BIOPOLITICS AND REPRODUCTIVE INJUSTICE: THE MEDICALIZATION OF REPRODUCTION AND TRANSITION

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ABSTRACT: Sexuality plays a central role in Foucault's philosophy, from his four volume series on the topic to his ideas about medicalization, biopower, and the abnormal. Many of Foucault's concepts, such as governmentality, biopower, and biopolitics, are useful for analyzing the effects of laws and policies regulating reproduction and sexuality. This article brings Foucault's ideas to bear on two aspects of sexuality, reproduction and trans health care, to show how the operations of biopower result in reproductive oppression. We briefly trace the history of the professionalization of medicine and the correlative shift in control over reproduction from midwives to doctors. Next we examine the issue of forced or coerced sterilization of people deemed "unfit" to reproduce; for example, those with cognitive or physical disabilities, non-whites, and poor people, exemplifying how biopolitics is a normalizing force. Biopolitics and normalization permeate trans health care as well, pathologizing trans people as deviant in order for them to be able to access gender affirming health care and imposing norms based on binary and stereotypical gender categories and whiteness resulting in a restrictive transnormativity. Trans reproduction is subject to passive eugenics which makes sterility a requirement for transition related care. We demonstrate how reproductive oppression harms those who are not cisgender, heterosexual, cognitively and physically abled, and white; sex and biological reproduction are at the center of these processes of reproducing white, middle class workers in dyadic heterosexual family relations to perpetuate a 'productive' capitalist system. We conclude by discussing the ways that active and passive eugenics work together in reproducing heteronormativity, the interimbrication of whiteness and heteronormativity, and the implications for citizenship, immigration, and population control in service to the nation-state.
KEYWORDS: Foucault, Biopower, Reproductive Justice, Transnormativity, Trans healthcare.

RESUMO: A sexualidade desempenha um papel central na filosofia de Foucault, desde sua série de quatro volumes sobre o tema até suas ideias sobre medicalização, biopoder e o anormal. Muitos dos conceitos de Foucault, como governamentalidade, biopoder e biopolítica, são úteis para analisar os efeitos das leis e das políticas que regulam a reprodução e a sexualidade. Este artigo traz as ideias de Foucault para relacioná-las com dois aspectos da sexualidade, a reprodução e o cuidado de saúde trans, para mostrar como as operações do biopoder resultam em opressão reprodutiva. Traçamos brevemente a história da profissionalização da medicina e a mudança correlata no controle sobre a reprodução, passando das parteiras para os médicos. Em seguida, examinamos a questão da esterilização forçada ou coagida de pessoas consideradas "inaptas" para reproduzir; por exemplo, aquelas com deficiências cognitivas ou físicas, não-brancos e pessoas pobres, exemplificando como a biopolítica é uma força normalizadora. A

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biopolítica e a normalização também permeiam o cuidado de saúde trans, patologizando as pessoas trans como desviantes para que elas possam acessar os cuidados de saúde afirmativos de gênero e impondo normas baseadas em categorias de gênero binárias e estereotípicas, e na branquitude, resultando em uma transnormatividade restritiva. A reprodução trans está sujeita à eugenia passiva, o que torna a esterilidade um requisito para os cuidados relacionados à transição. Demonstramos como a opressão reprodutiva prejudica aqueles que não são cisgêneros, heterossexuais, com habilidades cognitivas e físicas, e brancos; a sexualidade e a reprodução biológica estão no centro desses processos de reprodução de trabalhadores brancos, de classe média, em relações familiares heterossexuais diádicas para perpetuar um sistema capitalista "produtivo". Concluímos discutindo as maneiras como a eugenia ativa e passiva trabalham juntas na reprodução da heteronormatividade, no entrelaçamento entre branquitude e heteronormatividade, e nas implicações para cidadania, imigração e controle populacional a serviço do Estado-nação.
PALAVRAS-CHAVE: Foucault, Biopoder, Justiça Reprodutiva, Transnormatividade, Saúde Trans.

I. Introduction

Foucault's varied and wide-ranging work covers epistemological, ontological, methodological, socio-political and ethical fields. Many of his genealogical works trace the development of institutions in the 19th century to reveal the mechanisms behind shifts in frameworks of governmentality–particularly how sovereign power becomes diffused into state regulations though biopower. Far from being irrelevant forty years after his death, Foucault's theoretical contributions serve as important tools to illuminate contemporary operations of power. This article looks at the ways that the complex nexus of sex-gender-sexuality is regulated by using Foucault's concepts of biopower, discipline, normality, and governmentality to analyze the way that the heteropatriarchal norms governing sexuality reinforce the institution of the white, cis- able-bodied, hetero family as normative through eugenics and through pathologizing those who do not fit into this normative model. Repronormativity (Franke 2001; Weissman 2017) links heterosexuality, whiteness, and cisness together through sex, which Foucault (1980, p. 154) defines as: "anatomical elements, biological functions, conducts, sensations, and pleasures" grouped together into a "fictitious unity" that can be cited "as a causal principle, an omnipresent meaning, a secret to be discovered everywhere". Sex becomes the lynchpin not only for understanding ourselves as Foucault argues in *History of Sexuality, vol. I,* but also forms of control through the exertion of power. Bringing together Foucault's concepts of biopower, discipline, normalization, and governmentality with an intersectional reproductive justice framework we examine how the same normative mechanisms function to oppress those who do not fit the white, hetero, cis norm through controlling both sexuality and reproductive capacities.

In this article, we briefly trace the history of the professionalization of medicine and the correlative shift in control over reproduction from midwives to doctors. Medical professionalization goes hand in hand with regulation by the state–formal education, medical board examinations, licensing. In turn, this confers status and legitimacy on doctors who make decisions about reproduction–who is fit to reproduce and who is not—according to state directives and laws that align with the maintenance of a smoothly functioning capitalist society. Forced or coerced sterilization of people deemed "unfit" to reproduce–those with cognitive or physical disabilities, non-whites, poor people, and those viewed as morally degenerate, such as sex workers–served as the rule rather than the exception exemplifying the complex operations of biopower through normalization, medical authority, and laws or lack thereof. Biopolitics and normalization permeate trans health care as well, pathologizing trans people as deviant in order for them to be able to access gender affirming health care and imposing norms based on binary and stereotypical gender categories and whiteness resulting in a restrictive transnormativity. Trans reproduction is subject to passive eugenics (Radi, 2020) which makes sterility a requirement for transition related care. We demonstrate how reproductive oppression harms those who are not cisgender, heterosexual, cognitively and physically abled, and white; sex and biological reproduction are at the center of these processes of reproducing white, middle class workers in dyadic heterosexual family relations to perpetuate a 'productive' capitalist system. We conclude by discussing the ways that active and passive eugenics work together in reproducing heteronormativity, the interimbrication of whiteness and heteronormativity, and the implications for citizenship, immigration, and population control in service to the nation-state.

II. Foucault and Biopower

Many scholars find Foucault's analytics of power — which encompasses the link between the social body and the individual body — extremely useful for discussing issues of sex, gender, and sexuality. For Foucault, power is relational and pervasive operating between and among people, policies, and institutions, and through norms, laws, discourses and practices. Power functions at the micro and macro level; discipline is a form of micro-power operating directly on the body. Disciplines emerge from spatial relationships and from institutional arrangements; they affect the body at the level of behavior and gestures. Disciplines may be initially imposed from the outside but they often become internalized and persist through self-surveillance. While the concept of discipline addresses the way that power operates on

individual bodies, the idea of biopower concerns the way that power functions through the social body.

Biopower involves the control of populations with the aim of regulating birth, death, reproduction, health, life expectancy, and migration (Foucault 1980, p. 139–40). Biopower and biopolitics operate at the state level and must be seen in the context of the management of state and local forces. According to Foucault, biopolitics "aims to treat the 'population' as a set of coexisting living beings with particular biological and pathological features, and which as such falls under specific forms of knowledge and technique" (Foucault, 2007, p. 367). The knowledges and techniques of biopolitics serve the interests of capitalism. Foucault claims: "This biopower was without question an indispensable element in the development of capitalism; the latter would not have been possible without the controlled insertion of bodies into the machinery of production and the adjustment of the population to economic processes" (Foucault, 1980, p. 141). Biopower – the control of life through policies, practices, and regulations – arises within the context of the increase in knowledges and administration. It clearly articulates a connection between the microphysics of power (bodies, identities) and macro-power (populations, identity categories).

While biopolitics operates at the state level, Foucault's concept of governmentality operates transnationally. Governmentality links the idea of state power to individuals; the state operates upon individuals through tactics and strategies. However, Foucault explicitly distinguishes his idea of governmentality from government or state. Governmentality on Foucault's account does not replace a sovereign state or a disciplinary society but exists in tandem with them. He describes the relationship among sovereignty, discipline, and government as a triangle that works through apparatuses of security and whose primary target is the population (Foucault, 1991, p. 102). Governmentality includes a range of strategies and tactics used to achieve certain ends, such as population control or public health. This may include laws, policies, institutions, programs, or the circulation of specific information.

Foucault's idea of governmentality encompasses a broader notion of government than politics or the state; it includes government, population, and political economy. Hence governmentality is a form of power that exceeds state boundaries and is not primarily legislative or judicial. It is a form of power that precedes the formation of the state (Foucault, 2007, p. 109). As a form of power not confined to state territory or limited by exercising forms of state power, the idea of governmentality is useful for analyzing the ways power operates both within and across state boundaries.

Biopolitics and governmentality help to explain the ways that populations are regulated and controlled both through explicit laws and policies and through implicit social norms. With regard to sexuality, laws, policies, and norms control access to reproductive and sexual health care.

Foucault's ideas about abnormality and marginalization also serve as useful tools for analyzing the ways that sexuality has been regulated to produce normalized white, cis-, heterosexual bodies that reproduce the same through the traditional family structure. Prior to his multivolume series on the history of sexuality, Foucault explored the concept of abnormality in his 1974-75 lecture series at the College de France. His genealogy of the construction of the concept of abnormality through medicine and psychiatry reveals that: "the birth [...] of the field of abnormality, and then the crisscrossing, if not the subdivision, of this field by the problem of sexuality, are more or less contemporaneous" (Foucault 2003, p. 168). It is no coincidence that the emergence of sexuality and abnormality both occurred in the 1800's, which as we shall see was the same time that the practices of healing shifted from women to men and from community-based knowledges to a professionalized field of medicine. The medicalization of reproduction disempowers those who seek reproductive health care, such as IVF, hormone replacement, abortion, pregnancy care and childbirth as well as the midwives and doulas who have historically assisted women with their reproductive health care needs.

Reproduction and reproductive health care are sometimes portrayed as individual issues of choice but both occur in a larger social, political, and economic context in which the state plays a major role in regulating and controlling reproduction. Feminists have sought to push back against state regulation of reproduction not only through fighting for reproductive rights, such as legal abortion, but also through the more comprehensive framework of reproductive justice.

III. Reproductive Justice and Intersectionality

The reproductive justice movement founded by African American women in the United States in 1994 emerged out of the concern that the reproductive rights movement was focused too narrowly on abortion. Focusing on the right to terminate a pregnancy reduces reproductive rights to individual choice and confines the scope of reproductive health. This limited focus neglected to address the wide range of reproductive issues, such as forced sterilization, IVF, surrogacy, pre- and post-natal care, and appropriate conditions for raising children, such as economic stability, food and housing security, and a safe environment (Ross

and Solinger, 2017; Ross, 2017). While some of these concerns may be widely shared across racial and ethnic groups (food and housing security, safe and secure environment for raising children), other issues, such as forced sterilization, disproportionately targeted Black, Latinx, and Indigenous women (Smaw, 2021; Gutierrez, 2015). The reproductive justice framework revealed the implicit racial and class biases of the reproductive rights movement, which could focus on abortion as the most pressing concern for middle class, cisgender, heterosexual, abled, white women because they were not generally subjected to forced sterilization and other reproductive injustices. Reproductive justice from its inception emerged as an intersectional framework that acknowledged the various vectors of oppression and the ways in which they positioned different members of society differently depending on their social group membership and identities.

Asian Communities for Reproductive Justice defines reproductive health broadly: we believe reproductive justice is the complete physical, mental, spiritual, political, economic, and social well being of women and girls, and that it will be achieved when women and girls have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities. For this to become a reality we need to make change on the individual, institutional and social levels (2010).

We take an expansive reproductive justice approach that considers both the targeting of cis women for control over their reproduction and the medicalization, pathologization, and reproductive oppression of trans people. Taking up Asian Communities for Reproductive Justice's call for institutional and social change, we examine the history of reproductive injustice as a site of racial, sexual, gender, and ableist normativity and control. Race and sex have a common genealogy, as Ladelle McWhorter (2004, p. 39) notes: "Race and sex arise as elements within some of the same population management strategies, are dependent upon many of the same assumptions about human life and governmental responsibility, and are constructed by some of the same disciplinary means". We note that not only sex and race but also gender and ability emerge and are controlled within the biopolitical framework. Moreover, repronormativity– that only certain types of reproduction are legitimate and are subject to state control–serves nationalist and capitalist interests at the expense of those subjected to the demands of biopower to produce children as future citizens and laborers.

In what follows we trace the medicalization of reproduction, the population and birth control movements and we discuss how normalization, discipline and biopower have converged in the practice of sterilization abuse. Then we look at the way that biopower and biopolitics operate through normalization to construct trans subjects as pathological and medicalized. In turn, trans subjects are denied reproductive health care and the possibility of having children. We conclude by discussing the ways that Foucault's ideas provide the bridge to understand the complex operations of biopower through the regulation of sexuality and reproduction.

IV. Reproductive Injustice

A. Medicalization of Childbirth and History of Planned Parenthood

The regulation of reproduction through biopower involves the interplay of changes in the economy, medicine, and morality. In medieval Europe the church associated any form of contraception with heresy. The power of the church to shape behavior rested in part on its ability to define the limits of morality, associating immorality with unwanted behaviors: "heresy became associated with reproductive crimes, especially 'sodomy,' infanticide, and abortion" (Federici 2004, p. 36). In turn, morality and its power over reproduction was shaped by economics; concern about reproduction was heightened as a result of a labor shortage in the 14th century leading to an imperative to reproduce (Federici 2004, p. 36). Pronatalism shores up capitalism, militarism, and nationalism. In her history of control over women and the emergence of capitalism, *Caliban and the Witch*, Silvia Federici underscores Foucault's point that: "biopower was without question an indispensable element in the development of capitalism" (Foucault 1980, p. 141) noting "in all phases of capitalist development, the state has had to resort to regulation or coercion to expand or reduce the work-force" (Federici 2004, p. 91). State control of reproduction fueled the medicalization of childbirth and reproduction "the state has spared no efforts in its attempt to wrench from women's hands the control over reproduction, and to determine which children should be born, where, when, or in what numbers" (Federici, 2004, p. 91).

Foucault takes up the issue of the increasing codification and professionalization of medicine in *The Birth of the Clinic* noting, "Medicine made its appearance as a clinical science in conditions which define, together with its historical possibility, the domain of experience and the structure of its rationality" (Foucault, 1994, xv). Likewise, in their classic work, *Witches, Midwives and Nurses,* Barbara Ehrenreich and Deidre English document the history of the professionalization and male takeover of medicine by discrediting women healers. They make

a compelling case that gender and capitalism worked together along with patriarchy to replace women's healing practices with male doctors and health professionals. As they aptly put it: "The stakes of the struggle were high: Political and economic monopolization of medicine meant control over its institutional organizations, its theory and practice, its profits and prestige. And, the stakes are even higher today, when *control of medicine means potential power to determine who will live and will die, who is fertile and who is sterile, who is 'mad' and who sane*" (Ehrenreich and English 1973, 4 emphasis ours). During this shift to a male-dominated professionalization of medicine in the 1800's, midwives and doulas were forced to report when women were pregnant or miscarried enlisting them as part of the apparatus of biopower to regulate birth, reproduction, and health (van der Waal, 2024, p. 10-12). Moreover, "the knowledge and practices of midwives and healers regarding contraception and abortion were forbidden, resulting in women having more children from younger ages onwards than had been the case in the Middle Ages" (Federici, 2004, p. 88–89). This overt exercise of power coincides with the emergence of biopower, the field of medicine and the field of psychiatry; they worked together to classify individuals as normal or abnormal, sick or healthy, rational or hysterical.

Biopower operates at the individual level by controlling reproduction as well as at the social level by concerning itself with populations. While the birth control and family planning movement is often heralded as an advance for women in controlling their own bodies and reproductive capacities, it grew out of a concern with population control. Margaret Sanger, founder of the birth control movement in the United States and Planned Parenthood, endorsed the Malthusian idea that poverty is tied to overpopulation. She has been both celebrated and vilified for her early role in the birth control movement. As a public health nurse in the United States in the early 1900's, Sanger had witnessed preventable deaths from self-induced abortions as well as women dying in childbirth. She campaigned for women's access to safe and legal contraceptives so that women would have more control and autonomy over their reproductive lives (Ross, 2017, p. 65). However, as Reproductive Justice theorists note, her 'good intentions' were both intertwined with and resisted the eugenist and racist thinking of the time period. Although Sanger explicitly distanced herself from the leading eugenists thinkers of the day (Roberts, 1997, p. 73-75), she still accepted two tenets of eugenicist thinking. She believed "that social problems are caused by the reproduction of the socially disadvantaged and that their childbearing should [therefore] be deterred" (Roberts, 1997, p. 81).

Sanger's complicated relationship to her advocacy of birth control to increase women's choices and autonomy versus her Malthusian and eugenicist beliefs that social

problems such as poverty are caused by, and thus can be solved by, population control carried over to her international work. In 1952, coinciding with the founding of the International Planned Parenthood foundation, Sanger gave a talk in Bombay linking large family sizes with national instability (Wilson, 2017; Green 2018, p. 5). Her talk served as the impetus for India's government investment in population control; this emphasis on population control of the "socially disadvantaged" (read poor, disabled, minority, lower caste/Dalit, Adivasi and Muslim) populations can be thought of as the exporting of the eugenics program in the US to India. It can also be viewed as one way that biopolitics extends beyond individual nation-states to connect the concern with population control to racist stereotypes about hyper-fertility and fear of uncontrolled immigration (xenophobia). India was the first country in the world to institute a Family Planning Program with the explicit aim of population control; it was largely funded by the Ford Foundation in the United States (Singh, et. al., 2012). Not coincidentally at this same time, foreign development aid from Sweden and Norway was directed toward family planning, specifically sterilization programs (Hogberg, 2008). Under the guise of the Family Planning Program in India, sterilization for both men and women was introduced in 1966, and by 1967 the government was providing cash incentives for sterilization. Evidently, "[t]he intertwining and conflation of international pressures about family planning with population control indicates that 'family planning' is less about women's autonomy and control over their bodies than it is about international and state control over women's reproductive lives" (Rajat and McLaren, 2023, p. 90). Here we see the workings of governmentality through linking population control and fear of national security to economic prosperity.

B. Sterilization

The United States has a long history of using sterilization ostensibly to reduce population while targeting racial and ethnic minorities, as well as disabled and poor people. In the United States sterilization was widely used in the 1930s and 40s on people considered 'feeble-minded' and or those with 'criminal tendencies.' This type of eugenics weeded out those who were considered undesirable. Usually these sterilizations took place in institutions and were often a condition of being released from confinement. At the time, laws supported sterilization with or without the patient's consent. In 1927, in the infamous case of Buck v. Bell, the United States Supreme Court ruled that states could sterilize people if it believed their offspring would be a burden on society. Foucault charts the punitive measures against those who lacked rationality in *Madness and Civilization,* noting, "Madness-Disorder relations

centered on the theme of social and moral order" (Foucault, 1965, 170). Carrie Buck was portrayed as an "imbecile" by the Court but was more likely singled out for sterilization because her mother was a prostitute and was viewed by the community as a moral degenerate. The majority opinion of the Supreme Court justified its decision in part by stating that, "Three generations of imbeciles are enough" (Lee, 2009).

Control of reproduction through forced sterilization focused on those who were institutionalized or viewed as unfit or degenerate: "Madness was individualized, strangely twinned with crime" (Foucault, 1965, 228). The justifications emphasized their unfitness as parents, the burden that would be placed on society if the 'unfit' were allowed to procreate, and the benefit of 'weeding out' those perceived as criminal or lacking average intelligence. In other words, sterilization focused on the socially marginalized. Those justifications often cloaked other equally pernicious reasons for sterilizations, such as class and racial bias. Eugenics boards made decisions about who should be sterilized on the basis of very little information, but it usually included IQ rating and social and economic background. According to one Eugenics Board member: "We may well have sterilized some folk who weren't that much retarded" (Stern, 2005, p. 154). The majority of those recommended for sterilization were poor and uneducated.

In the mid-1970's eugenic sterilization because of mental illness or cognitive disabilities was no longer supported by most states' laws, nor by popular opinion. However, a new sterilization campaign was being waged, targeting poor women and women of color. In 1973 two young Black girls, the Relf sisters ages 12 and 14, were sterilized without their knowledge by Montgomery, Alabama Community Action Council's Family Planning Clinic. The reason for their sterilization—social workers had seen them with boys and wanted to prevent the possibility of future pregnancy if the girls were to become sexually active. The girls' mother, who was uneducated and illiterate, signed a form that she believed gave permission for her daughters to get birth control. Once she discovered that her young daughters had been sterilized, she was outraged and the Southern Poverty Law Center filed a lawsuit on her behalf. This brought widespread attention to the sterilization abuses that were rampant in the US at that time.

Another example of racist eugenics in the United States occurred in the mid-1970's in California where doctors performed involuntary sterilization on a large number of working-class women of Mexican origin. In this case, the women had been persuaded to undergo sterilization just after delivering their babies by Caesarean section. The women were in pain

and still under the influence of anesthesia from the surgery, clearly not ideal circumstances for making irreversible life decisions. In three of the cases no consent was obtained and in the other cases, consent was granted under duress, or patients were lied to or misinformed. These circumstances mean that informed consent was not obtained in any of the cases. In addition to the element of coercion present in these involuntary sterilizations, they were funded by federal agencies as part of the family planning initiatives included in the strategy of the "war on poverty" (Stern, 2005, p. 200). Additionally, medical residents pressured the women into getting tubal ligations so that they could meet the quota necessary for their medical training.

In the mid-1970s a class action suit was filed on behalf of the working class Mexican women in California who had been subject to involuntary sterilization. In 1979 the state of California finally struck the statute that allowed for involuntary sterilization from state law, after it had been on the books since 1909. Alabama and California were not alone in retaining involuntary sterilization laws until the 1970s, and there are a number of sterilization abuses recorded.

Shockingly, in the United States 31 states still have laws that allow permanent, forced sterilizations; the vast majority of these are carried out on children with disabilities (Luterman, 2022). Low-income women of color were specifically targeted for these federally funded sterilizations; one judge estimated that in the early 1970s alone, "100,000-150,000 low-income women had been sterilized under the auspices of federal programs" (Stern, 2005, p. 202). In 1973, 43% of all government sterilizations had been carried out on African American women. Native Americans, too, suffered disproportionately under this genocidal program of forced sterilization, between 1973-1976 more than 3,400 Native American women in just four states had undergone federally funded sterilization. Shockingly, by the late 1970s between 20-50% of all Native American women of childbearing age in the US had been sterilized without their consent. Likewise, Puerto Rican women both on the island and in New York City reported large numbers of non-consensual sterilizations. Because many of the sterilizations targeted poor women, one tactic used by social workers, medical professionals and government officials was to threaten to eliminate welfare benefits if the surgery was refused.

Recently, immigrants from Latin America were subject to forced sterilization while they were held in detention camps in the United States. Through these forced sterilizations primarily on women of color we can see what Foucault calls "state racism" at work (Foucault 2007, p. 61), as he notes the focus shifted from protecting the state from outside 'enemies' to protecting it from 'enemies from within: "we have to defend society from all the biological

threats posed by the other race, the subrace" (Foucault, 2007, p. 61-62). In these examples in the United States, we see the insidious operations of biopower at work; it is the putatively undesirable who are the target group for sterilization, those who are impoverished, the mentally and physically disabled, and ethnic, religious, and racial minorities. In Foucault's terms, it is the marginalized, the subaltern that are the target of violence, both social and physical, which is legitimized by the pathologization of these populations as abnormal.

V. Trans Biopolitics

A. Biopolitics and Trans Medicalization

Trans healthcare has a long history of pathologizing trans identity as something in need of 'correction,' and has been critiqued for the imperative, once explicit and now largely implicit, to normalize one's gender in line with dominant norms of heterosexuality and whiteness. And, contemporary trans healthcare is one of the primary targets of the rising wave of anti-trans legislation across the world.[3] Foucault's work on biopolitics and governmentality is helpful in formulating a critique of both the medical and psychiatric models for their pathologizing functions, and of the state's objectives of controlling and disciplining trans bodies and populations. Focusing on the disciplinary mechanisms of trans medical and psychiatric care shows that whiteness and heteronormativity remain at the center of the gendered and sexual regulation of trans populations.

Foucault (1980) argues that the *scientia sexualis* functions by claiming neutrality to present a 'truth' of sex; scientific discourses on sex are legitimated as having authority. This authority is particularly suspect for Foucault since scientific discourses construct, medicalize, and pathologize 'otherness.' Focusing on the development of discourses on transness within the medical and psychiatric institutions explains the mechanisms through which medicalization functions to construct the pathologization of transness.

The psychiatric model of dysphoria as a diagnosis sustains the pathologization of transness by establishing distress at the center of trans identity and medicalization as the 'cure.' Moreover, the psychiatric processes of diagnosing gender dysphoria serve to reify the authority

[3] For instance, in the United States, over 600 anti-trans bills were introduced in 2023 alone, tripling the previous year's record high. As of October 2024, the number of anti-trans bills introduced has already eclipsed that of 2023; the second largest category of these bills, only slightly behind those targeting education, are bills seeking to prohibit access to gender affirming healthcare (Trans Legislation Tracker). In the UK, the rise in Trans Exclusionary Radical Feminist (TERF) rhetoric has been well documented in its influence on laws and institutional policy, particularly as it concerns healthcare access (McLean, 2021). India's Transgender Protection of Rights Act 2019 has also faced significant backlash for its harmful impacts on trans communities, especially in enshrining medicalization as a condition for legal recognition.

of psychiatric institutions and legitimate their role as 'masters of truth' in scientific discourses. Constructing a gender dysphoria diagnosis as essential to being legitimately and legibly trans props up a regulatory script for transness that is binary and relies on medicalized transition, or transnormativity.

One of the central imperatives of transnormativity is to fit one's transition into a given model that is 'correct' because it adheres most closely to a linear, binary, and Western understanding of gender and trans identity. A transnormative framework assumes that all trans people experience transness the same way: they conform to the narrative of being born in the wrong body, they all require medical treatment, and they all should and do seek to present and be perceived as cisgender and binary (Riggs et al., 2019 p. 913). The goal of diagnosis and medical transition becomes embodiment in line with this transnormative narrative. An analysis that employs Foucauldian biopolitics is useful here in understanding how this process of medicalization aims to govern trans populations by imposing practices of discipline and normalization that then simultaneously exclude and pathologize those that do not adhere to this model.

The emergence of trans identity within the DSM and the development of the naming and diagnostic criteria over its various iterations illustrate the ways in which the pathologization of transness is constructed and sustained through the psychiatric model. From the DSM-III in 1980, which was the first edition to include psychiatric diagnostic criteria for trans people to the most recent DSM-V 2013, the diagnosis has moved from the terminology of "gender identity disorder" to now using "gender dysphoria" as well as a change in classification away from its original place in the "paraphilias and sexual dysfunctions" section (DSM-III-R 1987; DSM-III-R 1987; DSM-IV 1994; DSM-IV-TR 2000; DSM-V 2013; Zucker and Spitzer 2005; Drescher 2015). These changes were ostensibly an attempt to move away from the stigmatization of trans people as 'disordered' and to highlight the distress of dysphoria as central to the trans experience. Even with these changes, inclusion in the DSM is part of a larger system of marking certain people as deviant; this demonstrates the possibilities of coalitional solidarity between trans people, neurodiverse people, and other advocates of anti-psychiatry. Instead of reclassification within the DSM or removal from it altogether, a more radical Foucauldian approach would be to question the systems of power encoded in psychiatry.

Moreover, when dysphoric distress is established as the "core component of the diagnosis" (American Psychological Association, 2013, p. 453), it means that psychiatrists are tasked with determining whether an individual's distress is sufficient to diagnose them with

gender dysphoria. Psychiatric involvement becomes a prerequisite for healthcare provision and legal pathways of gender affirmation, which cements the power of psychiatrists in determining who is recognized and legitimized as trans (Davy, 2015). Thus, even if the change in diagnostic criteria and terminology can serve as a means of destigmatization, it still functions the same in terms of its operation in gatekeeping transitional medical care through psychiatry. The power and authority of psychiatric institutions is bolstered. As Foucault (1980, p. 54) points out, these discourses serve to construct and pathologize 'otherness,' and the "supreme authority" of the psychiatric and medical institutions as the determiner of who is trans.

When procedures for gender affirming healthcare are regulated through the psychiatric model, this "promotes regulatory, binary gender expression and denies access to medical procedures to those who fail to perform normative binary gender for their health care providers" (Spade, 2003, p. 18). This creates the imperative for trans people to articulate their experiences in line with "normative binary gender," regardless of whether this accurately or adequately describes their experience.

Not only do psychiatric institutions have the power to determine who is trans, they are also equipped with the power to determine "*how* to be properly transsexual. The only "acceptable" way to be transsexual is to desire to transition wholly from one side of the binary to the other" (Vipond, 2015, p. 25). This homogenization of trans experience is flattening, dehumanizing, and harmful, and it further sustains the pathologization of non-transnormative subjects. Those trans people that do not fit into these normative criteria are "simultaneously sick, as gender nonconformists, while not being sick enough—as cross-sex identification is the basis for a diagnosis—to access healthcare. Consequently, trans persons are pathologized regardless of the diagnosis. This creates a hierarchy of deviant and non-deviant, sick and no-longer-sick, normative and nonnormative trans persons" (Vipond, 2015, p. 29). So, binary trans people who conform to the diagnostic criteria are constructed as sick and in need of treatment in terms of trans healthcare, while on the other hand, gender nonconforming trans people or those who do not fall within these transnormative confines (or fail to adequately pretend to conform) are constructed as 'not sick enough' to access healthcare, but are pathologized as deviant regardless. It is also important to note that hardly any trans people are able to (if they even want to) actually embody transnormativity; rather, it acts as an ideal that props up medical and psychiatric institutional power.

Medical institutions providing trans healthcare also rely on "increasingly stringent" expectations from trans patients (shuster, 2021, p. 24). The mandate to normalize one's gender

in line with medical norms can be so strong, stef shuster (2021, p. 34) argues, that those who failed to meet them "were subject to the regulatory power and surveillance of the medical community and would be denied access to care". According to shuster, the drive toward normalization of gender presentation was integrated into transgender medicine, and providers were concerned with making sure that the administration of surgical and hormonal interventions was in line with this goal of "more gender conformity" (shuster, 2021, p. 35).

Transnormativity is also deeply intertwined with whiteness, and relies on a white, Western understanding of gender. Within processes of diagnosis, "trans persons of colour are expected to uphold ideals of white femininity and masculinity if they wish to gain access to medical services" (Vipond, 2015, p. 32), and conformity, nonconformity, dysphoria and euphoria are all framed in line with a limited understanding of gender. Class privilege is also tied in with transnormativity, as procedures are often expensive and insurance coverage is inconsistent. The norm excludes trans people of color, and the insistence on hormone treatment and surgery may also leave out poor and working class trans people who face financial barriers to access; through these exclusions, "a hierarchy of gender normativity" (Vipond 2015, p. 36) is created where assimilation of transnormative individuals is rewarded, but those who cannot or will not assimilate are denied care. Class and race discrimination also overlap in shaping trans medicine, as shuster's interviews and ethnographic research with medical providers show. shuster points out that "white trans people who held steady employment were perceived as the most suitable candidates for physical interventions" (shuster, 2021, p. 44), and provides examples of people being turned away for an inability to prove that they were "productive citizen(s)" (shuster 2021, p. 44).

Within the Foucauldian framework of biopolitics, Susan Stryker understands these psychiatric and medical processes as institutionalized mechanisms through which power operates. Indeed, Stryker argues that gender itself is "an apparatus within which all bodies are taken up, which creates material effects through bureaucratic tracking that begins with birth, ends with death, and traverses all manner of state-issued or state-sanctioned documentation practices in between" (Stryker, 2014, p. 39). Gender becomes consolidated and normalized through the repeated reinforcements of what is 'normal' and what is 'abnormal' within medical and psychiatric institutions. Trans people face scrutiny and surveillance at every step of the process, intensified by the medical and psychiatric imperatives to both demonstrate 'real' trans identity and to prove they can sufficiently assimilate into binary heteronormative gender

presentation to access care. Foucault's work on discipline and the abnormal is helpful in clarifying the techniques of pathologization embedded in trans healthcare.

B. Biopolitics and Trans Reproductive Justice

Foucault articulates biopower as operating at the level of the individual body as well as at the level of populations; sexuality acts as the apparatus that conjoins these two levels. In exploring the application of biopolitics to the regulation of trans bodies and populations, medicalization and pathologization help illuminate the effects of one aspect of the "apparatus of sexuality." The other aspect of how sexuality operates in a biopolitical formulation is the regulation of reproduction: both at the level of the body's reproductive capacity, and in terms of the reproduction of the population. By drawing on work that applies the framework of Reproductive Justice (RJ) to trans reproduction, we show the biopolitical operations of the state in controlling reproduction so as to discourage and curtail the reproductive capacities of those deemed to be 'unfit' for parenthood (particularly motherhood) through "passive eugenics." And, we demonstrate that race and heteronormativity are the throughlines of the control exercised over trans reproduction.

Policies governing trans healthcare often require trans people to choose between transition and reproductive autonomy. While such policies do not explicitly prohibit trans people from reproducing**,** the effect of this forced choice is still a discouragement of trans reproduction. According to Blas Radi, since the effect if not the intent of these healthcare policies is the curbing of reproduction, they constitute a form of 'passive eugenics' (Radi, 2020; Bowman, 1996).

A range of trans healthcare policies operate in this passively eugenic manner. Restrictions on trans people's reproduction are often framed as necessary, either medically, socially, or legally; institutionally, "infertility [is positioned] as an integral component of gender recognition for trans people" (Lowik, 2018, p. 425). Explicitly instituting sterilization as part of the process of gender affirmation, neglecting to inform patients that sterilization might result from procedures, or failing to provide adequate options for fertility preservation all enshrine these views into healthcare policies. Twenty-two European nation-states still had requirements for forced sterilization as a condition for legal gender recognition until 2017, when it was ruled as a human rights violation by the European Court of Human Rights. In many places, however, less explicit language may still mandate gender reassignment surgery; while this does not necessarily mean sterilization, the lack of clarity often means that medical or legal

professionals have the capacity to determine what is sufficient for legal recognition (Lowik, 2018). Even in situations without explicit sterilization requirements, patients are not provided adequate information about potential risks of fertility loss, or are not given options for fertility preservation via sperm or egg banking. Moreover, even though fertility preservation is increasingly becoming part of medical conversations, freezing eggs and sperm can be prohibitively expensive, preventing many trans people from accessing these services (shuster 2021 citing Martin 2010; Bakko and Kattari, 2019; Streed, McCarthy, and Haas, 2018).

Under a transnormative framework, trans people are expected to follow a normative linear trajectory of medical and surgical transition, reified through documents such as the DSM and gatekept by medical and legal systems (Lowik, 2018; Spade, 2003). And, the centering of dysphoria in these diagnostic processes institutionalizes the assumption that "if the trans person were truly *suffering* from a gender identity disorder, they would not use their genitals, especially their reproductive system, in accordance with the sex/gender system they renounced" (Lowik, 2018, p. 431; Cromwell, 2006). The renunciation of biological reproduction and the embodiment of 'authentic' trans identity thus come to be intertwined. The view that trans people ought to forego reproduction and parenthood has a long history in trans medicine; shuster writes that "[p]roviders believed that a 'successful' trans patient was one who left their family and had surgery that removed any possibility for reproduction" (shuster, 2021, p. 47). Alongside poor people, black people, and disabled people, trans people came to be seen as "undesirable others" (shuster, 2021, p. 47) who should not be allowed to reproduce.

Moreover, normative frameworks of the reproductive capacities of trans people as well as notions about pregnancy and 'womanhood' intertwine in the curtailing of trans reproduction (Radi, 2020; Lowik, 2018). As Emi Koyama (2003, p. 89) shows, cis women's reproductive rights struggles are intimately connected with trans women's struggles accessing transition-related healthcare, since "[a] society that does not respect women's right to make decisions regarding pregnancy is not likely to respect our right to make decisions about medical interventions to make our bodies in congruence with our gender identity". Restrictions on women's reproductive autonomy underlie both struggles. By viewing sterilization, access to hormone pills (for birth control, as emergency contraceptives, or for hormone replacement therapy), the pathologization of processes such as menstruation, pregnancy, menopause, and of gender identity as shared struggles, Koyama suggests that reproductive choice can be a locus of feminist solidarity.

Restrictions on the conception of womanhood are also related to broader eugenic ideas regarding who is considered 'fit' to reproduce or parent. These ideas are key to understanding trans reproductive and family policies. The notion of trans people as 'undesirable reproducers' is sustained in laws. As Weissman's frame of 'repronormativity' suggests, the preservation of heteronormative familial structuring has been paramount in the legal conditions for trans parenthood (Weissman, 2017).

Policies that, either explicitly or implicitly, encourage sterilization, neglect questions of fertility and overall construct trans people as unfit parents (or trans children as a result of poor parenting) all demonstrate the biopolitical investment of the state in controlling trans reproduction. Particularly when situated in the context of other restrictions on reproductive rights that target people of color, immigrants, disabled, and poor people, it is clear that these mechanisms work toward regulating reproduction to fit the confines of heteronormativity and whiteness. Making trans reproduction and parenthood seem unnatural, abnormal, and undesirable allow for control not just over the current generation of trans people, but also puts in jeopardy the continuation and survival of trans communities. The state's biopolitical investment in the management of life takes shape as control over sexuality and reproduction, centered around the preservation of whiteness and heteronormativity.

Conclusion

Many of Foucault's central ideas coalesce around sexuality and reproduction. From his early work in *Madness and Civilization* about how mental illness and irrationality become pathologized, to *Birth of the Clinic* which traces the emergence of modern medicine, to his claim in *History of Sexuality vol. I* that the power over life is centered around the disciplinary poles of an anatomo-politics of the human body and the regulatory controls of the biopolitics of the population (Foucault, 1980, p. 139) to the internalization of modes of actions and behavior though surveillance and disciplinary mechanisms in *Discipline and Punis*h, we can see how these forces work together. Repronormativity takes place through the confluence of laws, policies, medical practices, economic factors, state regulation, and social norms. It is a concerted effect of biopower. Reproduction is regulated through medical authority acting in service of the state, not in the interest of the individual. Eugenics, both active and passive, are at work in the forced sterilizations of indigenous, Black, and Latina women and the callous indifference to preserving trans fertility. As we can see from the justifications for forced sterilization, the targeted groups are presented as "degenerate;" classifying non-whites, poor

people, people with disabilities, and trans people as degenerate reinforces the eugenic operations of the state; degeneracy functions both as a moral and an economic category constructing non-productive bodies as criminal while rendering them non-reproductive.

The increased medicalization of processes of pregnancy, childbirth, and gender transition are mechanisms that reduce the scope of bodily autonomy in favor of bolstering medical authority. This allows a legitimation of the state's collusion with medical institutions in the controlling of reproduction for the purposes of population management. Control of bodily processes such as reproduction and gender transition have population level impacts. Whiteness and heteronormativity are interimbricated in the construction of the 'ideal' family and consequently the nation-state, since the family is seen as the site that reproduces the nation-state.

The not-so-hidden criteria for fitness for parenthood is whiteness, cis-gender, heterosexual, middle or upper class, educated, and physically and cognitively able. Not coincidentally, these same qualities are assumed to be necessary for productive bodies in the capitalist system. As Foucault points out, genocide no longer needs to operate through wars, it can operate through control of the social body "because power is situated and exercised at the level of life, the species, the race and the large scale phenomena of population" (Foucault, 1980, p. 137). Population control became a science alongside the emergence of sexuality and sex as loci of control. Social scientists, economists, and demographers provided tables, statistics and predictions of the effect of population growth, speculating that unchecked growth would lead to disastrous consequences of overcrowding and exhausting natural resources. These fears underlie the racism of immigration policies and the Malthusian population control programs imposed on many countries in the global South.

For Weissman (2017), repronormativity shows the control over nonnormative reproduction as an instrument of the state's interests in maintaining the patriarchal heteronormative family as a conduit to a racialized heteropatriarchal nation-state. The fixation on heterosexual reproduction within the family is thus linked with other mechanisms of controlling the population of the nation-state, such as regulating processes of immigration and citizenship. As Weissman shows, in the context of Europe, the same political parties that espouse Islamophobic and anti-immigrant rhetoric also take an interest in controlling gay marriage and same-sex adoption: "there has been a confluence of opposition to nonnormative sexualities (particularly in terms of reproduction/parenting) and the perceived Islamicization of French society and subsequent tightening of immigration laws" (Weissman, 2017, p. 296). The

reproduction of queer and trans, poor, disabled, and racialized communities, alongside immigration and mixed-race couplings come to be seen as threats to the sanctity of the nation-state, since they transform the imagined homogeneity and purity of the nation's composition (Ahmed, 2004). The "imagined hyperfertility" of poor, non-white, and immigrant populations was used as justification for *not* providing voluntary birth control to white middle- and upper-class Americans. Both the excessive reproduction and the inferior quality of this undesirable reproduction was viewed as a threat, fueling eugenic "assumptions and anxieties about how those populations seen as most fit might be overrun by those seen as least fit" (Russell, 2018, p. 29).

Foucault's conceptual framework of biopolitics thus allows us to bring together the seemingly disparate processes of the medicalization and pathologization of pregnancy, childbirth, and trans healthcare with population control, eugenic policies, and the privileging of the patriarchal heteronormative family as part of a capitalist process of remaking the nation-state.

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