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Reproductive governance and the affective economy

Jabulile Mary-Jane-Jace Mavuso and Rachelle Chadwick

Sociology Department, University of Pretoria

Abstract

The governance of reproductive practices, processes, decision-making, experiences, desires, subjectivities, and bodies has received and continues to receive significant attention in feminist efforts to name and resist reproductive oppression. And over the last 30 years, articles published in *Feminism & Psychology* have made significant contributions to the visibilisation and critique of this form of oppression. In this Virtual Special Issue on Reproductive Governance and the Affective Economy, we apply repronormativity and affect to our reading of 20 articles published in *Feminism & Psychology*. Collectively, these articles provide a glimpse of the wide-ranging scope of reproductive regulation (including that which is re-produced by/within feminism itself), and the various work that repronormativity and affect do in this governance. The challenging of reproductive governance notwithstanding, we conclude by arguing that the centring and circulation of certain reproductive subjects and their experiences within feminist knowledge production is itself a part of and upholds repronormativity and forecloses the possibility of reproductive freedom for all.

Keywords: reproductive oppression, repronormativity, affect, discourse, narrative, subjectivity

Corresponding author:

Jabulile Mary-Jane Jace Mavuso, 334 Mnqande Street, Zone 7 Pimville, 1809, South Africa, mavusojabulile27@gmail.com

Feminist scholarship has long theorised, visibilised and challenged reproductive oppression. This scholarship has traversed various manifestations of reproductive oppression, including compulsory motherhood, the role reproductive oppression plays in the gendered division of labour, the (global) politics of reproductive technologies, obstetric care and violence, access to abortion and contraception, and reproductive autonomy (Collins, 2000; Diniz & d'Oliveira 1998; Friedman, 2014; Huws, 2012; Klugman, 1990; Meyers, 2001; Senderowicz, 2019; Tamale, 2014; Vacaflor, 2016). This work has been important. At the same time, various scholars and activists have acknowledged/critiqued the centring of particular reproductive subjects in feminist theorisation on oppressive reproductive politics (for examples, see Cárdenas (2016), Chadwick (2021), George (2020), LaMarre, Rice, Cook and Friedman, (2020), Luna and Luker (2013), Morison and Mavuso (2022), Mavuso (2021), Price (2010), Radi (2020)). These scholars critique/visibilise the tendency to centre the impact that reproductive oppression has in the lives of women[1] who are white, non-disabled, non-fat, adult, cisgender, endosex (i.e., non-intersex), heterosexual, have citizen status in the country in which they live and work, have never been incarcerated, and/or live in the global north, and has centred their perspectives on, experiences of, and negotiation with the patriarchal regulation of reproduction. Furthermore, the re/production of motherhood as integral to white, middle-class, non-disabled, adult, non-fat, citizen, cisgender, endosex, heterosexual womanhood tends to be understood as *the* key, indeed distinctive, feature of reproductive oppression. This is challenged by (feminist) work that considers the impact of colonial, racist and anti-indigenous (e.g. Collins, 2000; Davis, 2019); de Bourbon, 2019; Ross, 2017; Tamale, 2020), anti-intersex, anti-trans, and anti-queer (e.g. Cárdenas, 2014; Ho, 2019; InterAct & Lambda Legal, 2018; Maquba & Sehoole, 2018; Moseson et al. 2020; Nixon, 2013), anti-sex work (e.g. Stevens, Dlamini & Louskieter, 2022), ableist (e.g. Jarman, 2015;

Mohamed & Shefer, 2015; Muswera & Kasiram, 2019), anti-fat (e.g. Fahs, 2019; Friedman, 2014), ageist (e.g. Chiweshe, Fetters & Coast, 2021; Hans & White, 2019; Macleod, 2017; Morison & Herbert, 2018) anti-immigrant (e.g. Desai & Samari, 2020; Chekero & Ross, 2018) and capitalist (Castro & Savage, 2019; Griffin & Woods, 2009) systems of power in reproductive oppression.

Indeed, the Reproductive Justice framework has enabled powerful analyses of the differential meanings that systems of power attach to different groups' reproduction, and the different ways that the state correspondingly intervenes, or not, to encourage (e.g., through restricting access to contraception and abortion) or discourage reproduction (e.g., through coerced long-acting reversible contraception and forced sterilisation, welfare caps and restrictions, imprisonment) (Luna & Luker, 2013; Ross 2017). Scholarship utilising this framework increasingly moves beyond the centring of particular subjects and demonstrates that the differential de/valuing of reproduction shapes and limits, in varying ways, people's ability to exercise and live out the right to not have children, to have children under conditions of their choosing, and to parent them in safe environments, free from violence. This stratification of reproduction also entails the channelling of resources (e.g., expensive fertility services and healthcare, information) towards groups whose reproductive capacities and futures are valued, and exclusion from these resources for those whose reproductive capacities and futures are disregarded, foreclosed, or demonised (Cárdenas, 2014; Mamo & Alston-Stepnitz, 2014).

In this Virtual Special Issue, we explore the specific contributions made by critical feminist psychologists publishing in *Feminism & Psychology* over the last 30 years to debates in the broad area of reproductive politics. Since the inception of the journal in 1991, feminist psychologists have richly explored the intersecting power relations that regulate, constrain, and shape childbearing, motherhood, reproductive subjectivity, and the fraught intimate

politics of the reproductive sphere. In this issue, we foreground the various ways articles published in the journal have contributed to understanding and conceptualising moments of regulation using a "reproductive governance" framework as a broader analytic (Morgan & Roberts, 2012) to speak to the wide-ranging regulation of reproductive subjects and subjectivities, experiences, processes and practices.

Within the feminist tradition of understanding reproduction as deeply political, "reproductive governance" features as a powerful concept to understand not only what reproduction means for patriarchies, and the systems of power with which they cooperate, but also patriarchal investment and intervention in reproduction, reproductive decision-making and experiences, and people's reproductive lives. With this in mind, we gladly took up the opportunity to put together a Virtual Special Issue that showcases knowledge produced by/within/through *Feminism & Psychology* on reproduction.

In terms of the process we followed in producing this VSI, we started by reading the abstracts of every paper published by the journal, dividing the work between us; Rachelle started with the most recently published articles and Jabulile the earliest ones, and we met in the middle. From this we identified a total of 43 abstracts that we felt spoke broadly to reproductive politics. We then independently read through these and each came up with a list of articles to feature and ideas of how to organise them into themes or categories, a process which reduced the number of articles to 31. Through discussion, we agreed to merge our ideas for themes. Jabulile took on the task of reducing the articles even further by selecting only those articles that could speak to our merged ideas. With agreement from Rachelle, the list of articles and themes were finalised.

As a culmination of this way of working, our VSI features articles published in *Feminism & Psychology* that either directly engage with, or are useful for helping to think

through, the ways in which discourses, practices and power relations work to govern and regulate reproductive processes, experiences, decision-making, subjectivities, bodies, and capacities, whilst also working to govern gender and sex. Specifically, we outline the role of the affective economy in reproductive governance, or the *work* that affect *does* in reproductive governance and the kinds of affect that (do not) have socio-political currency. We attend to: (1) how affect is an important effect of and mechanism through which reproduction, reproductive experiences, practices, processes, and decision-making are governed and regulated through repronormative discourses and relations of power, and (2) how affect can point to and visibilise the reproductive labour that systems of power do. In doing so, we take seriously global South and decolonial feminisms' tradition of troubling one-dimensional narratives by, where possible, highlighting resistances to this governance.

On reproductive governance: repronormativity, and affect

Morgan and Roberts (2012, p. 243) describe reproductive governance as "the mechanisms through which different historical configurations 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 incitements to produce, monitor, and control reproductive behaviors and population practices". Drawing on this definition, we understand reproductive governance as the ways in which systems of power, and the various actors implicated therein, (seek to) direct, control, and regulate reproduction. We suggest that repronormativity and affect are key (of several) ways through which reproductive governance occurs.

In 2001 Katherine Franke took legal feminism to task for its lack of engagement with compulsory motherhood, and the ways that this lack of engagement seemed to suggest legal feminisms' acceptance of, or the will *not* to know, the ways in which reproduction is socio-culturally incentivised, naturalised, normalised, and valued, at least for *some* women.

Expanding the concept, Weissman (2017) theorises repronormativity as the various ways in which the state works to govern reproduction by designating and encouraging *cisheterosexual* reproduction as "desirable", "natural", "legitimate", and "intelligible", and designating and discouraging *queer* reproduction as "undesirable", "abnormal", "illegitimate", "irrational", and "risky". Of course, such encouragement and discouragement of cisheterosexual and queer reproduction, respectively, is not uniform or equal, being shaped by racist, classist, endosexist, ageist, ableist, anti-fat, and anti-immigrant systems of privilege and oppression, among others.

Indeed, Craven's research-based book, *Reproductive losses: Challenges to LGBT family-making*, documents the family-making journeys of queer, including of colour, gestational and non-gestational parents(-to-be), and the ways in which heteronormativity creates expectations for queer family-making. Craven shows that simultaneously, however, heteronormativity means that both queer reproduction and queer reproductive losses are devalued at various levels, including within pregnancy-related healthcare, and family-related policy. In their review of Craven's book, Mavuso (2020) suggests that repronormativity may be a broader concept that is capable of attending to the narratives of invisibilised and unsupported grief told by queer of colour parents(-to-be) and non-gestational parents(-to-be), and the interactive workings of various systems of power that regulate reproduction. He therefore conceptualises repronormativity as a form of reproductive governance that not only operates by delimiting what counts as reproduction, how reproduction should take place, and who should reproduce, but that also operates by delimiting who is allowed to *desire* reproduction and who is not, whose reproductive desires count as intelligible/normal/legitimate and whose do not, and, therefore, whose reproductive losses count as *loss* and who is therefore deserving of support.

Building on past conceptualisations of repronormativity, we understand repronormativity as a key mechanism of reproductive governance that operates in two ways, through: firstly, the inclusion, visibilisation, normalisation, privileging, and legitimation of certain kinds of reproduction, reproductive subjects, reproductive decisions, trajectories and narratives, reproductive affects, particular relationships to/with our bodies, and reproductive capacities; and, secondly, the attendant erasure, denigration, abnormalisation, and delegitimation of "other" kinds.

We view affect as another key strategy mobilised by systems of power to achieve reproductive governance (Parker & Pausé, 2019). Affect is also one way in which reproductive governance is visibilised and made hearable. In considering the work that affect does in systems' efforts to regulate, direct, and control reproduction, how reproductive governance produces certain affects, and how affect visibilises the labour of reproductive governance, we therefore understand affect as "the flow, or repeating patterns of energy, that circulates across the body and mind, the individual and social, and the private and public, in which bodies and subjects are constituted and reconstituted" (Liu, 2017, p.45).

We now turn to the work featured in this Virtual Special Issue. In order to disrupt the normative narrative on who the subjects of reproductive oppression and governance are, we have been purposeful in selecting *Feminism & Psychology* articles which, collectively, showcase *some* of the diverse manifestations of reproductive governance *and* the role of affect therein. Indeed, as a black, trans, non-binary, queer person who has a uterus (Jabulile), and a white cisgender woman (Rachelle), our commitment to showcasing diversity in experiences of reproductive governance is shaped by our own experiences, and the similar and differential ways in which systems of power construct our identities and reproductive capacities, futures, subjectivities, and desires.

Despite, and also because of our purposeful selection of articles, the 20 articles showcased here are a limited reflection of feminist work on the issue, and an even more limited reflection of reproductive governance and the role that affect plays therein. Indeed, they reflect a combination of our own aims, space limitations, and of course, work published by *Feminism & Psychology*. Nevertheless, we conclude our article by offering brief reflections on *Feminism & Psychology* and feminist knowledge production on the subject. Lastly, we also wish to note that our use of the concepts of reproductive governance, repronormativity, and affect is *our reading of/on* the work featured here, and thus were generally not used by the authors themselves, except with very few exceptions (i.e., articles that used the concept of "affect").

In the next section, we discuss the featured articles according to themes[2]. We arrived at these themes by trying to attend to patterns across the articles, diversity in reproductive experiences and the governance thereof, and by grouping articles according to analytical categories as opposed to descriptions of reproductive experiences/processes. The themes are as follows: (1) Normative masculine reproductive subjectivities, (2) Regulatory discourses: managing the reproductive body, (3) Governing pregnancy: normative narratives and trajectories, (4) The production of normative reproductive subjects in healthcare encounters, (5) and Stigmatised maternal subjectivities: "bad" mothers and "bad" mothering. Table 1 is a list of the featured articles by theme.

Normative masculine reproductive subjectivities

Few articles have been published in *Feminism & Psychology* on men, masculinity, and reproduction, and even fewer address affect. The three articles themed together here are thus important exceptions. These articles visibilise and challenge repronormative discourses that delimit and prescribe particular masculine reproductive subjectivities and the reproductive

	Feminism & Psychology **articles featured in this VSI**
Normative masculine reproductive subjectivities	**Toze, M.** (2018). The risky womb and the unthinkability of the pregnant man: Addressing trans masculine hysterectomy. *Feminism & Psychology*, *28*(2), 194–211. doi: 10.1177/0959353517747007. **Riggs, D. W.** (2009). The health and well-being implications of emotion work undertaken by gay sperm donors. *Feminism & Psychology*, *19*(4), 517–533. doi: 10.1177/0959353509342844. **Terry, G., & Braun, V.** (2011). 'It's kind of me taking responsibility for these things': Men, vasectomy and 'contraceptive economies'. *Feminism & Psychology*, *21*(4), 477–495. doi: 10.1177/0959353511419814.
Regulatory discourses: managing the reproductive body	**Mondragon, N. I., & Txertudi, M. B.** (2019). Understanding menstruation: Influence of gender and ideological factors. A study of young people's social representations. *Feminism & Psychology*, *29*(3), 357–373. doi: 10.1177/0959353519836445. **Young, K., Fisher, J., & Kirkman, M.** (2020). Partners instead of patients: Women negotiating power and knowledge within medical encounters for endometriosis. *Feminism & Psychology*, *30*(1), 22–41. doi: 10.1177/0959353519826170.
Governing pregnancy: normative narratives and trajectories	**Kumar, A.** (2018). Disgust, stigma, and the politics of abortion. *Feminism & Psychology*, *28*(4), 530–538. doi: 10.1177/0959353518765572. **Chiweshe, M., Mavuso, J., & Macleod, C.** (2017). Reproductive justice in context: South African and Zimbabwean women's narratives of their abortion decision. *Feminism & Psychology*, *27*(2), 203–224doi: 10.1177/0959353517699234. **Marshall, H., & Woollett, A.** (2000). Fit to reproduce? The regulative role of pregnancy texts. *Feminism & Psychology*, *10*(3): 351–366. **Roberts, J., & Walsh, D.** (2019). "Babies come when they are ready": Women's experiences of resisting the medicalisation of prolonged pregnancy. *Feminism & Psychology*, *29*(1), 40–57. doi: 10.1177/0959353518799386.
The production of normative reproductive subjects in healthcare encounters	**Stephenson, N., Mills, C., & McLeod, K.** (2017). "Simply providing information": Negotiating the ethical dilemmas of obstetric ultrasound, prenatal testing and selective termination of pregnancy. *Feminism & Psychology*, *27*(1), 72–91. doi: 10.1177/0959353516679688. **Crossley, M. L.** (2007). Childbirth, complications and the illusion of 'choice': A case study. *Feminism & Psychology*, *17*(4), 543–563. doi: 10.1177/0959353507083103. **McAra-Couper, J., Jones, M., & Smythe, L.** (2011). Caesarean-section, my body, my choice. *Feminism & Psychology*, *22*(1), 81–97. doi: 10.1177/0959353511424369. **Chadwick, R.** (2017). Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives. *Feminism & Psychology*, *27*(4), 489–509. doi: 10.1177/0959353517692607.
Stigmatised maternal subjectivities: "bad" mothers and "bad" mothering	**Morell, C.** (2000). Saying no: Women's experiences with reproductive refusal. *Feminism & Psychology*, *10*(3): 313–322. **Parker, G. & Pausé, C.** (2019). Productive but not constructive: The work of shame in the affective governance of fat pregnancy. *Feminism & Psychology*, *29*(2), 250–268. doi: 10.1177/0959353519834053. **Staneva, A. A., & Wigginton, B.** (2018). The happiness imperative: How women narrate depression and anxiety during pregnancy. *Feminism & Psychology*, *28*(2), 173–193. doi: 10.1177/0959353517735673. **Wigginton, B., & Lafrance, M. N.** (2016). How do women manage the spoiled identity of a 'pregnant smoker'?. An analysis of discursive silencing in women's accounts. *Feminism & Psychology*, *26*(1) 30–51. doi: 10.1177/0959353515598335. **Macleod, C.** (2001). Teenage motherhood & regulation of mothering in the scientific literature: The South African example. *Feminism & Psychology*, *11*(4), 493-510. **Morison, T., & Herbert, S.** (2020). Muted resistance: The deployment of youth voice in news coverage of young women's sexuality in Aotearoa New Zealand. *Feminism & Psychology*, *30*(1), 80–99. doi: 10.1177/0959353519864376.

	Williams, K., Kurz, T., Summer, M., & Crabb, S. (2012). Discursive constructions of infant feeding: The dilemma of mothers' 'guilt'. *Feminism & Psychology*, *23*(3) 339–358. doi: 10.1177/0959353512444426.

affective states that are "intelligible", expected and deemed "normal" for men and masculine people.

Writing primarily about the UK context, Toze (2018) invites readers to question, particularly given that UK legal gender recognition laws do *not* require medical transition, the *medico-socio-cultural* preference for (as distinct from the individual decisions undertaken by) trans men and trans masculine people to have hysterectomies. In his article, Toze interrogates the medical discourse of risk as one in/through which this medico-socio-cultural preference is articulated. Through this discourse, trans men and trans masculine people with uteri are constructed as "at risk" for cancer, and hysterectomy is framed as the only/best solution to avert this "risk". His interrogation reveals that a medical discourse of risk is not supported by evidence that trans men and trans masculine people who have wombs *are* at greater risk for reproductive cancers. Instead, Toze (2018) argues that this preference, at a societal, systemic level, is underpinned by the normative socio-cultural assumption that trans men and trans masculine people "either cannot or will not bear children" (p. 201). And, given that "[r]eproductive ability is closely associated with social constructions of whether a body should be considered female or male" (Toze, 2018, p. 201), hysterectomy becomes the "obvious", preferred solution to "fix" bodies that destabilise the "truth" about whom gestational reproductive subjects should be and therefore are, and rules that govern manhood, masculinity, and normative childbearing. Importantly, Toze's article shows that repronormative discourses delimit whose desire to be a gestational parent and/or to reproduce gestationally is "natural", "imaginable"/ "intelligible", and allowable, such that males, men and masculine people are medico-socio-culturally defined by their socio-medically assigned status as *non*-uterine subjects and an *in*ability to gestationally reproduce. They are also defined by the presumed/required absence of the *desire* to be pregnant. Policing the boundaries of reproductive desire and who is recognisable and legitimised as a desiring

procreative subject, is shown to be a core aspect of the normative medical advice and hysterectomy protocols presented to trans men and masculine persons with uteri. These "solutions" ensure that (potential) procreativity and childbearing remain normatively gendered (as (cis) feminine) and sexed (as (cis) "female") and reiterate the gender/sex binary.

Riggs' (2009) article explores the various emotion work experiences of cisgender gay male sperm donors in Australia who have donated either to clinics or to friends and acquaintances. In his study, participants who had donated to a clinic described the discomfort they experienced as a result of the messages communicated by the clinic (through the design of sperm donation rooms and general interactions), messages which constructed sperm donation as a normatively "clinical", non-pleasurable experience. As Riggs argues, this construction of sperm donation requires gay sperm donors to align with the "stoic, non-pleasure seeking, and generally clinical" (2009, p. 525) reproductive subjectivity that is medico-socio-culturally allowed for sperm donors. The "medicalisation of sperm donation", and the attendant denial and problematisation of sperm donation as a (potentially) sexually pleasurable experience (including sperm donation as a reproductive activity that may be motivated by sexual desire), not only results in discomfit for sperm donors who depart from this normative reproductive subjectivity, but also constructs sexual pleasure in/through sperm donation as "inappropriate", "abnormal", potentially "pathological", and "shameful". This may be particularly harmful to, and require significant affective labour from, gay sperm donors whose sexual expression and identities as gay men are routinely heteronormatively shamed (Riggs, 2009). Furthermore, some clinics' normative provision of pornographic magazines that are aimed at men who are attracted to women constructs the "ideal" sperm donor as heterosexual. It also draws on repronormative discourses about who is a "desirable" reproductive subject and who is not (i.e., whose biomaterial is valued and whose not),

requiring further emotion work from gay sperm donors who must manage the emotional consequences of this reproductive/queer erasure.

Last in this theme, Terry and Braun (2011) analyse the narratives of New Zealand cisgender heterosexual men, the majority of whom identified as Pakeha or of European ethnicity with one identifying as of mixed Māori/New Zealand European descent, who had elected to have vasectomies after having had children. Their article adds to understandings of the reproductive subjectivities that are socio-culturally "imaginable", idealised, permissible, and normative for fertile men who produce sperm, but also the normative affect expected of the pregnancy-capable women who are in romantic partnerships with them. Terry and Braun show how the men in their study constructed hero narratives in which their decision to have a vasectomy was framed as an egalitarian, heroic and/or timely (albeit delayed— the vasectomy taking place at least one year after the couple had decided to stop having children) taking up of "their share" of contraceptive responsibility. Through this narrative, men constructed their partners' long-term contraceptive pill usage as dangerous to their partners' health, whilst also downplaying and disregarding their partners' years' long emotional labour of being the only person responsible for contraceptive use. Thus, Terry and Braun's (2011) article invites consideration of the ways in which cisgender heterosexual men's pride in their delayed decision to have a vasectomy and concern for their partners' health, and gratitude from their partners, reveal not only gendered discourses of contraceptive labour and responsibility, but also gendered reproductive subjectivities where certain affects emerge as socio-culturally intelligible and normative. Importantly, the circulation of these affects serves to reinforce the 'naturalness' of gendered contraceptive responsibility and labour, and regulates how contraceptive-using reproductive subjects are supposed to feel. While cisgender women's reproductive lives are often permeated by negative affects such as shame, guilt, fear, individual responsibility, blame, and inadequacy (as will be evident in later

themes) and their reproductive and contraceptive labour is naturalised as expected, this study shows that cisgender heterosexual men's efforts to share in contraceptive responsibility are framed as praiseworthy and heroic and made sense of via "economies of gratitude" that continue to exceptionalise (rather than require) masculine involvement in contraceptive and reproductive labour.

Regulatory discourses: Managing the uterine reproductive body

In this theme we have brought together two articles which speak to the different ways that cisgender women who menstruate (Mondragon & Txertudi, 2019) or suffer from endometriosis (Young, Fisher & Kirkman, 2020) are expected to understand, experience, and manage their bodies through regulatory discourses. These discourses simultaneously construct normative and non-normative feminine reproductive subjects and generate (mostly negative) affects that stigmatise menstruation, normalise pathology and distress, and engender feelings of embodied distrust and inadequacy.

Building on feminist work on menstruation, Mondragon and Txertudi's (2019) study sought to explore the meanings that menstruation holds for young cisgender females and males living in Spain. The authors describe discourses on menstruation, drawn upon by both cisgender females and males (albeit to varying extents[3]). Normative discourses which construct menstruation as a "hygiene crisis" and which construct menstruation as characterised by "negative" affect stigmatise menstruation. The menstruation-as-hygiene-crisis discourse circulates fear and repulsion of menstrual blood leakage, compelling menstruating people to use strategies (e.g., wearing particular clothing and not speaking about menstruation) and technologies (e.g., menstrual products) to manage their bodies by concealing their menstruation and limiting their public and social participation. In the "negative effects of menstruation" discourse, curtailed social and public participation also emerges as the inevitable result of menstruation, but does so through the circulation of anger,

irritability and emotional instability, all of which are problematised and pathologised whilst being constructed as normative *during menstruation*. In contrast to these normative discourses on menstruation, Mondragon and Txertudi (2019) point to the destigmatising effects of the counter-normative discourse titled the "positive acceptance of menstruation". Within this discourse, a range of affects, including happiness, empowerment, and pride are made possible, intelligible and normalised for menstruating women, menstruation is constructed as a natural cleansing and re-balancing process, and speaking about menstruation is framed as resistance to the a/shamed menstruating subject. This resistance notwithstanding, some participants' constructions of women *as* menstruating and gestational reproductive subjects, such that menstruation was in part framed as positive precisely because of the gestational reproductive capacity that menstruation socio-culturally signifies, for us reveals much about how repronormative and gendered discourses are mutually co-constructed and co-constructing. Indeed, this discourse constructs *non*-menstruating women and menstruating people who are *not* women as outside the bounds of socio-cultural imagination and intelligibility, and also limits the affect that is intelligible and normative for menstruating people who are unable or simply do not desire to reproduce gestationally.

In Young et al.'s (2020) paper, the authors analyse cisgender heterosexual Australian-born women's narratives of their experiences of negotiating with and navigating medical disciplinary power while seeking treatment for endometriosis. Endometriosis is "the presence of lesions containing endometrial-like tissue" (Young et al., 2020, p. 23) which can occur anywhere in the body, from which any person may suffer. Yet, normative socio-medical discourse constructs it as a "gynaecological disease" experienced by "childless women" with uteri. Within this discourse, "[t]he ''solution'' often reinforces women's socially constructed roles of wife and mother" (Young et al., 2020, p.23). Thus, some of the women in Young et al.'s study described how doctors who were both endometriosis and fertility specialists

"prescribed" gestational parenthood, through invitro fertilisation, as the "cure". For some participants, clinicians' dismissal of, and the potential for clinicians to dismiss and trivialise, their experiences of endometriosis as "just cramps" or "hypochondria" was harmful in that it produced frustration and anxiety, as well doubt and mistrust in their knowledge of their own menstruating bodies. Through medical practice, therefore, childlessness among women presumed to be capable of pregnancy continues to be constructed as pathological. On the other hand, uterine and menstruating subjects are constructed as "unknowledgeable", "untrustworthy", "passive" recipients of reproductive healthcare who have nothing to contribute to medical consultations for endometriosis, and their affective experiences of endometrial pain and discomfort are devalued and dismissed.

Governing pregnancy: normative narratives and trajectories

Collectively, the four articles in this theme speak to the ways in which reproductive governance takes place through repronormative narratives which construct idealised, expected and normative trajectories for pregnancy, and which abnormalise any deviations from these.

The articles by Kumar (2018) and Chiweshe, Mavuso and Macleod (2017) both deal with abortion. For us, they reveal much about the normative affects that stick to and are repeatedly circulated around abortion, how these affects are produced and normalised through anti-abortion discourses in which terminating a pregnancy goes against the expected trajectory of a pregnancy, and against the life trajectory expected of people who are presumed to be women with the capacity to gestate. Writing on the US context in which "the politics of disgust is in ascendance" (p.532), Kumar traces how anti-abortion activism has successfully managed to increasingly restrict abortion access by generating disgust around abortion and towards abortion seekers and providers, through a hyper-focus on the foetus/child. As Kumar (2018) argues, pro-choice activism, on the other hand, has avoided engaging with abortion as

a practice that involves or leads to a death or loss of potential life, instead framing activism around "choice" and thus conceding the moral and emotional ground to anti-abortion activists. For significant gains to be re-made, Kumar shows that those working to create unfettered access to dignified abortions and abortion care need to acknowledge death and loss whilst asserting pregnant people's "moral agency to cause that death or loss" (Kumar, 2018, p. 533).

Chiweshe et al. (2017) analyse the abortion decision-making narratives told by cisgender black women, most of whom were unemployed, in South Africa (where abortion legislation is fairly liberal) and Zimbabwe (where restrictive abortion legislation persists). Their paper documents how the women justified their abortion decisions, despite not being asked to do so. The authors argue that this points to the socio-cultural stigmatisation of abortion which demands that abortion seekers justify their decision in order to mitigate the shame circulated around abortion. Simultaneously, however, Chiweshe et al.'s (2017) paper illuminates how discourses demand that reproduction is appropriately timed (e.g., within adult marital relationships); and demand adherence to "good" mothering/parenting, gendered parenting roles, and gendered economic participation with the effect that economic support is withdrawn through male partner abandonment. Such discourses necessitate abortion by creating unsupportable, "shameful" pregnancies whilst nevertheless constructing abortion itself as shameful.

Focusing on a different aspect of gestational trajectories, Marshall and Woollett (2000) analyse UK-based pregnancy texts. Although already featured in a previous VSI, we include it here to highlight how, firstly, pregnancy is regulated through the construction of certain affects as normative, and non-normative, "good" and "bad", over the course of a pregnancy, and, secondly, how pregnant subjects are called upon to manage their affect in particular ways in order to be deemed "good" pregnant subjects. Since cisgendered women

are the imagined gestational subjects in the texts, "good" pregnant subjectivity is entangled with "good" motherhood, and "good" womanhood. As Marshall and Woollett's analysis shows, the texts describe pregnancy as an essentially happy time; happiness is both normalised and idealised. In contrast, emotional volatility, anger, depression, and stress are constructed as expected and therefore a normal part of pregnancy but are simultaneously problematised as needing to be managed and controlled. The discourse of risk features prominently in the texts, with "good mothering" centring on successfully managing this risk by "producing a healthy normal baby" (Marshall & Woollett, 2000, p. 355). As a result, shame, guilt and a sense of personal failure are normalised as what is to be expected for deviating from the normative pregnancy trajectory, the "good" pregnant subject, and "good" mothering.

Roberts and Walsh (2019) report on their UK study which explored cisgender women's experiences of being "overdue" in the context of medical discourse and practice that abnormalises "prolonged pregnancy". This is despite the reality that being pregnant for longer than what is medically expected or constructed as "normal" is a fairly common event (Adeniji & Akinola, 2013) and therefore within the *normal variation* of pregnancy duration[4]. The authors focus on narratives of resistance to labour induction. These narratives show how several participants contested (conceptually and/or during healthcare interactions) medical authority to determine the "due date" of their pregnancy. Providers' devaluation of their embodied knowledge resulted in the women feeling pressured and coerced to deliver soon or else accept induction, and feeling irritated, devalued, dismissed and unacknowledged as experts. As a result of healthcare workers' repeated framing of induction as the "moral" and "responsible" choice to make, the women in the study "felt they were being accused of recklessly putting their babies at risk" (Roberts and Walsh, 2019, p. 50) by delaying or refusing induction. Thus, Roberts and Walsh's (2019) article visibilises how fear, guilt and

shame are mobilised within/through normative medical discourses' construction of "prolonged pregnancy" as a health risk *requiring* induction of labour. The authors' paper demonstrates that normative medical discourses and attendant practices serve to regulate not only the duration of pregnancies but also *how* pregnancies come to an end, with important affective consequences for pregnant people's experiences of pregnancy and birth.

The production of normative reproductive subjects in healthcare encounters

Writing about prenatal testing and abortion for foetal anomaly in Australia (Stephenson, Mills & McLeod, 2017), and narratives of childbirth in the UK (Crossley, 2007), Aotearoa New Zealand (McAra-Couper, Jones & Smythe, 2011) and South Africa (Chadwick 2017), the articles in this fourth theme contribute to knowledge on the ways in which particular reproductive subjects and subjectivities are produced through discourse and the mobilisation of normative affects in reproductive healthcare encounters.

Stephenson et al. (2017) explore health professionals' understandings of the use of ultrasound technology to detect/interpret foetal anomaly, information which is used in abortion decision-making. In their narratives, healthcare providers tended to construct their role of interpreting ultrasound technology for foetal anomaly as ethically neutral, drawing on a "woman's choice" discourse to do so. As the authors show, these narratives construct pregnant cisgender women as *the* reproductive subject in these consultations. Healthcare providers are simply "interpreters" and "providers" of information and are therefore absolved of any ethical responsibility. As such, emotional neutrality and *lack* of emotional conflict circulate as normative affects for ultrasound professionals whilst emotional conflict and ethical dilemma circulate in/through/for pregnant cisgender women. In contrast to this dominant narrative, some participants spoke about the ethical implications of their role whilst supporting "women's" autonomy to make abortion decisions. Importantly, the framing of abortion as a "woman's choice" erases the sex and gender diversity of pregnant people and

abortion seekers. Furthermore, Stephenson et al.'s (2017) article invites a critical interrogation of how such a discourse expects the pregnant person (defined within this discourse as "women") to bear the sole responsibility, and the affective effects thereof, for abortion decision-making for foetal anomaly. Thus, as the authors show, the mobilisation of abortion as a "woman's choice "works to justify the relative absence of collective discussion around ultrasound and termination of pregnancies" and "isolate[s] the clinical space from its wider social context" (Stephenson et al., 2017, p. 75). This social context is one in which ableism manifests as the social and medical construction of disabilities as "*anomalies"* and "incompatible with a good life", the state's lack of provision of resources (including informational) for caring for disabled loved ones, and the imagining of families as *non*-disabled.

Exemplifying the feminist maxim "the personal is political", Crossley (2007) uses as a case study her own experience, as a middle-class cisgender woman, of eventually having a medical birth despite having desired and planned for a home birth. Crossley situates her case study and own experiences against the backdrop of the feminist birth movement's representation of childbirth in which "women" are *able* to "choose" how they would like to give birth, and "natural birth" is framed as the superior "choice" and is promoted as "a 'woman-centred alternative' to medical intervention" (p.547). Analysing her experience of her *minimal* ability to exercise choice when it came to the actual birthing encounter, the author troubles both rigid representations of childbirth by exploring "the tension arising as a result of the discrepancy between expectations and outcomes, and the psychological and emotional consequences this may have" (Crossley, 2007, p.546). Thus, Crossley describes how after deciding to abandon having a home delivery, once at the hospital she was not given a choice about having several medical interventions, each of which went against her birth plan, and each of which only necessitated the *next* intervention (hospital admission,

induction, Pethidine administration to slow down her 'hyper-stimulated' labour, and an epidural and caesarean section because her cervix was not dilating fast enough). In her account of her emotional experience of childbirth, the author describes increasing anxiety around having, and exhaustion leading up to, a home birth (which appeared increasingly unrealistic), relief at being admitted to hospital and being able to let go of having to *manage* her own childbirth, exasperation as each medical intervention was imposed, and, finally, isolation, guilt, shame and a sense of "failure" at having had a medical birth instead of a "natural" one. Crossley's (2007) account therefore visibilises how people who give birth are caught between the reproductive governance of coercive medicalised birthing practices *and* that of the intertwined feminist discourses of "choice" and "natural birth". Both of these potentially have important, harmful, and negative affective consequences for birthers' experiences.

McAra-Couper et al.'s (2011) article, too, critically interrogates the notion of "choice" in childbirth intervention, but focuses on the choice to have a c-section. Understanding 'choice' as "severely limited at any given time, and […] shaped by hegemonic discursive orders and social practices" (p. 82), the authors' analysis of white, cisgender, middle-class women's accounts reveals how their choice to have a c-section was informed and regulated by gendered discourses in/through which a c-section delivery emerges as the obviously "intelligible" and "desirable" way to give birth, being constructed as more closely aligned with patriarchal feminine respectability. Importantly, in the women's narratives, affect emerges as a powerful motivator. Thus, within the gendered discourses, shame, embarrassment, fear, loss of control, and indignity stick to the "grunting, pooing, foul woman giving birth" vaginally (McAra-Couper et al., 2011, p. 89), making vaginal births *unfeminine* and therefore a *non*-choice. By contrast, dignity, being in control, and a sense of certainty cohere around a caesarean delivery, which is *feminised*. Mc-Ara-Couper et al.'s (2011) article

thus visibilises how affect features as a powerful force in repronormative discourses that regulate birthing decision-making through gendered birthing respectability.

Last in this theme, Chadwick's article (2017), like McAra-Couper et al.'s (2011) above, implicates patriarchal feminine respectability in reproductive governance, but does so by exploring black cisgender low-income women's experiences of obstetric violence, which includes "both direct violence (physical, verbal, and sexual abuse), subtler forms of emotional violence (dehumanization, disrespect, nondignified care), and structural violence (stigma, discrimination, and system deficiencies)" (Chadwick, 2017, p. 492) during childbirth and the postpartum period. In her article, Chadwick shows how obstetric violence is mobilised by healthcare workers to produce birthing bodies that reflect the "good patient" and the respectable feminised subject: obedient, docile, silent, and still. Thus, in participants' accounts, healthcare providers worked to produce compliant birthers by threatening and using violence, and making degrading, humiliating comments about their sexuality which constructed verbal sexual enjoyment as *un-feminine*, and pain during birth as a just consequence or punishment that should be silently borne. As the author points out, these sexual innuendos draw on and reproduce the hyper-sexualisation of black people to problematise and discipline black people giving birth. Chadwick's (2017) article thus visibilises how affect is itself a key mechanism in the reproductive governance of birthing: healthcare workers deploy their own anger and annoyance, and obstetric arrangements, norms, and relations engender fear, shame, and humiliation. These collectively work to discipline and produce compliant feminised birthers.

Collectively, these articles showcase the central role of discourses and affect in the government of reproductive subjects in healthcare encounters. Normative discourses (i.e., "natural birth", "feminine respectability", "woman's choice", "the good patient") act as

regulatory devices that produce certain affects (i.e., fear, anxiety, shame, guilt). These affects work to shape actions and choices, and discipline reproductive subjects.

Stigmatised maternal subjectivities: "bad" mothers and "bad" mothering

With the most articles, this last theme brings together *Feminism & Psychology* contributions that perhaps reflect broader trends in feminist work on reproductive politics. The seven articles themed together speak to the ways in which repronormative discourses produce stigmatised maternal subjectivities. We highlight here the affects that circulate around "bad" mothers, the ways in which they are used to regulate ("good") mothering, and the affective consequences of this regulation.

Starting off this theme, Morrell (2000) looks at cisgender women's experiences of what she terms "reproductive refusal": saying "no" to motherhood. As Morrell argues, the American patriarchal construction of the woman-mother figure, and the attendant imperative to reproduce, problematises childlessness to encourage motherhood, and restricts "not-mothers'" affect by circulating regret and loss as the "intelligible", normative affects expected of intentionally childless women who are presumed to be capable of pregnancy. As a result, their experiences "are subject to misunderstanding and misnaming" (Morrell, 2000, p. 313). In contrast to this restriction on the possibilities for affect, Morrell's article visibilises the complexity and diversity in the experiences of the women in her study, all of whom were living in the United States. She achieves this by foregrounding narratives that speak to ambivalence, isolation, fulfilment, happiness, freedom, and wistfulness, and a recognition of the losses that will be incurred by refusing motherhood.

The next three articles of this theme add to work that highlight the repronormative rules for gestational reproduction and the conditions for pregnant subjectivity. Focusing on fat shame in pregnancy-related healthcare in Aotearoa New Zealand, Parker and Pausé (2019)

"question whether [self-governed] action can fulfil the promise of improved health outcomes for mothers and their babies. In other words, […] can mothers-to-be be shamed into health?". The authors interrogate fat shame, produced through constructions of fat bodies as "both disgusting and harmful to others/society" (p. 254) and fatness "before and during pregnancy… [as] associated with a wide range of adverse reproductive outcomes, from infertility to growing caesarean rates, stillbirth, and congenital abnormalities" (p. 251). Such discourses incite fat individuals to self-govern into "health" and into being "good" mothers'. Drawing on the experiences of cisgender, ethnically diverse (Māori indigenous New Zealanders, Pacific Island New Zealanders, European New Zealanders, Asian New Zealand, and European) self-identified fat pregnant people and new mothers, Parker and Pausé visibilise the "shaming encounters" participants were subjected to by healthcare workers. During these encounters, participants' bodies were framed as "burdensome" on the healthcare system and therefore "undeserving" of pregnancy related-care, and "a risk to their babies' present and future health" (p.258) and therefore as "bad" and "irresponsible" mothers. In answering their question posed above, and contrary to the promises of anti-fat and neo-liberal discourses, Parker and Pausé (2019) show how the shame, guilt, and feelings of failure produced within these shaming encounters *harmed* participants' health and well-being and meant that participants could not enjoy their pregnancies. Instead, their pregnancy experiences were shaped by stress, anxiety, despair, self-loathing, isolation, lack of confidence, and depression. Thus, the authors' interrogation of fat shame in pregnancy-related healthcare invites important consideration for how anti-fat repronormativity not only excludes fat people as pregnant subjects, but also sets rules for who is allowed to experience the happiness and pleasure that are socio-culturally quintessentialised for/during pregnancy.

Staneva and Wigginton's (2018) article analyses the narratives of pregnancy distress told by cisgender women living in Australia, focusing on the discourses used by the women to make sense of their experiences and to construct maternal identities in the context of "the happiness imperative". The authors locate participants' narratives within patriarchal discourses in/through which "good" mothering is constructed as intensive, always available, and child-centred, including emotionally, and is constructed around a de-prioritisation of the self. Working interactively with this discourse, neo-liberal and post-feminist discourses call upon mothers to regulate their feelings, to bring their feelings and themselves into alignment with discourses that construct pregnancy as a characteristically happy time: "good mothers should feel happy; or, put another way, "an unhappy mother is a failed mother" (Goodwin & Huppatz, 2010, p. 6)" (Staneva & Wigginton, 2018, p. 174). Apart from happiness, participants' narratives show that the affective imperative of pregnancy discourses allows and demands (constant) gratitude, excitement, positivity, emotional control, and emotional certainty (unambiguity). Love and pride are the allowable and idealised child-directed affects. Through/within this imperative, experiences of distress, depression, anxiety, frustration, anger, confusion, ambivalence, and exhaustion are unspeakable and abnormalised. Staneva and Wigginton's analysis visibilises how the affective consequence of *feeling* this way in an ideological and socio-cultural context that stigmatises these affects, is feelings of shame, inadequacy, failure, and being a danger to one's child.

Addressing a different "untellable" experience, Wigginton and Lafrance (2016) analyse private and public accounts of smoking during pregnancy, and the ways that cisgender women living in Australia and Aotearoa New Zealand manage the identity of a pregnant smoker. As the authors' show, this identity is stigmatised through and *between* discourses which construct smokers as "lepers, underclass and outcast members of society who effectively pollute the air by smoking" and 'good' mothers as "unfailingly nurturing and

consumed with the care and protection of their children (Irwin et al., 2005)" (Wigginton & Lafrance, 2016, p. 32). Indeed, Wigginton and Lafrance's analysis reveals how pregnant smokers may be *suspended* between these two positionings. Thus, participants tended to employ discursive strategies to distance themselves from the identity of a smoker, and rarely took up the identity of "mother" or "mother-to-be", except in the few instances when they defended themselves against being positioned as "*bad* mothers". Including in their analysis a focus on the material consequences of ideological constructions of pregnancy and smoking in/through which women who smoke during pregnancy are positioned as "bad mothers", the authors demonstrate how such constructions produced shame, guilt, loathing, disgust, and embarrassment. These affects are not only normative but also socio-culturally and ideologically required of pregnant smokers (i.e., for their "redemption"). In contrast, some participants' narration of happiness over their decision to smoke challenges the affective regulation that these discourses seek to effect.

Shifting to the ways in which ageism and racism interact to shape the regulation of motherhood, both Macleod (2001) and Morison and Herbert (2020) critically analyse representations of cisgender teenaged reproduction in scientific literature and news media in South Africa and Aotearoa New Zealand, respectively. In their articles, the authors show how a hyper-focus on young motherhood, which is constructed as an indication and a cause of social and individual problems, a "natural" cause for fear, concern, alarm, and pity, and as shameful, holds young pregnant women solely responsible for reproduction and problematises their reproduction whilst invisibilising fathers. Their analyses demonstrate how racism interacts with ageism to mean a hyper-focus on black young motherhood in South Africa (Macleod, 2001) and Māori young motherhood in Aotearoa New Zealand (Morison & Herbert, 2020).

In terms of the normative affect expected of young mothers, shame and regret emerge as intelligible in much of the news coverage in Morison and Herbert's (2020) article, in a narrative that constructs this kind of affect as a requisite for young mothers to "redeem" themselves. And in the scientific literature analysed by Macleod (2001), jealousy, resentment, and a lack of maternal affection emerge as "characteristic" of young mothers. Such affect or lack thereof is framed within scientific literature as inappropriate and harmful, and as leading to "bad" mothering. These two articles thus show how in normative discourses of teenage reproduction, certain affects stick to and circulate around young motherhood and young mothers to stigmatise both and to construct "good" motherhood as the preserve of adults, whilst pathologising black and indigenous people's reproduction. In contrast to these dominant representations, pride, competence, and satisfaction featured in young mothers' resistant talk in Morison and Herbert's (2020) article. However, as the authors argue, the framing of this affect within a "redemption narrative" wherein the young mothers are "fallen subjects" who (must) "redeem" themselves through responsible motherhood, offers limited resistance to the repronormative framing of young motherhood/mothers as "bad" and young women as "unruly".

Finally, and also focusing on public discourse, Williams, Kurz, Summer and Crabb (2012) analyse childcare materials available to Australian parents (published in Australia, the UK, and the US) for the ways in which infant feeding is constructed. The authors show how infant feeding is gendered (*and sexed*), maternalised through the construction of a *maternal* identity. Simultaneously, infant feeding is moralised through a construction of "breastfeeding" as "the morally correct infant feeding choice" (p. 353): beneficial for infant health, reflecting and enabling a 'natural maternal bond', an easy and enjoyable task, and "natural" and therefore "fundamentally and undoubtedly wholesome, good, and safe" (p. 346). In contrast, formula feeding was constructed as lacking health benefits or even harmful,

incommensurate with the "maternal bond", and "artificial" and therefore "bad" and "risky". Through these constructions, anxiety, guilt, and shame circulate around formula feeding, with little room for other kinds of affect. Instead, "mothers" who "*choose" not* to "breastfeed" are called upon and responsibilised to manage and control any anxiety, guilt and shame they feel "as a result" of their "choice", and to be "content". Any inability to manage their emotions is framed as a personal failure. Furthermore, Williams et al. (2012) show how "mothers" are given additional affective work: to ensure that their emotions and desires align with their infant feeding decisions and practices; to *want* to "breastfeed", or else face harming their infant (by "breastfeeding" for the "wrong" reasons). Infant feeding discourses thus not only seek to regulate infant feeding but also seek to control the affect of parents with the capacity to "breastfeed" whilst individualising the harm produced by/within these discourses. As the authors point out, by denigrating formula feeding, these discourses exclude the involvement of parents who do not have the capacity to "breastfeed". Moreover, we argue, by constructing infant feeding as a maternalised identity, such discourses also erase and construct as "unintelligible" and "unimaginable", parents who *do* have the capacity to chestfeed/breastfeed and are not cisgender women and/or "mothers".

Conclusion

Reproductive politics and oppression has received significant attention in feminist knowledge production, and work published by *Feminism & Psychology* has made an important and critical contribution to this body of knowledge. Through this Virtual Special Issue, we have demonstrated the usefulness and power of reproductive governance as a concept for understanding and highlighting oppressive reproductive politics, the ways in which repronormativity and affect are deployed therein, and are a consequence thereof.

As mentioned earlier, our selection of articles was motivated by our desire and need to showcase the diverse ways in which repronormativity and reproductive governance occurs

(and is resisted). Indeed, the articles featured here powerfully demonstrate how affect for men and masculine people is tightly circumscribed: reproductive desire is non-gestational, cisheterosexualised, and not sexually pleasurable (in the context of sperm donation), men and masculine people's role in parenting precludes caring for and bonding with their infants through feeding, and the exceptionalisation of cisgender men's contraceptive responsibility privileges their reproductive capacities/futures and circulates particular affects which align with patriarchal rules for hetero-masculine inter/subjectivity. Healthcare systems' constructions of reproductive, gestational and maternal "health" undermine embodied expertise and dismiss experiences of endometrial pain, and mobilise and engender shame to pathologise and erase fat motherhood/parenthood and tightly manage childbirth by pathologizing "prolonged" pregnancies. The "bad mother/ing" construct requires mothers to affectively self-govern, essentialises happiness and joy during pregnancy, but only for *some* pregnant people, and wields shame to produce "good mothers". Racism interacts with patriarchy, ageism and capitalism/classism to mask white teenaged reproduction/motherhood whilst hyper-visibilising and pathologising black and indigenous teenaged reproduction/motherhood, and to hypersexualise, feminise and discipline black low-income people during childbirth. And, with harmful affective consequences, the feminist discourse and politics of "women's choice" has limited emancipatory potential, operating as a site of reproductive governance through restrictive rules and possibilities for *feminist* reproductive agency and subjectivity. In different spaces and through various practices, then, reproductive "choice" and decision-making is circumscribed through affective governance.

However, we note how much of the work on reproductive politics published in *Feminism & Psychology* and included in this Virtual Special Issue reflects dominant patterns of presence and absence in feminist work on the subject, wherein *specific uterine* reproductive subjects circulate as *normative reproductive subjects*. Relatedly, the re-

circulation of particular kinds of reproductive oppression means that these experiences are taken to be definitive while those that are invisibilised may not be understood *as* oppressive.

These patterns of presence and absence in feminist knowledge production on reproductive oppression is aptly captured by Phoenix's (2002, 2022) normalised absence. The centring of some reproductive subjects and their experiences of reproductive oppression (and resistance), and the attendant exclusion of "others", is often taken for granted as rational, and unproblematic. Whether by intention or effect, this pattern in and of itself reinforces and draws on repronormativity and reproductive governance by constructing as "unintelligible" and "unimaginable" various reproductive subjects whose reproduction is devalued, and who are peripheried through systems of power. In turn, this limits understandings of and actions against the immense scope of reproductive governance taking place globally.

In challenging these patterns of representation, however, feminists must guard against the equally problematic tendency of pathologised presence (Phoenix, 2002, 2022). Indeed, when their experiences are visibilised in mainstream feminist knowledge production on reproductive politics, multiply marginalised people's reproductive practices are often pathologised. This can be seen, for example, in mainstream feminist work on global south people's experiences of reproductive oppression that focuses on increasing contraceptive provision as *the* solution, or that locates son preference within global South cultures themselves (particularly Asian countries), as opposed to patriarchies where son preference may be expressed in varying ways in different parts of the world (including among white communities in the global north).

Thus, we look forward to further work that explicates how parenthood and the right to parent safely is denied through policies and laws (e.g. adoption, child removal, state/welfare assistance, and anti-immigration policies, the criminalisation of sex work) and various

practices (e.g. lack of equitable access to fertility preservation prior to gender affirming care, forced sterilisation and contraceptive provision, hateful acts of physical violence towards marginalised groups, military occupation, war and conflict). In this, we especially look forward to further scholarship that centres the experiences of people who are imprisoned, intersex, trans women, black, brown and indigenous people, sex workers, disabled, young and *old*, fat, immigrants (particularly undocumented immigrants), men and masculine, non-binary and gender non-conforming, *not* heterosexual, live in global south countries, and who are *not* capable of pregnancy (including people with and without uteri). Work that does so in ways that expose how systems of power intersect and interact to regulate the reproduction of people who are multiply marginalised therein is particularly needed. Such work, we believe, is incredibly important in ensuring that feminist knowledge production is a vital part of social justice efforts to end reproductive oppressions for everyone.

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Notes

1. Our use of “women” and “men” recognises the sex and gender diversity of those who identify this way. For specificity, we use “trans” and “cisgender” as specifiers. In using “cisgender” as a specifier, we acknowledge that the concept has come under some critique by trans scholars who see it as unintentionally reinforcing the normativity of cisness (see Aultman, 2014). Our own use of it here serves to visibilise and challenge the often-silent, taken-for-granted assumption in much feminist work that the categories “women” and “men” *necessarily* and *obviously* refer to cisgender people.

2. Although we have organised the articles in this way, we did find that several articles were relevant for more than one theme.

3. Cisgender women were more likely to draw on the hygiene crisis, and positive acceptance discourses. Cisgender males were more likely to use a biological discourse to describe menstruation as a biological process that is socially tabooed (we did not discuss this discourse as the data presented by the authors does not refer to affect).

4. The percentage of pregnancies lasting longer than 41 weeks may vary by hospital, country, and region, with Roberts and Walsh (2019) citing 20.1% of all pregnancies in NHS England hospitals for the period 2015-16. Global estimates vary as well, with figures of 1.5-10% (Kortekaas et al., 2015) and 4-19% (Moradan & Nejad, 2012) being quoted.

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Biographical note

Jabulile Mary-Jane Jace Mavuso is a postdoctoral researcher in the Sociology Department, University of Pretoria, and Research Associate for the Critical Studies in Sexualities and Reproduction (CSSR) research programme, Rhodes University. Their research interests are in sexual and reproductive politics, and the narratives, discourses, and power relations underpinning them. His recent publications are a special issue on Reproductive Violence co-edited with Dr Rachelle Chadwick, published by *Agenda*, and a book, *Sexual and Reproductive Justice: From the margins to the centre*, co-edited with Dr Tracy Morison and published by Rowman and Littlefield.

Rachelle Chadwick is a senior lecturer in the Sociology Department, University of Pretoria. She has written widely on birth politics, obstetric violence, and feminist methodologies, publishing articles in journals such as *Feminist Theory*, *Qualitative Research, Health, Risk & Society*, *Feminism & Psychology* and *Violence Against Women*. Her book, '*Bodies that Birth: Vitalizing Birth Politics*' was published in 2018 by Routledge.