

# INTRODUCTION: REPRODUCTIVE AGENCY, MEDICINE AND THE STATE

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*Maya Unnithan-Kumar*

The main objective of this volume is to consider the relationship between human reproductive processes (including attitudes to fertility, pregnancy, childbirth and the postpartum period), medical technologies and state health policies in diverse cultural contexts, especially outside Northern Europe and North America. Bringing together researchers from several disciplines, the volume discusses the relationship between local and global ideas, practices and policies concerning reproduction and health across the developing and post-industrial worlds. It seeks to understand the connections between biological and social reproduction: between how the physical processes of childbearing are connected to the reproduction of social institutions and values. The contributions are connected by a common interest in examining the exercise of medical power and the role of state policies and programmes to do with reproduction and health. The concept of 'reproductive health' provides a means of exploring various epistemological positions, and of understanding state ideas and practices relating to planned social change. At a more local level, a focus on the reproductive agency of women and men enables social and cultural responses to the processes of modernisation, in particular to the increasing intervention of biomedicine and reproductive technologies in people's daily lives, to be explored. The focus on reproductive technologies is pertinent in this context because 'reproductive technologies crystallise issues at the heart of gender, reproduction and family relationships and give insight into the engagement with modernity' (Stanworth 1987: 4). Examining the issues raised by reproductive technologies provides a useful insight into the ways in which people understand themselves to be connected (Strathern 1992a, Ginsburg and Rapp 1995, Edwards et al. 1993, Edwards 2000, Becker 2001, Ragone 2000).

Since the late 1980s, there has been a surge in scholarship on the relationship between human reproduction, biomedical technologies, and the related area of childbirth (Martin 1987, Stanworth 1987, Petchesky 1987,

Strathern 1992a, Edwards et al. 1993, Ginsburg and Rapp 1995, Davis-Floyd and Sargent 1997, Lock and Kaufert 1998, Davis-Floyd and Dumit 1998, Franklin and Ragone 1998, Rapp 2001, Edwards 2000, Inhorn 1994, 2000, Inhorn and Van Balen 2002). In anthropology, much of the scholarship on human reproduction was previously 'narrowly cast within the form of androcentrism, ethnocentrism and biological determinism that greatly limited the ways in which reproduction could be studied or analysed' (Franklin and Ragone 1998: 2). As a result, reproduction has only recently become central to social theory (Rapp, 2001: also see Weiner, 1995 for a similar concern).<sup>1</sup> Rapp notes that medical anthropology in particular has benefited from the feminist interrogation of problematic fertility and childbearing, as well as the more general critiques of the mind/body distinction. The current volume engages with these emerging perspectives, but it also addresses certain gaps in the literature.

Firstly, acknowledging that anthropology is not the only discipline to undertake empirically based and critically reflective methodological work in the area of human reproduction, the volume brings together demographic, public health, clinical and political science perspectives alongside anthropological ones to understand fully the local, academic and policy aspects relating to human reproduction. Approached through different disciplinary perspectives, a critical analysis of human reproduction, sensitive to hierarchical relations of power, serves, in turn, to bridge the gaps between, for example, anthropology, public health and demography (also see, for example, Greenhalgh 1995, Kertzer and Fricke 1997, Kielmann 2002, Ravindran and Panda 2002). Secondly, there are still relatively few studies on the engagement with reproductive technologies such as the ultrasound scan, assisted conception techniques, caesarian sections or genetic risk testing in non-Northern, Euro-American and especially 'developing/southern' countries, and amongst people from these regions (the recent work of Morsy 1995, 1998, Gruenbaum 1998, Boddy 1989, 1998, Kielmann 1998, Inhorn 2000, 2002, based mainly in Egypt and Sub Saharan Africa are notable exceptions). This volume aims to move beyond the dominant Northern Euro-American setting of the scholarship on medicalisation<sup>2</sup> to get a broader view of the cultural responses to the reproductive technologies and reproductive health programmes in Sri Lanka, India, Iran, Italy and amongst Pakistani groups in Britain. Going beyond the prevailing models of Euro-American kinship and citizenship, for example, we find that contestations around reproductive technologies take a different form and invoke different understandings of the ways people see themselves as connected.

In the following lines I first explain the three central themes: state power, medical control and reproductive agency, which inform this volume. I then discuss how these are addressed in the different chapters, and contribute to understanding the role of authoritative knowledge, emotions, kinship ideologies, development discourse, fertility, ethics and rights issues in reproductive change.

## The State

State operations in relation to reproduction vary both in terms of the controls exercised upon its citizens and in terms of the reproduction of state values, subjects and institutions. By 'state' I mean 'both an illusory as well as a set of concrete institutions; as both distant and impersonal ideas as well as localised and personified institutions; as both violent and destructive as well as benevolent and productive' (Hansen and Stepputat 2001; 5). In 'southern' countries such as Sri Lanka, India and Iran, which are represented in this volume, development paradigms frame social realities for the people as well as for the state (see section on the state, childbearing and development, below). These, in turn, shape the state's actual and perceived approach to reproduction and, linked to this, people's experiences of governance (Foucault 1978, Moore 1999, Hansen and Stepputat 2001, Gupta 2001) as mediated through the arena of reproduction. Thus, when the issue of fertility is addressed at the level of the state and development organisations, it gains meaning beyond the concerns and anxieties of individuals and their families. The state is both galvanised and controlled by the global discourse on reproductive health and, at the same time, it uses it to produce and reproduce its own mechanisms of status and control. These processes, in turn, have important mental and physical implications for individual reproductive experiences and ideas of citizenship. Apart from the authority asserted by the medical establishment, poorer men and women, especially, must contend with a much more intrusive surveillance from state health officials, as well as with the power of development organisations.<sup>3</sup>

Where population planning and state medical programmes tend to converge, the national concern with the fertility of women in southern states results in experiences of medicalisation very different from those in Northern Euro-American contexts, where medicine and development are more distinct. As Foucault (1973, 1978) suggests, population classification exercises and medical advancement are both expressions of the power of the ideological controls that modern institutions have of the body; in combination, their control is overpowering. Embedded, as they are, within processes of reproduction, women's bodies become key targets of medical advancement, and embody and signify the power of science in late capitalist societies (Martin 1987). In developing countries, women also become key targets of population planning exercises, signifying the 'economic and social progress' of the nation (see overview section below).

## Medicalisation

A central and contested issue in feminist scholarship on the relationship between women and technology has been the extent to which women are empowered by their resort to technological interventions. Popular belief, supported by medical interest, has tended to associate reproductive

technologies with the attendant *choices* that they facilitate, therein enhancing women's control over their own reproductive processes. Yet increasing medical intervention in the area of birth has actually led women to experience a lack of control and a 'fragmentation' of their bodies, generated by the biomedical focus on the partial body or the body in terms of its parts (Martin 1987, Stanworth 1987). Reproductive technologies act as symbols, reflecting the ways in which birth and reproduction remain anchored in patriarchal and late capitalist ideologies, which continue to devalue women's role in social and biological reproduction. As Martin argues, however, such a situation does not preclude women's ability to 'manage their bodies in resistance to prevalent forms of thought that would impose certain regimens of time and behaviour' (according to Strathern 1992a: 67). In other words women's responses to medical intervention in biological reproduction can be quite complex. Feelings of empowerment are themselves connected with women's reproductive consciousness, which is a product of their 'social and biological constitution' (age, class, sexual preference) and individual circumstances (Petchesky 1987: 73).

In their volume on body politics, Lock and Kaufert (1998) suggest that one way of characterising women's complex responses to medicalisation is to describe them as 'pragmatic'. According to Lock, this means that 'individuals are not inevitably made into victims of medical ascendancy (although this clearly happens at times) but act most often on what is perceived by them to be in their own best interests' (2001: 481). Thus, Lock and Kaufert suggest that the dominant response of women to medicalisation is that of ambivalence coupled by pragmatism (1998: 2). The present volume supports this position, and at the same time reveals contexts in which medical authority and intervention are sought with deliberation and experienced as empowering. The chapters here highlight a spectrum of people's engagement with reproductive science and technology, from those who seek it unreservedly as in fertility treatment in Italy or caesarean section births among the middle class in Calcutta, to those who engage fearfully or ambiguously with such technologies, as in the responses to genetic counselling among British Pakistanis or in the case of poor women in rural Rajasthan; and finally to a public disengagement in their use, as found in the ethical debates surrounding Quinacrine sterilisations.

The fact that women may also feel empowered in their engagement with reproductive technologies leads us to focus on the role of physicians in these processes. Although clinicians and health workers play an important role in determining the nature of clients' engagement with medical technologies, their role in enforcing compliance to medical regimes cannot be straightforwardly assumed (see for example, Good 1993 et al., Good 1994). Physicians may also support clients' views and desires against the dictat of the state. Private gynaecological services in India, for example, present clients with opportunities to enhance their child bearing potential, thus helping them to resist state pressure to control their fertility, as may also be the case in Northern Euro-American contexts. In this

context, it becomes important to consider the doctors' own perceptions of medicalisation and their agency in relation to the desires of their patients. Lock (2001), for example, documents the refusal of physicians to carry out tests for a recent gene associated with Alzheimer's disease, despite pressure from families that this be done. Furthermore, the differences in the culture of medical practice (such as the differences between the culture of public medicine and private medicine in India, or in the ways biomedicine is itself practised in the Indian context) may lead to different experiences of medical control.<sup>4</sup>

Aside from the role of biomedicine in governance and the routinisation of state discipline, recent feminist analysis has also critically reflected upon its significance in social reproduction more generally. Haraway (1993), Franklin and Ragone (1998), Rapp (1999, 2001), Ragone and Winddance Twine (2000), for example, show how current medical practices and ideas reproduce differences of gender, race, class, nationality. While the technological engagements described in this volume often have a class dimension to them, the effects of class are almost always qualified by caste, kin and gender ideologies in the contexts which these chapters describe. The material in this volume also challenges us to think about medicalisation in contexts where there are different conceptions of body and society, and where, for example, there may be a more collective as opposed to individual sense of 'ownership' of the body. This means exploring the different ways in which bodies and society are connected in different cultures. As Strathern (1992a: 76) observes in relation to the people of North Mekeo in central Papua New Guinea, bodies are not owned by persons because they are constituted by social relations. When reflected in body imagery, this suggests both social disjunction as well as conjunction, rather than the body as an integrated social whole. Petchesky (1995), on the other hand, shows how the Western idea of the body as individually owned is a recent development and a product of the dominance of Lockean thought which favoured individual over collective notions of property.

The term 'collective ownership', as I suggest in the volume, refers to those instances where the body is primarily constituted through others. Here the connection between notions of body and self involves the mediation of, and negotiation with, others in the social group. In such contexts, the introduction of the techniques of assisted conception may not result in separating women's bodies from their selves, or in conferring an individual identity on the foetus, as they would in societies where bodies are considered to be individually owned (Petchesky 1987, Strathern 1992a, 1992b, Franklin and Ragone 1998, Taylor 1998, Layne 1999). The reproductive technologies in Euro-American contexts have contributed to shaping perceptions of mothers/women and fetuses as distinct entities, even pitting the rights of one against the other (as reflected in the traumas of women who face abortion, for example). Such divisions do not necessarily arise outside these contexts partly because of the way gender dichotomies and reproductive processes in particular, are cross cut by notions of social obligation and responsibility engendered through the

membership of social institutions such as class and caste. This leads us on to the question of the nature of women's reproductive agency in such relatively collectively shaped societies.<sup>5</sup>

## Agency

Since Martin's (1987) study, there has been a continued emphasis on the need to think critically about the body, to continue to interrogate the assumption that the body is a fixed, material entity, subject to the rules of biological science. More recent thinking on the body suggests that it should be understood not as a constant amidst flux, but as the epitome of that flux (Csordas 1994); we should move beyond the tendency to treat the body as a passive entity upon which society imposes its codes towards an understanding of it as a source of agency and intentionality. This phenomenological approach to the body is concerned to develop a model of the body where the body is 'not only subject to external agency but also simultaneously an agent in its own world construction' (Lyon and Barbalet 1994: 48).

The concept of 'reproductive agency' is approached in this volume in terms of the ideas, actions, thinking and planning in the domain of human reproduction by women and men who engage in reproductive activities and seek healthcare services, as well as in terms of the strategies, compulsions and motivations which inform the actions of medical, clinical and health personnel. In the development literature especially, the notion of reproductive agency has tended to equate women in post-industrial countries with agency, while outside these contexts women are perceived as lacking in reproductive autonomy. However, a challenge to this dichotomy is implicit in the recent anthropological literature on the rising intervention of medicine in assisting procreation (Edwards et al. 1993, Franklin 1997, Becker 2001 and others). Contesting the romantic notion of women's reproductive freedom in the West, this challenge portrays, for example, the constraints and lack of choice and helplessness that in vitro fertilisation (IVF) seeking couples experience. Moreover, as the contributions to this volume suggest, the notion of agency itself has to be interrogated. Several chapters in this volume show a clear difference in strongly medically plural societies between seeking medical information, for example through ultrasound scans, and intending to *act* upon the information received. In other words, actions considered 'natural' following a particular technologically assisted medical diagnoses may often not take place, either because the goal of the exercise in the first place was simply to experience the technology and gain information, or because the diagnosis is used to confirm existing ideas, whatever its outcome. Thus, we can have 'reproductive agency' accompanied by a *lack* of visible action. The decision to forgo action, rather than action itself, also reflects autonomy, as Madhok argues in this volume. This assertion is further borne out in the contributions by Shaw, Unnithan-Kumar, Kilaru, Donner and Patel,

whose work is about women who negotiate autonomy within conditions of structural subordination. This approach takes the very embeddedness of women's bodies as a focal point of understanding their agency.<sup>6</sup>

## A Thematic Overview of the Chapters

### *Authoritative Knowledge and Reproductive Agency*

Issues of power and agency are crucially connected to pre-eminent forms and practices of knowledge in society. In this volume, 'authoritative knowledge' (or the dominance of one knowledge system over another; Jordan 1997, Davis Floyd and Sargent 1997) is considered in the face of competing knowledges of reproduction and healthcare at the local level. The authority of medical personnel or of the scientific community is further complicated when, in medically plural societies, it is juxtaposed with other forms of knowledge and authority relating to reproduction and healing. The main questions which emerge from several of the chapters have to do with the framing of authoritative knowledge on health where there are competing knowledges of reproduction, such as technologically-informed knowledge, experientially-based knowledge and knowledge framed by religious and gender ideologies.

In thinking about the interweaving of biomedical and indigenous knowledge on childbirth the idea which emerges in this volume, is that 'indigenous' knowledge systems are not as closed or as bounded as they are often perceived to be. Shaw's chapter on Pakistani responses to genetic counselling in Britain, shows that reproductive decisions are the product of a complex interrelationship between locally based knowledge (as provided by spiritual healers and the experience of childbirth and healthcare in Pakistan and Britain), biomedical knowledge (represented by the genetic counsellors), and social and economic circumstances. The respondents in Shaw's study – the religious experts and the counsellors – all have differing ideas on the Islamic prohibitions relating to genetic testing and the termination of pregnancy. As Shaw's analysis suggests, even the religious interpretations may be modified by religious experts in response to an individual's circumstances.

Kilaru, Mathew, Ramakrishna, Mahendra and Ganapathy's contribution reveals overlaps as well as mismatches in biomedical and local views on postpartum healthcare, with biomedical prescription being followed only where it 'fits' in with indigenous knowledge (for example in the idea of 'rest' following childbirth). Kilaru et al. suggest that women's approaches to health seeking in the postpartum period are influenced by local knowledge about the accumulation and loss of water and blood in pregnancy and childbirth, by ideal type notions of the female body, and by the hot/cold humor based etiology of Ayurveda. In practice, this translates into constraints being placed on postnatal women's consumption of food and water, which contradict biomedical ideas about the importance

of drinking fluids to facilitate breastfeeding. Unnithan-Kumar's chapter demonstrates the selective responses of local healers to biomedical techniques to facilitate conception. Local midwives respond positively to ultrasound scanning techniques, the results of which are used to confirm their own predictive power regarding the state of the foetus and, in turn, serve to raise midwives' prestige vis-a-vis other healers in the community. In so doing, the midwives appropriate women's reproductive experiences much in the same way as, Petchesky (1987) observes, men appropriate women's reproductive experiences in their use of visually linked technologies such as the ultrasound scan, enabling male doctors to reproduce not just babies but motherhood itself.

A key issue for several contributors to this volume is to understand how medical authority is constructed and asserted through the technologies of reproduction. Simpson describes the way that novel reproductive and genetic technologies in Sri Lanka are stimulating debates and interweaving local perspectives on health, body and personhood with contemporary western bioethical discourses. Clinicians in Colombo are caught between the opposing pull of a medical ethics which favours distantly related egg and sperm donors, and the logic of kinship traditions which prefer more closely related donors. In particular there appears to be a desire to use the husband's brother's sperm to achieve pregnancy. For some specialists, these local preferences were to be discouraged, while others believed, as did their clients, that allowing sperm to pass between known persons was the culturally appropriate way to approach the new technologies.

Both Bonacorso and Donner show how the doctors' interests and those of their clients are closely allied and serve to reinforce each other. In the cases of IVF treatment in Italy and caesarean section hospital births in Calcutta, physicians reflect the intensity with which women and couples seek out the relevant reproductive technologies. Bonacorso's chapter describes how clinicians working in private clinics for assisting conception simultaneously employ a highly medicalised language to impose their authority on their patients while using a 'language of common place' to empathise with their clients. The parallel use of two languages assists clinicians in their interaction with the couple and makes programmes of gamete donation, which are highly problematic because egg and sperm of third parties are used to achieve conception, a possible option. The two languages operate in complex ways: they shorten or create distance between clinicians and couples when necessary, and alleviate much of the tension and anxiety attached to the programme.

Donner's chapter describes how urban middle class women in Calcutta believe that amniocentesis, intra-uterine devices (IUD) and caesarean sections are medical technologies used by doctors to promote the health and welfare of mothers and children. These perceptions fit in well with the interests doctors have in the technical interventions which both enhance their authority and, at the same time, due to the great expense of these procedures, bring them good money. The local knowledge of healthcare

provided by traditional midwives, on the other hand, is disappearing with the rise of hospital births where women are no longer 'allowed' to return to their natal homes after giving birth.

In his chapter, Stones, an obstetrician/gynaecologist working in the British health service provides a clinician's perspective on doctor-patient consultations. Focusing on the language of pain related to women's menstrual and chronic pelvic disorders, he discusses the boundaries between medical certainty and uncertainty. He suggests that sociocultural factors are critical in determining when both doctors and patients regard pain as clinically significant. George in her contribution to the volume, also interrogates the medical community's use of highly technical language. Taking the example of Quinacrine sterilisation, George focuses on the activities of specific scientists and doctors involved in research to promote it as a method of contraception. She suggests that Quinacrine researchers are able to influence their medical colleagues by presenting findings in scientific journals, technical fora and seminars, spaces that are rarely populated by critical voices from the non-medical community. George argues for a balance of power between the authoritative knowledge regimes of the scientists and its critics, which, if unchecked, always tend to favour the scientists. She emphasises that the scientific community should not be immune from analyses of how it achieves its authority, or of the social consequences of its pre-eminence.

#### *Ambivalence and Desire in Human Reproduction*

Differing responses to reproductive technologies are often the result of wider negotiations that invoke non-medical frameworks of procreation and are embedded within family and religious life as much as in previous experiences of healthcare. A significant point to emerge in a number of recent studies on reproductive technologies has been the ambivalence associated with the use of the technologies of assisted conception (Edwards et al. 1993, Franklin 1997, Lock and Kaufert 1998, Becker 2001, for example). The studies in this volume also suggest that there may be differing reactions to different reproductive technologies, with some engendering a more positive response than others. As Shaw describes in this volume, her respondents were well-disposed to the use of ultrasound technology, but unwilling to seek further technological intervention if the results showed the baby to be handicapped. We find that local notions of procreation were used to question and resist scientific authority and that rather than prepare for handling a disabled child, the respondents question the dominance and certainty of scientific knowledge.

Unnithan-Kumar describes a similar desire to seek scans as compared with any other technology among Rajasthani women. Further technological intervention is resisted due to a number of factors such as the fear of discriminatory treatment by doctors, fear of the pain accompanying biomedical treatment, notions of what it means to be a good wife and mother and, most significantly, a primacy accorded to spiritual agency in reproductive matters. As I have argued elsewhere (2001, 2002), women's

choice of certain healers and certain techniques reflects a complex inter-relationship between intimacy (the influence of those amongst one's kin whom one is intimate with) and notions of efficacy (healers whose cures are perceived to be effective) and depends on women's poverty and their social position (for example, the extent to which there are other women whose help can be called upon in the household).

The role of feelings and emotions<sup>7</sup> in shaping women's engagement with reproductive technologies and related health services emerges, for instance, in studies of assisted conception in the form of anxieties and fears of patients and relatives (Edwards et al. 1993, Franklin 1997, Layne 1999). However, there has been no direct focus on this in the Euro-American studies, and such a perspective is also absent from discussions of women's health in countries of the South. The work of cultural psychologists (Shweder and Levine 1984, Lutz and White 1986, Lutz and Lughod 1990, Shweder 1994, 2001, for example) and phenomenologists (such as Csordas 1994, Lyon and Barbalet 1994) could be valuably applied to an understanding of the ambivalences that surround women's recourse to biomedical intervention (Unnithan-Kumar 2003a).

#### *Kinship Ideologies and Changing Practice*

Recent scholarship on English and North American kinship<sup>8</sup> (Strathern 1992b, Layne 1999, Carsten 2000) shows how kinship ideologies and practices are embedded within wider social processes such as those of individualism, biological reductionism and consumerism. The recourse to reproductive technologies in these societies reflects this connection and is shaped by it. For example, in the idea that you can buy and sell babies or substances from which babies are created, or in the idea that you can engineer birth to suit your individual requirements, or in the construction of maternal altruism which underlie surrogacy arrangements (Cannell 1990, Strathern 1992a, Edwards et al. 1993, Ragoné 1999). The studies of Ragoné, Edwards and others suggest that the reproductive technologies both change ideas of kinship (such as when parenthood becomes fragmented into multiple social and biological aspects) and at the same time serve to maintain and reinforce the biological (genetic) basis of relatedness in Euro-American societies. For example, in her ethnographic work on surrogacy in the U.S., Ragoné (1994, 1999, 2000) suggests that the increasing popularity of gestational surrogacy (where use is made of donated ova) over traditional surrogacy (where the surrogate mother provides the ova) lies in the priority given by the commissioning parents for there to be no genetic connection between the surrogate mother and the child she gives birth to. So while surrogacy and donated ova are an increasingly accepted method of having children, the importance given to biological relatedness (in that the ova cannot be of the surrogate) continues to define who is regarded as a parent. The demand for such arrangements, as Ragoné describes, comes not only from the intending parents but also from the would be surrogate mothers.<sup>9</sup>

Simpson's chapter in this volume shows how the positive reaction to the reproductive techniques of assisted conception in Sri Lanka stem not only from a desire for 'western goods' but also because they are seen as a means of combating the violence following the recent political conflict within Sri Lankan society. New reproductive techniques are also seen as offering some redress to growing concerns, real or imagined, about the decline in male fertility due to changes in lifestyle, on the one hand, and high rates of abortion, on the other. He goes on to highlight the ways in which for the Sinhalese, aspects of the new technologies are linked to traditional kinship institutions of adoption and polyandry. That is, passing gametes and embryos between persons was regarded as similar to adoption, and receiving the husband's brother's sperm was like the traditional polyandrous relationship, where several brothers shared a wife. These ideas are very similar to Kahn's (2002) recent observations on kinship, 'adultery' and 'appropriate conception' as framing the ultra-orthodox Israeli Jews' acceptance of the IVF technologies. As Kahn suggests, the use of non-Jewish donor sperm to overcome the problem of 'adultery'<sup>10</sup> is a solution perfectly compatible with the ultra-orthodox Jewish notions of appropriate conception, as Jewishness is conferred through the matriline. The IVF techniques are also embraced by the Israeli state, according to Kahn, for they are perceived as a means of replacing community members lost to war at the same time as enabling Israel to maintain a parity with Arab and Palestinian birth rates.

The significance of local ideas of kinship in framing responses to the reproductive techniques is further evident in Bonacorso's chapter on IVF treatment in Italy. Medical doctors use the language and idioms of kinship to strengthen their client's belief in IVF techniques and outcomes. The language used evokes associations of 'naturalness' by connecting the present techniques to a past, non-medical, biological realm of child conception.

The desire for and use of reproductive techniques can be the source of disagreement and conflict within the family and between couples, as the bearing, birthing and nurturing of children is of central importance in gaining social recognition not only by the parental generation but also by grandparents and the wider kin group. Pakistani, Indian or other women in patrilineal contexts in South Asia, need not always be guided by their husband and his family's desires for children. At the same time, the husband may not always contradict his wife's desires not to have children. Women do act on their own initiative in matters of childbirth and this is further reflected in their uptake of reproductive technologies. However, there seems to be greater uncertainty attached to the outcomes when women contradict the wishes of their family than when they acquiesce to them as emerges in one of the cases in Shaw's chapter.

Intrakin conflicts can also be generated by a spatial relocation of the actual place where birth takes place. As Donner shows, the shift to birthing in hospitals associated with caesarian sections among the Calcutta middle-class radically alters the established obligations around birthing

between the two sets of kin related by marriage. What is at stake is the right to provide and partake of postpartum care, and conflicts emerge in the tussle between the birthing woman's parents and her parents-in-law regarding where she should go from hospital. Increasingly, as Donner suggests, hospital births remove women's automatic rights to spend time in their natal homes after childbirth, thereby contravening established rules of kinship. Unnithan-Kumar suggests that the ways in which women respond to ultrasound techniques in Rajasthan is connected with their concern to demonstrate their fertility in response to the social value attached to childbearing and thus leads to a sense of reassurance and bonding with the affinal group rather than with the baby. At the same time, reproductive technologies help to interrogate patrilineal kinship ideologies, through for example, techniques which help counter what is widely regarded as women's errant or pathological reproductive conditions and behaviour, as seen in conditions of infertility.

*The State, Childbearing and Development Discourse*

Ideas on health and biological reproduction play a key role in processes by which the state (as represented by its various agents) is seen to reproduce its own institutions, values and attitudes. One important, recent concern within the anthropology of policy (for example, Shore and Wright 1997) is to consider not just how anthropological perspectives can contribute to the framing of policies but also the importance of anthropological reflection on the ways in which the policies of the government and non-government sectors alike construct their subjects (also see Grillo and Stirrat (1997) for a similar argument relating to an 'anthropology of development' that reflects critically on development discourse). Pigg (1997: 252, 253) demonstrates the practical consequences of health development discourse in its imposition of conformity on midwives to speak a specific language, at the same time as marginalising the importance given to local techniques and ideas of physiology. Focusing on midwifery training programmes in Nepal, she shows how the development practices of 'translation' (of local categories and knowledge) through which practitioners know, classify, manage and thereby 'develop' local traditions, serves to delink local practices of midwifery from their social context. This development practice results in widening the gap between planning processes and local realities, at the same time as presenting the development exercise as authoritative and beyond reproach.<sup>11</sup>

The centrality of midwifery programmes in the state agenda on health planning in itself reflects the significance placed on childbirth as defining women's reproductive experiences and needs. Such a perspective tends to de-emphasise other defining moments in the reproductive process more tangentially associated with childbirth, such as the onset of menstruation or its decline, the postpartum period which occurs just after birth, or conditions such as infertility which are associated with the inability to produce children. Kilaru, Mathews, Ramakrishna, Ganapathy and Mahendra argue in their chapter that in its focus on childbirth as central

to reproduction, the Indian state is unable fully to acknowledge or address the postpartum risks faced by women who have given birth. The postpartum period has received little attention in maternal health planning and policy exercises, despite clear evidence that postpartum deaths in developing countries are more common than deaths during pregnancy and childbirth. In the postpartum phase, in contrast to the antenatal or delivery phase, the mother is physically separate from the child she has given birth to; her health is thus decoupled from the health of the child she has gestated, making it easier to ignore. The state's ignorance of the importance of the postpartum period contrast with the significance it is accorded by members of the southern Karnataka communities which Kilaru et al. studied, where the postpartum period (*bananthana*) is culturally well recognised and defined. Kilaru et al. call into question the mismatch between health policies which emphasise routine care to consist of tubectomies and immunisation, and the local realities of women's postpartum vulnerabilities. In some states in India, such as in Tamil Nadu, there is provision for postpartum care (Van Hollen 2002). Van Hollen describes the state's capacity to 'manoeuvre' and educate Tamil Nadu women in relation to their nutritional practices in the postpartum period, at the same time as constructing them as backward and even criminal (2002: 176). Thus, even in these contexts, we find that the state care provided is limited by specific notions of development that are at odds with local practices.

There is also an important, underlying class dimension to the practice of state health service delivery. Very often, as Pigg and Van Hollen's studies have pointed out (also see Ram 1998), it is poor women who are most subjected to the 'top-down' impositions of health officials. Poorer women are more likely to be subject to development intervention and medical coercion. Unnithan-Kumar (2003b) observes in Rajasthan these women are pressured by public health personnel to undergo tubectomies at the same time as having an abortion. Poor women may resist such impositions through their recourse to indigenous systems of care and this may lead them to be cautious of equating modernity with the use of recently available reproductive technologies. Women from more affluent families can choose the type of health intervention they prefer, and often use wider middle-class ideologies to negotiate along the lines of their desires. Donner's chapter in this volume describes, for example, how the equation of caesarean sections with 'progressiveness' is a key factor in its popularity among the Calcutta middle classes.

The processes by which state health policies and programmes marginalise, stigmatise or completely ignore locally important issues or even categories of people, is also the subject of Tremayne's chapter in this volume. Examining what are considered by many to be progressive population and family planning programmes of the Islamic Republic of Iran, Tremayne finds that the policies ignore the most sexually active and vulnerable group of Iran's population group, i.e., young people under twenty years, but more specifically under fifteen years. Going through the history and political economy of the region, Tremayne shows how state policies in

a religious context can be simultaneously progressive and regressive. Political and economic realities constrain the religious leaders, as is reflected in the shifting nature of reproductive health policies. At the national level, religious beliefs are used to support the shifts in policy emphasis. So while, in the aftermath of the revolution, the Iranian clergy restrain birth control to encourage larger families, in the following decade they are seen as supporting birth control in order to promote economic prosperity, even arguing in terms of its roots in ancient Islamic practice.

In his chapter on the responses to the reproductive technologies in Sri Lanka, Simpson makes a similar argument about the connection between economic and political vulnerabilities of the state, and the politicians' and health planners' promotion of fertility. Simpson suggests that the growing sense of national vulnerability, as a result of the recent conflicts, is reflected in the anxieties around the reproduction of the family and around fertility, especially because of women's resort to abortion and the decline in male fertility. There is the fear that distortion of traditional arrangements for family reproduction will imperil the country's future. In Simpson's chapter we see clearly the parallel between the reproduction of culture, values and institutions of the state, and individual desires for biological reproduction.

Even communities living in post-industrial societies may have state agendas relating to reproduction imposed upon them, and may in turn have ways of negotiating or resisting such impositions. The reproductive practices and possibilities of, especially, the weaker, minority sections are prone to get caught up in the reproductive politics of the state. In the British Pakistani case, discussed in Shaw's chapter, an unintended result of genetic counselling discourse is that it can feed into the politics of race and immigration and further stigmatise the minority community of British Pakistanis deemed 'at risk' of genetic disorders through its marriage patterns. On the other hand, the connection between reproductive risk and migration is played out very differently in the British Pakistani discourse on racism, in which the perception is that there is greater 'risk' in the U.K. compared to Pakistan, where either the religious healers make people better, or fate ensures healthier families. Although the geneticists point to the fact that genetic disorders are likely to be present but less likely to be identified in Pakistan, the British Pakistanis whom Shaw interviewed do not necessarily share this perception.

#### *Fertility, Women's 'Autonomy' and Reproductive Change*

One of the ways in which the study of fertility aims to be connected to social realities – bringing the concerns of public health, anthropology and demography closer together – is through the link that is made between the potential to bear children and women's ability and freedom to make reproductive decisions. Further correlations are made in demographic, public health and development literature between women's ability to control their fertility and their overall health. However, it is less clear, in this literature, whether the primary aim is to control women's fertility, or

to improve their health: the two issues may be less closely connected than is widely imagined. In population planning, the reduction in fertility and number of live births is a primary concern, but its connection with women's health may be more tenuous than health experts believe. In a recent study based on empirical findings from Tamil Nadu, southern India, for example, Ravindran and Panda (2002) question the premise of population transition theory that women's fertility and their overall social and health status are directly related. They suggest that increasing women's autonomy is not a necessary prerequisite for increasing women's use of contraceptives, and that fertility decline (as a result of the increase in use of contraception) does not necessarily lead to improvements in women's health.

Despite the global agreement on the significance of paying attention to women's health as defined by their own concerns, over and above the fertility driven planning processes of national governments, fertility and mortality rates continue to govern the health policies in developing countries such as India (this is not to deride the state and NGO-generated community initiatives in health). Health statistics, whether in the form of fertility and mortality rates or as part of Human Development indicators, continue to constitute authoritative knowledge in health policy and planning decisions (Kielmann 2002: 160) and fertility remains 'situated' within a typical demographic discourse (Greenhalgh 1995).

The issue of the demographic definition of 'autonomy' as related to women is at the heart of the chapters by Madhok and Patel in this volume. Both argue that the demographic understanding of autonomy has failed to pay attention to women's agency primarily because it equates autonomy with individualism. The subordinated conditions of women's lives in the developing world should not be taken as evidence of their lack of agency. In order to recover their agency, Madhok suggests we have to modify individualistic and 'act-centred' conceptions of autonomy. Accordingly, she argues that demographic and public health studies need to recognise autonomy capacities, and that in oppressive circumstances the autonomy capacity of individuals may not translate into actions. Drawing on her study of the village workers of the Women's Development Programme in Rajasthan, Madhok shows that in most cases Sathin women's desires and preferences on issues ranging from childbirth to political participation, are in contrast to their actions. The gap between the development of personal agency and ability to exercise agency needs to be acknowledged, through improved qualitative indicators and narrative methods. Patel, on other hand, argues for a more fluid understanding of social status in demographic literature. These studies complement Kielmann's (2002: 159) interrogation of the social relevance of public health assumptions, where she suggests that the variables used to measure women's status have rarely included discussions of how women themselves define health, how they perceive change and its impact on their well being, and how they situate themselves and respond to the multiple discourses on women's health to which they are exposed. She argues that

perceived morbidity is an important indicator which can tell us far more about social change and its impact on health than do statistical representations.<sup>12</sup>

We question a further assumption in the literature on women's fertility in this volume which is the idea that women in developing countries are only concerned with controlling conception and have no interest in enhancing their childbearing potential (also see Inhorn and Van Balen 2002). The anti-natalist policies of governments in countries where human fertility is connected with the aims of population reduction often contrasts with the reproductive desires of the local people in these countries. In her chapter, George describes how the promoters of Quinacrine sterilisation believe that their method of sterilisation empowers women and addresses maternal mortality, in a process cheaper and easier than surgical sterilisation. However, in contrast to the Quinacrine promoters, access to contraception alone is not a direct solution to maternal mortality as pregnancies may be wanted and planned.

#### *Medical Ethics and Reproductive Rights*

The concept of 'reproductive health' as it is used in population-development programmes is a further example of the irony of development: where rights in the domain of conception and access to healthcare are acknowledged by the state and 'given' to its citizens, but are seldom 'taken' (or made use of) because of the social and economic inequalities which frame such access. The emergence of the concept of reproductive health is closely allied with the contribution of feminist critiques of development policies. Longstanding feminist and health activist concerns regarding the gender injustice of the population and family planning policies of governments were acknowledged only as late as 1994, at the International Conference on Population and Development. Feminists from the North and South argued that the state's control of female fertility could not be regarded as solely a demographic or economic issue but had to be connected to the issues of human rights and welfare (Correa 1994, Sen et al. 1994, Hartmann 1995, Petchesky and Judd 1998).

The issue of ethics around medical practice and state health interventions arises in the context of the concern with institutional accountability and the responsibilities and capabilities of those empowered by the healthcare programmes such as medical doctors and health officials and workers at various levels. In this volume, George's chapter highlights the complex issues and agendas of various institutional agents involved in the clinical trials to establish the efficacy and safety of Quinacrine as a female contraceptive. George stresses the need for large collective institutional mechanisms of accountability, especially significant given the rise of global pharmaceutical and medical networks against whom state controls may be ineffective. The global nature of inequalities generated by multinational corporations together with the cross-national authority of scientific knowledge significantly weakens the authority of the state as a player in the international politics of health.

In countries such as Iran and India (Tremayne and Kilaru et al. this volume) the state may be conscious of the need for regulation but is either caught up in promoting its own agenda or unable to regulate private medical interventions in health. As Rao (1999) and others argue for India, for example, the ethics of the state is compromised by foreign funders such as the World Bank. In the case of Italy, Bonacorso explains that there is a lack of legislation on assisted conception, except for an administrative act which establishes a general rule. The public sector (NHS) can provide any treatment in the field of assisted conception, except when third party gametes are used. The provision of treatment with third party gametes, which is highly controversial, is left entirely in the hands of the private sector.

These realities raise serious questions about safeguarding individual and community mechanisms of reproductive and bodily control. The role of feminist and other health activists becomes crucial in redressing miscarriages of justice in relation to reproduction and health, given the unequal context in which poor women, especially, receive medical care. In the long run, the issue of how reproductive rights are locally conceptualised, and the extent to which these ideas play a role in framing global discourse and national agendas on childbearing, health and development, will be critical (Petchesky and Judd 1998, Cornwall and Wellbourn 2002, Unnithan-Kumar 2003a). Recent anthropological studies make connections between knowledge and ethics, and explore conceptualisations of kinship in ways that inform medical ethics, policy and legislation surrounding the use of the health technologies (Strathern 1992a, Edwards et al. 1993). In the area of ethics and autonomy, Petchesky and Judd (1998), for example, have worked on reproductive rights from a feminist, activist and political theory framework.

Issues of power, knowledge and agency in relation to reproduction are emerging concerns in disciplines and sub-disciplines that include the anthropology of medicine and policy, ethnodemography, health studies, feminist studies, and legal studies.<sup>13</sup> The contributions to this volume complement and, in important ways, extend these emerging perspectives.

## Notes

1. Weiner (1995) holds the lack of attention to reproduction as responsible for the theoretical differences between the more biologically orientated and the more culturally inclined feminists. Weiner argues that women's power should be seen as a synthesis of biological and cultural activities. Weiner suggests that a focus on reproduction enables a better understanding of kinship in particular and social theory in general. She emphasises the role of the political relations of biological reproduction in shaping western political and social histories.
2. Following Lock (1998, 2001), I use the word medicalisation to refer not only to the appropriation of women's bodies as a site for medical practice, but

- also to the social arrangements and political forces that contribute to such experiences.
3. Edwards (1995) addresses a similar issue of the surveillance of poor men and women by the health services in her work in Northern England.
  4. Also see Adams (2002) on how Tibetan doctors characterise 'outside medicine' as representing sinicised biomedicine in relation to their own practice of biomedicine.
  5. I use the word relatively in describing the collective nature of many societies operating outside the frame of Anglo-Saxon ideologies because as Dumont (1966 [1980]) and Parry 1974 have shown, that despite the dominance of a collective orientation of the self in Indian society, individualism is nevertheless practiced and upheld as a value in certain contexts (also see Unnithan-Kumar 1997).
  6. There is no doubt a focus on women's agency in this volume, nevertheless, men emerge as significant reproductive agents in their role as influential kinspersons (as husbands, brothers, fathers), as well as in relation to their position as custodians of authoritative knowledge (as doctors, healers, health officials).
  7. In my use of the word emotion, I follow Richard Shweder's definition of 'emotion' as a complex notion wherein particular emotions of sadness guilt, envy are derived from various combinations of wants, beliefs, feelings and values (Shweder 2001).
  8. I am aware that the term North American kinship is a very generalised one. In fact, recent work on kinship (Carsten 2000, Bodenhorn 2000) underscores the need to qualify such general notions. Bodenhorn's work on the Inupiat of Northern Alaska shows, for example, that for these Americans, biological ties, though valued, may be seen as optional rather than given and need to be considered in terms of the high value given to individual autonomy. Bodenhorn's work presents us with a contrary view to the singular 'essence' of American kinship as portrayed in Schneider's work.
  9. The driving factors behind the demand for gestational surrogacy arrangements come from both the women who act as surrogates as well as from the intending parents. As Ragone (2000) observes, the surrogates prefer this arrangement because it is easier to undertake surrogacy when the child is 'not theirs'. this was especially the case in overcoming the 'problem' of race presented by interracial surrogacy arrangements. Parents also preferred gestational surrogacy as it allowed them a greater choice of ova, and also because they believed in cases of conflict, that the courts were likely to grant custody of the child to the traditional as opposed to the gestational surrogate mother.
  10. In order to overcome the problem of adultery caused by the artificial insemination of sperm of another man, a Jewish woman married to an infertile Jewish man is inseminated by non-Jewish donor sperm (Kahn 2002: 290)
  11. Pigg powerfully argues that what are marginalised as merely custom or belief are in fact 'actual practices through which people care for bodies that are understood in terms other than those of biomedicine' (1997: 247). Her work emphasises the extent to which the idea of development as 'progress', as the idea of leaving behind traditional ways, is entrenched among the people and the state alike and reflected in practices surrounding conception and birth.

12. Kielmann supports Caldwell's position that the positive aspects of this health transition result from the interplay of 'modernising social forces' as well as direct 'biomedical interventions' (Kielmann 2002: 161)
13. In the legal field see, for example, the work of Sheldon (1997), also for an analysis of the recent legislation in the U.K. relating to men's reproductive concerns (1999).

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