we managed to get his documents. This story is humorous now, but the lived reality was full of anxiety. This anecdote illustrates the ways that identity documents require extensive and expensive performative legitimacy and serve to discipline families into conforming to Swiss norms of a patrilineal family structure.

Many of the expat women in this study whose families did not conform with Swiss requirements had problems obtaining Swiss identity documents for their children. Usually, a

mother had not changed her name after marriage, or the parents were not married at the time of the birth. Our experience was not unusual. Ruby and her Swiss husband were engaged when their daughter was born, and Swiss law forbade them from giving the child her husband's name until they married. Ellen was married to her husband but had kept her maiden name, and her process took months:

> Ellen: Well that was a complete nightmare. The initial thing about his passport and his birth certificate seemed really easy. So, at the hospital, someone came round to hospital and gave me a form to fill out and said, "you know, we'll sort out your birth certificate and everything for you." And we filled out the form and sent it away. But because his name, his surname is different from mine, because I haven't changed my name on my passport since I've been married, that's what caused the issue. I think had we just all been Moles we would have just gotten his birth certificate within 16 days of him being born and it wouldn't have been a problem. But because our names were different, I then had to go to Bern and get an affidavit or whatever they're called. I can't remember what they're called, to say that I WILL change my name and blah blah blah, and I don't think he got his, he didn't get his birth certificate until October, four months after he was born.

The state tightly regulates marriage and family practices in Switzerland, and they are a frequent source of anxiety and controversy. During my fieldwork, these laws were in flux. In January 2013, women got the right to keep their names after marriage through a bill passed by popular referendum[4]. The Swiss also voted through a referendum in 2011 to make it illegal for people without documents to marry in Switzerland and to marry Swiss people[5]. This law stemmed from fears about foreigners, specifically women, moving to Switzerland and making claims on citizenship through "marriage blanc" or a white/paper marriage. Although this was a federal law, it was interpreted more generously by the Cantonal authorities in Geneva, who continued to allow marriages between Swiss and undocumented people in situations where they

[4] https://www.ch.ch/en/married-name/

[5] https://www.swissinfo.ch/eng/legality-of-swiss-marriage-law-questioned/29957390

judged the person well integrated[6]. The relative flexibility of the Canton of Geneva reflects the commonality of binational marriages in Geneva as shown in the graph below which shows marriages in the canton between 1994 and 2005.

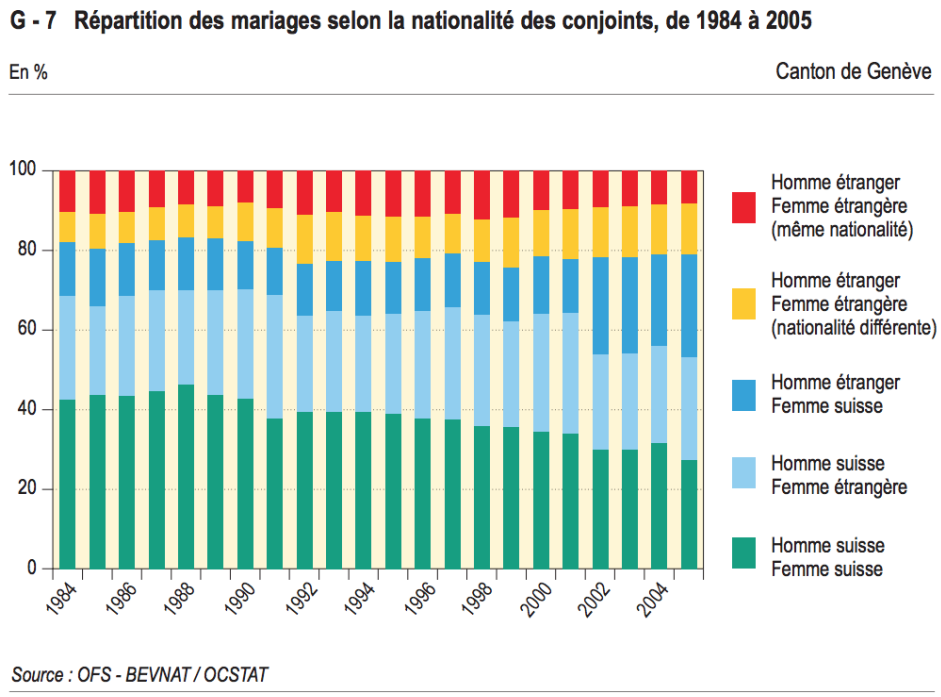

Figure 5. Marriage demographics in Geneva between 1984-2004

Family life is a central area for surveillance and control in the modern nation-state. Through using citizenship strategically to extend personal possibilities for mobility, expat families subverted these projects of state regulation and control, while at the same time artfully managing them (Ong 2007:88). Begonia Arextaga (2003) expanded on Foucault's model of biopower to highlight how bodies governed by the state are gendered, sensual and sexual (2003:403). Reproduction is a biopolitical space *par excellence* that highlights "connections between the individual and the collective, the technological and the political, and the legal and

[6] http://www.tdg.ch/geneve/actu/mariages-papier-toleres-geneve-2011-12-12

the ethical" (Rabinow and Rose 2006:208). Sexuality, and particularly heterosexuality and domesticity, is central to the constitution of the state and its control and governing of its citizens.

Creating Communities in Gendered Space-time

I call the liminal and new experience of space and time for expat mothers in Geneva gendered space-time, following the usage of this term in feminist geography, to describe the way gendered norms and roles shape people's activity patterns (Kwan 2000). For many of the women I spoke with, pregnancy and the areas opened up and closed off by caring for a young infant was the first time they perceived themselves to live in spaces shaped and determined by their gender. This framing draws from the idea that people move in gendered geographies of power, simultaneously formed by spatial, social, and cultural scales (Mahler & Pessar 2003:42). Women in Geneva did almost all of the work of caring for babies and young children, and the geographies of care that expat women moved in were female spaces (Hanson & Pratt 1995). Norms of consumption (coffee dates, lunch, etc.) and underlying reliance on digital spaces structured the activities that women did in these spaces and constrained access to these spaces to people in social locations and class identities.

Space and time are strictly regimented in Geneva. Laws regulate everything from when stores and businesses can be open to when people can make noise in their homes. These explicit rules restrict and shape the ways people navigate the city. Most stores and other businesses are open until seven pm on weekdays (seven-thirty on Thursdays), six pm on Saturday, and closed on Sunday[7]. These rules reflect and reinforce the Swiss ideal of single-earner households. For the women in my study, they limited the possibilities for the many errands necessary when caring for

[7] Exceptions exist for stores in hotels and the airport, etc. The text of the law: https://www.ge.ch/legislation/rsg/f/s/rsg_i1_05.html

small children (grocery shopping, doctor's visits, etc.) and created new rhythms to for daily life. Yvonne Riaño showed how Swiss restrictions on work permits for spouses, combined with lack of childcare, prevented Latin American women in German-speaking Switzerland from continuing professional lives at their previous level. Her study, one the few studies of highly-skilled women migrants in Switzerland, discussed how women found their integration capabilities constrained and built robust networks for support and activism (Riaño 2003).

The geography of the city changed for women when they became pregnant. Pregnant women have designated seats on public transit, parking spots, and priority checkout lines at stores. With an infant, strollers must be hauled off, and on buses and trams, they take up uncomfortable amounts of space during crowded times, revealing how inaccessible the city is for those who rely on wheeled mobility aids. Many elevators in Geneva are too small to fit anything but the smallest stroller, and what Hartblay coined "checkmark ramps," litter the city. These are places where a ramp or elevator exists in an unusable form, rendering them inaccessible (Hartblay 2015). Women found the transportation and urban space of Geneva changed radically with the arrival of children, and the areas where they were welcome shifted with their bodily experience (Silvey 2006).

Most of the social life of young mothers in Geneva, and probably in many contexts, is invisible. This was especially true for the expat women I studied, who tended not to participate in local events and rarely knew about what public resources existed for families. To join the forums and meetup groups and find out about events and activities, I petitioned to participate and got approved by a mother who acted as the admin for the group, making sure that only pregnant women and mothers joined. Play-dates and socializing took place in parks, play spaces, department stores and homes that were the almost exclusive domain of women in Geneva. The

women I studied socialized strictly within the traditional workday while partners were absent before the early nighttime routines of infants and small children began. This space and time was explicitly gendered female, with women the almost exclusive caretakers of infants and small children (Mahler and Pessar 2003, Silvey 2006).

Expat mothers living in Geneva found themselves engaging with these gendered spaces much more intensely than before they had children. I argue that while women used these spaces to build networks of community and belonging, they were developing expat communities rather than integrating into Swiss social life. My baby functioned as a key to this secret world, and made me intelligible as an ethnographer, friend, and peer to the women whose stories I eventually came to collect and analyze for this research.

Geneva has a robust infrastructure of parks, play-spaces, toy libraries and *zone d'allaitments* (nursing zones) in stores and restaurants that create safe spaces for public breastfeeding and encourage women with babies to integrate into the social life of the city, in the gendered role of caretaker. In addition to these implicitly gendered places, time is gendered and classed in specific ways as women learn to move around the city in new ways. This gendering of time and space happens in other places, but for the women I interviewed in this study, the strict regimentation of time in Swiss society made these codes overt. Many of the places new mothers in Geneva spent time were simply not accessible to people who worked full-time because of limited hours.

The Mommy Meetup Group (MMG) which I'll discuss at length in this chapter, allowed expat women to meet other mothers online and move through these physical spaces together, creating friendships with other expat mothers. The MMG was a was the primary site for community building amongst the women in my study. To join the MMG, women had to submit a

picture and information about their due date or children's birthdays, as well as share where they were from and how long they'd lived in Geneva. Their requests to join were then reviewed by the woman who had started the site and controlled it. Once she approved requests to join, new members could log on to the site and create a username and profile, similar to the ones on Facebook and other social networking sites. Once inside the community, women could participate in forums and attend events to meet other mothers in Geneva.

> I think it would be really hard without (the MMG), it definitely makes you feel sane to be meeting up with other mums, and particularly I think in the early months I really remember feeling like, "It's so nice to be going out with, to be you know, around town with people who don't mind if you stop and breastfeed for half an hour. Um, and you know, and do that on multiple occasions, multiple breastfeeding stops. And would really understand the need to stop and change a nappy, stop and pick up a crying baby, and it wasn't, it's nice to be with people where that's not an issue. And you know, talking incessantly about, you know, sleeping at night, baby issues, breastfeeding stuff. (Ruby, UK)

Consistent with Riño's findings in 2003, the women in my study spoke openly about their negotiations with the expectations for mother's roles they encountered in Switzerland. The women I spoke with who worked were keenly aware that by working, they were going against local expectations for early family life. Samantha and her husband both worked in the UN/ NGO community in Geneva and lived in a new townhouse in the neighboring Canton of Vaud. During our conversation she brought up navigating time as one of the major challenges in her life as a parent in the city:

> Oh, actually one thing, the assumption that women aren't working. I don't work on Wednesdays which helps a lot but often things; you can't do them unless you're there in the daytime because there is an assumption that the woman is staying home. That's pretty, that's probably linked to the poor childcare facilities, the lack of them because it's an assumption that women should just stay at home. It's a bit backward. A bit backward in that respect. (interview notes Samantha, UN employee, UK expat)

The unspoken presumption in Geneva is that when women have children, they don't work. Expat families were not exempt from this expectation. Also, The UN system relies on two-

year forced rotations for many professional positions, creating a community of "trailing spouses" unable to maintain and establish careers across multiple moves, and specifically in Geneva. Speaking to a Swiss professor about the difficulty finding childcare and housing in Geneva, she said: “Yes, these two-income expat families, they are making it very hard for normal Swiss families. They can’t afford to live in the city anymore with one income.” Although Swiss interlocutors viewed expat women as career-focused, the women in my study faced many barriers to working in Geneva, including obtaining work permits often not covered under their spouse's employment, language barriers, and the demands of continuously-uprooted expat lives.

The assumption that women should not work with babies shaped many aspects of mother's lives in Geneva, from deciding whether and when to go back to work, to the structure of their daily lives. Also, the expectation of single-worker families underlays how the Swiss state approached families. Childcare came up as a constant source of frustration for the women I interviewed. Finding infant care in Geneva was extremely difficult. Like in many major cities, to get a spot in *crèche* women had to register as soon as they found out they were pregnant, and expat women usually did not find out about the unspoken realities of infant care until after giving birth. At this point, they were too late to register and faced a scramble to find childcare that ultimately often shaped their ability to continue working.

Ruby felt forced to resign from her job as an aid worker with the UN when her child was born because she’d been working in a country that was a non-family duty station and she would have had to leave her daughter to return to work. Ruby used her experience and connections in her field to find a new job in Geneva and negotiate a start-date three months after her daughter’s birth, only to turn down the job when her childcare fell through.

> Ruby: So, people heard that I would be coming back, and a job opening came that I was encouraged to apply for, which I did. I got this job, which is a Geneva-based job, full-time, working in a similar field to what I'd been working on but at a global level. And I negotiated, they kind of immediately offered me a start date of the first of December when she would be three months. Which at the time, this was before she was born, I immediately thought, "She'll be three months, that's like ages of maternity leave, that's totally fine, it's a really good job. I'm going to have a job, this is like the perfect job, I should take it." So, I did. But then, sort of the closer and closer it got to the start date, I just got more and more stressed out about the prospect of leaving her, I worked quite hard to find childcare options, I really didn't want her to be in a crèche that young, so I wanted to find her a nanny who could be with her. I found someone who I was really happy with, a French young lady; I started to come to terms with sort of leaving her in her care. But in the end, she kind of quit on me two weeks before starting, and two weeks before I was meant to start. I'd been really emotional and upset about everything, and just not really feeling in my gut, just like, instinctually this is not what I wanted to do. And then when she quit it was the sort of straw that broke the camel's back and I was just like, you know what? I can't do it. My mum had four kids, worked full-time throughout, and I think it was partly because of her that I thought I'd be able to do it. But in the end, it was her saying, "you know what, you do have a choice, you don't have to go to work." And it was sort of, someone saying that, because I hadn't really even considered that as an option. You know, could we manage financially? We then did the maths and figured out that you know a) that's probably what savings are for and b) we probably could manage and that it would be worth it. You know, that's what money is for. So yeah, gave in my resignation and I feel very very very glad that I did. I sometimes feel, you know, slight regret but then I think that the, the job itself was very interesting and I would have enjoyed it, but no regret at all in the sense that I really wouldn't for the world have missed that time with Elodie, and even now I don't feel ready to go back full time, so there's just no way that it would have worked I think. So now I'm like dipping my toe into the world of consulting which I've never done before; but which is ideal because I can work from home and I can pick and choose a bit more and work part-time. (Ruby, UK expat).

For Ruby, having her nanny quit was the “straw that broke the camel’s back” and came on top of rising unease that she was doing the wrong thing by going back to work with a young infant. She framed her feelings as instinctual, but it also reflects the dominant cultural narrative in Geneva, where it is highly unusual for women to go back to work full-time within a year of the birth of their first child and both implicitly and explicitly discouraged.

However, the expectation that women stay home and adopt new social identities with the birth of their children also informed policies that supported families, including a standard 300 CHF per-child monthly payment to families with children in Switzerland. The state also showed

a strong commitment to fostering inclusion and "integration" for women with young children into public life through providing free and publicly-funded indoor play spaces and toy libraries as well as other events. Although not explicitly "women-only" these public play-spaces and toy libraries were heavily gendered female and served as a central site of community building for mothers in the city. However, as I learned, the communities women built were not what the Swiss planners had in mind.

Expat mothers' communities, built online and during the days, often became the central sources of social life for their families. Many of men in the expat community worked in international organizations and multinational businesses in Geneva that required long hours and provided little opportunities for them to participate in family life and build their social networks. During lunch with Sheila, a woman I met through the meetup site, she discussed how the stress of their social isolation and adapting to life in the city manifested in physical illness for her and serious unhappiness in her husband.

Sheila, another expat mom (Australian), moved to Geneva a month before the birth of her 7-month-old daughter. Sheila and her husband were thinking of leaving Geneva early because of the stress of his job and the expat lifestyle. He was (like almost all the husbands of the women I speak to) working nearly 12-hour days and never got to see the baby. She was feeling physically sicker and sicker with headaches, backaches, and exhaustion, although when we spoke, she said she's been feeling better emotionally. She described their family life in chaos, with almost total separation all week, no time alone with each other, no breaks for her and no time for him with their little daughter. She said that she wanted to stay in Geneva while her husband wants to return to Australia because she felt she was just getting settled.

The de-facto sex segregation of expats lives stemmed from men's absence during the workday combined with traveling, and explicitly motivated a lot of the organizing the women I interviewed did. While I met fathers who were staying at home while their wives worked, they were both implicitly excluded from the social spaces in which women gathered and made communities in Geneva and explicitly excluded from the local digital communities through which they built connections and social networks. During an event with the meetup group, I asked about whether or not men were able to participate in the activities. I learned that play-dates excluded dads unless they come with the female partner. The organizer of the group said that since the play dates were for women with young children and babies, they often discuss sex and bodies. She also said her husband would not be comfortable with her having strange men over for playdates during the day (a sentiment that the two other women in our conversation agreed with). Mia and David provide an example of a couple who reversed the normative expectations about gender and work. Mia maintained her role as the one making social connections and participating in community life A Swedish UN worker, she engaged with mother's communities and social life while working full-time for the UN while her husband David stayed at home with their son after her maternity leave. David felt uncomfortable and unwelcome during events for babies during the day as he was always the only man (if he could even go). Besides, he was less comfortable speaking English than Mia, who worked in English. David, an introvert by nature, spent most of his time alone with the baby or having one-on-one playdates with close friends. Although Mia and David's family had the working roles reversed, the gender segregation of time remained. Another father I met in Geneva described waiters teasing him for not being at work when he was out at a restaurant with his baby during the day.

This quote from Clarissa highlights how this played out in lived experience. Clarissa outlined how her husband's professional life shaped her friendships. She also articulated a core defining aspects of the expat mother's community: transience.

> Clarissa: Yeah, when we moved here actually my husband's contract was a 3-year post, and it's up June 30th this year. He was then offered a permanent contract, so we accepted and extended our stay somewhat indefinitely. But kind of like most typical situations here, there's a spouse working and a spouse home with the children, it's usually the wife at home with the children, and the husband is working, and the jobs here are pretty intense and very time consuming and a lot of travel. So, my husband travels more than he would like to pretty far-away places, he's going to Burma next week and um, and he's gone for 10 days, he can work really late nights and really early mornings, and it's [...] So that, I think that's one of the other reasons why like connecting with other expat women, wives and mothers is really huge here. One of the other challenging things about Geneva though is that it's really transient. So, I have lost, if you will, several good friends that have already like come and gone. And you connect with people really quickly but then they move because there's some other post or a job, you know, some other change or something. (Clarissa, American).

Mobility as Belonging: Digital Communities

Women used communication technologies and digital networks intensely as tools for reassurance and community building. I focus on the ways that these technologies shape users' relationships to their everyday life and imagined communities (Anderson 1983). The women I interviewed used ICTs (Internet and Communication Technologies) to build communities and learn the urban space of Geneva during the transitions of pregnancy and motherhood and to maintain relationships and social lives simultaneously here and away. I argue that in addition to using these technologies to maintain ties with family and communities in their home country, expat women used English-language meetup groups and other forums to create their local communities based on their shared identity as outsiders. The women in this study all had access to advanced digital technologies including smartphones and home computers. Also, they were all frequent users of communication software such as Skype and WhatsApp, as well as email and social networking sites.

Although they met in physical places, much of the work of making community happened online in private, members-only groups. While scholarship often focuses on the ways immigrants and migrants use ICTs to maintain ties with their home countries, this study focuses on how women used these technologies to create communities in their local context with others in similar situations and life stages. These hybrid communities were at once local and de-territorialized, and I argue these technologically-facilitated communities shaped a model of sociality and belonging that was private and personal, one in which the idea of integration had little meaning. Digital anthropologists Miller and Horst (2012) caution against viewing digital culture as more mediated or unreal than any other kind of social life and cultural production, pointing out that all cultural life is equally mediating. They point out that the rules that govern digital communities, and the networks people create online are just as authentic and mediated as in-person interactions (Miller and Horst 2012:9). For expat mothers in Geneva, there was no clear line between the digital and real community spaces they built in the city as they navigated their cities with their phones in hand. Conversations, relationships, and events moved seamlessly between the two in ways I'll outline in this section of the chapter. However, while taking digital culture seriously as a site of cultural production and authenticity, digital anthropologists point out that digital presence facilitated through tools such as Skype and Facebook do not offer a substitute for physical presence in long-distance intimate relationships. Through anthropological work on transnational mothering and kinship ties, these works reveal that technologies of presence, while they help people manage enforced separation, do not substitute for being there (Parrenas 2001, 2010, Madianou 2012, Kang 2012)

The essential digital spaces for the mothers in this study split between sites for women in Geneva and internationally-focused sites focused on child development and parenting advice.

The Geneva-focused sites were English-language: a meetup group for pregnant women and new mothers in Geneva, as well as an expat community site that incorporated forums for advice, classifieds, discounts, and in-person events. Most of the women in this study read BabyCenter.com and BabyCentre.co.uk, as well as similar sites hosted by their home countries (for example, the Swedish Public Health Department's site on child development). I'll start by discussing how the women in this study interacted with and viewed international parenting websites.

Jenna came to Geneva with her husband when he got a job at CERN. She was in contact with her family in Scotland several times a week via email, as well as weekly phone calls. However, she did not rely on these relationships and connections for reassurance and answers to parenting questions. As she said:

> I have a theory about this. I think that because we are the Internet generation, we can now consult the Internet before I consult my parents a lot of the time. In fact, I have not once run up my mom and said "Mom, the baby is doing this. What do I do?" I think I go to the Internet instead, which is a bit a shame. My mother-in-law is a GP, though, and I occasionally ask her some stuff like, is it ok that he is doing this? Or like one day when he was screaming a lot, shall I give him some Paracetamol? You know that sort of thing. Generally, though, I don't go to them for baby advice. (Jenna, 29, CERN wife from Scotland)

While the women in this study were in touch with their families in their home country regularly, usually daily or weekly, they did not view them as their primary source of parenting advice and reassurance, instead preferring to do their research online and learn from the experience of other parents. BabyCenter.com and BabyCentre.co.uk are commercially-run websites that provide short articles and information on pregnancy and early childhood development. They contain material such as lists of recommended baby products, guides to understand the size of the fetus during pregnancy via fruit, as well as short articles on general sources of anxiety for new parents such as sleep, illness, nutrition, and poop. However, the most

compelling aspects of these sites for the women in my study were the forums where it was possible groups based on shared interests and experiences. One of the most popular types of discussions were "birth month clubs" which contained threads posted by mothers seeking advice and reassurance that their experiences were normal from others in the same stage of pregnancy or with infants the same age. There were forums for diverse ranges of interest groups including women pregnant after a miscarriage, mothers of multiples, single mothers, queer mothers, attachment parents, and many others. These groups relied on shared experience to create a sense of community among complete strangers. For many of the women in my study, the anonymity of these groups made them a safe space to share their most intimate concerns and anxieties and receive support and information from others who were similar but distant enough to not share their confidences with people they knew. These groups were often far from a utopia of supportive comments; they were often spaces of intense conflict over parenting decisions. Bullying and judgmental comments were pervasive especially on sensitive topics like sleep, car seats, circumcision, vaccines, nutrition, and bed-sharing. Most of the women I interviewed described their participation in these spaces as "lurking," observing the conversations without actively participating. Lurking allowed them to gain information and reassurance without putting themselves in a position to receive negative commentary. These sites provided a crucial source of community for women who were isolated and away from friends and family. Ruby was working in Africa for much of her pregnancy and was the only pregnant woman on her team. She relied on the parenting sites as a source of information and community.

> And as a result, actually (of being pregnant on assignment in Africa), I mean, I use the internet a LOT, I use online stuff a LOT, but particularly I think because I was there, quite isolated. None of my female friends there were pregnant, none of, very few of them had kids, and if they had kids, there were maybe grown up because they weren't with them. Um, so I really, really relied on online communities and uh, when sort of, dealing with pregnancy issues. So, I joined a couple of and would sort of obsessively read, quite a

> couple of pregnancy communities and also anyways I'd read loads and loads of mum blogs and craft blogs and that kind of thing, so I continue to do that. (Ruby, UK)

The women in this study did not choose BabyCenter sites over advice from family because their information was higher quality or because of the safety of anonymity, since these sites were regularly the sites of intense conflict. They chose to look to BabyCenter and similar websites primarily because of time and the convenience of on-demand information. Despite the advances in communication and presence offered by ICTs, they did not help women manage the time-differences involved in long distances, which presented ongoing challenges in maintaining ties with family abroad. This quote from Becky illustrates the challenge time posed to her in keeping her long-distance relationships intact:

> Well with Facebook you can kind of communicate without really directly communicating. Um, but I mean, we FaceTime with my Mom and Dad at least once a week, I talk other a few times a week. We talk with about the same regularity to Rasheed's family. My friends, I chat with a little bit, we see each other, like pictures on Facebook, that kind of thing. Phone calls are a little more difficult because of the time difference. I usually go to bed while people are still working. (Becky, American)

In addition to participating in a global community through maintaining ties with their family and friends from previous countries and global parenting forums, the women I studied created intensely local digital communities in Geneva. The two most significant digital networks that came up in this study were a site called Glocals and a meetup group specifically for international pregnant and parenting women. These two sites were significant spaces of community formation and played different roles in the women's lives.

Glocals (shown below) serves as a central hub of information and resources for the international expat community in Geneva. The name contains multiple levels of significance that reflect the importance of mobility and the tension between local and global identities in its user base. One reading of the name is a combination of the words global and local, into "glocal," a

term capturing the liminality of expat identity. An additional interpretation is an abbreviation of the term "Geneva-local" which claims authoritative knowledge over the social life of the city. Both of these readings are intentional and correct, existing simultaneously. Glocals now hosts activities for people of diverse ages and areas of interests, but during the time of my study, the target population for their events was young single professionals and couples without children. The site hosted large in-person events such as club nights, as well as smaller events like pizza parties. In addition to Glocals branded events, the site is a platform for users to publicize their events, and most of the content on the site is user-generated. People post on the site looking for all kinds of things, including others interested in pursuing hobbies and exploring the Geneva area. Glocals is explicitly NOT a dating site and to keep the events inviting and safe, before joining users must click a box that says, “I understand that Glocals is not a dating site.”

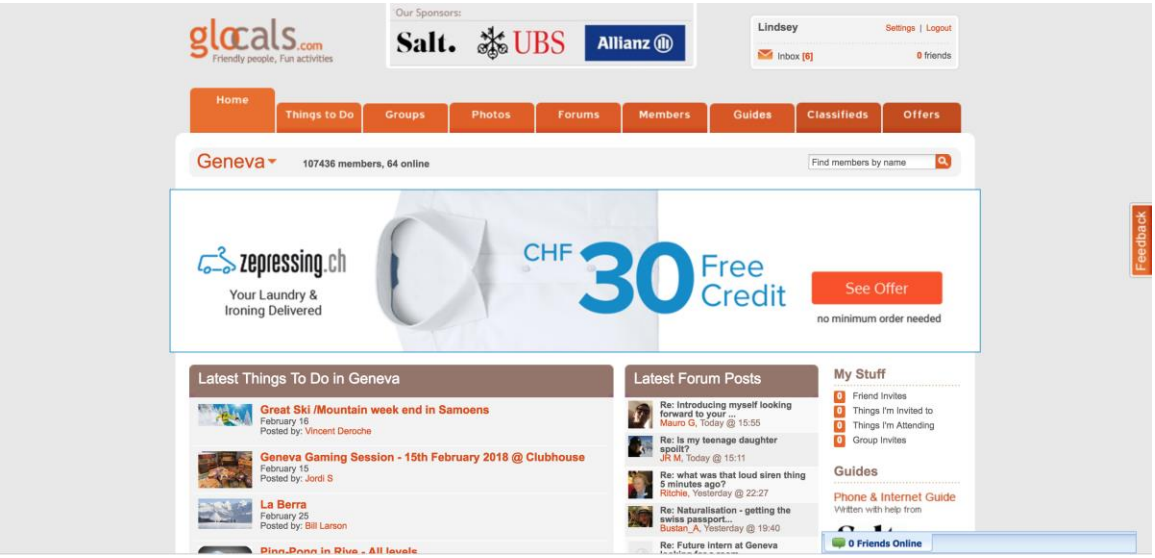

Figure 6. Screenshot of Glocals homepage from February 8, 2018

While the site has grown significantly in scale since my fieldwork in 2011-2013, the kind of information and resources provided has not changed. During the time of my study, the site did not have extensive corporate partnerships.

Ruby's use of Glocals was reasonably typical and highlights the importance of meeting new people quickly in the transient expat community.

> Ruby: The main thing for me when I first arrived in Geneva, so right before I was pregnant, whatever, was Glocals, an online community for expats and locals although it mainly ends up being expats. That I found really good. I joined quite a few groups when I like first arrived and did various social activities, mainly around sports. Um, and then also there you can find places to stay there, you can get um, I did some like language tandems and that kind of thing. So that was really useful. I think that was the main thing. And then um, sort of for mums and mums to be there's that whole sort of online community. That for me was very useful. Because when I came back there after being away like most of my, most of my friends I'd made the first time around were not really around or weren't quite at the same stage as me, so I definitely wanted to meet other, other mums.

The Mommy Meetup Group (MMG) was a was the primary site for community building amongst the women in my study. To join the MMG, women had to submit a picture and information about their due date or children's birthdays, as well as share where they were from and how long they'd lived in Geneva. Their requests to join were then reviewed by the woman who had started the site and controlled it. Once she approved requests to join, new members could log on to the website and create a username and profile, similar to the ones on Facebook and other social networking sites. Once inside the community, women could participate in forums and attend events to meet other mothers in Geneva. At the time of my research, the MMG had 850 members, all women who were pregnant or with children under the age of 6. The expat sites in Geneva did two simultaneous types of work to build communities. The first was to help people connect with others to create communities based on creating personal networks and friendships based on shared experiences and empathy. The community people talked about in interviews was this one of shared experience, the one that they explicitly recognized and valued. It will be the focus of much of my discussion.

However, in addition to the affective work women did through these websites, they also created private and exclusive markets for the exchange of goods and services. These sites encouraged transactional relationships and the circulation of goods within the community of users, concentrating these things within their closed space. This work went mostly unspoken and unrecognized by the participants, but I want to call it out briefly. There were two primary forms of market-relationships built through Glocals and the MMG. The first one was through sponsorships and referrals in which local businesses would advertise on the site and organize discounted or free events for site members. The MMG regularly broadcast for paid early childhood activities and courses, often with a special rate or open class. The second and more intensive use of these sites was the participants selling and exchanging goods and services among each other. These included women starting small businesses such as exercise courses, as well as the circulation of second-hand baby gear. People also posted job opportunities, housing, and other informational currency on the site. While it was not the apparent purpose of these sites, they served to concentrate and preserve resources within the expat community, as well as to direct the economic capital of their user-base towards specific businesses, which became recognized and legitimated through their participation in the "private" space of the site.

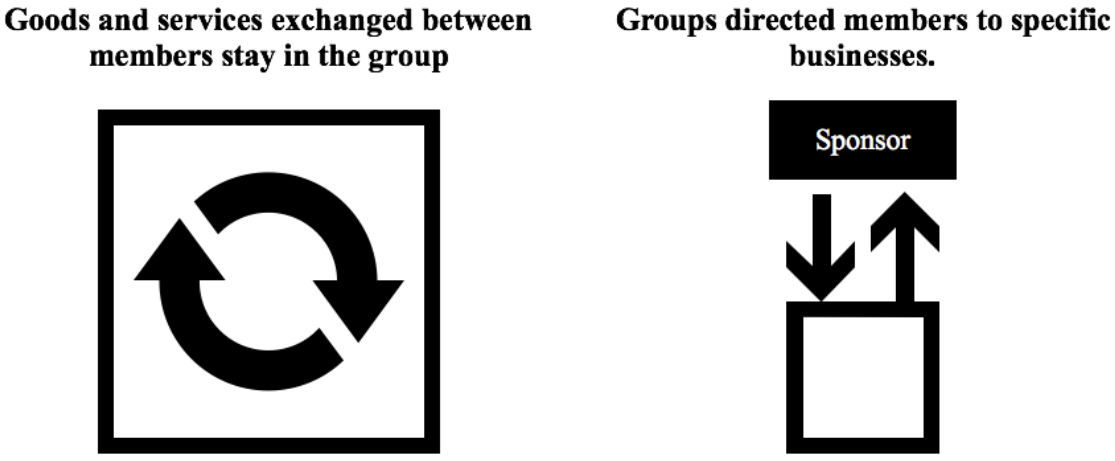

Figure 7. Representing the flow of resources and services through expat internet groups

My discussion focuses on the first, explicit use of these sites as sources of community and companionship for mothers away from home, while recognizing the economic role these sites also played for women and families.

Moriah, Australian, moved to Geneva from Singapore while pregnant with her first child. She was naturally shy and her experience traveling internationally with her aid-worker husband for the past several years showed her that making friends and social networks was something she could not do on her own without the help of organized groups. She joined the MMG before arriving in Geneva and signed up for a lunch event for pregnant women the first week she came. She used the MMG as her primary source of social connections and information about Geneva:

> Well, the greatest thing I've found is the mothers' Meetup site, just putting you in contact with other people in the same position, and what they're doing, and how they get around and, umm. What other resources are there? That's all I really use.

Like Moriah, Clarissa viewed the MMG as an integral part of the landscape of Geneva, and the primary way she connected with the expat network she belonged to in Geneva, grouping it with the people she met through her church, her previous job, and the people she met around town. In the quote below she identified the importance of shared experience to building friendships in Geneva. The experience of becoming a parent "not at home" served as a compelling source of camaraderie for her.

> I mean, I am part of the MMG as well as the expat mom group, infants, and toddlers... So, I have found those sites incredibly helpful for like, you know, places to take kids or playgroups or language classes or something. And then, kind of going to some of those things I have met other women who are, who either have like lived here longer than I have or have older kids or might have some better understanding of the language here. Because I didn't know anything about like a *ludothèque*[8] until I met a woman who I became friendly with and she knew what *ludothèques* were and I had never even heard of them, and she was another American woman. So, in terms of resources in Geneva, I, I mean we also belong to a church that I think was kind of helpful because we met a few

[8] *Ludothèques* are toy libraries with play areas run by city governments in Switzerland. They usually offer free admission and children can check out toys to borrow and bring home.

> families there and you know, they kind of guided us. I also had a job, um, and so just, people like, for me because Geneva's filled with a bunch of expats it's easy to get information word-of-mouth from other people who know what it's like to, to not be home if you will. You know, to be out of their comfort zone. (Clarissa, American)

The expat women in my study viewed mobility as a central problematic and pre-occupation. For many, it was also a defining feature of their identity. Many women spoke of their mobility as an asset, setting them apart and providing them with a more vibrant and more exciting life history and sense of self than they felt they would have achieved in their home countries. Mobility was a double-edged sword, both positive and negative. The experience of movement was complicated and shaped by their increasing enmeshment with the digital realities of Skype, Facebook, and other technologies of presence. The women I worked with in Geneva created opportunities for friendship and social connection through viewing mobility and the experience of mothering out of place as a point of commonality and community building. Women who otherwise would have been unlikely to know or identify with each other made friends and connections through sharing this rite of passage in the city together, virtually. Jenny from Scotland discussed the importance of shared experience.

> I... the women that I have become really good friends with are all, we're a little bit in the same situation, around the same age group, and also have had careers and had travels and had other experiences prior to having children. So, it makes it easy because we don't only have to talk about our children, we have other like life experiences and other things that we can share and talk about and interesting stories. And I think that that's been really important for me here, and most people that you meet in Geneva, I would say, have kind of an open-mindedness because they are here. Right? They are not from here, but they chose to move here, and they were open-minded enough to move here. Try something new, be someplace new, raise their families here or have children here. And that's kind of, that's nice. I mean it's nice that, I would say that most people enjoy traveling and seeing places and doing things. (Jenny, Scotland)

Conclusion

For the women in this study, the transition to parenthood was a moment of integration into an expat community that spanned the local and global, rather than into the Swiss society of the nation-state. They made ties bed on shared experiences with parenting and mobility. Being in Geneva offered the women I interviewed challenges, opportunities, and possibilities for mothering that many would not have experienced in their home countries. For women in relationships that provided some economic security, not having a work permit could justify a pause in their careers that sometimes functioned as extended maternity leave and that would not have been otherwise possible. The women I interviewed negotiated having limited support networks in the city and the ways their movements were constrained to create communities with other women facing the same challenges and provide mutual aid and support. Also, women living away from their traditional authorities on child-rearing and outside of Swiss childrearing practices often talked about having freedom as mothers to decide how they wanted to raise their babies outside of the strictures and judgments of their home cultures, an absence many found freeing. However, the ways expat women built support networks based on shared experiences of life-stage and dislocation meant that expat women did not have the tools to fully understand the implications of their choices in the context of Swiss medical care and had riskier birth experiences in private clinics that projected a sense of safety, rather than seeking care in the public hospital where care was less personalized but statistically produced better outcomes.

This chapter outlined the many ways that expectations of national belonging and integration shape the experience of starting a family in Geneva. From naming and documents to prenatal education, political and social expectations influence women's embodied experiences of becoming mothers in Geneva. The differing and intersectional positions of migrant and expat

women vis-à-vis the state formed the ways that they experienced pregnancy and belonging as well as the kinds of integration projects they undertook. Expat women could resist conforming to Swiss expectations by treating citizenship strategically.

CHAPTER 2: PREGNANCY, INTEGRATION, AND EDUCATION

Introduction

In the first section of this chapter, I define the Swiss concept of integration and explain why it is essential to Swiss migration and family policy. I build on anthropological research that shows how reproductive politics reflect gendered understandings of citizenship and social belonging (Arextaga 2003, Gal and Kligman 2000, Paxton 2004, Lim 2008, Rivkin-Fish 2005, 2010). The Swiss viewed pregnancy as a time of transition and vulnerability, calling for women to undertake new projects of "integration" as their social roles changed. However, expat women stayed outside of these efforts because of shared perceptions between expat women and midwives that they were highly competent and uninterested in undertaking projects of integration in Switzerland and so were vulnerable to problems during the physical and social transitions to parenthood marked by pregnancy, birth, and new parenthood.

"In our (western) societies as in other cultures, the transition to parenthood figures as a major life transition. Pregnancy is a period of profound psychic reorganization and important changes on the level of identity and social life, which causes prenatal stress for pregnant women.[9]" (Ratcliff, Borel, Suardi, Sharapova 2011: 26). Writing on the importance of prenatal education, this quote from a report from the Major Midwife Organization (MMO) makes explicit

[9] "Dans nos sociétés occidentales comme dans d'autres cultures, le passage à la parentalité figure parmi les transitions de vie majeures. La grossesse est une période de profonds remaniements psychiques et de changements importants au niveau identitaire et social, qui induit un stress prénatal chez les femmes enceintes." (my translation)

their view of pregnancy as a time of vulnerability and change in social belonging, connecting pregnancy to integration.

In the second section, I explore how integration informs social support for both expat and migrant pregnant women through examining the specialized prenatal education course for migrant women designed by the midwife organization, "*Maman a Genève*." This course attempts to recognize migrant women's intersectional (Crenshaw 1991) identities and support the specific vulnerabilities and challenges they face during this bodily rite of passage. I argue the courses focus on the individualizing project of educating women about Swiss medical norms for pregnancy, birth, and childcare. Rivkin-Fish defines individualizing practices to encompass both official and personal projects to affect social change through educational projects that focus on improving individuals' moral and behavioral practices (Rivkin-Fish 2005:10). Secondarily through educating women about what to expect and providing information about resources, the midwife organization seeks to build trust between migrant women and the Swiss medical system. These courses teach women to be responsible maternal subjects and familiarize them with Swiss medical practices and social resources. The goal is to reduce the amount of anxiety and isolation they experience transitioning to motherhood, as well as the adverse health outcomes for women and their babies caused by stress. In this context, pregnancy becomes an opportunity to access resources and care in addition to a time of vulnerability (Goldade 2011). This individualizing framework aims to help women improve their integration and face structural barriers to integrating and empowering birth experiences through educating women about their bodies, Swiss healthcare practices, and resources in Geneva.

In her account of prenatal healthcare in post-socialist Russia, Rivkin-Fish describes how private and public care intersect in that context. Her framework of personalized, privatized, and

public medical care is useful for thinking through the complexities of the Swiss system and understanding how the different groups of women I interviewed moved through it during their pregnancies (Rivkin-Fish 2005:11). Rivkin-Fish defines personalization as "replacing official, standardized protocols with the obligations and interactions of kinship and friendship" (Rivkin-Fish 2005:10). For the women in the expat course, the obligation to establish connections and friendships with the teacher was explicit and the teacher presented this as a core aspect of the course.

I compare "*Maman a Genève*" with the courses offered in English to expat women. The differences in these courses reflect differing positions vis-a-vis Swiss society and expectations for birth and motherhood. The expat course exists in the context of highly privatized healthcare, expat women replaced the state-provided standardized care of HUG with a consumer model in which they paid for services and to choose their provider (Rivkin-Fish 2005:11). This course operated within the same framework of personalization that shaped expat women's reliance on their physician guides (outlined in chapter 3). The instructor emphasized helping women build support through practices of personalization and personal connections and friendship with her and each other. The personalization framework lay uneasily atop a situation of privatized medical care in which the women paid large amounts of money to see the same physician throughout their pregnancies and have them attend their births. In the English course, the instructor assumed women had a high level of knowledge about health practices during pregnancy and childbirth. The class focused on discussing personal emotions, fears, and anxieties, and helping women advocate for themselves and make choices about where to give birth and how they wanted the experience to go. The instructor also addressed the women's anxieties about giving birth in a strange place and tried to address the risks of isolation after

birth. She focused on building interpersonal relationships between participants in the course and between herself and the participants and helping the women make better choices as consumers of care. Because the course focused on affirming women's personal choices and building connections, women did not get the same understanding of how to operate effectively in Swiss medical institutions independently.

Integration & Citizenship

To become a Swiss citizen requires an extended (12-year) residence in the country, as well as for the applicant to prove that they are participating in Swiss social life. Citizenship is a three-step process, requiring approval on the municipal, cantonal, and federal level. Children born in Switzerland have no basis to claim citizenship unless one of their parents is Swiss or they live in the country for at least six consecutive years. Citizenship is intimately bound with expectations for integration and belonging, and it is cultural and genealogical as much as legal. From the Federal Office of Migration's website for citizenship applications: "You will have to satisfy the following requirements for naturalization: you must be socially and culturally integrated in Switzerland, comply with the Swiss rule of law, and you must not endanger Switzerland's internal or external security.[10]"

The concept of integration became central to my research and frames this dissertation. Although citizenship in Switzerland relies on a *Jus Sanguinus* framework, it does incorporate naturalization based on length of legal residence in the country for people who can prove they integrated well into Swiss society. The numbers of foreigners living and working in Switzerland are also very high compared to other European countries, and a traffic study conducted during my fieldwork showed that the borders around Geneva are crossed by more than 550,000 cars

[10] https://www.sem.admin.ch/sem/en/home/themen/buergerrecht/faq.html

every day[11]. “Switzerland for the Swiss” is an unlikely rallying cry in the immigration debates in this context of constant mobility and border-crossing.

However cosmopolitan Geneva feels, Switzerland requires people applying for citizenship (and long-term visas) to be “*bien integré*," and the city of Geneva has a “Bureau of Integration” that funds programs to help migrants integrate into Swiss life. The concept is slippery, as defining “well integrated” is difficult and subjective. In practice, economic status plays a large role in defining successful integration for foreigners in Switzerland. The concept of integration emerged as particularly problematic for women, both for economic and cultural reasons. In Geneva, a large apparatus of social services organizations focuses on teaching new immigrants how to integrate into Swiss society and embrace Swiss norms and ways of living. I summarize integration as the concept that people should participate in a shared social life and share certain ideas and practices. This concept informs Swiss understanding of changes across the lifespan in addition to encompassing geographic mobility and cultural difference. These ideas about integration are heavily gendered and shift over people’s lives according to their social role. Swiss expectations for sociality for women change with motherhood when women go from producers to re-producers in the eyes of the welfare state.

Decisions about whether or not someone applying for citizenship is integrated rest on the ability to speak the local language (French in Geneva), whether or not someone works outside the home and pays taxes, knowledge of Swiss culture, engagement with the community and (informally) appearance. Officials at the cantonal level evaluate applications and make these decisions. Both Swiss and non-Swiss informants viewed these decisions as highly subjective. The procedure for proving integration varies depending on who you are and what country you

[11] http://www.tdg.ch/geneve/actu/jour-frontiere-traversee-550-000-fois-2011-12-09

are from originally. A professional, white, American woman married to a Swiss man reported never having a citizenship interview during her process. However, informants from other EU countries (France and Greece), as well as from outside of the EU, reported multiple conversations. There was an informal, unspoken, and yet rigid script applicants must follow to pass these interviews. I spoke with a Greek female friend about integration during a casual conversation about her experience moving to Switzerland. I mentioned the case of a woman I had met through a feminist NGO focused on the integration of women where I conducted significant fieldwork. This woman was home with young kids, studied French, and adhered to Swiss norms for maternal behavior. The Swiss denied her application because she was not "integrated" enough. She thought because she wore a headscarf. My friend responded, "I cannot imagine showing up to an interview in a headscarf, it would be very difficult to pass." The Islamic headscarf functions in Swiss political discourse as a flag of otherness that symbolizes unwillingness to engage with the Swiss community. Debates about the veil in Geneva echo those documented by anthropologists across Europe and North America, in which the veil reflects and stokes anxieties about immigration and otherness. The heavily racialized and gendered veil stokes a lot of controversy in discussions of integration (Ahmed 1993, 2011, Fernando 2014, Scott 2007, 2010, Yurdukal 2014). Formally, women cannot be denied citizenship for wearing a headscarf, but informally, this is a common practice, especially given the unique “flexibility" of the Swiss government, whose slogan was “democracy with a human face.” Democracy with a human face was meant to convey a system that cares about people as individuals and allows officials a degree of subjectivity in how they work. Many Swiss and Genevois informants took great pride in their country’s robust program of “education” to help new immigrants integrate

into the society, but integration required a commitment to performing Swiss norms that in many situations implicitly excluded women based on their religious observance and dress.

"Integration" in Switzerland was both a problematic and anti-racist project. The ideology behind it was that with the proper education and support, people could learn to function in Swiss society and earn the right to become Swiss through conforming with Swiss norms and mastering Swiss practices. In the context of Swiss politics, this was a very progressive stance, opposed to the rhetoric of right-wing political parties for whom the only "real Swiss" were white and European. In practice, it was much more difficult for some to "prove" their Swissness than others. On the ground the organizations promoting integration were well aware of these challenges and focused on providing their clients with the tools to negotiate the structural inequalities and discrimination they faced in Swiss official and social life.

Integration and Preparation: Prenatal Education

It is not possible to talk about pregnancy, childbirth, or motherhood in Geneva without talking about what I'll refer to as the Major Midwife Organization (MMO) - the union for independent midwives in the city. The MMO sat across the street from the University of Geneva, near the University Hospital (HUG), on a tiny street filled with trendy bars and restaurants whose tables spilled out onto the sidewalk and catered to a hip and student-centered clientele. With its unobtrusive and un-illuminated sign, it was easy to miss walking by, and in fact, finding it for the first time was a challenge. As you walked into the grey 100-year-old building and opened the door, on your right was a large desk recessed into a hallway. Past the desk, a door lead into an open classroom that looked like a dance studio but filled with Swiss style nursing pillows – about 4 feet long, thick and heavy. On your left, there were a couple of worn armchairs, a coffee table, a rack of pamphlets in a panoply of languages (but predominantly French) on pregnancy, sexual health, breastfeeding, family life, *crèche* options, introducing solid food, and almost any topic

about pregnancy through early childhood you could imagine. Behind this sitting room was a more extensive room that functioned as a kind of consultation/exam room. Near the front were more armchairs, and further back was a changing table, sink, and scale for weighing babies. There were more nursing pillows, and often a yoga ball or two. A near-constant bustle filled the room, as women brought their babies in to be weighed by the midwives, dropped in to nurse and ask questions, or even changed diapers while they were out in the city. Off to the side was another private consultation room for prenatal appointments.

It seemed like every new mother in Geneva, regardless of background, found themselves in this space for one reason or another, irrespective of their feelings about midwifery or natural birth. It was the central hub of support for new mothers in the city. Many women first interacted with the MMO while pregnant, during prenatal classes, which they offered in Italian, German, and English as well as through "*Maman à Genève*," a course offered through a partnership with the University to provide a program for non-francophone migrant women. In this class, which was designed for a multi-lingual audience, the instructors spoke French and interpreters provided translation into a range of languages. The MMO offered prenatal education and exercise classes to pregnant women across social class, geographic, educational, and linguistic backgrounds. It was one of the only organizations in Geneva's three-tier and mostly stratified health care system that worked with women of all economic, class, and linguistic backgrounds.

During "*Maman à Genève*," migrant women attended the sessions without partners and visited the family planning clinic during the class to learn about contraception, the menstrual cycle, and female anatomy and sexuality. The MMO and other healthcare organizations viewed women migrants in Geneva as particularly vulnerable, recognizing the effects of precarious housing, uncertain legal status, trauma, and social isolation. They approached teaching women

migrants as if these women had little formal schooling or knowledge about living in western societies (Ratcliff, Borel, Suardi, Sharapova 2011: 25). They viewed these women as needing help learning to live in Switzerland and becoming successful citizens and mothers (Ginsberg and Rapp 1991, Paxton 2004, Rivkin-Fish 2005).

If women didn't encounter the MMO during pregnancy, they often learned about it when their babies were small, as mothers discussed the perennially fraught topics of early weight-gain and breastfeeding. Through these conversations, and sometimes through midwives, they learned that they could have their babies weighed for free as often as they'd like without going to the doctor's office. The MMO became a center of social and medical support and information for pregnant women and new mothers across the city, and the first resource for integrating into Swiss social life as a new parent. The MMO supported women's integration as part of their mission. They worked with women across the social and geographical spectrum.

The Swiss focus on the concept of "integration" both during pregnancy and migration meant that migrant pregnant women and families with young children were the focus of intense efforts at support and integration into Swiss society. Specific organizations and interventions aimed to support migrant families integrating both into Swiss society and into family life. These interventions went far beyond medical care to shape and support the social aspects of family life and subjectivity. They helped these women and families transition, not just to family life, but to a mainly Swiss vision of family life (Kaufman & Morgan 2005:331, Goldade 2011). Expat women stayed outside of the reach of these efforts.

Midwives were the central figures in Swiss medical care during pregnancy, birth, and postpartum care. Midwifery was also a much more diverse practice in Geneva than in the US, and midwives were generalists, trained in a holistic model of care for pregnancy and birth. Since

hospitals mostly employ midwives, there was not the same identification between midwifery and homebirth as you might see in an American context. The midwives at the MMO all shared training but focused on a range of specialties and practices including home-birth, hospital care, lactation support, and prenatal and postpartum care. Midwives in Switzerland performed care work that midwives, nurses, doulas, pediatricians and lactation consultants do in the American health care system.

During my fieldwork, I attended and observed both a prenatal class run in English for anglophone pregnant women and the multi-lingual class. The goal of both classes was to inform women about the Swiss healthcare system and teach them to advocate for themselves in healthcare settings. However, the types of information, strategy for delivering lessons, and the choices presented to women differed significantly between the two programs. These differences reflected the different social position of the participants and the differing expectations of the midwives about the women, their knowledge, and how they would be able to access care and negotiate with providers.

"Maman à Genève"[12]

This course was open to pregnant women from any non-francophone background. Women came to the course through many sources, including their healthcare provider, *foyers d'asile* where they lived, city-funded NGOs offering language and integration help, and government-run language classes. The course was provided free of charge, and there were no income restrictions for participation. Participants in the sessions I observed included graduate students from the EU, undocumented women from around the world, refugees from Syria, and newly-arrived asylum-seeking women from Africa. During the two 6-week sessions I observed,

[12] "Mother in Geneva"

ages of participants ranged from 15 to 40. Unlike most childbirth courses, many of the women participating already had older children. The class focused on educating women on the Swiss ideas of healthcare and what to expect giving birth in Geneva, in addition to primary pregnancy and birth information.

"*Maman à Genève"* was designed and led by Etienne, a senior midwife at the MMO who pioneered their outreach to non-Francophone patients, along with Odile, the midwife in charge of the *Maison de Naissance*. Both were veteran midwives with extensive experience and knowledge about pregnancy, birth, medicine, and transitioning to motherhood. "*Maman à Genève"* was designed to lower rates of post-partum depression among migrant women in Geneva, estimated to be as high as 60% (Ratcliff, Borel, Suardi, Sharapova 2011: 26). A partnership between the University of Geneva, the MMO, and the HUG funded the course. Since the course was an experimental intervention, the providers of the class worked with researchers to provide information for studies and reports, and women who participated in the class also participated in the study. This dynamic of services provided in exchange for study participation and at the cost of a level of privacy is a core part of health care for marginalized populations across the globe.

"*Maman à Genève*" differed from the other course I attended at the MMO, a prenatal course for Anglophone women, in many ways. "*Maman à Genève*" was held weekly during a 3-hour midday block during regular work hours. Women attended alone and male partners were explicitly forbidden. The midwives' goal was to create a safe space for women to discuss sexuality, birth, and intimate aspects of health that mixed company cannot discuss in many cultures. Also, the content of this course was incredibly comprehensive, ranging from the basics of reproduction and anatomy to information about clinical practices in Geneva and tips for inducing labor and caring for a newborn. Although the course was designed to be part of the

women's "integration" into Swiss practices and ideas about motherhood, the primary focus for the midwives was giving the women the tools they needed to have healthy pregnancies and births. Specifically, the course was meant to help address high levels of surgical births and post-partum depression among migrant women. Therefore, the midwives focused on helping the women participants feel supported and confident going into their birth experiences. The midwives also tried to give the women tools to negotiate and resist Swiss medical authority during birth so they could reduce the chances they would be pushed into medicalized birth experiences. Primarily, this took the form of making sure women knew about their rights to refuse an induction until 10 days after their due dates and encouraging them to wait to go to the hospital. I'll discuss specific examples in this chapter. However, the midwives also taught them Swiss ideas about pregnancy and childcare because they believed them to be scientifically based and healthful. They often asked women about practices in their home country and then discussed the differences in Swiss methods, engaging the women in friendly discussions about different cultural and medical practices.

During the courses I observed, the midwives began the class with lessons on the ways that conception occurred and necessary information about the functioning of the female reproductive system. During a discussion with the lead midwife, Etienne, I asked why they focused on sexual education. The midwives explained to me: "many women come to the course knowing nothing about their bodies, they come from cultures where this just is not discussed." The midwives viewed the course as a tool to support women not just through pregnancy and birth, but in their journey to becoming knowledgeable modern subjects and in their minds, the women needed scientific understandings how their bodies worked so they could control their future fertility and effectively educate their children. It is worth noting that this kind of education

comes from a long tradition of western feminist thought and activism, dating back to the 1970s and the women's health movement (Boston Women's Health Book Collective 1970). All of the Swiss midwives I met were caring, compassionate, and explicitly feminist in their views of women's participation in society, and yet they played integral roles in a system that maintained highly gendered ideas of integration and women's roles in society. Specifically, many midwives I spoke to expressed views about how "natural" and important it was for women to stay home and be the primary caregiver to children for the first few years of parenthood. They also encouraged women not to work near the end of pregnancy and in fact, this view was manifest in Swiss leave policies in which maternity leave began eight weeks before birth unless a woman could get a note allowing her to work until closer to her due date.

I learned about the complexities of delivering culturally-sensitive material through translation first-hand through participating in the session as an ad-hoc interpreter. In this scene, I am providing translation for Esme, a woman from Indonesia in her late 20s, pregnant with her first child. She never had a translator who could speak to her in Indonesian, and I worked with her throughout the course translating French into English, which for her was imperfect but an improvement over the French. Esme came to Geneva to study hospitality at the hotel school three years before our meeting. She spoke almost no French and a small amount of English. Her partner was Swiss, and they had separated during her pregnancy, causing her anxiety about her legal status and ability to manage alone in Geneva.

> The midwife, Etienne, began by asking "do you know how babies are made, generally?" There was a flurry of translation, I looked at Esme and realized I had to translate this question to a woman who was seven months pregnant. I was suddenly uncomfortable. I looked at her and took a deep breath and said, "Do you know how babies are made?" She nodded and looked at me with a kind of confused incredulity. We proceeded to the first page of illustrations in the booklet the midwife had passed out, which showed how breasts and vaginas change as women go through puberty. I translated Etienne's explanations: "And the lips get

> bigger… the anus is very close to the vagina, so if you use paper, you need to wipe from back to front to avoid germs, that is why we always tell women who get a lot of urinary infections to pee after sex". At this point, the young woman from West Africa and her mother asked about using water instead of paper, which Etienne approved. "And by the end here, when you are done growing, your breasts are ready to produce milk, but as you probably know, they grow more when you are pregnant…." I kept looking at Esme, trying to determine if she seemed interested, bored or insulted by this information. After that, the next page showed an illustration of the uterus and the ovaries and explained the menstrual cycle. I tried to translate Etienne's narration with a straight face and using as few medical terms as possible. "This is what happens on a month that you don't get pregnant, the egg grows here in the ovary, and then after about nine days, it is released. These little things pull it into the tube part of the uterus here and into the uterus, the lining thickens to welcome the egg, some women feel cramps during this part of the cycle…" As I was unsure of how much Esme knew of this information and how she was experiencing my narration, I kept stopping to check, "Do you have any questions? Do you need me to slow down?" It was hard to tell how the women were experiencing the lessons as they all sat silently and looked extremely uncomfortable. I could not tell if they were, bored, interested in the information, or insulted that the midwives focused on things they already knew. Most of the women looked like they would rather be anywhere else. – (Field notes May 2012)

"Maman à Genève" happened in the *Maison de Naissance* (birth house), a brand-new birth center near the Augustins tram stop and next to the maternity hospital. The midwives chose the location so that the women attending would have the chance to see it and learn about the option of giving birth out of the hospital, since primary Swiss insurance entirely covered the birth center like a hospital birth. The birth center is in a beautiful 18th-century mansion with a large walled garden on a small side street tucked off a park. A discreet sign on the gate announces the center, and you walk in and ring the bell on the large wooden door.

Women who wanted to give birth at the *Maison* needed to work with a midwife and have an uncomplicated pregnancy. The birth center only offered un-medicated births and did not have any doctors, only midwives. They had a birthing tub and encouraged women to use water to help manage pain. Women who give birth there were assisted by two midwives and parents could stay for up to 4 days. Meals were cooked in advance, and there were three menu choices. Also, unlike

at the hospital, husbands were allowed to stay at the birth center overnight for no additional charge.

The center had two delivery rooms and accommodated up to four couples in the post-partum rooms. It was an intimate and private setting. One delivery room had a tub, and the smaller one did not. Both had balls, birthing stools, beds and fabric hanging from the ceiling for women to support themselves. Everything was beautiful and bright colored, like a warm and welcoming Scandinavian bed and breakfast. There was oxygen in case of complications. Midwives could start first aid before the ambulance arrived to take women to the maternity across the street. Holding the class at the *Maison de Naissance* was only one of many strategies the midwives used to help the women build confidence in themselves and their ability to make choices during pregnancy and birth, negotiating medical authority and clinical space.

> During class, Odile brought up the topic of cesareans. She said, "sometimes things just don't work, labor won't progress, the baby won't engage, and in this case, women had to just, trust your doctor and don't worry." We spent about 5 minutes discussing cesareans. Midwives don't feel like there is a lot to say about them. She said that in Switzerland the longest the doctors would allow women to go over our due date was ten days, at which point they would schedule an induction. She explained that sometimes doctors used forceps because the babies got stuck behind the pubic bone and got too tired (she explained this only happens with an epidural). She also warned us that many women poop during the pushing part of labor because they are so focused on releasing everything. She said, "we don't talk about this much, but there is a close relationship between sex and childbirth" and she told us how both orgasm and childbirth produce the hormone oxytocin and vaginal lubrication.
>
> She said that often women were discouraged from making noise during labor because it was too sexual. Both the West-African and Albanian women nodded their heads and said that in their countries women were not supposed to make noise during labor. The mother of the Senegalese woman said she had given birth mostly silently at home two times. The midwife encouraged women to breathe and yell deep during labor and demonstrated some grunting and primal screaming. She said women should have the freedom to work and make noise. She restated the importance of support from midwives during labor, "If you want a natural birth you'll need to tell the midwives. They have two or three women at once, but you will need a midwife (the whole time). - (Field notes May 2012)

Odile's lessons outlined above centered on explaining Swiss medical practice. She wanted to teach the women to distinguish between when interventions were necessary (and they should "trust your doctor and don't worry") and when women needed to make their needs known by asking for an intervention-free birth and the extra resources requires of time and care from the hospital midwives. In her lesson, the Odile also instructed the women to advocate for themselves and scream and make noise during their delivery[13]. Her goal in demystifying the hospital experience was to help the participants in the course master their fears and approach motherhood calmly through building their trust in the Swiss medical system and their bodies and capacities. Odile and Etienne saw part of their goal as encouraging women to face their fears and reduce the medicalization of their birth experiences. However, this agenda was not accepted uncritically by the course participants or their translators, who expressed desires for interventions to minimize pain in labor, particularly the epidural, which they viewed very positively.

In the exchange below, Odile is talking with one of the participants, Eva. Unusually, Eva is speaking to her directly in English, and she is replying in French, which I'm partially translating for Eva. Eva is in her mid-30s, thin-framed with a triangular face, brown curly hair and large grey eyes. She's lived in Geneva for six years but does not speak French (although she understands it). Her husband is Bolivian, and they met in Geneva. He worked as a gardener and construction worker. They spoke English, Spanish and (a little) Polish at home and many of her friends were Polish. She found out about the class from a friend who had taken it and called the MMO to register. She was excited about having a little girl but scared about labor and delivery. Her doctor spoke Polish with her, which she found reassuring. She planned to give birth at HUG,

[13] The midwife used the French construction "il faut que" throughout her explanations in this course, which translates to "it is necessary that" and operates roughly like the English word "should" to convey a sense of rightness and imperative.

which meant she wouldn't be able to have the same doctor with her during her birth. Eva viewed the hospital as a refuge from pain and expressed a desire for the epidural even as the midwives warned about the passivity and loss of control and agency it can cause during labor.

> As we discuss what a contraction feels like at the beginning (menstrual cramps) and when to go to the hospital (when they are 3-5 minutes apart for an hour or 2 and so strong you have to concentrate), Eva got more and more anxious. As the instructor discussed techniques for managing the pain and what a contraction will feel like, Eva kept saying, "In the hospital, right?" and the instructor kept replying that this is the part where you labor at home. It was sweltering in the room, and as we discussed labor and the contractions, Eva was increasingly agitated. The midwife, Odile, asked her why she is so scared. Eva said, "I don't think I can do it, I don't think I am strong enough." Odile asked what she is nervous about and Eva replied, "the pain." She says it is not about being in Switzerland, "It would be the same in Poland." Odile then told us about epidurals but highlighted the risks. That they slow down labor, the risks for the baby, and that she thinks they are sad for the mother who misses parts of the experience. Eva was very pro-epidural, and when Odile described it as being like an airplane, where you get on, you are in an artificial space for hours, and you get off somewhere else, Eva said she liked the airplanes. We talked about fetal monitoring, induction, how the contractions ripen the cervix and the process of the cervix opening for the baby that is guided by the contractions. Odile showed us how the baby comes out with a baby-doll and plush pelvis. The soft baby-doll had a hard, plastic head that she illustrated twisting through the birth canal as it will during birth. It was sweltering in the room. We discussed the muscles in the perineum and the importance of resting in between contractions and Odile explained pain during birth is different from other pain, labor causes natural endorphins that help manage the pain. She also said it was important for women to have confidence in themselves and their bodies going into labor. She told us 90% of women in the hospital have an epidural during childbirth in Switzerland. As she continues to discuss the disadvantages of epidurals she says: "When you don't have an epidural it is you who delivers, but with the epidural, it is the doctors and nurses (who deliver the baby)." She explained how epidurals could sometimes work only on one side and sometimes can make things worse. She also said that epidurals could make the babies have to work harder during birth to compensate for the mother's inability to push and can slow down their heart rates. At this point, the Indian and Bosnian translators both jumped in to tell the stories of their children's births with epidurals and to express their satisfaction with them. The midwife told the story of an epidural leading to a vacuum delivery and explained that epidurals cause women to need catheters and lead to more medicalization of childbirth. Odile ended by telling the class that no matter what you anticipate and whether you want an un-medicated birth or not, delivery never goes as planned and we should think of it as an adventure that we go with as far as we can. She explained that at *la maternité* we'd always have a midwife with us for reassurance and encouragement. (Field Notes)

Epidurals emerged as a point of contested discourse during the class, with the participants expressing desire and acceptance of epidurals and the biomedical embrace (Delvecchio-Good 2007). The midwives focused on the risks and dangers of over-intervention and medicalization of birth in response to women's fears about physical pain. The midwives' feminism (generally and regarding birth in particular), led them to disregard or at least not support the migrant women's desires for medicalized births. Like the expat women I will discuss in the next chapter, many of the women attending "*Maman à Genève*" desired medicalized births and trusted physicians more than the midwives. Unlike the expat women giving birth in private clinics that catered to these desires, the women in this course were giving birth in the public hospital, where their ability to request interventions was limited to the epidural. To the midwives, the best way women could control their births was by limiting the number of medical interventions and advocating for their rights to a less medicalized birth experience. The midwives sought to address the anxieties that fueled the women's desire for interventions through giving women comprehensive information about the usual difficulty of pregnancy and birth and warning them about Swiss medical practices. They worked to replace the women's trust in biomedicine and the authority of physicians with confidence in themselves and their bodies' strength and ability to successfully give birth. To the midwives, desires for medical interventions and pain relief during birth were signs of fear and ignorance to be addressed with education and preparation rather than legitimate informed choices based on personal preference. They viewed themselves as arming women with the information necessary to be taken seriously by physicians and hospital midwives and participate in their care (Fortin 2009). Etienne and Odile were preparing women for birth experiences during which they would be limited in their ability to ask questions and might feel like things were being done to them rather than with them.

The prenatal course for migrant women illustrates how health education during pregnancy became a moment of targeted efforts to integrate women into Swiss society and make women feel welcomed and supported in their transition to parenthood in Geneva while encouraging them to improve their education. The experienced midwives leading the course understood birth as not only a medical but also a social experience. Their lessons aimed to help women not just achieve a less medicalized birth, but exercise agency over their births to develop confidence in themselves as strong and capable mothers practicing Swiss childcare methods. The course aimed to address women's pre and post-partum mental health through healing and strengthening their subjectivities and confidence in themselves. Throughout the course, the midwives learned about the women and tried to improve their networks of support in Geneva by connecting them with organizations and resources. The class used an individualizing (Rivkin-Fish 2005) logic to help these women become self-sufficient enough to navigate Swiss medical care and bureaucracy competently. This course is an example of how imperatives of integration can be used to include migrant women in the realm of those deserving of care (Mol 2008, Biehl 2005, Petryna 2002, Rivkin-Fish 2005). Although these women's intersectional (Crenshaw 1991) identities created situations of social, legal, and economic exclusion vis-à-vis Swiss policy and society, the liminal state of pregnancy created space for inclusion. Through this course pregnancy and motherhood became forms of social capital, enabling women to access resources to build family lives in Switzerland. The midwives highlighted the presence of the babies inside the women as sources of comfort and companionship for women alone in a strange place.

Odile emphasized the connections between mothers and babies before birth and explained that emotional states could directly affect babies because babies already have emotions. She said there was research showing that if you put your hands on your belly, the

baby's heart rate will speed up. She also said that the women did not need to worry about hurting their babies with fear or stress but that they should explain why they were unhappy to the babies so that they understood their emotions. She told us she was emphasizing this because they might feel isolated, alone, and miserable living in a strange place; and they should know that their babies were with them, and also that it was ok.

Anglophone Class

The MMO held prenatal classes in English at night from 7-9 pm on Thursdays for five weeks or in one 8-hour session on Saturdays. I attended these classes during my pregnancy while I was formulating my dissertation project. I disclosed to the midwife teaching that I was simultaneously a pregnant woman and studying women's experiences with pregnancy and birth. I also introduced myself as an anthropologist on the first day of class and had permission to talk about the course in my writing. I met many of the women who would go on to become both my core social group and key informants through the course. I attended with my husband; we chose the 5-week session because I wanted the chance to get to know other couples taking the class at the same time and meet women with similar due dates.

The English prenatal classes happened in a classroom at the MMO. The small, carpeted, room was furnished only with large cushions. The cushions were a mix of both crescent-shaped pillows for breastfeeding and pregnancy support and square floor cushions. The space was cozy and inviting, and the atmosphere was intentionally relaxing. As we walked into the room, everyone took off their shoes and sat in a circle on the floor. Couples sat next to each other or with the women leaning propped against their partners, using them as pillows, or supplemented with one of the abundant cushions. At every session, there was a small assortment of healthy Swiss snacks and drinks such as crackers, fresh and dried fruit, juice and tea.

The Anglophone prenatal courses cost 300 CHF (about 325 USD), partially reimbursed by Swiss primary health insurance. The course was designed for couples, although the instructor was clear that partners did not have to be romantic partners but could be friends, relatives or any other person who would be supporting the pregnant women during birth, the course also welcomed same-sex couples. The focus of most of the content was on the biological and social changes of pregnancy and preparing for the experience of labor and birth. The five couples in the course were encouraged to socialize and form friendships that continued beyond the class. The course had roughly four main topics: pregnancy health, labor and delivery processes, what to expect at the hospital and interventions, breastfeeding and early infant care. The midwife covered one item per week in informal presentations. People had many opportunities to stop and ask questions and discuss the course material relating it to their personal experiences.

Eliza, a working midwife with MMO, led the course. She worked extensively as a hospital midwife at HUG and the private hospitals and focused her current practice on providing post-partum support as a postnatal midwife. Eliza assumed a high baseline level of knowledge of the biological mechanisms of reproductive processes, including pregnancy and birth, and the mechanisms of conception and contraception. The content of the course focused on easing pregnancy symptoms, preparing emotionally and physically for labor, choosing where to give birth, the rights of pregnant women in Switzerland, and the kinds of interventions to look out for in delivery. In this course, few if any expectations of integration were placed on the participants.

On the first day of the course, Eliza asked us not to repeat or discuss what was said in the class to others outside of the course, to make it a safe space for people to ask any questions they may have. This rule is why I only discuss the general outlines of the kinds of content and subjects covered, which I received permission to do. I'll address the participants in similarly

general terms, noting the ones who became vital interlocutors and whose birth stories I include in the next chapter.

The request to keep the contents of the course confidential echoed themes of privacy, confidentiality, and security about health, bodily experience, and family life that come up again and again in conversations about health and support in the expat community in Geneva. Often, women talked about these concerns in the language of seeking "trust" and individualized attention from their healthcare provider. I argue this is part of the transnational ethos of individualized care (Rivkin-Fish 2005) and safety that expat women expected and received as global consumers of healthcare. This privacy was costly, both in money and paradoxically in risk. The private hospitals and doctors that met these desires effectively operated outside of much state oversight. Although private care was expensive and built on trust, patients did not know how to complain and rarely did if something went wrong, as I'll discuss in chapter three. In the context of the prenatal courses at the MMO, the focus on privacy and confidentiality in the expat class stood in stark contrast to the expectations in the course for migrant women. In that course, women agreed to interviews with researchers from the University of Geneva, welcoming them (and me) as observers and participants each week as the terms for attending class.

The underlying purpose of the class was to give the participants a chance to form relationships with other new parents in the course, the MMO, and the instructor. A post-partum midwife, she would care for most of the women in the class and their babies immediately after birth and became a trusted support person for those with complicated deliveries and whose babies needed extra care. She helped women find pediatricians, and when necessary provided translation and mediation for women dealing with the French hospital and healthcare system

after birth. This course allowed expat mothers to build networks and obtain personalized care (Rivkin-Fish 2005).

I met Ellen in the Anglophone course, and she became a core interlocutor of my research. Ellen moved to Geneva for a high-level job with a multinational corporation shortly before becoming pregnant with her first child, a boy. Outgoing and friendly, she worked actively during her pregnancy to build a support network in Geneva with other expat women during her pregnancy through taking prenatal classes in English. She hosted brunches and other get-togethers with the other families from the course, and got involved with the significant expat mother's groups online and went to in-person meetups. Ellen's social world was entirely anglophone; she spoke no French. Ellen took the prenatal course as a strategy to make personal connections in Geneva that supported her as she adjusted to life with a new baby and transitioned to parenthood.

> Ellen: I wanted to do it [take the course] because in the UK it is a really big thing with how you meet, like, mums that are close to you in your community and also close to you in the time that you are going to have your baby. So, all of my friends that have had babies in the UK have made really good friends from their classes. So, like 20% of it was learning how to have a baby and 80% of it was meeting people that I could then stay friends with, build friendships with since our kids would be the same age. And I thought the class was brilliant; I'm really glad I did it. I really loved it. Even though I started it thinking 20% was about the childbirth, having, if I hadn't been to those classes I think I would have had a nightmare labor. Because we got left quite a long time when we were in labor and had we not gone through all the techniques [...] I'm really glad that we did the classes because they gave us, they were invaluable when we were in labor.

Eliza viewed herself as empowering the students to take control over their birth experiences and become confident mothers, but she also built personal relationships with the students in the course and became a trusted resource for questions and support before, during, and after birth. Eliza, like Odile and Etienne, worked to help the women in the course overcome their anxieties and build networks of care for after birth. However, Eliza developed trust with the

course participants through building a personal relationship of care and friendship, making arrangements to provide care for the women after birth personally. In contrast, Odile and Etienne worked to build trust between the women in their course and Swiss midwives more broadly through talking about the midwives they would meet at the hospital and beyond.

> Ellen: Yeah. I mean, Eliza came ‘round here pretty much every day for the first probably four months of Reuben's life because he wasn't gaining weight, he had lots of trouble on top of the not moving thing, so feeding was a challenge and weight, putting on weight was just not happening at all. So, she came and weighed him pretty much every day. And she was instrumental in phoning the hospital up and getting to the bottom of the very first initial phone call I had from them about his test results. And she was just here a lot and she kind of went through it with us. And again, like all of the other specialists, I could text her at any point and say, "I've got a lump on my boob, what should I do." And she would just come round and see me. And I really built a strong relationship with her because she was, you know, here so much in the beginning.

Eliza, like Etienne and Odile, tried to give the participants in her course the tools to advocate for the birth experiences they wanted through encouraging the students to write birth plans to give to their doctor before delivery. She reviewed and helped revise these plans, helping to translate them into French so the hospital staff and doctors could read them. She encouraged women to advocate for less medicalized birth experiences and focused on giving them tools to have vaginal births and minimalize medical interventions. However, as I’ll show in chapter three, birth plans were an ineffective way for women to communicate with their physicians. The tradeoff of the physician guide relationship created dynamics of trust but also put physician guides in positions of authority where they expected to control the course of labor and delivery for their patients (Grimen 2009). Also, some course participants feared childbirth and actively desired medicalized birth experiences, including elective cesareans, which were only available to women with private insurance. Birth interventions around pain relief emerged as a site of contested discussion in the Anglophone as well as the migrant prenatal courses. One of the

critical aspects of the Anglophone course was the expectation that the women would be supported through private care and should be able to exert active control over their births. Eliza became a trusted care-provider to women in the course and inspired one participant, Mia, to change doctors and re-evaluate her birth plan to give birth at HUG where midwives were a more significant part of the process.

> Mia: Although I did feel like it was great, I did feel, now reflecting on it afterward, because the midwife was so great and sort of very much in line with what I had hoped. I think that I was kind of lulled into a false sense of security but that is how midwives are. And the midwives that I encountered at the hospitals weren't at all like that. I think that now thinking back on it that was why it was a little bit of a shock I guess to me. I guess she was just very in tune with the experience of giving birth and what that means to women. And even though of course I had never given birth before, she managed to kind of convey that in a very accessible way and I felt that the exercises we did during the class were very helpful. I felt that she created a very safe environment. I guess she's just a natural midwife. I mean it's hard to pinpoint what that is you know, but she just feels very committed. She feels very knowledgeable it feels she is there for you. And even like outside of whatever you paid for or whatever you know she's just very much like a support. And a voice in a way that a doctor would never know. I find it very hard to believe that a doctor could ever play that role, or would play that role.

Swiss providers and social institutions viewed pregnancy as a time of particular vulnerability and liminality for pregnant persons and their partners. The transition to family life is difficult, and they recognized the need for targeted support and interventions for pregnant persons and families during pregnancy, birth, and childhood for new families, which differed depending on migration status. The difference in these models both reflected and reinforced expat women's status as consumers who primarily related to Swiss medical, social, and legal institutions as consumers in a market relationship rather than as subjects of state power. The Swiss state and society intervened to varying degrees into women's lives during their transitions to parenthood and provided targeted support to help women integrate into Swiss society as maternal citizens (Ginsberg and Rapp 1991, Rivkin-Fish 2005, 2009, 2010, Paxson 2004). As

women transitioned into motherhood, they interacted with a range of formal and informal, public and private social support organizations that focused on helping them integrate into their new roles and participate in Swiss social and political life.

CHAPTER 3: RITES OF PASSAGE UNMOORED

Introduction

> […] being in charge can be difficult, you must call the shots, but how? (Mol 2008:16).

For the expat women I interviewed, the imperative to "be in charge" by making good choices shaped the way they sought care and made decisions about where to give birth in Geneva. The interviews I conducted with expat mothers about their births revealed the vulnerabilities faced by women living highly mobile lives as they became mothers, even in the best circumstances where women had access to economic and social capital and were able to make choices about where and with whom they wanted to give birth.

The model of personalized care normalized in the private clinic and through services for expectant expats made it more difficult for them to integrate, both into their new roles as mothers and into the Swiss community. Their identity as consumers of care, and their preference for finding "physician guides" to mediate their pregnancy and birth experiences, both culturally and linguistically, often kept them from building strong on-the-ground relationships with local experts and caregivers while furthering their subjectivity as outsiders and sense of isolation.
In Switzerland, a medicalized system of obstetrical care provided by physicians co-exists with a vital midwifery community that takes a holistic approach to care. Swiss healthcare works on a fee-for-service basis, in the context of a healthy welfare state. A high baseline level of care is available under the compulsory basic insurance program which offers subsidized health insurance that must cover essential health conditions including maternity care. The Swiss understand birth as a moment of vulnerability and provide exceptional social and medical

support for new parents. This chapter explores the logic of care in these parallel settings to look at the way that these systems shape birth into very different rites of passage, leading to different maternal subjectivities (Kaufman & Morgan 2005:320).

> Whereas earlier anthropological approaches to reproduction tended to focus on how reproductive practices and beliefs *reflected* social and cultural systems, scholars now argue that anthropology can benefit from viewing reproduction itself as a key site for understanding the ways in which people *re*conceptualize and *re*organize the world in which they live (Van Hollen 2003, p. 5; emphasis in original, in Kaufman & Morgan 2005:322).

In this chapter, I focus on the stories expat women tell about their birth experiences in Geneva to examine the ways the private clinics and the strategy of choosing a personal "physician guide" to shepherd them through pregnancy and birth create conditions where women feel unable to question physician authority. Birth stories are potent stories women tell about themselves, and vulnerability, shattered trust, and the limits of control in consumer-based healthcare profoundly shaped these stories. Although the women I interviewed did not share native languages, histories, or countries of origin, they all believed in the prestige and power of biomedicine and chose to give birth in hospitals in Geneva. However, medicine in the local Swiss context was shaped by local practices and beliefs in ways that made Swiss medical practice feel significantly different from what women anticipated based on clinical medicine in other places. This difference reflects the paradox identified by Delvecchio-Good: while the prestige and images of bio-medicine are global, practice is shaped by how knowledge circulates and gets interpreted through local beliefs and norms (Delvecchio-Good 2007).

In these stories, women express broken trust, trauma, and feelings of powerlessness in the face of unexpected medical problems and interventions. These stories highlight widespread fear and reluctance towards learning French and engaging directly with the Swiss medical system, but also reveal the importance of building that knowledge and those relationships with medical staff

for women to feel confident in their birth experience. I argue that the model of the physician guide promises women empowerment as consumers through offering care in their language from a trusted physician, but this promise is unfulfilled because of the absolute authority the physician-guide accrues and the economic incentives for medicalizing births in the private clinics.

The ways expat women navigated pregnancy and birth in Geneva Switzerland provided a case-study for understanding how market-driven identities can undermine state-driven projects of social cohesion through creating blindness in both circulating subjects and state interventions. For the expat women I studied, the communities through which expat women sought care and the kind of prenatal care they received, both shaped their choices to rely on physician guides and made engaging with the Swiss clinics and learning French often feel optional.

Expat strategies for navigating Geneva and forming communities of support created blind spots in their understanding of Swiss medical culture. They searched for information to make birth decisions through English-language websites and forums, they often interacted with and sought advice from other expat mothers, and when they took prenatal education courses, they worked with instructors who viewed them as highly informed and competent subjects who needed support during the social transition to parenthood rather than information about how to find quality healthcare. Examining these processes reveals how women form and reproduce communities of outsiders and families in which citizenship and social participation is strategic and voluntary. Expat pregnant people and families mainly operated outside of the scope of Swiss efforts for integration. They had no trouble accessing care and social support such as language classes through the private market, so they barely interacted with the institutions that supported

and shaped family life in Switzerland. Expat women viewed their interactions and relationships with Swiss care providers through the lens of individual bonds and market transactions.

Birth as a Grounded Rite of Passage

Giving birth in a hospital is both a medical and ritual act. Writing about the American hospital births she witnessed during her research, Davis Floyd highlighted the form and meaning of medical interventions as ritual in American hospitals:

> Obstetrical procedures are in fact rational ritual responses to our technocratic society's extreme fear of the natural processes on which it still depends for its continued existence. Cumulatively, routine obstetrical procedures such as intravenous feeding, electronic monitoring, and episiotomy are felt by those who perform them to transform the unpredictable and uncontrollable natural process of birth into a relatively predictable and controllable technological phenomenon that reinforces American society's most fundamental beliefs about the superiority of technology over nature (Davis Floyd 2003:4)

What Davis Floyd documented in the American hospital held true for many of the women I spoke to during my research. They viewed the private hospital as a space of safety and control, and private physicians offered the promise of predictability to make the unknowns of birth less frightening. Birth also became a key rite of passage into the expat community, and the choices women made about their births signaled belonging into this specific social and class milieu.

I examine the birth narratives of selected women to serve as case studies showing the ways that the privatized world of expat healthcare and the strategies women used to mediate their interaction with Swiss medical culture and practice shaped their transitions to motherhood. I look at birth as a rite of passage that women approach and understand through the contingencies of their identities as privileged outsiders in Geneva (Kaufman & Morgan 2005:322). Over ninety percent of women who give birth in Switzerland use an epidural, and the rates for cesarean section in 2010[14], were 32.6% overall and 30.5% in the canton of Geneva and over 41.4-41.6%

[14] the most recent year reported

in private clinics (Hanselmann, von Greyerz 2013:12-16). In 2010, 31.5% of women who gave birth in Swiss hospitals were non-Swiss. These women also had higher rates of cesarean sections than Swiss women, 1.5% higher for women from South America, and 1.2% higher for women from Africa and Italy (Hanselmann, von Greyerz 2013:17).

Strategies such as relying on a partner or a physician guide in a private clinic allowed them to mediate and translate their engagement with the health system, to make the strange familiar. These strategies also allowed women to experience themselves as in control over the extent of their interactions with it. However, dynamics of privilege and power shaped the success of their efforts in ways often unpredictable and non-straightforward and increase medicalization of birth.

Over the course of my research, I observed that most of the expat women I interviewed either did not interact at all with the support structures that Swiss and migrant women relied on or associated with them in limited ways. While it seems self-evident that they would not interact with NGOs and clinical outreach aimed at low-income and vulnerable women, expat women rarely sought care at the HUG where the vast majorities of babies are born, and their interactions with Swiss healthcare and support for new parents centered around midwifery care during prenatal classes and post-partum visits. Birth almost always happened in private clinics, with a private doctor attending. Unlike in many settings where government-provided care is lower quality than care available through the consumer economy (Rivkin-Fish 2005), that is not the case in Geneva.

Although HUG is the public hospital in Geneva, it is also the best one from a patient care perspective. Private maternity hospitals around Geneva only take mothers who have surpassed their 34th week of pregnancy, because they do not have NICU facilities. Any families that

experience severe complications during pregnancy birth or the post-partum period end up transferred to HUG.

The private clinics highlight the care they can provide to expectant parents rather than being explicit about their limits. For example, the neo-natal unit at La Tour is called an "Intermediary Care Unit" and is described on their website with reassuring copy about the difficulties babies experience in the first days after birth:

> The Neonatology Intermediary Care Unit at the Hôpital de La Tour treats premature infants from 34 weeks of gestational age as well as babies born at term with difficulties in adapting after birth. **It is important to underline that neonatal adaptation difficulties are usually temporary. This intermediary care unit therefore strives to avoid hurried and costly transfers for babies to the Geneva University Hospital**, but through the most suitable framework, helps to nurture parental ties, which are still fragile at this particularly vulnerable time in neonatal development.[15]

In addition, the hospital's website (available in French and English) highlights its unique ability to provide a nurturing and safe experience for parents of new babies and encouraging them to "take an active role" in their child's care, creating an image of the parent as in control and empowered within the hospital.

> The structure of the department has been designed to provide the best and closest proximity of the parents to their sick child. **In order to reinforce parental ties, the team encourages parents to take an active role in every aspect of their baby's care.** Parents are also invited to use the "kangaroo" technique as soon as possible. This involves holding the baby against their body, with skin-to-skin contact right from birth, which helps to forge the initial parent-child bonds[16].

HUG, as a public hospital, does not have marketing websites in English to appeal to expat parents. It also has much lower cesarean rates than the private clinics and practices less medicalized and more midwife driven birth. However, at HUG care was provided mostly in

[15] https://www.la-tour.ch/en/doctors-db-en/medical-specialties/neonatology/

[16] https://www.la-tour.ch/en/doctors-db-en/medical-specialties/neonatology/

French and it was not possible to request a particular doctor or midwife to attend labor and delivery. Private doctors were unable to supervise births at the HUG, so women often gave birth with a provider they did not personally know.

The expat women I interviewed often chose a much more medicalized and potentially risky birth experience to be able to have a trusted doctor attend their birth, speak to them in their native language, and directly supervise their care in private clinics. Most of the expat women I talked to did not speak French or have much awareness of Swiss laws or norms. Instead, expat women worked to form a parallel community of women in a similar situation and relied on paid services and consumer-based care to take the place of the public services and support. When they researched hospitals, they looked at marketing pages in English from private clinics, often not even encountering information about HUG.

In the pregnancy and birth narratives of the expat women I interviewed, what Annmarie Mol calls "the logic of choice" and the "logic of care" (Mol 2008) interact and conflict. The women I interviewed were mostly used to being in control, and would often try to be good, informed consumers choosing where and with whom to give birth. In fact, making these decisions was a source of anxiety and endless discussion among expat women. However, they also expressed the desire to trust their physician, and relinquish the task of making choices to someone who would care for them. In our current capitalist moment, the consumer model of care is increasingly dominant, and we valorize the idea of being empowered and informed consumers of information and healthcare.

This model of care could lead expat women to misplace their trust into their doctors and cultivate relationships with their "physician guides" while ignoring or dismissing the robust structures of social and medical support offered by the midwifery community and social

organizations for mothers across Geneva. Reproduction, pregnancy, and birth are bodily experiences that are limited to female bodies and thus coded as essentially female, although they are by no means universal processes (Martin 1987:4). "Beginnings and ends are contingent local concepts, the meanings of which are neither stable nor self-evident" (Kaufman & Morgan 2005:320). Therefore, following Davis-Floyd (1994, 2003) I think about pregnancy and birth as rites of passage, and examine the kinds of relationships and interactions that shape women's experience of "integration" and transition to maternal identities.

The exclusive communities expat women built with other mothers (described in chapter one) were helpful and comforting but did not encourage women to access the local Swiss networks of care, since women in the groups did not tend to be aware of them or be able to speak French well enough to use and build relationships with them. These communities can only provide certain kinds of support.

Class identity is an essential factor in constructing and resisting commodified migrant subjectivities (Constable 2009:52). Chapter two explored how expat women's positions of privilege shaped their ability to access the extensive support networks for mothers in Geneva and the information they got during pregnancy to prepare them for birth. I argue that the model of personalized care normalized in the private clinic and through services for expectant expats made it more difficult for them to integrate, both into their new roles as mothers and into the Swiss community. They do not become "*bien-integrées*." Their identity as consumers of care, and their preference for finding "physician guides" to mediate their pregnancy and birth experiences, both culturally and linguistically, often kept them from building strong on-the-ground relationships with local experts and caregivers while furthering their subjectivity as outsiders and sense of isolation.

The physical process of pregnancy and giving birth is a moment that challenges assumptions of expats as autonomous subjects in control of their bodies[17]. I argue that birth is a moment when women are simultaneously leveraging their privilege and social capital to manage the strange environment of Geneva and the clinic, and also a moment at which this privilege, combined with their foreignness, makes them particularly vulnerable to losing control of their experiences. Birth is a messy and unpredictable process, and one in which the women I interviewed found themselves in the role of the patient, struggling to both maintain their autonomous selves and build new identities as mothers. Despite coming from very different national backgrounds, the expat women I interviewed shared a belief in what Melissa Cheyney has coined the "obstetric imaginary" defined as the belief that obstetrics care in a hospital guarantees a safe birth outcome.

Davis Floyd (1994, 2003) and Cheyney (2011) examine American hospital and home births respectively, to show the different ways that women participate and conform to their role as subjects and ritual participants during delivery. Davis Floyd treats the American hospital as a site for rituals illustrating the control of science over the unpredictability of nature, and discusses the subjectivities women build from their experiences. In this chapter, I examine the ways women actively engage with this process and the strategies they use for managing both the strangeness of the city and the Swiss health system and the strangeness of liminality they experience during this process.

Both of these accounts show how the process of pregnancy and birth are transformative

[17] This is a small part of the social reproduction women do as part of mothering (Maher 2010). Mothering should not be essentialized as co-terminus with this limited aspect of embodied experience. We need to avoid essentializing motherhood as exclusively female or viewing women's lives solely through the lens of maternity. Women's experiences and ideas of motherhood contain multiple levels of identity and meaning (Maher 16: 2010).

rites of passage through which women become new social subjects: mothers. “Attention to the production of mothers emerges from the feminist conviction that mothers are agents (rather than objects) of social reproduction” (Kaufman & Morgan 2005:322). Focusing on women’s narratives of pregnancy and birth allows us to examine the ways they experience themselves as agents and how they consciously use privileged aspects of their identities to control their experiences.

At the same time, this chapter seeks to examine the contingencies and circumstances that shape women’s decision making as they attempt to navigate pregnancy and birth with information that is always partial and incomplete. This view complicates the picture of women as "rational actors" deliberately timing and controlling pregnancy and childbirth (Rivkin-Fish 2010:722).

Expat mothers in Geneva navigate this rite of passage at the same time they are dealing with the many challenges of finding a sense of belonging and establishing an identity in the city. In this situation, they are experiencing pregnancy and birth as outsiders, and bring their ideas about the meanings and rituals that should accompany delivery into the unfamiliar Swiss setting. Becoming mothers in a strange city encompasses additional challenges, as many women don’t understand Swiss medical practices or the types of rituals they participate in having babies there. However, expat women in Geneva have access to varying and diverse kinds of privilege that can both aid them in navigating these challenges, and sometimes work unpredictably, get lost, or create additional hazards and vulnerabilities.

Location and Economies of Control and Care

Thinking about birth as a rite of passage demands thinking about the structures, practices, and rituals that surround and shape it. This chapter examines the experiences of women giving birth in two types of clinical locations (the public hospital and the private clinic) and examines

two different strategies the women I interviewed employed to tame this unfamiliar environment. In discussing the private clinic, I'll focus on the figure of the "physician guide." In this model of care, women see the same provider throughout their pregnancies, and that person follows them to the clinic to deliver their baby. The public hospital is a less personalized setting and forced women to accommodate more to the Swiss system by navigating in French, often sharing rooms, and working with whatever doctors and midwives are on-call at the hospital.

Location matters in these stories regarding both the micro-geographies of clinical space and as part of women's narratives of becoming mothers for the first time in a strange city while displaced from their home society or as part of highly-mobile lives lived abroad. Space and place play critical roles in the narratives of expat women becoming mothers. The women I interviewed positioned their stories of becoming mothers within larger narratives of motion and migration, first coming to Geneva, and then navigating the city as they became mothers. Managing the strangeness of clinical space was just one aspect of a more extensive task of managing the weirdness of Geneva.

Given the stratified nature of the healthcare system in Geneva, “Where will you/ did you have him/her?” was a loaded question almost always asked during the first “getting to know you” conversation involving pregnant women and new mothers. Whether a woman had given birth at *la maternité* or a private clinic (and further, which private clinic) revealed information about that person's class background and desires and ideology around pregnancy and birth. These codes were often implicit in discussions among pregnant women and new mothers, and sometimes explicit, as when I was near delivering my son in the summer of 2012 and a Swiss friend I met during my research with a feminist organization asked where I planned to have him. I explained I’d be giving birth at the private clinic near where I lived on the border since it was

an hour into town to *la maternité* for me and I wanted my gynecologist with me (and I had American private insurance that actually would not cover care at the HUG). She looked at me seriously and said, "You will get the real expat experience then! Swiss women can't give birth there. Be careful you don't let them give you a cesarean; they want to do them for extra money!" Her warning was not the last time I heard warnings like this about the private clinic, the midwives I interviewed and worked alongside during my research also warned me about the pervasiveness of the profit motive in private clinics. "*Attention!"*

My friend and many people outside of the expat community I spoke with in Geneva, coded private clinics as spaces of both privilege and danger. They were places where very few women could afford to give birth because of the high cost of supplementary insurance, and, conversely, where you had to be careful to guard yourself against unnecessary care, because the hospitals and doctors were seen to be concerned with financial gain. However, among expat women, the presence of one's personal doctor during birth and the highly advertised luxe amenities of the clinics often made them less intimidating and more desirable than *la maternité*.

Expat mothers in Geneva navigated many challenges as they worked for a sense of belonging in the city. In this situation, they experienced pregnancy and birth as outsiders, and brought their ideas about the meanings and rituals (Davis Floyd 2003, Cheyney 2011:521) that should accompany delivery into the unfamiliar Swiss setting. Becoming mothers in a strange city encompassed additional challenges, as many women didn't understand the Swiss medical practices or the types of rituals they participated in having babies there. "Women's mothering is constituted and conducted in the context of intersecting institutions of gender, family, the market, and the State." (Maher 2010:18).

La Maternité

In Switzerland, most births take place in a hospital where midwives provide the majority of prenatal, delivery, and postpartum care. The vast majority of babies in Geneva are born in the cantonal hospital, the *Hôpital Universitaire de Genève* (HUG), which is run by the University of Geneva and is a teaching and research hospital.

The women's hospital in the HUG is known simply as "*la maternité*." Part of the sprawling hospital complex that dominates a busy area of downtown Geneva, during my research it inhabited a kind Franken-building, the bones of the previous early 19th century stone hospital still visible as the modern version had expanded out the side through a knocked down back wall and glass and steel appendage, dug underneath to connect to the main hospital through a system of tunnels, and connected to an ever-expanding set of modern buildings through the side. It is the largest maternity hospital in Switzerland, and according to their website, about 4000 babies are born there each year. Similar to an established public teaching hospital in the United States, births are attended by whichever doctors and midwives happen to be on call at the time. While it is possible with primary insurance to see a doctor for prenatal care (at *la maternité* midwives provide all routine prenatal care), they are not allowed to accompany patients to *la maternité* to attend births. The HUG system runs entirely in French, although individual doctors may speak English. After birth mothers share rooms with up to 3 other mothers and babies during their postpartum care, depending on the level of insurance they carry as well as the health of the mother and child. In addition to the standard practice, it is possible with private insurance to see one of the doctors on staff at the HUG for prenatal care and delivery and to have a private room after the birth.

The HUG is known for lowering cesarean section rate and just built a birthing center, the *Maison de Naissance*, across the street from the main hospital (opened in January of 2012). The

four-room birthing center provides a setting for un-medicated and midwife-assisted birth in a less medicalized environment and is accessible to women with all types of insurance. It is in a beautiful Victorian house, and the interior is cozy and redolent of blonde wood.

However, not a single expat woman I interviewed (including Diana and Ruby) gave birth in the *Maison de Naissance*, and when I asked women whether they felt they had a choice of where to give birth, either they answered "yes" and discussed the factors that made them choose the private clinic where they gave birth, or "no" and described going to *la maternité* because of their basic insurance coverage. Although the majority of women in the canton of Geneva give birth in *la maternité*, the majority of expat women I interviewed in the course of my research gave birth in one of the three private clinics in the city. The working class "migrant" women I met during "*Maman à Genève*" gave birth at HUG or in the *Maison*.

Of the expat women I interviewed about their births, only one had elected midwives for prenatal care, and although she saw only midwives for her prenatal care, she still gave birth at *la maternité* rather than the *Maison de Naissance*.

Out of the thirty expat women I interviewed during my research, four did give birth in the HUG. Most of the women who did prenatal care and gave birth in the HUG did so because they had moved to Geneva already pregnant and were unable to qualify for the private insurance needed to deliver in a private clinic. However, some women also chose the HUG looking for a less medicalized birthing experience based on its reputation of working to minimize C-section rates. One woman I interviewed had moved to Geneva from the Netherlands and participated in a pilot project at the HUG that provided entirely midwife-led care in a group setting during pregnancy. Another left her private physician shortly before giving birth to have her baby at the HUG instead of a private clinic (although with private care, which entailed a private room at the

hospital and the ability to choose and receive care from a designated physician on staff who would attend her birth).

Samantha's experience giving birth at *la maternité* as part of the pilot project for *accompagnement global,* a new method in which women were cared for in groups by a group of midwives throughout their pregnancy and birth, differed significantly from the experiences of most of the women I interviewed. Samantha was a mobile UN professional in her early to mid-thirties. Formerly from England, she was married to an Irish professional, and both of them had built their careers entirely abroad. She had traveled in and out of Geneva a few times in the course of her professional life, and unlike most expat women I interviewed, she had made a very deliberate choice to move back to the city during her pregnancy and establish a life there that she viewed as permanent. In part because of this, her and her husband both worked very hard to learn French, both for their daily life in the city and particularly for the birth of their first child. Although neither of them was fluent at the time she gave birth, they were both able and willing to work to communicate primarily in French with the midwives and nurses. Her husband Sean had even taken an accelerated course in French before the birth. Samantha was six months pregnant when she moved to the city from the Netherlands, and her insurance only covered her at HUG. Because she was migrating from a country with a midwife-led approach to birth, she was approached by the hospital to participate in the group midwife project. As part of that project, she took prenatal classes with the midwives (in French) and delivered at the hospital under the care of the same midwives she'd seen through the portion of her pregnancy she spent in Geneva. Her husband Sean accompanied her to the classes and was the only male partner who participated.

Rather than deferring to the midwives during her birth, Samantha relied on Sean to be "in

charge" during labor and delivery. When I asked if she felt comfortable asking questions during her pregnancy and birth she responded:

> Samantha: Yeah, I think so, leading up to, I mean, again there wasn't really any issues as such, and then even in the labor, I mean there were just a couple of little complications, and Sean was in charge. And he felt like we were asking questions and just clarifying what was happening at each stage, so it was really good.

He took an active role in the entire process, from attending prenatal classes, learning medical French, physically and emotionally supporting her during labor, and communicating with the midwives and doctor during the birth.

Although there were moments of tension and medical complications during Samantha's birth that required a doctor to step in, she described the process as healthy and normal ("a lovely birth"), even being able to time birth so that she avoided her child being born on Halloween.

During her birth at the HUG, Samantha engaged with the francophone hospital more than most of the other women I interviewed, although she still noted a strong preference to have medical providers who spoke English, in case there was a problem. Instead of having a personal relationship with a particular doctor to guide her through birth and mediate her engagement with the hospital, she relied on her husband to work with her during delivery.

Mia also gave birth in HUG as a private patient, so even though she was at the public hospital, her care was more like the care provided in the private clinic. She very deliberately chose to give birth in the public hospital because coming from Sweden and working in public health, she did not believe private healthcare was ethical and did not want to support a private clinic. However, since her UN insurance was private, she was compelled to receive care from a private physician in a private room.

Mia changed physicians late in her pregnancy after attending the English prenatal class to find someone she felt was more likely to allow her to have the low-intervention birth she wanted.

However, she had a difficult labor ten days after her due date. Desperate to avoid a medical induction, she induced labor at home by drinking castor oil and had an unpleasant and prolonged labor that ended in an emergency cesarean.

> I mean I think that because very little of the information is presented to you as options, you don't feel the need to disagree. Or you feel the need to reflect on whether or not this is the right thing for at least, I don't, then maybe that's, again I don't know if this was a Swedish thing with me very high trust in the state and you know health care workers, and so you know the system. And also, you know, who am I to challenge based on what mean if this is a medical doctor and they say that this is the case I don't have a medical degree. Why would I? But I could definitely think through having now gone through it then because also I mean, and I'm sure that we'll get to that later but because the birth hse been quite complicated there I do feel that there were a number of decisions along the way, where if I had known then what I know now I definitely would have challenged my doctors. But I didn't at that point because I didn't know any better.

Despite switching doctors, having taken a prenatal class and written a birth plan, as well as being a professional health worker, she did not feel like she could disagree with or question her doctors during her complicated birth. She ended up having a very unwanted Cesarean. During her delivery, she didn't feel like she could trust her doctor and struggled to communicate with midwives at critical moments because she could not speak French and found Swiss medical culture overly formal and alienating.

"She's holding my leg saying "Push Madame H----, push!" I mean, you're calling me Madame at this moment? It was absurd". Like Samantha, Mia's husband did the work of managing her interaction with the hospital during birth, even refusing care from a midwife who she disliked and insisting that she leave and someone else come in. In this case, she did not view her physician as a trusted guide, but rather as the English-speaking representative of a frightening and adversarial medical system. Mia talked about her birth as a traumatic experience and had intense feelings of guilt for agreeing to the medical interventions that led to her surgical

birth. She left Geneva to spend her maternity leave recuperating in Sweden but returned to resume her job at the UN when her son was four months old.

Language and the Physician Guide

Although Geneva is an incredibly diverse city regarding population, it is not linguistically diverse. Language ability maps onto class and professional status in Geneva. In a healthcare setting, midwives, nurses, and hospital administrative employees are often exclusively francophone, whereas doctors and higher administration are at least bilingual in French and English. For the most part, people speak French, and this is particularly true in the context of healthcare and official business at the level of the front-line workers who interact with patients. Most women I interviewed did not speak French at the time of their pregnancies and used various strategies to navigate the Francophone healthcare system.

Many expat women managed their pregnancies and births through the strategy of finding a doctor they felt they could trust who spoke their language to act as a guide and intermediary between them and the hospital and follow them through prenatal care and delivery. Finding a physician and being able to communicate freely with them in their native languages also provided important confidence and reassurance during their pregnancies. Of course, women's ability to find providers who spoke their native languages depended on what those languages were. Women who spoke English had a wide variety of choices when choosing providers. Women who spoke Spanish, German or Portuguese were often able to find doctors to work with them in those languages, but their options were more limited. Interestingly, many women chose to seek healthcare providers in English even if it was not their native language. This reflects both the global dominance of English and the market-demand for English spurred by the international community in Geneva, who were willing to pay a premium for English. Also, many corporations and international organizations based in Geneva kept lists of English-speaking providers, which

women commonly used to find their healthcare providers.

Women expressed over and over in our interviews that even if they were capable French speakers, communicating with medical providers in their native languages was safer. It was vital for them to understand what was going on, an understanding they felt like they could not trust in French where they might miss nuance and have to guess at meanings.

Trust and Care in the Private Clinic

The private clinics in Geneva are extremely small compared to *la maternité* (the largest clinic I discuss had 200 births a year), and all operate in English and French and advertise their amenities and spa-like atmospheres as well as top-notch medical care. Ellen gave birth in a small private clinic that marketed itself based on its luxurious and relaxing service and surroundings, seeming more like a hotel than a clinic. This particular clinic was most famous for offering new parents a post-birth romantic and celebratory dinner of steak or lobster with Champagne while the new baby was cared for in the nursery by the clinic staff.

The clinic where Ruby, Clarissa, and Diana had their babies was less expensive than many of the others and looked and felt more like a hospital and less like a spa, although unlike at *la maternité*, they mostly guaranteed women a private room (sometimes if they had semi-private insurance and the hospital was very crowded they might have had to share). While some clinics advertised to pregnant women with perks such as romantic post-birth dinners, this clinic was a WHO certified baby-friendly hospital.

The baby-friendly hospital encouraged breastfeeding through not giving formula or pacifiers, practiced rooming in for mothers and babies, and promoted the idea of natural deliveries. Two of four delivery rooms included bathtubs for labor, some had birthing stools, and all included birth balls. Midwives also did the vast majority of delivery and post-partum care at this clinic, with the doctors just checking on women every few hours during labor, actually

catching the baby, and performing cesareans and other interventions. Like all private clinics in Geneva, this clinic only handled births after 34 weeks because they lacked the full NICU resources at *la maternité*. In short, this clinic, in particular, promoted an image of birth centered on a healthy and natural experience for the mother and the child, with as few medical interventions as possible, and in the presence of the woman's own trusted gynecologist. However, there was still champagne.

Figure 8. Evian and Champagne at the birth of the author's baby in a private clinic outside of Geneva

All of the private clinics in Geneva contracted with certain ob-gyns who had privileges to practice there, and the primary draw was the promise that women would deliver with the physician they had seen throughout their pregnancy, and who they trusted.

> Ellen: I wouldn't disagree with him because he knows way better than I do if my baby's head is in the right place or not. I mean, I really trusted him. He was, you know right from the start I could tell that he was very high in his profession and knew what he was talking about. So […] I would have just gone along with it anyways because I just trusted what he was saying. If I had wanted to disagree with him, I'm sure I could have, and he

would have been fine with it.

Ellen had a mildly complicated pregnancy and gave birth to a medically fragile baby boy at 36 weeks. Although she was able to have the drug-free "natural" labor and birth experience she had wanted, with the support of her physician, her son's early days were scary and confusing. He was severely ill and needed what ended up being six weeks of hospitalization post-birth, followed by months of confusion, tests, and interventions. She spent the first ten days in the private clinic before moving to the HUG for her son's care. Her story and her interaction with the Swiss medical system is complicated and contradictory due to the ambiguity and intensity of her son's medical condition.

> Ellen: I mean, good and bad, but I think the best thing is that they are, they are really thorough. And if they think that there is an issue, they will stop at nothing until they can put a label on it. Which, in [her son's] case was, was good but then also bad because he got diagnosed with something that was quite serious, and then subsequently, he didn't have it as bad, so we had a traumatic time because we thought that he was very sick. Whereas actually, he wasn't.

Later in our conversation, Ellen noted that her son received a battery of tests he would not have gotten in the UK and that the thoroughness of the testing arguably led to his misdiagnosis with a severe enzyme disorder which was almost always fatal in the first year. At the time, a doctor at the hospital told her bluntly that her son would not survive to be 1 and there was nothing to be done.

Despite the fear and uncertainty generated by her son's misdiagnosis, Ellen was comforted by her perception that the doctors she saw were doing everything possible for her son's health and their willingness to speak English with her and help her and her baby. Ellen benefitted from several different types of privilege that she was able to access in working to secure the best possible care and support for her son. In addition to her outgoing personality and commitment to building social networks of support in the city, she had access to vast economic

resources and private insurance. Her job provided her with a year of paid maternity leave, which enabled her to devote herself entirely to her son's care and maintaining her support networks without suffering any economic penalty.

In addition to having a trusted medical provider for her son's birth who typified the trusted "physician guide," she also built a relationship with the bilingual midwife who taught the prenatal class she attended. In Geneva, midwives usually visit new mothers at home for the first ten days after they return home from the hospital, but this midwife came almost daily to visit Ellen and her son for the first months.

The midwife provided much-needed emotional support and information to Ellen during the excruciatingly challenging first months of her son's life as she worked desperately to establish and continue breastfeeding him. She also helped Ellen mediate her interactions with the hospital and the francophone medical system, even calling the hospital to follow up after the phone-call with the wrong blood test results to clarify and make sure that Ellen understood and received not only the correct information but the proper significance from this information.

> Ellen: They've all been brilliant, they've all spoken English, they've all like I say, I've been able to contact them out of hours. But then I think our experience has been very different to a lot of people's because he was very sick when we first, at the beginning because he was very sick, you kind of get people going out of their way to help you because you know, you've got a sick baby.

During her pregnancy and her son's first months, Ellen built personal relationships with both her midwife, who became her cultural broker and advocate, and several healthcare providers who were heavily engaged in her son's care. Although she saw her experience as being out of the ordinary because of her son's fragility in the early months of his life, it was also out of the ordinary because of the resources she was able to access as she worked to get them access to the best care and help.

For Ellen, accessing a range of resources around Geneva, including mother's clubs and prenatal classes, helped her create a robust social network that helped her during her son's painful first months. Also, her strategy of relying not just solely on her gynecologist to act as a guide through the birthing process and enlisting the help of her prenatal course instructor and midwife allowed her to have multiple voices advocating on her behalf when she did hit barriers and misunderstandings with the hospital. Besides, she also was in some ways fortunate that the physician she chose turned out to be caring and supportive, even referring her to a pediatrician for after her son's birth, a connection which seems logical but almost never happened.

When I met Clarissa, a stay-at-home mother of two, she had just had her second child while in Geneva. American, she had relocated to Geneva with her husband for his job at an international organization. Although she was able to get a permit that allowed her to work in Geneva, she had quit her job teaching at an international school shortly after the birth of her first child. She has seen the same provider for both pregnancies, a Nigerian-Swiss woman ob-gyn with whom she had an exceptionally close and trusting relationship. Like most women I interviewed, she chose her provider based primarily on language.

> Clarissa: Certainly, I mean first and foremost, to be able to communicate in English, because I don't speak French, so that wasn't that convenient. And you know, the simple thing of geography, I mean somebody that was close by and, you know what's meeting her… And I wanted a woman and then once meeting her just making sure that I kind of clicked, and one of the things that I really like about my OB/GYN is that she really takes time out for the pastoral care, like that side of the medicine, and checking in on me.

Although choosing her provider had been based mostly on chance and shared language, she won her trust prior to the beginning of her first pregnancy. Clarissa had suffered a miscarriage prior to moving to Geneva and went to her doctor for the first time when she and her husband started to think about conceiving again. During that appointment, the doctor gave her an ultrasound and told her she was ovulating and to "go home and make a baby," and she

immediately became pregnant with her son. In our interview, she often emphasized the "pastoral care" and reassurance her doctor provided to her during her anxious first pregnancy. Everything from literally telling her when the time was right to conceive, to monthly ultrasounds in the office, to signing her out of work for sickness and at the end of her pregnancy.

> It was great because every visit that I went to for both of my children for my pregnancies I had an ultrasound every single time. […] but it just, it was fantastic because I got to see the baby. And I know in the US you get like two or something like that and it was really helpful to have the doctor take a look, explain things that were going on, the growth…

In Clarissa's case, she experienced this extremely close medical supervision as comforting and reassuring, increasing her trust in her doctor. Although both her children were born via cesarean section (the first one an emergency after a failed induction at 39 weeks), she did not experience this as a traumatic birth outcome. The private clinic where she gave birth was well-equipped for the cesarean, and she felt well-supported and cared for during the entire experience.

> Clarissa: Very positive. The medical, the care was really great. I think when I left [the clinic] after Evan was born, I, I mean I wept. I was so sad to leave [the clinic]. I mean clearly it was like hormonal, but I just, I think part of it was just, I mean everything was taken care of for me, the meals are amazing, it's so clean, they come and they change my sheets and they sweep my floor and they bring me Evian, like... And I was like oh my god, when we go home, our world is different.

As I discussed in the beginning of this chapter, private clinics have high rates of cesarean sections, and there is much debate about what drives these numbers. One factor is women can only demand elective cesareans in private clinics. Another is patients who can afford private care are often older. There is also a profit motive for doctors and clinics who can charge higher rates for a surgical birth and the attendant longer hospital stays (usually six or seven days for cesarean delivery in contrast to four for a vaginal birth).

The rates of cesarean section in Switzerland are higher than the United States, and the 3rd

highest in the world (Hanselmann, von Greyerz 2013). Despite the centrality of midwives to pregnancy and birth, birth is a highly medicalized experience for most women.

The problem of high cesarean rates lies outside the scope of this research. However, I want to highlight that many of the women I interviewed experienced becoming mothers in a highly medicalized context. The security and amenities of a private clinic with a trusted birth attendant statistically made them more likely to have interventions during their births. Narratives of disempowerment, alienation, and trauma were reoccurring in my interviews although, as Clarissa's story illustrates, unplanned cesareans were not always traumatic. For some women, cesareans were desirable birth outcomes. However, one woman told me during our interview that at thirty-seven weeks her OB had asked her what day she'd like to schedule her surgery, as he would only deliver via cesarean. She was able to find another provider at the last moment.

In my interactions with my Swiss gynecologist, I also experienced the close and attentive care that Clarissa received during my pregnancy and also found it very reassuring as an anxious first-time mother in a strange country. However, I came to feel there was a trade-off in that I had bought into a much more medicalized model of pregnancy than I had anticipated. When I reached the end of my pregnancy, my doctor informed me that she preferred to induce women on their due-dates. I pushed back, bringing up that I had learned in my prenatal class that under the medical guidelines we had the right to go ten days past our due date before being induced. She told me that every day past the due date increases the risk to the baby and that since she had such close relationships with her patients, she preferred not to let there be any risk for them. She said: "In the public hospital where there are 5,000 patients, and the doctors do not know the women, maybe they accept there more risks, but I follow my patients, and I really know them, and I want no risk". In the end, I had a failed induction three days after my due date that led to a cesarean.

Even as a medical anthropologist immersed in understanding the culture of medical care, well-connected with information and support, I did not feel confident enough to resist my provider's recommendations based on an ethic of care and avoiding risk, although cesareans can pose serious risks for women and babies. The close relationships women and private physicians develop over the course of pregnancy can bring with it its own set of complications and incentives. In addition to and apart from the economic incentives created by the Swiss system of private insurance, "care" and "control" and "safety" operate to incentivize doctors to seek to manage and tame women's birth experiences in ways that can bring them into conflict with their patient's desires and hopes.

Vulnerability and Control

I met Ruby as part of a meetup group for pregnant women and new mothers in the international community in Geneva shortly before the birth of my son and her daughter. In her early thirties and originally from the UK (although she lived in many countries before her move to Geneva), Ruby had circulated through Geneva a few times over the past five years but had been living and working in Sudan with the UN before and during the majority of her pregnancy. When I asked Ruby what language she spoke when she talked to doctors she explained to me:

> Ruby: I will only speak English. I kind of will only, kind of, deal with people who speak English. Just cause I feel, I'm willing to try speaking French in most situations, but that's actually something I really want to know what's going on. And it's slightly; it slightly irritates me that my daughter's doctor I sort of spoke to him and chose him because he spoke English. And every single time he'll start speaking to me in French, and every single time, I have to say, 'I'm sorry, would you mind speaking English?' Which, you know, in most situations, you know, is absolutely fine. […] Yeah, I don't want to be guessing about what they're saying when it involves medical stuff basically.

Ruby and the other women I interviewed saw interactions with medical providers as realms where being able to speak their preferred language was crucial to ensuring good health for themselves and their families. Controlling the language of interaction with healthcare

providers was a moment where women exercised their elite status. Choosing not to communicate in French was only possible for women with access to private care. "I will only deal with people who speak English" reflects Ruby's sense of herself as a consumer empowered to select the provider of her choice and set the terms of their interactions.

Ruby had to find a provider and prenatal care mostly from a distance and with very little local knowledge and ability to speak French. While Ruby had many advantages as she managed her pregnancy (including a Swiss partner and private insurance from the UN), she faced many of the same challenges as she tried to learn the Swiss medical system and maintain a sense of control and autonomy over her birth experience. She found her provider through a mix of referral from her insurance and personal recommendations.

> Ruby: I asked my insurance company for a list and picked one that was around the corner from the UN office and checked that she spoke English and she did, so that's sort of how I went with that. […] And I got really lucky. I was quite happy with my gynecologist. And since like, I've just found out like one of my colleagues had used her and was uh, and was happy with her. So that all felt like a good sign.

Although Ruby started out our interview by stating she was happy with her gynecologist, as we talked, it became clear that her feelings were pretty conflicted. Ruby wanted a non-medicalized birth with minimal interventions and discussed her goals in advance with her doctor. She chose the private clinic based on its location and promotion of natural delivery as well. “She was relatively pro sort of natural birth in theory, although, I think in reality and in retrospect maybe less so...”

Ruby’s provider insisted they go to the hospital at the very beginning of her labor, even though she had wanted to labor at home as long as possible. She listened to her and followed her instructions although it went against her instincts. When her birth became slightly complicated and required medical intervention, she blamed herself for bowing to medical authority and disregarding her instincts and sense that it was too early to go to the hospital.

Even though Ruby knew what she wanted in her birth and had taken a childbirth class to prepare, she still found herself in a position where the directions she was getting from her doctor contradicted what she felt and had learned to be best. She ended up with a more medicalized birth experience than she wanted. In her narrative, she continually discussed her doubts in a way that suggests she felt responsible for the outcome. For Ruby, her birth experience made her question the trust she had placed in her provider. Her belief in her doctor fell apart during her painful recovery when she had a lot of complications including infections from her tearing and episiotomy and pelvic floor problems. Throughout the narration of her birth and recovery experience in Geneva, Ruby expressed a lack of trust in her physician-guide. After her traumatic birth, the relationship became openly hostile.

> Ruby: I felt like she really um, kind of was like not interested in all the problems I was having and didn't really follow up, I don't feel like she followed up enough. And, and at one point, like on the third infection, she looked at me and said, like, saw this thing that was extremely painful and said, "I think you've got herpes, I think it's herpes." Which totally freaked me out! She didn't say anything else. She said, "Oh, I'll take a swab and um, send it off, but it looks, looks to me like herpes." Which I was totally surprised at, because I've never had a, you know, an STI, and I didn't really entirely know what it meant, but knew that that was bad and that I'd have it forever kind of thing. […] But she gave me no more information than that, just sort of sent me away. And I was really upset!

Eventually, Ruby's doctor referred her to a specialist in Geneva for pelvic floor problems. She described this experience as "the worst medical experience of my life." The doctor was rough with her and did procedures on her without her consent.

> Ruby: If I was in the UK, FOR SURE I would have reported him, no questions asked. But here I was just, I just kind of couldn't be bothered to deal with how to figure it out, figure that out, and didn't really want to try to do it in another language. […] He spoke very good English, and it wasn't a language thing, which was, it was maybe a cultural thing, but it definitely wasn't a language thing, because he could totally communicate with me.

Although the doctor she saw for her injury spoke English and was reputed to be the expert in pelvic floor therapy in this encounter, Ruby's status as an outsider and reluctance to engage in French with the Swiss medical system made her vulnerable to mistreatment.

For the women I worked with, the physician guide played a central role in their narratives of pregnancy and birth and trust in biomedicine and medical authority often made them feel silenced and unable to change the course of events. However, this central relationship was often fraught, with women frequently expressing doubts about their providers' intentions and decision-making, even if they described their relationship as positive. Women voiced high levels of confidence and trust in their providers and often went to great lengths to ensure the presence of the one particular doctor at the birth of their children, including paying out of pocket for private hospital births and traveling long distances so that they could have this trusted doctor as their birth attendant. Doubts about medical decision-making often became internalized as self-blame ("if only I had refused x") and women rarely blamed these outcomes on the provider, who the women often described positively.

Diana was the first woman I met while beginning my research, and her birth story is unusual in that it illuminates the contingency of privilege and offers a peek at how things can go wrong and women could lose their advantage. When I met Diana, she was working on her second master's degree at one of the bilingual universities in Geneva. Originally from Columbia, she had left her country years ago and had lived in the UK for university and spent six years in Spain before moving to Geneva when her husband got a job there. When she arrived in Geneva four years earlier, in her early thirties, she was five months pregnant with her daughter. Three months after they moved to Geneva, immediately before the birth of her daughter, her husband was laid off. Like many of the women I interviewed for this research, she had to find a doctor

and make decisions about her pregnancy and birth before coming to Geneva and with almost no information about how things worked there and no ability to speak French. She also faced the additional challenge of economic insecurity and precarity. Her story illustrates many of the vulnerabilities faced by expat women navigating pregnancy and motherhood in Geneva and offers a counter-case that shows how the intersections of race, class, and gender shape women's ability to control their birth experiences.

Despite the centrality of midwives to birth in Switzerland, the expat women I worked with immediately sought out physicians for their prenatal care upon arriving in Switzerland if they had the option. Most of the time in interviews this was presented without comment, but in my first interview with Diana, she spoke at length about her choice to seek an obstetrician:

> Diana: For me, the thing about having a midwife was very strange. For me, in Columbia, you don't have that. In Columbia, the midwives are a thing that, they don't exist. And the ones that exist are like in the countryside with the peasants. You know, it doesn't exist. So, for me when I arrived here it was absolutely *como*, strange? When I arrived here, and they told me, ok, so, you have a doctor, and then at the end, the birth of the baby is with a midwife. I was like, "What? How can I have a baby with a midwife? How can I have my baby with a midwife?" And they almost all do the episiotomy if you need an episiotomy, and for me, that was absolutely, No. I didn't want that, so that's one of the reasons why I went to that doctor, the Spanish one. And I told him, I want you to be in the birth of the baby. I don't want to have one of those women. So, I had a very bad concept of them. For me, I did not understand the thing. It was a cultural thing. For me they did not exist, here they are the center, they are the most important thing in anything related to babies and all that. So, I mean, it was a mistake. I should have heard them. Eh, no say, it was a mistake (excerpt from interview May 2012).

The prestige of bio-medicine is international whereas, from Diana's perspective, midwives were lower status and more likely to subject her to unwanted interventions during birth. To find prenatal care in Geneva, Diana asked people she knew to help locate a doctor who spoke Spanish before she arrived in the city because it was necessary to her to find a provider who spoke her language who she could trust. Using connections through her husband's office, she learned of a Spanish-speaking doctor who she saw immediately upon arriving in Geneva.

> Diana: I mean, it, I think that it wasn't that he wanted to impose his ideas, but it was more like I was so, so, so scared to have a baby here, in an environment that I didn't know, with a language that I didn't know, and without any support from anyone, that I just took that man like, I just trust him, and I just want to do everything that he tells me without questioning him. Because I was very scared, you know?

As Diana saw the doctor for the remainder of her pregnancy, she began to doubt his competence, professionalism, and ethics. But she did not think she could find another doctor who would work with her in Spanish and was invested in her relationship with him, so she felt she had no choice but to trust him and continue.

> Diana: Yes. I had many doubts, because he seemed to be not very professional, I was, worried, no? Sometimes, for example, he, I don't know, I was 33 weeks pregnant, and he said, 'Ok, well let's have this baby next week.' And I was, what do you mean? We still need to wait seven more weeks? And he said no, no, no, I think babies are ready since they are 32 weeks or something like that. You know? He was, he was very, *como*, chaotic. […] You know? He was very chaotic and *bueno*, in the end, it was a disaster with him.

Already five months pregnant when she moved to Geneva, Diana only qualified for basic public insurance. Supplemental private insurance with maternity coverage had to be purchased before pregnancy and often included waiting periods. The basic insurance covered Diana for care at *la maternité*. Diana, who did not speak any French at the time of her pregnancy, felt very strongly about having her Spanish-speaking doctor accompany her for the birth of her child, and ended up paying out of pocket to give birth in the private clinic.[18]

> Diana: The only thing they say was something like when you are pregnant here you have a doctor for seven months, six months, and then at the end, you go to *la maternité*, and you have your child there with the doctor in *la maternité*. So that was very scary for me. That was horrible and that's why I, that's another reason that kept me with the other doctor. Because we told him to stay with us until the birth, we wanted him to be all the time. And of course, it cost us a lot. We had to pay him the, everything, the *accouchement*. And of course, it was very expensive. And of course, we had to go to a private hospital because at *la maternité* it is not possible.

[18] About 30,000-40,000 CHF (31,000-41500 USD).

Although Diana was extremely unhappy with her doctor by the end of her pregnancy, she was so reluctant to navigate the francophone Swiss hospital system without his guidance and translation, she agreed to all of his terms for her delivery and felt unable to advocate for herself with him. Her doctor (whose behavior was extreme but not wholly unique among the doctors that the women I interviewed saw) used his position and her trust to dictate to her how she could give birth.

> Diana: I wanted to have that doctor so the guy because I wanted to have him, he told me, we have to induce the birth because I'm really busy, he told me, I have 4,000 patients, 4,000. So, I, I cannot be sure if in the moment that you are going to have the baby that I am going to be available, so we have to induce the birth. And, and it was very strange. Because I went to see him, it was a Thursday afternoon, and I had an appointment with him, I went to see him, and he says,"Ok, I think this baby's ready, go now to the hospital.

The doctor neglected to arrange for her admittance to the hospital, so when she arrived they did not expect her, and she had to navigate the misunderstanding in French. This experience made her feel more dependent on her doctor to be her sole advocate in the face of an unintelligible system.

> Diana: And I asked, I was very scared, so I asked, I said, Ok, there is someone who speaks English here? At least? Or Spanish or English or something? No. In French is alright. And he just turned and went. Well, yes, it is alright for you, but not for me. You know? It's alright; we speak here French.

After waiting alone for a long time in the hospital, Diana was refused food by the midwives, which she did not understand, but which is relatively standard medical practice in Swiss hospitals. She called her doctor to intercede on her behalf and order them to feed her, which she says, in the end, made everything with her birth "start wrong" because of the resentment between the midwife and her doctor. During her birth, the conflict between the doctor and the midwives only grew.

> Diana: So, the first little pain I felt, I said that I wanted anesthesia, which was also a mistake. The thing is, unfortunately, you must resist a little because anesthesia also goes to the baby, and the baby cannot have anesthesia for so many hours, it's wrong for them. So, but I was so scared, and so, I was like, OK anesthesia! I […] The *sages femmes* [midwives] they didn't want to do it, but the doctor, he had a tension relationship with them. So, I think he wasn't thinking about me, but about winning the battle with them. You know, so he called them, "give her food" "Give the anesthesia" but he wasn't thinking about the baby or me or the situation. It was more a personal thing between them. So, *les sages femmes*, they were ok, ok, we're going to do it, and they did it. And I remember when I started to feel that pain, one of them told me to sit on a ball, on a big ball, one of those Pilates balls, the big ones? […] And I was like no, I don't want to sit on the ball when I am in pain. And she suggested me to go into the jacuzzi, there was like a little jacuzzi, and I was like, no, no, no, no. Jacuzzi is nothing; I wanted something very medicalized. [....] At the end when she was born... *bueno*, the moment was very stressful because I had the doctor in front of me speaking with me in Spanish, Dominic in English, and all of the other people, all the *sages femmes* in French at the same time. And I just could not understand all of them at the same time! You, know, so it was like, "shut up!" So, then Carlotta was born, and she was terrible. Terrible. She was this color, like beige, she was absolutely how do you say, pallid? […] And of course, when he left all the *sages femmes*, of course, they were really, really, really upset. They didn't tell me, but I knew that they were very upset and they were like absolutely like, 'what is this?!' And at the end, the next day I met Carlotta in the morning, I was exhausted.

Despite her relatively privileged position of being able to choose where and with whom to give birth, Diana's lack of familiarity with the Swiss medical system and inability to speak French led her to trust a doctor who did not prioritize her safety and autonomy. Her options were further limited by speaking primarily Spanish and by her sudden economic precarity during her pregnancy. Diana's strategy of relying on her doctor to guide her through birth and manage her relationships with the midwives and the hospital did not work. Her daughter experienced trauma during the birth and had to be resuscitated after being born without breathing. In the end, the hospital's ethics board banned her doctor from attending births there based on his behavior during her birth. During her birth, the midwives advocated for a cesarean delivery due to fetal distress, and the physician refused. In Diana's words: "Because he didn't want to, to do what they want him to do. It was a power thing between them." Also, her close personal relationship with

the physician and their openness about the economic costs they were managing to work with him also led to her and her daughter getting inadequate care.

> Diana: And also, you know what also influenced the thing, that David, in some ways we had created a very close relationship with him, and David had told him what happened to him […]; that he had lost his job and we didn't want the *accouchement* to be so expensive because he has lost his job. And of course, a cesarean is more expensive, and we have to pay it. So, I think in part it was also that. That the guy, in some way he wanted to help […] but of course it was a mistake. It was a mistake because it had consequences on the baby.

Diana experienced giving birth as a moment of intense trauma, and she often spoke of feeling very guilty for her initial choice of a private physician and rejection of the midwives and *la maternité* because of her desire to understand and communicate during her pregnancy and birth care. She counted all the mistakes she made during labor: agreeing to the induction, asking for food, the anesthetic. In our discussions, she interpreted all of the things she had experienced as being her fault and a product of her poor decision-making. While this view allowed her to maintain her sense of agency, it had devastating effects on her confidence as a new mother.

These women's narratives illustrate some of the broader trends that I observed in my interviews with expat women and highlight both the advantages that women in this population had in managing their birth experiences and also the limits they faced in trying to enact being informed patients and cosmopolitan mothers. Diana's story further illustrates the contingency of privilege and the ways that it can be lost, constrained and can even work against women when it makes them desirable patients for unscrupulous doctors and creates perverse economic incentives for medical interventions. I want to mention that although Diana and Ruby's stories paint a reasonably negative picture and involved women with medical complications in their births, the difficulties these women expressed in navigating their pregnancies and the types of relationships they had with their doctors were common. Both Diana and Ruby were already

pregnant when they came to Geneva to give birth, and both gave birth in the same private clinic, but with different doctors and desiring very different birth experiences. In both cases, their reliance on the relationship with their physician to manage the strangeness of the birth process broke down and ended up leaving them feeling stripped of control of their experience and alienated and overwhelmed.

[…] being in charge can be difficult, you must call the shots, but how? (Mol 2008:16). For the expat women I interviewed, the imperative to "be in charge" by making good choices shaped the way they sought care and made decisions about where to give birth in Geneva. The logic of care (Mol 2008) also operated in unstable ways in women's experience of their births. For Ellen and Clarissa, despite having medically complicated and traumatic birthing experiences, feeling "cared for" allowed them to maintain trust in their physician guides and come away with positive feelings about their births.

Conclusion

In this chapter, I've shown that although pregnancy and birth are moments of intense engagement with, and submission to, Swiss medical and cultural norms about motherhood and parenting, the interventions and preparation migrant and expat women receive during pregnancy reflect and affirm their differing positions in relationship to Swiss civil society. Prenatal courses for migrant aimed to teach them how to behave following Swiss cultural and medical expectations in an individualizing (Rivkin Fish 2005:10) framework. The sessions aimed to build trusting but relatively impersonal relationships between the participants and resources for social and medical support in Switzerland. In this context, pregnancy for migrant women was an opportunity to establish themselves as integrated mothers and strengthen their social support networks with local institutions in Geneva.

In contrast, expat women did not experience pregnancy as a moment of integration into

Swiss society or acceptance of Swiss norms. Because they interpellated themselves as members of an international community and learned about birth almost exclusively from others in the same social positions, they created a model of safety which privileged continuity of care in the private clinic, although this model created vulnerabilities. Additionally, prenatal courses in English encouraged and emphasized personalized relationships of support through friendship and informal networks (Rivkin-Fish 2005:11) and reflected the privatized (Rivkin-Fish 2005:11) world of care that the women navigated during pregnancy, birth, and beyond. This, combined with the ways expat women built support networks based on shared experiences of life-stage and dislocation, meant that expat women did not have the tools to fully understand the implications of their choices in the context of Swiss medical care and had riskier birth experiences in private clinics that projected a sense of safety, rather than seeking care in the public hospital where care was less personalized but statistically better.

The interviews I conducted with expat mothers about their births revealed the vulnerabilities faced by women living highly mobile lives as they became mothers, even in the best circumstances where women had access to economic and social capital and were able to make choices about where and with whom they wanted to give birth. All of these women had advanced degrees and highly cosmopolitan lives. The experiences of expat women in Geneva offers a particular opportunity to examine the symbolic power and prestige of biomedicine transnationally that motivates women in this context to choose private doctors over the local practice of midwife-led care.

These cases reveal the potential trade-offs involved in a model of birth care in which patients rely on one provider to guide them through this passage. In this context, they often felt like they had no recourse against the provider in the case of adverse outcomes since they did not

understand and often were not interested in learning the Swiss system, but instead preferred to interact with it as little as possible. Expat women experienced the breakdown of trust with their physician-guides as a moment when they blamed themselves for failing as informed patients and mothers.

For expat women, choosing a doctor who would work with them in their preferred language allowed them to maintain a sense of autonomy and choice while interacting with the Swiss medical system, although the doctor themselves often became an authoritarian and unreliable figure in women's stories. The women I interviewed rarely expressed a desire to replicate the practices of pregnancy and birth they knew from their "home countries" (often the idea of home was itself ambiguous and uncertain). Rather, becoming mothers in Geneva was a moment where women perceived themselves as constructing hybrid identities as international mothers through attempting to control their interactions with Swiss medical practices and choosing where to give birth. Feminist anthropologists have analyzed the differentially distributed social consequences of choice as applied to pregnancy, prenatal testing, child rearing, and narratives of perfectibility (Kaufman & Morgan 2005:330). For the women I interviewed, negotiating their relationships with their providers, navigating the clinical space, and giving birth, were pivotal moments in creative processes of forging hybrid and original identities beyond the framework of citizenship and belonging.

CONCLUSION

This study examined the world of expat women in Geneva, looking at pregnancy and birth as critical rites of passage (Ratcliff, Borel, Suardi, Sharapova 2011:26, Davis-Floyd 2004, Cheyney 2011) through which women formed new subjectivities and identities that were transient, shaped both by being away from home and by the constraints and opportunities of Swiss social policies and norms around gender and parenthood. Studying expat communities revealed that they were sites of active identity formation both for women and families, through which women made strategic choices about belonging and managed the bureaucratic and emotional labor of mobility. These communities became the incubators for a model of citizenship and belonging that was based on strategically using citizenship to further individual and family possibilities for work and travel. This model conflicts with traditional views of citizenship as membership in an "imagined community" with corresponding obligations which is evidenced in the Swiss emphasis on "integration."

I argued that although expat women preserved a distance from Swiss norms around gender and motherhood, their strategy for creating alternative models of belonging in Switzerland led to riskier interactions with Swiss hospitals and medical providers during birth. Although the expat women in this study were undoubtedly privileged, they often entered the clinic unable to communicate with anyone except for their providers and unable to understand and advocate for themselves as they gave birth and became parents. The trust they put into Switzerland's privatized healthcare system, and the close personal and trusting relationships they built with their providers during pregnancy created a severe power imbalance that manifested as

often traumatic loss of control over their birth experiences

In chapter one, I gave a high-level overview of how expat women created communities based on transience and being away from home and outlined the model of belonging and strategic citizenship. I examined how expat women made communities using both digital and physical meeting spaces to build networks based on shared life stage and dislocation. This chapter revealed the hidden, deliberate work expat women did to maintain their family's "frictionless" (Ong 2007, Redfield 2012) mobility through managing the bureaucracy, creating local communities of support, and even strategically choosing which citizenships to give their children. This study highlighted divergences between the Swiss view of citizenship as a set of practices to integrate and create belonging in shared civil society and the expat model of citizenship as a kind of symbolic capital (Bourdieu 1989), acquired strategically to benefit the bearer and facilitate ongoing mobility. This chapter also highlighted the ways that expat women used strategic citizenship and their digitally-enhanced communities to claim freedom and mobility in the context of the strictly gendered division of space and time in Switzerland.

I looked at how expat women created and frequented digital spaces to extend the view of ICTs from being focused on how they facilitate ties across distance to how they can be used to enhance the experience of the local while maintaining the separation of expat communities. Through examining digital communities as sites for social connection, support, and resource sharing, I've shown that expat women used these technologies not only to manage relationships across distance but to create exclusive "local" spaces which overlay but don't often intersect with Swiss areas for community-building. The communities expat mothers built allowed them to pursue family and social lives outside of the narrow confines approved by the Swiss state.

Chapter two examined the importance of the Swiss model of integration and how prenatal

classes in Switzerland helped women prepare for birth and motherhood. This chapter highlighted how stratified reproduction shaped the experiences of migrant and expat women by determining the education and support available to them and the models of care they were able to access during their pregnancy and birth. This chapter highlighted ways that expat women's position was recursively formed and reinforced in their interactions with care providers in ways that interpellated (Althusser 1971) them as outside of Swiss social communities of care (Mol 2008, Biehl 2005, Petryna 2002, Rivkin-Fish 2005) and reinforced their reliance and trust on the market-based model of private prenatal and obstetric care. I examined how the model of transient expats as successful rational actors placed expat mothers outside the bounds of Swiss efforts to encourage integration during pregnancy.

Comparing the courses offered for lower-income immigrants to the Anglophone classes targeted at expats revealed that they were preparing for very different experiences. Sessions for migrant women included education about the Swiss hospital system and advice on how to negotiate the system and their interactions with care providers to achieve less medicalized outcomes. The midwives teaching migrant women viewed them as lacking education and needing support to integrate successfully into Swiss society and have healthy births and babies. In contrast, the course for expat women focused on helping them choose the best private care and expressing their desires for their birth to their providers, as well as building personal affective bonds with the instructor and the other couples in the class. In this course, the instructor approached the expat women as though they already had a high level of knowledge and were well prepared to give birth and parent in Geneva. Integrating and learning how to navigate Swiss norms and structures for accessing care was not a focus of the course.

The third chapter examined how expat women attempted to maintain control over their

birth experiences through finding a private clinic and physician guide who spoke to them in their native language, or at least English instead of French. This chapter looked at the breakdown of that strategy in the Swiss context, where private care offered luxury amenities and slick marketing, but often carried risks of more intensive medical interventions during birth. While expat women often built trusting relationships with their physicians during pregnancy, the one-on-one model of private care meant they often came to Swiss hospitals to give birth with very little understanding of how the hospital worked or preparation for dealing with the midwives and nurses who provided the bulk of their care during childbirth. The birth narratives I highlighted in this chapter show that in this context birth was often traumatic and represented a rupturing of trust with Swiss medical practices rather than a moment of increased acceptance of them.

Looking at birth as a rite of passage (Kaufman & Morgan 2005, Davis Floyd 2004, Cheyney 2011) and reproduction more broadly as a site of political and social discourse brings into focus the importance of understanding this dynamic for understanding why not-belonging became such a central facet of community-building for expat new mothers. This shared distancing caused by the model of personalized care in private clinics and services for expat mothers made it more difficult and unlikely that they would integrate easily into their new maternal identities and Swiss society. Instead, I observed the ways that they built new and hybrid identities that gave them a sense of freedom and possibility, while also transforming the scope of their imagined communities from being primarily around shared language, culture, or national belonging, to one that hinged on shared class identity, position as outsiders in Geneva, and shared life-stage.

This research was deeply informed by feminist anthropology which has made women's experiences of birth and motherhood a locus of scholarly inquiry. Feminist theory in

anthropology and geography has collapsed the false distinction between public and private life to reveal the effects of social, economic, and political power on the most intimate aspects of embodied experiences. This scholarship shows that possibilities for citizenship and belonging are gendered (Arextaga 2003, Gal and Kligman 2000, Paxton 2004, Lim 2008, Rivkin-Fish 2010). Michele Rivkin-Fish, in her 1995 study of post-Socialist Russia, examines how women work to exert agency over their reproductive experiences in constraints shaped by social and political forces. Her research provides a framework for understanding modalities of care and thinking through women's relationships with healthcare systems and providers and the strategies they use to navigate them and achieve their reproductive and bodily goals (Rivkin-Fish 1995). Intersectional (Crenshaw 1991) feminist thought shows that far from being simple, the effects of stratified reproduction on individual experiences are shaped by the interplay of aspects of identity including race, class, and gender, all of which carry social meanings, privileges, and burdens.

This dissertation used the model of "studying up" (Nader 1972) and was framed by a small but growing anthropology of expats and global elites. There has been a concurrent move within anthropology towards "studying up" through studying institutions. Anthropologists are increasingly ferreting out hidden places such as behind the scenes at central banks (Holmes 2013), the UN and global pharmaceutical companies (Petryna et al 2006) among others. There is an overlapping and growing scholarship on the international elite and expat families including Coles and Fechter (2007) which highlights the ways gender and power shape expat experiences, as well as work by Aiwha Ong (2007, 2012) which examines the ways expats move relatively freely outside of state constraints to maximize their success in the global capitalist system. Redfield (2012) examines the place of international expert expats in global policy-making and

their positionality within state and non-state organizations. Through focusing on birth and pregnancy, aspects of expat life framed as explicitly private, as well as foregrounding the creative work of women, this dissertation contributes to this literature by highlighting the ways that women's "private" and unspoken work profoundly shapes mobility and models of belonging across communities.

These strains of thought turn the ethnographic gaze on to the powerful and away from the periphery, driven by problematics highlighted by Mintz (1985).

> The movement toward an anthropology of modern life has been somewhat halting, and it has usually tried to justify itself by concentrating on the marginal or unusual enclaves in modern societies: ethnic clusters, exotic occupations, criminal elements, the 'underlife,' etc. This surely has its positive side. Yet the uncomfortable inference is that such groups most closely represent the anthropological notion of the primitive. (Mintz xxvii 1985)

Understanding how elites conceptualize citizenship and create non-territorialized models of community and belonging is critical to doing anthropology in the age of global fast capitalism and widespread anxieties about immigration. In the years since I lived in Geneva, understanding the mobility and communities of the powerful and the ways the digital divide shapes access to resources has only gotten more pressing. The bifurcation of mobility between rich and poor predates the modern mobility regime and shaped even regimes of "free movement" (Salter 2003:103). The lives of the wealthy become more invisible and also more demanding of anthropological scrutiny as inequality between the rich and the poor grows. These communities of concentrated power carry outsized impacts on societies and technologies, which they shape to fit their logic and desire.

A crucial question that lays outside the scope of this dissertation is how expat women and families negotiate community and belonging over time as children become more autonomous and have desires for social life. There is a burgeoning genre of blogs, novels, memoirs, and

discussion forums devoted to the challenges of mobility, even for the most expert practitioners. In these works, family life emerges as precarious and belonging is always transient.

> I think I'm growing to appreciate Switzerland more and more. Like I'm, I'm really starting to get very comfortable here. But it's that weird lingering expat feeling of "when are we leaving? when are we leaving?' Like, I truly don't make myself feel quite at home because I always know I'm going to be leaving." (Clarissa, American)

Many women with older children who stayed in Geneva engaged less with these kinds of communities as they remained longer in the city and their children grew up. These communities were transient both because people and families in the expat community moved frequently, and because they were limited in scope. However, they dominated the social world for recent arrivals and new parents, becoming primary sources of support and information.

Diana eloquently summed up how she engaged with the expat community and her recognition of the difficulties this community caused for integrating into the city. She felt like she needed to help her daughter build an identity and sense of belonging in Geneva as she grew, creating new imperatives to integrate into Swiss social life:

> The locals don't speak English, so it is difficult, with the international people it is easier. And they are all in the same situation as you. But in some ways, it's a problem because of course, you do not integrate, never. So, I am thinking now about what I'm going to do with Carlotta about school for example. Because if I put her in the international school, she will be with children of the international people, and all of them will be leaving at some point. So, Carlotta won't have friends. We intend to be here. The other option is to put her in the local school. So, I'm thinking about that maybe it's better for her to go to the local school so she can have a sense of belonging to something. Because I don't know what kind of identity she will have, she's British, Columbian, Swiss…. I think maybe it will help more for us to integrate more to this society if Carlotta goes to the local school. And then, probably we'll have to put her with an English teacher to help her improve her English. That is what we are going to do. (Diana, Columbian)

When I asked the mothers how they expected to manage being abroad as their children got older, three central themes emerged. Many parents made the start of formal schooling their deadline to move back to their home country so that their children could attend their local schools and learn their native languages. Others, like Diana, planned to enroll their children in

Swiss schools and work to help them integrate into Swiss society, potentially becoming Swiss at some point. The third was families who intended to send their kids to international school and continue living mobile lifestyles. Many women were not sure which strategy they would pursue, linking their choices explicitly with job opportunities and which option would afford the best opportunities for future mobility and success. Within the expat community families, relationships and children were the subject of scientific discourses of management. While the ethos of parenting in particular as a complex science and children as fragile and perfectible projects is widespread in affluent American society, the expat parenting literature focuses on the work women must do to raise "third culture kids." Third culture kids are children who are from neither here nor there, whose identity will be shaped by the experience of growing up in a context of permanent contingency.

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