Consider two archetypical scenes of state-provided prenatal care, one drawn from my ethno-graphic fieldwork in Havana, Cuba (2004–2009) and the other from my research in a public prenatal care clinic in New York City (2015–2017). In the first, it is a steamy afternoon in Havana. I am wandering with Dr. Janet Torres, the doctor in whose neighborhood clinic I am conducting clinical observations, through the maze of buildings that comprise a poorer section of the city. It’s a Wednesday, the day that Janet closes the clinic at 1 pm to do home visits of all her embarazadas (pregnant women) living in the area assigned to her care. She is an easily recognizable figure with her distinctive white lab coat, and people cross the road or lean over crumbling balconies to call a greeting or to ask a quick question about a sick family member.

Without warning, Janet stops and ducks through a scarcely noticeable alley. We emerge into a tiny, dark, and airless interior courtyard where the material conditions are noticeably worse than on the street outside. In many of the dilapidated buildings, the formerly high ceilings of the Spanish colonial architecture have been dissected both vertically and horizontally to carve extra living quarters out of the limited space. Janet raps on one of these doors, and a heavily pregnant woman welcomes us in, kissing Janet warmly and offering us both a cup of sweet Cuban coffee. After an exchange of pleasantries, Janet gently quizzes her patient about her diet, exercise, and general well-being. Telling her that she is looking well, Janet leans forward and presses her fingers to the woman’s ankle, looking for any signs of swelling that might indicate preeclampsia, a potentially fatal condition that requires additional monitoring. Straightening up with a look of satisfaction, Janet bids her patient goodbye, reminding her that she has an appointment at the clinic the following week for her routine prenatal appointment. As we stroll to her next patient, Janet remarks, “Do you see now? It’s a lot of work to do these home visits, but I learn a lot about my patients—their emotional state, their living conditions, if they are stressed economically. It helps me to know if there are any risks to the mother and baby [fetus] that I should be looking out for.”

The second scene takes place in a public prenatal clinic in New York City. On this particular day, the waiting room is overflowing with pregnant women waiting for their appointments. As usual, the majority of the women waiting are Black, either born in the United States or on one
of the Caribbean islands. Today is a particularly bad day: A midwife and a nurse-practitioner in the clinical suite dedicated to low-risk pregnancies have called in sick. Other providers, including two doctors who normally exclusively handled high-risk cases such as pregnant women with gestational diabetes, high blood pressure, or previous Caesarian sections, have been asked to absorb the patient load. Receptionists have been instructed to accept only obstetric visits and to re-schedule any patient with non-urgent gynecological concerns, sometimes delivering this bad news to women already waiting for their appointment. Adding to everyone’s discomfort, the hospital’s ancient and overburdened cooling system is proving no match for the August heat. Both patients and clinic staff are feeling the strain; as a doctor hurries past on a quick bathroom break, she mutters in an aside to me, “Not only is it stinking hot back there [in the providers’ rooms], but everyone is overworked, overtired, and underfed.”

In this stress-filled atmosphere, patients wait, listlessly fanning themselves with the literature distributed during the morning’s breastfeeding class. Finally, a pregnant patient in blue scrubs, clearly on her own way to or from a hospital shift, approaches a hospital educator that I am shadowing and tells her that she has been waiting for an hour for her PPD (a skin test for latent tuberculosis). The midwife in charge of her care overhears and apologetically admits that she has forgotten to put this order into the nurses’ system in the chaos. A nurse is called but, while sympathetic, tells the woman she is already busy tending to a pregnant patient suffering from heat exhaustion. The woman sighs deeply and exclaims, “I’m dying out there [in the waiting room], I’m dying, you don’t understand.” Immediately, both nurse and midwife chide her, saying reprovingly, “Don’t say that, you don’t say you’re dying. That’s a terrible thing to say here.” Only slightly repentant, the woman modifies her statement: “I’m suffering out there. I can’t be here anymore.” Acknowledging my sympathetic gaze, she sighs, “It’s like a broken record here. Every time, the same thing. I can’t take it anymore.”

These contrasting scenes bring into sharp focus two very different conceptualizations of the state’s responsibility for reproduction, particularly for its poorer and more vulnerable sub-
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Projects. In Cuba, free and accessible reproductive healthcare is upheld as a key symbol of the socialist state’s commitment to egalitarianism and the well-being of all citizens. In practice, this means that the same standards and protocols of public prenatal care are extended to all pregnant women, regardless of race, economic status, or region. By contrast, in the US, state approaches to reproductive healthcare have been shaped by culturally dominant ideologies around individual responsibility and choice, as well as a widely held suspicion about the role of government in the lives of its citizens. The effect has been a patchwork and uneven system of reproductive health that may optimize choices for middle-class and wealthy families but severely constrains options for the poor. Drawing on my research on state-provided reproductive healthcare in Cuba and the United States, this chapter illustrates how political agendas, cultural values, and state ideologies are expressed through practices of reproductive governance, engaging larger ideological struggles about belonging and the relationship of the state to its citizens (Ginsburg and Rapp 1995). State reproductive policy thus articulates with the social landscape at large, in the values, ideologies, tensions, and inequalities that they reproduce—or at times, transform.

From political demography to reproductive governance

Anthropologists have long been concerned with the role of states in shaping reproduction. In the 1990s, Gail Kligman (1998) coined the term political demography to describe state intervention into fertility for political purposes. She describes how, in socialist Romania, the dictator Nicolae Ceaușescu, who held power from 1965 to 1989, viewed the (re)production of an ever-larger human labor force as a crucial step in the state’s effort to realize its vision of industrialized modernity. Pronatalism became official policy and the patriotic duty of citizens. Abortion and contraception were criminalized, and women who sought to prevent or terminate unwanted pregnancies, as well as anyone who aided them, were subject to criminal prosecution and imprisonment. The consequences were predictable and tragic. Maternal mortality skyrocketed as desperate women subjected themselves to unsafe abortion practices or were forced to give birth despite medical contraindications. At the same time, destitute parents gave up untold numbers of children to grim state-run orphanages where many suffered the lasting effects of neglect and abuse.

In China, state concerns about the economic and social effects of a rapidly growing population produced a different calculus. Arguing that demographic decline was necessary to produce a “high quality” population that would bring the country out of poverty, the government of Deng Xiopeng implemented the notorious one-child birth policy in 1979. Achieving national “compliance” with this extreme state-imposed fertility limitation entailed intensive surveillance over individual bodies to identify unauthorized pregnancies and terminate them, forcibly if necessary (Anagnost 1995; Greenhalgh 2008). As Susan Greenhalgh (2003) has shown, however, state attempts to realize modernity through reproductive control often produced its opposite. Since some women with unauthorized second or third pregnancies were always able to evade the state’s gaze, the one-child policy also resulted in the births of officially “unplanned” children whose births could never be formally recognized by the state. Growing up without rights to education and other benefits accorded to “planned” citizen-children, this shadow population thus represented the underside to the Chinese state’s efforts to produce a modern population through fertility limitation.

Political demography was not limited to socialist states. Often under pressure by international development organizations and global financial lending structures, the governments of many “developing” countries have also sought to achieve demographic profiles considered synonymous with modernity by encouraging—and at times, coercing—their subjects to limit their
fertility (for critiques of such programs, see, for example, Brunson 2016; Chatterjee and Riley 2001; Tarlo 2003). Anthropologists have also demonstrated how, in many global contexts, state efforts to harness reproduction for political purposes have been highly targeted, reflecting wider classist, racist, xenophobic, and ablest ideologies. Examples of such interventions into fertility range from eugenicist efforts to sterilize the largely poor, minority, incarcerated, or disabled women deemed “unfit” to reproduce to state policies that seek to encourage the fertility of “desirable” groups while limiting those seen as outside the national imaginary (e.g., Briggs 2017; Davis 2019; Kanaaneh 2002; López 2008; Smith-Oka 2013).

Building on such insights, anthropologists concerned with reproduction and the state have expanded their gaze to consider state intervention into reproduction more broadly. Research in this vein has demonstrated how reproduction is not only enabled or constrained by policies explicitly conceived as regulating fertility, but also by policies around healthcare, labor, housing, migration, and so forth, that often have uneven and contradictory consequences for reproductive practices and outcomes. Through close attention to the ever-present slippages and gaps between policy and practice, anthropologists thus foreground reproduction as a lens onto the unpredictable and often unintended consequences of state policy, economic pressures, familial politics, and personal aspirations.

In this area, Lynn Morgan and Elizabeth Roberts’ (2012) concept of reproductive governance has proved particularly generative (see Browner and Sargent in this volume). Underscoring how control over reproduction is central to a variety of moral regimes and diverse religious, economic, and demographic agendas, reproductive governance refers to the “mechanisms through which different configurations of actors … use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviors and population practices” (2012: 243). It thus provides an incisive analytical framework for further unpacking the relationship between state priorities and the management of reproduction. To use examples relevant to this chapter, reproductive governance could be expressed in efforts to optimize population birth outcomes through policies that provide high-quality prenatal care to all residents. Alternatively, reproductive governance could involve the selective distribution, or even denial, of the resources that communities need to nurture and sustain children, reproducing entrenched hierarchies around class, ethnicity, migratory status, as well as other axes of difference. Thus, in a process that Shellee Colen (1995) termed “stratified reproduction,” the reproductive capacities of some groups may be valued and enabled while the reproduction of those marked as Other is devalued and discouraged.

Attention to the ways in which states organize, distribute, and control access to reproductive services for their more vulnerable citizens can thus reveal broader tensions and struggles over social citizenship—who is perceived to truly “belong” in the national body—and the shape of cultural futures (Ginsburg and Rapp 1995). The remainder of this chapter draws on my research in Cuba (see Figure 7.2) and in the US to compare these distinct state approaches to reproductive governance through the provision of prenatal care and technologies of fertility limitation.

Cuba: Reproductive health as state morality

Prenatal care

In January 2019, the Granma, one of Cuba’s state-run newspapers, proudly announced that the country’s 2018 infant mortality rates had declined for the eleventh consecutive year, reaching the record low rate of 4.0 deaths per 1,000 live births (Fariñas Acosta 2019). To put this into
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context, the infant mortality rate for the United States, a significantly wealthier albeit far more unequal nation, was 6.6 deaths per 1,000 births for the same year.² Further, Cuba’s maternal mortality rate (always higher than the United States, although far lower than most of its neighbors in Latin America and the Caribbean) has shown the same downward trend, declining from 59 per 100,000 live births in 1990 to 39 per 100,000 live births in 2015 (see Figure 7.3).

Figure 7.2  A consultation room in the family doctor clinic.

Figure 7.3  The front page of one of the daily newspapers, Granma, publicizing the record-low infant mortality rate of the previous year.
Elise Andaya

Cuba’s superb reproductive health statistics are thus an achievement of which the government is justifiably proud. Outside the island, these infant and maternal mortality statistics are often viewed as a paradox, with commentators marveling at the country’s “developed” reproductive health profile within an “underdeveloped” country. But the means to their achievement is far from a secret. As the Granma article went on to declare, these rates are the result of the determined will to prioritize universal health access, and inclusive and human social development. It is the expression of effort and perseverance on the part of thousands of health professionals throughout Cuba—from doctors’ offices to hospital services … [as well as] intersectoral and community support for health measures.

(Fariñas Acosta 2019)

Reproductive health outcomes represent an expression of the Cuban state’s political will and the investment of significant financial and human capital. Since the 1959 revolution that unseated the dictator Fulgencio Batista and brought Fidel Castro to power, reproductive health policy in Cuba has been driven by socialist ideological commitments to gender, class, and racial egalitarianism. For the youthful revolutionaries, the high rates of infant and child death among the Cuban poor reflected the moral bankruptcy of capitalist society and its system of racial and class segregation. They thus set about producing a free and accessible health system that would serve the needs of all, regardless of race, class, gender, or region. In the 1980s, this commitment to healthcare culminated in the family doctor system that placed a doctor–nurse team in virtually every urban block and rural area.

But public health was not the only issue at stake. In 1987, Fidel Castro made clear the terms of the engagement, stating, “Public health became a challenge and a battleground between imperialism and ourselves … That is why we have developed the field and are striving to become a medical power with the best possible health indices” (Feinsilver 1993: 203). In this argument, the fully inclusive “public” of public health functions as a discourse of counter-hegemony that is explicitly compared to both the United States and to Cuba’s pre-revolutionary history of Spanish and American domination. For the Cuban government, the provision of free and accessible healthcare for all citizens embodies the moral superiority of socialism over the inequality and exploitation considered characteristic of human relations under capitalism. Cuba’s excellent reproductive health outcomes, and the quality of its prenatal care, are thus held up as concrete evidence of the state’s commitment to all of its citizens. Indeed, when international bodies such as Humans Rights Watch charge the government with a lack of political freedoms, Cuba has repeatedly pointed to its health indices—particularly its reproductive health statistics—as evidence of the moral legitimacy of its system.

The continual improvement of infant and maternal mortality rates has thus long been a central priority, especially given the symbolic importance of reproductive health statistics to international health institutions such as the World Health Organization (WHO) that use such measurements as an indicator of good governance. The emphasis on maintaining reproductive health statistics has continued even under the difficult economic conditions precipitated by the fall of the Soviet Union in 1991 and the loss of its considerable financial support to the island. More recently, the death of a vital economic and ideological ally in the leftist Venezuelan president, Hugo Chávez, has been another blow to the island’s economy. Until Chávez’s death in 2013, Cuba’s government received millions of barrels of subsidized oil in exchange for the work of Cuban doctors in impoverished areas of Venezuela. The collapse of the Venezuelan economy under Chávez’s successor, President Nicolas Maduro, as well as the hardening of the American embargo (which prevents American companies from trading with Cuba under
most circumstances) under the hostile Trump administration, has been disastrous, resulting in the rationing of electricity that not seen since the years immediately following the fall of the Soviet Union.

Yet despite conditions of chronic and worsening scarcity in recent years, Cuba’s reproductive health statistics continue to improve, even for its poorest citizens. The national prenatal care program follows general WHO guidelines: Women with low-risk pregnancies are initially seen once a month in the clinic, with clinic visits rising to once every two weeks in the third trimester and once a week in the final month of pregnancy. Those with high-risk conditions, such as gestational diabetes or high blood pressure, attend clinic visits more frequently throughout their pregnancy, as well as consultations with specialists to track their condition. In addition to this routine care, pregnant women receive special supplemented food rations, genetic testing, and ultrasounds to identify potential congenital anomalies, and may be evaluated by a dentist, a nutritionist, and a psychologist who reviews family relationships, preparation for motherhood, and underscores the importance of breastfeeding. Finally, women may also be admitted to a hospital or maternity home for in-patient care and closer medical monitoring if their health condition suggests a potential risk to the health of the mother or fetus.

As the opening ethnographic vignette underscores, Cuba’s excellent reproductive health statistics would not be possible without the ground-level labor of the island’s extensive network of medical and public health professionals. The state’s promotion of medical training and guarantee of free medical education has resulted in an extremely high doctor per capita ratio (approximately 67 doctors per 10,000 people). Moreover, since doctors must work for two years in underserved communities in exchange for their free education (Andaya 2009; Feinsilver 1993), Cuba is able to provide prenatal care to women even in remote or impoverished regions. By contrast with the US where no federal system (and not even a state-level one, in many places) exists to investigate causes of maternal death, the Cuban Ministry of Public Health holds doctors accountable for their patients’ reproductive outcomes, and infant and maternal deaths are carefully tracked and analyzed. Although critics have viewed the Cuban medical system as an expression of state surveillance and oppression, my experience suggests that women generally appreciated the investment into the health of their pregnancies, even if they at times expressed ambivalence about the time-intensive labor of prenatal care. For Cubans, reproductive health—and indeed, health and healthcare more generally—is widely viewed as a key responsibility to which governments should be held accountable. Through policies and practices of prenatal care, the Cuban state thus works to mitigate the effects of economic and social inequality, bringing into being babies whose health and vitality stand as a symbol of the health and morality of the state itself.

**Contraception and abortion**

Policies around fertility control are similarly informed by ideologies about the state’s role in promoting (gendered) citizenship. Despite many tensions and contradictions in both policy and practice, official attitudes to fertility control in Cuba are deeply shaped by historic socialist commitments to female “uplift” and, in particular, the effort to “liberate” women’s labor from the private domestic sphere. Translated into reproductive health policy, this means that abortion and contraception are viewed as an essential part of women’s right to reproductive autonomy and are accessible without charge through most health clinics. The assertion of women’s right to choose the number and timing of their pregnancies means that the socialist government has never made intervention into fertility an explicit part of its political agenda. This remains true today, despite the fact that shifts in gender roles coupled with ongoing economic crises have
resulted in a below-replacement birth rate and a demographic shift of the magnitude more commonly associated with “developed” countries.5

Officially, all women can receive oral contraceptives, intrauterine devices (IUDs), and condoms free of charge through clinics and pharmacies. In practice, access to high-quality contraceptives is sometimes more complicated than official representations may admit, and the range of options is limited. Interruptions in supply due to the US embargo and other factors have often compromised the availability and thus the effectiveness of oral contraceptives since these must be taken daily to reliably prevent pregnancy. Although Cuba began manufacturing generic versions to circumvent this problem, it has not been entirely alleviated since necessary materials may be manufactured or licensed by US companies and thus remain subject to the embargo. IUDs are also not always readily available, and many women report problems such as pain and bleeding with this method, leading to high rates of removal.6 Further, despite sustained public health efforts to promote condom use in order to maintain the island’s extremely low prevalence of HIV, condoms tend to be associated with brief sexual encounters rather than monogamous relationships, and some women—as in many other global sites—continue to experience male resistance to their use.

Abortion care is safe, free, and accessible, at least until the end of the first trimester of pregnancy. Although public health and medical professionals have sought to lower abortion rates for reasons discussed below, about half of all pregnancies on the island still end in a termination. Perhaps because of this prevalence, abortion care is relatively unstigmatized, especially by the standards of the United States, and I found that women usually had few reservations about speaking about their abortion histories. In a shared reproductive context in which many women only bring one pregnancy to term, women almost never spoke about abortion in terms of rights, but rather as an unavoidable necessity given contraceptive failures and sometimes grim economic conditions (see also Luehrmann 2016). After the end of the first trimester of pregnancy (12 weeks of gestation), however, Cuba’s relatively liberal policy for early abortions becomes more stringent. In the second trimester, a panel of medical professionals considers any request for an abortion and petitions may be denied if the case is deemed too medically risky. But unlike the US context, limits to abortion access are driven by public health anxiety about risk and the potential fatalities that injure families and damage Cuba’s reputation rather than concerns around morality and fetal personhood.

Cuban reproductive policy thus both reflects and reproduces broader state political commitments to social and economic egalitarianism. Although choices tend to be limited (99.9% of all Cuban births occur in hospitals, for example, and no officially recognized system of midwifery exists), access to reproductive healthcare is determined primarily by what the economically strained state can provide rather than the individual ability to pay for services. For the Cuban state, intervention into reproduction is a key avenue through which it works to bring about hoped-for futures, even for its poorest and most marginal citizens. Since the fall of the Soviet Union, social and economic stratification has been growing, and some women are able to access resources, primarily through overseas connections, that are not available to everyone. However, state policies underscore a broader ideological commitment to reproductive healthcare as a universal right to which all citizens should have access.

The United States: Stratified reproduction

Prenatal care

The case of the US reveals a starkly different approach to the role of the state in regulating reproduction. Reflecting dominant cultural values, American reproductive policy is informed
by ideologies about individual responsibility and self-reliance, accompanied by a historic distrust of state intervention into the practices of its subjects. In the 1980s, under the presidency of Ronald Reagan, this cultural worldview found expression in the increasing political influence of neoliberalism and its belief in the power of the market, rather than the state, to respond to the needs of citizens. Although a full exposition of neoliberal philosophy is outside the purview of this chapter, it is important to note that it has both economic and cultural dimensions; as the US government implemented cutbacks in many social services and safety net programs, it asserted that these services were more efficiently provided by private and faith-based organizations rather than the state (economic rationale) and that such public programs encouraged dependence on government largesse at the cost of promoting self-reliance (cultural rationale).

In the realm of health, adherents of neoliberalism argue that it is the right and the responsibility of the individual to optimize their own health through making good economic and lifestyle choices (Rose 2007). This emphasis on the individual, however, obscures the state’s role in reproducing social and health inequalities. In the US, the lack of a national single-payer healthcare system such as that which exists in Canada, the UK, Australia, and most of Europe means that access to, and quality of, reproductive healthcare is deeply stratified by economic status, which is in turn linked to racial/ethnic hierarchies. The negative consequences of this system are evident in US infant and mortality rates, which consistently rank at the bottom of “developed” countries. Maternal mortality statistics are particularly concerning: Between 1990 and 2014, the US maternal mortality rate more than doubled, from 10.3 per 100,000 live births in 1990 to 23.5 deaths per 100,000 live births in 2014. Moreover, the burden of premature and often preventable deaths falls more heavily on poor and minority communities. In New York City, for example, maternal mortality rates have remained relatively stagnant since 2010, but the racial gap in maternal mortality rates has almost doubled, a consequence of a dramatic drop in maternal mortality for White women that has not been replicated for Black women. Maternal mortality rates for non-Latina Black women is 12 times higher than those of non-Latina White women, a disparity three to four times greater than national rates (New York City Department of Health and Mental Hygiene 2015).

In America’s fragmented system of health coverage, middle and upper-middle-class pregnant women tend to be covered by robust employer-based insurance, while the very wealthy pay out-of-pocket for the personal on-call attention that is part of a growing practice of boutique medicine. The healthcare choices of low-income women, disproportionately also minorities, are more constrained. Although those in low-wage jobs may in theory have access to employer-provided health insurance, poor coverage—high copays and deductibles, and/or limited range of providers or services—push the majority of income-eligible workers to enroll instead in state Medicaid programs. (Indeed, critics of companies like Walmart have charged that this is a deliberate strategy to push employees onto public insurance paid by taxpayers rather than having the company assume the costs of coverage.) Pregnancy is also a time when previously uninsured or under-insured women may opt to enroll in Medicaid, since federal guidelines mandate a higher eligibility threshold for pregnant women (generally between 133–223% of the federal poverty level, depending on the state) and some states also extend Medicaid-covered healthcare to pregnant undocumented women. This expanded eligibility provides qualifying women with temporary healthcare coverage, although only until 60 days after the end of their pregnancy.

Medicaid is thus the largest insurer of pregnant women in the country, covering nearly half of all births nationally in 2017 and more than 50% of births in some 24 states (Martin et al. 2018). The division between private and public insurance, as well as the negative value often attached to public services, however, reproduces broader social inequalities and exclusions. Many doctors and health institutions do not accept Medicaid-covered patients, citing low reimbursement rates.
and excessive bureaucratic demands. Further, in a system of privately funded medical education, the considerable burden of debt assumed by medical graduates often serves as a deterrent to working in lesser-paid public health institutions. Women with public insurance thus tend to have fewer provider options than do their privately insured counterparts. They are also more likely to be restricted to over-burdened public institutions with time-pressed providers and strained resources with potentially negative consequences for the quality and experience of care (Andaya 2017, 2019). Further, although some states provide Medicaid coverage to all pregnant income-eligible residents, the majority do not permit undocumented women to access any kind of insurance coverage, who therefore may end up receiving their first “care” while delivering in a hospital emergency room.

Anthropologists have also argued that the practices and policies of Medicaid-covered prenatal care are deeply racialized, reflecting entrenched ideologies and stereotypes around race and class (Bridges 2011; Gálvez 2011). For example, Medicaid regulations dictate that providers ask pregnant women a range of personal and often intrusive questions that are never demanded of privately insured women, from domestic violence screening to questions about sexual partnerships, housing, and household budgets. A benevolent reading of such regulations might argue that such screenings are necessary to ensure that low-income women have access to appropriate services during their pregnancy. However, these are only mandated for publicly insured (and therefore low-income) women, despite the fact that issues like domestic violence occur in all kinds of class contexts. Anthropologists and other critics thus charge that this policy is informed by a racist and classist logic in which—regardless of their actual individual risk factors—racialized low-income women are considered by definition “at risk” from their own lifestyle choices as well as their social, economic, and familial environments (Bridges 2017).

Contraception and abortion

Stratification is also evident in unequal access to techniques of fertility limitation. Since the passage of the 2010 Affordable Care Act, federal regulations have required that all state Medicaid programs provide contraception without co-pays, although they are not required to offer all FDA-approved options. However, state Medicaid programs vary greatly in their coverage of other means of fertility limitation, including condoms, emergency contraception, and sterilization (Walls et al. 2016). In addition, a number of states limit the number of oral contraceptives that Medicaid-covered women may receive at one time, increasing the likelihood of a lapse in protection if women are unable to refill their prescription in a timely manner.

The state’s role in constraining reproductive options for low-income women is also evident in other ways. Planned Parenthood is the largest provider of reproductive healthcare in the country, offering services from mammograms and pap smears to contraceptives and diagnosis and treatment for sexually transmitted infections. Until 2019, much of the funding for these services came from Title X, a federal program instituted in 1970 to facilitate access to reproductive healthcare to low-income and uninsured people who otherwise would not be able to afford care. According to Planned Parenthood, 78% of all people covered by Title X fall under the federal poverty line, while 21% identify as Black or African-American and 32% as Hispanic or Latinx. As the only federal program dedicated to funding family planning, Title X has played an essential role in ensuring widespread access to contraception. In 2019, however, the Trump administration finalized a rule prohibiting Title X funding to organizations that performed, or even provided referrals for, abortion care. This “gag rule” was widely viewed as a deliberate attack on Planned Parenthood, which has long been a target of anti-abortion rights activists even though abortion care represents only about 3% of the organization’s reproductive health
services. In response, Planned Parenthood announced its withdrawal from Title X, stating that it could not conform to federal mandates that restricted providers’ ability to provide information about all healthcare options to their patients.

The administration’s willingness to hold low-income women’s access to routine reproductive healthcare hostage in the fight against abortion represents a shocking lack of regard for the reproductive well-being of its poorer and more vulnerable subjects. Although at the timing of writing it is too early to determine the full effects of the loss of this funding, Texas provides an instructive and devastating case study of the human costs of such state divestment of responsibility for care. In 2016, legislators allocated 800 million dollars to border security while slashing the state family planning budget, which serves 60% of the state’s low-income women, from 112 million to 40 million dollars (Wright 2017). Eighty-two family planning clinics shut down as a consequence, leading to a disproportionate rise in births funded by Medicaid since low-income women—largely migrants and minorities—no longer had access to either birth control or abortion. Unsurprisingly given these sustained attacks against low-income women’s reproductive well-being, recent maternal mortality statistics find that Texas is now also one of the most dangerous places to give birth in the “developed” world.

As the Title X case suggests, the past decade has seen an unprecedented escalation of attacks against rights to abortion care in the US, more than in any other decade since the landmark 1973 Roe v. Wade case that legalized abortion in the United States (for further details, see Andaya and Mishtal 2017). Abortion is thus one of the most highly regulated medical procedures in the US, despite the extremely low risk for first-trimester abortions (Bartlett et al. 2004). In this increasingly polarized context, women's state of residence may determine their ability to receive abortion care. While some states, like New York, have responded to the hostile national climate by passing legislation to shore up rights to reproductive healthcare, including abortion, others have imposed severe limits on access through legislation designed to drive providers and clinics out of practice. As of the time of writing, in Kentucky, for example, only one abortion clinic still exists to serve the entire state.

Abortion is increasingly concentrated among minority, immigrant, and/or low-income women who, particularly given Planned Parenthood’s recent loss of Title X funding, have less access to the necessary health education and healthcare that would prevent unwanted pregnancies. Further, the 1976 Hyde Amendment prohibits the use of Medicaid dollars for abortion care. Although some states have instituted funds to help low-income women who want or need to end their pregnancies, in others, low-income women are forced to divert money intended for rent, food, schooling, or other necessary expenses in order to pay for abortion care.

Those who suffer most from state-imposed constraints on their reproductive agency are thus precisely those who have historically been disadvantaged within US society. Since women with resources can make the potentially expensive and difficult trips across state or national borders to obtain abortions, the burden of both unintended pregnancies and unsafe abortions disproportionately impacts poor, young, rural, and minority women and communities. For women living in states with few abortion providers, requirements for counseling and/or mandatory wait times may mean incurring added costs of overnight accommodations or multiple trips to a clinic. This is especially onerous for women with little economic means, for those who would prefer to keep the procedure private from family and coworkers, or for women living in states that have reduced the gestational age for legal abortion. Denial of abortion care can be life-altering; studies have shown that women who must continue a pregnancy due to their inability to obtain a legal abortion are often placed at heightened social, economic, and health risks (Mauldon et al. 2015).
Reproductive governance in the United States thus reflects and reproduces a deeply unequal society, where better-off women may exercise a considerable degree of reproductive autonomy while those women who depend on state resources encounter significant constraints. While proponents argue that this system rewards the key American values of individualism and self-reliance, the effect in practice is to stratify access to care and reproduce stark inequalities of race/ethnicity, class, documentation status, and region. Anthropologists have repeatedly argued that viewing reproductive health as a matter of individual “good choices” ignores the wider structural constraints, such as low-wage jobs with inadequate health coverage, that negatively impact the health of low-income pregnant women and their fetuses. The longstanding reluctance of the US state to assume financial and moral responsibility for its more vulnerable subjects places substantial, financial, labor, and emotional burdens on individuals’ own support systems to ensure the survival and well-being of their dependents. At the same time, the fact that state-imposed requirements and restrictions fall more heavily on low-income women and families than on wealthier ones reveals, as Ross and Solinger put it, the “entrenched project of marking vulnerable people for reproductive management” (2017: 143). Such inequalities are surely directly correlated to America’s poor record for infant and maternal mortality, particularly for poor and minority communities.

Conclusion

Diverse state approaches to the issue of reproduction thus sharply underscore how cultural values and contested political imaginaries shape reproductive policy. Attention to reproductive governance in Cuba and the US starkly reveals the power of the state to, in Foucault’s famous formulation, make live or to let die. This is the essence of his notion of biopolitics, or the work of states to sustain and optimize their populations through interventions into public health, education, and so forth. Yet biopolitics does not necessarily mean an equal investment into all citizens; it can also entail the selective state divestment from responsibility. In this context, some groups may be given the resources and ability to prosper while others are denied these opportunities, either directly or through state policies of non-intervention that become de facto abandonment. Comparing the Cuban and American systems of state-provided reproductive healthcare thus underscores how states draw upon techniques of reproductive governance to realize culturally valued visions of society and citizenship. In so doing, they are deeply implicated in the reproduction—or at times, the amelioration—of inequalities across social groups and over the generations.

Notes

1 Postcolonial scholars have trenchantly critiqued the use of this term, pointing to its complicity in a worldview that sees the adoption of Western economic and political models as necessary to prosperity while simultaneously eliding the history of colonialism and exploitation that produced the “under-development” of the Global South.
2 https://data.unicef.org/country/usa/
5 According to state outlets, as of 2017, almost 20% of the island’s population is over the age of 60. With a birth rate that has remained at below-replacement levels for decades, high levels of emigration by young people, and—unlike Europe countries—with virtually no immigration to the island, demographers and state officials worry about the social and economic costs of caring for a rapidly aging population.
6 Women in many global sites reported high rates of negative side effects, such as pain and bleeding, with the early versions of the IUD that circulated in the 1980s and 1990s. Since newer versions available in the US and Europe seem to be less associated with complications, it is unclear whether Cuban women’s dissatisfaction with this method (despite the prevalence of its use) is due to the type of model still used in Cuba or to some other factor.

7 Medicaid is a jointly funded federal–state program that provides health coverage to eligible low-income adults, pregnant women, children, and people with disabilities. Although general guidelines are provided by the federal government, individual states differ on inclusion criteria such as documentation status or income caps.

8 https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0 &sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed December 12, 2019.


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