Obedient mothers, healthy children: communication on the risks of reproduction in state-socialist Czechoslovakia

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ABSTRACT

The article analyses medical communication in popular media relating to the risks in reproduction in the state-socialist Czechoslovakia between 1948 and 1989 and shows how it used emotions as an instrument to control women's reproductive behaviour. In particular, we use an approach inspired by Donati's (1992) political discourse analysis and by Snow and Bedford's (1988) framing analysis to explore communication on the risk of infertility in the abortion debate, the risk of fetal abnormalities in the prenatal screening debate, and the risk of emotional deprivation and morbidity in infants in the debate on mothering practices. The analysis contributes to the knowledge on how the construction of risk in reproduction, including childcare, serves to create a moral order of motherhood by defining what constitutes 'irresponsible' reproductive behaviours and their associated risks, and in doing so may lead to the further marginalisation of already marginalised people. We explain how expert discourse on reproduction and care aimed at the general public worked by constructing risks, a fear of these risks, and women's responsibility for avoiding them in order to regulate women's behaviour through self-discipline, which worked alongside other disciplinary techniques. These techniques were applied unequally and mainly to marginalised groups of women, such as women of Roma ethnicity and single mothers.

This article examines the construction of risk in popular and expert communication on reproduction in Czechoslovakia during the state-socialist period (1948–1989) and shows how it used emotions as an instrument to control women's reproductive behaviour. Communication on risks to health, together with the emotions this generated, represented 'soft disciplinary techniques' used in the regulation of reproduction. We build on the existing historiography and literature on biopolitics in socialist East Central Europe, to which we contribute with a discussion of the role of emotions in the communication of risks.

Communication on risks to health is a powerful instrument for influencing people's thinking, actions and decisions. It is thus one of the key strategies of what Foucault called 'governmentality': 'the ensemble formed by the institutions, procedures, analyses and reflections, the calculation and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population' (Foucault 1991: 102). Governmentality (Rose 1999) is constituted by language (and communication). Media texts, as an assemblage of textualities or discursivities, can be used to empirically examine the ways in which the rationalities and apparatus of governmentality operate (McIlvenny, Zhukova Klausen, and Lindegaard 2016: 3).

Using this framework, we explore medical communication on reproductive issues in state-socialist Czechoslovakia between 1948 and 1989. We analyse three topics in the debate on reproductive risks and discuss the role of emotions in this debate. First, we analyse the communication of the risk of infertility in the abortion debate. Second, we analyse the communication of the risk of genetic disorders and 'foetal abnormalities' in the prenatal screening debate. Third, we analyse the communication of the risks of emotional deprivation and morbidity in infants in the debate on mothering practices. We apply a framing analysis (Snow and Benford 1988) to texts dating from 1948 to 1989 to explore the ways in which medical expertise on reproduction and childcare was communicated to the public. We outline what these historical debates tell us about the discursive construction of risk in reproduction, and the role of emotions in this communication even today.

Czechoslovakia, like other state-socialist countries, legalised abortion and introduced prenatal screening earlier (in 1957 and 1960, respectively) than Western countries did. Like in other state-socialist countries, there was a rapid increase in women's participation in the labour force after World War II as families needed two incomes to live off and the Communist Party promoted women's emancipation through paid work to solve the postwar labour shortage. In the late 1950s, economies throughout the Soviet bloc stagnated, and fertility declined more quickly than in the West. The socialist countries then started to apply pronatalist measures (Lišková 2021; Hilevych and Sato 2018; Klich-Kluczewska 2017; Varsa 2021a). In Czechoslovakia, the State Population Committee was established in 1957. Through the Committee, various experts influenced reproduction and childcare policies (Heitlinger 1987).

From a demographic point of view, women's reproductive behaviour changed and became less differentiated. The pronatalist policies contributed to a lasting decrease in the age at which women became mothers and an unprecedentedly low rate of childlessness (Hašková and Dudová 2020). Two-child, dual-income families—where women acted as primary caregivers and secondary earners—became

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the predominant family model. After the labour shortage vanished in the 1960s, policies and expert discourses sought to encourage mothers to stay at home longer. Life history statistics confirm that despite educational, social, regional and other differences, mothers on average stayed at home with each of their children longer in the last decades of socialist Czechoslovakia than they did in the first decades (Hašková, Maříková, and Uhde 2009). The policies at that time aimed to structure a woman's life course into periods of study, childbearing and paid work, in order to fully use the 'capacity' of women in a way that best met the regime's goals of maintaining an adequate size and quality of population (Hašková and Dudová 2020). Some important differences nevertheless existed among women. Roma women in particular resisted the two-child trend. Moreover, reproductive health and childcare policies were often applied differently to various groups of women based on whether their childbearing was or was not recognised as contributing to the regime's goals (ibid.).

REPRODUCTION IN STATE-SOCIALISM AS A 'COLLECTIVE INTEREST'

The regulation of fertility, reproduction and childcare was (and is) not something exclusive to the state-socialist regimes (Varsa and Szikra 2020). However, the political pluralism that existed in Western countries in the second half of the twentieth century made it impossible to create a fertility policy that was as systematic, extensive and resolute as those prepared in the Eastern European states (Heitlinger 1987).

Under the state-socialist regime, women were viewed as responsible for the biological reproduction of the 'collective'; therefore, it was women who were the targets of pronatalist policies. However, these policies were not applied to all women in the same way (Varsa 2021b). Prajerová 2018 has demonstrated how the Czechoslovak socialist state assumed the responsibility for caring for the life and health of its citizens by disciplining, regulating and imposing self-regulation on the behaviour of women-mothers in many spheres of life. This included, for example, making available preventive gynaecological counselling services, abortions, prenatal care, child healthcare and hygiene. The policies that regulated women's bodies and the policies that governed proper childcare were designed to tie women to their 'duty' to reproduce the nation, as well as surveilling them and distinguishing between those who were 'fit' and those who were 'unfit' to reproduce society (Hašková and Dudová 2020). By conflating 'healthy' with 'good', a new kind of morality was produced that created distinctions between good mothers and bad mothers (Murphy 2000; Varsa and Szikra 2020). These distinctions were (and still are) marked by race/ethnicity: the advice given to women was different when it was given to Roma women.

In the USA, African-American activists and academics developed the political and theoretical framework of 'reproductive justice' to explore and tackle the intersecting systemic oppressions that shape the reproductive lives of women, focusing specifically on racism, sexism, classism and heterosexism (Eaton and Stephens 2020; Price 2020; Rosenthal and Lobel 2016). The three core values of the reproductive justice paradigm (and movement) are: the right to have an abortion and use birth control, the right to have children under the conditions of one's choosing, and the right to parent those children in environments free from violence by individuals or the state (Ross 2017). While this paradigm has been only rarely explicitly applied to Central and Eastern European countries (see Chełstowska 2011), a number of studies in these countries have shown how women from marginalised groups (such as Roma women, women with disabilities, non-heterosexual women or poor women) faced many reproductive challenges, were objects of state surveillance and targets of oppressive reproductive policies, and have less access to quality medical care (eg, Dudová 2012; Varsa 2017; Shmidt 2019; Varsa 2021b; Sokolová 2008).

Michel Foucault's concept of 'biopower' is a useful tool when studying the policies and discourses of reproduction (Foucault 2003; in the CEE context see, eg, Dudová 2012; Hegburg 2005; Prajerová 2018; Šmídová, Šlesingerová, and Slepičková 2015). Biopower refers to the mechanisms of power that are intertwined with technologies of security. This concept shifts attention away from the body of the individual towards environmental, genetic and intergenerational factors. In biopower, disciplinary mechanisms and the mechanisms of population control are overlapping and inter-related. As a 'global strategy' biopower relates to how medical power moves into the sphere of political control over the population (Foucault 1980: 25).

Foucault saw power as a relationship that is localised, dispersed, diffused and typically disguised through the social system, and operates at a micro, local and covert level through sets of specific practices. Power is embodied in the day-to-day practices of the medical profession, social workers or legal officers (Turner 1997). It exists through disciplinary practices that produce particular individuals, institutions and cultural arrangements. The 'self' is produced through practices of self-subjection to a moral authority. Preventive health policies are an extension of self-regulatory activities. Foucault named this apparatus of techniques and strategies 'governmentality' (Foucault 1980).

Foucault's concept is useful for understanding the forms of power that are wielded by the practices of medicine. Medicine is a coercive institution in that it disciplines individuals and exercises forms of surveillance over everyday life. It exercises a moral authority by explaining individual 'problems' and providing solutions to them. The object of the medical gaze and governmentality is the body (Turner 1997). Most instruments of biopolitics have targeted women's bodies, as they have been considered the ones who are responsible for the reproduction of the national body (Orloff 1993).

In state-socialist Czechoslovakia the politics and policies directed at the population were far-reaching (Dudová 2012). Like in liberal societies, the technologies of power were exercised not just through legislation but also through more subtle and diverse means (including the self-government of subjects) (Rose, O'Malley, and Valverde 2006; Hilevych and Sato 2018). Even though in state-socialist countries, only a limited range of actors were allowed to engage in the public debate (Heitlinger 1987), experts played a significant role in formulating population policies. Input from experts was applied to the kinds of policy issues that were problematic but did not threaten the existing political order or leaders (Hilevych and Sato 2018). Medical experts held a prominent position in these debates (see also Lišková 2021).

(MEDICAL) COMMUNICATION ON REPRODUCTION

Medical communication refers to the use of communication strategies to inform and influence the individual and community decisions that are made in an effort to enhance health (Thomas 2006). Health messages may be communicated through public education campaigns that seek to create awareness, change attitudes and motivate individuals to adopt recommended risk-reducing behaviours. How a risk is defined is therefore crucial.

Risk and safety exist in and through social organisation rather than as objective conditions that individuals perceive more or less accurately (Mitchell 2016). Only some conceptions of risk make it into the public discourse. According to Stallings (1990), it is the task of research to identify who influences the social construction of risk and how they do so.

For most people, the image of what constitutes a risk is created by specialists, social movements or the media (ibid.). Since the emergence of public health and social medicine, health campaigns have relied on mass communication. By selecting which facts to report and quoting experts who interpret those facts, and by distributing mass media products, the media discourse (see Gamson and Modigliani 1989) participates in the process of the construction of risk.

Emotions are an important component of health communication around risk. Fear, especially, is a powerful tool of persuasion: most studies show that the more fear generated by communication, the greater the persuasive effect (Biener and Taylor 2002). Emotional messages are remembered better than non-emotional ones (Keller and Block 1996). Fear is often the prevailing context of risk communication—something is to be dreaded, avoided and even intervened against in order to keep us safe. Such claims about risk may become 'common sense' if they are repeated enough and left critically unchallenged, even though they are not based on facts (López 2014).

Furthermore, the discourses around risk intersect with moral discourses. Expert risk assessments are not morally neutral (Lupton 1993). Risk-taking behaviours raise questions of accountability and responsibility. The moral jeopardy is greater if the individual puts someone other than him/herself at risk, especially if this other is in a relationship of dependence on him/her. Any maternal behaviour that appears to increase the risk of disadvantage or disease to the baby can potentially attract blame (Murphy 2000). Health communication that focuses on the risks in reproduction thus constructs normalcy and morality (in reproductive choices, pregnancy and childcare), and serves as an important tool of governmentality that disciplines women's bodies and minds.

METHODOLOGY

Our analytical approach is inspired by political discourse and framing analysis. Our analysis focuses on the discourse of the risk of infertility in abortion debates, the risk of fetal abnormalities in the debates on prenatal screening, and the risk of deprivation and morbidity of infants in the debates on mothering practices.

To examine the socialist-era communication on risk in the public discourse, we first identified the texts that represent the voices that can be considered a 'relevant part of the discourse' (Donati 1992:144). We focused on two loci where the discourse was aired: political institutions and organisations and the media. As for the popular media, we analysed the content of *Vlasta*, the most widely read women's magazine in Czechoslovakia, published between 1948 and 1989. It routinely covered issues relating to family, health, child psychology, education and lifestyle. We first manually and then electronically searched the content of the magazine for articles that included relevant keywords (abortion, contraception, artificial reproduction, prenatal screening, reproductive health, childbearing, childcare, nursery, kindergarten, childcare policy, maternity leave, maternity allowance, Roma, tzigan). Based on this search, we identified 345 articles. We then selected the articles that were relevant to our topic (defined as communicating risks related to human reproduction), which resulted in a sample of 23 articles dealing with abortion and contraception, 5 articles dealing with artificial reproduction, 7 articles dealing with reproductive health in general and 55 articles on care for children under 3 years of age. We also included debates in some other popular magazines, namely the debate that took place on the pages of the *Literární noviny* (*Literary news*), a weekly periodical focusing on cultural events and philosophical issues, in July–September 1957, after it published an article on the government's plan to legalise abortion. We also analysed popular and semipopular books on childcare published in the 1950s–1980s that we were able to find in the archives (12 books). To get an overview of the expert discourse on reproduction, we analysed: the contents of the journal *Československá gynekologie*, the leading gynaecology journal in Czechoslovakia during state socialism, and the journal *Demografie*, the leading demography journal (altogether 47 articles were selected for the analysis); reports produced by The State Population Committee; and monographs published by experts in gynaecology and obstetrics, genetics, paediatrics, psychology, psychiatry, demography, and sociology in Czechoslovakia between 1948 and 1989 that dealt with the issue of planned parenthood, abortion, reproductive health, reproductive technologies and early childcare. In order to observe the discourse in policymaking, we analysed laws, legal regulations, and the related parliamentary debates that took place and were published between 1948 and 1989. We used the Parliament of the Czech Republic's online database to track them. The database contains a full transcript of all parliamentary documents and debates. We ended up with 24 laws, 46 governmental edicts, 10 amendments of laws, 4 law proposals and 24 parliamentary debates. Since the public discussion was influenced by governmental propaganda, we also analysed the literature on state-socialist Czechoslovakia published after 1989 and eight interviews with experts (demographers and gynaecologists) who contributed to or were a part of the discourse of the time.

The arguments used in the texts were identified, coded and then grouped into categories through comparisons on multiple levels, mainly intratextual and intertextual comparisons, comparisons of different types of texts, comparisons of texts by different authors, until several 'systems' of argumentation (ie, frames) emerged. Within these frames, we examined how health risks were presented. We looked at how the risk was constructed, who presented it and with what aims. We focused on the role of emotions in the presentation of risk: fear, happiness, regret and guilt.

INFERTILITY RISK IN COMMUNICATION ON ABORTION

The Czechoslovak government legalised abortion on social grounds in 1957. Unlike in the Soviet Union (see Nakachi 2021), the final decision about whether to terminate a pregnancy was not in the hands of women, but was up to special expert commissions, which had to give authorisation for an abortion. In public discussions leading up to the liberalisation of abortion, the main participants were gynaecologists, and most of the arguments put forth were medical (Dudová 2010). Liberalisation was interpreted as a pro-population measure: the reproductive health of women would be saved by hospital-performed abortions, so these women would be able to have children later in life. Infertility as a consequence of an illegal abortion was the most important argument for the liberalisation of abortion. It was, however, made clear that hospital abortions also came with some health risks (this was similar to the situation in Poland in the 1950s–1960s, see Ignaciuk 2021, and in the USSR in the 1950s, see Hilevych and Sato 2018).

Infertility was mentioned as an important risk of abortion, both spontaneous or induced, in almost all texts that appeared in the media before the adoption of the Abortion Act. Fear of infertility was a powerful instrument that public communication sought to wield towards reducing the number of abortions among young women. For instance, in March 1957, in an article titled 'Why abortion is harmful' published in *Vlasta*, Dr Rudolf Slunský described the health complications that can follow an illegal abortion:

> The forcible removal of a first pregnancy is very often a tragic operation, because it leaves as many as 75% of women permanently infertile. (…) Therefore, every woman should always consider the dangers and severe consequences that always accompany abortion. (Slunský 1957, Vlasta 11: 11, p. 11)

In July 1957, an article by a group of lawyers named Radvanová, Nezkusil and Novotný was published in *Literární noviny* (*Literary News*). The authors were involved in drafting the new law on abortion. Their text initiated the discussion that then unfolded in this magazine. The authors argued:

> *Every abortion comes with some risks for the woman. We must take this into account. The aim is to find a solution that will cause as little harm as possible*. (Radvanová, Nezkusil, and Novotný 1957, Literární noviny 6: 27, p. 9).

According to this article (as well as other articles in the Czech press in the late 1950s), women should be given the option to terminate a pregnancy, but should not just decide on their own. Women who asked for an abortion for 'selfish' reasons (meaning that they did not want a child even though their material and social conditions were deemed satisfactory) were to be educated and their morals improved. The texts repeatedly mentioned the risk of infertility, especially for young women who had never given birth. This risk served as the main argument for not liberalising abortion completely.

Communication formulated by experts relied on an analytical mode of thinking (Slovic et al. 2013), using probabilities, rational arguments and statistical information. However, the fact that they were published in the popular media that targeted women, and that they focused solely on the negative lifelong outcomes of abortions, can be interpreted as an attempt to generate an emotional response in women. As motherhood was still regarded, by society and by most individual women, as the ultimate fulfilment of a woman's life (Rákosník and Šustrová 2016), we can assume that the information about the risk of infertility that was part of all texts presenting the legislation on abortion to the public would have been distressing for women. Moreover, the use of scientific language and experts' authority added a seriousness to this communication, thereby contributing to its impact on women's feelings.

During the course of the late 1950s and 1960s, *Vlasta* published several articles describing the life stories of women who could not get pregnant after an abortion, and contributions from medical doctors explaining the risk of infertility after abortion (eg, Spirmanová 1958). The analytical communication mode was accompanied by an experiential mode of communication using metaphors, images and narratives (Keller, Siegrist, and Gutscher 2006). The dangers of induced abortion came to be a widely accepted truth in the years after abortion was legalised in Czechoslovakia (as it did in Poland, see Ignaciuk 2021). The argument about the risk of infertility also appeared in the parliamentary debate about the new Abortion Act (19 December 1957) and in a regulation issued by the Ministry of Health in 1961 that sought to limit the number of abortions that commissions authorised in the case of first pregnancies because of the alleged infertility risk.

It is not clear whether the high probability of an induced abortion negatively affecting a woman's fertility was true in this first period after legalisation and was the result of poor medical skills and equipment, or whether it was exaggerated by the opponents of abortion. In the 1960s and 1970s, some gynaecologists tried to modernise existing abortion procedures, while others continued to emphasise the dangers of abortion[1] (eg, Kotásek and Fuchs 1976; Birgus 1977). In an interview (with one of the coauthors 19 June 2009), Dr Jiří Šráček[2] suggested that the opponents were Catholics, although they did not reveal their religious identity (like in Poland in the same period, see Ignaciuk 2021). The infertility threat was used as an instrument of fear to dissuade young women from having abortions. This warning was rather effective, as few young childless women opted for abortion during this period (Vácha 1970).

The debate over the negative consequences of an abortion on women's biological fertility resurfaced in the years 1973–1974, when an amendment to the Abortion Act introduced much stricter abortion regulations. This tightening of regulations coincided with the period that followed the defeat in 1968 of the democratisation processes of the 1960s and was accompanied by the introduction of many pro-natalist measures. Havelková (2014) called this period 'the era of the family': in 1970–1989, the principal identity of a woman was to be a 'wife who cared for her marriage and mother who cared for her family' (p. 63). The media presented these stricter regulations as a measure to improve population development. In 1973 a journalist named Karel Zajíček, writing on the pages of *Vlasta*, lamented the fact that the abortion commissions approved abortion for students: '(Y)oung, healthy, able to produce the highest quality population' (Zajíček 1973). Experts' cries fearing the destruction of the national population were backed by emotional images aimed at individual women. For example, in 1973 *Vlasta* published a photo of a nurse holding a newborn accompanied by the caption: 'You could be deprived of this forever…!' (Houdek 1973).

In 1986 a new Abortion Act dissolved the abortion commissions, thanks to the invention of a new method of early term abortion—vacuum extraction. This could be performed within the first 6–8 weeks of pregnancy with minimal risk of negative health consequences and could be performed without full anaesthesia and hospitalisation. Thus, the experts who stressed the risks of infertility and health complications found it hard to object to this new method, although they still argued that every abortion presented a risk:[3]

> Early abortions have a lower risk of health consequences, especially infertility. While complications in abortion by traditional methods range from 20 - 30 %, early abortions result in complications on average in only 4.4 % of women. (Memorandum to the 1986 Abortion Act).

The communication concerning 'other' women—those who did not meet the idea of a white, heterosexual, young and healthy mother—was quite different. A more liberal attitude towards authorising abortion was recommended in the case of pregnancies where the parents had some genetic disorder or where some kind of disorder was detected in the fetus: 'in order to prevent the emergence of a low-quality population' (Zajíček 1973).

As we shall see below, disability resulting from 'congenital abnormalities' was in the discourse strongly associated with ethnicity (Sokolová 2008). The experts viewed the reproduction

of the Roma population, which was deemed 'low quality', as undesirable (Maršálek 1968; Černý 1971; Vojta 1966; see also Pellar and Andrš 1989). An analysis of the reports produced by the National Committees in the 1970s showed that Roma women were prioritised when they requested an abortion and were granted it 'willingly and almost free of charge' (Motejl 2005). The ableist and racist aim was to discourage young, healthy, white women from seeking abortions and, conversely, to grant easier access to abortions for those who did not meet these criteria. In the popular discourse, articles warning of the risk of the 'uncontrollable reproduction of lower-quality population groups', who were explicitly labelled 'tzigans' (Gypsies) or Roma, reflected experts' concerns. The texts used emotionally laden words such as 'avalanche', 'explosion' or 'degeneration' in reference to the reproduction of such population groups (Menert 1968) in an effort to stoke fear in readers:

> But how to prevent a population avalanche that comes mainly from conflictual tzigan families? Sterilisation? But how to convince a tzigan woman to undergo this procedure (…) when even twenty or thirty thousand crowns as payment in return is not persuasive enough? (Homolová 1989, Vlasta 43: 47, p. 12)

The regulation of abortion in Czechoslovakia was a technology of governmentality (Dudová 2012). Communicating the health risks of abortion (namely infertility and childlessness) was part of this governmentality in that it was one of the strategies used to limit the number of abortions in periods of decreasing fertility. The risks of infertility were not only relevant to the policymakers and demographers concerned with population numbers; they also held strong significance for women making decisions about their reproductive lives. As motherhood was the primary source of a woman's identity and self-respect, especially in the 1970s and 1980s, when it was the only sphere of women's activity that had not lost its prestige and relative power (Hájek and Vann 2015), not being able to have children represented a serious threat to a woman's identity. In contrast, Roma women were not discouraged from having an abortion, and their reproduction and sexuality were framed as a risk to the majority and a threat to the health and vitality of the population.

PRENATAL SCREENING AND THE RISK OF FETAL ABNORMALITIES

State-socialist medicine assigned a prominent role to prenatal care. In Czechoslovakia since 1948, the goal had been to establish a network of prenatal clinics accessible to every woman from the early stages of pregnancy. The gynaecologists-obstetricians provided prenatal counselling in their offices and in clinics. In 1957, 49% of pregnant women were registered in prenatal clinics before the end of the first trimester of their pregnancy; 10 years later it was 88% and in 1976 it was almost 96% of them (Heitlinger 1987: 79). Pregnant women were to be observed, educated and classified. Those considered to be 'at risk' were to be subjected to a quasi-continuous medical gaze. In 1953, visiting an antenatal counselling clinic became a precondition for obtaining food stamps. When the rationing economy ended, women were encouraged to regularly seek prenatal care with arguments that highlighted their responsibility towards their children and the guilt they would feel if the child was not born healthy:

> But you are risking your own health, which can deteriorate in all sorts of ways during an unsupervised pregnancy, and some damage is so difficult to repair. And your health is not your own after all! You have a husband, children, parents, and your health is precious to all of them. (Tůmová 1954, Vlasta 8: 32, p. 12)

In the beginning of the 1950s, women were advised to visit a prenatal clinic three times in the course of a pregnancy (Trapl 1947). In the mid-1980s, nearly every woman saw a medical specialist nine times in the course of a pregnancy (Heitlinger 1987), and seeking medical care during pregnancy became a widely accepted norm (Heitlinger 1987: 179). Prenatal clinics played a crucial role in educating women about hygiene and health prevention (Rákosník and Šustrová 2016: 52). Their role was supported by the introduction of maternity allowances in the early 1970s, receipt of which was conditional on the mother providing 'proper childcare', which included ensuring the child attend school, the use of prenatal and paediatric counselling services, the vaccination of the children, and household hygiene (ibid.: 65).

Throughout the observed period, health was defined not just in physical terms, but encompassed social, moral and ethnic characteristics as well. As Dr Otakar Machotka stated in a speech he gave at the Convention of Czechoslovak Women in 1946:

> We need citizens with certain physical, mental, and moral qualities. The population decrease in the healthy classes is being replaced with an undesirable increase in the classes that are poorly equipped both physically and morally (Machotka 1947, p. 75-76).

The tradition of eugenic thinking that had existed in prewar Czechoslovakia was officially abandoned in 1951 as being contradictory to communist ideology (see Vojta 1951). However, after Stalin's death in 1953, genetics slowly regained popularity and 'positive' eugenic interventions started to be seen as an instrument for obtaining a 'quality population' (this was equated with physically, mentally and genetically healthy and able-bodied individuals) (Varsa and Szikra 2020; Shmidt 2018). This concern grew stronger with the political thaw in the 1960s and the advances in genetics made in the late 1960s–1980s (Prajerová 2018; Vojta 1966). Czech physicians tied in with a tradition of interest in eugenics from the prewar period and referred positively to the Czech Eugenics Society that was founded in 1915 (Vojta 1965). Although in the 1970s–1980s the term 'eugenics' was steadily supplanted by 'genetics' in expert as well as popular texts, it was still used in a positive sense in those decades.

Czechoslovakia was the first of the socialist countries to widely begin using prenatal diagnostics (Zwinger and Jirásek 1983). Genetic counselling was introduced in 1966 after the Commission for Medical Genetics was founded as part of the Endocrinology Society in 1963. Genetic counselling offices, to which gynaecologists referred women considered to have a high-risk pregnancy, were opened in university hospitals and clinics. In 1971, demographer called for 'the registration of families with an incidence of unwanted genetically determined indices and the use of the methods of fertility regulation', the 'identification of carriers' (of genetic disorders) and the introduction of the practice of 'opting for healthy children', the label applied to abortion if the fetus was not completely healthy. If prenatal screening detected a defect, the woman was recommended to undergo an abortion:

> The family should make the choice for a healthy child based on the results of a prenatal diagnostics. …Ultrasound diagnostics for all pregnant women up to the 20th week of pregnancy should reduce the number of developmental defects on a population-wide scale. (Hájek 1984, Cs. Gynekologie 49: 1, p. 22).

Although the final decision was up to the parents, counselling was 'semi-directive' in its approach, the aim being to prevent defects in the population (Židovská and Kapras 1985). Since 1968 *Vlasta* had been publishing articles informing readers about progress in genetic research and the positive effects of genetic screening (Pfleger 1968; Seemanová and Goetz 1971; Fuchs 1977). These popular texts emphasised the peace of mind and sense of security that a genetic examination gave to pregnant women whose pregnancy was at risk of a genetic disorder. Abortion was presented as a rational decision in the case of a higher risk of abnormalities, and the potential risks of the examination procedures were never mentioned:

> Several hundred women have undergone this examination in our country so far. It enabled the vast majority of them to deliver a healthy child in peace, or to terminate the pregnancy in time when a defect was detected. (Fuchs 1977, Vlasta 31: 21, p. 18)

Popular articles written by medical experts in *Vlasta* argued that if women underwent genetic counselling and followed expert advice, they could enjoy the security of going on to have a perfectly healthy child. Giving birth to a child with a disability (or simply with a health problem) was equated with suffering and unhappiness. Media portrayed women who refused to follow the advice as irresponsible and as ultimately regretting their wrong decision:

> In the waiting room for genetic counselling, we usually see faces marked by suffering. And yet many [women] leave the doctor's office with new hope in their eyes… (…) Based on the (scientific) assumptions, parents can bring a child into the world without fear of irresponsibly risking its physical or mental disabilities. (Heroldová 1982, Vlasta 36: 12, p. 10)

In the 1950s medical experts also began emphasising environmental influences on 'congenital abnormalities': not only hygienic and socioeconomic factors, but also the influence of the working environment on women as future mothers. This debate led to the adoption of a new Labour Code in 1965, which prohibited women from working in certain types of professions and workplaces. As Havelková (2014) showed, from the 1960s onwards the law increasingly focused on treating women differently and on protecting and supporting their motherhood. The popular media played a role in communicating the risks to women and telling them what constituted 'responsible' behaviour during pregnancy. *Vlasta* regularly published articles counselling women on how to behave and what to eat during pregnancy (eg, Fugnerová 1951). In 1984, Dr Alena Finková explained in an article aimed at the public that the embryo is most vulnerable in the early stages of pregnancy; therefore, even before a pregnancy is confirmed women should avoid risky activities. For this reason, women should 'plan to conceive when they have the optimal health, economic, psychological, and emotional conditions' (Finková 1984, p. 26). Warning against potential risks was designed to increase awareness among young women about these risks when pregnant and about their responsibility for their future children and to prompt self-discipline in this light (responding to a fear of the risks).

'Risk' in the expert debates was defined rather widely: the list of hereditary diseases that justified seeking abortion included those incompatible with a 'high-quality' life (see Edict of Ministry of Health 71/1957 (2022). Moreover, health was not defined only in medical terms. Some ethnic groups such as the Roma were excluded from the category of 'quality population'. Since the late 1960s, demographers and medical experts had together been warning against the risk of a massive deterioration of the quality of the Czechoslovak population. This was marked by a decrease in average intelligence and physical health as a result of 'an explosion' of the Roma population and low birth rates among university-educated couples, which would ultimately lead to the nation's intellectual decline (Menert 1968; Maršálek 1968; Černý 1971). In an article presenting the 'population problem of tzigan (Gypsy) families' published in *Vlasta*, Ján Sojka, a high-ranking civil servant in education and culture, argued:

> The socialist solution to this problem does not lie in suppressing the so-called impure races, but in consistently respecting current knowledge in genetics, biology, and the social sciences, and trying to create the conditions (…) in which physically and mentally healthy individuals are born. (Sojka 1966, Vlasta 20: 45, p. 6)

As showed by Sokolová (2008), the Roma population was implicitly equated with low intelligence and disability. This was supposed to be the result of poor environmental conditions, congenital effects (such as from alcoholism) and genetic conditions (such as those arising from consanguineous marriages) (see Sojka 1966). Roma women commonly violated the norm of seeking prenatal care. According to Heitlinger (1987), an estimated 21% of Roma women did not receive any prenatal medical care in 1984, and another 23% only registered their pregnancies 6 months after conception. This further contributed to the fact that Roma reproduction was constructed as unhealthy, leading to both physical and mental disability. The popular media reproduced the expert discourse in which disability was conflated with ethnicity (see also Shmidt 2015):

> An unbearably large proportion of children in tzigan families are born disabled. They come into the world from parents who usually already have some kind of (physical) defect in their lives. (…) Raising a disabled child is a difficult human task for all of us, not counting the fact that it costs roughly a million Crowns. (Homolová 1989, Vlasta 43: 47, p. 12)

The introduction of prenatal counselling and screening in state-socialist Czechoslovakia was framed as a means for 'improving' the population. The role of prenatal clinics was not only to discipline pregnant women; they were described at the government level as an 'integral part of the formation of the socialist (wo)man' (Rákosník and Šustrová 2016: 114). Women as responsible citizens were expected to make reproductive decisions that would help build a healthy, able and good-sized population. These decisions were, in fact, moral choices—being a good mother meant being a healthy mother, which in turn meant raising healthy and able-bodied children. Those who did not (even potentially) fulfil these expectations (such as the Roma population) were defined in terms of the risk they were alleged to pose to the population and were described as 'constitutionally defective' (Pachner 1946, p. 37), 'feeble-minded and illiterate' (Sojka 1966, p. 6) and prone to 'congenital or acquired retardation' (Homolová 1989, p. 12). The norm of regular medical care was enforced by hard disciplinary techniques (such as making entitlement to food stamps or social benefits conditional on regularly seeing a doctor for medical advice), but also by soft techniques, for example, in the form of articles aimed at the general public that highlighted women's responsibility for their health and for the health of their children, and tried to make them feel guilty if their children had any health problems.

NURSERIES AND THE RISK OF CHILDREN'S EMOTIONAL DEPRIVATION AND ILLNESS

Experts closely monitored and advised women on their mothering practices as well. The discussion around mothering

practices constructed risks relating to the poor development of children. State regulations relating to mothering were designed to affect different groups of women differently. The share of employed women among women aged 15–54 years rose from 55% in 1949 to almost 90% by the end of the 1960s (Historical Statistical Yearbook of Czechoslovakia 1948-1983 (1985). Like in other socialist states (see eg, Jarska and Ignaciuk 2022; Varsa 2021a), the Czechoslovak state increased the number of nurseries for children aged 0–3 years, kindergartens for older preschool children, school canteens and after-school clubs in an effort to support women's employment. To accommodate the continuous operations of state factories, boarding nurseries were built, where children stayed day and night from Monday to Saturday. Like in Hungary (see Varsa 2021a), the use of such nurseries was recommended mainly in the case of mothers who were identified as being unable to provide proper childcare, which in most cases meant Roma and single mothers. The reason nurseries were recommended for these women was not just so that they could work but also and above all so that their children could receive what the state deemed proper childcare. As Shmidt (2016) has noted, removing Roma children from their families was not invented by the socialist regime. The practice was long historically entrenched in the eugenics that had served ideals of nation building in the region. Varsa (2021a) has moreover shown that the practice of removing Roma children from their families and resocialising them in care institutions was not specific to the state-socialist countries of Central Eastern Europe, as it had already existed in the region during the Austro-Hungarian Empire, and similar practices were also applied in some 'Western' countries to their ethnic minorities or indigenous populations, whose lifestyles were constructed as a risk to children and to society as a whole.

The high rate of infant mortality after World War II led to nurseries being defined as preventive healthcare facilities. Children received care from paediatric nurses and weekly check-ups from paediatricians in nurseries (Act No. 130/1951, Act No. 24/1952 Coll.) to ensure that they had the proper nutrition, physical activity, and a safe environment and to check for any diseases. The ultimate aim was to ensure that the children had healthy development and that their mothers (and grandmothers) were able to work. In discussions about care for infants and toddlers, the dominant voices in society were those of paediatricians, along with those of the psychologists who studied children in boarding childcare facilities and children's homes (Hašková and Dudová 2017).

From the very start, however, these voices were divided. Not everyone viewed collective childcare in a positive light. Paediatricians highlighted the high illness rates in overcrowded nurseries. Already in 1947, a well-known paediatrician published an opinion piece on nurseries in the City of Prague's bulletin, and claimed to be speaking on behalf of medical doctors:

> Whenever setting up nurseries has been written about recently, it has always been just about enabling mothers to go to work. Let a doctor say a word on this subject: There are serious downsides to collective infant care … [N]urseries make it possible for a woman to return to work sooner … at the expense of the child's healthy development. Decision-makers should think about what is responsible not only for the present but also for the future of the nation. … [M]edical experts advocate rather for more effective support for employed mothers so they can stay at home longer (Lukášová 1947, Věstník hlavního města Prahy III – L 17, p. 398).

During the 1960s, paediatricians repeatedly pointed to the higher illness rates observed among children who attended nurseries compared with children who stayed at home, and warned that the long-term effects of higher illness rates in infants and toddlers were not yet known (eg, Dunovský and Suchá 1967). Nurseries were seen as especially harmful for younger children: 'The younger the children in nurseries are, the more often they get sick' (Dunovský 1971: 154). The State Population Committee reports stated that: 'one of the main problems children face in nurseries is a higher illness rate than children cared for at home' (Bařinová 1965: 11). The reports also noted the fact that employed mothers frequently had to stay home from work to care for a sick child because of the spread of illness in nurseries (Kuncová 1963), and this also drew attention to the 'economic ineffectivity' of mothers going back to work too soon after having a child.

Psychologists claimed that children placed in boarding nurseries and children's homes developed at a slower pace and had a higher risk of suffering emotional deprivation (eg, Langmeier and Matějček 1974; Damborská 1963 (first published in 1963)). They argued that emotional deprivation occurs when a child's emotional needs are not met, and this happens when they are separated too early and for too long a period from their mother. Emotionally deprived children then have long-term difficulties in their personal relationships. The psychologists argued that these findings could be applied to day nurseries as well, because children spent an average of 9 hours a day, 6 days a week there (Dunovský and Suchá 1967). Psychologists and paediatricians thus strove to reduce the operating hours of nurseries and extend maternity leave so that children would be separated from their mother for shorter periods and not as early in life.

The risk of lifelong emotional deprivation resulting from long hours spent in nurseries was communicated to the public through instructional literature for parents and even in a popular documentary film from 1963 called *Children Without Love*. The psychologists interviewed for the documentary emphasised that children who spent a long time in collective childcare were at risk of emotional deprivation. The film is filled with emotional shots of rooms filled with baby cots, groups of children 'hungry for love' tugging on one nurse, and children waiting for their mothers to pick them up from the nursery in the evening.

In popular instruction books on childcare, psychologists reiterated their opinion that there was some risk of emotional deprivation in every type of collective childcare, and that children below the age of 3 years do not need other children to play. They were thus implicitly advising mothers to stay at home up until their child was 3 years old:

> If we look at collective facilities in terms of the time children spend there, we must distinguish between day institutions and boarding institutions. … In both cases, the mechanism that leads to [emotional] deprivation may be activated. But the risk of this happening … is very different (Langmeier and Matějček 1974 : 125)

Gradually, the terms separation and deprivation began to be used almost interchangeably in the popular discourse on childcare (ibid.). The discourse used by psychologists and paediatricians influenced politicians to extend maternity leave to 1 year in 1964 and then, in the course of the 1970s, to 3 years. The assumption was that longer leave would reduce the burden placed on mothers and they would have more children, and the children would be healthier. Because initially the maternity allowance was only for mothers who had at least two dependent children, this measure also motivated mothers to quickly give birth to a second child (Hašková, Maříková, and Uhde 2009).

Certain categories of mothers were excluded from the message not to rush their children into collective childcare. Even the critics of nurseries favoured the 'protective function' they served for children in a situation deemed to be at odds with the prevailing ideas about 'proper' childcare. For example, like in Hungary and Poland (see Kuźma-Markowska 2020; Varsa 2021a), in Czechoslovakia single mothers were one of the categories of women who were suspected of child neglect. They were associated with 'broken homes', which prevented 'proper' childcare (Junková 1975: 12), and with children in emotional distress (Matějček 1986: 35). Their children were thus given priority admission to nurseries. In the case of Roma women, even boarding childcare facilities were advocated as helpful for advancing their children's development, nutrition, personal hygiene and language skills, and even for transmitting 'good' habits back into the families of these children (Štětinová 1976; Petříková 1976). *Vlasta* actively reported on the efforts to 'assimilate' Roma children and described Roma families as 'freeloaders' and 'parasites' on the family support system (Sojka 1966; Procházková 1966). Roma were seen as having too high a fertility rate, becoming parents too young, and providing substandard care for their children or even subjecting them to neglect. This view led to adjustments to family policies in the 1970s that were designed to reduce 'excessive' fertility (understood to mean fertility in the Roma community) by paying higher child benefits only for the first three children in a family and by lowering the age of eligibility for retirement and a pension in connection to only the first three children in a family (for Czechoslovakia see also Sokolová 2005; for other socialist countries see, eg, Varsa and Szikra 2020)

Even the maternity allowance was designed to support only mothers who were considered capable of ensuring their child's healthy development, because payment of the allowance was conditional on a mother attending prenatal care and providing all her children with 'proper care' (Maternity Allowance Act No. 107/1971). Roma mothers were thus more often excluded from this financial support because their mothering practices were often deemed improper and their children were more frequently placed in children's homes (Sokolová 2005).

Finally, an article in *Vlasta* (published not long after the maternity allowance payment period was increased) that explained the purpose of the maternity allowance and the eligibility criteria also stressed (in an almost threatening tone) that it was a mother's responsibility to ensure her children were raised properly. It even highlighted in bold the part of the text explaining that mothers whose older children were in institutional care were not eligible to receive the allowance:

> [In addition to increasing the birth rate], the maternity allowance is also intended to encourage families to improve the quality of childcare. …if a woman's way of life endangers the development or upbringing of her children, then the allowance cannot be paid or will be withdrawn. … Care for a child's physical and mental health begins even before the child is born. Therefore, the law requires a woman to undergo regular care during pregnancy … the allowance will not be paid to mothers who … have a child or even multiple children in, for example, a children's home … because the mother has not properly cared for them. (Hrdá 1972, Vlasta 26: 1, p. 10)

Texts on childcare aimed at the general public sought to play on the readers' emotions not only in the verbal messages they used but also in their choice of pictures—for example, using an image of happy children or, in contrast, stressed and unhappy children shown, for instance, standing behind the bars of a cot. In the articles about Roma children published in *Vlasta*, the pictures presented them as orderly, clean, and engaged when they were in a nursery or kindergarten in order to demonstrate that they were being properly socialised in institutions, in contrast to the widespread negative constructions of Roma as work-shy and living in conditions unsuitable for child-rearing (see eg, Varsa 2021a; Sokolová 2005).

In contrast to Roma women, university-educated and career-oriented women were encouraged not to postpone motherhood. In 1978, sociologist Ivo Možný published an article in which he expressed alarm about 'the problem of families of dual career partners'. The problem was defined as highly educated women having fewer children because of their higher age at first birth, having more stress-related morbidity in pregnancy and returning to employment too early. Možný warned that:

> unlike the more frequently discussed problem families, there are also problems hidden within the families of highly qualified, hard-working, and highly paid partners … the risk being that problems left unresolved will be reflected in the next generation – in their children's behaviour (Možný 1978 : 320 - 321).

Like the paediatricians and child psychologists in the book for parents cited above, Možný's message was to warn against the possible negative impacts of women's reproductive and childcare practices on future generations at both the individual level (for her children) and the level of society as a whole.

In sum, women were divided up into categories and on that basis were advised on when to have children and how to care for them. The expert discourse on reproduction and care that was aimed at the general public worked by constructing risk and generating in women a fear of the risks that were brought to their attention. Then it asserted that it was their responsibility as mothers to avoid them. Women were made to fear that they would have problems if they got pregnant at an older age, and that they would have emotionally deprived and unhealthy children if they returned to work too soon. One was also risking the label of irresponsibility by having more than three children and not attending health checks during pregnancy. Control operated in two modes—from within as self-governance in response to fear and from without through the threat of punishment, though the punishment was applied unequally and more often impacted racialised women. Both the sense of fear and the threat of punishment were potentially magnified by the fact that the risks affected not (just) the women themselves but mainly their children.

CONCLUSION

Communication in the popular media on the risks relating to reproductive health and the reproductive behaviour of women is an example of the soft disciplinary techniques of governmentality. In this article, we examined how this communication used and built on emotions. We followed up on previous studies analysing the effects of biopower in state-socialist countries. Public communication of expert opinions, especially from medical doctors, played an important role in women's self-discipline. The media presented expert information about the risks that women and their children (even unborn) potentially faced if women did not behave 'responsibly' and did not follow the advice of experts. Communication on the risk of infertility resulting from an abortion (or in the case of highly educated women from postponing parenthood to a later age), the risk of having a child with disabilities if a mother avoided prenatal medical checks and screening, and the risk of having children who suffer from emotional deprivation or compromised health because they are in nurseries too young and for too many hours,

was designed to invoke fear, which contributed to the construction of women as self-disciplining subjects.

These risks were communicated through the public media (especially in the magazine *Vlasta* and in popular science books on childcare). The opinions of experts, especially medical doctors, were used to construct these risks. Sometimes the risks were communicated by experts themselves (as in the case of the documentary movie *Children Without Love*), and sometimes the media communicated the risks through a selection or even a misinterpretation of data. In any case, the communication on such risks typically referred to research evidence but also worked with narratives and expressions of values. Although our analysis focused on reproduction-related communication aimed at the public, we identified similarities in the expert knowledge and judgements communicated through the public media (such as *Vlasta* and popular science books on childcare) and expert media (such journals as *Československá Gynekologie* and The State Population Committee reports). The knowledge thus circulated from experts' outlets to popular media.

Emotions such as fear and guilt were used on two levels in the communication on reproductive health: the individual level, when communication addressed women as (future) mothers, alerted them to the risks their behaviour posed to their children, and appealed to their individual responsibility; and collective, when the threat was the 'irresponsible behaviour' of entire groups or ethnicities and the population was threatened, not just one particular child or fetus. Emotionally resonant terms and images were used on both levels. Even when the communication appeared to be 'analytical' and used statistics and rational arguments, it aimed to appeal to emotions. Women who did not follow experts' recommendations were labelled as irresponsible. Irresponsibility then justified the use of other disciplining techniques, such as less financial support, placing potentially endangered children in boarding nurseries or children's homes, and, in the case of the Roma, involuntary sterilisation. This moral discourse was highly gendered. While the most visible experts (gynaecologists, demographers, paediatricians and clinical psychologists) who communicated reproductive risks were men, they constructed the risks in relation to women's bodies, which were then subjected to persistent observation and classification attended by moral judgement.

From a demographic point of view, it seems that women on average followed the medical advice of experts (not to postpone motherhood, to attend prenatal care and later also to stay at home longer with each of their children). The sources we analysed, however, can tell us about the forms of risk communication but not about the reception and implementation of this communication by individual women. As Jarska and Ignaciuk (2022) showed, although expert advice on reproduction became widely accepted in Poland from the late 1950s, individual negotiations played a key role in the incorporation of such advice in people's individual reproductive lives. In Czechoslovakia, Roma women in particular were reluctant to adhere to the norm of making early and regular visits to prenatal clinics, as they did not trust non-Roma medicine (Sokolová 2005).

Applying an intersectional perspective to reproductive politics in state-socialist Central Eastern Europe clearly reveals that reproductive politics in the region targeted different groups of women differently. The revival of eugenics in the 1960s, intertwined with racialist thinking and prejudices against Roma, resulted in antinatalism directed at Roma women (through easier access to abortion and forced sterilisations), the main aim of which was to ensure the 'quality' of the population (see Varsa 2021b). Soft disciplinary techniques were thus accompanied by hard ones as well.

Feminist scholarship has already shown that there were distinct periods of reproductive politics and gender in state socialism (eg, Lišková 2021; Varsa and Szikra 2020). In Czechoslovakia, the period between 1948 and 1965 was marked by such changes as an increase in women's employment, the transition to the dual earner family and legal access to abortion. It was only in the 1970s that an explicitly pronatalist set of policies was introduced that cemented women's roles as mothers. Our research, however, also highlights significant long-term continuities—most notably eugenic thinking and politics towards the Roma population. In the late 1950s, physicians built on the interwar tradition of national eugenics in Czechoslovakia and then refined it as genetics, without subjecting this to any major critical scrutiny. Concerning the Roma population, in the 1950s more emphasis was placed on re-education and assimilation, but after 1970 attention clearly turned to selective reproductive policies to reduce the birth rate of Roma women. The foundations for this however had already been laid in prewar eugenics. As the scholarly and popular articles cited above illustrate, the overall perception of the Roma as a naturally inferior and unhealthy population did not change during this period.

Our analysis builds on previous research and contributes to the knowledge of how the construction of risks relating to reproduction, including childcare, served to create a moral order of motherhood, and to educate women to become responsible citizens to produce 'quality population'. Our contribution is in deepening the understanding of the processes by which social structures make women self-disciplining subjects, using their bodies and reproductive fates. In particular, we highlight how emotions were used in this process during the state-socialist period. It deepens our understanding of how the soft disciplinary techniques of 'governmentality' operate. Articles in popular magazines in state-socialist Czechoslovakia mainly worked with the emotions of fear and of guilt, and the aim of this was to make individual women responsible not only for their own reproductive fate, but for the reproduction of the entire population as well. The three discourse topics explored here illustrate how the construction and communication of risk can lead to further marginalisation, devaluation, and discrimination of ethnic minorities and other people on the margins.

Correction notice This article has been corrected since it was first published. All authors' ORCID iDs have now been added.

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NOTES

1. International review studies from this period provided no evidence that abortion significantly increased the risk of secondary infertility (Hogue, Cates, and Tietze 1982; Huggins and Cullins 1990). Czechoslovak demographers observed a decrease in long-term and short-term complications after induced abortions over the course of the 1960s (Vácha 1970). In the popular discourse, however, abortions continued to be associated with a high risk of subsequent infertility.
2. Jiří Šráček was a gynaecologist and obstetrician. In 1972 he became chief of the gynaecological-obstetric department of a hospital in the city of Ostrava. He founded the Czech Society for Planned Parenthood and Sexual Education.
3. Conversely, in Poland, expert debates in the 1970s ignored these less harmful methods of abortion. The dominant framing of abortion as unhealthy contributed to self-censorship on the part of the medical authorities about innovations that could diminish the risks (Ignaciuk 2021).

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