6

THE NECROPOLITICS
OF REPRODUCTION

Racism, resistance, and the Sojourner Syndrome
in the age of the Movement for Black Lives

Leith Mullings

Editors’ preface

Leith Mullings (1945–2020) was a friend, colleague, and mentor to many of the contributors in this volume, and a figure of inspiration for all of us in the anthropology of reproduction. Her work centered on inequalities and their consequences, particularly as they are experienced by Black women and mothers and their children, as well as on resistance and what Mullings (2018) called the transformative work that Black women perform—that is, the “efforts to sustain continuity under transformed circumstances, and efforts to transform circumstances in order to maintain continuity.” In recent years, she had been engaged in work with and on the Movement for Black Lives (M4BL) (Spencer et al. 2020; Mullings 2020; Hale and Mullings 2020).

In her previous work, Mullings had provoked us to think about how the structures of race and racism operate so that resistance is, on the one hand, as celebrated and valorized as it is necessary as a survival strategy—and, on the other hand, exacts tremendous costs from the Black women who undertake this transformative work. This is what has come to be known as the Sojourner Syndrome, a term that Mullings herself coined (Mullings and Wali 2001; Mullings 2005). In the current chapter, Mullings propels us toward a critical understanding of what she calls the reproductive “necropolitics” of racism by providing a clear and devastating analysis of the various ways in which reproduction has been weaponized against racialized people as their end, not their continuity.

At the time of her passing, Leith had nearly completed writing this chapter. There were a few passages in the text that Leith herself had highlighted or marked to revisit, so in these places, we added material from her own notes for this paper. In addition, the section titled “Challenging structural racism: The Movement for Black Lives and reproductive justice” is constructed from these notes, which were included at the end of the file for this chapter, but separated from the rest of the text. While it was unclear to us what Leith’s intentions were, we suspect that she might have drawn readers into some concluding thoughts on the strong and stern hope offered by M4BL. Otherwise, the chapter appears here as we received it, with some editing for clarity.

Only the conclusion was unfinished. Not long before her death, Leith Mullings spoke at a roundtable on “The Science of Racism,” held in November 2020 as part of the American
Anthropological Association’s online conference. At the time, Leith was hard at work finalizing her draft chapter, and she shared her reflections on her central argument. “There are several moments in history which we must label reproductive necro-politics,” she said, remarking on the manipulation of racialized people’s reproduction in the US. Necropolitics refers to “the production and reproduction of racialization, colonialism, and capitalism and the resultant accumulation of wealth through the dispossession of racialized people” that have produced “the biological effects and other disparities that we see today” (Fuentes et al. 2021).

Leith’s withering critique, succinctly and pointedly summarized in her formulation of a concept of “reproductive necropolitics,” is elaborated in depth in this chapter. Despite the devastating effects of reproductive necropolitics, Leith remained hopeful for a future filled with a “different vision of humanity”—one she saw emerging from M4BL. It is now on us to take up this work and carry it forward.

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**Introduction**

The concept of reproduction has developed to encompass many levels. The narrow biological reference has been expanded by Marxist feminists to take into consideration activities connected with reproduction, particularly care work. More recently, anthropologists have expanded it to a lens through which we can contemplate the reproduction of life itself on levels that include individuals, households, communities, and nation-states—from the imagining of creating future generations to genocide. How do we connect the dots between the levels, the micro- and macro-structures?

As crises such as the COVID-19 pandemic foreground and give new meaning to the concept of reproduction, one of the major contributions of anthropology has been to demonstrate that reproduction is about the future, the past, and most importantly, the past in the future. I write this chapter in the midst of the COVID-19 pandemic. The official estimates are that between the first recognition of the virus in January 2020 and November 12, 2020, there were 1.2 million deaths worldwide and 242,000 deaths in the United States. Biological, civilizational, and cultural futures (of reproduction) are up for grabs. In the US, the fractures in society immediately became clear. Black and Latino people were far more likely to contract the disease than White people. Cases for Black people at 62 per 10,000 were almost three times the rate of White people at 23 per 10,000. The cases were even higher for Latinos at 73 per 10,000 people. They were also twice as likely to die as White people (Oppel et al. 2020). In the United States, 100,000 Black and brown people have died, with a hugely disproportionate mortality rate for African Americans and Native Americans. The mortality rate for Black Americans was 2.4 times the rate for White Americans (Wood 2020). When adjusted for age, death rates are more than three times higher for Black, Latino/Latina, and Native Americans than for White Americans (Bassett 2020). While data on Native Americans is sketchy, in Arizona and New Mexico, which contain portions of the Navajo Nation, the death rate is respectively five and seven times the rate for all other groups. Given the lack of attention to the impacts on Black and brown people, indeed even implementing measures that make the pandemic worse, it is appropriate to introduce the concept of the necropolitics of reproduction: Not only policies that value some lives more than others, but the use of political power to determine who will live and who will die.
Encounters: Reproduction, anthropology, and Black feminist theory

Our current understanding of reproduction drew on several theoretical streams. The emergence and proliferation of gender studies in the 1960s and 1970s, in the context of the civil rights movement and second-wave feminism, transformed knowledge production. Similarly, Black feminist knowledge from both inside and outside the academy revised feminist theory, advancing a comprehensive and nuanced approach to reproduction.

Initially focused on the household as a site of women’s oppression, Marxist-feminist scholars gradually expanded the field of study to encompass the activities associated with the processes through which labor power is produced (Giménez 2019; Ferguson 2019). Anthropology interrogated and broadened the lens of reproductive theory by introducing the experiences of women in other cultures, such as their work in the productive sphere (Leacock and Safa 1986), their reproductive experiences as a source of power (e.g. Leacock 1978), as well as their asymmetric, but no less powerful roles in some societies (Brodkin 1998).

At the same time, women of color in communities, social movements, and the academy—through biographical and political statements, conferences, and scholarship, and following a long tradition of activists, scholars, and writers—were critically interrogating the universality of traditional gender constructs based on our own experience. As Cheryl Mwaria (2001: 204) put it, we “live our anthropology.”

The experiences of women of color literally had to be excavated. There were multiple and sometimes very different forms of Black feminisms, but the bottom line was the critique of a notion of universal womanhood, based on the simultaneity of axes of oppression beyond gender (Combahee River Collective 1986). One of the most influential forms was what I have called the coalition approach. In the early 1980s, a small working group of working-class and women of color scholars, studying the consequences of race, class, and gender, created the Center for Research on Women of Color and Southern Women, based at what was then Memphis State University. They created free space in which to both unearth the experiences of women of color and imagine new approaches to gender. Through organizing seminars and dissemination of curricula, bibliographies, and teaching tools (before the common use of the Internet), they played a major role in creating a critical analytic framework, conclusively demonstrating that gender could not be understood without an analysis of stratification that included race and class. Following the work of a long line of women scholars including Claudia Jones and Angela Davis, they seriously undertook the study of what is now popularly known as “intersectionality” (Crenshaw 1989), but with a firm grounding in the study of the consequences of class as well as race and gender. The coalitional approach also created a foundation for us to think about the racialization of different populations throughout the history of the US, i.e., by racialization we refer to the process by which perceived differences are transformed into inequality through various forms of dispossession (Mullings 2005: 684). At the same time, the coalitional approach allows us to recognize specific histories and differences, common roots, and important distinctions, as well as how forms of oppression have intersected. By creating the study of women of color as a body of literature and organized field of knowledge production and canon formation, this initiative contributed important analytic elements to how we think about reproduction and laid the foundation for a broader and more comprehensive view.

The Wenner-Gren conference on “The Politics of Reproduction,” held in 1991, with the agenda “to transform traditional anthropological analyses of reproduction and to clarify the importance of making reproduction central to social theory” (Ginsburg and Rapp 1995: 1) drew heavily on this theoretical work. Important insights established the interrelationship of the biological, social, and cultural components of reproduction and its role as an important lens through
The necropolitics of reproduction

which to examine social life. Perhaps one of the most critical insights codified at the conference was Shellee Colen’s generative notion of “stratified reproduction,” underscoring that “the physical and social reproductive tasks are accomplished differentially according to inequalities of class, race, ethnicity, gender, place in a global economy” (Colen 1995: 78). Stratified reproduction also pushed us to think more deeply about the historical and contemporary global relations of power that produce the context in which some populations are empowered to reproduce and others are not, as well as how this is deeply imbricated in how people imagine race, nation, and the next generation. In the case of the US, the lack of recognition that racialized reproduction has been at the foundation of its history obscures a range of contingent issues such as the causes of problematic birth outcomes.

Reproduction in a minor key

Unfortunately, this expansive view of reproduction has not found its way into medicine and public health, which are dominated by the biomedical model, “characterized by a narrow focus on disease, individual bodies, health care and treatment in a clinical setting” (Weber et al. 2018: 145). In part because infant and maternal mortality rates are an international measure of the health and development of a society, public health activists and others continue to express concern about problematic birth outcomes in the US, especially health disparities between Whites and racialized populations. Over the years, maternal death rates for African Americans have generally been twice that of Euro-Americans.

An oft-quoted definition of racism, “the state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death” (Gilmore 2007: 247), is a useful place to start thinking about this. While it is clear to those who are willing to look at the evidence that racially differentiated exposure to police executions, mass incarceration, residential segregation, and other such exposures have and frequently continue to be state sanctioned, there continues to be debate about infant and maternal morbidity and mortality.

In searching for the causes of the disparity in infant mortality and maternal deaths, investigators’ second set of explanations has focused on genetic/biological factors or behavioral traits, culture, or lifestyles, such as a proclivity for promiscuity, smoking, or drug addiction. They were parallel in that the concept of culture was essentialized, and much like biology, was to a great extent considered to be fixed, never changing, and handed down from generation to generation. Studies examined behavioral issues such as smoking and drug addiction. As Weber (2006) points out, the “unique though marginalized contributions of feminist intersectional approaches … could change the landscape of health sciences and policy on disparities” (22).

The Harlem Birth Right Project

More than a quarter of a century ago, what became a landmark Centers for Disease Control and Prevention (CDC) epidemiological study demonstrated Black women have problematic birth outcomes regardless of their socioeconomic position, faring worse than White women at every level, and even college-educated African American women have twice the infant mortality rate of college-educated White women (Schoendorf et al. 1992). Subsequently, the CDC funded the Harlem Birth Right Project to illuminate the causes of low birth weights in the Central Harlem area of New York City. Interrogating the traditional explanations of race as biology/genetics or culture, an interdisciplinary team set out to study the role of racism in the lives of Black women. While incorporating a population-based survey, focus groups, and longitudinal study of individual women, the core of the methodology was traditional anthropological
participant-observation through following the experiences of women at eight different neighborhood and work sites.

Community participation was central to the research (Mullings and Wali 2001; Mullings et al. 2001) and it is worth noting that at the project’s outset, when we presented it to the community, we were asked why we had to study this since everyone already knew the reasons. One nurse at the public hospital said frankly, “Black women have a hard life and catch hell.” Nonetheless, we went on. In the course of the two-year study, the research demonstrated the very specific ways in which racism affects the lives of poor, working-class women in the areas of housing, environment, and employment, demonstrating not only the institutional effects of racism in the everyday lives of working-class and middle-income Black women, but also the ways in which they resist these forms of oppression. At the CDC’s request, we presented the findings in an admittedly problematic model of stress and chronic strain, which scientists were beginning to document, subsequently demonstrating their specific physiological effects, including the secretion of oxytocin that can cause premature uterine contractions. We created a model, the “Sojourner Syndrome,” to underscore the ways in which demonstrating the interaction of race, class, and gender on one hand and resistance and agency on the other may combine to produce problematic health consequences. The Sojourner Syndrome presents a paradox—that the care work of women in ensuring the survival of the Black community contributes to their health vulnerabilities—bringing us full circle back to the questions about care work raised by the Marxist feminist theorists of reproduction.

The findings of the study were published in a book, Stress and Resilience: The Social Context of Reproduction in Harlem (Mullings and Wali 2001), as well as in several articles. In addition, we presented the findings to medical schools, medical associations, schools of public health, and anthropology departments. The lack of response made it clear that while state institutions were willing to deal with small-scale changes, such as focusing on lifestyle, they were not willing to address the findings of the study that pointed to institutional racism as a cause of stratified reproduction. They were comfortable with the micropolitics, but not with the broader historical context of “stratified reproduction.”

Twenty-five years later, despite significant efforts on the part of scholars, activists, and advocacy organizations (see S. Morgan 2002; Weber et al. 2018; Ross 2017), disparities between Euro-Americans and racialized populations have remained, if not worsened. In 2018, the infant mortality rate of non-Hispanic Black women was 10.75 per thousand per 1,000 live births—more than twice as high as that for infants of non-Hispanic White women at 4.63 (Ely and Driscoll 2020: 2); for American Indians, it was almost twice as high as that of White women at 8.15 (Ely and Driscoll 2020: 4).

Socioeconomic status continues to be no protection. Between 2007 and 2016, pregnancy-related mortality per 100,000 live births among White women with less than a high school degree was only 25%, as compared to Native American women at 50.8% and African American women at 45%. More startling, however, was that African American women with a college degree or higher had a 40.2% rate, almost twice as high as White women with less than a high school education (Petersen et al. 2019: 763).

Neither does fame or wealth offer protection. In 2019, prominent and wealthy Black women such as professional tennis champion Serena Williams and entertainer Beyonce have spoken out in the popular media, sharing accounts of their survival of potentially fatal pregnancy complications and difficult birth experiences (Chiu 2018), helping to renew attention to the continuing racialized disparate experiences in the survival of mothers and babies, stimulating a host of accounts in popular media.

Over the years, the dominant explanations for these disparities have remained boringly similar: Biological or genetic factors or cultural/lifestyle causes. The go-to explanations for the med-
ical world favor biological/genetic explanations. As Richard David and James Collins, Jr. (2007) note, since 1950, there has been a quest for “preterm birth genes” that can explain the disparity in prematurity and infant mortality between Blacks and Whites (1192). The plethora of work by social scientists demonstrating that what is popularly known as “race” is a social and historical construction held the promise of undermining these reductionist explanations. However, the advent of the Human Genome Project, initially lauded as a way to demonstrate the irrelevance of race, to improve health, and to address disparities, seems to have in fact stimulated biological reductionism. It is clear that some ancestry studies (note: Ancestry, not race) have led to some health benefits. However, Troy Duster (2015) argues that the application of the Human Genome Project in several fields has “actually served to reinscribe race as a biological category” (2) that will “dwarf the health achievements” (4). Relying on notions of continentally based racial types that result in largely circular outputs, locating the causal factors in ancestry-based medical genetics, and the notion that the role of genetics is central ignore the social determinants (Fullwiley 2015: 42).

In the search for the explanation of racial disparities, funding talks. Studying all new grants recorded in the NIH Reporter between 2006 and 2015, Weber et al. (2018) report that the NIH and CDC awarded 25,293 new grants indexed with the term “genetics,” including 818 additionally indexed by “race” and only 171 indexed with terms of “racism” or “racial discrimination”—a ratio of 500 to 3 (Weber et al. 2018: 146). New scholarly studies emphasized psychosocial aspects, often employing the black box of stress and chronic strain to function as the bridge between social conditions and specific reproductive consequences—such as depression and substance abuse (Creanga et al. 2013) or health care disparities and/or care across the life course (e.g., see Thoits 2010, Fiscella and Sanders 2016; National Center for Health Statistics 2016; Phelan and Link 2015; Lu et al. 2010; Obasogie et al. 2017) or specific policies in the workplace (Sawyer 2012) or by the state. Others emphasized the multifactorial causal framework (Giscombé and Lobel 2005). While some of these studies make important interventions, they continue to be restrained by the biomedical framework and often refuse to name racism, even as they attempt to struggle with the broader social forces. Their emphasis tends to be on the intermediate manifestations of racism and on emphasizing correlations rather than demonstrating precisely how these institutions affect racialized people.

There is certainly enough data and sufficient hand-wringing about racial health disparities. What is the obstacle to change? I would suggest that the answer is to be found in the knowledge production of our research collaborators in the Harlem study. At the outset of the research, we described the project and the research proposal to an open meeting in a local public hall. It was attended by a diverse group in age, gender, and occupation. When we described the research and its significance, a lively discussion ensued. They acknowledged the problem of infant mortality (one woman said, “every week in my shop someone buys a card for a baby’s funeral”), but argued that everyone knew the causes of infant mortality and asked why the project did not examine the pressing issues such as unemployment (Mullings and Wali 2001: 1). When asked in a focus group, while acknowledging individual behaviors, most discussed larger social issues. One Harlem resident said: “You can’t statistically analyze the impact of racism” (Mullings and Wali 2001: 159).

Taking a cue from our research collaborators, if anything is to be learned from the 2020 COVID-19 pandemic, it is that 1) it is important to link the local (“a small-scale arena” [Ginsburg and Rapp 1995: 8]) to the global and 2) there is an extricable relationship between health and all racial disparities. One clue to health disparities is to be found in historical global interactions. This involves not only a willingness to name racism, but also a reckoning with the deep underlying historical structure. Understanding the mutually constitutive relationship of
capitalism, racialization, patriarchy, and the role of reproductive politics as they developed historically is essential to an analysis of the current conditions. Only a reckoning with the racial history of the US will provide a firm foundation for understanding disparities in reproductive health and all other disparities.

Reproductive warfare

Reproductive options have been imposed and challenged, forced and impeded at specific historical points in time, a concept captured in part by Elizabeth Roberts and Lynn Morgan (2012) in their definition of reproductive governance—“the mechanisms through which different historical configuration of actors—such as state, religious, and international financial institutions, NGOs and social movements—use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical commitments to produce, monitor, and control reproductive behaviors and population practices” (2012: 243; L. Morgan 2019: 113)—which points us to how reproduction is imposed and challenged in specific historical times and places.6

As the US moved through the overlapping social formations of a settler society, a slaveholding society, an industrial society, and an imperial nation-state (see Maskovsky 2013: 492), racialization—the creation of populations deemed different and inferior—was central to the projects of dispossession. In this endeavor, the management and manipulation of reproductive options of various populations, particularly Indigenous peoples and Africans and their descendants, was a key device in the toolbox of dispossession of land, labor, and life. Though the deep structure of racism and White supremacy underlay relationships with both populations, the different goals required somewhat different approaches to reproduction. As a settler society, securing Native land took place primarily through genocidal practices of elimination of Native people and secondarily through their forced assimilation. Exploitation of the labor of Africans and their descendants required different technologies of control.

For both populations, rape was a tool of reproductive control. Patriarchal gender violence against Native American women was an instrument of elimination (Gurr 2011). As settlers proceeded to create a nation-state on occupied land, tens of thousands of Native American infants, children and adults were killed and forcibly removed from the land that the colonists sought to settle. During the forced marches following the Indian Removal Act of 1830, and in particular during the “Trail of Tears” when the Cherokee Nation was forcibly relocated to Oklahoma, women’s bodies were targeted for genocidal violence. Sarah Rose (2015) writes: “It is impossible to count the number of rapes that occurred during these forced migrations, just as it is impossible to count the number of deaths” (69).

As the US emerged as a slaveholding society, exploitation of the labor of enslaved Africans and African Americans was the driving source of wealth accumulation for the colonists required a more nuanced though no less cruel approach to reproduction control, reflecting paradoxes negotiated by calculations of wealth through extreme exploitation of enslaved labor and the necessity to protect and maintain the investment in enslavement. The rape of African and African-American women served the purpose of control through terror, at the same time reproducing the labor force. Particularly after the abolition of the transatlantic slave trade, the enslaved force had to reproduce to ensure the profit from slavery.7 Nonetheless, overwhelming the entire system was the particular cruelty arising from the necessity to dehumanize enslaved people.8

Though enslaved mothers, fathers, and classificatory kin made strenuous efforts to care for children—for example, providing them with extra food and clothing—by law, an enslaved woman’s children were the property of the slave owner and could be sold away at any time. The slave owner’s absolute power over their children also functioned to control the enslaved
The necropolitics of reproduction

population, exploiting their very human affective bonds. Enslaved women made efforts to limit
the slave owner’s control of their reproductive options through resisting (usually unsuccessfully)
the advances of the slave owner as well as refusing to procreate in the world in which they lived
through abortive and contraceptive practices, even infanticide, to prevent their children from
growing up in a system of slavery, thus attempting to undermine the foundation of the system
(among many others, see, for example, Gutman 1976: 80–82; Shaw 1994: 247–248; J. Morgan
2004; D. Roberts 1997).

During the era of industrialization, though for White women there was a new imaginary of a
separate sphere of domesticity and womanhood, this was not true for Black women. Following
emancipation, given the lack of a family wage, Black women worked inside and outside the
home, the vast majority as agricultural or domestic workers. Susan L. Smith (1995) documents
the struggles of Black women during the Jim Crow period of legal segregation to improve
conditions for their health, which often entwined with protection from sexual exploitation (see
also Giddings 1984; Hine 1997: 82). The Black Women’s Club Movement, associated with the
National Association for the Advancement of Colored People, sought to address reproductive
justice for Black women.

Controlling reproduction through sterilization

With the end of slavery, the expansion of industrialization, and the race to build an empire, labor
needs and reproductive controls shifted. One blunt instrument of reproductive control was steri-
lization (see Lopez in this volume), rationalized by the pseudoscience of eugenics and scientific
racism. Eugenic theory became popular among the political elite, and White supremacy took
the form of stoking fear of the “decline” of the White race. This applied not only to racialized
populations, but also to migrants from eastern and southern Europe, many of whom became
industrial workers and organizers. Popular books such as Madison Grant’s (1916) The Passing
of the Great Race and Lothrop Stoddard’s (1920) The Rising Tide of Color Against White Supremacy
fanned the flames of White supremacy. Between 1907 and 1937, 32 states in the US adopted
sterilization laws, and between 1929 and 1941, more than 2,000 eugenic sterilizations were
performed each year (Reilly 1991; D. Roberts 1997) with a total of over 70,000 persons invol-
untarily sterilized (G. Smith 1988; D. Roberts 1997). Sterilization laws were applied to prevent
the reproduction of individuals deemed to be “unfit.” The designation of “unfit” was dispropor-
tionately working-class people and people of color.

While during slavery, enslaved Black women were forced to bear children, after slavery, vari-
ous policies sought to reduce their childbearing (see D. Roberts 1997; Ross and Solinger 2017).
Although sterilization laws had been repealed by World War II, involuntary sterilizations were
increasingly performed on Black women. In the 1950s and 1960s, the establishment of family
planning programs facilitated sterilization by linking to Medicaid and Aid to Families with
Dependent Children (AFDC). Doctors were paid for sterilization through Medicaid. Indeed,
Dorothy Roberts (1997) reports that there was an attempt to pass a bill in Congress that facilitat-
ed the sterilization of single Black mothers. As late as the 1970s, poor Black women by the
thousands were being sterilized (Roberts 1997: 90), as reproduction governance was now in the
hands of the medical profession. By 1990, 24% of Black women in the US had been sterilized
(Roberts 1997: 97).

On the ideological level, Black motherhood was consistently devalued and attacked, both at
the level of public policy, as evident in US Senator Daniel Moynihan’s 1965 report, “The Negro
Family: The Case for National Action,” in which he held that Black mothers were responsible
for the “deterioration of the Black family,” and in the popular stereotypes of Black women as
“welfare queens.” As Black women were being forcibly and ideologically discouraged from reproducing, government, medical, and media institutions were whipping up a frenzy about the falling rate of fertility among White women (Briggs 2017). At the same time, the so-called War on Drugs and mass incarceration were decimating Black and Latino communities, as neoliberal economics intersected with a brutal form of racialized reproductive governance (Briggs 2017). As the US became an empire, racializing the populations it encountered, reproductive control was critical. In 1898, Puerto Rico was invaded and conquered and, as was true with many metropoles and colonies, the US established a monocultural crop export economy, displacing traditional patterns of land ownership, disrupting agricultural practices and products, and making Puerto Rico dependent on US markets (López 1993; see also López in this volume). The Great Depression of the 1930s aggravated the growing number of unemployed and their emigration to the US mainland. As one solution to the problem of “surplus population” and migration during the late 1930s, Clarence Gamble, a director and heir of the Procter & Gamble corporation who also supported the Negro Project of the South (Roberts 1997: 77) spearheaded the establishment of 53 clinics across the island that performed sterilization, popularly known as la operación. This rather blatant initiative was contested by the Coalition to End Sterilization Abuse (Briggs 2017: 29), and accusations by the Independence Party regarding the implementation by the US of a mass sterilization campaign resulted in the closing of several clinics. But as concern about the “demographic pressures” increased, by 1965, approximately 34% of Puerto Rican women of childbearing age had been sterilized, two-thirds of them in their early twenties (Presser 1969).11

In 1970, the Indian Health Service accelerated a sterilization campaign by paying for sterilization for Medicaid patients. In 1976, the US General Accounting Office released a study reporting that between 1973 and 1976, four of the Indian Health Service regions sterilized 3,406 American Indian women between the ages of 15 and 44 (including 36 women under the age of 21), approximately 5% of all Native women of childbearing age in these regions,12 and admitting that the consent procedures were problematic and not in compliance with US regulations (US GAO 1976). Other investigations of Indian women sterilized during the 1970s, often without their consent, have shown these numbers to be much higher (Lawrence 2000: 410). D. Roberts (1997: 95) reports that 25% of Indigenous women are infertile, which for small tribes can be characterized as genocidal.

Between 1907 and 1937, California performed approximately 60,000 sterilizations, with one-third of the individuals having Spanish surnames, most of Mexican origin (Lira and Stern 2014), and Latinas/os 3.5 times more likely to be sterilized (see also Novak et al. 2018; Stern et al. 2017). Though California holds the record for the sheer number of sterilizations, North Carolina, between 1929 and 1974, “sterilized more than 7,500 of its residents. Most were operated on without their consent, having been deemed ‘feebleminded’ and unfit to reproduce by the state Eugenics Board. Eighty-five percent were women; they were disproportionately black or Native American” (Dusenberry 2012) and some as young as 12 years old (Severson 2011; Rose 2011; Brophy and Troutman 2015).13 In the 1960s and 1970s, women of all racialized populations organized against coerced sterilization, culminating in a suit brought by a group of ten Chicana women against the Los Angeles County Medical Center (Briggs 2017: 29).14

Although in 1978, what was then the US Department of Health, Education, and Welfare issued rules restricting sterilization under programs receiving federal aid, this has not stopped sterilization abuse. Most recently, on the southern US border, 16 women detained by US Immigration and Customs Enforcement at the Irwin County Detention Center in Georgia—an ICE facility run by a private prison contractor—found themselves unable to conceive as a result of procedures undertaken by the resident gynecologist without their consent. This came
The necropolitics of reproduction

to light as a result of a whistleblower complaint filed on behalf of nurse Dawn Wooten, a former employee of the center. Five gynecologists, independently reviewing the records on behalf of The New York Times, concluded that the doctor at the ICE center, Mahendra Amin, “seemed to consistently recommend surgical intervention, even when it did not seem medically necessary at the time and nonsurgical treatment options were available” (Dickerson et al. 2020). An organizer for Project South, one of the groups that filed the whistleblower complaint and has been monitoring conditions at the Georgia center and calling for its closure, proclaimed their effort as a fight for generations.

Weaponizing children

As I discussed earlier, one element of reproduction is imagining the future and future generations. The loss of children and thus the society and the future—weaponizing children—is a feature of the racialized politics of necro-reproduction. This has been accomplished in various ways: Tearing children from their parents through sale, forced acculturation, foster care, and detention.

While during slavery, it was simply a matter of ownership of enslaved Black children, in some cases, forcibly removing children was rationalized by the notion that the parents were unfit. Formalized under Grant’s Peace Policy in 1869, the administration of Indian Reserves was turned over to Christian missionaries, with a notion of assimilation rather than extinction. Based on the notion that Native families were unfit to raise children, Native children were separated from their parents and forced to attend boarding schools. More than 100,000 children were forcibly taken from their homes to attend these schools. The first off-reservation boarding school, established in 1879, was directed by US Cavalry Captain Richard Pratt, who described the initiative as: “Kill the Indian in him, and save the man” (Little 2018). Children who were boarded at these schools were forbidden to speak their native language or practice cultural elements and sometimes leased out to White families for labor (Gurr 2011; Deer 2015: 71). Many did not survive due to malnutrition, inadequate medical care, disease, and rampant abuse. Those who did survive were often unable to fit into Native culture. By the 1940s, Indian children were being placed with White families, which Native communities fought (Gurr 2011). Congressional hearings in 1978 found that 25% of all Indian children were either in foster care, adopted homes, or boarding schools, resulting in the Indian Child Welfare Act, which allowed tribes to determine the placement of children taken from their homes (National Indian Child Welfare Association, n.d.).

I have already alluded to how the affective bonds of children and parents were used to control enslaved people. The foster care system, as Dorothy Roberts (2001) puts it, is “a state run program that disrupts, restructures and polices black families” (viii), tearing children from their families to place them in state-run institutions, causing many to liken it to slavery. Like mass incarceration, the number of children “served” by the foster care system has ballooned in the last four decades, from 262,000 in 1982 (D. Roberts 2001: 7) to 673,000 in 2019 (US Children’s Bureau 2020a: 1). Of the 423,997 children in foster care as of September 2019, 97,142 of them (23%) were African American (US Children’s Bureau 2020b: 2).

Like the “disintegrating household” rationale for removing Native American children from their parents, there is a basic belief that the African American family is pathological and African American women are unfit mothers. D. Roberts (2001) argues that poverty is confused with neglect (27) and the acceptance that there is a fundamental problem with the Black family. D. Roberts (2001) and Tina Lee (2016) describe the strenuous efforts of parents to have their children returned, but for Black children, this happens in far fewer cases. There is a financial
motivation as well. States receive federal funds on the basis of each day they keep a child in foster care. In many cities, such as New York City, the foster care system is increasingly privatized with states and agencies having significant incentives to keep children in foster care. The US National Commission on Children (1991) found that children are removed from their families prematurely or unnecessarily because there is “a strong financial incentive” (290) to do so, rather than providing services to keep families together. According to the National Coalition for Child Protection Reform (2020), for every dollar to be spent on preventing foster care (through family services) or speeding reunification, the federal government is expected to spend nearly $12 on foster care and adoption (1).16

One of the most recent and egregious cases of the weaponization of children—and one that demonstrates a direct relationship to issues of citizenship and the politics of reproduction—is the Trump administration’s policy at the US southern border. This was perhaps the cruelest culmination of the Trump administration’s verbal attacks against immigrants that began with his election campaign and the policies that were implemented after he won the electoral college. All this was accompanied by openly racist rhetoric about race, citizenship, and reproduction (see CA articles). As of October 2019, it is estimated that approximately 5,500 children have been separated from their families at the border under the Trump administration (Washington 2019; Dickerson 2020). “It was the worst moment of my life, when officers tore my crying daughter from my arms,” said a detainee (Aratani 2019). Recent media investigations have revealed that the parents—who were deported—of 545 children cannot be found (Dickerson 2020).17

Stoking fears of replacement and implementing policies to oppress the reproduction of racialized people were but the building blocks for the recent public upsurge in White supremacy, which found particularly deleterious expression in the campaign and electoral college election of Trump as US President in 2016. His campaign and subsequent presidency brought into the open racism and fear of “displacement” (that is, racial change) expressed in the form of the rise of White supremacist groups, attacks against and murders of people of color (Beirich and Buchanan 2018; Southern Poverty Law Center 2020), and rampantly anti-immigration rhetoric and policies. Reproductive governance is at the heart of these “destructive projects of resentment … around race, class, gender, sex, ethnicity, migration, and inclusion” (Maskovsky and Bjork-James 2019) which can be summarized as “Make America White Again.”18 Indeed, in the US, the share of the White population has been declining and people of color are predicted by demographers to become the majority by 2045 (Frey 2018). Accompanying this are the imperative for White women to reproduce (Franklin and Ginsburg 2019), the opposition to the right to choose, and the White settler narrative of lost values and “raced nation as persecuted by foreign enemies” (Bjork-James 2019). It is therefore not surprising that while Black women undergo procedures to prevent them from having children, the vast majority of ART is utilized by White women.

Challenging structural racism: The Movement for Black Lives and reproductive justice

The Movement for Black Lives (M4BL), the most recent iteration of the centuries-long Black Freedom Struggle, is perhaps somewhat unique in its emphasis on structural change as well as public attention to health and care. In this sense, it has elaborated the model put forward by the Black Panther Party for Self Defense of the 1960s and 1970s, which opened breakfast programs for children and health clinics.

The M4BL emerged in 2015 in the context of a spate of executions of unarmed Black men, women, and children, primarily by police officers. Currently a coalition of over 80 organizations, it organized demonstrations against police brutality involving hundreds of thousands of people.
nationally and internationally, and in 2016 presented an extensive platform for social change. The M4BL has launched several projects around direct action, electoral engagement, building local power, and building coalitions.

As young people protesting police executions faced down the police in direct actions that lasted sometimes for months, conscientiousness grew about the health consequences not only from structural racism, but also from their activism. Jamala Rogers, a long-time activist, described the “battle fatigue” among the young demonstrators on the front line of the protests in Ferguson: “Protestors were displaying PTSD symptoms. You don’t face an army every day and remain unscathed” (quoted in Mullings 2020: 274).


What is key about the Movement for Black Lives is that “care” is combined with addressing, on several levels, the structural racism that is a major factor in health disparities. They do so by fighting the structural racism resulting in health disparities through direct action, electoral politics, advocacy for legislation, policy and education, and activity on the ground—and building alternative institutions.

The M4BL has consciously addressed the issue of health and reproduction on three interrelated levels: Harm reduction, building alternative institutions, and transforming society by any means necessary. The SisterSong Women of Color Reproductive Justice Collective was one of the original organizations to join the M4BL. In 2003, SisterSong organized its first national conference, where they challenged participants to go beyond the issue of women’s rights and address the question of reproductive justice based on these three principles: 1) The right not to have a child; 2) the right to have a child; and 3) the right to parent a child in safe and sustainable communities (Ross and Solinger 2017).

The M4BL also mounted several national initiatives such as National Mama’s Bailout Day for Mother’s Day in 2017 when several organizations, including Southerners on New Ground (SONG), Color of Change, and bail reform groups, collaborated to raise over one half a million dollars for low-income Black women across the country who had been jailed, but not convicted of a crime, and were unable to raise bail money as they awaited trial.19

An example of building alternative institutions is the National Black Food and Justice Alliance (NBFJA), a founding member of the M4BL coalition, which seeks to expose the systemic factors that create food inequality and work toward “Black institution building and organizing for food sovereignty, land, and justice” (https://www.blackfoodjustice.org).

Writing for the Huffington Post in 2017, Aletha Maybank, then Deputy Commissioner of New York City’s Department of Health, described M4BL’s policy platform as a public health agenda because it speaks to the various social factors, now widely acknowledged by health professionals, that determine and have tremendous influence on our health such as access to quality education, fair employment, affordable and quality housing, equitable policing practices, and inequitable mass incarceration. The Movement’s policy demands reinforce that our individual choices in health are a reflection of the community conditions we live in and what resources we have access to.

(https://www.huffpost.com/entry/the-movement-for-black-li_1_b_12363870)
Most important is the movement’s visioning of a new notion of humanity.

**Conclusion**

What does all of this tell us? It tells us that racial disparities in health in general, but particularly in infant and maternal morbidity and mortality, will never be addressed by focusing on such low-hanging fruit as health behaviors or even policy changes. They are manifestations of a long history of reproductive necropolitics arising from the triangulation of racial capitalism and they will never be addressed until we name it and resolve to address it.

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**Notes**

1 Editors’ endnote: By June 2021, these numbers had multiplied, totaling about four million globally and 600,000 in the United States.
2 These represent cases through the end of May 2020 and the lack of transparency of the CDC suggests that the discrepancies are much higher.
3 Central Harlem was majority African American at the time. In the intervening years, Harlem has been gentrified and less than 50% of the population is Black.
4 Another factor was the change of administration. In the contested race between Al Gore and George Bush, the Supreme Court anointed George Bush as president. With the new administration, many agencies, including the CDC, moved in a more conservative direction.
5 This analysis has been enthusiastically received by pharmaceutical companies, constructing designer drugs based on “race.” BiDil, advertised as an “ethnic drug” for treatment of heart failure, is one of the best known.
6 As I indicate in the citations, there are excellent books and articles on some of the topics I will touch on. My interest is in their relationships.
7 The Abolition of the Slave Trade Act in 1807 made it illegal to engage in the slave trade throughout the British colonies. Historian Gerald Horne (2014) argues persuasively that the lead-up to this was decisive in the decision of the colonies to secede in 1776.
8 Given this, unlike for Native Americans, assimilation never became a possibility.
9 These migrants were often initially temporarily racialized (see for example, Roediger 2005; Brodkin 1998; Ignatiev 1995).
10 The bill passed in the house, but was dropped by the Senate because of protests by SNCC.
11 There is very strong popular feeling from opposition, scholars, and politicians about the sterilization of Puerto Rican women as a “covert campaign to sterilize women,” as a genocidal initiative (see e.g., Bauza 1994), and as abuse. However, as López demonstrates in her study of Puerto Rican women in Brooklyn, it is often a choice complicated by the absence of other birth control measures.
12 The GAO report is ambivalent on the issue of consent, stating that “we believe such an effort would be counter-productive.”
13 In 2013, North Carolina passed legislation to compensate those sterilized under the Board’s jurisdiction, but many did not qualify (Mennel 2014).
15 Congressional Democrats called for an immediate congressional investigation into the center by the inspector general of the Department of Homeland Security.
16 Let us stipulate that it is certainly important to protect children and there are instances when they need to be removed from parents. But let us also consider that wealthy families can easily avoid scrutiny by the state and that most White children who enter the system are permitted to stay with their families while Black children are separated from theirs (Roberts 2001: 17).
17 Editors’ endnote: In January 2021, US President Joe Biden signed an executive order to reunite the separated families and establish a task force to locate deported parents. https://www.nbcnews.com/politics/immigration/lawyers-have-found-parents-105-separated-migrant-children-past-month-n1258791
18 This fear of reproductive replacement is also evident in anti-immigrant sentiment and policies all over Europe, as indeed the hegemonic decline of Europe and the United States has been accompanied by demographic issues that threaten Euro-American dominance within some nation-states. In Europe and North America, the fertility rates are significantly below replacement level (United Nations 2017).
The necropolitics of reproduction

19 Not only were they able to bail out more than 100 mothers who could now spend Mother’s Day with their family, they also raised awareness about the fact that 62% of people in jails (who are disproportionately Black and Latino), have not been convicted of a crime but are unable to raise bail money as they await trial. Many of those who were bailed out had been arrested for low-level alleged offenses such as loitering or small-scale drug possession, allowing organizers to underscore the ways in which class, race, and gender identity interact in criminalization.

References


Leith Mullings


