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REPRODUCTION AND THE STATE

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Introduction

Every modern state has a population policy through which it seeks to govern reproductive behavior. These policies are implemented through laws, practices, and institutions such as public hospitals and social welfare organizations; yet it is often institutional practices that most directly affect women's reproductive lives. The extent of states' success at regulating reproduction and achieving their demographic goals has varied greatly.

In this chapter, we identify the sociopolitical conditions that both enable and impede women's ability to act in their own reproductive interests. We argue that, in today's world, neoliberal policies and the global rise of authoritarianism are the gravest threats to women's reproductive autonomy. Yet women—and men—exhibit resilience and resourcefulness in pursuing their individual, family, and community goals.¹

How states shape reproduction

The idea of population control is at least as ancient as Plato's Republic, which described how a 'Guardian' class could be bred to rule, the unfit left to die, and everyone sold the same myth that political inequality reflected the natural order.

(Connelly 2008: 7)

In their brilliant book *The Logics of Gender Justice*, Mala Htun and S. Laurel Weldon (2018) pose the vexing question of why state policies on women's rights vary so greatly throughout the world. To help answer this question, they created a dataset of 70 countries (85% of the world's population) and selected five major women's rights issues: Reproductive rights and freedoms were one of them. Their cross-sectional dataset for all countries came from the years 1975, 1985, 1995, and 2005. They found that women had more *reproductive freedom* (access to contraception and abortion) in formerly communist countries and advanced democracies with relatively weak religiosity. This freedom was more constricted in more religious societies and countries with close state-religion relations.² In contrast, social class was more consequential for *reproductive rights* (the right to decide freely whether and when to reproduce). Nevertheless, the mere legality of reproductive health services did not guarantee equitable access (Htun and Weldon 2018: 227–228).

Threats to women's reproductive freedom began to intensify in the late twentieth century with the global rise of authoritarian governments and the proliferation of neoliberal agendas.³ Hallmarks of neoliberal policies include decentralization of state controls, sharp cuts in government spending on social services, financialized market principles driving public policies, and emphasis on individual rights (and responsibilities) over the public good (Himmelweit 2017: 1). Neoliberal policies have led to eliminating or significantly cutting access to the reproductive health services and programs that enabled mothers raising young children to engage in remunerative labor.

States influence reproduction in three main ways:

- *Policies* reflect a government's intentions—i.e., the goals it hopes to achieve for the society *in toto*. Policies are not per se enforceable but may be the bases on which laws are made.
- *Laws* are enforceable rules and guidelines that set the standards, principles, and procedures a society observes, and the sanctions for violating them.
- *Practices* are the actual applications of laws, guidelines, principles, or procedures.

Each is discussed below.

Policies

Every country has a population policy. It may be explicit with highly coercive implementation, it may be a hidden agenda that can be achieved through existing trends, or it may be the sum of implicit and often conflicting policies... [S]ince the availability of birth control technology and the encouragement or discouragement of its use always reflects some kind of population policy, birth control is not conceptually distinct from population control ... It would be to all women's advantage if implicit policies and hidden agendas regarding fertility were made public because women's freedom is to be found more in their participation in decisions about aggregate reproductive goals than in access to birth control.

(Moen 1979, 138)

Pronatalism and anti-natalism are two major state population policies.⁴ Sometimes they are combined—e.g., reproduction may be encouraged for powerful groups while sanctioned or discouraged for the rest. Also, countries that once had anti-natalist policies may shift to pronatalist ones and vice versa.

Pronatalist policies

These policies promote childbearing by idealizing or glorifying parenthood and offering financial and social incentives for populations to reproduce. Such policies may also limit women's reproductive options by, for example, outlawing contraception or abortion. Births may be encouraged: Ideologically (motherhood as a patriotic obligation); culturally (widely shared ideologies surrounding reproduction); psychologically (parenthood as a source of identity), and on the cohort level (e.g., laws that incentivize having children) (Heitlinger 1991: 344). "Selective" pronatalism references a state encouraging reproduction by particular groups (e.g., elites, specific racial or ethnic groups).

Countries with very low fertility, such as Sweden, France, and Poland, have enacted pronatalist policies, including subsidies and tax breaks, generous parental leave, public daycare, and flex-

ible work schedules. But while countries with the most generous policies tend to have higher fertility (France 1.91, Sweden 1.97) than those that do not, these policies have not prevented population decline (World Population Review 2019).⁵

Japan instituted a pronatalist policy in the early 1990s to little effect; it still has one of the lowest fertility rates in the world (1.37). There and elsewhere in Asia, marriage rates are also declining, as is sexual activity (Hsu et al. 2015). The Japan Family Planning Association found that 45% of women and 25% of men from 16 to 24 “were not interested in or despised sexual contact” (Haworth 2013).

Anti-natalist policies

These policies aim to discourage births. They may target an entire society or subsets within (e.g., females, the mentally “deficient,” impoverished, members of disparaged minorities). They may be coercive, incentivized financially, or enacted through means such as increased contraception access.

The widespread decline in infant mortality in the mid-twentieth century following the introduction of antibiotics saw a global rise of anti-natalist policies. Western politicians and scientists became gravely alarmed about “excessive” rates of population growth in the Global South.⁶ Alan Guttmacher, director at the time of the Population Institute, an international non-profit organization, argued, “civilization is less threatened by cancer than by the present epidemic of human beings” (as quoted in Jackson 2001: 21). Whether or not such an “epidemic” actually existed (Hartmann 1995), international development agencies and Western governments invested hundreds of millions of dollars in the belief that the widespread use of new contraceptive methods would benefit humanity. By the late twentieth century, anti-natal policies were adopted virtually worldwide, albeit to uncertain effect (United Nations 2014). For example, Obono finds that Nigeria’s 1988 population policy “had at best a modest effect on fertility, in part due to the policymakers’ erroneous assumption that Nigeria had a monolithic culture, and the disregard of men’s reproductive motivations” (Obono 2003: 103).

Fertility was *already* declining in most of the world before the introduction of family planning programs, coercive or otherwise. Indeed, these programs explained under 5% of the change in fertility levels, and it is unclear if they caused even that (Connelly 2008: 338). Historian Matthew Connelly observes:

It turns out that about 90 percent of the difference in fertility rates worldwide derived from something very simple and very stubborn: whether women themselves wanted more or fewer children ... [This is] consistent with both historical experience and common sense. After all, French peasants did not need Napoleon to provide them with pessaries. Even then, avoiding childbirth was less expensive and troublesome than unwanted children.

(2008: 373)

China offers a striking example of the unintended consequences of coercive population policies. In 1979, the state mandated its one-child policy to assure concordance between population growth and economic development, and to ease the environmental impact of too rapid an increase in births. It was enforced through incentives both positive (e.g., better work opportunities, higher wages) and negative (e.g., fines, impeded access to government assistance and work opportunities, mandatory abortion and sterilization). The policy was immensely successful in improving gender equality in education and labor force participation. But the unintended harms

included severe gender imbalance favoring male children and a shrinking workforce to support an aging population (Chang 2015). The policy was rescinded in 2015 to allow two-child families, and further loosened in 2018.

Whether China's two-child policy accomplishes its revised objectives remains to be seen. But it has already considerably affected women of childbearing age by making it harder for them to find jobs since employers are less willing to hire them, fearful they will lose them to a second pregnancy, and due to a resurgent conservative ideology that women belong at home. Consequently, women's labor force participation fell from 75% to 61% in 2018 (World Bank 2019). Moreover, as women's professional advancement opportunities decline, the gendered wage gap is also widening. Some provinces have made divorce and abortion more difficult to obtain and governments are pressuring women to leave their jobs for the domestic domain in the hope that this will lead them to want more children (Stevenson and Chen 2019).

China, moreover, provides an example of the co-existence of pro- and anti-natal population policies: Even while the government seeks higher birth rates for its majority Han ethnic population, among the most common reasons for sending Uyghurs and members of other predominantly Muslim minority groups into "indoctrination camps ... to curb terrorism and separatism" is the violation of Chinese birth restrictions by having "too many children" (*The New York Times* 2020).

While coercive measures were central to most twentieth-century population control policies, there were exceptions. Cuba's national health system lowered fertility by making contraceptive and abortion services freely available. Taiwan and South Korea launched intense propaganda campaigns that denounced families with more than two children as unpatriotic (Hartmann 1995).

Laws

Creating a regulatory framework capable of accommodating all of the ethical dilemmas thrown up by rapidly shifting terrain [pertaining to reproduction] undoubtedly represents one of the most important and difficult tasks for law in the twenty-first century. In addition to the speed with which law may inevitably become obsolete, the regulation of reproduction is further complicated by the existence of profound moral disagreement about the propriety of human intervention in the reproductive process.

(Jackson 2001: 1)

Laws regulating reproduction may be either pro- or anti-natalist. During the past four decades, the global rise of authoritarian governments along with neoliberal policies has generated harsh mandates and anti-natalist laws designed to limit reproductive rights and behavior.

Compulsory sterilization

The late nineteenth and early twentieth century saw widespread compulsory sterilization laws to limit the childbearing of all but the dominant groups (Mass 1976). Upper-class White women were typically at the forefront of these early eugenics movements that idealized motherhood for themselves while seeking to punish it for the rest (Lewis 2019). Among the main targets were women with intellectual disabilities. President Theodore Roosevelt voiced the prevailing elite attitude that "fecund feeble-minded females" were threatening America's greatness. US Supreme Court Justice Oliver Wendell Holmes famously remarked,

It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are

manifestly unfit from continuing their kind ... Three generations of imbeciles are enough.

(as quoted in Bayles 1981: 168)

White male anxiety about falling birth rates among elite educated women also bred fears of “race suicide.”

Nazi Germany’s compulsory sterilization program was modeled on the US (Longerich 2010). Physicians were required to report to state authorities patients deemed intellectually or physically disabled, mentally ill (e.g., manic depressive, schizophrenic), blind, deaf, and epileptic—and were fined for failing to report them. About 600,000 people were sterilized during this program, which continued until WWII began.

India’s compulsory sterilization program was notorious for its harshness and scope; since the 1960s, millions of both sexes were sterilized. Although the earliest program was voluntary (albeit aggressively promoted by international organizations), it became mandatory by the mid-1970s (Hvistendahl 2011). In parts of India, coercive sterilization continues to this day.

While most compulsory sterilization laws were repealed by the end of the twentieth century, some remain. Targets include HIV-positive women in South Africa, Mexico, and Central America (Essack and Strode 2012; Amnistía Internacional 2016); Romani women in the Czech Republic (ERRC 2016); Indigenous women in Peru (Mooney 2010) and Uzbekistan (Bukharbaeva 2005); and Native Americans and female prisoners in the US (Gurr 2012). As recently as 2017, some Indigenous Canadian women were prohibited from seeing their newborns until the women consented to sterilization (Cecco 2018). In the US, moreover, involuntary sterilization of individuals deemed “undesirable” continues to this day: Some women held in immigrant detention facilities report having been subjected to unwanted hysterectomies when they sought gynecological attention for minor problems (Shahshahani 2020).

State-sponsored sterilization programs are not necessarily coercive. The US territory of Puerto Rico offers an instructive example. Although some attributed very high rates of female sterilization to coercion, Iris López argues that “there are different degrees of agency, resistance, and reproductive freedom and these are not mutually exclusive” (2008: xix). She characterizes Puerto Rican women as active decision-makers who choose sterilization as the best among a set of poor choices. Anne Line Dalsgaard (2004) makes a similar argument: In northeast Brazil women’s motives for agreeing to and in some cases actively seeking sterilization derive from their desire for a sense of control over their lives.

Importantly, however, eugenics and coerced sterilization cannot be dismissed as antiquated social engineering; they remain alive today in embryo selection for sex and other characteristics, and for promises of genetic enhancement. Mark Largent (2008) cautions that it is crucial to understand how good intentions can dramatically lead to unintended negative outcomes. This is a perspective all too often overlooked in the rush toward embracing assisted reproductive technologies to arrest the global decline in male and female fertility (Gammeltoft and Wahlberg 2014).

Contraception and abortion

[A]ttempts to suppress the dissemination of information about birth control techniques through persecution of witches might constitute an early example of the state seeking to control the fertility of its citizens.

(Jackson 2001: 11)

Avoiding unintended childbirth. Contraceptives are regulated by: 1) Controlling access to specific techniques (e.g., by licensing particular methods and/or how they may be obtained); 2) determining options in the event of failed contraception or sterilization; and 3) authorizing involuntary fertility control (Jackson 2001: 13).

Unintended pregnancies and attempts to end them have been documented in all known societies (Devereux 1976). When women cannot obtain safe, legal abortions, many resort to unsafe and/or illegal ones. Between 2010 and 2014, an estimated 25 million illegal abortions were performed worldwide *annually*, constituting 45% of all abortions (Guttmacher Institute 2018). Many of these illegal abortions required travel to areas with safe, legal abortions (Sethna and Davis 2019).

Criminalizing and decriminalizing abortion. In the Global North, the past two centuries have seen repeated waves of political struggle as women sought to decide for themselves whether and when to have children. Although abortion and even contraceptive rights in the US and elsewhere are increasingly under attack, it was not always this way. The Catholic Church permitted abortion until late in the nineteenth century based on the understanding that human life did not begin until fetal movement (“quickening”) is perceived. However, by 1880, most of Western Europe and the US had criminalized abortion due to its growing use and the associated toll on women’s health from unsafe procedures, pressure from allopathic physicians to consolidate their monopoly over medical care, and fears of demographic suicide among wealthy Whites. Still, the practice remained widespread during most of the nineteenth century (Potts and Campbell 2002).

Beginning in the twentieth century with the Soviet Union and the Eastern Bloc countries, governments began decriminalizing abortion. Driving forces were the Leninist doctrine that no woman should be forced to bear a child and the enormous toll on women’s health from unsafe abortions (Heer 1965). Also, Central and Eastern Europe have a long history of socially acceptable illegal and legal abortion (David 1972: 146). Meanwhile, distinct legal perspectives defined the terms of abortion access in Western Europe. In England, for example, the medical system was entrusted with regulating abortion, while Italian legislators reached a compromise between Catholic dogma and the need to protect women’s health by keeping abortion criminal while establishing many medical, social, and economic exceptions (Liviatan 2013). Yet, today in the UK and Europe, pregnant women’s right to abortion is increasingly threatened by the “moral obligation” to protect a fetus’s welfare and the idea that a pregnant woman’s body is not hers to control (Templeton 2017).

In contrast with Europe, where abortion debates produced consensus-based regulation, the US Supreme Court granted women the right to abortion based on their constitutionally protected right to privacy. But it simultaneously ruled that the right to abortion was not “absolute” and did not entail “an unlimited right to do with one’s body as one pleases” (Petchesky 1984: 290–292). Ofrit Liviatan (2013) argues that, by legalizing abortion as a privacy right but limiting it with a competing fetal right to protection, the court laid the groundwork for a perpetual struggle between activists with diametrically opposed worldviews (Andaya and Mischal 2016).

Throughout Latin America, activists are employing the Universal Declaration of Human Rights as a framework for legalizing abortion, on the grounds that prohibiting abortion violates a woman’s fundamental right to health. Given the continent’s history of strict prohibition, countries where abortion is available (e.g., Bolivia, Colombia) have adopted a “gradualist” approach: Rather than sweeping legalization, activists have successfully advocated for laws that allow it in situations that have strong public backing—to save a mother’s life, preserve her health, and in cases of rape or a nonviable fetus. Yet, even where abortions can be obtained legally, obtaining

approval is generally onerous and the vast majority of abortions in Latin America continue to be performed illegally (Marcus-Delgado 2019), with medication abortions accounting for a rapidly growing proportion (Oberman 2018).

Abortion's perpetually precarious status. The global status of abortion access remains mixed. Twenty-seven countries, primarily in East and South Asia and the Pacific Islands, have liberalized abortion laws since 2000 (Singh et al. 2018). Meanwhile, abortion access is eroding in parts of Europe in light of increasing immigrant flows; rapidly declining White birth rates; the growing power of conservative religious institutions and xenophobic activist groups; and a more generalized “remasculination” of politics (De Zordo et al. 2017). Even Norway, considered among the most progressive country on women’s issues, passed a more restrictive abortion law in 2019 (*NewsinEnglish.no* 2019).

Throughout Latin America, although abortion has historically been illegal under most circumstances, its practice has seldom been prosecuted. But during the past decade, this has changed. In Ecuador, for instance, criminal proceedings have been initiated against hundreds of women suspected of abortion, including in instances of unintentional miscarriage (*The Nation* 2019). Hospitals and healthcare providers have reported women showing signs of obstetric complications to legal authorities, in effect colluding with the legal establishment in prosecutions. Widely available misoprostol⁷ has made chemical abortions safer and more accessible, although an unintended effect has been to make women themselves the targets of abortion law enforcement. Activists fighting to legalize abortion continue to encounter strong resistance from the Catholic Church and increasingly from evangelical denominations (Morán Faúndes and Peñas Defago 2013). Only Cuba, Uruguay, Mexico City, and the Mexican state of Oaxaca allow abortion for most circumstances, albeit with limitations.

As we write, US public opinion remains strongly supportive of abortion rights, but attacks are intensifying. Laws virtually outlawing abortion for any reason have been passed in several states, although judges have stayed their implementation as overly restrictive (Guttmacher Institute 2018). In response, other states have passed laws strengthening women’s right to abortion. And telemedicine is offering new hope for women in states that prohibit abortion (<https://www.ansirh.org/research/telemedicine-improve-access-abortion-care>). Indeed, in 2017, medication abortions accounted for 39% of US abortions, a development characterized in *Rewire News* (2019) as “a seemingly unstoppable medical revolution.” Still, women, especially those in rural areas of states with limited economic resources that already have highly restrictive abortion laws, may lose access entirely.

Who may bear and raise children

Prosecuting mothers. The twenty-first century has seen intensifying efforts in the US to terminate the parental rights of women deemed unfit to raise children. Under feticide, anti-abortion, and “personhood” laws, economically disadvantaged women of color, principally African American, have been imprisoned for delivering “illegal substances” to their fetuses (Nelson 2003). Yet, obscured by the politics of fetal rights is the politics of race, which has enabled or even encouraged prosecuting pregnant women and punishing Black women for having babies (Roberts 2008). Moreover, an analysis of prosecutions of pregnant women between 1973 and 2005 found male partners mentioned in only 23% of the cases—a stark reminder that gender, in concert with race and class, can reproduce breathtakingly complex matrices of reproductive oppression (Paltrow and Flavin 2013).

Alabama leads the US in arrests of pregnant women, with at least 479 new and expectant mothers prosecuted for “chemical endangerment” since 2006. Many other women have also

been investigated in “the chemical-endangerment version of stop-and-frisk,” their lives shattered by drug testing without their knowledge (*ProPublica* 2015). The law’s purported intent is to protect children by removing them from unfit mothers, a policy without empirical support. Moreover, the statute lacks criteria to distinguish between mothers engaging in chronic substance use and those taking an occasional dose of anti-anxiety medication. This lack of criteria breeds discrimination—women convicted under chemical endangerment laws are generally impoverished women of color (Whiteford 1996; but see <https://www.nbcnews.com/news/us-news/woman-charged-murder-after-delivering-stillborn-baby-meth-its-system-n1078266>). One might speculate that this lack of precision is intended to enable racist targeting.⁸ Florida offers harsh examples; pregnant women testing positive for illicit substances have been charged with criminal neglect, delivery of drugs to a minor, and involuntary manslaughter, and have been sentenced to up to 15 years of incarceration (McGinnis 1990).

Selective pronatalism. Racialized discourses conflating “Britishness” and “Whiteness” reflect the UK government’s view that “overly fertile” immigrant women will “pollute” the native stock and import “alien” family forms. Policies have been enacted that make it difficult for many UK immigrants to reproduce (Lonergan 2015). For example, family migration rules make family reunification dependent upon income; only those who can demonstrate that they will not “burden the welfare state” are allowed to bring spouses and children.

Selective pronatalism has also been seen in France. From the early twentieth century, child-birth was encouraged through financial allocations and state-sponsored childcare for those with French ancestors. Yet, it was discouraged for immigrants by, for example, prescribing contraceptives (without necessarily explaining their purpose) (Sargent 2006; Sargent and Cordell 2002). Indeed, abstract debates about the perceived costs to social welfare systems of immigrant fertility play out in the everyday lives of immigrants who are “strongly urged”—and at times coerced—to use contraception to reduce “excessive” childbearing. The dynamics in Burma are similar, although the axis of tension is ethnicity, not race; Rohingya refugees (but not the native Burmese population) are limited to just two children (Human Rights Watch 2013).

Israel has practiced selective pronatalism since its inception, based on fear that its relatively small European-origin Jewish (Ashkenazi) population would be overwhelmed by the much more populous Middle Eastern Jews (Mizrahim) and Arab Israelis (Rigsby 2018). Access to contraception and abortion was restricted for Ashkenazim, and incentives were offered for them to use assisted reproductive technologies, while access to contraception was more easily available for the latter groups (Kahn 2000).

In a different vein, twentieth-century revolutionary movements such as El Salvador’s Farabundo Martí National Liberation Front and Nicaragua’s Sandinista Front for National Liberation typically had pronatalist agendas (Marcus-Delgado 2019). Although women could be combatants and activists, they were also expected to be mothers, as symbols of a more just society.

Reproductive rights for transgender individuals have raised new legal, medical, and ethical issues, as clinicians increasingly recognize that infertility is not an inevitable consequence of transgenderism (Pfeffer 2018). Indeed, some providers and transgendered individuals assert that they should be entitled to the same range of infertility treatments as those whose reproductive capability is compromised for other reasons. Political entities (i.e., countries, states) have responded in different ways (James-Abra et al. 2015).

“Assisted” reproduction. The mid-twentieth century saw an explosion of “assisted reproduction technologies,” collectively known as ART. These scientific techniques are effective to varying degrees for producing healthy children and enabling the selection of embryos and fetuses imbued with certain traits desired by prospective parents (e.g., sex, absence of known genetic anomalies).

While regulating ART is often considered novel, there is nothing new about governments interfering in reproduction, including laws regarding marriage, divorce, birth outside marriage, adoption, contraception, and abortion (Spar 2005). Because procreation is essential to society's perpetuation, US courts including the Supreme Court found a woman's right to use assisted technologies a fundamental right under both the Bill of Rights and the "liberty" definition in the Fifth and Fourteenth Amendments (Hecht 2001).

Throughout the world, governments have passed widely different laws regarding ART. Regulation of markets for eggs, sperm, and surrogacy is largely absent, but gestational surrogacy is sometimes a contentious issue. While banned as exploitation in most of Europe and India, 47 US states allow it based either on the right to biological children, female bodily autonomy, or because there are no laws prohibiting it (*The New York Times* 2019).

As of 2017, virtually all European countries provide some financial assistance for ART; use was highest where national health plans cover costs completely (e.g., Denmark, Slovenia, Spain). Coverage may differ by patient characteristics, e.g., the age of the prospective mother and the number of children she already has. Most countries require women seeking ART to be married or in a stable relationship (Präg and Mills 2017). Only half of European countries permit single women to undergo ART and even fewer cover access for lesbians.

Taking a step back, Laura Briggs posited "there is good reason for the sense that ARTs are haunted by eugenics." After all, their primary market is largely White professionals, the same group that early twentieth century eugenicists worried were not having enough children (2017: 107).

Movements for reproductive justice and other acts of resistance

No woman can call herself free who does not own and control her body. No woman can call herself free until she can choose consciously whether she will or will not be a mother.

(Sanger 1919: 7)

Every society has norms regarding which women may bear children, how many, and with whom, along with means to enforce these norms. Yet, in every society, some women have sought to influence the circumstances of their pregnancies, and in some, reproductive rights may be codified into laws that enable women to more effectively act in their own reproductive interests. The assumption that the concept of reproductive rights is alien to women in the Global South because it derives from Western individualistic, secular traditions is ethnocentric and mistaken. Although Southern women's reproductive activism may not necessarily have been framed in terms of "rights" per se, since the early 1970s reproductive health movements have been mobilized throughout Asia and Latin America (Corrêa and Petchesky 2007).

In a study remarkable for its comprehensiveness and scope, Rosalind Petchesky and Karen Judd (1998) collected data from seven countries in distinct world regions to investigate the extent to which women valued reproductive "freedom," that is, unimpeded access to contraception and abortion. Their main finding, subsequently documented widely, is that women did indeed want to decide whether to have children and how many to have. They also found that those who earned money or otherwise controlled economic resources were significantly more able to exercise this form of reproductive agency, and that in some settings, belonging to a community group or labor union further enabled their ability to do so.

Beginning in the late twentieth century, US women have resisted reproductive abuses through "reproductive justice" movements that conceptualize reproductive rights struggles within a

social justice framework (Luna and Luker 2013: 328). Reproductive justice is “the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities” (SisterSong n.d.). Loretta Ross, a founder of the SisterSong movement, argues that reproductive justice is a more productive way to analyze how class, race, gender and sexual orientation, culture, country of origin, and (dis)ability shape politics to produce a “complex matrix of reproductive oppression” (2011: 1).

Other examples of reproductive justice activism include grassroots Mexican human rights groups offering emotional and logistical support to women seeking medical abortion. Abortion remains illegal in most of the Republic yet is the leading cause of maternal mortality. Women seeking legal abortions confront nearly insurmountable bureaucratic obstacles and clinicians who range from hostile to outright refusing. This reality has spawned organizations working “at the margins of legality;” while their activities are not technically illegal, they directly challenge state control over reproduction (Singer 2019; *The Nation* 2019). Poland offers another example. Despite having one of the EU’s most restrictive abortion laws, women have been holding instructional workshops on obtaining and self-managing medical abortions (*Harper’s Bazaar* 2019).

Gail Kligman’s (1998) research in mid-twentieth-century Romania further illustrates how despite severe legal constraints, women may resist state control of reproduction. Nicolae Ceaușescu’s dictatorship (1966–1989) featured a repressive pronatalist policy designed to boost the population and strengthen socialism. Abortion was banned and modern contraception rarely available. Yet, despite the risk of imprisonment for women seeking abortions and clinicians performing them, women nevertheless continued to resort to abortion when childbirth was not an option.

China provides an example of women’s resistance to coercive *anti*-natalism. Susan Greenhalgh (1994) has shown that, despite repressive state efforts beginning in 1974 to limit family size to one child, rural Chinese families successfully evaded them by, for example, illicitly removing IUDs and adopting out female babies to guarantee a male heir for their families.

Practices

Better never means better for everyone ... It always means worse, for some.

(Atwood 1998: 211)

The reproductive interests of the state may manifest through institutions such as public hospitals and social welfare organizations. Their day-to-day practices often have the most direct impact on women’s reproductive behavior. Here, we offer accounts of women’s interactions with public healthcare systems in the context of the larger policies associated with them.

Prenatal care

A robust literature has documented barriers to prenatal care access worldwide (e.g., Haddad et al. 2016; Sesia 1996; Winston and Oths 2000). In a provocative analysis, Elise Andaya (2019) offers fresh insight into how neoliberalism can combine with racism to shape the experiences of pregnant patients and their clinicians. Her work in New York City public prenatal clinics documents how long wait times, burned-out providers, and sub-standard working conditions reflect the broader racist dynamics found in public healthcare throughout the US and the low priority given to such care.

Failure to prioritize prenatal care in public health facilities is widespread elsewhere, too, where it is consistently under-resourced in comparison with the private sector due to “the effects of material and biopolitical disinvestment in public health care” (Andaya 2019: 2). Overcrowded

facilities with outdated or nonfunctional equipment reflect the low value that neoliberalism places on the public sector; this, in turn, harms not just patients but also providers. Public health maternity workers in Tanzania, for example, consistently lack resources to provide quality care. This disinvestment has led to delayed pay for workers and a lack of protection from infections that pregnant women may carry, and vice versa. It also fosters a workplace environment where nurse-midwives may vent their frustrations onto patients through abuse and/or neglect. Nurses, in turn, may be blamed, physically harmed, and/or face legal repercussions for poor maternity outcomes (Cogburn et al. 2019).

Childbirth

Childbirth offers a productive lens through which to examine concrete consequences of neoliberalism on women's reproductive health. The case of Mexico, for example, illuminates challenges faced by neoliberal states that seek to assimilate Indigenous groups. Rosalynn Vega (2018) has shown that state efforts to socialize Indigenous women to hospitals over midwife-assisted home births reflect reproduction as a "site of racialization." Characterizing home deliveries as unsafe and "backward" and hospital and clinic births as safe and "modern" are among the tactics employed (El Kotni 2018). Another tactic has been to expand the definition of the biomedical concept of risk. Women who fail to conform to the state's designation of hospitals and clinics as the appropriate site for childbirth are seen not simply as "bad mothers" but also as impeding their country's modernization efforts (Smith-Oka 2012). Many women in Balochistan, Pakistan also prefer midwife-attended home births (Towghi 2018). But the biomedical establishment similarly seeks to convince them that hospitals are the "proper place for childbirth" through fear-based narratives highlighting the dangers of home birth and control tactics like unwanted and even unnecessary medical interventions.

There is yet another state barrier to site-of-childbirth choice in Tanzania. Should a woman choose a midwife-attended home birth, she may find herself unable to register her newborn, thereby preventing its access to the country's medical system of free vaccinations and general health monitoring for children aged zero to five years. Although the registration cards are technically not for sale, nurses can illegally impose a fine that must be paid before a card will be issued. This has meant that, in addition to the standard reproductive challenges faced by poor and rural women worldwide, Tanzanians' selection of home delivery may subsequently limit their children's healthcare access (Cogburn et al. 2019).

State-sanctioned removal of children

State governments require loyal populations that accept their authority as legitimate; challenges to state authority come from many quarters including enslaved populations; ethnic minorities; and women and other stigmatized groups who are not afforded rights and opportunities equal to the dominant elites. Children are often the targets of these efforts.

Assimilation

Beginning in the mid-nineteenth century, children of native groups in the Northern and Southern Hemispheres were forcibly taken from their families and put in boarding schools. In the US and Canada, it was not until the 1970s that the last of these schools closed. Among "assimilation" techniques were mandatory European-American haircuts and names, bans on traditional clothing and languages, and compulsory conversion to Christianity (Dawson 2012).

Investigations of these institutions have documented widespread sexual, physical, and mental abuse. Said one Navajo activist, “I was forced to eat an entire bar of soap for speaking my language” (<https://laratrachentz.wordpress.com/2015/10/09/soul-wound-the-legacy-of-native-american-schools/>). In Canada, the Royal Commission on Aboriginal Affairs (1996) issued a report documenting abuses in residential schools. “Children were frequently beaten severely with whips, rods and fists, chained and shackled, bound hand and foot and locked in closets, basements, and bathrooms, and had their heads shaved or hair closely cropped” (352). The report added that children’s faces were rubbed in urine and excrement, and that the typical punishment for children who ran away from school was to run a gauntlet where they were beaten severely (cf., Haig-Brown 1988, Milloy 1999).

In Australia and New Zealand, mixed-race aboriginal children were similarly taken from their families by federal and state governments and church missions for the purpose of “assimilation,” with estimates ranging from one in ten to one in three children taken between 1910 and 1970 (Read 2006).

Efforts to assimilate Native American children by extinguishing their cultures have not been entirely abandoned. The US Indian Child Welfare Act requires that adoption priority of Native children enrolled in state foster care be given to relatives or other Native families. But a wealthy White Texas couple is challenging this, arguing that the best interests of their two Native half-sibling foster children are for the couple to adopt them. Declaring the law unconstitutional, a federal judge has ruled in the foster parents’ favor. The case remains under appeal (*The New York Times* 2019). Similarly, a punitive US immigration policy at the southern border is forcibly taking children as young as four months from their parents and putting them into foster care or up for adoption, despite the fact that their parents or other relatives desperately wish to care for them (*New York Times* 2019).

China’s efforts to assimilate its own ethnic minorities have also included the forced taking of children. China’s Uyghurs, for example, are much more similar culturally and linguistically to Turks and other Central Asians; most are also Muslim. The state has adopted a two-pronged assimilation strategy: Relocate adults into “re-education” camps, and establish massive residential schools and even nurseries, where Uyghur children are taught to renounce their religion, language, and culture (Uyghur Human Rights Project 2018).

Baby theft

Seizing the newborns of political opponents has been a practice designed to shield authoritarian regimes from domestic threats. Babies stolen under Franco’s dictatorship in Spain (1939–1975) and Videla’s in Argentina (1976–1981) are twentieth-century examples. These programs were a “eugenic” attempt to “stamp out the red gene.” Both dictators authorized the seizure of infants born to communist opponents to give to (ostensibly infertile) Catholic couples, who pledged to raise the kidnapped children to despise communism. Public opinion was mobilized in both countries to discredit mothers’ search for their children by misogynistically labeling them as crazy, out of control, hysterical—classic stereotypes used to discredit women for speaking up worldwide. And while the impetus in both countries was political, after Franco’s fall, baby theft simply became a lucrative business, with at least 500,000 Spanish babies ultimately taken (Escudero 2018).

State-sponsored baby theft was not only political in intent. In a purported effort to “eliminate extreme poverty,” Chilean dictator Augusto Pinochet (1971–1990) enlisted social workers, nuns, physicians, and lawyers to seize newborns from the poorest women for adoption to rich countries (e.g., the US, Sweden, and Holland). Mothers were told that their babies had died

postpartum and were not permitted to see their bodies because, as they were told, it would be too upsetting (nor were they given death certificates). The climate of fear during Pinochet's rule stopped the mothers from seeking further information (*BBC News* 2019).⁹

Conclusions and directions for future research

All societies intervene in procreation, because giving birth and raising children are too important to societies for them not to intervene, though their attempts to do so do not necessarily produce the desired results.

(Heitlinger 1987: 15)

In this chapter, we have considered the principal ways modern states work to achieve demographic characteristics favorable to elites' interests. Neoliberalism and global authoritarianism are twin threats to reproductive freedom today. While they arise from distinct processes and operate on different planes, they share the effect of limiting women's—and men's—ability to control their bodies and the resources to care for themselves and their children. Women have been the main focus of our analysis because states have generally had little interest in controlling men's reproduction

But states are neither all-powerful; nor do they exist in a vacuum. To ameliorate this lacuna, Lynn Morgan and Elizabeth Roberts (2012) pioneered the concept of *reproductive governance* to frame the impact of the wide-ranging mechanisms throughout history by which powerful actors (e.g., religious institutions, international financial institutions, NGOs), *in consort with state governments*, impose oppressive social controls including direct coercion, legislation, economic incentives, and moral injunctions in attempts to control the reproductive behaviors and demographic characteristics of their populations (Morgan and Roberts 2012: 243).

As Latin Americanists, Morgan and Roberts's illustrations of reproductive governance are drawn from that continent. Other Latin Americanists have taken up the concept and in doing so, are generating an important body of literature; they include Singer (2017, 2018, 2019) and De Zordo (2016) on abortion in Mexico and Brazil, and El Kotni (2018) and Castro and Savage (2019) on obstetrical violence in Mexico and the Dominican Republic. The concept of reproductive governance has been fruitfully employed in other parts of the world to similarly explicate interacting, interdependent dynamics that can shape a population's characteristics, for example, Suh (2018) in Senegal and Mishtal (2019) in Poland.

A spotlight on reproductive governance has stimulated long-overdue attention to the vast global phenomenon of "obstetrical violence," a coercive form of the phenomenon that prevents certain groups of women from exercising autonomy over virtually all aspects of the childbirth experience. Poor pregnant women are much more likely to deliver without clinicians in attendance (Strong 2020), be subjected to forced episiotomies (Diaz-Tello 2016) and cesareans (Morris and Robinson 2017; Quarini 2016), and be required to share hospital beds due to their shortage in public facilities. They are also commonly subjected to hostility and verbal abuse (Smith Oka 2015) and are targeted for coerced sterilization (Longman 2018).

States try to influence reproduction via explicit and implicit policies; laws that can facilitate or hinder individuals' reproductive goals; and social practices that inhibit certain groups from flourishing. The broad result has been that a wide range of stigmatized groups faces legal and other obstacles to fulfilling their reproductive desires.

Yet, inevitably in both the Global North and South, resistance movements have challenged oppressive state reproductive policies, laws, and practices. These movements are emerging in a rapidly changing world simultaneously facing accelerating globalization processes, massive

technological innovations, new levels of environmental stress, and the interdependencies and interactions among them. Examples of growing resistance today include movements against obstetrical violence and for choice in contraception and childbirth. Even amidst the proliferation of authoritarian regimes and broad-based societal change, we find examples of resourcefulness, courage, and resilience throughout the world among those who seek rights to reproductive freedom in the face of obstacles to deter them.

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Notes

- 1 Given that the vast majority of state efforts to control reproduction target women, they will be the main focus of our analysis.
- 2 Although the US is considered an "advanced democracy," a 2018 Pew research study found Americans far more religious than people in other wealthy Western democracies.
- 3 Neoliberalism is a set of capitalist policies designed to foster a "free" (i.e., unregulated by the state) market. At its heart are "structural adjustment" programs and austerity policies ostensibly imposed to foster economic growth, but which have also engendered the upward redistribution and concentration of wealth and power (Flew 2014).
- 4 Immigration policies are also designed to manage the characteristics of state populations.
- 5 In rich countries, 2.1 children per couple are needed for a society to "replace" itself from one generation to the next.
- 6 We lack satisfactory terms for what used to be called developed and developing countries. Global North and South are commonly used today to distinguish affluent, privileged states from more economically marginalized ones, despite obvious conceptual limitations.
- 7 Misoprostol is used to induce abortion, either alone or with mifepristone or methotrexate.
- 8 We thank Cecilia Tomori for this observation.
- 9 Baby theft is known elsewhere, such as Guatemala, but not as a state practice.

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