UNIT 4 THE POLITICS OF REPRODUCTION

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Structure

4.1 INTRODUCTION

The unit discusses reproduction as a concept which attributed biological symbolism and social interpretations and political connotation. It starts with analyzing reproduction to show how the notion of biological reproduction and social reproduction are interlinked. In this course: Women and Social Structure, the concept of reproduction is discussed by analyzing questions like how moral codes are drawn;how attitudes towards sexuality get normativized and specific cultural attributes are produced;and how are property inheritance, rights and values are operationalized and linked to the notion of biological reproduction.

The unit juxtaposes reproduction with politics. In the present context by politics, we mean the way power is structured and enacted in the social arrangements (Ginsburg and Rapp, 1991). By 'politics of reproduction' we mean the social arrangement in which reproductive relations are embedded may be viewed as inherently political. By which it does not benefit all but is structured to benefit certain sections of the population.This unit will familiarize learners to develop a critical thinking of the social arrangement of institutions like family to understand how the 'politics of reproduction' has been central to patriarchy's repressive regime.

4.2 OBJECTIVES

After going through this unit you will be able to:

- Define reproduction and discuss it in relation to social structure;
- Examine the concept of motherhood in the contemporary context of India; and
- Analyse the politics of reproduction in relation to new practices and technologies.

4.3 STRUCTURING REPRODUCTION

Power relations within the society play a crucial role in hierarchically organizing the very process of reproduction. Accordingly experiences of reproduction are hierarchically organized into different normative categories such as appropriate/inappropriate, normal/deviant, legitimate/illegitimate. In describing this process of categorization **Shellee Colen** (1995) uses the term **'stratified reproduction'**. According to her 'stratified reproduction' means "physical and social reproductive tasks are accomplished differently according to inequalities that are based on hierarchies of class, race, ethnicity, gender, place in global economy, and migration status that are structured by social, economic and political forces" (Colew, 1995, p.78). The concept 'stratified reproduction' helps us in analyzing how reproductive experiences such as bearing, nurturing and socializing children are differently valued and rewarded according to inequalities of access to material and social resources. Further, it helps us in addressing some of the crucial issues such as who is normatively entitled to be give birth to children, to take care of children and have ownership and control over the offspring.

4.3.1 Cultural Construction of Gender Hierarchy in Reproduction

Gender ideology of a particular society plays a crucial role in valuing/ devaluing the contribution of sexes to the process of biological reproduction. An influential contribution to this approach in Indian context has been **Leela Dube's** (1986) work on South Asian procreative metaphor of 'seed and earth'. She also points out that in most parts of India, the process of biological reproduction is often expressed by the metaphorical use of already gendered terms like 'seed' and 'earth'/ 'field', through which the sexual asymmetry in relation of production and reproduction is established. While the 'seed' is referred as father's contribution, the field/earth is referred as the part of the mother. Man's contribution in the form of seed is considered to be the essence for creation of the offspring. Through these metaphors, the culturally conceived notion on biological reproduction is articulated in terms of relations of production (expressed as seed and earth), which in turn expresses the structural rules that govern ownership, control and use

of productive resources and also structure and functioning of the domestic organization. In the context of patrilineal kinship structure and in an agrarian economy, where the land and labour are the principal resource, the metaphors clearly imply the inferior position of women both in relation to reproduction and land. Equating woman's body with field and man's semen with the seed, the process of biological reproduction is equated with the process of production and the rights over the children is equated with the rights over the crop. The inferior position of women in relation to reproduction and production is expressed through these metaphors, which stress culturally the rights of man over women's sexuality and women's lack of rights over children in the events of separation. Such kind of correlation between the principle of patrilineal descent and its expression in a masculinist procreative ideology, and that of the secondary status of women in the Indian society is undeniable (also see Uberoi, 2004).

4.3.2 Articulating the National Body and 'Others'

Women's reproductive body becomes the medium through which national image comes to be articulated. In the articulation of 'national honor' and purity of the nation, women are often drawn as reproductive and sexual beings. **Veena Das's** (1995) narration of the post-colonial Indian state's involvement over recovering the Hindu and Sikh women abducted during the violent upheaval of the partition of India and Pakistan clearly manifests how the state conflates national identity with women's bodies. Hence, recovering the abducted women was articulated as preserving national honor. In the process, new kinds of disciplinary power were exercised on people, whereby the state was able to curtail the rights of the abducted women. Women refusing to go back to their original families were put under coercion. Emphasis was also made on recovering women in their reproductive age group. In the process, the Indian state was engaged in a process of defining its national body/honour, and despising some 'other' reproductive bodies as outside its national honour.

Check Your Progress:

Do you agree that reproduction is structured in a particular way for women? Use any one example to explain it briefly.

4.4 TRACING STRATIFICATIONS IN REPRODUCTION

Even though gender inequality and male domination have been identified as the main sources of reproductive repression, a complex terrain of discursive politics surrounds the politics of reproduction. Such politics challenge the understanding of gender and family as monolithic categories, and brings to fore that women's social location also plays an important role in shaping of their experiences with sexuality and reproduction. Their differences in caste, class, racial, marital status and geographical locations shape their sexuality and reproductive experiences differently. For example, in India the intersection of caste and gender identity has historically been crucial in shaping upper caste women's sexuality differently from dalitand lower caste women. The fundamental principle on which the Hindu social organization is based is to construct a closed structure to preserve land, women and ritual purity. These three are internally linked and it is impossible to maintain all three without stringently controlling female sexuality and reproduction. Hence, purity of upper caste women has a centrality in the brahmanical caste system, since purity of caste is contingent upon it (Chakravarti, 1993).

Safeguarding the purity of upper caste women and the caste structure is achieved through highly restricted movement of upper caste women. Caste purity is prescribed to be maintained through endogamous marriage, and through this upper caste women's purity is preserved. On the other hand, such a restrictive structure positions lower caste women in a vulnerable way. Sexual violence on lower caste women is one of the ways through which normative caste order is maintained. This oppressive caste structure gives power to the upper caste men and the right to exploit the dalit and lower caste women. Vulnerability of dalit women for sexual violence is equated with the caste privilege of upper caste men. This consequently makes the upper caste men view the dalit and lower caste women as their property (Rao, 2009).

Similarly the intersection class of race and gender identity has often been imperative in shaping the reproductive experiences of Black women in America differently from that of white women. Historically, regulating Black women's reproduction has been a central aspect of racial oppression in America. African women who were exported to United States were exploited in both their productive and reproductive capacities. Female slaves were preferred and fetched a higher price because they were agricultural workers and they could give birth to more slaves. After the abolition of the slave trade in United States in 1807, a pronatalist approach to African reproduction dominated, and African women were used as breeders. These practices correspond to the need of agricultural elite for a renewable labor force to exploit (Kuumba, 1999, p. 452). Hence, poor African women's reproductive

capacities were manipulated in response to the market. In the modernizing American economy the unregulated reproduction of Black women has been viewed as dangerous. Hence they have been subject to dehumanizing experiences such as sterilization abuse, implantation of harmful injectives like Norplant and Depo-Provera, in order to control their reproductive body (Roberts, 1997; Davis, 2011). On one hand while the poor Black women are stereotyped (both in policy discourse and popular representations) as undisciplined breeders who sap the resources of the state through incessant demands on welfare, on the other hand they are seen as 'good enough' nurturers to work as child care providers for others (Ginsburg and Rapp, 1995, p. 3).

Along with the Black women, the other 'social misfit' categories like drug addicts, epileptics, the mentally ill, criminals, poor people, and people with limited mental abilities and prostitutes have been the targets of the reproductive regime led by the Eugenic movement in America. The Eugenic movement identifies genetics as the main source of human defects and limitations. For example, as a part of the early eugenic movement in America, in 1931 over thirty states passed compulsory sterilization laws which sought to eliminate the 'unwanted' elements from the society. In the process a whole range of people were designated to be unfit to reproduce (Browner and Ann Press, 1995).

The eugenic movement has also been influential in shaping the imagination of a national body by equating it with women's reproductive body. For example, the 'hygienic' model of public health in the colonial nationalist discourse in India articulated its national body through the medium of women's reproductive body. It associated the health of the nation with the physical strength and purity of the 'race'. The role of the scientifically informed, hygienically enlightened mother, who is uninfected by 'outsiders' was idealized. By equating the nation with builders of a healthy race, women's role was naturalized as biological reproducers. Women's health status was considered to be a matter of importance for the eugenics philosophers, because for them if mothers were physically underdeveloped and sickly, the whole nation would become weak and enfeebled (Whitehead, 1995). The primacy of the motherhood role of women has been maintained through the discourses of state as well as family.

4.5 THE CONCEPT OF MOTHERHOOD

Women are primarily addressed as bearers and nurturers through the institutionalization of motherhood roles. The socially ascribed primacy of the motherhood role of women has been criticized by most of the radical feminist scholars. Patriarchal institutionalization of motherhood has been articulated as a source of women's oppression. Feminist scholars like

Adrienne Rich pointed out that the terms like 'barren' and 'childless' have been used to negate any further identity of women. Through institutionalization of motherhood women are expected to cultivate the virtues of 'maternal instinct' and selflessness. Motherhood role for all women is also not valourized. It is considered as 'sacred' as long as the offspring is 'legitimate', i.e. as long as the child bears the name of the father who legally controls the mother (Rich, 1976).

The state discourses also play a crucial role through which the boundaries of 'proper' motherhood are patrolled. In this regard it is also worth looking at the health discourse and how it primarily addresses and anchors women to the discourse through motherhood roles. Women are addressed both explicitly and implicitly through such stereotypical constructs. The Indian state health sector can be taken as a case in point in this regard; women's health is addressed mainly through 'maternal and child health' programmes. Further, through the health policy interventions, women's sexual and reproductive conduct has come under the closer scrutiny of the state.

In this discourse, women's health has been constructed only as 'reproductive health' (Qadeer, 1998), and women's reproductive behaviour as 'risks', which leads to high maternal mortality, high fertility and infant mortality rates. Hence the state health programme aims at managing the 'risk' through its health policy interventions. In this discourse, women's health is often translated into the concept of the healthy mother. A healthy mother is seen as a prerequisite goal for having healthy children (Simon-Kumar, 2003). Consequently, by constructing them only as reproducers, potential reproducers and care takers, women are drawn into the health policy framework. A range of institutions including Anganwadi centres, Primary Health Centres (PHCs), sub-centres and District hospitals are directed towards exercising surveillance of the state over women's reproductive behaviour and prescribe 'normative' judgments.

The state agents such as Anganwadi Worker (AWW), Accredited Social Health Activist (ASHA), and Auxiliary Nurse Midwife (ANM) are appointed at the grass-root level to exercise surveillance over women as mothers and care takers.The ideal mother is constructed by the health functionaries as someone who gives full attention to the child. The women who fail to cater to the child's nutritional requirement only through breast milk are considered to be 'risking' the child's health and failing in their commitment to be good mothers.In this discourse, the woman's joining of the workforce out of desperate economic condition is looked down upon as 'irresponsible mothers'. Hence, the responsibility for the ill health of the child is shifted towards the mother rather than the health system and the social condition in which they live in (Biswal, 2009). Further, adolescent girls are anchored to the health discourse through conceptualizing them within the category of 'future

mothers'. Health programmes have come to recognize that in order to reduce infant mortality and malnourishment, it is extremely important to focus on the health of the mother. Initially the health programmes used to focus on a woman from the period she got pregnant until she delivered a child. Now it has come to be realized by the state that mothers need nourishing much before they get pregnant (Sinha, 2006). Hence, the programme for adolescent girls has started through Integrated Child Development Services (ICDS) programme by the Government of India in the year 2000-2001. The state has started taking interest in the adolescent girls' health only through their identity as potential future mothers.

On the one hand while the health/medical discourse serves in valourizing women's motherhood roles, on the other hand women's reproductive roles also come to be pathologized through medical discourse. For example the natural bodily changes in women has come to be medicalized and pathologized. Menopause has come to be described as a deficiency disease by the gynecologists and the bodily changes during this period are described as symptoms which can be relieved through hormone implants, patches, pills and gels (Hockey, 1997).

Feminist academics influenced by women's health activism of the 1970s and 1980s have challenged the way in which health has been defined in the language of biomedicine. They have challenged the biomedical construction of woman's body as a deviant body. These works have brought to light the misogyny in biomedical science in addressing issues concerning fertility control, the politics of birth and reproduction.

Check Your Progress:

How do the government programmes conceptualize motherhood and heath?

4.6 THE REPRODUCTIVE FEMALE BODY AND THE STATE'S POPULATION CONTROL PROGRAMME

The nineteenth century campaign for birth control was born with the feminists demand for 'voluntary motherhood'in the western countries, more particularly in America. With the emergence of black civil rights movement and the women's movement in 1960s the 'rights' aspect of birth control gained momentum. The eugenic movement discussed in the Unit 3: Racialised Body, Block 1 of course MWG 004 also had an impact upon the modern population control advocacy programmes. The population control advocates in America began to target developing countries like Puerto Rico as a laboratory for field studies and after World War II played a crucial role in the family planning policy. Developing countries in particular have been the targets of the family planning programme. In the World Population Conference held in Bucharest 1974, the developing nations attacked the western nations for imposing population control programmes on Third World countries instead of addressing the issue of redistribution of wealth (Critchlow, 1996).

India is the first country to have officially committed to a population control programme under the synonym of Family Planning Programme in 1951. In the official state discourse population growth was conceptualized as a 'problem'. The 'small family' norm was promoted to control the population growth of the country, thereby controlling the problem. A state of Emergency was declared in the year 1975. This facilitated the passage of the new population policy in 1976. A radical approach to population control was adopted by mobilizing the entire political and administrative apparatus to gain fast results. Consequently, coercion was inflicted on people to accept vasectomy or male sterilization in which men became the prime targets of the population control programme. The officially inflicted atrocities to force people to accept vasectomy became the main reason for the downfall of the government in 1977. Due to the experience of the Emergency period, women targets of family planning programmes of the government subsequently (Antia et. al, 2000). Women have been identified as a category responsible for breeding too many children.

Many Third World women, including Indian women are subjected to medical trials for contraception and sterilization. Contraceptive pills were first tested on Puerto Rican women. In India there has been widespread use of poor and non-literate women for new contraceptive trials without their informed consent. The volunteers for these trials were recruited through family planning clinics without being informed that they would be subjected to such trials. In opposition to Quinacrine sterilization trials, women's groups in India initiated an intense campaign after which the Supreme Court of India banned Quinacrine sterilization in 1998 (Dasgupta, 2004).

4.6.1 Abortion

In the western countries the liberalization of abortion was achieved in 1970s as a result of a long drawn women's struggle. Contrary to this, abortion right has been made available to Indian women as a part of population control exercise, through the Medical Termination of Pregnancy (MTP) Act 1971. This is one of the gender progressive legislations in the country which was available to women without much fanfare. Even though abortion is legalized in India, the unavailability of abortion service in most of the government health centres, has also supplemented the popular belief that abortion is illegal. **Rani Duggal** (2004) points out that, though abortion is legalized in India, the state has not become the leading provider of abortion. The limited engagement of the state in providing abortion services has led to the perception that it is illegal. The issue of abortion has got a new dimension and raised public concern with the availability of New Reproductive Technologies (NRTs), in some of the South Asian countries like India and China, which are marked by son preference. It has given rise to sex dictation and sex selective abortion of female child. You may be able to think of several cases of sex selective abortion, where women are subjected to coercion under the culture of son preference.

4.6.2 New Reproductive Technologies

Let us now look at New Reproductive Technologies (NRTs) which you have already read in the first year course MWG 004: Gendered Bodies and Sexualities in the context of motherhood and body. Advances in reproductive medical technology since 1960s, broadly known as new reproductive technologies have enabled people to monitor pregnancies through various pre-natal diagnostic techniques. Developments in NRTs have also introduced different forms of assisted reproductive technologies such as in-vitro-fertilization (IVF), embryo transfer, surrogacy etc. These assisted technologies makes biological parenthood possible for categories of people like same sex couples, infertile heterosexual couples, single women, who previously had few options for genetic parenthood.

Diverse feminist viewpoints have emerged over the challenges and possibilities of NRTs. Some feminist scholars which you have come across in the unit 3, Block 3 of MWG 004 recognize the enabling potentials of NRTs. Others highlightthe unequal access to NRTs. It can only benefit the upper-middle class who can afford to purchase these services. They have also underlined how different gender, class, racial, geographical, and other social inequalities are reproduced, reinscribed and reinforced through these technologies. Different forms of NRTs like pre-natal diagnostic testing and assisted reproductive technologies have also thrown up diverse debates. In the context of pre-natal diagnostic screening, while some of the scholars view

it as a humanitarian method of preventing unnecessary grief and suffering by disabled persons and their families, others see it as an example of 'new eugenics' whereby pregnant women and other associated parties are left personally responsible for deciding what kind of life is worth living (Browner & Press, 1995). In India the pre-natal diagnostic technique's potential of becoming a new eugenic force has resulted in the proliferation of sex selective abortions, resulting in adverse sex ratio of the country.

4.6.3 Pre-natal Diagnostic Testing

The antenatal screening techniques like amniocentesis were originally developed in the West to make it possible to diagnose genetic disorders in the foetus. It opened up the option for people to continue with the pregnancy or terminate it. In India the amniocentesis technique was introduced in the mid-1970s for research on genetic abnormalities. In the process the volunteers in the research were excited to discover that, through this process the unborn babies' sex also could be determined. Soon it came to be used in genetic clinics for determining the sex of the foetus. Private sex determination clinics were established in north-western and western states of India, and sex selective abortions became popular in the 1970s and early 1980s. While amniocentesis was largely confined to urban areas with the increasing availability of ultrasound machines in mid 1980s it became pervasive. Historical evidence shows that female infanticide was practiced among certain caste groups in some pockets of India. But what we are witnessing since the introduction of foetal screening techniques is that sex selective abortion has spread across caste groups and become a pan Indian phenomenon (Patel, 2007; Bhalla, 2004).

Sex selective abortion demonstrates how the state and global interests intersect with the family. Firstly, the development of NRTs at the global level and its dissemination at the local level is an indication of globalization. Secondly, the intervention of state health policies had an active role to play in the growth of sex selective abortion. India is the first country to have started an official family planning programme in 1951 where the ideal modern family depicted as a'small family'. It also redefines this model from time to time. In the 1970s the small family had three children, in the 1980s it reduced to two and in the 1990s it meant 'either boy or a girl' (Patel, 2007). The state's stress on population magnitude and idealization of modern family as 'small family', without addressing the pathological syndrome of son preference has resulted in spread of sex selective abortions. It is not only prevalent in rural areas, but it is widely practiced in urban areas, among educated and middle class families. There have been attempts to prevent sex selective abortions in India. PNDT (Pre- natal Diagnostic Technique) Act, 1994 was passed against sex selective abortion due to the efforts of the women's movement. But newer technologies like pre-conception

sex selection arrived in India. In order to prevent the misuse of the new technology, an amendment in the PNDT Act was brought about in 2002 and implemented from 2003.

The experience with pre-natal diagnostic testing techniques in some of the South Asian countries like India makes it clear that the technologies by themselves are not effective. These technologies do not get translated uniformly across the societies. Power dynamics, historical, cultural and geographical location of people plays a crucial role in shaping the experiences of these technologies. In this regard pre-natal diagnostic testing can be taken as an example.

NRTs pose many challenges to our existing understanding of kinship ideology, family formation, the concept of motherhood and the connections they exhibit between economy, class formation and gender ideology. In the mainstream understanding, families are traditionally constituted through mechanisms of marriage and procreation. But NRTs have introduced new actors into the process of procreation such as the assisting clinician, gamete donor and surrogate mother. These new actors create a field of relationships which does not overlap in any simple way with the normative family relationships (Strathern, 1995). Different procreative technologies have come to fore, which potentially separate genetic parenthood from social parenthood. This changing notion of the very process of biological reproduction, has in turn forced the orthodox notions of kinship, mothering, fatherhood, family to change. For example, surrogacy has put a challenge to the very definition of motherhood, fragmenting motherhood into distinct components like genetic motherhood, birth motherhood and social motherhood (Markens, 2007).

4.6.4 Debates on Surrogacy

The literal meaning of the word 'surrogate' is substitute or replacement. Hence, the surrogate mother signifies 'substitute mother'. Surrogate mother is someone who agrees to bear (for financial or compassionate reasons) the child for another woman who is incapable, or less often, unwilling to bear the child herself (Liezel and Zyl, 1995, p. 345). There are mainly two different kinds of surrogacy, namely gestational surrogacy and genetic surrogacy. In case of gestational surrogacy, through in-vitro fertilization the egg and sperm is obtained from the commissioning couple, and the resultant embryo is implanted into the surrogate mother. In this case the surrogate mother performs the role of gestation without having any genetic link with the child.

In case of genetic surrogacy the woman's egg (either through artificial insemination or through natural intercourse) is fertilized by the sperm of

the male partner of the couple desiring a child. Here the surrogate is the genetic mother of the child, while the role of social and legal mother is taken over by another woman.

Diverse feminist interpretations of surrogacy have been articulated. One group of feminist scholars criticize surrogacy as a weapon of patriarchy, which uses women as empty vessels. One of the major criticisms against surrogacy has come from Marxist feminist scholars. They argue that surrogacy reflects class exploitation and commodification of women's bodies. Different inequalities on the basis of race, class and global capitalism play an important role in the surrogate market. They argue that in surrogacy women's labour is outsourced. Women and couples from developed countries travel to poor countries like India to hire women at cheaper rates to gestate and deliver babies. The 'surrogacy industry' is booming because of the outsourcing of reproductive labour, and people from developed countries are travelling to purchase a cheaper source of contract labour. Women from lower economic backgrounds are selling their reproductive labour on a competitive global market. In this context surrogacy has been projected to be opening up 'reproductive supermarket' (Twine, 2001).

Contrary to the Marxist feminist positions on surrogacy, liberal feminists have tried to defend it as a woman's right to use her body as she chooses. They argue that surrogacy is no different from any other form of contract wage labour. Hence, special treatment in this area would only result in undermining women's autonomy and equality as citizens. Another group of feminist scholars argue for a more complex and less polemical understanding of surrogacy. These scholars recognize the simultaneously liberating and oppressive potentials of surrogacy and new reproductive technologies in defining what family, women and motherhood mean. Hence they argue that women's diverse and conflicting interests to be taken into account in response to challenges posed by advances in reproductive medicine (Markens, 2007).

The debates in surrogacy and other reproductive debates bring to fore that women are drawn into the reproductive discourse in diverse ways. Though women as a category have been subject to reproductive repression, they experience it in different ways. The experiences of reproduction are hierarchically structured, and women at the bottom of the hierarchy are subject to such oppression in the worst possible way.

Check Your Progress:

What is Pre-conception and Pre-natal Diagnostic Act (PCPNDT) ACT?

4.7 LET US SUM UP

This unit discusses the social arrangements in which reproductive relations are embedded.The unit analyses the political character of the reproductive female body. It informs the learners about the power relations within society that play a crucial role in hierarchically organizing the process of reproduction. The unit unveils that cultural construction of women's biological reproduction has always received secondary status in terms of ownership and control over the offspring.

The reproductive body is always drawn to the centre stage in the articulation of honour of the community and family.Motherhood as an institution has always been controlled by the structures of the state, community and the family. The state discourse also contributes significantly in approving certain motherhood roles as normative and despising others as deviant. The unit

states that how science, technology and bio-medicine, are also not inherently free from such power dynamics in the analysis of surrogacy, abortion and reproductive technologies.

4.8 UNIT END QUESTIONS

1) What is "Polities of Reproduction"? Discuss with the help of examples.

2) Analyse the notion of motherhood in relation to the State's population Control programme.

3) Discuss the notion of "Structural reproduction". Give examples to substantiate your answer.

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