UNIT 12 REPRODUCTIVE TECHNOLOGIES

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Structure

12.1 INTRODUCTION

The unit analyses the inter-connections between woman's body and the institutionalization of various reproductive technologies through the discourses of population policy and the market. The focus of this unit is to discuss a range of discourses epitomizing the development of new reproductive technology since 1970s across the globe.

According to **Lene Koch and Janine Morgall** (1987), there are two forms of reproductive technologies which are categorized as: i. Assisted reproductive technologies (e.g., contraceptive and treatment of infertility) and, ii. New reproductive technologies (e.g. artificial reproduction combined with genetic engineering). According to **Jyotsna Agnihotri Gupta** (2006), globalization of new reproductive technologies is increasingly penetrating in arenas of contraception, assisted conception, and screening of embryo/foetus for genetic purpose and sex selection leaving impacts on the female body and her health. Technologies for sex-selection, genetic testing of foetus, artificial reproduction through IVF, contracts concerning use of reproductive body organs such as eggs, sperm, embryo and renting of uterus are some examples of new reproductive technology, which have called for feminist assessment of these technologies across the world.

As a critique of these new reproductive technologies, international feminist movements see these innovations and insertion related to women's body as a new form of oppression. This is because these technologies are essentially experimental in nature yet are proliferating in the marketplace with a view to

curing infertility. The expansion of these technologies in the West and in the Third World countries not only are evidence of women's access to these technologies but also are reflective of the high-tech subjugation of women's body. With this background, the unit will expose the learners towards understanding of reproductive technologies from a feminist perspective while narrating the embodied experience of women in access to these technologies of various forms.

12.2 LEARNING OUTCOMES

After reading this unit, you will be able to:

- Critically analyse feminists discourses associated with reproductive technology debates;
- Describe women's concerns in the use of new reproductive technologies;
- Analyze the role of state and market in the promotion of reproductive technologies; and
- State the critique of reproductive technologies from a Third World perspective.

12.3 REPRODUCTIVE TECHNOLOGIES AND FEMINISM

12.3.1 Technology is Liberating or Enslaving?

This sub-section is adopted from the unit: Feminist critiques of technology from the course BGS-002. Now let us move on to a continuing debate among feminist scholars about whether technology liberates or enslaves women. In the early phase of feminist movement a group of scholars advocated technology as having potential to liberate women from the clutch of reproductive and domestic responsibilities (Firestone, 1970). But this position has been challenged by other scholars. Many feminist scholars have argued against 'biological determinism' that emphasizes on biological factors such as genetics and physiology to explain the gender division of roles and responsibilities in society. The attempt to explain and justify women's lack of agency and their subordination with the help of biology is a deterministic approach and was challenged by many feminist scholars (Beauvoir, 1972). Feminist scholars argue that the role of women's biology in human reproduction is conflated and thereby women's restricted freedom around sexuality has been justified. Therefore, technology can help as a tool to enable women to express sexuality without being bounded by the "tyranny of reproduction" (Firestone, 1970). There is a need to innovate new technology of contraception as well as Assisted Reproductive Technologies (ARTs) to provide choices to women. **Shulamith Firestone** in her book "The Dialectic of Sex" has advocated the need of appropriate technology to free women from the compulsion of biological motherhood. Following Firestone's view many feminists have argued that technology indeed has potential to liberate women. With the help of technology women can experience motherhood more safely and even without having to go through pregnancy. With technology women can experience motherhood as a choice rather than accept

it as their biological fate. Assisted Reproductive Technologies (ARTs) now has created a spectrum of possibilities which can help men, women, and transgender persons to experience motherhood and fatherhood. Technologies such as 'intrauterine insemination' and 'in-vitro fertilization' open up many possibilities. Feminist scholarship observed that these technological innovations have liberated women and have enough potential to even alter the existing gender equation in future. Biologically deterministic approaches should no longer limit women's potentialities. Likewise when sexuality and reproduction are seen as separate and contraceptive technologies become available, women may experience and express sexuality without the compulsion of motherhood, thus, creating plurality of choices in the field of human reproduction (Giddens, 1991). On the other hand, another group of scholars argued that reproductive technologies are responsible for strengthening patriarchy. In 1984 the Feminist International Network of Resistance to Reproductive and Genetic Engineering (FINRRAGE) was formed to advocate against technologies related to contraception and reproduction. Scholars like Gena Corea (1985B) and **Maria Mies** (1987) along with other scholars in the group argued that motherhood is an essential biological prerogative of women and it should not be considered as limiting for women. Unlike Firestone, these scholars argue that the separation between sexuality and reproduction with the help of technology is an attack on the women's unique ability to procreate. Motherhood is seen by these scholars as the unique reason for women's power, and the technological interventions to destabilize this unique source of power is a form of patriarchal control. Scholars have also linked reproductive technologies, such as in-vitro fertilization to eugenics and technological production of human beings and, thus, with a new form of social control (Klein, 1985). Gena Corea (1985A) even imagined a time in future when women will be redundant because technology will help create babies with the help of professional breeders replacing natural human reproduction. They argued that this will devalue women and the entire human society will be an expression of men's control and conquest of nature and women. Although this view is inherent to the philosophy of ecofeminism, other feminists and environmentalists have critiqued its biologically deterministic approach.

12.3.2 Reproductive Technology and Gender Relations

This sub-section is adapted from the Unit 3: Gender and Technology from the course BGS-002.

In the later part of the twentieth century, a series of technological advancements have taken place in the West in the domain of biomedicine. The spread of these technologies has also happened at the global scale which has both positive and negative outcomes for women. The biomedical technological developments in the realm of human reproduction include In-Vitro fertilization, embryo transfer, surrogacy, contraceptive methods, surgical sterilization, fetal monitoring through ultrasound, amniocentesis, genetic testing, and so on.

Box 12.1: What is New Reproductive Technology Project?

The advent of New Reproductive Technologies is often projected by the scientific establishment as a positive intervention, which is claimed to have significantly contributed to change women's life and paved the way for gender equality. These technological interventions are hailed to have reduced painful and difficult child deliveries. On the one hand, these new reproductive technologies are claimed to be having the potential of ensuring birth of healthy babies through monitoring of the development of fetus during the early stages of pregnancy, whereby the 'abnormalities' in the fetus could be detected at an early stage of pregnancy and the 'defective' fetus could be aborted. The advancement of new reproductive technologies is also projected to have opened the possibility for the infertile heterosexual couple, single women and same sex couple, to have their biological child.

Reproductive technology such as in-vitro fertilization is perceived to have narrowed the concept of parenthood to a biological base, rather than conceiving it as a social relationship. However, scholars like **Amrita Pande (2009), Spar (2005) and Dillaway (2008)** offer a much more complex understanding of technology and its relation to women. They argue that the advancement in reproductive technologies rather than being inherently favorable to men or serving patriarchal interest, have diverse effects on different groups of women depending on the social context in which these women are situated. For example, the expensive technique of in-vitro fertilization becomes beneficial to women who can afford such treatment. Contrary to this, on many occasions the poor women are drawn into the reproductive industry as egg donors or to serve as surrogate mothers for the rich couple at a low price and are subjected to much exploitation.

Most of the money is syphoned by the infertility clinics and the middlemen rather than being availed by the surrogate mothers and egg donors. Hence, it could be argued that these reproductive technological interventions reproduce social inequalities like gender, class, race etc. And such technologies are used to serve the interests of the powerful groups in the society. Often female contraceptive methods are hailed to have empowered women by giving them the opportunity to exercise control over their own reproduction, enabling them to choose how many children they want and when. Contrary to such claims, scholars like **Mohan Rao (2004), Rachel Simon-Kumar (2006)** have criticized such claims and pointed out that much of the birth control techniques have mainly become female centered. Not much research is done on male contraceptive methods. Further, much of the contraceptive methods are tested on the poor women of the Global South, mainly women from vulnerable social categories. These women are subjected to clinical trials of injectable contraceptives like Depo-provera and Norplant, without their informed consent. In pointing to the historical pattern of such clinical trials in the domain of medical technologies, Emily Martin (1987) argues that medical technologies are often tested on poorer patients and only after the physicians learn to use the new methods, if it is recognized as an accepted practice only then it is passed on to the private sector and presented as a modern practice. The hegemonic potential of reinforcing intersecting hierarchies of gender and

class get well demonstrated through the studies on new reproductive technologies.

However, the upper- and also middle-class women are not able to escape the gendered nature of the new technological interventions. The studies on new domestic technologies effectively demonstrate how middle-class women are trapped into playing gender roles in a much more systematic way through the introduction of new domestic technologies. The following section critically examines the impact of new domestic technologies on the domestic division of labour.

12.3.2 Reproductive Technologies: A Feminist Analysis

The issues of reproductive technologies have been the centre of concern in the context of the women's health movement across nations. On the one hand, various feminist movements have linked women's freedom and women's rights issues with their access to various reproductive technologies. On the other hand, the women's movement and health movements have raised different concerns relating to issues of fertility, abortion, use of unsafe contraceptive technologies, medicalisation of child bearing and the adverse effects of reproductive technologies. Feminists are questioning whether the right to choose is not slowly turning into women's duty to choose? (Gupta, 2006, p. 6). Some feminist activists fear that state eugenics, as earlier practiced in Europe and America, might turn into private eugenics with the proliferation of these technologies. According to **Cynthia R. Dar** and **Erin Heidt-Fors** (2012), in the Unites States, sperm banking and egg donations are coming up as big businesses in the free market economy to provide reproductive services. They argue that the practices which are followed in various sperm and egg donation banks are based on underlying eugenic beliefs in which sperms and eggs are being traded on the basis of individuals' class, gender, race, occupation, and ethnic identities.

For radical feminists and lesbians community in the West, various assisted reproductive technologies can be seen as alternatives through which single women and lesbian couples can claim their right to motherhood. On the contrary, for some feminists, these technologies are primarily essentializing women by re-enforcing the norm of motherhood and compulsory pregnancy, while health advocates have warned against using fertility drugs (cited in Gupta, 2006). To put it more precisely, the mushrooming of these technologies in the market explain the trend towards reproductive freedom for a few, and technological dependence for a majority, of women.

Differences within feminism continue to exist with regard to the assessment of reproductive technologies. Some have argued that the use of assisted reproductive technologies involves the commodification of woman's body, reproductive process and motherhood. According to **M.E. Gimenez** (1991), the process of commodification may lead to the reinforcement of women's domination by the oppressive pronatalist ideologies. On the other hand, feminists like **Firestone and Beckman & Harvey** see Assisted Reproductive Technology (ARTs) as offering a wider scope for women to exercise freedom in the arena of reproductive choice (cited in Hammons, 2008). These debates are different and conflicting. However may enable us to draw inter-linkages

between women's bodies and the impact of new technologies.

Globally, there has been a shift in health care services from the public sector towards privatization that is making poor people the victims of private health care services. The paradox continues to exist as poor women interact with public health care as objects of bio-medical research, while their need for treatment is met through an unaffordable private sector. Similarly, new reproductive technologies like IVF have come to the market as a type of treatment for infertility for white women of elite class. In Asia, countries like India and Thailand are seen as emerging hubs for promoting reproductive tourism due to factors such as: available medical infrastructure, limited regulatory framework for controlling the ART related services and lower wage structure that allows ARTs to perform at lower costs (Whittaker and Speier, cited in Whittaker, 2010). On the one hand, India is evolving as the preferred international destination for reproductive services. On the other hand, this country has increasing maternal mortality and morbidity rate. To quote, "the basic reproductive health care is available more to Indian women as surrogates than as mothers of their own children" (Bailey, 2011, cited in Jaiswal, 2012, p.19).

These technologies are not empowering for all as they operate within the hierarchies of gender, race, religion, and class. For instance, in the U.S., the marketing practices of sperm and egg banks highlight the fact that masculinity and femininety are intertwined with race and class identities through online advertisements of reproductive services. Similarly, racial and class differences are obvious in the use of these technologies. As stated by Chandra et.al (2005), in U.S., middle and upper income whites are more than double of African Americans as users of the fertility services (cited in Dar and Heidt-Fors, 2012, pp.720-21). The reproductive technologies, IVFs in particular, are certainly proliferating in the new reproductive market economy, raising serious concerns with regard to their use, access, and their impact on the commodification of the body.

According to **Merete Lie** (2002), in the same way that the pill revolution has brought a change in the social arrangement between sexuality and reproduction, the separation between sexuality and procreation is gaining prominence with the introduction of assisted reproductive technology. Many reproductive groups have also looked at the use of assisted reproductive technologies (ARTs) such as women's access to legalized abortion and pills within a right-based framework. Similarly, the discourse of right to life and the right of the fetus have engaged feminists in the debates around women's reproductive health rights and ARTs.

Some feminists within the reproductive liberal framework have argued that reproductive technologies can enable women's empowerment as they will free women from the burden of child bearing. Hence, reproductive technologies have been seen as liberating measures for women in establishing their autonomy over the reproductive body. For example, in the West, the use of reproductive technologies has been the cause of celebration for many women as they had access to successful treatment for infertility, pregnancy for post-menopausal women, possibility of gestational motherhood, selective

abortion, and IVF. However, the same experience is exploitative for women in specific societies especially where the individual's right over the reproductive body is deeply embedded in the community, culture and norms. Family and community as custodians of the female body often limit a woman's choice to access reproductive technologies. The same family often uses the bodies of poor women (case of gestational surrogacy) in the interest of white/upper class women to secure procreation (Kumkum Sangari, Friday Seminar Series Lecture in IGNOU, 2012). In both these instances, one can see how woman's body has come under the control of technology.

As **Saetnan** (2000) argues, historically, contraceptive research has been accorded a lower status within medical sciences. The lack of financial and professional support for contraceptive research has led to a marginalized status for both the professionals working on contraceptive research as well as its users. This marginalized nature of contraceptive research provides a scope for women professionals to enter into the arena of Pill development as technicians or physicians. Women scientists have often been seen as cultural entrepreneurs for the development and dissemination of the reproductive technologies (cited in Isaacson, 2002), but they have limited roles in the sphere of testing, disseminating and introducing the various reproductive technologies into the market.

According to **Vineeta Bal** et.al. in the field of reproduction and contraceptive research, there is an underlying gender bias link with regard to publishing research papers, development of products and the market. For instance, there is a strong bias towards making research visible for those who work on female contraceptives than on male contraceptives. Similarly, most of the contraceptive research is technological in nature; hence, it strongly governed by social attitude and market demand. The history of contraceptive research has been marked by a continual struggle of women scientists towards achieving mainstream status within the scientific community. Again, working class women's bodies were used callously while undertaking the clinical trials of contraceptive pills. The testing and dissemination of assisted reproductive technologies like contraceptive pills in in the Third World completely targeted women of a particular race and class while paying limited attention towards the potential health risks. As **Clarke** puts it, the moment reproductive researchers attempted to claim the field of reproductive contraception as a legitimate scientific field, simultaneously, women-centered contraceptive research was pushed to the periphery and aggressively infused in the developing countries in integration with population control methods. For feminists both these domains, that is, women's involvement in the development of reproductive technologies, and women as users of these technologies seem to have inherent challenges. Hence, they cannot as always be seen as having liberatory potential for women. Within the field of contraceptive research, the woman as 'researcher' and as potential 'user' have received scant attention.

Check Your Progress: *Name and briefly describe any three issues of concern to feminists in the field of reproductive technology.*

12.4 CULTURAL NOTIONS OF REPRODUCTIVE TECHNOLOGIES

In this section, we will primarily look at the proliferation of various reproductive technologies in the market in the context of the notion of motherhood as culturally accepted phenomena. Let us begin by understanding this relationship.

12.4.1 Cultural Acceptance and Reproductive Technology

The development of reproductive technology has been built on the cultural notion of parenthood and infertility. Therefore, new reproductive technologies have been put to use and accessed in relation to infertility treatment exclusively. In this section, we will focus on the understanding of reproductive technologies, in particular, IVF, through a cultural lens. Reproductive technologies are the embodiment of cultural norms and are entwined with the lives of people in a complex way. The advancement of reproductive technology has shaped the way women, in particular, experience their body, motherhood, and their lives. For a majority of women, the female body has been the primary site for innovations in reproductive technology.

These technologies are not liberating in themselves, but are instrumental in shaping the lives and thoughts of men and women in and around conception, childbirth, and infertility. **Sarah Franklin** uses the term 'embodied progress' to explain the growth of IVF in the late twentieth century as a range of resources which produce new form of reproductive choices with the expansion of science and technology. Innovations related to reproductive technology have been rooted in the cultural values of scientific growth and moved by market and economic indicators. Here, both scientific progress and reproductive based innovations are supported through the cultural notion of childbirth and the biological family. As feminists and anthropologists argue, the progress of reproductive technologies have not only seen nature as a category that can be manipulated, but also acquired an understanding of human interventions in the process of reproduction as being 'normal'. Women and couples, undergoing assisted conception became the passive

recipients of technological culture, which has been created through the new reproductive practices. As **Franklin** has pointed out, with the new culture of procreation some reproductive dilemmas have emerged as follows:

Box 12.2: Associated Reproductive Dilemmas

- **New forms of scientific innovation, new uncertainties are gaining momentum;**
- **Human interventions in reproduction are seem to be a natural process;**
- **Discrepancies are seen between the representation of IVF as a progressive technology and the experience of women and couples with IVF as a failure to achieve progress**

According to **Lene Koch and Janine Morgall** (1987), reproductive technology like IVF can be viewed as involving simple procedures from a woman's perspective. However, the procedures become complicated the moment the body is subjected to a number of unknown processes.In spite of its low success rate at different phases of reproduction, many women from middle and upper classes have conceptualized these technologies as enablers in infertility treatment. Reproductive technologies have been used by both women and men to shape their lives around biological reproduction. This in itself is an embodiment/expression of cultural and social expectations. Not necessarily are technologies used by women to have control over their reproductive bodies— rather their using them reinforces the existing gender norms. The growth and design of these technologies are determined from the perspective of both women and men who have access to these technologies as prime users. In the present context, IVF is primarily meant for heterosexual couples, and seen as the last hope in dealing with the infertility stigma that is attached to a woman's identity.

Let us take the example of Laura, a thirty-year old woman who underwent IVF treatment and had experienced the failure of the technology. She argues that her experience with IVF treatment had posited her in another identity, i.e., patient-consumer position. The advancement of reproductive technologies has transformed the nature/culture divide (Becker, 2000). **Gay Becker**, a feminist anthropologist, describes her experience with IVF as a process consisting of retrieval of eighteen eggs from her body and her realization that the process could not lead to conception in reality. In particular, the hope for success forces both women and men to undergo intensive treatment for childlessness. In this context, women and men feel that these technologies are necessary as a means of having a biological family, which in itself is tried to cultural norms.

As **Anthony Giddens** notes, "although in most parts of the globe, people now live in created environments subject to human control, in everyday life people continue to view their bodies as natural, resisting the idea that the body reflects cultural notions of bodiliness, even when that body has been modified by implants and other technological changes" (cited in Becker, 2000, p. 7). A couple's access and use of these technologies are central to the

growth of fertility industries across the globe. Similarly, the presence of these technologies in the market has accelerated their use and has also accentuated the shift from nature to culture, and private to public in case of reproduction. Increasing use of these technologies is fundamental to the transformation of the natural practice of reproduction; however, this has challenged the fundamental norm of prioritizing a biological child over adoption.

12.4.2 The Growth of the Fertility Industry

After the birth of the first test-tube baby in England, IVF and other assisted reproductive technologies had moved from the laboratory and experimental stage to its operational-use stage across the developed and developing worlds. Initially, reproductive medicines such as oral contraceptive pills, IUD (Copper T), hormonal injectable contraceptives, hormonal implant, morning-after pills were developed in order for women to have control over their bodies and for treatment of problems related to the fallopian tube. Other advanced technologies, including IVF, started to focus on the problem of male and female infertility directly while viewing infertility as a form of 'illness'. Eventually, these technologies were advised to patients/couple when they visit infertility clinics for medical guidance and counseling. Recently, IVF has been projected as a viable option within the range of medical options in the name of infertility treatment. Such programmes were specifically encouraging women in their thirties to experiment with the notions of a 'take-home baby'. In spite of its high cost, many couples in the developed world saw IVF as an option to treat infertility. During the 1990s, there was a significant growth of IVF centers in United States to facilitate infertility treatment. Similarly, the criteria for accessing IVF became flexible - raising the age limit from thirty-five to forty, accommodating consumers of various income levels, and treating all kinds of infertility in the name of IVF. With this process of corporatization, IVF aggressively penetrated into the market of both developed and developing countries. The flexibility in the criteria was targeted at creating a consumer-friendly culture towards these technologies. Owing to this, the reproductive technologies have been able to enter into mainstream medical practice, as these technologies are intrinsically associated with social and cultural expectations of the individual and society. Therefore, understanding the growth of these industries entails an examination of such technologies in the context of social relations, norms, social structures and systems.

Similarly, the promotion of IVF related technology in United States and other developing countries is intricately connected with the perception of infertility as an illness within a larger cultural framework which promotes the family and biological children as a form of the old-age social safety net. Hence, reproductive technologies can be seen as propagating a 'culture of reproduction' that had its origin in patriarchal practices and social institutions such as family and marriage. As Becker has pointed out, "new reproductive technologies can tell us about how the consumption of technology evolves as a cultural process; that is how it emanates from social forces. These processes are occurring at a time when technological advances are appearing at quick

succession, when cultural meanings are in a flux, gender is in continuous negotiation, and when technology itself can be seen as a culture" (Becker, 2000, p.11).

When a specific aspect of any technology can reproduce and confirm set social norms, identities, and institutions, it can come to have meaning for the individual over any other costs, such as the cost of life, body, and emotion. For instance, IVF is embodying the truth of motherhood or parenthood for every individual promotes itself in a market driven economy. Progress as a modernist ideology gained ground worldwide in the early 20th century. With this was promoted the idea of industrialization and innovation in the fields of agriculture and biomedicine. In American society, innovations in biomedicine were often used as a metaphor for progress. The developments in the field of biomedicine primarily focused on various assisted reproductive technologies for safe conception. Media coverage on new technology along with consumer choice, promoted public acceptability for reproductive technology. This led to a shift in the public's attention from viewing reproductive technology as coercive to 'normal'.

In the West, people often see images about the advancement in medical technologies in the newspapers and magazines with a pictorial depiction, i.e., a doctor holding a baby; often, the mother is placed in the distance background and the father is rarely present (Lie, 2002). Science and technological developments have been the fundamental principles of explaini Since, procreation is seen as being central to motherhood, with the biological child as fundamental to the notion of family technology which promotes these ideas becomes accepted as natural by society. Many women and men in America have felt that their perception about reproductive technology has changed after viewing news reports and talk shows on innovations in biomedicine (Becker, 2000).

When any innovation in biomedicine goes past the stage of experimentation, and becomes available in the market, it simultaneously gets wider dissemination and public acceptance. As you have seen, these technologies had wider popularity as they were viewed as being meaningful by people and were seen to be capable of sustaining and supporting the identity of motherhood. Any resentment of the idea of technology as a form of control over the body gets suppressed because of the larger cultural acceptance of these technologies as they linked to the 'natural'.

Check Your Progress: *How does culture influence the growth of reproductive technology market? Try to explain this in your own words in the context of India or any other country.*

12.5 NARRATING WOMEN'S EXPERIENCES

In the previous section, you have seen how reproductive technologies embody cultural notions of fertility and promote traditional constructions of gender, motherhood and family. Historically, reproductive technology was advanced with a view to provide women economic empowerment, and to contest patriarchal and expected gendered roles (of enforced motherhood).

12.5.1 Women's Embodied Experience with 'IVF'

Feminists have raised concerns about the mental and financial health of couples who are under the surveillance of IVF. Hence, the liberating or empowering impact of these technologies can only be assessed from the individual's embodied experience of new reproductive technologies. In the subsequent paragraphs, we will explore the differential impact of various reproductive technologies on women of privileged position vis-a-vis women from less privileged classes.

Becker narrates the experience of Ashley with IVF as: *"They gave me a 20 percent chance in one cycle, and I see this as 80 percent failure of IVF. But I feel, I need to go through this motion, so that when I look back, I would not feel that I hadn't tried this method. But I do not know if I can stand it. The money that is involved is not covered by insurance, and our saving is just going. I think we are going to see how bad it is"* (Becker, p.13).

The above description shows that often consumers who contemplate opting for assisted reproduction feel hard-pressed to find money to invest in the entire process. Even though the economic costs of these technologies are high, the market reinforces the justification of expensive technologies since they may help the couple in having a biological child. The cultural construction of reproductive technologies and their costs are valued with regards to pregnancy and gaining a biological family. Since the latter's value is perceived as immeasurable, it sustains the acceptance of these technologies in spite of the high costs involved.

Use of different assisted reproductive technologies for procreation has resulted in the documentation of conception, embryos and fetuses. Such a documentation in turn leads to the control of the female body. **Merete Lie** describes this process as the "new transparency of the body" (p. 186) in which pregnant women's bodies have become the site of experimentation. Thus, the woman's body becomes an integral part of the public sphere and aspects of public life.

12.5. 2 Experiences in the Global South

In the last section of this unit, we will look at various contraceptive technologies and practices associated with these technologies from a critical position. In the global south, women's access to reproductive technologies can be comprehended in two ways: i. the inter-linkages between economic growth, high fertility rate, and enforced family planning and ii. the role of women in developing countries as providers of ova and surrogacy service.

In the global south, reproductive technologies were introduced to women not within a larger discourse of the individual's right to one's body, but within the discourse of family planning and population control. The control of population in developing countries is mainly achieved by imposing restrictions on reproduction and women's sexuality. Developing countries have been viewed as a potential site for introducing contraceptive alternatives to women. In this regard, **Vineeta Bal** et.al. (2008) has critically examined three major issues: sterilization, popularization of hormonal contraceptives, and testing of contraceptives within the field of reproduction. The sterilization drive during the Emergency period in India has been severely criticized. However, scanty attention was paid to the suffering of women who underwent tubectomy operations during that period. Instead of this, international funding agencies in collaboration with the state machinery started pushing permanent methods such as sterilization for women.

Similarly, for popularizing pills and injectable hormonal contraceptives, developing countries like India and Bangladesh are seen as obvious grounds for testing such reproductive medicines. Most of the clinical trials have been conducted on women who are relatively poor and belong to the underprivileged sections of the society. Therefore, understanding reproductive technologies in the context of global south becomes important for all of us, as it reflects the underlying complexities between the state, market and other donor agencies that project female bodies differently in relation to specific reproductive technologies. According to Richey (2004), the family planning programme in Tanzania categorizes Tanzanian female bodies as traditional and modern in order to facilitate the dissemination of modern family planning technologies. To quote, a service provider who had been working at a regional hospital explained, "times have changed and women do not want as many children as their parents had: you see women who have had many children – they have breasts that hang down to here—breasts like socks" (Richey, 2004, p. 66). Here, Tanzanian female bodies have been referred to as backward, in-disciplined bodies that are in need of disciplining technologies like modern contraceptives. As you can see, family planning technologies are grounded in the wider socio-economic, racial and political structures.

Various factors such as state led policies, lack of gender sensitivity, and opening up of the world market are potential threats to women's individual rights and their access to preferred technologies. To quote Richey, " I am not arguing here that modern contraceptives should not be made available to Third World women, simply that their prioritization in the Tanzanian family planning programme reflects an interest in contraceptive continuity, not one in increasing the choice of individual women" (2004, p. 62). Similarly, **Wangari** (2010) has argued that although feminists have articulated upon the discourse of family planning in the global, there is a need to evaluate Western hegemony and its control of resources from class-based, race, and gendered perspectives. Further, she argues that certain assisted reproductive technologies like treatment for infertility, successful pregnancy for women during menopause, gestational motherhood, artificial insemination, and selective abortion have been a matter of liberation for a few women in the

west and women of upper classes. However, for a majority of women in the Non-western world these technologies have only focused on reducing the fertility rate. In the developing countries, the choice of pregnancy often does not rest with women. Although the reproductive rights debates are framed within the context of women's empowerment and development, the question of women's access to reproductive technologies can not be dealt within isolation.

While giving women access to birth control pills is assumed to empower women, and enable them to gain autonomy over their bodies and reproduction, what needs to be questioned is who these women? When such 'population control' measures are introduced within working class populations, or amongst people of colour, the state's agenda needs to be interrogated and questioned. The history of pill research in Puerto Rico stands as a glaring example of understanding the interconnections between biomedical research, women of colour and overpopulation. When **Thomas Parran,** head of U.S. Public Health Service, thought of the use of birth control measures to check the growth of overpopulation, he mentioned countries like India, China, Java, and Puerto Rico. In these countries, overpopulation was seen as a critical factor to be controlled, while other concerns such as health risks associated with drugs or steroidal contraceptives were ignored (Briggs, 2010). Pill research shows a lack of concern about women's bodies as it was construed that the risks of using an untried pill can be taken since the women involved were largely working-class women from the third world. Hence, Puerto Rico was considered as the laboratory for testing the new drugs for the benefit of other women (from the first world). Later, Puerto Rico was justified as an appropriate site for the research, as the pill was developed and intended for women from the third world and the working-class. Gamble, one of the architects of pill research promoted the slogan—''simple- method for simple–people'' to back the distribution of contraceptive pills in Puerto Rico (Williams & Williams, 1978, p. 4, cited in Briggs 2010). The history of pill research shows how women of different class, caste, and region were imbricated differently in the web of policies, programmes, and biomedical research. Therefore, it is important to discuss the individual's rights or rights of ownership of women's bodies from a Third World perspective where reproductive technologies are imposed upon women with the institutionalization of family planning policy and the establishment of international financial institutions.

While western feminists have emphasized the women's agency in reproductive choices, these debates have been articulated largely around abortion. Contrary to this, in India, the rate of illegal abortion or forceful abortion is increasing, as there is a strong prevalence of son preference norms. Reports like Planning Family Planning Gender clearly indicated that India has been witnessing a drastic decline in overall sex ratio and child sex ratio in particular with an exception to 1971 Census. This trend raises questions pertaining to the missing girls and daughters in Indian society due to the practice of gender differential treatment within the family and community. The study reflects that in the current context, families unconsciously and consciously employ various household strategies to

achieve ideal family type with desired number and sex distribution. At the level of conscious planning, families are using various technologies for achieving the family planning goals. Various technologies such as as ultrasound and MTP are intervening at a much earlier stage of pregnancy for sex determination and aborting the female foetus. The Family Planning Programme has been campaigning for a family of two children as an ideal family and families try to adhere to this norm with the introduction of reproductive technologies such as contraceptives and MTP pills. While the increasing use of technology is touted as a normalized part of safe pregnancy, the normalization of certain technologies is undoubtedly helping families to remove female foetuses. The study reported that there is mushrooming of MTP facilities in Punjab and Haryana, and women have been subjugated to multiple abortions in search for a male child. The maternal body succumbs to technological surveillance under the pressure of family and community (John et.al, 2008). Such a usage of technology throws light on how western notions of women's reproductive freedom can be interpreted differently in other contexts.

The perspective of global south on reproductive technology does not disagree with the notion of women's access to technologies; however, it emphasizes the question of women's autonomy and agency in the context of various issues like access to safe abortion, health care and both women and men making reproductive choices over contraceptive measures. As **Ranjani K. Murthy** observes, "the liberal discourses of reproductive choice are being imposed upon the women of Asia and India in particular, by the international development agencies and the sexual and reproductive rights lobby without educating women towards the discriminatory realities of their lives on the basis of caste, region, migrant workers, and ethnicity" **(Ranjani K. Murthy , 2011).** In the developing countries, the concept of reproductive rights and choice needs to be seen as concomitant with challenging the gendered power relations that govern issues of son preference, female infanticide, sex-balancing, and so on.

Box 2.5: Wacera's Embodied Experience with Contraceptive Pills

Wacera's experience with contraceptive pills in rural Kenya is evident of this fact. She is a mother of five children and given pills without any prior physical examination. She accepted the fact of pills as she was believed that pills would improve her life condition by controlling her body and reproduction. She used to walk over twenty miles to reach the family-planning centers to get the pills. The campaign for family planning pills did not include information about various side-effects of the pills, health care delivery system, and issues of transportation and proper nutrition. Since, there was no follow-up examinations after having the contraceptive pills, Wacera was hospitalized three times with heavy bleeding (Wangari, 2010).

The story of Wacera can well represent the experience of many women of the developing world especially, those who do not have decision-making rights over their bodies and reproduction. The women's right to choose to have a

baby or not to have a baby in Third World countries is determined by cultural norms and expectations, information, access, availability of reproductive medicines, and the state. Agencies of patriarchy and market driven forces such as, the state, pharmaceutical companies, and the market, turn women into the passive recipients of both banned and new reproductive technologies. Determinants such as ethnicity, caste, class, and region, increase the vulnerability of many women.

The fundamental factors of women's health like poor nutrition, inaccessibility to health care facilities, and death during pregnancy and childbirth still go unnoticed in different countries. Women's health issues in the developing countries of global south are limited to the matter of using contraceptive measures and its distribution. Hence, this limited vision of women's health has led to the infusion of more powerful contraceptive technologies into the market. The acceptors and recipients of birth control are made to believe that their living conditions can be improved by the use of contraceptives; however, for the majority of women in the global south, it is actually the further exploitation of their bodies.

Finally, we also need to ask questions such as: To what extent do new reproductive technologies (IVF) reinforce heteronormativity? Do they possibly de-link reproduction from sexuality and marriage? In other words, have these technologies expanded the option of reproductive choice and rights for LGBT identified communities and individuals? The availability of these technologies is usually limited to heterosexual women, thereby excluding other gendered identities. IVF is simply a technological fix to the socially constructed notion of infertility; within the confines of marriage and biological family, it however, does not enable us to question the notion of infertility as social stigma. As **Koch and Morgall** (1987) have pointed out, single and lesbian women are completely excluded from the treatment of IVF. Hence, while technology in itself may not be gendered, its usage within particular socio-cultural contexts does propagate gendered and exclusionary mindsets and practices. The heterosexual family is upheld as the norm, to the exclusion of all others.

Assisted reproductive technologies can be conceptualized not merely as mere technology. These technologies have inter-linkages with other aspects of society such as social arrangements, patriarchy, power relations, and health issues. We need to contextualise the issues of motherhood, progeny, and the stigmatization of infertility within the framework of new developments, such as the growth of reproductive technologies in the market. The globalization of reproduction has intensified the growth and establishment of fertility industries in South Asian countries which is further leading to commercialization and commodification of the women's bodies, reproductive tissues and organs. We will be reading more about the new reproductive technologies and the transaction of reproductive body parts in the unit on "Surrogacy" (Unit 3, Block 3). The exploitation of women's bodies has become inevitable in this period of globalization of market and reproductive technology, hence provoking critical questions for feminist engagement.

Activity: *You have already read about different contraceptive technologies. Go to any Primary Health Care (PHC) Centre or any dispensary nearby your locality and find out the contraceptive options available for women. What conclusion can you draw from your findings?*

12.6 LET US SUM UP

This unit provides an insight into different ways of linking gender and reproductive technologies within specific cultural and social contexts. We began with a discussion of the feminist interrogation of reproductive technologies as liberating in nature. Next, we looked at the cultural and historical emergence of the fertility industry in the West, and the changing gender relations with relevance to the use of technology. We further analysed the relationship between gender and fertility technology by citing the different experiences of women undergoing IVF treatment. Finally, we employed perspective of women in the global south in the assessment of reproductive technologies within the discourse of a rights-based approach. This unit discusses the intense complexities between gender, technology, race, ethnicity, and class. The progress of reproductive technology has directly focused on the female bodies as biological resources for its expansion in the market, thereby perpetuating the unequal power relations between genders.

12.7 UNIT END QUESTIONS

1. Discuss and debate the use of reproductive technologies from a feminist perspective.
2. Reproductive technologies are liberating in nature. Do you believe this and if so, for whom?
3. How do socio-cultural expectations attached to the female body help in the growth of reproductive technologies in market?
4. If you know any doctor or couple who are willing to share experiences with IVF treatment, you can interview them and relate the associated dilemmas and risks that you have become familiar with.

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