INTERPRETING IVF FROM A FOUCAULDIAN PERSPECTIVE

by

BURCU GORGULU

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APPROVED BY:

Dr. Nedim Nomer …….

(Dissertation Supervisor)

Dr. Ayse Parla Alpan ……

Dr. Asli Carkoglu ……....

DATE OF APPROVAL: …….

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ABSTRACT

My research aim is to operationalize Foucault's 'biopower' in three layers –that is coproduction of nature and culture, construction of new forms of spaces of governance such as new definitions of race, gender or religious domains and new modes of subjectification in relation to truth discourses – on the political and cultural construction of in vitro fertilization technique. I claim that production of discourses in legal institutions and media and their interactions with existing social values based upon gender, ethnicity and race found a substantial domain in which people (patients) set their standards to make sense out of *in vitro fertilization* (IVF) technologies and by doing so they become both the producers and the subjects through out their (bodily or visually) experience of IVF. In this sense, Foucault's theory on bio-power can be used as an *analytical tool* to understand the recent developments in the assisted reproductive medicine, particularly in the case of IVF. In order to unpack the codified forms of power that reside control, surveillance and governance of bodies, I have developed a four level strategy. Firstly, I historicize IVF as a technological, cultural and economic site. Secondly, I focus on the concepts and discourses legal documents and mass media employed while telling stories about IVF. Thirdly, I demonstrate, through a survey study how these discourses are translated into people's understanding of IVF. What differentiates this piece of research from the entire industry that had thrived upon Foucault and feminism is the attempt to combine conceptions of biopower" in a Non-Western context.

ÖZET

Bu araştırma Foucault'nun "bio-güç" kavramını üç aşamada –yani doğa ve kültürün ortaklaşa yapılanmasını; ırk, toplumsal cinsiyet ve dinsel öğelerle yeni yönetim alanlarının geliştirilmesini ve yeni hakimiyet mekanizmalarının doğruluk söylemleri arasında şekillenmesini- incelemeyi amaçlıyor. Toplumsal cinsiyet, etnisite ve ırk kavramları bu anlamda yasal düzenlemeler ve medya insanların (hastaların) in vitro fertilizasyon (IVF) teknolojileri uzerindeki anlamdırmalarının oluşturdukları ve aynı zamanda bu anlamlara maruz kaldıkları sosyal değerlerin ortasında temel bir zemin oluşturduruyor. Bu anlamda, Foucault'nun "bio-güç"u yardımcı üreme teknolojilerinin ve bilhassa IVF'nin gelişmesini anlamak için bir analitik araç haline dönüşüyor. Bedenlerin kontrol, gözetim ve yönetimlerini düzenleyen kodlanmış güç ilişkilerini çözümlemek için dört aşamalı bir strateji geliştirdim. Birincisi, IVF'yi teknolojik, külturel ve ekonomik bir alan olarak tarihselleştirdim. İkincisi, yasal dökümanların ve medyanın IVF uzerindeki anlatımlarını inceledim. Üçüncüsü, anket aracılığıyla, bu tanımların bireylerin IVF'yi anlamak için nasıl kullandıklarını inceledim. Bu araştırma böylece Foucault'nun bio-güç kavramını ve feminist teorileri Bati-olmayan bir alanda inceleyen bir araştırma olarak benzerlerinden ayrılıyor.

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CHAPTER 1

FOCUS AND RATIONALE OF THE STUDY

1- Main Problematic

This dissertation attempts to analyse how assisted reproduction technologies became integrated in personal, social or political adherences, whereby public opinion formation and decision making processes of individuals are determined through discourses. Social aspects of new reproductive technologies have been an area of extensive study since 1980s; however most of these studies cover Western European-American frameworks and they are limited in terms of explaining social dynamics outside their geographical area. Having noticed this gap, I have focused on the Turkish case. I questioned how Turkish legislation and Turkish media constructed in vitro fertilization and then later studied to what extent these discursive practices were translated in a relatively small population (106 people), who were going under IVF. While undertaking the narrative analysis, I have chosen to include comparisons with the British case. Britain was selected for various reasons: First, historically first IVF baby was born in UK in 1978 and the subject has received a wide public interest since then; secondly, with the attempts to harmonize EU law in the medical field, Turkey could eventually choose to reorganize its regulations that are being widely discussed in the

UK context; thirdly UK has been one of the exceptional cases where IVF was included in health security system and this was a recent development in Turkish case.

2- Rationale for the Study

2-1- IVF: Meanings Produced in the Clinic

According to the figures provided by the Ministry of Heath in Turkey, there are more than two million couples in Turkey, who experience infertility and 150,000 couples out of this population initiate an IVF programme each year. These figures are similarly conserved in elsewhere, for instance according to the numbers provided by National Health Institute, three and a half million people in the UK alone experience infertility[1]. and 30,000 women sign up for the waiting list on IVF programme. [2] The cost of IVF changes significantly in accordance with the location the treatment takes place. As I will discuss in the section devoted to "Economics of IVF", there is a substantial financial difference between countries and even hospitals – which in turn translates into "health tourism" for various couples.

IVF, as a medical procedure, is complicated, multi-level, relatively long term and at times it is highly invasive in its nature. At the first step of IVF, women undergo the super-ovulation step, which requires number of fertility medicines to stimulate egg production and increase the number of eggs from one to several eggs per month. This first step is observed and controlled by trans-vaginal ultrasounds. Ultrasound at this stage initiates the establishment of "medical gaze"[3] –as the medical authorities' control over women's bodies[4]- as well as the possibility of provides more of "certainty"[5] and

[1] http://www.bbc.co.uk/health/fertility/bigissues_access1.shtml#current_access (accessed March.2007)

[2] http://www.bbc.co.uk/health/fertility/bigissues_access1.shtml#current_access (accessed March.2007)

[3] Jennifer Shaw, "Alien Life: Ultrasound as Extension of and Challenge to the Medical Gaze", *Visual Knowledges Conference*, ((University of Edinburgh, 2003)

[4] Katherine Boulay, "Perfecting the Match: The Visual Economy of the Fertility Industry", *Visual Knowledges Conference*, (University of Edinburgh, 2003)

helps to found "kinship through spectatorship."[6] At the second step of IVF, women undergo a surgery follicular aspiration to collect eggs from ovaries [7] and if the woman had been unable to produce eggs, doctor might suggest egg donation as an alternative procedure, if it is allowed in accordance with the national law. This step is followed by the actual insemination, fertilization outside the body, hence *in vitro.* Couples at this stage choose to run a pre-implantation genetic diagnosis for the embryo culture to check if "genetic deficiencies" are transmitted to their offspring. Reactions to genetic testing among women, their partners, medical authorities, religious groups and even among feminist writers are diverse but these discussions are often attempted to be mediated by the introduction of "informed consent".[8] At the final stage, embryos are transferred into the woman's womb and in order to increase the possibility of pregnancy, it is a general practice to implement multiple embryos at a time. Current medical practice often allows implementing a maximum of three embryos at a time, but as I will discuss in the "Media Analysis" chapter, there has been "dramatic" exemptions to this practice. Certainly, the risk of and difficulties of multiple pregnancies are traded over the risk of decreasing the chances of conceiving a child. The pregnancy rate as a result of IVF in the current medical practice is 34.8%, but only 27.6% of this number translates into successful births.[9]

As a result, IVF within the clinics, emerges as a commonly used, widely accepted medical procedure, which requires significant economic investment, patience

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[5] Price, Francis. 'Now you see it, now you don't: mediating science and managing uncertainty in reproductive medicine', in Alan Irwin and Brian Wynne. *Misunderstanding Science? The Public Reconstruction of Science and Technology*. Cambridge University Press (1996): 84-106.

[6] Taylor, Janelle S. 'Image of Contradiction: Obstretical Ultrasound in American Culture' in: Sarah Franklin and Helena Ragone (eds*) Reproducing Reproduction. Kinship, Power, and Technological Innovation.* Philadelphia: University of Pennsylvania Press (1996).

[7] http://www.nhsdirect.nhs.uk/articles/article.aspx?articleId=460

[8] PND, PGD feminism and 'informed choice' newsletter article: http://www.propeur.bham.ac.uk/NewsletterVol2.pdf

[9] IVF Success Rates, Oxford:Oxford Fertility Clinic http://www.fert.org.uk/index2.php?option=com_content&do_pdf=1&id=89

and support during the period taken up with the waiting list, decisiveness about medical procedures and acceptance of possibility of failure, as well as "political economy of hope" for reproduction.[10]

2-2- IVF: Meanings Produced Outside the Clinic

Assisted reproduction technologies, such as in vitro fertilization, ultrasound imagining, artificial insemination have their potential to diagnose, cure, and even prevent certain conditions and diseases. However, they are not constrained in the boundaries of laboratories or clinics; they perpetuate their existence through already existing cultural and societal structures and value systems. The questions they pose, the problems they attempt to solve, their extend to reach out larger populations in this regard raise various legal, ethical, social questions, which stem from the power structures they arise in. They act as carriers of culture, where medical authority and medical gaze are constantly kept on and influence the nature of the lay understandings of science as well as their action. Hence, far from being a peripheral part of the social and political life, reproductive technologies are in fact primal locus, where power relations are set and exploited. As yet, naïve to suggest that reproductive technologies tend to stay in the boundaries of the existing cultural values, in fact as Webster points out, such technologies find ways to "reinvent the boundaries between bodies in space and time"[11] and they act as resistant points by which deconstruction of morals and discourses that determine "subjects" and "agents". The relationship between self and others are therefore in a constant process of deconstruction and reconstruction and has the potential to create its own dynamic relations and "regimes of truth."[12]

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[10] Alexandra Plows, "Women in the Frontline? Feminist Issues in Genetic and Reproductive Technologies" *The Emerging Politics of Human Genomic Technologies,* (Belfast: 2006)

11Andrew Webster, "Innovative Health Technologies and the Social: Redefining Health, Medicine and the Body", *Current Sociology*, Vol. 50, No. 3 (2002): 443-457

[12] Foucault, Michel, *Power/Knowledge : Selected Interviews and Other Writings, 1972-1977* (NY: Pantheon, 1980): 133

2-3- Feminist Reviews

The literature on the effects of new reproductive technologies has grown since 1980s onwards, thanks to the feminist interpretation of science and society studies. These studies centralized the gender differences in terms of defining boundaries of reproductive technologies shaping the new forms of justices and injustices within the society. In this sense, they have focused either on the "men versus others" in terms of the measurement of experience[13] or the economic basis of technologies, which lead new types of coercive "interrelations between patriarchy and capitalism."[14] They were invaluable in terms of depositing how social institutions and economic class differences translate into the construction of sexuality and reproduction. They have formulated stages of "motherhood" as gestational, genetic and cultural relatedness[15]. For instance, Stanworth argued, along these lines that, new reproduction technologies could deconstruct the nature of motherhood, by dividing practices of carrying the baby (i.e. by surrogate mothers) vis-à-vis raising children.[16]

Surely, there were wide divisions among different feminist perspectives. Firestone[17] and Haraway[18] attempted to show how technological change could result in

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[13] Eisenstein, Z.R 'Developing a theory of capitalist patriarchy', in: Z.R. Eisenstein (Ed.), *Capitalist Patriarchy and the Case for Socialist Feminism,* (New York: Monthly Review Press, 1979)

[14] Heidi Hartmann, "Capitalism, Patriarchy, and Job Segregation by Sex" *Signs,* Vol. 1, No. 3, *Women and the Workplace: The Implications of Occupational Segregation*. (Spring, 1976), pp. 137-169. http://links.jstor.org/sici?sici=0097-9740%28197621%291%3A3%3C137%3ACPAJSB%3E2.0.CO%3B2-E

[15] Middleton, Chris. The familiar fate of the famulae: Gender divisions in the history of wage labor. In ***On work,*** edited by R. E. Pahl. (New York: Basil Blackwell, 1988)

[16] Stanworth, Michelle. **"**Reproductive technologies and the deconslmction of motherhood". In *Reproductive technologies: Gender, motherhood and medicine,* edited by *M.* Stanworth. Minneapolis: University of Minnesota Press. 1978

[17] Firestone, S., *The Dialectic of Sex: The Case for Feminist Revolution*, (London: Jonathan Cape. 1971).

the change in cultural institutions and transform the meaning of motherhood, kinship relations and women's identities. On the contrary, a body of feminist work have focused on the conservation of traditional means of kinship, motherhood and familial ties through the introduction of reproductive technologies. Among these Rothman argued that technologies that are created by 'men' inevitably result in the unequal distribution of power, for these technologies tend to place women's bodies under masculine and medical control.[19] Radical feminist response has been suspicious about the change, that is implemented through medical technologies; simply because they argued new generation of technocracy would legitimize the already established power relations within the society. [20]

2-4- What does Foucault's Theories Offer?

As the debates about the nature of technology and its social effects continued, a whole body of Foucault's work have been opened up into contestation. This is because the definition and nature of power, how it is formulated, asserted, maintained have been one of the key areas in sociological and philosophical theorizing; hence one might use various theories to explain such tangible relationships. Still, Foucault remains as one of the most suitable ways to problematize how sexuality is constructed and regulated within the public domain. This is particularly because of his immense writings on how mechanisms of discipline and regulation translate into "dividing" practices and how individuals are governed through multiple set of actors, often resulting in a totalizing discourse[21]. The revival of biological, particularly genetic constituents of our

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[18] Donna Haraway, "A Cyborg Manifesto: Science, Technology, and Socialist-Feminism in the Late Twentieth Century," in *Simians, Cyborgs and Women: The Reinvention of Nature* (New York; Routledge, 1991), pp.149-181.

[19] Rothman, S. M. Woman's proper place: A history of changing ideals and practices 1970 to the present. (New York: Basic Books, 1978)

[20] Corea, Genea *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs, (*New York: Harper and Row, 1985)

[21] Foucault, Michel, History of Sexuality, The Will to Knowledge (London: Penguin,1978)

contemporary society reflect a similar problematic to the questions he had posed in his writings, even more powers over selves and bodies are not only polarized towards death, but of life politics and the micro-relationships they entail.

Foucault provides the following conceptual tools, which enable one to analyse in vitro fertilization as a social construct, which is defined within the society, and as a social agent, which redefines the societal relations. One of the terms in this context is that of "biopower"[22], which categorizes subjects in terms of their gender, sexuality, fertility, race and healthiness and attempts to suppress those who do not fit in this category or to normalize them through institutional and discursive practices. Second conceptual term he introduces is that of "apparatus"[23], which claim that power relations are deeply embedded and that they extend to everyday practices, such as hospitals and schools. Thirdly and most importantly, he recognizes multiple relationships and multiplicity of "truth claims"[24], by that every actor, doctors, clinicians, media develops its own discursive strategy and subjectified individuals according to their status of bio-power. Hence bodies become "arenas for the wars of sovereignty"[25] where, culmination of truth and modern power act all together on, shaping individual's choices and actions.

Foucault differentiates from other contemporary social theoreticians, who attempted to unpack the power relations firstly because of his particular interest in "micro-politics"[26] especially those practised within clinics, hospitals, schools. He does not understand politics specific to the parliamentary documents, rather he is interested in the reflections and reconstructions of power in every day life. Secondly, he recognizes multiplicity of actors and multiplicity of relationships among them. This is

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[22] Dreyfus, Hubert L. & Rabinow, Paul. *Michel Foucault: Beyond Structuralism and Hermeneutics*. (Chicago: The University of Chicago Press, 1982).

[23] Foucault, et. al. 1978: 56

[24] Hoy, D. C. 'Introduction'. *In D. C. Hoy, Foucault: A Critical Reader*. (New York: Basil Blackwell, 1986): 1-25.

[25] Michel Foucault, *Discipline and Punish: The Birth of the Prison*, (New York: Vintage: 1975).

[26] Michel Foucault, 'Two Lectures', in C. Gordon, ed., *Power/Knowledge* (New York: 1980)

not visible in Gramsci's analysis, for instance, Gramsci's theory of subordination and hegemony is based on the rules that are determined by the singular "political society" which consist of central capitalist state and its institutions, over- imposing its rules to the consenting "civil society"[27]. Foucault, on the other hand, would argue that members of civil society are both the rule-setters and the subjects within a bidirectional manner and he would argue that state institutions are not the only site of contestation. Thirdly, Foucault sees technologies and those who undergo these technologies as both "agents" and "subjects"[28]; again the bidirectional process of governing the self is a conscious attempt that is deconstructed and reconstructed within a regime of truth, which have multiple "claims of truth". Unlike Althusser's analysis, Foucault does not suggest that there is a constant" battle against the ideology"[29]- he rather emphasizes the way in which numerous claims of truth could survive well together despite the contradictions they produce.

2-5- Foucault and Feminism

Correspondingly, Foucault can be said to influence feminist theory, on themes of power, sexuality and technologies. Feminist theory, which attempts to delineate boundaries between body and self within a certain set of power relations, have long utilized Foucaultian terms but in the meantime developed a unique perspective to the interpretations of practices that are determined through discourses and practices of biomedicine while discovering the definitions of femininity, motherhood utilized within the medical technologies. Similarly, feminist analysis of assisted reproduction technologies and their ways to reshape societal structures or their means to perpetuate the gender-based power structures question similar problems, where secifically, cross cultural studies that base the relationships between new technologies, fragmented, relative moral standards, kinship, and motherhood have been discovered. Nonetheless,

[27] Antonio Gramsci, *Selections from the Prison Notebooks*, (International Publishers, New York, 1971)

[28] Foucault, et. al. 1978:202-203

[29] Louis Althusser, Lenin and Philosophy- Part:2, (New York: Monthly Review Press, 1971) 134

the interaction between Foucault and feminist literature is a double-edged sword, it has many overlapping sights, as well as sites of divergence. In this particular section, I will attempt to identify how these divergences emerge.

For the purposes of my analysis, the first domain of feminist work, I argue, is the work that focuses on articulation of bio-power and how certain discursive practices constrained women into "docile bodies"[30], which are disciplined by both cultural values and by means of self regulation.[31] In this regard, Foucault's description of "techniques of self" through "docility" became means of internalizing the power relations that exist within the society.[32] As Foucault argues, the internalization of these values and subjectification do not arise from a sovereign, that is centralized to oppress the population, but these values are inherited in the institutions and micro-politics of everyday life[33]. Schools, clinics, prisons and any other institutions come in effect to form a mechanism of self control for individuals. Sawicki argues that women's experience of their bodies is constructed along the lines of masculinity and femininity, by utilizing several occasions and techniques of self, i.e. health, exercise, beauty techniques. This in turn resulted in the construction and empowerment of "male gaze" on women's bodies.

The second domain of feminists took the alternative pathway and analysed multiple power holders and delimited power as a resistance point. Foucault, having identified multiplicity of meanings, hence resistance within the power relations, asserted that all identities are constructs. As Butler suggests, the resistance derives from the fact "to locate strategies of subversive repetition enabled by those constructions, to affirm the local possibilities of intervention through participating in precisely those practice of repetition that constitute identity and, therefore, present the immanent

[30] Foucault, Michel. *Discipline and Punish* Trans., A.M. Sheridan Smith. Vintage Books, Inc., 1995)

[31] Bordo, S. "Feminism, Foucault, and the Politics of the Body." *Up Against Foucault: Explorations of Some Tensions Between Foucault and Feminism*. C. Ramazanoglu. (New York: Routledge**,** 1993), pp. 191.

[32] Foucault, et. al. 1995.

[33] Foucault, M., Ed. "Concern For Truth." *Foucault Live***.** (New York,: Semiotexte, 1996): 462.

possibility of contesting them."[34] This way, Foucault seems to deposit a space for the accommodation of those, who do not fit into the categories of "young, heterosexual, and married." The third domain of feminists[35] took a post-modern approach and identified discourses on sexuality as a transition to the modern regimes of power and criticized modernism as a source for proliferating subjectification and subordination.

However, in all these overlapping attempts to combine Foucault's work with feminism, they have faced with certain dilemmas. Firstly, Foucault focused on self as a source of governance and his theory was gender-blind and the resistance he pointed out was a de-sexualized one. As Bartkey argues, "his analysis as a whole reproduces that sexism which is endemic throughout Western political theory."[36] Secondly, gender differences that are taken into account in Foucault's work is based on the duality between male and female –and furthermore the effects of power on the body were equated equally. Such an attempt limits the power of many activist groups today, which choose to seek recognition for identities that based on difference. Secondly, Foucault's position on sexual identity leave almost no room for understanding ways to improve the conditions which result in oppression and they lack to preclude empowerment of women as agents in the socio-political arena; his description of resistance could only exist within the certain resistance points, which is determined by the power relations and consistencies in the regime, hence every opposition against the system is in fact predictable and there is not much room for change. It is Foucault's mutability on gender that makes him in conflict with feminist debates and activism.

[34] Judith Butler, Gender Trouble: Feminism and the Subversion of Identity (New York: Routledge, 1990).

[35] Sarah Franklin 'Post-Modern Procreation: Representing Reproductive Practice'. *Science as Culture*, (1993) 3, 4, 17.

[36] Sarah Bartky, *Femininity and Domination: Studies in the Phenomenology of Oppression*, (New York: Routledge, 1990).:63-82.

3- Research Objectives and Strategy

I argue that assisted reproduction technologies are, as any other technological development, social constructs which are shaped by the discursive practices that we come across in everyday life. Biomedical decisions are not only regulated at the domain of parliamentary proceedings or by legal documents but they are defined through multiplicity of actors particularly by mass media; and patients are governed through the existing discourses, which might categorize, suppress, alienate, exclude them. Such attempts of discipline, regulation and governance takes a more severe for women and at this stage, feminist studies can be implemented so as to understand how these regulations translate into new definitions of family, fatherhood, motherhood and how in turn such definitions alter individuals' experiences while undertaking assisted reproduction technologies.

With this framework in mind, my research aim is to operationalize Foucault's 'biopower' in three layers –that is coproduction of nature and culture, construction of new forms of spaces of governance such as new definitions of race, gender or religious domains and new modes of subjectification in relation to truth discourses – on the political and cultural construction of in vitro fertilization technique. I claim that production of discourses in legal institutions and media and their interactions with existing social values based upon gender, ethnicity and race found a substantial domain in which people (patients) set their standards to make sense out of IVF technologies and by doing so they become both the producers and the subjects through out their (bodily or visually) experience of IVF. In this sense, Foucault's theory on bio-power can be used as an *analytical tool* to understand the recent developments in the assisted reproductive medicine, particularly in the case of IVF.

The precise question I am interested in is how to define 'biopower' in a way that it becomes a measurable quantifiable tool that seize the technologies, bodies, time and spaces surrounding it. My belief was that if what is meant by "power" is somehow codified, then the model in which we operate where the ambiguities of nature and culture exist ever strongly then before would become an understandable network and as

a result the power that generates control, fear, surveillance, monitor of bodies is exchanged into an exercise at the level of deciding how to live.

Following Foucault's insights on how to problematize the issue of bio-power, I ended up using the complex relationships between power and knowledge- how they are co-produced in a cyclical manner, authority and management of populations, surveillance (of bodies) and their mechanisms of life, particularly birth and its morality. If one seeks to 'invest life through and through' as Foucault suggests, then it eventually appears that 'claims to life' on one's body, on one's health becomes a political question-where micro-politics is the sole producer and subject of the technologies it produces. In general then, the decisions over life and death, health and illness are collected in claims of 'bio-power', which enables the production of particularistic knowledge –the medical gaze-, and the support for regimes of authority –if not a sovereign, a liberal state where governance is held by its own dynamics-

In this regard, bio-power refers to the entire contested field of problems and strategies that are part of the every day life in our contemporary society and hence it has an analytical and critical value to address the issues we read about on newspapers, exercise in clinics and practice in our social lives. What comes out of biopower is a three-fold analytical tool:

Firstly, discourses that produce claims of truth and knowledge that characterizes understandings about 'nature' and 'biology' is produced at the scientific level. However these productions are never purely 'scientific' or 'biological' or 'natural' claims –they are extensions of demographic, sociological thoughts. Secondly, certain strategies are adapted on collective bodies that are territorialized either by the boundaries of nation-state (i.e. in the field of law) or by the boundaries of clinic (i.e. categories of deviance, illness and disease). Thirdly, particular modes of subjectification develop where there is no longer need of an authoritative figure to coerce individuals' behaviour. Rather the authority is established through 'truth discourses' (i.e. how we came to understand ourselves within gender relations, how maternity is produced or how families emerge). At the end, the self is governed in the name of her/his life or health or in the name of survival of their family and kinship.

Having identified, these three levels where biopower acts upon, I have selected to work on *in vitro fertilization* as an area where concepts of sexuality, reproduction and technology combine and set news relations between patients, doctors, families and politics. The new reproductive technologies are not restricted in the boundaries of physical coercion and state interest – although such examples did occur at the beginning of the 20th century. What is now rising and promising is the matter of 'individual choice' or at least the discourse of *individual choice.* For the first time in history, we can realistically debate on the possibilities of going 'against the nature'- having babies, which we would have not had if we were constrained to our 'nature.' Similarly, almost every day newspapers and TV announces about the possibilities (and 'hope') these technologies could offer, Hype, hope and interest is combined with public disguise, scientists' or medics' devotedness and social scientists' scepticism marks the ways the management of populations now take place. It is also my aim however, not to fall into Foucault's gender blind analysis and be adequately representing the experience and construction of IVF that are perpetuated along with the gender differences.

In order to do so, I will take a three step approach. Firstly, I investigate how meanings are produced at the domain of law and regulations concerning IVF. To do so, I have first historicized IVF as a technological and cultural site. Secondly, I will focus on the concepts and discourses mass media employed while telling stories about IVF. Thirdly, I will demonstrate, through a survey study how these discourses are translated into people's understanding of IVF. What differentiates this piece of research from the entire industry that had thrived upon Foucault and feminism is the attempt to combine conceptions of biopower" in a Non-Western context. Studies of reproduction technologies and their social meanings in non-Western geography are extremely limited and I hope that this dissertation will contribute some new information and insights in this whole body of knowledge.

CHAPTER 2

HISTORY OF IVF

1- History of IVF in UK

1-1 - Late 18th- Early 20th Century: Artificial Insemination

Reproductive technologies can be analyzed in their relation to the emergence or rising interest in studying biology in the 18th century Europe. Although the artificial insemination technique was used in animals since 15th century in Middle East[37], the actual first attempt to utilize the technique on humans was not until 1785, when a Scottish surgeon named John Hunter successfully employed artificial insemination on

[37] A.M.C.M. Schelien, *Artificial Insemination in the Human* (1957):9 IN Law Reform Commission of New Wales, "Discussion Paper 11- Artificial Conception: Human Artificial Insemination" (1984)
http://www.lawlink.nsw.gov.au/lrc.nsf/pages/dp11chp1 (accessed March.2007)

humans in London[38]. Later in 1845, Robert Dickinson experimented with donor sperm[39]; however the Church condemned such experiments, hence all experiments were run in secrecy.[40] Around the same time, Heape, who was a recognized reproductive biologist, published an article in which the relationship between seasonality and reproduction in isolated mammalian systems were examined[41]. As Foote points out this paved the way for Cambridge to "become a world centre for reproductive studies."[42]

It was not until mid 20th century that scientific journals and public discussions of scientific developments were enabled on donor insemination. In 1909, Davis Hard published an article in the Medical World, an American journal of medicine, in which he claimed that the first human donor insemination had been performed at the Jefferson Medical College in Philadelphia in 1884[43]. The donor insemination in England was not recognized in his letter. Hard, in his letter, asserts that a Quaker merchant family applied to Dr. William Pancoast for their inability to have children. His examinations suggested that the husband was azoospermic, sterile; consequently in order for them to have a child, the wife received donor sperm without knowing that the sperm did not belong to her husband. Donor insemination (DI) had been seen as a practical solution to

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[38] Stedman, *Medical Dictionary* (1982): 660.

[39] Robert Dickinson, "Lifting and Manipulation of the Uterus through the Abdominal Wall to Control Postpartum Hemorrhage" Brooklyn M J, 13, 137, March 1899 IN Alan F. Guttmacher "Artificial Insemination", *Annuals of the New York Academy of Sciences* 1997 (3) (accessed March.2007)

[40] R. Nactingall, Secrecy, A resolved issue in the practice of donor insemination, American Journal of Obstetricians Gynaecologists no. 6 (1993):1846-1851

[41] William Heape, "The artificial insemination of mammals and subsequent possible fertilization or impregnation of their ova" Procreative *Reproduction Society London* no. 61 (1897) :52–63 IN ReproMED (University of Warwick, Centre for Reproductive Medicine) "In vitro fertilization history" (2001)
http://www.repromed.org.uk/history/ (accessed March.2007)

[42] R. Foote, "The history of artificial insemination: Selected notes and notables", (2002) *American Society of Animal Science. 2,* http://www.asas.org/symposia/esupp2/Footehist.pdf (accessed March.2007)

[43] California CyroBank, 'sperm banking history" http://www.cryobank.com/sbanking.cfm?page=2&sub=126 (accessed March.2007)

the male infertility problem and the doctor, William Pancoast, did not feel any obligation to present consent from his patients. Later, when finally the wife was pregnant, the husband was informed about the procedure –that is his wife got pregnant by some donor's sperm-. Luckily, the husband accepted well but the woman was never –before or after the procedure- informed.[44]

1-2- First Half of 20th century: Science Fiction to Scientific Hope

In Europe, in the first half of the 20th century, several papers on artificial insemination and its methodological efficacy on mammalian populations were published. For instance, Ivanow studied domestic farm animals, dogs, foxes, rabbits and poultry[45] and his work on horses were published in the Journal of Agricultural

[44] Although the article was published in an American Journal, it is relevant in terms of medical practice in the UK in late 19th century, since artificial insemination by donor sperm was recognized as a technique and a medical practice at that time in UK. Since there was no specific regulation, other than the condemnation by Church, I argue that similar practice denying patients' informed consent could have taken place. It is interesting to see how several mechanisms of power function in relation to practicality, knowledge, gender and religion can function together even in the lack of official or state-centred regulations. Artificial insemination was such a powerful technology in terms of providing a solution to male infertility that doctor did not hesitate to employ this tool without actually informing the couple prior to the procedure. In other words, the held knowledge and practicality of technology easily triumphed over the 'informed consent'. Such attempt can also be seen in contemporary cases, i.e. in Turkey, where sperm donation is still illegal, a doctor was arrested for using donor sperm (collected from the hospital staff) without informing his patients. http://www.radikal.com.tr/haber.php?haberno=205574 (Accessed November.2006) Furthermore, Pancoast chooses to inform only the husband, after the procedure takes place and never informs the woman, who have gone under the procedure. If knowledge, as Foucault suggests, is a form and source of power, one could claim that holding knowledge (by the doctor) and access to knowledge (by the husband) does not reach to women, hence the woman is deprived of the power that stems from the knowledge.

[45] E. I.. Ivanow. "De la fe´condation artificielle chez les mammife`res." *Arch. Sci. Biol*. No. 12 (1907):377–511. IN ReproMED (University of Warwick, Centre for Reproductive Medicine) "In vitro fertilization history" (2001) http://www.repromed.org.uk/history/ (accessed March.2007)

Science in England in 1922[46]. Japanese researchers, particularly Niwa[47] and Nishikawa[48] also published their research on poultry in English. At a time when artificial insemination could only be accepted within the animal sciences, Aldous Huxley published his book called "Brave New World" in 1932. Although, Huxley's book was a science fiction novel, it became, and still remains, largely influential in the public debates of "producing babies". In his novel, Huxley described in vitro fertilization and "exogenesis" (developing embryo in vitro, outside women's bodies). In 1937, an editorial appeared in the New England Journal of Medicine on Huxley's piece, which read as:

> "The "Brave New World" of Aldous Huxley may be nearer realization. Pincus and Enzmann have started one step earlier with the rabbit, isolating an ovum, fertilizing it in a watch glass and reimplanting it in a doe other than the one which furnished the oocyte and have thus successfully inaugurated pregnancy in the unmated animal. If such an accomplishment with rabbits were to be duplicated in the human being, we should in the words of "flaming youth" be "going places.""[49]

In this regard, I argue that Huxley's science fiction novel provided a novel ground for medical knowledge, whereby the boundary between fiction and reality is blurred and construction of scientific reality became more dependent on fictional stories. As Van Dijck suggests "[t]he dissemination of genetic knowledge is not uniquely contingent on the advancement of science and technology, but is equally

[46] E. I.. Ivanow. "On the use of artificial insemination for zootechnical purposes in Russia". *Journal of Agricultural Sciences* no. 12 (1922):244–256 IN ReproMED (University of Warwick, Centre for Reproductive Medicine) "In vitro fertilization history" (2001) http://www.repromed.org.uk/history/ (accessed March.2007)

[47] T. Niwa, 1958. "Artificial insemination with swine in Japan". *National Institute Agricultural. Sciences*, *Chiba-shi, Japan*. IN R. Foote, The history of artificial insemination: Selected notes and notables, *American Society of Animal Science.* (2002):2, http://www.asas.org/symposia/esupp2/Footehist.pdf (accessed March.2007)

[48] Y. Nishikawa, 'studies on Reproduction in Horses". *Koei, Kyoto, Japan*. IN R. Foote, "The history of artificial insemination: Selected notes and notables", *American Society of Animal Science.* (2002):2 http://www.asas.org/symposia/esupp2/Footehist.pdf (accessed March.2007)

[49] Judith Lorber, "In Vitro Fertilization and Gender Politics" *Women & Health* Volume: 13 Issue: 12 (1988)

dependent on the development of images and imaginations. "Imaginary tools" are crucial assets in the dissemination of genetic knowledge, as they are used to shape this science's public face."[50] In other words, the boundary between science and science fiction is not always as clear as one might hope; script, context and metaphors employed in a fictional narrative can stimulate the way science is produced. The themes and metaphors are therefore hybrid in their nature, what appears as "literature" is at the same time "cognitive", it functions as a tool to express hopes, create hype, collectivize interest, as well as it frames and flames fears and concerns over scientific "facts."[51]

1-3- The Second Half of 20th Century

In 1945, Mary Barton, a gynaecologist, published a report on donor insemination in the British Medical Journal.[52] The report received substantial public and parliamentary debate. The artificial insemination was rejected on the religious grounds, firstly due to the disapproval of masturbation, secondly due to the fear that it would weaken the family bonds and eventually lead to positive eugenics[53]. In 1946,

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[50] J. Dijck , *Imagination of Genetics,* (Huondsmills London: Macmillan Press.1998):2-3

[51] It would be inadequate argumentation unless the role of fiction in framing and flaming fears and concerns over scientific facts was not recognized. Huxley, in *Brave New World* portrays IVF as a form of eugenic practice in which state owned centres "create" and "produce" babies according to the qualities they desire. The current discussions, employing the "designer babies" metaphor that target IVF babies selected by the use of genetic technologies, are linked with Huxley's imagination. Perhaps the only difference is that Huxley "imagined" babies designed according to state-interest, where as public "imagines" babies designed according to individual choice. A profound discussion is provided in:
Nerlich, B. "Metaphors and images in individual and popular consciousness and imagination", http://www.info-metaphore.com (2002) (accessed February.2006)
Nerlich, B., D. D. Clarke, and R. Dingwall "Fiction, Fantasies, and Fears: The literary foundations of the cloning debate". *Journal of Literary Semantics* 30, (2001):37-52.

[52] Barton,Walker K. and Weiner B. "Artificial insemination", *British Medical Journal* (13th January, 1945): 40-3

[53] Pfener, N. (1987) "Artificial insemination, in vitro fertilization and stigma of infertility" IN Michelle Stanworth (et. al.) *Reproductive Technologies: Gender, Motherhood and Medicine*, (Polity Press: Cambridge, 1987): 81-97.

The National Health Service (NHS) Bill passed in order to assist public health, with the argumentation that need for medical care would eventually be eliminated[54].

The National Health Service was established; following the passing of the National Health Service Bill in 1946.It had been marshalled through Parliament by Aneurin Bevan, the Labour Health Minister and was described as the "jewel in the crown" of Labour's post-war achievements. Initially there was opposition from some quarters who speculated that the population would get healthier and would therefore need less medical care -and therefore fewer doctors and nurses would be needed as the years went on. In correspondence with the foundation of NHS, the Archbishop of Canterbury suggested to establish a special commission to investigate the artificial insemination. Committee, in 1948, decided to ban artificial insemination by donor sperm; they reasoned their decision with the fear of technology utilized by "wrong" hands.

Despite the ban of artificial insemination by donor sperm, the scientific research in assisted reproductive medicine continued. In 1949, Hammond developed a complex medium in which mouse blastocysts (8-cell stage of an embryo) could grow.[55] Later in 1953, the interest in biology went sky high with Watson and Crick's article, in which they described the molecular structure of DNA.[56] Just the next year, in 1954, Gardner and Edwards started to experiment on human oocytes, obtained from ovarian biopsy from humans. After several attempts to have oocytes grown in vitro in short intervals, finally in 1965, they found out that the time required for HCG treatment was approximately 37 hours, which was much longer than they initially expected.[57] They discovered that embryonic growth beyond the blastocyst stage could not be done in

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[54] http://www.bbc.co.uk/election97/background/issues/heafac.htm (Accessed March.2007)

[55] Hammond, J, "Culture of mouse embryos using an egg-saline medium" *Nature*, 163, p 28, (1949)

[56] Watson J. and Francis Crick, , "Molecular structure of nucleic acids: A structure for deoxyribose nucleic acid", *Nature*, 171, (1953):737

[57] William A.W. Walters and Peter Singer, *Test tube babies*, (OUP Australia and New Zealand Publishing, 1982)

vitro; hence they suggested that the oocytes should be collected from the follicles via biopsy, after they had full fertilizing capacity. Edwards, who succeeded in fertilizing the human ova in vivo, moved to Oldham in order to work with Steptoe, a surgeon who developed the laparoscopic extraction of human eggs. Edwards planned to use the eggs that were readily available in Steptoe's laboratory. They have started studying infertility due to tubal dysfunction and male factor.

As the scientific research continued, British Medical Association enquired to use artificial insemination with donated sperm should be legalized and made available in NHS in 1970. Following this demand, the British Fertility Society (BFS) was formed in 1972 and first meeting was organized at the Royal Society of Medicine in 1974. The academy-business associations were first formed in 1974 in a meeting at the Royal Northern Hospital in London and consequently BFS joined the International Federation of Fertility Societies. In 1977, British Andrology Society[58] was founded to bring together scientist and clinicians working in the fields of human and mammalian reproduction, with specific interest in "male infertility."[59]Studies on spermatogenesis (sperm formation), semen analysis, fertilization, contraception and cyropreservation were marked as fields of interest.

On 25.July.1978, the birth of world's first IVF baby Louise, to John and Lesley Brown in Bristol, was born in Oldham. Consequently, Robert Edwards and Steptoe published their scientific work, describing how the egg, extracted from woman was

[58] http://www.britishandrology.org.uk/BAS/PDF%20Files/BAS%20Constitution.pdf (Accessed March.2007)

[59] Artificial reproductive technologies were discontented by feminist critiques, precisely because of its historical emphasis on resituating 'male fertility' and for reconstructing female bodies in 'male' practices of medicine. See Ann Snitow "Feminism and Motherhood: An American Reading" *Feminist Review*, No. 40 (1992):32-51. (Accessed March.2007)
Furthermore, Marcia C. Inhorn discusses that childless marriages typically experience procreative blame, even when male infertility (glossed as "weak worms") is socially acknowledged. She demonstrates that Egyptian women married to infertile men experience diminished gender identity and threats of male-initiated divorce. Ironically, the introduction of new reproductive technologies to overcome male infertility has only served to increase this divorce potential. See Inhorn, M. "The worms are weak: Male infertility and patriarchal paradoxes in Egypt", *Men and Masculinities*, Vol. 5, No. 3, (2003): 236-256

fertilized with the man's sperm in a glass dish[60]. Steptoe's technique to extract eggs via laparoscopy was combined with Edward's previous experiments on growing blastocysts in vitro.

The first "tube-baby" received tremendous public interest and consequently became a part of political debates. In 1982, Warnock Committee was set up in order to institute legislative controls in the field of Assisted Reproductive Technology. The Committee brought scientific experts, legal representatives, religious figures and lay public together and in this regard, it was one of the early attempts to officially integrate lay opinion with expertise and to provide a multi-disciplinary action in the field of science. Warnock Report, which was published in 1984, summarized the public concern about the assisted reproduction technologies and recognized the level of sophistication of public engagement with science.[61]

In January.1985, Kim Cotton gave birth to the first baby born to a surrogate mother. In February.1985, the first IVF baby from a frozen embryo was born in the UK, under the supervision of Edwards and Steptoe at the Bourn Hall Clinic Cambridge. Surrogacy initiated a political upheaval: MP Enoch Powell presented the Unborn Children Protection Bill to Parliament, to ban 'surrogate motherhood" completely and to centralize the Health Secretary to authorize the woman who will receive the fertilized egg. The bill was defeated on June.7.1985. Consequently, Warnock Committee published a recommendation on the practice of gamete donation. They suggested that gamete donation should be allowed and AID child should be treated as the legitimate child of the mother and the father, who gave consent to the treatment[62] but the gamete donation should remain "anonymous."[63]

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[60] Steptoe, PC, Edwards, RG, "Birth after re-implantation of a human embryo", *Lancet,* 2, (1978):366

[61] Warnock, M. Report on "Assisted Reproductive Technologies" *British Medical Journal*, Vol. 289, (1984)

[62] Warnock, M. *A Question of Life: The Warnock Report on Human Fertilization and Embryology*, (1985) :.5

[63] Warnock (1985) et. al. p.15

In 1986, Dr. Steptoe, at the European Society for Human Reproduction and Embryology Annual General Meeting in Cambridge, asserted that the frozen eggs, rather than fresh eggs, resulted in higher success rate in IVF and the use of frozen eggs significantly reduced the number of multiple births. Such assertion raised the problem of how many eggs to be extracted in each cycle and how unused eggs were going to be stored.

Consequently it became clearer that scientific research followed a much faster pace than its legislation. On October.21, Hargreaves, Congressman of Windburn introduced a new bill on the law "relating to human embryos produced by in vitro fertilisation" in order to "protect embryo". The Bill was passed by 229 to 129 votes at the first Reading. The protection of embryo was situated in opposition to the treatment of infertility and inherited diseases and as Thurnham, Congressman of Bolton, implied "You speak for a vociferous minority fermented by religious doubters. You fly in the face of public opinion, which is in favour of human embryo research for the prevention of congenital handicap … I speak for the silent minority who suffer from very personal grievous hardship through problems of infertility and problems of inherited diseases"[64]. Such opposition was finally resolved by the foundation of The Voluntary Licensing Agency for In Vitro Fertilisation. The Agency was responsible for setting voluntary guidelines until government legislation could be introduced (which in fact did not happen until 1990s).

In 1987, the first baby of POST (Peritoneal Ovum and Sperm Transfer) was born. POST, which was developed by Stuart Campbell and Dr. Bridget Mason, enabled the mixing of sperm and egg in woman's abdominal and then migrating into the fallopian tubes to start pregnancy. In the same year, in the London Cromwell Hospital, another woman became pregnant with the use of multiple assisted reproduction technologies that combined ova donation and frozen embryos placed in fallopian tubes, rather in womb. In 1988, the GIFT oocyte donation and combining clomiphene and bromocryptine with HMG was attempted for the first time, took place[65] and later in

[64] Repromed. <http://www.repromed.org.uk/history/20th_uk.htm>

[65] Yovich, J. L., Yovich, J. M. and Edisrisinghe, R.w. "The relative chance of pregnancy following tubal or uterine transfer procedures." *Fertilization and Sterilization,* 49, (1988):858-864

1989 Serhal and Craft suggested that the use of GIFT resulted in higher rates of pregnancy, even in women over 40 years of age[66].

The Voluntary Licensing Authority was renamed as the Interim Licensing Authority, confirming its intended non-permanent status and the Human Fertilization and Embryology Act was first proposed. The initial proposition suggested that IVF should only be available to married women and this amendment was defeated by one vote. Eventually in 1990, The Human Fertilisation and Embryology Act was passed.[67] The Act aimed to prevent exploitation of patients and to enable scientific and medical progress as an acceptable socially responsible manner. The Act addresses various issues including the regulation of staff and clinics, standardization of techniques, assessment of patients, collection and publication of data, number of embryos transferred and embryo and stem cell research.

Human Fertilization and Embryology Authority was founded in 1991, under the regulation of 1990 Human Fertilisation and Embryology Act to regulate and license the fertility clinics.

> "All of the HFEA's policy and licensing decisions are taken by the HFEA's 21 Members, who are appointed by UK Health Ministers in line with the "Nolan" principles. Members are selected not as representatives of any particular group or organisation, but because of their personal knowledge and expertise. To enable a wide spectrum of interests and views to be heard, more than half of the HFEA's membership must come from disciplines other than medicine or human embryo research."[68]

As stated in their website the HFEA regulates "the clinics offering IVF or donor insemination or storing eggs, sperm or embryos" and is responsible for collection of statistical data to inform public and to provide detailed advice. "The HFEA also

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[66] Serhal, P. and Craft, I. "Oocyte donation in 61 patients" *Lancet* (1989):1185–1187.

[67] Human Fertilisation and Embryology Act (HFEA) (1990) http://www.opsi.gov.uk/acts/acts1990/Ukpga_19900037_en_1.htm (Accessed July.2006)

[68] Human Fertilisation and Embryology Act (HFEA), "What We Do" http://www.hfea.gov.uk/en/390.html (Accessed March.2007)

licenses and monitors all human embryo research, supervising controlled research for the benefit of humankind."[69] We must consider the ethical implications of a number of key issues, and we always take account of the national debate which these often stimulate."

After the foundation of HFEA, Dr Francoise Shenfield, of the Fertility Unit, Middlesex Hospital, London, suggested that there had been two problems concerning the sperm donations, collected for IVF.[70] As all donors were obliged to register their details while donating sperm, the number of sperm donors significantly decreased for they were concerned with the abolishment of their private date. Second problem was related to the re-thawing sperms that were frozen prior to the chemotherapy, as prevention from the possible side effects of cancer treatment resulting in infertility or in the case of death due to cancer. His mini-survey among 80 male participants, suggested that 66 out of 80 men preferred the disposal of their sperms in the case of his death or mental incapacity and the remaining 14 agreed the use of sperm only by their supposes/partners. As Shenfield suggests, the use of sperm after the man's death means that man is not legally eligible as "father" –which appears as an impediment in British law, which so far was organized to preserve the name of father who gave consent to treatment.

In 1993, the first National Fertility Week was celebrated and an umbrella organization called the National Infertility Awareness Campaign (NIAC) was founded[71]. "NIAC is funded through Ferring Pharmaceuticals Ltd, Organon Laboratories Ltd, and Merck Serono Pharmaceuticals totalling £31,500 per year and its activities are directed by the NIAC Committee, with strategic advice, information and administrative assistance from Portcullis Public Affairs." The primary concern for

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[69] Human Fertilisation and Embryology Act (HFEA), "What We Do" http://www.hfea.gov.uk/en/390.html (Accessed March.2007)

[70] F. Shenfield, IVF News, Autumn, 1992, p 3 IN http://www.repromed.org.uk/history/20th_uk.htm (Accessed March.2007)

[71] Infertility Network UK "National Infertility Awareness Campaign: History and Achievements" http://www.infertilitynetworkuk.com/index.php?option=com_content&task=view&id=49&Itemid=42 (Accessed April. 2007)

NIAC is to establish equal access to infertility treatments on NHS, provide information on the assisted reproduction technologies and the risks they employ and more interestingly, supply information about infertility treatments abroad.

In 1997, Dolly –the cloned sheep- was created at the Roslin Institute of Scotland, under the leadership of Dr. Ian Wilmut. Cloning acquired the transfer of the nuclei of a single adult somatic cell into an unfertilized egg without a nucleus. The resulting embryo, which has the same genetic qualities of the adult sheep, was then transferred into a surrogate ewe. Cloning became a defining moment in terms of the public discussions on artificial reproductive technologies. Although there has been some concern about "going against the nature" of infertility, cloning resulted both in public fascination and surprise with the new science and in a moral resentment about the possibilities science could create. As previously analysed by Nerlich, Clark and Dingwall[72], Dolly represented mixed symbols and imaginations. "Dolly as nightmare" suggested the dystopian stories of Frankenstein or Brave New World; where as soon after these images were placed by "Dolly as pop icon" , "Dolly as cuddly sheep" and these images were carved into public's cognition. "Dolly as the Holy Grail of science" and "Dolly as medical advance" were the two most influential imaginations in which ARTs were re-framed. Cloning revealed the possibility of having "biological" children of homosexual couples, without need of sperm or ova donation, hence as Alexander suggests it intimidated the traditional family structures, which were in one way or another preserved in what the other reproductive technologies could offer[73]. Later in 1998, Dolly produced her first normal, healthy offspring, Bonnie and the following year she had triplets, none of which suffered from identifiable defects.

In 1998, HFEA published a report on cloning issue. It highlighted the pubic fear, arising from the imaginaries founded by Brave New World and therefore differentiated between therapeutic uses from reproductive use of cell nucleus

[72] Brigette Nerlich, David Clarke and Robert Dingwall "Fiction, Fantasies, and Fears: The literary foundations of the cloning debate". *Journal of Literary Semantics* 30, (2001):37-52. http://www.metaphorik.de/aufsaetze/nerlich-fictions.htm (Accessed July.2006)

[73] Jablokov Alexander, "The cloning of Joanna May: Reproductive technologies, motherhood, identity", *Michigan Feminist Studies*, NO. 13, (1998): 41-61

replacement (CNR). In this framework, HFEA only permitted licensed research on embryonic stem cells, of which bill passed from the House of Commons by a large majority. Nonetheless, as the Section 2 in HFEA 1990 regulation suggested that a technology would only be licensed if it was for "promoting advances in the treatment of infertility, increasing knowledge about the causes of congenital disease, increasing knowledge about the causes of miscarriage, developing more effective techniques of contraception, developing methods for detecting the presence of gene or chromosome abnormalities in embryos before implementation"[74] and that CNR did not satisfy any of the above conditions, it was not backed by the HFEA. However there were also debates about placing cloning as an alternative to IVF, overcoming infertility. For instance Eisenberg and LaBar suggested that human cloning could enable women having no ova or men who have no sperm to produce offspring[75], or the reverse case could be argued that homosexual couples could be able to have their own biological children[76]. National Advisory Board on Ethical Reproduction also published a report that suggests embryo cloning could increase the number of embryos for implantation, hence improve the possibility of successful conception.[77] Alternative international policy responses and ethical debates also took place. [78] [79]Finally, UK set to ban on human cloning, both for scientific experimentation and reproduction in 2001.[80]

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[74] Alexander, et. al. p.23

[75] Eisenberg, L.," The outcome as cause: Predestination and human cloning" *Journal of Medical Philosophy,* 1 (1976):318-331.

[76] Martin LaBar, "The pros and cons of human cloning", *Thought,* 57 (1984):318-333.

[77] NABER (National Advisory Board on Ethics in Reproduction), "Report on human cloning through embryo splitting: An amber light", *Kennedy Institute of Ethics Journal,* 4, (1994): :251-282.

[78] For a detailed discussion of key debates that have taken place in the cloning debate, see: Brock, D. *Cloning Human Beings: an Assessment of the Ethical Issues Pro and Con.,* (1997) Paper prepared for the National Bioethics Advisory Commission. http://bioethics.gov/pubs.html June 1998 and May 1999.

[79] Häyry M., "Philosophical Arguments for and Against Human Reproductive Cloning", *Bioethics,* Volume 17, Issue 5-6, (Oct 2003):447-460,
In this article Häyry discusses that philosophers cannot provide a unified answer to the moral questions raised by the possibility of human reproductive cloning, for they have 'relative' solutions to multiple concerns.

Another report was published by HFEA in 1998, highlighting the concern about the multiple birth cases due to IVF. It was shown that the most effective way to limit the risk of multiple pregnancies was to replace only one or two embryos simultaneously and this process did not reduce the pregnancy rates[81]. This strategy, however, is thought to reduce pregnancy rates, as it figures implied that there was only a marginal difference in live birth rate between two and three embryo transfer (20.0 to 22.5%), where as multiple birth rate increased from 22.4% to 32.2%.[82] These figures translated into medical practice, where most centres started a two-embryo transfer policy in women under 35 years of age. Two-embryo transfer policy has been criticized by Ozturk and Templeton, who demonstrated that "individuals who work in IVF units that do more frequent ETTs are more likely to achieve singleton births than triplets, without compromising success rates,"[83] and therefore suggested single embryo transfer should become an accepted policy.

1-4- Contemporary Developments in UK

Since the first IVF baby was born in 1978, there had been a rapid increase in the number of clinics providing infertility treatments. Considering one person out of seven is diagnosed for infertility, which adds up to 3.5 million people in the UK alone, the population of number of people that can go under infertility treatment is massive[84]. Until 2000, 50.000 IVF babies were born[85] and according to the NHS figures, 30.000

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[80] "Britain to ban human cloning" http://news.bbc.co.uk/1/hi/health/1285151.stm

[81] HFEA, "Huge rise in ICSI but half of all babies still come from multiple births" (1998) http://www.hfea.gov.uk/en/954.html

[82] Ibid.

[83] Okan Ozturk, Allan Templeton "In-vitro fertilisation and risk of multiple pregnancy",*The Lancet*, Volume 359, Issue 9302, (2002):232-232, http://linkinghub.elsevier.com/retrieve/pii/S0140673602074779 (Accessed June.2006)

[84] http://www.bbc.co.uk/health/fertility/bigissues_access1.shtml#current_access (accessed March.2007)

[85] HFEA, 2000 Ninth Annual Report and Accounts, p.10

women undergo IVF each year and with the average success in conceiving a child of 15%, that is 8300 IVF babies per year. In 2004 it was shown that the UK is falling behind our Northern European counterparts with the amount of fertility treatment we provide, and consequently, the proportion of babies born as a result of ART[86]. The survey showed that during the year 2000 in the UK there were 580 cycles of fertility treatment per million people, compared to an average of 1057 per million in other Northern European countries.

The complications due to IVF procedure remain significant, with five fold increase in small birth rate and pre-delivery, two-fold increase in still birth rate, in comparison to the natural conception methods[87]. Another major complication about the IVF treatment is the risk of multiple births due to multiple embryo implementations. Women who become pregnant through IVF have a 25-30% of having twins, compared to 1 in 90 of the general population.[88] Multiple births lead to increased risk to the babies and the mother because there is a higher chance of stillbirth, miscarriage, and premature delivery. There is also a financial implication, according to a news article published on BBC website, triplets cost more than £32,000 compared to about £9,000 for twins and just over £3,000 for single births. [89] Current practice limiting the number of embryos implemented is reduced to a maximum of two in women under 40 and a maximum of three for women over 40-for their chances of "failing" the procedure is higher.[90]

Age limit in IVF procedures is also a significant issue in UK. 2004 more babies were born to women in their early 30s in England and Wales than to any other age

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[86] E ESHRE. Assisted reproduction technology in Europe, 2000. Results generated from European registers by ESHRE. Human Reproduction, 2004: 19: 490 – 503

[87] http://www.ivf-infertility.com/ivf/standard/outcome.php (accessed March.2007)

[88] http://www.babycentre.co.uk/refcap/4094.html (accessed March.2007)

[89] http://news.bbc.co.uk/1/hi/health/4120398.stm (accessed March.2007)

[90] HFEA, 2000 Ninth Annual Report and Accounts, p.10

group but the birth rate was also rising fastest among women in their late 30s and early 40s. In 2005, 22.246 women over the age of 40 have birth.[91] After a woman had received donor egg and donor sperm in order to conceive pregnancy at the age of 66 and subsequently became the oldest recorded mother after undergoing fertility treatment for 9 months in 2005, the issue attained a noteworthy public interest and political debate. Currently, HFEA does not specify an upper age limit for women seeking treatment, and most clinics will treat women up to the age of 45. However, NICE guidelines propose that the NHS should offer treatment only to women aged 23 to 39 because of the 50 per cent drop in success for the over-40s[92]. NHS on therefore compels an age limit of 39, yet the fact that only about 25 per cent of fertility treatments are state-funded leaves its financial prominence in query[93].

Eligibility for IVF treatment in UK is also concerned with women's life styles. In 2005, Linsten suggested that obesity was linked with infertility and dropping BMI from 36 to 32 could redeposit fertility, without any further need from infertility treatments.[94] In the same article, it was indicated that the chance of becoming pregnant through IVF in a smoker women equalled to her 10 year older non-smoker counterpart.[95] In September 2006, the British Fertility Services attempted to regulate all NHS clinics under the same rule and by that it was proposed that a BMI limit of 36 should be put forward, which is essentially the same with the surgery criterion.

IVF regulation is also interlinked with Pre-implantation Genetic Screening: (PGD). PGD involves several methods, including ultrasound imaging, chorionic villus sampling (CVS) and amniocentesis. PGD allows diagnosis of certain genetic disorders

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[91] http://www.bbc.co.uk/health/fertility/bigissues_access2.shtml#upper_age_limit (accessed March.2007)

[92] http://www.bbc.co.uk/health/fertility/bigissues_access2.shtml#upper_age_limit (accessed March.2007)

[93] http://www.bbc.co.uk/health/fertility/bigissues_age1.shtml

[94] Lintsen A, Pasker-de-Jong P, Boer E et al. "Effects of subfertility cause, smoking and body weight on the success rate of IVF". *Human Reproduction* (2005): 20: 10.

[95] Ibid.

that has been created in vitro and if there are not any genetic defects, embryo is then implemented into woman's uterus. This procedure has received particular public interest, since its early stages and with the wide use of PGD from 1990s onwards, tabloids have alarmed public for "designer babies". In fact, HFEA in UK currently licenses PGD of cystic fibrosis, haemophilia, beta -thalessaaemia, sickle cell disease and Huntington's among others and also "CVS and amniocentesis are not routinely offered to all pregnant women, as it carries a small risk of miscarriage but it may be offered to parents who have a high risk of passing on a genetic disease their child, or when the mother is older".[96] In the UK, there are only 9 clinics that are licensed by the HFEA to offer PGD and clinics must apply to the HFEA each time they want to test for a new genetic disorder. Two clinics are licensed to use PGD to screen for chromosomal abnormalities. All licensed IVF clinics are forbidden from carrying out sex selection, unless to prevent sex-linked diseases, i.e. diseases such as haemophilia and Duchenne's muscular dystrophy that only affect males.[97]

HFEA also regulates donation and preservation of eggs, sperms and embryos. HFEA 1990 permits egg and sperm donation for reproductive purposes, however all sperm donation needed to be done in anonymity prior to Disclosure of Donor Information Regulations 2004[98]. This act removed the right of new donors to remain anonymous once the child has reached 18 years. 1990 regulation was also unclear about the status of child, if she/he was born after the death of her/his father. HFEA Deceased Fathers Act 2003 Chapter 24 allowed a man to be registered as the father of a child conceived after his death using his sperm or using an embryo created with his sperm before his death[99].

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[96] March of Dimes Foundation, "Chorionic Villus Sampling (CVS)" http://www.marchofdimes.com/professionals/14332_1165.asp (Accessed March.2007)

[97] Parliamentary Office of Science and Technology Post on Sex Selection, July 2003. number: 198
http://www.parliament.uk/post/pn198.pdf (Accessed March.2007)

[98] The Human Fertilisation and Embryology Authority, "Disclosure of Donor Information Regulations" (2004) http://www.opsi.gov.uk/SI/si2004/20041511.htm (Accessed March.2007)

[99] The Human Fertilisation and Embryology (Deceased Fathers) Act (2003). http://www.hfea.gov.uk/en/552.html (Accessed March.2007)

HFEA also regulates the providence of excess IVF embryos. HFEA 2001 Regulations Statutory Instrument No. 188 permits to freeze embryos and six protocols out of eight permits the use of excess IVF embryos for scientific purposes other than reproduction[100]. The other two licenses, including one granted to the Roslin Institute (Edinburgh, UK), permit researchers to derive human embryo stem cells from IVF embryos and to use parthenogenesis to create parthenotes as a source of hES cells[101].

2- History of IVF in Turkey

2-1-Early Attempts for IVF in Turkey and 1987 Regulatory Response

In comparison to the extended history of IVF in UK as a continuum from artificial insemination technologies to recent debates about cloning, the history of IVF in Turkey is rather recent. After the first IVF baby was born in 1978, the technology became widely available in UK. IVF became more widely available elsewhere in Europe before the interest in IVF emerged in Turkey. Erol Tavmergen, the doctor of first Turkish IVF baby describes this process in an interview with Sabah.[102] In 1985, Refik Çapanoğlu, Professor in Ege University assigns Erol Tavmergen an internship position in an IVF centre in Germany. At the time, there is no regulation in artificial

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[100] The Human Fertilisation and Embryology (Research Purposes) Regulations 2001, Statutory Instrument No. 188 (2001)
http://www.opsi.gov.uk/SI/si2001/20010188.htm (Accessed March.2007)

[101] Lori P. Knowles (2004) A regulatory patchwork-human ES cell research oversight, *Nature Biotechnology* 22, 157 - 163
http://www.nature.com/nbt/journal/v22/n2/full/nbt0204-157.html (Accessed March.2007)

[102] "İlk tüp bebekler Egeli", *Sabah*, (05.12.2005)
http://www.sabah.com.tr/2005/12/05/sag116.html (Accessed March.2006)

reproduction technologies at the time in Turkey and Tavmergen starts working on in vitro fertilization with mice in Ege University. It is not until 1987 that necessary regulations for artificial insemination and in vitro fertilization is established in Turkey, immediately after the regulatory network was introduced, Tavmergen starts working on IVF on humans.

The first regulatory framework on artificial reproduction technology (ART) in Turkey was the "By law on centres for in vitro fertilization and embryo transfer" and it was issued on 21. August.1987. According to the article 5 in this law, faculty members of medical schools were elected in order to set up a "IVF-ET Scientific Committee", who were responsible for investigating the candidate for IVF and to advise on regulating the foundation and shutting down of IVF-ET centres.[103] The shut-down criterion for IVF clinics was inactivation of research and medical practice for more than two months. Following this regulation, The Turkish Presidency for Religious Affairs (Diyanet İşleri Başkanlığı) announced that it was religiously acceptable for couples to undergo IVF procedure, provided that they are married.

In 1987, Tavmergan selected 10 couples as potential candidates for IVF. As a result of series of trials, the first IVF baby in Turkey was born in 18.04.1989, named Ece. The first IVF twins Kenan Refik and Evren Erol were later born in 02.05.1989. Just one year after that, the second IVF clinic (and the first private IVF clinic) was founded in Istanbul. After the first successful IVF treatment, public demand for IVF increased, nevertheless at the time, the procedure was much more expensive than it is now today. As a result of this public demand for IVF, the IVF-ET Scientific Committee organized a meeting on 28.07.1992 in order to discuss if government should provide IVF treatment free for married couples who are government officials; the committee did not advise free services but they defined IVF as a treatment on Article.4.

2-2 - Second half of the 1990s and Regulatory Framework Offered in 1996

[103]" Tüp Bebek Masraflarının Ödeneceğine Dair Mahkeme Kararı", http://www.memurlar.net/haber/12347 (Accessed March.2007)

IVF as a medical technique became largely available in the late 1990s. Only in 2001 alone the number of private clinics offering infertility treatments raised from 2 to 7. Currently there are 60 centres offering infertility treatments. The cost of IVF also decreased 5 times since 1980s.

Name of Law on Centres for In Vitro Fertilization and Embryo Transfer was changed in 19.11.2006, in conjunction with the 23222 numbered article on Official Gazette and it became "the Regulation for Assisted Reproduction Centres". This particular legal document defined assisted reproduction technologies as "medical methods that assist to bring the mother's ovum with her husband's sperm and provide fertilization ex vivo or that implements embryo's to mother's genital organs."[104] Article (17) includes maintenance of embryos in culture, their storage and transfer into the regulatory framework. This article allows freezing embryos and their storage for up to three years. Selective foetal reduction in Turkey is allowed and can be undertaken in centres which are previously authorized by the State. However, sex selection is strictly prohibited.

2-3- Current Status of IVF in Turkey

Under current Turkish legislation on assisted reproduction technologies, sperm, egg and embryo donation, surrogate motherhood are prohibited in Turkey. The infertility treatments are also provided only to married couples; hence single women and civil partners are not eligible for the treatment. This legislation also requires "informed consent" by the subjects who undergo any assisted reproduction technologies, patients are expected to fill in and sign an informed consent form, prior to undergoing treatment.[105]

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[104] Tüp Bebek Masraflarının Ödeneceğine Dair Mahkeme Kararı", ttp://www.memurlar.net/haber/12347/ (Accessed March.2007)

[105] See: Informed Consent Form for Assisted Reproduction Technologies, recommended by Turkish Gynaecology and Obstetrics Foundation.

According to the figures provided by the Ministry of Health, there are more than 2 million couples in Turkey who experience infertility problems, 150,000 couples out of this population join the IVF waiting list every year.[106] As yet the cost of IVF treatment was a grave concern for many couples in Turkey, prior to the 2005 arrangements in health bill that subsidizes cost of one IVF cycle.

On 14.11.2005, SSK Administration Committee published their decision to subsidize the cost of IVF treatments that are undertaken in SSK institutions with the Act no: XV/927. In order to harmonise the practices between different branches of the institution, eligibility criteria to undergo infertility treatments are decided to be managed according to the 2005 Financial Year Practice Guidelines and Act no: 2056/64 of Ministry of Health and Act no:72713 of SSK.

The article 1-C related to the individuals with one or more healthy child[ren] on Act no:7135 of Ministry of Health, published on 11.04.2005, the cost of IVF treatment of individuals ,who have developed secondary infertility [male or female] after procreation of their own one or more child[ren] either through natural or in vitro fertilization methods prior to the date of guideline was published, are not be paid for by the government budget, even if their condition of infertility is reported by an official medical committee.

In order to subsidize the cost of IVF treatment, individuals are further required to obtain a medical committee report that confirms that infertility treatment is needed. University hospitals, Turkish Military Forces Hospitals and Ministry of Health Hospitals for Research are the only acceptable places to have free IVF treatment. There is also a list provided for the private clinics for Assisted Reproductive Technologies that are specifically assigned to provide government-subsidized IVF treatment.

Furthermore, according to the current institutional arrangements, drugs used during the IVF treatment are not be charged separately nor paid by the patient, since the unit cost of all drugs and equipments that can possibly be used during the treatment are

[106] "'100 çocuktan 5'i tüp bebek olacak'" , Hurriyet (30 December 2006) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=5699941 (Accessed May.2006)

already determined. However, every drug that is used either prior to or during the infertility treatments needs to be reported by a medical committee so as to subsidize the drug costs. These drugs are prescribed to non-hospitalized patients and individuals are expected to pay the patient participation fee.

CHAPTER 3

ECONOMICS OF IVF

1- Economics of IVF in UK

1-1- Cost of IVF in UK

Cost of one IVF cycle at a private clinic in UK varies greatly according to the location, facilities and services provided, reputation of its staff members of the clinic, as well as the public demand available in that location. According to the NHS figures,

the typical cost of one cycle IVF alone is approximately £3,000.[107] However, a web-search of UK IVF centres, revealed that the cost can vary from £2,300 at a local hospital[108] and could go up to £10,000[109] at a hospital which ranked high in the IVF league table, due to its "compliance" with several categories including: risk management, the safety of equipment and procedures, staff competence, the quality of patient information and arrangements for donor selection".[110] Considering the average number of cycles required for IVF treatment is 3.15 cycles, and that the chance of successful birth increases double fold by raising the number of cycles by three,[111] the cost rises up to £6,900-30,000.

There is also what might be referred as "invisible cost", in arrangements of egg donation, surrogate mothers and in having multiple embryos implemented. The price dramatically increases in cases where egg donation occurs. According to the NHS figures, IVF treatment with egg donation typically cost £3,500-£4,000 per treatment cycle at a private clinic in 2005.[112] In the UK, surrogacy is arranged altruistically and all reasonable expenses such as travelling, loss of earning in the form of

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[107] HFEA, "Facts and figures 2006-2007 HFEA Guide to Infertility - treatment and success data based on treatment carried out between 1 Apr 2003 and 31 Mar 2004" http://www.hfea.gov.uk/en/1215.html (Accessed March.2007)

[108] Private Health Care UK, "Infertility treatment in London: Assisted Conception Unit at Guy's and St Thomas' NHS Foundation Trust" http://www.privatehealth.co.uk/hospitaltreatment/find-a-treatment/infertility-treatment/infertility-centres/guys-and-st-thomas (Accessed March.2007)

[109] BBC, "Cuts force patient to take loan" (9 January 2006) http://news.bbc.co.uk/1/hi/england/oxfordshire/4594908.stm (Accessed March.2007) IN Thames Valley Strategic Health Authority, "Cuts force patient to take loan" http://www.healthdemocracy.org.uk/healthdemocracy.org.uk/HealthPolicy/GovernmentPolicy/Resources/ResourceShortfall/Thames%20Valley%20Strategic%20Health%20Authority%20.htm

[110] "League table of IVF clinics" http://news.bbc.co.uk/1/hi/health/6247567.stm

[111] Kaan Osmanagaoglu1, Tournaye, Camus, Vandervorst, Steirteghem and Devroey, "Cumulative delivery rates after intracytoplasmic sperm injection: 5 year follow-up of 498 patients" *Human Reproduction*, Vol. 14, No. 10, (October 1999):2651-2655. http://humrep.oxfordjournals.org/cgi/content/full/14/10/2651 (Accessed May.2006)

[112] The Daisy Network "Egg donation IVF" http://www.daisynetwork.org.uk/ivf.html (Accessed March.2007)

"inconvenience fee". However some clinics offer help in arranging surrogate mothers and charge their patients for this arrangement. A web search on surrogacy arrangements demonstrated that £3,500 would represent an accurate figure.[113] There is also a financial implication, according to a news article published on BBC website, triplets cost more than £32,000 compared to about £9,000 for twins and just over £3,000 for single births.[114] Current practice limiting the number of embryos implemented is reduced to a maximum of two in women under 40 and a maximum of three for women over 40-for their chances of "failing" the procedure is higher. This regulation in turn suggests that women older than 40 years old need to pay more in order to access IVF.

1-2. Figures Compared With GDP and Minimum Wage in UK

In 2006, it was estimated that official exchange rate of GDP $2.341 trillion and that it was distributed as $31,400 (approximately £15,902) per capita. The minimum wage for adults (people aged 22 and over) is £5.35 an hour. If an individual works 40 hours/week for 50 weeks a year, her/his annual income would be £10,040.

Considering that IVF cost of one cycle IVF alone is approximately £3,000 at a typical clinic and £10,000 at a high-ranked clinic and that the average number of cycles required for pregnancy is 3, below cost analysis can be made:

[113] The London's Woman Clinic, 'standard Treatment Costs" http://www.londonwomensclinic.com/treatments/standard_treatments_costs.html (Accessed March.2007)

[114] IVF multiple births 'drain NHS', BBC News (23 June, 2005)

Table- 3- 1- Affordable number of IVF cycles in UK

Patient/Cost	One cycle at an average clinic (£3,000)	One cycle at a high-ranked clinic (£10,000)	Three cycles at an average clinic (£10,000)	Three cycles at a high ranked clinic (£30,000)
Couple with average income (£31,804)	9% of their annual income	31% of their annual income	31% of their annual income	Approximately their annual income
Couple with minimum wage (£20,080)	14% of their annual income	Approximately their annual income	Approximately their annual income	Cannot afford without previous savings
Single woman with average income (£15,902)	18% of her annual income	62% of her annual income	62% of her annual income	Cannot afford without previous savings
Single woman with minimum wage (£10,040)	29% of her annual income	Approximately her annual income	Approximately her annual income	Cannot afford without previous savings

This simple cost analysis suggests that IVF as a medical procedure is significantly expensive and it requires additional funds from the savings of individual patients to cover "out of pocket expenses" for most individuals, especially for single women, who are at/below the average GDP.

1-3- State Funding for IVF treatments in UK

There is an apparent difference between IVF clinics, in terms of facilities offered, number of staff employed and their success rates. For instance, the live birth

rate per cycle is 40% at University College Hospital in London, where as it is only 11% at the Cromwell IVF and Fertility Centre.[115] Similarly, waiting lists change from one centre to another; for example, individuals applying for IVF treatment needs to wait for 4 years in Telford and Wrekin, two years in Wolverhampton or one to two years in Walsall.[116] Likewise, according to 1998 NIAC estimates on the number of provisional IVF services per 10,000 people in South West UK was as little as 0,3, where as it reached 21,3 in Anglia and Oxford and 21,5 in Scotland. [117] The significant variance in "compliance" of IVF treatments is often referred as "postcode lottery of IVF treatment" in the news articles and it highlights the inequality in accessing infertility treatments.

In 2002, British Fertility Society conducted a survey among over 800 members of public, highlighted that there had been an increased level of public awareness of unequal distribution of health services and public demand to end the "postcode lottery".[118] In 2003 The National Institute for Clinical Excellence (NICE) guideline was published in order to eliminate the difference in clinical practice. However there are certain criterions for eligibility: Firstly, women must be aged between 23 and 39 to qualify for free treatment. She should also have a body mass index under 36.[119] Couple must either have been unable to conceive for three years despite regular intercourse and no identifiable problem or have a specific problem such as absence of sperm or blocked

[115]BBC News, "IVF clinic 'postcode lottery" (29. August.2002) http://news.bbc.co.uk/1/hi/health/2223303.stm (Accessed March.2006)

[116] "NHS funding still a lottery" *The Birmingham Post*, (2.April. 2007) (Accessed April.2007)

[117] Lord J, Shaw L, Dobbs F and Acharya U. "Provision of fertility services A time for change and a time for equality - infertility services and the NHS" *Human Fertility*; no.4 (2001):256-260 IN Julian Jenkins, Richard Fleming, Clare Brown, "Key facts on infertility, IVF and NHS provision", *BFS Fact Sheets*, (February.2005) http://www.britishfertilitysociety.org.uk/public/factsheets/docs/BFS-keyfacts.pdf (Accessed June.2006)

[118] Jenkins" Public awareness of infertility and views on provision of NHS treatment" 2003

[119] http://www.bbc.co.uk/health/fertility/bigissues_access2.shtml#upper_age_limit

fallopian tubes.[120] It was also decided that priority would be given to couples without children.[121] Those individuals who would like to undertake IVF treatment on NHS needs to apply to a local NHS infertility clinic. Since April.2005, Primary Care Trusts offer at least one cycle of IVF treatment on the NHS to infertile couples. The guidelines published by NICE is conserved as eligibility criterion.

2- Economics of IVF in Turkey

2-1- Cost of IVF in Turkey

Although there is not any official figure published by the Turkish government about the cost of IVF treatment, news articles and websites of clinics suggest some reliable figures. According to an article, which was published in Milliyet, cost of one IVF cycle at a private clinic would cost about $2,000-3,000whereas at a university hospital, owned by the state the cost would be about $500-1000.[122] These figures, however, exclude the cost of drugs used during the treatment, which adds a further $1000-2000 at private clinics and $500-1200 at university hospitals, hence the total cost of IVF (including drugs) is $3000-4000 at a private clinic and $1000-2100 at university

[120] Maxine Frith, "Almost all NHS trusts fail on IVF pledge", *The Independent,* http://news.independent.co.uk/uk/health_medical/article1822191.ece (Accessed February.2006)

[121] Anna McGrail, "How will we pay for fertility treatment?" http://www.babycentre.co.uk/preconception/suspectingaproblem/payfortreatmentexpert/ (Accessed March.2007)

[122] Semra Kardeşoğlu , "Tup Bebek Luks Degil", *Milliyet,* http://www.milliyet.com.tr/content/dosya/saglik/kisirlik/kisirlik05.html (Accessed February 2006)

hospitals.[123] These figures are also confirmed by the typical costs that are published on individual clinic websites. Again considering that the average number of cycles required for IVF treatment is 3 cycles, the actual cost of infertility treatment reaches up to $9,000-12,000 at a private clinic and $3000-6300 at a university centre. These figures are significantly lower than the cost in UK (with the assumption that individuals earn equally), in fact as most of the private clinics offer equal success rates with their counterparts in UK, the cost of treatment is cut down by more than half. Nevertheless, there are some inconsistent sky-high figures exist, for instance, Dr. Bulent Urman, who is one of the "celebrity IVF doctors" in Turkey claims that in the case of multiple pregnancies due to IVF treatment, price can increase up to $80-90,000 for twins, and $140,000 for triplets.[124]

Current regulations on IVF in Turkey bans egg and sperm donation and does not allow surrogate mother arrangements. However, Turkish health agencies are not often strictly monitored and individuals often "invent" their own ways to access sperm and egg donors and to arrange surrogate mothers. It is reported that approximately 1000 couples conduct "health tourism" where these arrangements are allowed.[125] United States, Israel, UK, Belgium, Greece, Greek Islands (Cretan Island in particular) are sites which Turkish tourists often visit[126]. Cyprus and Greece are the most popular "reproduction destinations" out of these options, for they offer sperm-egg donations for only $4000-5000 (in comparison with $25,000 in the US, $10,000 in UK, 15,000 in Belgium). According to the news article, there are approximately 10-20 applicants per month to Cyprus alone.

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[123] Mesude Ersan, "Kısırlığın çok sayıda çözümü var", Hurriyet (4.June.2002) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=76236 (Accessed February 2006)

[124] Ayse Arman, "Tüp bebek işi çığrından çıkti", *Hurriyet,*02 March 2002 http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=57498 (Accessed February 2006)

[125] Eda Berkbayrak, "Yunanistan'dan sperm ithal ediyoruz", Hurriyet (22 November 2002) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=111065 (Accessed February 2006)

[126] Mesude Ersan, "Yumurtalar Kıbrıs'tan spermler Danimarka'dan", *Hurriyet* (15.November.2003) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=183779 (Accessed February 2006)

The reverse "reproductive tourism" is also a relevant issue in Turkey. This is firstly because Turkish IVF clinics offer a "competitive price" of $2,000-3,000 -which is about 1/3 to1/2 of the price offered by British clinics. Secondly current Turkish legislations offers some treatments that are illegal in Europe, for 'selected embryo transfer" with PGD (currently testing is done for Down's syndrome, thalessaaemia, muscular dystrophy, cystic fibrosis, hyper-immuno-glabulinemia and acute leukaemia) and also for implementation of more than 3 embryos in one cycle (which was possible prior to 9. July.2005). According to the data provided by Dr. Semra Kahraman, the director of Memorial IVF clinic, patients from the United States, the Netherlands, Germany, Austria, Italy, Iran, India, Italy, Dubai, Kuwait, Azerbaijan visit Turkish clinics in order to access to these services.[127]

2-2- Figures Compared With GDP and Minimum Wage

In 2006, it was estimated that official exchange rate of GDP in Turkey is $667.2 (approximately ¼ of UK) and that it was distributed as $5,300 (approximately £2,600, less than 1/5 of UK) per capita.[128] The minimum wage for adults (people aged between 18 and 75) is 18.75 YTL (£6.92) ($13.69) per day. If an individual works 50 weeks a year, her/his annual income would be 6562 YTL ($4,793) (1/6th of UK minimum wage).[129]

Considering that IVF cost of one cycle IVF alone is approximately is $3000-4000 at a private clinic and $1000-2100 at university hospitals that the average number of cycles required for pregnancy is 3, below cost analysis can be made:

[127] "Emily'nin hayatını embriyonu Türkiye'de seçilen küçük kardeş Daniele kurtardı", Hurriyet (02 September 2006) http://www.memorial.com.tr/basindamemorial.php?Day=&Month=09 (Accessed February 2006)

[128] "Turkey fact sheet", *The Economist*, (27.march.2007) http://www.economist.com/countries/Turkey/profile.cfm?folder=Profile-FactSheet (Accessed March.2007)

[129] Asgari Ucret Tespit Komisyonu Karari no. 2006/1, (26/12/2006) http://www.alomaliye.com/aralik_06/asgari_ucret_2006_1.htm (Accessed March.2007)

Table-3-2- Cost of IVF in Turkey

Patient/Cost	One cycle at a state owned clinic (bottom end) ($1000)	One cycle at a private clinic (top end) ($4000)	Three cycles at a state owned clinic (bottom end) ($3000)	Three cycles private clinic (top end) ($12,000)
Turkish Couple with average income ($10,600)	9,4% of their annual income	37,76% of their annual income	28,3% of their annual income	Cannot afford without previous savings
Turkish Couple with minimum wage($9,586)	10,43% of their annual income	41,72% of their annual income	31,29% of their annual income	Cannot afford without previous savings
British Couple woman with average income ($32,000)	Not eligible	12,5% of their annual income	Not eligible	37,25% of their annual income
British couple with minimum wage ($20,100)	Not eligible	19,90% of their annual income	Not eligible	59,70% of their annual income

When the above cost-analysis table is combined with Table 3-1, following points can be argued. Firstly, both Turkish and British couples who earn at the GDP per capita level and who are employed at minimum wage paying jobs, find it equally hard to pay for IVF treatments in their own countries. In both cases, three cycle, which is the average number of cycles required to actually get pregnant, cost at a top end private clinic is above their annual income and in fact even at a clinic which offers bottom prices, individuals have to spend approximately one third of their annual earnings- which means that they have to sacrifice from most of their essential needs if they decide to go under infertility treatment.

Secondly, a British couple, who work in the UK, can afford the IVF treatment much easily in Turkey. If the demand for having a child is high enough to travel overseas, it would be more "rational" for British couple to be treated in Turkey. As a matter of fact, one a Google search is done for "IVF Turkey" , the computer screen fills up with 244,000 results in just 0,10 seconds, and most websites offering or advising on

"health tourism", "reproductive tourism"[130]. What makes these commercial websites so interesting is that IVF treatment is not only marketed through 'scientific facts", such as 'success rates", "experience of staff", "efficiency of methods" or through "low costs", but they are actually structured as "tourism" sites. Most of these websites display picturesque sites of Istanbul or Mediterranean coastline; they give information about the accommodation, city, food and Turkish culture. "Packet prices" for IVF in Turkey then includes hotel-hospital-hotel transfers, accommodation in luxurious hotels, day city tours and even yacht trips. For instance Acibadem IVF centre offers an IVF package that costs 3,267 Euros, which includes "transportations, 5 star accommodations for 15 days and medical procedure"[131] and provides detailed information about the arranged hotel, as well as touristy sites of Istanbul.

Hence the debates about the commercialization of IVF is not only related about the high cost (due to supply-demand mechanisms) at a local site but also is related to marketing a relaxing holiday while undergoing a stressful and invasive technological intervention.

2-3- State Funding for IVF treatments in Turkey

Like UK, there is a significant difference between IVF clinics in Turkey, in terms of facilities offered, number of staff employed. In order to obtain more information about the live birth rate per cycle in different sites, I have visited websites of the 60 IVF clinics in Turkey and all of them talk of "high success rates" and three of them claim that they have the highest 'success rate" in Istanbul, however they do not provide actual data. That is to say, there is only a logical expectation that the rate of live births change according to the experience of medical staff and available technologies;

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[130] Following websites provide splendid examples to illustrate the issue: "IVF in Turkey" http://www.ivfinturkey.com/ ; Jinemed Hospital: http://www.ivfturkey.com/ ; 'silkroad hotels: Health Tourism" http://www.silkroadhotels.com/travelandtour/health/healthtourismturkey.htm (Accessed March.2006)

[131] Acibadem Healthcare Group, Acibadem International Infertility Centre http://www.acibademinternational.com/packages.asp?Cat=Cat4_1 (Accessed March.2006)

however the variation between sites can only be deduced or imagined –not compared- with the amount of information they provide on their websites. There has been news coverage on the long waiting lists in IVF centres in Turkey. In an interview with Radikal, Bülent Tıraş, a professor in Gazi University Faculty of Medicine, claims that 150,000 couples are currently on the IVF waiting list and half of them are on Social Security Institution (SSK) programme.[132] As there are only 24 state owned infertility clinics in Turkey, the number of people waiting per clinic is massive.

In April.2005, AKP government passed the first "Test-Tube Baby Bill" (Tüp Bebek Genelgesi)[133]. This bill covered those individuals who are on the Emekli Sandığı (Retirement Fund -for previous government officials-), Bağ-Kur (Retirement and health fund for Independent Institutions) and owners of Yeşil Kart (health fund for poverty-stricken) and excluded members of SSK (Social Security Foundation). The bill proposed to at least partially subsidize the cost of IVF treatments and costs of drugs used during the infertility treatment, to do so government agreed to pay 1016 YTL (which covers 100% of the cost of one IVF cycle at a state-owned hospital and 30% of the cost of one IVF cycle at a private clinic) and to pay for nine units of drugs that are used during the IVF treatment. In order to access to these services, couples need to fit into certain criterions: IVF is only available for married couples who have not been able to conceive pregnancy for 3 years, although they had been engaged with unprotected intercourse. Women should be under the age of 40[134]. If these criterions are provided, couples should take infertility tests in an infertility clinic that is on the recommendation list of government in order to obtain "need to be treated" report. Those patients with reports can then apply either to a private or state owned institution. This bill faced public opposition on the ground that it has been exclusionary. It left out 5, 5 million individuals who were on SSK programme and also women over the age of 40. Furthermore, an NGO named "Çocuk İstiyorum Derneği" (I Want Children

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[132] "Tüp bebekte sıkıntı: 75 bin çift SSK mağduru" *Radikal,* http://www.radikal.com.tr/haber.php?haberno=179795 (Accessed March.2006)

[133] "Tup bebege hucum" *Radikal* (22/05/2005) http://www.radikal.com.tr/haber.php?haberno=153478 (Accessed February.2006)

[134] Emeklilikte 'standart' devrimi, *Milliyet* (15/04/2006) http://www.milliyet.com.tr/2006/04/15/ekonomi/axeko01.html (Accessed May.2006)

Organization) suggested that individuals were directed to certain hospitals for infertility treatments.[135]

These criticisms were widely published in media reports and resulting public debate forced the government to take an immediate action. Consequently, in May.2005, Fatma Sahin, AKP MP, proposed revision to extend the bill for those individuals on SSK programme[136]. This proposition was backed by Recep Akdağ, Minister of Health. Sami Tandoğdu, CHP MP, also proposed to change "the definition of infertility as a disease and IVF as a cure" He suggested that such interpretation would enable to envisage the issue as a "constitutional right [to access medical services]". In January.2006, AKP government decided to revise the previous bill to include those individuals on SSK programme.[137] Recep Akdağ, Minister of Health, explained their decision on the grounds that the new bill would eliminate the negative psychological and social effects of infertility on couples and that the new bill will assist the protection of integrity of families.[138]

3- Discussion of Economics of IVF in Turkey and UK

In this section, I have demonstrated that both in the UK and in Turkey, IVF stands as an expensive medical technology. Individuals who are at the GDP per capita level cannot easily attend IVF services, unless they have some previous savings and/or financial support from their friends and family. The cost of IVF in Turkey, still, remains lower than the numbers reflected in the UK. As rational actors, most of who are deprived of services in their home countries, choose to take "health tourism" route

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[135] "Tup bebege hucum" *Radikal* (22/05/2005) http://www.radikal.com.tr/haber.php?haberno=153478 (Accessed February.2006)

[136] "SSK'lıya 'tüp bebek' için Bakan desteği" *Radikal* (25/05/2005) http://www.radikal.com.tr/haber.php?haberno=153779 (Accessed February.2006)

[137] SSK'lıya 'özel'de tüp bebek müjdesi, *Milliyet,* (25/01/2006) http://www.milliyet.com.tr/2006/01/25/yasam/yas02.html (Accessed February.2006)

[138] Emphasis added by Author.

and have IVF treatments elsewhere, the cost is lower. As a consequence, there is a growing tendency to market "reproductive tourism", with package programmes of IVF and holiday in Turkey.

Although IVF is an expensive procedure, both British and Turkish governments decided to provide funds for IVF programmes. This inclination to officially and financially support IVF is intriguing. If one ignores the feminist literature that analyzed the psychological effects of infertility and social forces –that is the demands and expectations of family and friends- which urge "the rush to reproduction" for a moment, and rather adapts a purely economic welfare point of view, infertility treatments appear as optional. One can then argue that there is no "political coercion" that stops individuals from not having a child. Then, series of questions immediately arise: Why does the state bother to fund these expensive infertility treatments? And why does it do so now?

I argue that state funding of IVF in the UK is a policy to abolish the financial problems associated with aging population. It is estimated that by the year 2050, the number of Europeans, over the age of 65 will have doubled, from the current rate of 15 per cent of the population, to 30 per cent. The aging population means that healthcare and pension costs will significantly increase. In order to prevent aging of the population, demographers suggest that 2.1 children per woman are needed to sustain existing population levels.[139] Jonathan Grant, a researcher in an independent think-tank called RANT, claimed that ART has the potential ability to stimulate total fertility by 0.06 and 0.07 in the UK[140] and that IVF could potentially contribute to increase in population size.

In 2006, a group of scientists, led by Professor William Ledger, from the University of Sheffield presented a report in the annual conference of the European

[139] Kirsty Horsey "Call for free fertility treatment to boost Europe's population" BioNews (24 June 2006) http://www.ivf.net/content/index.php?page=out&id=2095 (Accessed June 2006)

[140] Ferring Pharmaceuticals Newsletter "Assisted Reproductive Technology helps address demographic challenge in Europe" (19.June.2006) http://www.ferring.com/newsroom/archive/2006/Assisted+Reproductive+Technology+helps+address+demographic+challenge+in+Europe.htm (Accessed in June.2006)

Society of Human Reproduction and Embryology (ESHRE) in Prague. This report, which suggested that the economy makes a net gain in the long run for each IVF baby born, was accepted with great enthusiasm in UK media. [141],[142] They claimed that the average cost to conceive a baby, which is £13,000 on IVF would be greatly surpassed by the average of £160,000 in taxes and insurance which will be paid by an adult in full time employment. Therefore, for each state-funded IVF baby, British economy would boost a net gain of £147,000.

In other words, state funding of IVF in the UK is a policy to abolish the financial problems associated with aging population. British government needed to take measures to increase the size of the population; however traditional tools of population management, such as financial help for people with children, were no longer enough. With the declining fertility rates due to changing social attitudes decentralizing "parenthood" and from individual's minds at least until their late 30s, the only plausible method to increase population size appeared as infertility treatments and particularly IVF. In this regard, IVF can be said to receive political support from government to hinder the financial loss of aging population, if not for its possible financial benefits.

However, same figures do not hold for Turkey. According to July 2006 estimates, the current population size of Turkey is 70,413,958, with a median age of 28. The rate of population increase is 1.06%, which means population increases by one million each year. According to UN estimates, by 2050, its population will be 101 million and this size will constitute one in six individuals in Europe will be Turkish. Given these numbers, state funding of IVF in Turkey can not possibly be a policy to abolish the financial problems associated with aging population as it was the case in UK.

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[141] Carolyn Ryan, "IVF 'good for British Economy'" BBC News 19 June 2006 http://news.bbc.co.uk/1/hi/health/5095884.stm (Accessed June.2006)

[142] Steve Connor," Free fertility treatment would 'combat problem of ageing population'" The Independent, (20.June.2006) http://news.independent.co.uk/uk/health_medical/article1090898.ece (Accessed June.2006)

In order to understand the rationality behind the policy making in Turkey, I argue that two questions should be raised: Which government decided to take these measures? And what kind of discursive practice and implications were present?

IVF became available on the National Health Service programme with AKP government in 2005. The ideological orientation of AKP was determined when it split off from Welfare Party (Refah Partisi) in the late 1990s after a critical disagreement of Erdoğan with the party. The actual conflict within the party was never revealed but the issue of leadership and ideological disagreements can be seen as one of the influential disputes. Shortly after this event, AKP managed to form the government in 2002. Both during the campaigns and after election, Erdoğan adopted a traditionalist, possibly conservative discourse, attempting to combine traditionalist structures, spiritualism and religiosity within the democratic system. In this sense Erdoğan's position resembles "compassionate conservatism"[143], in which economic liberalism translates into a new form of welfare state that is responsible for maintaining the equal opportunity of education and healthcare along with a moralist stance to how institutions are governed.

It is true that demand for IVF has not decreased even at the time of 2001 economic crisis in Turkey. According to the statement of Bülent Urman, Assistant Professor and practitioner in American Hospital IVF Unit, individuals did not hesitate to use up their savings and even to sell their houses in order to access IVF. This particular stipulation on IVF was surely combined with the pronatalist discourse of AKP government. When the second bill on IVF babies was proposed, Recep Akdağ - the Minister of Health- attempted to legitimize their interest to strengthen "integrity of family." In his statement there was an evident discursive tendency to stick to the traditional script of family; in a way, his statement can be interpreted as "desire to form and institutionalize family is essential and it needs to be done even if it requires the destruction of natural barriers".

[143] Martin Olasky, *Compassionate Conservatism: What it is, What it Does, and How it Can Transform America*, (New York:The Free Press, 2000)

CHAPTER 4

MEANING OF FERTILITY AND INFERTILITY

1- Meaning of Fertility and Infertility in Field of Medicine

According to the data provided in the European Society of Human Reproduction and Embryology (ESHRE) in June.2006, more than three million IVF babies have been born world wide, since the first IVF baby was born in 1978. The International Committee for Monitoring Assisted Reproductive Technologies (ICMART) estimates that one million IVF cycles are performed each year, which result in the production of 200,000 babies a year.[144] IVF is such a widely available and accepted medical technology that the way IVF constructs infertility as a treatable condition is often surpassed by the "hopes" it offers.

IVF, as well as other assisted reproductive technologies, define "infertility" through "biological facts" –i.e. inability to reproduce due to some physical

[144] Kirst Horsey. "Three million IVF babies born worldwide" , *BioNews* (28.June.2006) http://www.ivf.net/content/index.php?page=out&id=2105 (Accessed July.2007)

malfunctioning and chemical imbalances. The same type of definition is also conserved in the policy documents that provide guidelines and in the legal documents that provide regulation in the field of IVF. For instance, The Practice Committee of the American Society for Reproductive Medicine bluntly states "infertility is a disease" [145] And disease is defined as follows:

"Disease: any deviation from or interruption of the normal structure or function of any part, organ, or system, or combination thereof, of the body that is manifested by a characteristic set of symptoms or signs, and whose aetiology, pathology, and prognosis may be known or unknown."

Similarly, HFEA 1990 regulations in UK and "By law on centres for in vitro fertilization and embryo transfer" define infertility as:

a) In the absence of a pathological cause - "the inability to conceive after 2 years in the absence of any physical cause and unprotected intercourse".
b) In the presence of a proven pathological cause – "the inability to conceive over a limited time period due to a physical cause"

As the above data indicates, the meaning of infertility is constructed through "biological causes" within the medical documents and in the legislations surrounding artificial reproduction technologies. Consequently, infertility becomes a disease and its effects can be "fixed" by what IVF (along with other assisted reproduction technologies) might offer.

2- Meaning of Fertility and Infertility in Anthropological Studies

How did we come to think infertility as a condition caused by malfunctioning of organs, imbalances in hormone levels, and situate the necessity for treatment with assisted reproduction technologies? Does any other definition of infertility exist outside the boundaries of biological and medical discourses? In fact can the biological definition of infertility outside the social and cultural constructs? In order to address

[145] The Practice Committee of the American Society for Reproductive Medicine, "Definition of infertility" (June.2006)
http://www.asrm.org/Media/Practice/infertilitydef.pdf (Accessed July.2007)

these questions, two pieces by Carol Delaney was selected. Her book 'seed and soil: Gender and Cosmology in Turkish Village Society"[146] provides an excellent account on how fertility and infertility is constructed in Turkey and her article called "The Meaning of Paternity and the Virgin Birth Debate"[147] provides a comparable metaphor of 'seed and soil" for UK ("Western/Christian" constructions of procreation).

2-1- 'Seed and Soil"

Delaney in her book Seed and soil: Gender and Cosmology in Turkish Village Society conducts an ethnographic study of a small Turkish village of Sunni Muslims and investigates how thee meaning of procreation are constructed in their cultural setting. She focuses on the metaphor of seed and soil through out the book to refer to the mechanisms of defining gender, procreation, maternity and paternity. To broadly put, 'seed" or "tohum" represents both the actual seed and semen that is planted and the "field" or "tarla" represents both the actual agricultural field and women that nourishes the seed planted.

In her discussion of the Turkish proverb "cocuk tohumdan gelir, tohum erkekten gelir", which can literally be translated as "child comes from the seed, seed comes from the man", Delaney suggests that the identity and qualities of the offspring is determined by the identity and quality of the father. The role of mother, which is to nourish and take care of the child, can be realized by any women, as the seed can grow in any field. Similarly the word "dollenmek", which means "to inseminate" derives from the word "dol", which has multiple meanings of 'seed" and "offspring". Correspondingly word "dol yolu", literally translated as 'seed-path", signifies vagina and "dol yatagi", literally translated as 'seed-bed", signifies womb. So in order to realize insemination, men

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[146] Carol Delaney, 'Seed and soil: Gender and Cosmology in Turkish Village Society' (University of California Presss : Oxford, 1940)

[147] Carol Delaney, 'The Meaning of Paternity and the Virgin Birth Debate', *Man*, New Series, Vol. 21, No. 3. (Sep., 1986), pp. 494-513. http://links.jstor.org/sici?sici=0025-1496%28198609%292%3A21%3A3%3C494%3ATMOPAT%3E2.0.CO%3B2-V (Accessed March.2007).

metaphorically plant their seed (sperm) into seed-bed (womb). This metaphor therefore suggests that fertility is defined through active involvement of men; the role of woman to nourish the "foetus" starts if and only if men provides the 'seed"; that is to say in procreation, the role of men is active and generative, where as the role of women is passive, secondary and nurturing. So men can be potent/impotent, fertile/infertile, but women would always nurture. This metaphor, Delaney suggests, provides a "monogenetic basis for procreation".

2-2- "The Virgin Birth Debate"

Delaney suggests that "monogenetic basis for procreation" is also evident in the story of Virgin Birth. Although the religious text does not refer to actual "insemination" or 'seed" in this case, the explanation provided for procreation is the same as 'seed and field". The story suggests that Jesus, with his all entirety was a product of God, and the only role Mary had was to nurture his son; she did not provide any further identity. In fact, one could argue that it could have been any other woman who gave birth to Jesus. This is just like the argumentation with the ability of seed to grow on any land, in Turkish case. Hence she suggests this story discloses a "monogenetic" theory of procreation.[148]

2-3- Motherhood and Kinship – Revisited

The dichotomy created by the scientific interpretations of infertility based on biological and natural facts and the anthropological interpretations based on culture is attempted to be resolved by the third generation feminists, who had written extensively on the construction of motherhood and kinship in the height of IVF technology. Although the third wave of feminist criticism is large in its context and extends from Donna Harraway to Judith Butler, from Sarah Franklin to Robert Snowden, here I will summarize some of the key issues they raise in order to resolve nature-culture polarity.

[148] Ibid, 500-501.

Arendell points out, mothering and motherhood is constructed as an indispensable part of the feminine identity, which is a result of socially constructed gender belief systems[149]. By this way, biological parenthood, particularly motherhood is built as a necessity so as to be able to assert a reliable identity. In a society, in which voluntary childlessness is rare, involuntary childlessness may be regarded as social deviance[150], therefore individuals who are infertile often feel deprived due to the lack of social acceptance of their identity as "infertile individuals" and hence what appears to be "choice" to produce is rather a naïve idea- it is rather a means of integrating one self into the societal norms. Snowden suggests that the AID became acceptable because it firstly preserved the initial traditionalist assumption that "women" have their maternal instinct, secondly it took away the responsibility of father as "impotent" or as "less manly" and it creates an illusion of "our (genetic) children"[151]

Sarah Franklin suggests that the reproductive medicine, especially the case of IVF have been regulated by the kinship practices that are embodied in the cultural values[152]. In this regard, kinship is a predominating factor, which manages the social relations that formulate individuals' choice of going under IVF, such as emphasizing the physical paternity, acceptance of heterosexuality, domain of natural facts and genetic relatedness. She argues that there is an "unspoken assumption that a genetic link exists between brothers and sisters and their parents"[153] and these relations are based on "blood", "blood relations", 'stock" or "kinship". She suggests that artificial insemination techniques particularly IVF, preserves the societal norm of married

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[149] Arendell, T. "Conceiving and Investigating Motherhood: The Decade's Scholarship." *Journal of Marriage and the Family* 62 (2000): 1192–1207

[150] Inhorn Marcia C. Infertility *and Patriarchy: The Cultural Politics of Gender and Family Life in Egypt.* (University of Pennsylvania Press, Philadelphia 1996)

[151] Robert Snowden ,G. D. Mitchell , E. M. Snowden *Artificial Reproduction: A Social Investigation* Unwin Hyman (1983)

[152] Sarah Franklin, *Embodied Progress. A Cultural Account of Assisted Conception*. (London: Routledge, 1997).

[153] Sarah Franklin 'Post-Modern Procreation: Representing Reproductive Practice'. *Science as Culture*, (1993) 3, 4, 17.

couples to have a child and to continue their kin in a way that allows their genetic relatedness.

Similarly, Widdows argues that new reproduction technologies "promote concepts of genetic relatedness and reinforces wider societal presumptions"[154] (2006: 151). She argues that the low success rates and risks associated with the IVF procedure are attempted to be overcome by its "promise" of genetic-relatedness. This comparison can be made if it were compared to adoption. In our survey, slightly more than half of the participants denoted they would not consider adoption of a healthy Turkish baby, this preference dramatically decreases when they were offered a handicapped baby or a handicapped older child. Results suggest that individuals prefer their "own" off-spring, experience stages of pregnancy and if not at least be a spectator for the growth of their child, rather than adopting an older child.

A correspondent interpretation of the case is reported by Mahowald who states that gestational relatedness compromises a larger section of the despair for childlessness.[155] In order to compare "genetic relatedness" with "gestational relatedness", we raised the acceptance of ova or sperm donation in order to be pregnant. Snowden suggests that the AID became acceptable because it firstly preserved the initial traditionalist assumption that "women" have their maternal instinct, secondly it took away the responsibility of father as "impotent" or as "less manly" and it creates an illusion of "our (genetic) children."[156] Ova transfer, likewise, can be interpreted, in which women would still be able to live the gestational stage and benefit from the deposition of above benefits.

[154] Heather Widdows, Itziar Alkorta Idiakez and Aitziber Emaldi Cirión, *Women's Reproductive Rights,* (London: Palgrave, 2006)

[155] M. B. Mahowald. *Genes, Women, Equality*, (Oxford: Oxford University Press, 2000)

[156] Snowden et. al. 1983, 86

3- Conclusion and Discussion

In vitro fertilization, as a technique, might appear to be a straightforward medical intervention or an unadorned engineering practice, which "fix" an undesired medical condition -that is infertility. Indeed, the emphasis of medical and legal documents display that the construction of reproductive technologies as natural, standard, typical procedures. The normalization of IVF as a procedure and its acceptance by public are facilitated through remedial constructions. It is often the case that "infertility" is positioned in opposition to "fertility" as the lack of capacity to generate offspring of one's own, as well as the aptitude to cultivate family of one's own. Thus, any "assistance" to solve this "problem" is mediated as desirable objectives within the society. However, the technology itself is not one of "assistance" but intervention and equally "fixation"[157] to the "normal, healthy, and fertile." Furthermore, the shifting interest in combining genetics and germ line gene therapies with IVF are increasingly at height, where modification of genotype is understood, not only in terms of treatment but also "enhancement."[158] The boundary between pathology and re-engineering human genealogy become more and more blurred. Furthermore, the economics of IVF limit the number of its participants to only who can afford going under treatment; as a result on the one hand competitive economic forces prosper economic injustices in terms of the availability of services and on the other promote the technocratic mentality for those who can afford it.

At the other end of the biologically-determined understanding of infertility, there resides the cultural forces within it emerged. Surely, the definition of infertility, as a medical condition, is only evident as such in the last two centuries; however its discursive practice is deeply entrenched in the cultural norms and societal exercises for centuries. Anthropological studies in this framework offer an alternative comprehension on how meaning of infertility and fertility are produced in different cultural settings. Deriving from Delaney's work, I suggest that procreation is formed

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[157] Clarke, Adele E. *Disciplining Reproduction: Modernity, American Life Sciences, and the Problem of Sex.* Berkeley: University of California Press (1998)

[158] F. Baylis and J. S. Robert. "The Inevitability of Genetic Enhancement Technologies" *Bioethics* 18, 1 1-26 (2004).

within a complex set of cultural relations, where feminine role is passively defined, as the provider of nourishment and masculine role is defined as the provider of seed. One sided comprehension of procreation ultimately concludes a partial view not only on the function of women's bodies but also on the responsibility of child care. The right to own the offspring's virtues are attributed to the father, within the context of kinship and any derivation from father's righteousness and goodness are accredited to the fault in the process of carrying and caring the child.

The emergence and even more the spread of reproductive technologies have dramatically changed our discernment about fertility and infertility. It is no longer possible to situate procreation as a neutral cultural process, where men and women are free from the culpability of their generation or from their incapacity to conceive an offspring. The convergence of medical and cultural boundaries distorts the way we make sense out of our bodies and they alter the familial relationships. The duality between culture and nature now need to be reinterpreted within the domain of social sciences; as a consequence, the ever growing literature provided by the studies of cultural feminists can be seen as attempts to overcome this dichotomy. It is clear that relation to self and family are mutually constructed at several domains, where imaginaries of motherhood are reconstructed. Motherhood, as an essential role of women has been supported by the cultural domain and this imagination of genetic and gestational relatedness is further enabled with the introduction of reproductive technologies, for those who can not have children. Cultural domains contribute to the reconstruction of motherhood as an essential role of women, where scientific domain provides the conceivability of such images. Even though, new technologies could "technically" offer the top-bottom change in the appropriation of parenthood, the legal boundaries they operate, hinder their competence to permit procreation for "others", who do not fit into the "heterosexual, young, married" women. As a result, the meaning of infertility and fertility that are constructed discretely within spheres of science and culture do not provide a comprehensive evaluation behind the rationale for reproduction technologies. Science and culture construct the meaning of IVF reciprocally and the significance of this technology can only be comprehended without falling into the isolated categorizations, provided by this two spheres of influence.

CHAPTER 5

IVF REGULATIONS- LAW AS A DISCURSIVE PRACTICE

1- Theoretical Perspectives

1-1- Legal Order as Power

Feminist researches have often focused on how women's bodies become a battle of power, where meanings over women's bodies are challenged and recreated. The employment of language and specific metaphors are widely recognized and investigated[159] however the understanding how these produced meanings are sustained through legal institutions have been rather limited. The symbolic interactionism between legal institutions and medical profession is of particular interest, since medicine habitually provides a legitimate physical control over women's bodies and legality introduces the control mechanisms of exercising this control; indeed the reverse direction within the interaction scheme is possible- that is: the negative attributes of medical discourse could signify a certain dispossession of rights in legal discourse. It therefore becomes important to identify the instances of producing medical definitions that are translated into legal discourses, where negative attributes towards women's bodies are socially attained.

[159] Dale Spender, *Man Made Language*, (London: Routledge & Kegan Paul, 1980); Casey Miller and Kate Swif, *The Handbook of Nonsexist Writing (* New York: Lippincott & Crowell, 1980).

If the cooperation of medicine and institutionalized social control mechanisms is certainly an extension of misogyny, what Foucault's theory on bio power might be able to offer is to investigate the strategies for intervention in the form of law and regulations to address populations that may be specified in terms of bio-collectivises, i.e. gender. There is, for sure, always multiplicity of meanings and heterogeneous of truth exerting mechanisms- which can offer resistance points to already existing values. The heterogeneity of truth exerting mechanisms is again vital to point out to resistant points of patriarchal position and to bolster the comprehension of alternative meanings. The power of legal discourses and multiplicity of power mechanisms stem from Foucault's work, where truth is defined as:

> "by truth I do not mean the ensemble of truths which are to be discovered and accepted but rather the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true. Truth is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements. […] Truth is linked in a circular relation with 'systems of powers" which produce and sustain it, and to effects of powers which it induces and which extend to a regime of truth."[160]

Conversely, inclusion and exclusion of other forms of knowledge, particularly of medical knowledge is present in law, which in turn construct the law as a unique "regime of truth." So the legal truth is bounded with the social values in which they are created. As I have pointed out in the historical developments of IVF, the social values surrounding gender and motherhood is evident in the production of legal truth. Furthermore, as I have pointed out in the meaning of infertility in current legal discourse, "medical gaze" is inevitable. If legal codes are powerful and structured mechanisms to exert power and if they stem from medical and societal interpretations of what truth are, then it can be argued that power exerted in the legislations and regulations are not purely legalistic, but also societal and medical. In other words, what at first seems to be outside the legal truth –that is societal and medical "claims of truth" are constantly added and applied to control, manage populations. The managers of life,

[160] Graham Burchell, Cikin Gordon and Peter Miller, *The Foucault Effect: Studies in governmentality,* (Chicago: University of Chicago Press, 1990): 19.

birth/fertility, health, body, species of body become individual claims of "right" and "duties" in relation to one's body, health and fertility/reproduction.

If power is produced through legal knowledge and if legal knowledge stems from societal structures, how can one explain the particularistic gender-blind interpretations of law and legality? Is it possible to establish matters of sexuality and reproduction outside the bodies that are governed within the legal discourses? Is the rule of precedence relevant in terms of defining the capacity of legal conductor's rationality or does it need to refer to established moral codes? How can one deconstruct legal codes in a way to produce desired societal and medical outcomes- or is it at all possible to do so? These intricate questions and many more can be asked within the domain of construction of truth through legal codes. In order to answer these questions, I suggest, one needs to the question of "how legal codes are constructed" prior to understanding "how power is exerted through law." I argue that Foucault's description on governmentality offers a powerful tool to understand the question of how- The exercise of authority and power is managed through law which manages to "administer" populations (population size, life, birth and mortality) in a web of 'spaces" (clinics, courts), furthermore the rule of law provides a moral narrative that is extracted from embedded societal norms, i.e. gender inequality and neoinstitutionalism, while governing bodies.

1-2- Legal Order as Male Power

Law's claim to truth also arises from its readily established institutionalization. From a neo-institutionalist perspective, the law is more subject to deconstruction, when compared to elements that retain in the field of sociological or cultural knowledge. Furthermore the legal definitions, if managed to be enforced, could determine new values, resulting in desired cultural outcomes. Although the above claims would be relevant in certain cases, however the power of law's claim to truth could further penetrate existing cultural values and as MacKinnon suggests, the legal discourse can

translate into particular "maleness"[161], while being more appeal to masses. A number of feminist studies exemplify the historical development of this instance: Smith and Walkowitz are one of the preliminary examples describing how women's bodies gain contested meanings of morality and disease, in the 19th century.

In A Brief Summary in Plain Language of the Most Important Laws Concerning Women, Together with a Few Observations Thereon, Smith highlights that scientific discourse based on nature dominates the legal discourse governing women's bodies[162]. Particularly, the reproductive capacity and the hormonal oscillations during menstruation were accepted as the basis of the reduced rationality of women's behaviour. For instance, during pregnancy and child birth, women were deposited for a form of psychological instability hence the retribution of criminal law against women were less due to medical discourse on psychosis. The less strict penalization is indeed malevolent, for it bases a dogmatist presumption that women are less rational and hence less morally responsible, when compared to men.

Conversely, Judith Walkowitz who investigates the prostitution in Victorian England in her book City of Dreadful Delight demonstrates that working class women became a contagious public space, where a shared sexuality was appropriated both through moral stance and medical knowledge on communicable disease[163]. Unlike Smith's description of lenient criminal code, women's bodies in this case became a stronger subject to legal discourse. The orthodox morality based on religious doctrines, combined with medical knowledge on women's bodies thereof constructed the gaze over women's bodies. In both cases, women's bodies are reduced down to their

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[161] Emily Jackson, "Catharine MacKinnon and Feminist Jurisprudence: A Critical Appraisal"
Journal of Law and Society, Vol. 19, No. 2 (Summer, 1992), pp. 195-213

[162] Barbara Leigh-Smith [Bodichon], *A Brief Summary in Plain Language of the Most Important Laws Concerning Women, Together with a Few Observations Thereon* (London: J. Chapman, 1854) In Susan Groag Bell and Karen M. Offen, eds., *Women, the Family, and Freedom: The Debate in Documents*, *Volume I, 1750-1880* (Palo Alto, CA: Stanford University Press, 1983)

[163] Judith Walkowitz, *City of Dreadful Delight: Narratives of sexual danger in late-Victorian London* (New York:Virago Press, 1992)

sexuality and their reproductive capabilities in the legal discourse. On the one hand, women were disqualified from certain punishment measures in the criminal law and paradoxically on the other they were kept responsible for their bodies in terms of regulating their sexuality.

Although the legal codes have drastically changed from nineteenth century till today, there is still a powerful element of governing women's bodies in the field of reproductive rights. It is true that women have managed to establish themselves as qualified individuals making legal contracts in various social and economic realms; however the linkage concepts of nature of women's bodies and disqualification from certain rights still pertain today, especially in the field of reproductive law, with the emergence of new reproductive technologies. Many regulations have situated the rights of foetus, duties of parenthood, conceptualization of kinship prior to women's reproductive rights. The new medical technologies enable women to follow the development stages of foetus and establish presumed "maternal bonds" prior to birth, legal parental duties are challenged by sperm and ova donations, surrogacy determines the ownership status of children; genetic relatedness triumphs of marital ties. The legal discourse which is intricately related with the medical developments prevail the redefinitions of bodies, body parts along with women's self determination. The nineteenth century definitions of bodies which acted punitively on women's bodies are redefined with the developments in medicine, where more comprehensive responses are given to issues of motherhood, kinship and sexuality. Some of the responses appear more liberal than previous traditional modes, but their power to infiltrate private lives and to construct women's bodies as public space; hence oppression in the criminal law is now being translated into other means in the legal discourse.

1-3- Legal Order as Foetal Power

The central argument in the development of legislation in fertility laws is based on the historical process that I have attempted to argue above; but perhaps more interestingly new subjects are yet to emerge, where women are defined more than their bodies. The definitions of infertility in the medical discourse effect the designation of appropriate age of motherhood, along with requirement to implement new public

policies on the social security, while accepting women more than their "mother role". Similarly, the guardianship of legitimate children in terms of profession they would employ. The ideal of motherhood being bound to sexuality is now being replaced by different kinds of disentitlements, such as the alienation of homosexuals from their right to raise a child. Old issues in a way are being reassessed in the light of new developments in contradictory manners, on the one had women hold the right to terminate their pregnancies. There are also other developments or perhaps more correctly old issues are being reappraised in the light of new developments. For instance screening technologies, particularly in ultrasound controls[164] and in the "unreal imagery" of test tube babies[165] induce a conception of foetus outside the boundaries of mother; mother becomes an incubator, similar to the "violinist analogy". In turn, doctors become the central actors who govern these incubators, so as to protect foetuses from any damage their mother would bring; whereby specific legal regulations are taken to enabling the governing role of doctors and preventing potential threats from mothers. Gallagher reports that medical procedures are commonly applied involuntarily in order with ranging prospect of disciplining methods[166] The nineteenth century procedures, in which suspected women are kept under surveillance is in a way re-emerging but this time, focus of protection is shifted from men to unborn offspring.

Similarly, control of foetuses becomes a conception of ownership, in the case of IVF, AID treatments and surrogacy agreements. In the current British legal regulations, the married couple, who has occupied these medical procedures, is protected from possible prospective demands of sperm donators as a legal father; whereas the unmarried mother, who accepts sperm donation, has no protection against the donator's demand to register as a father. This position makes clear that the traditional conception of motherhood is reserved; the biological reproduction is only acceptable under the

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[164] Farran, D.'Practices in the compilations of fieldwork notes'. *Department of Sociology Occasional Papers*, (Manchester: University of Manchester, 1985)

[165] Petchesky, Rosalind Pollack. Foetal Images: the Power of Visual Culture in the Politics of Reproduction" in Reproductive Technologies: Gender, Motherhood and Medicine. Ed. Michelle Stanworth, US: University of Minnesota Press, 1987.

[166] *Mary Campbell Galangher, "Bill on Parental Consent for Abortions Poses Quandary",* The New York Observer*, (30 April 1990): 12.*

supervision of the authority of the "legitimate" father. In Turkey, IVF is not provided to single women, as sperm donation is not allowed. If a woman desires to have a child, without the authority of "legitimate father", she can take the risk to obtain sperm through informal arrangements that health tourism might offer.

Clearly, taken and applied preventive measures under the law do not necessarily empower women, and law, which is a space for production of cultural meanings, can enforce government of women's bodies in an explicitly public manner. It therefore becomes important to investigate contemporary legal regulations in a comparative vision, so as to fully comprehend how different meanings are reproduced in the realm of law. European Fertility Medicine regulatory texts along with national derivations, in UK and Turkey will be analyzed so as to position how definitions of infertility, emphasis on informed consent, protection of embryo, ownership, commoditization of foetuses and new forms of eugenics are constructed. The regulations through these reproduced meanings determine women's reproductive rights and the extent to which their bodies are governed within the domain of reproductive medicine.

2- Interpreting Common Themes in IVF Regulations

Reproductive medicine has not been specifically regulated under an international law, nor even has been harmonized in the European legal framework; nevertheless the foremost important step to base the regulations have been the principles of biomedical ethics, including terms of genetic data, dignity of human embryo[167] in the signed Convention on Human Rights and Biomedicine of 1997[168].

[167] Romeo Carlos, "Ethical, legal and social issues related to cell therapy", *Cardiff Centre for Ethics, Law & Society*
http://www.ccels.cf.ac.uk/literature/publications/2006/casabona.pdf

[168] Convention for the protection of Human Rights and dignity of the human being with regard to the application of biology and medicine: Convention on Human Rights and Biomedicine CETS No.: 164
http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=164&CL=ENG

German and British committees, by that time, refused to sanction on a common international regulation, simply because there were not adequate domestic laws on the growing field of biomedicine to harmonize; still the protocols, particularly Chapter IV of the Convention addresses several subjects related to ART which became a common ground of national laws. Predictive genetic tests and sex selection have been strongly prohibited and later (in 1998) with a secondary protocol, particularly through Charter of Fundamental Rights non-therapeutic cloning have been proscribed[169]; however ART remained to be a unwieldy subject that remains to be addressed.

In light of this framework, European states have defined in vitro fertilization and prenatal diagnosis as forms of treatments of infertility and as a means of preventing hereditary diseases. Similarly since the pass of "the Regulation for Assisted Reproduction Centres" in 1996, infertility is defined in the same manner, in Turkey. From a wider perspective European laws on biotechnology have taken the side of limiting the uses of reproductive technologies, where state is formulated as the protector of basic rights which might be interfered by new technologies. Nevertheless, the definition and mistreatment of these basic rights is still obscure and varies greatly in different national contexts.

2-1- Women as "Vessels"

As mentioned earlier, ART have been adopted as means to overcome infertility of both men and women, while the security and efficiency of the current methods are of constant debate: Most medical procedures offered by fertility clinics fail to recognize the comparably low rates of succession and depleted amount of risk analysis associated with the techniques, furthermore it limits the amount of patients" choices, diminishing the arena of choice over their bodies. For instance, both in Turkish and British legislations limit the number of ova's to be extracted and implemented and it s not up to individual choices of women who undertake the treatments. With the ongoing moral and legal debates on the protection of embryo versus women's corporal rights, the

[169] Charter of Fundamental Rights of the EU (2000)
www.europarl.europa.eu/charter/default_en.htm

scene points out to that the women's reproductive rights are often traded over foetus; the continuing practices in the abortion debate, hence, are effecting the assisted reproduction technologies as well.

The cyclical repetition of the debate grew a social interest whereby women are conceptualized as "vessels."[170] By this metaphor, women's bodies are meant to become a semi-public territory, in which political debates and social values are preserved, whereby means of public control, along with legislations are set. The 2003 Code of Practice of the Human Fertilization and Embryology act states that account should be taken of the prospective mother's ability to provide a stable and supportive environment. Health and consequent future ability to look after or provide for child's needs, ability to meet the needs of child or children who may be born as a result of treatment, including the implications of any possible multiple births and any possibility to known to the centre of a disrepute about legal fatherhood of the child. This is especially the case, in the British legal institutions, which put foetuses rights in front of women's choices, as Eisenberg and Schnecker points out there have been cases in which women were denied from their right as carriers, due to their psychological status[171], i.e. drug or alcohol abuse.[172] As yet, definitions of mental health and disorder are highly susceptible to social mores and even political trends; what Foucault calls "medical gaze" in this sense settles to various behaviours over time and there is nothing that guarantees that another condition will be added to this list of ban in the future. Psychiatrists have long engaged in dialectic with the legal community over who has

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[170] Hester, Donne's Epigrams in Theresa M. DiPasquale, Donne's Epigrams: A Sequential Reading. *Modern Philology*, volume 104 (2007), pages 329–378 http://www.journals.uchicago.edu/cgi-bin/resolve?id=doi:10.1086/517937

[171] E. Showalter, *The Female Malady: Women, Madness and the English Culture 1830-1980*. (Virgo Press Ltd,: London, 1987)

[172] In Turkey there is not a specific law regulating women's actions while they are pregnant, however the lack of legal action does not directly translate as: women's bodies are prioritized over foetuses. As Foucault suggests, "our society is a society of judges"- Mundane practices of every day life, mass media and possibly doctors and nurses influence women's behaviour during pregnancy (and even prior to pregnancy). The recent media interest in the scientific study that cigarette smoke could reduce chances of pregnancy was published as a warning message in all of the Turkish newspapers I had studied.

administrative control over individuals who commit crimes and yet appear to be suffering from a disorder of mind. Boundaries erected to the partition off the "mad" from the "bad" may be extremely mutable since conceptions of moral deviance and improperness are not universal across time and space.[173] Knowing that prominent examples of activities that have fallen under the rubric of mental disorder are female sexual activity and homosexuality, the danger of further categorization becomes even more threatening.[174]

2-2- Informed Consent

Another problem concerning the legislation of artificial reproduction technologies is of commodification. Both Turkish and British legislations emphasize the importance of "informed consent" prior to starting IVF treatments. In order to provide an informed consent, they need to be fully informed about the procedure, risks and success rates and need to sign a form, stating they had understood all the terms and conditions and it was their sole interest and choice to start treatments. Informed consent is rather a problematic area. Alkorta indicates that most women participating in these programs "often feel deprived of correct and realistic information about risks and success rates, compounded by the fact that clinics often make up figures about pregnancies and "take home baby rates"" [175] Similarly Koch demonstrates that most women, who have been informed by their doctors or medical personnel, often accept

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[173] Peter Miller and Nikolas Rose, The Power of Psychiatry, (Cambridge: Cambridge Polity Press, 1986)

[174] For a more detailed discussion of psychiatric institutions and eugenics, see:
Alexander, Leo. "Public Mental Health Practices in Germany: Sterilization and Execution of Patients Suffering from Nervous or Mental Disease" from National Archives, Combined Intelligence Objective Subcommittee, G2 Division, SHAEF (Rear) APO 413. (1949)

Dowbiggin, Ian. *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada 1880-1940* (Ithaca: Cornell University Press, 1997)

[175] Alkorta Idiakez, "European Fertility Medicine Regulation", *Women's Reproductive Rights* (Widdows, H., Idiakez, Cirion, et. al.) (London: Pelgrave, 2006): 121

any terms offered by the doctors -as IVF becomes an imperative for those, who otherwise have to accept their status of infertility.[176]

It is clear that emphasis on "informed consent", with the hope that it would prevent any form of coercion does not simply hold for women, who undergo IVF. This is firstly because, as the above literature indicates, is the absence of "feeling fully informed" about the medical procedures, individuals can hesitate to ask detailed questions, primarily because they would choose to represent themselves as rational, informed, understanding and even "docile" to a certain extent. The asymmetrical power relations between doctors and patients, in this regard, become means of acceptance and docility. Secondly, even when the individual fully understands the medical procedure – hence escapes the possible physical coercion, - their decisions to undergo IVF programme are rarely –if ever- socially isolated decisions. That is to say, "neo-institutionalism" modifies their choices, reinforces family bonds, kinship and necessity of having a family and a child; in the midst of such social environment, infertile couples (or women) may experience a social intimidation, which result in their decision to sign up for IVF.

In this sense, the nature of limiting liberty to take decision not to be on IVF programme brings out the disposition of an old political and theoretical debate between "negative and positive liberties"[177]. Discussions about the distinction normally take place in the context of political and social philosophy and they are interrelated with the discussions about "free will"[178]. Berlin showed that negative and positive liberties are not merely two distinct kinds of liberty; they can be seen as contenders of a single political ideal. The way liberty is interpreted and defined, then, result in alternative political implications. Negative liberty is the absence of physical obstacles, barriers or constraints; where as positive liberty, which is often used for politics of collectivised identities, is the pursuit of actions towards self realization and self determination.

[176]Koch, L. "IVF-An irrational choice?" *Issues in Reproductive and Genetic Engineering* 3 (1990):235-42.

[177] Isaah Berlin, 'Two Concepts of Liberty', in I. Berlin, *Four Essays on Liberty*, London: Oxford University Press (1969).

[178] Kant, I. (1785) Groundwork of the Metaphysic of Morals, in Practical Philosophy, trans. M.J. Gregor, Cambridge: Cambridge University Press, (1996).

Political liberalism and liberal feminists[179] for that manner, argue that negative definition of liberty- that is absence of physical obstacles, barriers or constraints, either by state or medical authorities provide the adequate liberty to make decisions. For instance, if state or medical authorities are not forcing women for IVF, women are said to be free in the negative sense of the word. In contrary, critics of liberalism, particularly Marxist feminists[180] and radical feminists[181], often contest that the pursuit of actions are delimited, unless self realization and self determination are not provided and sustained. In this regard, positive liberty includes the economic status, gender based institutions and power relations that might take in effect in terms of making decision to/not to be treated –hence "autonomy" is what is at stake.

In this framework, I argue that the ideal informed consent cannot function, precisely because of the conjecture it emerged in. I suggest that informed consent, by emphasizing *individual's choice* on her/his body actually appended the self into the domain of politics and self governance (and associated morals with it) starts to act on individual's body –resulting in subjectification. That is to say, although informed consent takes away the risk of physical coercion, it does not alter the power structures they emerge in, i.e. gender relations, "medical gaze"[182] on women's bodies. Hence informed consent does not resolve the problem of 'associated risks' on women's bodies. Hence, it can be deduced that neither inconvenience fee nor informed consent form legitimize the risks associated with undergoing an invasive procedure such as IVF. I suggest that although women's decision to go under IVF might be shaped partly according to the presence/absence of these two factors, there is one other and more important factor in constructing the legalities of this medical intervention.

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[179] Gena Corea, *Man-Made Women: How New Reproductive Technologies Affect Women*, Bloomington: Indiana University Press, (1987). 109

[180] Martha E. Gimenez , "The Mode of Reproduction in Transition: A Marxist-Feminist Analysis of the Effects of Reproductive Technologies" *Gender and Society*, *(*Sep., 1991), Vol. 5, No. 3, *Special Issue: Marxist Feminist Theory.* pp. 334-350.

[181] Janice Raymond, *Women as Wombs*, North Melbourne: Spinifex (1993)

[182] Foucault, Michel, *Birth of the Clinic, The : An Archaeology of Medical Perception*. (A. M. Sheridan Smith, trans.)New York: Vintage Books (1975). 54-55.

2-3- Governing Single, Homosexual and Old

In fact, this is exactly the case, in the laws governing the status and availability of ART for homosexuals and for single mothers.[183] The large majority of European regulations state that reproductive technology treatments should only be available for married or cohabiting heterosexual couples.[184] This is a result of Human Fertilization and Reproduction Act (1990), which regulates the reproductive medicine at whole, which base the promotion of technologies only for heterosexual couples. However there are exceptions to the above case and deviants might occur from a more traditionalist or libertarian stance. For instance, Turkish case goes one step beyond and by taking pros de conscience of traditional values allows only married couples to take advantage of the medicine. Sperm and ova donation, along with surrogate mother are not allowed. British law, on the other hand, constitutes an exception and allows lesbian couples and single mothers to take advantage of sperm donation, ova donation and surrogate motherhood. This is not to say however that all couples have been eligible for such treatments- only those who overcome the stigma attached can apply to hospitals and those who live in areas that are not devoid of applications and treatments. The tendency to preserve traditional societal structures can be seen as a form of "neoinstitutionalism", whose major goal is "to save all that can be saved of traditional family structures, opening them to partially to the technological developments, in a sort of institutional surviving adaptation of traditional family." [185]

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[183]Alberta M. Dooley and Stephen C. Anderson, "Practice Interventions With Special Populations" In McClennen, Joan C. and Gunther, John Joseph. *A professional's guide to understanding gay and lesbian domestic violence: understanding practice interventions*. L (N.Y.: E. Mellen, 1999)

[184] This can be exemplified by Sweden Act. no. 1140/1984, on Artificial Insemination; Norway act. no. 56/1994 on Medical Use of Biotechnology and Denmark Act. no. 460/1997.

[185] Busnellid 'Quali regole per la procreazione assistitita?' *Rivista di Diritto Civile,, no*. 5,(1996): 574, in Itziar Alkorta Idiakez, "European Fertility Medicine

Regulation",: *Women's Reproductive Rights* (Widdows, H., Idiakez, Cirion, et. al.) (London:Pelgrave, 2006)

Neo-Institutionalism or the conservation of traditional family values also appears in the definition of infertility and hence in determining who is eligible for ART. Both in Turkish and British regulations, definition of infertility and eligibility to public funds are defined through age. Both Turkish and British governments refuse to provide free IVF services for woman who are over the age of 39. Also, the law suggest that in order to be categorized as "infertile" women less than 35 years of age need to engage in six months of sexual intercourse or women over 35 years of age need to engage in twelve months of sexual intercourse resulting in no pregnancy. Eventually, women who are under the age of 35 are left with the "duty" of pregnancy in order to increase their chance to pregnancy but the lack of social security network for working mothers left women in a dilemma over whether they should choose their career or family.

3- Conclusion and Discussion

What is so fascinating about the legal truth is that legal codes make their truth claims through a 'scientific fact" –i.e. "women over a certain age has less capacity to produce". In fact this is not any different than Foucault's description of "governmentality"[186] through statistics. Foucault argues that statistics eliminate the possibility of individual differentiation, decentralizes the focus on choices made at the level of family; but centralizes the role of economics, i.e. economics of economics of life, mortality, births. That is not to say however, family is no longer "governed"- in fact, just the opposite: "what now emerges into prominence is the family considered as an element internal to population, and as a fundamental instrument in its government." [187]

If it is more unlikely for women over the age of 39 to get pregnant, then the "rational" government chooses not to include them in "free IVF programme"-as in UK

[186] Michel Foucault, "Governmentality" IN Graham Burchell, Cikin Gordon and Peter Miller, *The Foucault Effect: Studies in governmentality,* (Chicago: University of Chicago Press, 1990)

[187] Michel Foucault, et.al. 1990: 19.

and Turkey. If there is an aging population, which would damage the economic prospects, the "rational government" would provide free IVF-as in UK. Likewise, if the government aims to amplify traditional values, the easiest way to do so is to promote notions of family and family-bonds (and perhaps to promote IVF to let them have "proper families with children" as in Turkey).

What now emerges in IVF regulations is a number of several complex mechanisms of cyclical relations, which can be analyzed through utilization of Foucault's term "biopower": Firstly, IVF requires legislation, legislation is made up from the societal values they emerge in, but the legislation itself utilizes 'scientific facts" for legitimacy. So the power of legislation is not "biological" in the restricted sense of the discipline but it is a hybrid biological, sociological and demographical mobilization that requires "biological facts" in its core.

Secondly, legal discourses allow (and constitute) strategies for intervention upon collective existence in the name of health –as infertility is a disease and IVF is a medical technology to "fix" it- that is pre-determined, i.e. for those who are not "married/heterosexual/young."

Thirdly, families/society makes the "moral narrative" for legislation, in turn legislation promotes these values whilst describing IVF and they are diffused again into societal values through the practice of IVF. The neoinstitutionalist substance within the legal discourse sets the mode of subjectification of homosexuals and women, - particularly if they are single, middle age. These subjectified individuals are brought to work on themselves in the name of their own life - i.e. get married, have children earlier before it is "too late to have a child."

CHAPTER 6

DISCOURSE ANALYSIS OF MEDIA

1-Theoretical Grounding

1-1- Foucault, Truth Formation and Role of Discursive Practices in Media

In the last decade, artificial reproduction technologies, particularly IVF, have attracted the attention of mass media as a revolutionary attempt to fix infertility problem and to pose threats to the ways in which individuals can reinstitute their familial ties, social relationships. Unlike the medical literature, mass media channels offered an understandable, less specified language in which people considering to undergo IVF could judge the technology, prior to making their decisions. Given this increased attention to report, analyse and comment on IVF on mass media channels suggests that the mass media is involved in the formation of truth behind IVF- how it is organized in clinics, how it is perceived by patients. By doing so, the boundary between the expertise and lay knowledge have been blurred, as more people read about it, they claimed their own knowledge and started to contemplate on their power to 'self-making" through technology.

Certainly, different media groups according to their ideological stance point, offered different interpretations of IVF technologies, this eventually resulted in the formation of multiplicity of truth claims and relativization of scientific facts. In a way, the array of truths provided a world view in which power can no longer function as unitary, top to bottom fashion; the polarity between the sovereign (of knowledge) and absolute subjects have been eliminated- IVF became an area where different interests

(treatment, governance, having a child) and different power holders (medical practitioners, government, scientists, patients) interacted in a complex web of relations. Mass media provided what Foucault suggested as "power comes from below; that is, there is no binary and all-encompassing opposition between rulers and ruled at the root of power relations, and serving as a general matrix."[188]

This is not to suggest however, all actors contribute equally in the making of truth. The intricate relationship between truth and power still remains and it is produced within the "general politics of truth-that is, the types of discourse which it accepts and makes function as "true."[189] Therefore, what is previously labelled as "deviant", "abnormal" can be represented as such and mass media can function as a tool to perpetuate and re-integrate these values into society by generating and regenerating it. As yet, each generation and repetition of these images can be interpreted differently by readers and such interpretations can possibly contribute to the reversal of the power exerted- since "where there is power, there is resistance."[190] In other words, the power which mediates the dominant discourse in media is not simply used in repression, but also in production of different truth claims and possibility to render reversal of power.

Mass media is also an "apparatus" that creates a virtual space where subject can be theorized through discursive practices of previous forms of power and norms. These discourses can in turn re-establish the codes to define identify and label the "deviant." For instance, in the discursive practices of IVF, deviance refers to all others, who are not "fertile, married, heterosexual" and unnatural sometimes refers to "any attempt to reproduce without sexual intercourse." What makes the issue of deviance interesting is the tendency to redefine what was previously labelled as "deviant" through the same terms which initially labelled it as "deviant"- that is to say, the attempt to problematize and normalize is again governed by the employment of same discourse. For instance, physicians that run IVF centres emphasize the disposition of "natural" in order to

[188] Michel Foucault The History of Sexuality, Volume 1: An Introduction (First American Edition ed. Vol. 1). New York: Pantheon Books. (1978): p.220.

[189] Michel Foucault, "Truth and Power", (edt. Paul Rabinow) *Foucault Reader*, (London: Penguin, 1984)

[190] Foucault, et. al. (1985), p.85

challenge claims that constructs "IVF as unnatural." As a result, widely used and accepted discourses determine the discursive boundaries in which opposition can act. This limitation, I think, sets the biggest challenge in Foucaultian analysis, even the disposition of deviance changes, the norms in which they are created lingers.

1-2- Revisiting Foucault through Butler: Embodiment of Gender Relations and Performativite Function of Media

Butler takes the Foucault's concepts of power and discourses that generate norms and introduces a new schema in which the production of subjects, particularly gendered subjects, is created. She suggests that performance of discourses is as important as the language they are proposed in. The "embodiment of genders" she suggests is through the process of performing the gender norms that penetrates into the society. As the gender identity is created through a heterosexual and masculine discourse and deviance is defined through "ideal" forms of identities, the performance of gendered behaviour is never fully achieved. What consequently emerges is the impossibility of social recognition of individuals that do not fit into these categories as "full humans"[191]

Hence, mass media again becomes a space in which linguistic conventions of societal values, cultural norms, political beliefs, ideologies, medical practices is reconciled. As yet, none of these discourses emerge from a single sovereign, they are mutually created within the society they function in- so an idea which is generated in society is planted again in the discourses mass media offers for them. In this regard, discourse is both "derivative" and "generative" – it derives from societal norms but it also offers to regenerate society.

1-3- Performance through Metaphors

[191] Judith Butler, Gender Trouble: Feminism and the Subversion of Identity (New York: Routledge, 1990): 171-180.

Lakoff points out that "our bodily experiences and the way we use imaginative mechanisms are central to how we construct categories to make sense of experience."[192] This view that cognitive linguistics offer is interesting for they suggest that metaphors that are used to bridge seemingly two subjects from seemingly unrelated subjects, not only enables individuals to grasp complex relationships and concepts much easier but also that they derive from the bodily experiences. The physical experience can be as broad as the perception, movement, reproduction and sexuality- so the sphere of interaction between the physical and its social environment can be performed through the use of metaphors.

Discourses employed by the media in defining IVF processes are dominated by the use of metaphors. If metaphors offer to resolve how bodily experiences are translated into discourses and if discourses derive from and re-generate the societal structures, then there is a possibility that bodily experiences can make up the social facts and in return social facts contribute to the bodily facts. This cyclical interactionist model offers to understand the relationship between the actual biological and physical being with the social being, without falling into the trap of nature/culture dichotomy.

Certainly, IVF itself is a bodily experience. If metaphors can translate bodily experiences into linguistic tools, then the metaphors surrounding IVF should be accurate representations of the actual bodily experiences. Furthermore, if metaphors are central in discourses and that discourses emerge from the social facts, then metaphors need to be somehow related to the societal norms. If both claims are true, then it can be claimed that there is a direct link between the bodily experience (and embodiment) of IVF and its social norms, which can be traced in its discourses. I, therefore suggest that the analysis of metaphors that are used in order to describe IVF can help us to conceptualize how "embodiment" is materialized.

With this theoretical model in mind, the questions I would like to answer in this chapter are: How do Turkish and British mass media talk about IVF? What are the

[192] George Lakoff, *Women, Fire and Dangerous Things: What Categories Reveal About the Mind.* (Chicago: the University of Chicago Press, 1987)

popular imaginaries and metaphors used that claim to truth? What is the role of scientist/practitioner represented in relation to the lay knowledge? How is ethics of IVF conceptualized, or what is the role of religious authorities, public figures, doctors in establishing these ethics? And how are these popular accounts relate to other "discourses", i.e. medical, legal?

2- Themes and Metaphors

2-1- IVF: Progressivism, Modernity and National Pride

2-1-2- Infertility as a Disease to Fight Against

Both HFEA 1990 regulations in UK and Law on Centres for In Vitro Fertilization and Embryo Transfer in Turkey define infertility as "disease". According to Stedman's Medical Dictionary, disease is:

> "any deviation from or interruption of the normal structure or function of any part, organ, or system, or combination thereof, of the body that is manifested by a characteristic set of symptoms or signs, and whose aetiology, pathology, and prognosis may be known or unknown."

In the medical definition of the term "disease" there is already a set relationships of power, the "normal" state in terms of reproductive health is the "ability" to produce and any impediment towards this definition is a "deviance". Therefore, there is a clear boundary between what is "healthy and normal" that is to produce and what IVF, as an infertility treatment technique, is to "fix" infertility. Hence, IVF is not actually in the domain of "assisted reproduction technologies",

because IVF does not assist reproduction, it rather fixes the deviance and normalizes the subject in this deviance.

IVF as a disease is also a definition both Turkish and British press largely employs. Traditionally, a disease in written and spoken English is associated with military metaphors.[193] [194] Gwyn suggests that "the power of the military metaphor lies in its ability to arouse people into a state of fear and preventative activity, to mobilize against an emergency." In this sense, construction of infertility as a disease does not only defines the deviance of "infertility" but it also generates the urge to organize action against it. Such formulation of oppositional parties (infertility versus IVF) can be fitted in the conceptual metaphor of TREATING ILLNESS IS FIGHTING A WAR.[195]

Indeed, after examining British and Turkish articles, I have realized that one of the most dominant metaphors is TREATING ILLNESS IS FIGHTING WAR. In these articles, infertility is understood as enemy, IVF as a weapon, doctors as warriors and patients as victims. Some potential mappings of this metaphor are outlined below:

[193] Susan Sontag, *llness as Metaphor and AIDS and Its Metaphors,* (New Tork:Anchor, 1990)

[194] Gwyn, R (1999) "Captain of my own ship: Metaphor and the discourse of chronic illness" In L.Cameron and G.Low (Eds.) *Researching and Applying Metaphor* (Cambridge:Cambridge University Press, 1990): 110.

[195] Lakoff, Espenson and Schwartz 1991

Table-5-1-Infertility Wars

Source: WAR	**Target:** INFERTILITY
The enemy	Infertility (biology)
The war	Infertility treatment
The battlefield	Body
Weapon	IVF (and other ARTs)
The soldiers	Doctors (occasionally patients)
Attacks	Chemical or hormonal imbalances
Attacks to defend	IVF
Winning the war	Pregnancy
War tactics	Bravery and patience, funds available for treatment

DISEASE AS WAR:

1."Kısırlık tedavi edilebilir, iyileştirilebilir bir hastalık . . . [Bu] çiftler aile kurma hayallerini kaybedenleri, pes edenleri reddetmiş ve mücadeleyi seçmiş aileler".

"Infertility is a treatable, curable disease . . . [These] couples are families that refused those who lost, give up on their dream to form a family and chose to fight [196]

2. Ölümle yaşam arasındaki bu savaşın bir de maddi boyutu var

There is also the financial aspect of this war between life and death.[197]

3. One woman's battle to become mother at 40[198]

4. We will fight on to save our son, say 'design baby couple'

5. His [IVF baby] case won't be fought in vain.[199]

BIOLOGY AS ATTACK:

1. Dr. Sacks said: It was the high presence of the killer immune cells, which occur naturally and roam the body destroying foreign bodies[200]

2. Yumurtalık rezervinin giderek düştüğü 35 yaşındaki kadınlara öneri: Yan yollarda dolaşmadan etkili yollar deneyin

A recommendation for women at the age of 35, whose ova reserves are constantly decreasing: Use effective ways, avoiding detours.[201]

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[196] Mesude Ersan, "Kısırlığın çok sayıda çözümü var" *Hurriyet* (04 June 2002) *http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=76236*

[197] "Orak hücreli anemiye çare: Genetik ayıklama", *Zaman* (26..02.2006) http://www.zaman.com.tr/webapp-tr/haber.do?haberno=259643&keyfield=2274C3BC7020626562656B22

[198] Jerry Johnston, "It took us 14 years and finally we got this little bundle of life", *The Mirror*

[199] Saah Boseley, "we will fight on to save our son, say 'designer baby' couple, *The Guardian,* (22.11.2006)

[200] Claire Masters, 'study offers miscarriage hope", *The Telegraph* (02.04.2006)

[201] "Yaş 35 ise acele etmeli", *Hurriyet* (02/12/2005)

3. Yanlış tedavi sonrasında çiftlerin hem servet harcadığını, hem de anne adayı ve bebeğin hastalanabilir: Tüp bebek atom bombasıdır"[202]

After wrong treatments, couples spend a fortune and both the mother candidate and baby can become sick. Test-tube baby is an atomic bomb.

As it can be seen from above examples, the metaphor is employed both by British and Turkish newspapers. This war metaphor highlights an opposition of IVF and infertility- in a way that infertility is constructed as undesirable condition. The battlefield of infertility is always "women's bodies" where the outcome of war (pregnancy or failure of pregnancy) is conceptualized. Similarly, strategies of IVF are clearly stated in interviews with doctors, step by step; just like the strategies of war. What this metaphor might suggest is that the war against infertility is motivated by correlation in experience based on couple's perceptions of loss, fear, grief –Infertility is then understood as a devastating experience, just the like one of war.

2-1-2- Nations as Pioneers of Science

2-1-2-1- Blairs Public Speech

Tony Blair conducted a public speech on the emerging biomedical technologies in March.11.2001. This speech was unique in the sense that for British Prime Minister conducted a speech to "defend" scientific developments against those who criticize them for their potential ethical problems. In this speech, he states:

> ". . . We can tackle genetic diseases that reduce the lives of so many children. We can tackle the mass killers of our society-cancer, heart diseases- and offer future generations the prospect of an active old age. How to keep Great Britain at the forefront of biotechnology research is currently a debate among scientists. We have to value scientists and their work. They will describe to us the future scenario. Then we will be able to apply them for the sake of the progress of our people"[203]

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[202] http://arsiv.sabah.com.tr/2001/10/07/g10.html

203Available on World Wide Web < http://ngin.tripod.com/230602b.htm>

Blair refers to a group of people that have the capability to sustain biotechnological research to meet the demands of health issues; this group of people yet are not restricted to the scientists who conduct the research but it includes also those organizations and citizens who are in the favor of scientific research. Although the geographical constraint is not absolutely highlighted, it can be alleged that the countries who are incapable of accomplishing research due to the limited number of educated individuals or due to the restraints in funding and those groups who are due to their moral or religious attachment are excluded from the active inheritors of this debate. This ideal is more perceivable in his designation of Britain as the precursor and supporter of genetics study. An exclusionary principle is visible again in the depiction of "our" scientist, in the service of "our" people: which demonstrate a particular national relevance in the performance and collaboration in science; but it is not clear whether and to what degree members of other nations or non-supporters would become the beneficiaries of consequent medical progresses. It is clear that a collective action at the national level is taken over, with a positivist belief that science would provide better life for people.

The Enlightenment ideology combined with the emergence of nation states flares the power and the display of power and mobilizes the nation within its territories with the idea that science would fuel their prosperity. While making this assertion, the state or the sovereign is not enough by itself to materialize this goal- it needs to aspire the community it talks to- i.e. the nation- and needs to establish apparatuses and authorities that will implement its demands on the periphery. Seemingly, the power that is held by the public is so vast that "the social body" needs to acquire its own power so as to fulfill the state interest. In this perspective, Blair's attempt to "defend science" in fact implies that the "presumed prosperity science will bring" is in fact challenged on the public domain. What Blair is attempting to do is to gather together, organize and rationalize the bonds between medical and scientific knowledge, campaigns of health/environment/gender politics in all one pot. With reference to Giles Deleuze's interpretation of Foucault's work, I can argue that the molar (macro) politics designed by the state attempts to pull the molecular (micro) politics of every day life.

In the remaining part of the speech, Blair explicates the scientific tradition in British society, starting from Newton, reaching to Darwin and finally to biotechnology. He positions the country as the foremost leading one, after US, in the world, by comparing the number of reputable works produced by scientific communities divided by the population. Afterwards, he accentuates the number of Nobel winners as a statistical verification of nation's success on conducting science. Stressing the British "victory" in science, he states that:

> "We have relied for too long on tradition and sentiment to aid our scientists. We need strong funding and strong public support, not just the warm glow of our traditions . . . I want to prove those entrepreneurs in Bangalore wrong. I want Britain and Europe to be at the forefront of scientific advance."

At this instance, the reference to tradition is in fact a reference to a republican patriotism and sentiment mentioned is a national sentiment, which citizens should be proud of and connect via the common heritage and value. The Enlightenment ideology sets the boundary of national pride and what science could offer in this respect is to rebuild the national pride through its successive exercise. Nevertheless, success of science is particularistic- it does not refer to how science is embodied or how it affects the experiences of those who exercise it or who are governed by it. The typical themes of Enlightenment, progressivism and national pride were already present in UK news coverage and they continue to exist.

Firstly, one of the signifiers of nationalization of IVF is that articles from tabloids to broadsheets often refer to the fact that "first test-tube baby was born in England" –in a way, this discursive practice enables the historization of IVF within the borders of UK. On 14.January.2007, all British newspapers I had investigated published the same news: "The first IVF baby had a child of her own." IVF in a way produced its own national celebrities.

Secondly, news coverage of IVF and other assisted reproduction technologies offer a commonly mediated discourse of "national success" setting the frontier of science. For instance, on May.20.2005, Hwang, a Korean scientist who works in the

Newcastle University hits the news with the claim that they had managed to clone human embryo for the first time in the world. Immediately, this news is published on the first page of all British newspapers. The Guardian celebrates the event as "UK breakthrough as human embryo cloned: British and Korean scientists lead revolution in stem cell technology." "Reproductive revolution"[204] is indeed one of the commonly used metaphors for all biotechnological research, including the utilization of "excess" eggs that are extracted in IVF processes but the way the news is conveyed implies not only a revolutionary breakthrough, but one that is realized in a British university. Again in May.2005, another news report complains about "the shortage of eggs" that is necessary to conduct stem cell research.[205] In the consequent month, newspapers continue to report this scientific development. In fact on October.22.2005 the Guardian suggests that "Britain will vote against the cloning ban"[206], the motivation being the realization of embryo cloning in Newcastle.

Soon after however, in November.2005, it is soon realized that Hwang actually coerced her researchers to donate eggs for his research; he apologizes for the action he has taken but attempts to legitimize it by suggesting that it was for the "good of science". On 15.December.2005, one of his colleagues claims that his stem cell research was "faked" and the investigation initiated on that day results in the confirmation that his research results were in fact fabricated. He eventually gets dismissed from his faculty position in Korea in March and is charged with fraud in May.2006. In the midst of this scandal, there is a discursive shift in the British press. The newspapers, which celebrated --or at least acknowledged, although approached with some resentment about ethical aspects – "the British scientific breakthrough"

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[204] Sarah Franklin, *Reproductive Revolution,* Professorial Inaugural Lecture, The London School of Economics, London, 24 November 2005. Online text available at http://www.lse.ac.uk/collections/pressAndInformationOffice/PDF/Sarah_Franklin_TheReproductiveRevolution.pdf (Accessed December.2006)

[205] Ian Sample, "A giant step forward for science, but quest for new medical treatments goes on", *the Guardian* (22/05/2005) http://education.guardian.co.uk/higher/research/story/0,,1488392,00.html (Accessed March.2006)

[206] Polly Curtis, "Britain to vote against global cloning ban", *The Guardian,* (22/10/2005) http://education.guardian.co.uk/higher/sciences/story/0,,1333933,00.html (Accessed March.2006)

dropped the "British" identity in news coverage. Hwang's fraud was still discussed but this time he was referred as Korean scientist, disregarding the news they have produced a year ago.

Thirdly, in the UK newspapers, there is a concern that UK started to fade away in the European IVF league tables and these articles urge to reorganize fertility treatments so as to "catch up" with its European counterparts. This inclination to catch up is present, for instance in the news article published on July.3.2003 in the Guardian, reporting about the data represented in Madrid Fertility Conference was entitled "UK lags behind most of Europe for IVF." Again a discourse of "war" was utilized: "Britain was beaten by France, Iceland, Slovenia and Switzerland among others."[207] Similarly, on 22.June.2006, the Guardian published another article on the issue, this time UK was ranked 12th out of 15 countries in the IVF league table[208]. The statement of Clare Brown, chief executive of patient support group Infertility Network UK, is interesting in the way it combines historical origin of IVF with its current status in UK. She states: "It is totally unacceptable that most other European countries have better service provision for infertility patients than the UK, where IVF was pioneered."[209]

There are three remarkable points in how these news articles represent IVF. Firstly, biotechnological developments particularly IVF are labelled as signs of development and success in them can fuel national pride (and any failure is seen as an attack to the national pride). As a result, secondly, IVF is conceptualized as a "war" between nations in which different nations compete with one and other. Thirdly, IVF is a site, where issues of scientific development, progressivism, and access to services become the morals of governing populations –in other words, embodiment of power in fertility treatments is measured by its bio-economical value, how much it is practiced and produced.

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[207] Ian Sample, "Madrid Fertility Conference: UK lags behind most of Europe for IVF" *The Guardian* (03.July.2003) [Emphasis added by the author]

[208] Ian Sample, "Britain given low rating in access to IVF treatment" *The Guardian* (22.June.2006) [Emphasis added by the author]

[209] Ian Sample, "Britain given low rating in access to IVF treatment" *The Guardian* (22.June.2006)

2-1-2-2- Turkey: "No Longer Orient"

The positioning of Orient and its uneasy relationship with the Occident is also clearly evident in Turkish news coverage on IVF, whereby advances in new reproductive technologies and the high 'success rates" fabricated the sketching of nationalism. Fabrication of success rates is interesting, as news articles claim much higher vales than what is "practically" managed.

For instance, Hurriyet offers an average of 40-50% success rate, which can vary from 20-70% from individual to individual due to the variance of biological make up and type of fertility treatment previously applied. Milliyet offers a 25% success rate, which decreases as the age of woman increases.[210] Later, in April.2003 Milliyet, an article compares the success rate in IVF in Turkey with its counterparts in the US and Europe and claims that average pregnancy rate is 61% and birth rate is 30% in one clinic in Turkey- which is as good as the Western countries[211].

In this regard, through out Turkish newspapers, three loci are determined as sources of national pride and these are (i)doctors who provide infertility treatments, (ii) infertility clinics and hospitals, which provide high standards of technology, (iii)the domain of health tourism, which was situated as an evidence that medicine was advanced enough to attract Europeans.

2-1-3- Doctors

In Turkish newspapers, doctors are constructed as agents that set the moral agenda of progress, scientific development and they are positioned almost always in their relation to national context and public lay opinion. Their exceptional success stories are emphasized and valued in various reports. They are at times defined through

[210] Asiye Ergul, "Erkekler de kadinlar kadar kisir", *Milliyet,* (26/06/2001) http://www.milliyet.com.tr/2001/06/26/yasam/yas04.html

[211] Aysegul Erdogan, "Ilk tup bebekler 15 yasina giriyor" *Milliyet* (22/04.2003) http://www.milliyet.com.tr/2003/04/22/pazar/paz02.html [Emphasis added by author]

terms such as ‘stars of tube babies”, “medical prides”, whose successful careers have become a central definition of ‘sufficiency” to counterpart the Western frontiers of medical world.

Below are some examples of how “medical prides, celebrities” are constructed:

An article published on 02.21.2001 in Hurriyet announces that “Tube-baby star/celebrity” (“tup bebek yildizi”), who has developed a drug-free IVF method in Canada, has come back “home” and will make “Turkish couples to have children”[212] In another news published on 20 May 2005 in Hurriyet states that in the 6th World IVF and Prenatal Diagnosis Seminar, which took place in London and in which more than 1000 delegates participated, Prof. Dr. Semra Kahraman and her team “represented Turkey” with eleven report and two Turks have “marked” the event (“damgasini vurdu”)[213]

Again, below are some examples of how ‘sufficiency of Turkish doctors” are displayed:

An article published on 31.May.2004 in Hurriyet reports about a “miracle baby” They celebrate that a Turkish couple, who have been told that they could not have children by German doctors, had a boy as a result of the treatment they had in a clinic in Istanbul. [214] Similar news was published on 07.04.2005 on Zaman about a Turkish couple who had tried IVF eleven times in Germany but succeeded pregnancy as a result of the treatment they had in a clinic in Istanbul.[215] A very similar story again is published on 21.April.2006 in Zaman, about a Turkish couple who had tried IVF, again

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[212]“Tup bebek yildizi” *Hurriyet.* (21.01.2001) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=-209289 [Emphasis added by author]

[213]“Tup bebekciler Londra’da bulustu” *Hurriyet,* (20.05.2005) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=320716[Emphasis added by author]

[214]“Mucize bebek”, *Hurriyet* (31.04.2004) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=229862

[215] “Almanya'da bebeğiniz olmaz denilen aile İstanbul'da ikiz bebek sahibi oldu” *Zaman* (07.04.2005) http://www.zaman.com.tr/webapp-tr/haber.do?haberno=148070&keyfield=2274C3BC7020626562656B22

eleven times, in Switzerland but succeeded pregnancy as a result of the treatment they had in a clinic in Istanbul.[216]

Doctor's sufficiency or excellence in expertise knowledge is not only a display of empowering the nation's "image" but it is also a way to "enlighten" the patients –or readers per se. All newspapers conduct –almost- regular interviews with the "celebrity doctors" to get information about the cutting-edge technology, success rates and occasionally risks about IVF. In these articles, doctors appear as the only source of knowledge and none of these 'step by step to IVF" articles refer to patients. The only story told about patients" experiences, which I will discuss later on, are emotional responses or "maternal instincts"- either about "actually, finally getting pregnant or having a baby" or about "irrational inclinations" to have an unsafe pregnancy. In this regard, doctors are constructed as knowledge holders and patients are "consumers" driven by their emotions.

For instance, in an interview conducted with a director of an IVF clinic states[217]:

> "There are no regulations [about the number of embryos implemented]. Among my patients, there was one person who had had 10 embryos planted. Think about it: 10! If she got pregnant, she would have six or seven children or what not."

In the same interview, she continues:

"Campaigns are prepared, meetings are organized, some centres sponsor those meetings, and free tube babies are made for those who win the lottery."

Proliferation of such discursive practices reached its peak after a woman, named Sibel Deniz, got pregnant for seven babies and resisted her position as pro-life; most of the discussions which attempted to place the woman as the sole responsible and she

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[216] "12. tüp bebek denemesinde başarıyı yakalayan çift, bebek için gün sayıyor", *Zaman'* (21.April.2006) http://www.zaman.com.tr/webapp-tr/haber.do?haberno=278057&keyfield=2274C3BC7020626562656B22

[217] "Tup bebek isi cigrindan cikti" *Hurriyet,* (24.02.2002) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=57498

was accused of acting irrationally, driven by "maternal instincts". This was managed at three levels, firstly they had announced that Sibel Deniz would like to keep the babies, she stated that:

> "I asked my doctor how the number of my babies would reduce down to three by foetal reduction method. Their life would come to an end by a drug into their hearts which will be injected through my womb. This devastated me. All of my 7 children are healthy now. How can I sacrifice them? Hence I decided to keep them. My husband respected my decision"[218]

In response to her statement, her doctor said the law did not allow them to coerce her into abortion. So although there was a risk involved, he stated there was nothing they could do "as the law did not have any obstacle for birth but did for abortion."[219] Therefore, first response was that the patient was acting irrationally and emotional. Yet, doctors were guilt-free for not warning about the risk of implementing a minimum of seven embryos and could not be kept responsible for the risk associated with multiple pregnancies was the first response.

As yet, all doctors did not agree. Second wave of response was developed in the interim. One doctor stated that "if pregnancy for seven babies appeared in European newspapers, the doctor would have been imprisoned"[220]. Although what he was suggesting was true, there questioning the quality of doctor's work, his colleague again referred to European standards, rather than some immediate "ethical response." And as a result, corresponding newspaper articles followed as a response to reposition doctors in the modern-modernist framework. Another doctor suggested "it was wrong to accuse their doctor and suggest his imprisonment" for "we would not desire any doctor who participated in a project of science and good will. We are not in the age of inquisition"[221]

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[218] "Yedisini de doguracagim" *Hurriyet (*24.02.2005) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=299023

[219] "Yedi cocugu dogurmasi mumkun degil" *Hurriyet* (24.02.2005) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=299023

[220] Yediz, başarı değil', *Milliyet* (23.02.2005) http://www.milliyet.com.tr/2005/02/23/yasam/ayas.html

[221] "Yediz gebelik haberinde cezaevi onerisi haksiz" *Milliyet* http://www.milliyet.com.tr/2005/02/28/ombudsman/aokur.html

Such statements situate doctors as the agents to set moral agenda to advance scientific studies, independent from any criticism; their actions are legitimized through 'scientific expertise" and "good will", where as their patients were to be associated with certain risk because of their own "ignorance." Difference between the role of expertise and subjectification of patient within the clinic is analyzed in this respect.

Eventually, Sibel Deniz faced health problems, she was hospitalized and she had lost all seven of her babies. In the hospital, her doctor Ozer Gurbuz had these corpses photographed, him standing next to them, demonstrating the consequences of not listening to doctors" advices. And the third wave of response emerged. These photographs got published next day on several newspapers. Although there were responses from readers, implying the "unethical" display of corpses, none of the newspapers published an apology –it was simply constructed as legitimate. The final event was an excellent example as how knowledge creates power- the doctor can implement as many embryos as demanded and then make his statement about the risks associated. If the patient chooses not to take her doctor's word, then consequences would need to be accepted.

To sum up, doctors play a crucial role in constructing IVF in Turkish press and they are the primary loci of the relationship between power and knowledge. As they are seen as the only legitimate source of knowledge, their power is three fold: informative, representative and authoritative. They have the power to represent the truth about IVF (i.e. 'success numbers" and techniques), hence they are at the first level informative. They represent their nation (i.e. 'stars of IVF), and they are representative. Thirdly and more importantly, they govern their patients" decisions, even under conditions where risk is high, hence they are authoritative.

2-1-4- Fertility Clinics

Similarly, in the media coverage, fertility clinics are constructed as agents, which had reached the same level of excellence of fertility clinics elsewhere in Europe. Fertility clinics are constructed along with health tourism, hosting individuals, mostly from European countries for a "deal-package", where they have the opportunity to go under IVF and "take a vacation" at the same time. These centres are formulated as sites where notions of family formation, nationalist pride are all integrated at once.

For example, on 26/03/2005, Hurriyet reports that an Italian family decided to have their IVF baby, who needs prenatal diagnosis and intervention, in Turkey after reading a success story about Sinan, a Turkish boy whose thalessaaemia was treated.[222] As Turkish press is not keen on personal narratives on IVF (unless they are particular achievement stories), their story is interesting not only in the sense that it glorifies the medical advance in Turkey and highlights an European family's interest in having their children in a Turkish institution.

Another example in this respect was published by Zaman informing that 17 thousand Netherlanders chose Turkey to be treated and in the last four years, the number of Netherlanders have reached 35 thousand.[223] Similarly, a news article on Milliyet, announces that an IVF hospital would be opened in Antalya to potentially serve the tourist. The decision is legitimized as "Antalya has a population of one million and hosts 7 million tourists a year." [224] They also state that they had already contacted Ministry of Tourism (not Health) to receive support for their entrepreneurship.

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[222] Birsel Sancar, "Oğlunu yaşatmak için Türkiye'de hamile kaldı " Hurriyet http://webarsiv.hurriyet.com.tr/2005/03/06/609370.asp

[223] "17bin Hollandali tedavi icin Turkiye'yi tercih etti" *Zaman* (14.04.2006) http//www.zaman.com.tr/webapp-tr/haber.do?haberno=275809&keyfield=2274C3BC7020626562656B22

[224] "Antalya'ya turist hastanesi kurulacak" *Milliyet* (01.08.2004) http://www.milliyet.com.tr/2004/08/01/business/bus19.html

Health tourism is also a bidirectional process, by that I mean by pointing out that there is a significant number of individuals who are going to Greece for sperm donation and Cyprus for ova donation, news articles attempt to advocate for institutionalizing sperm and ova donation in Turkey, so as to make sure sperms provided are 'safe" and they have the necessary genetic components to resemble his "biological parents."

For instance, Radikal claims that "Cyprus is collecting eggs"[225] while Hurriyet claims that sperms had been imported from various countries, particularly from Greece. What makes this article interesting is the statement provided by a doctor "Greece has been taken good advantage of Turkey's deficiency in this area"[226]

Nationhood, perhaps with race, is again re-entering the domain of biological truth at this instance. Perhaps, the concern about importing sperms or eggs is not only related to the economics –possibly it defines firstly the capacity to do the same, to prove the nation to be as equal, if not better, against its rivalries. In this regard, a new type of "war of nations" is emerging just like the massive biologization of race in nineteenth century and as Foucault suggests as Society must be defended.[227] Furthermore, medical gaze is operationalized as the determinant aspect in the strategy of defence.

In conclusion, assisted reproduction technologies can be interpreted in the larger pot of new biomedical technologies, which define the scientific and national boundaries, in which scientific research takes place. News coverage both in UK and Turkey point out to a particularistic "nationalist" project, in which provides them a certain progressivist agenda of science, whereby doctors, clinics, patients are integrated into a regime of truths.

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[225] http://www.radikal.com.tr/haber.php?haberno=182834

[226] "Yunanistan'dan sperm ithal ediyoruz" *Hurriyet* 22 November 2002 http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=111065

[227] Foucault, M. *The essential Foucault: Selections from essential works of Foucault, 1954- 1984* ed. Paul Rabinow and Nikolas Rose, (New York and London: New Press, 2003).

2-4- IVF as Fiction and Drama

2-4-1- IVF as a Romantic Film

Significant amount of news coverage both in UK and in Turkey focus on personal stories of couples giving birth to their children, after a certain period of IVF treatment. In these news articles, physicians are constructed as "life-givers", where as patients are represented as "happy parents", who have long waited this moment of "miracle". News coverage tends to exclude the process of IVF and rather choose to focus on the result; such attitude is also consistent with their formulation of success rates of IVF centres, based on the actual "born" rates, rather than minimizing undesirable and often painful processes women take under. Below news articles exemplify this point:

In Radikal, 06/01/2006, a woman who gave birth to an IVF baby at the age of 57 states: "I am very happy. Motherhood is every women's right. I had this opportunity at 57."[228] In Hurriyet 29.12.200, another woman states: "I have admired and yearned at all pregnant (woman) for 17 years . . . 24. November is the date that changed our lives. . . . I am perhaps the happiest woman in the world."[229] In the IVF series entitled "Infertility is not faith" on Milliyet, another woman tells her experience of IVF: After every pregnancy test, I was leaving with a paper saying "Result: Negative." We had spent enough money to buy two flats. We were about to lose all our hopes. The reason why I could not get pregnant was not understood. Due to an advice of a friend of ours, we applied to Alman Hastanesi . . . My doctor said "Congratulations" –I lost myself . .

[228] "57 yasinda ikiz bebegi oldu" *Radikal* (06/01/2006) http://www.radikal.com.tr/haber.php?haberno=174989

[229] "Tup bebek yildizi" *Hurriyet* (29.12.200) http://hurarsiv.hurriyet.com.tr/goster/haber.aspx?id=-*209289*

. hugged her (him) and cried for hours. I had waited for a doctor to tell me that I am pregnant, how could I not hug her (him)?" [230]

Similarly in the British media, examples are present:

In the Daily Mail, 30th October 2001, Mrs Duce, the first woman in Britain to undergo PGD "describes her doctors doctors, as "miracle workers"[231] In another article published in Daily Mail, 6th April.2006, a womanwho won IVF lottery and conceive a child after free treatment describes her experience as "This is the best feeling in the world - worth all the agony, tears and upset."[232]

This above tendency to narrate couples stories of actually 'seeing the baby" (or 'seeing the results of pregnancy test" does not however provide a direct link to personification of technologies. In fact, their price focus on "result"- that is birth, rather than the "process"- conception, gestation, technological intervention are often neglected. Such concepts only become visible, when the newspapers prepare a special issue, or a case study on the in vitro fertilization techniques. These case studies always involve hosting a medical doctor, who is well known in the field and asking her/him about the medical side of the story. In the language they employ, doctors often reduce women into "body parts" in a specific use of language. In this regard, women are only visible through their organs that are involved in the fertility treatment, until the final stage of giving birth. Women are represented not as whole beings, but only parts; their names are not mentioned until they give birth and achieve "motherhood".

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[230] "Kisirlik kader degil"*Milliyet,* www.milliyet.com.tr/content/dosya/saglik/kisirlik/kisirlik01.html

[231] James Chapman, "Miracle workers give us triplets" T*he Daily Mail* (30.10.2001) http://www.dailymail.co.uk/pages/live/articles/news/news.html?in_article_id=81274&in_page_id=1770

[232] Suzy Austin, "We've won a top prize - IVF twins" *The Daily Mail* (06.04.2006) http://www.dailymail.co.uk/pages/live/articles/health/womenfamily.html?in_article_id=382208&in_page_id=1799

2-4-2- IVF as Nightmare or Horror Film

IVF does not always appear as a romantic film, in which couples yearn for children, suffer for long periods of time while failing to have a child and at the end they conceive a child. Some occasions appear as a horror film -in which doctors are "monsters" or "Dr. Jekyll, who plays God", where women and foetuses are "victims" and IVF is the ultimate "weapon."

One of the most recurring terms that turn as a horror film in British media, is "designer babies" or 'selected babies."[233] The initial set up of this terms goes back to October.2000, when Adam Nash was selected to be born in order to save her sister Molly, who needed marrow transplant to overcome a rare genetic disease called Fanconi Anemia. Many articles from than onwards, have employed these two terms, referring to the use of preimplantation genetic diagnosis (PGD) and in vitro fertilization (IVF). From this point onwards, British tabloids, which are mainly pro-choice, objected PGD and made "horror stories" out of them.

For instance Daily Mail, on 17.June.2001 quotes from a pro-choice campaigner Paul Tully: "this is another step towards the reduction of human reproduction to a manufacturing process and the modification of the child to serve others."[234] Again, in response to PGD treatment, Telegraph, 20.06.2003 quotes Jack Scarisbrick, of the anti-abortion charity Life, said: "This is a heart-tugging story but it is wrong that of nine

[233] I argue that although they have are employed to address the same phenomenon, term "designer babies" have a negative connotation, which stimulates thoughts about Genesis and other metaphors on "playing God". The "selected babies" metaphor on the other hand does not necessarily imply a religious link in Turkish case; if at most, newborns are constructed as "saviour(s)", who protect the elder child.

[234] Rachel Ellis, "Couple having designer baby" *Daily Mail* (17.07.2001) http://www.dailymail.co.uk/pages/live/articles/news/news.html?in_article_id=53959&in_page_id=1770

human beings created, eight have died. There has been a huge deliberate wastage of human life."[235]

As it can be depicted from the above examples, there is a grave concern about potential of IVF, combined with PGD to lead positive eugenics. This is indeed a point that could be interpreted within Foucaultian biopower, which operates according to "logics of vitality, not mortality."[236] Decisions that are made through IVF implies how the population needs to be created and the possible use of biomedical technologies are directed towards shaping the management of populations and these demands appear matters of personal choice, rather than state-imposed eugenic practices. The issue of self governance is the new turn that differentiates from eugenic practices in totalitarian regimes in the first part of the 20th century.

Interestingly, the tendency to conceptualize positive eugenics is combined with the possibility to re-conceptualise race late in 2002 in British media. A white woman and a black man, who were married to other people had a court appeal of custody of their biological children. The case was caused by IVF mix up, where a white woman gave birth to "black babies". Interestingly, when the court appeal started, all the newspapers constructed them as "black" babies. When the court was finalized in September, mother won the full custody of children. However, on February 26, it was decided that the biological father, black man, was the legal father of children. The woman has the right to be legal mother because she provided the eggs and similarly the black man has the right to be legal father because he provided the sperm.

What seems so logically coherent so far showed a great incidence, babies who were constructed as "black" suddenly turned into "mixed race" babies in all of the newspapers. This sudden rotation was quite interesting in the sense that "race" was understood and widely used as a 'social" concept –it did not matter who the biological father was to say "children were black"- possibly a fundamental visual-biological

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[235] "Designer baby gives hope to his brother's life" *The Telegraph* (20.06.2003) http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2003/06/20/nbaby20.xml

[236] Paul Rabinow, Nikolas Rose, "Biopower Today" B*ioSocieties* 1 (2006): 195-217, 211.

assumption was being made, but the concept of "mixed race" was only possible after the legal recognition of black man as the father.

It was not surprising that tabloids showed a vast interest in the subject –after all their reputation of provocative right-wing politics is well known to any reader of British public. As yet, they remained rather short and blunt. the Sun summarized the event as "Judge rules in IVF mix up" [237]and the Mirror said "Biological dad declared the father of IVF mix-up twins." At total the tabloids had eighteen references to the event. Perhaps more interestingly, the event also caught the attention of the Guardian, possibly the most "liberal" among those. The article published on 14.July.2002 read:

> "It is the *miracle* that can become a *nightmare.* A slip-up with a sperm- or an accident with the eggs- and a white woman gives birth to black twins. A black couple wishes to claim the twins; the woman who gave birth to them wants to keep them. The story is terrifying, its legal and ethical implications hard to entangle."[238]

Definitely, the whole process of getting custody for children, being recognized as legal mother/father along with biological mother/father are important issues and their experience could be distressing, but how does the transition from miracle to nightmare translate? I suggest, the Guardian is not only referring to the experience of court appeal or starting a public debate about your innermost private life, but it refers to this mix up with a "race" – "a white woman giving birth to black twins" and her being threatened by the "black couple."

The interplay of words implies a racism, that is somehow internalized, is regulating the public domain. The racial categories which were once imposed as" biological (arti)facts" are now 'social facts" and the power of discourses of resistance, speaking of trauma, employs the categories of race as much as the dominant discourse. This was precisely Foucault's concern about the limitation of language; the resistance derives and gets limited by the dominant discourses.

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[237] John Kay, "Baby Mix Up, Court Steps in" *The Sun* http://www.thesun.co.uk/article/0,,2002311228,00.html

[238] Suzette Ebanks "*Ca Plus Change*-- How the Black British IVF Mix-Up Twins Became Mixed Race Thanks to the 2001 Census"

2-5- IVF through Religious Lens

2-5-1- Human Dignity

Tabloids in the British case followed a conservative discourse, relating to ideas of "human dignity" and "Christian moral values". Similarly, in the Turkish case the conservative language was employed by Zaman, which quoted the Presidency of Religious Affairs statement that any attempt to alter the genetic make up of the offspring would be one of the biggest 'sins". Indeed, human dignity was defined as "the recognition that human beings are worthy of a particular level of esteem or respect simply because they are human beings." This perspective does not take into account neither the liberal understanding of individual who can act as an autonomous agent not the Kantian perception of humans as responsible and rational beings but is more accurately linked to a religious conception of "humans as creations by God"- which constructed the foetus as an independent agent.

In Milliyet, 10/08.2001 Necati Tayyar Tas, mufti of Istanbul, suggests that:

"This application will create chaos, from which ever perspective you look. Yet, human is the most honoured creature. And this honour comes from its descent. . . This cloned baby has neither a father nor a mother. . . If you deprive her/him from this values and morals, a strange opulence starts. Although s/he is a person in shape, s/he is without the qualities of what makes human a human."[239]

In other words, the human dignity is suggested to derive from descent, by that he means, traditional familial bonds. This is a further point as to how traditional views on parenthood is transmitted to the debates on new technologies; although there is a

[239] "'Kopya insan caiz değil' *Milliyet, (*08/10/2001) http://www.milliyet.com.tr/2001/08/10/guncel/gun02.html

theoretical possibility that new reproductive technologies can help to evaluate and reshape the social facts surrounding them, they often face a resistance from traditions.

2-5-2 Appropriation of Parenthood

Religious authorities are also interested in taking part to appropriate who might be eligible for parenthood, via the use of these technologies. Turkish newspaper, without a single exception, reported the views of The Presidency of Religous Affairs on sperm and ova donation, surrogate motherhood. Institution for Religious Affairs states that heterosexual married couples are the only ones who are appropriate within Islamic culture. They further claim that practices of egg and sperm donation can be interpreted as "pre-marital sex". The surrogate motherhood is not appropriate, for it "weakens" the bond between "mother and the child" otherwise "value of motherhood" is damaged. They interpret any technological use outside these boundaries as not only 'sins" or in the distinction of "good versus evil"; they rather pose a structural position and assert that "generations [produced otherwise] are spoilt".

This perspective situates the rights of foetus, duties of parenthood, conceptualization of kinship prior to women's reproductive rights. These metaphors suggest that the new medical technologies enable women to follow the development stages of foetus and establish presumed "maternal bonds" prior to birth, legal parental duties are challenged by sperm and ova donations, surrogacy determines the ownership status of children; genetic relatedness triumphs of marital ties.

3- Conclusion and Discussion

In this chapter, I aim to show that systems of thought that is formulated by the media coverage impose a kind of structural obligation for subjects while determining their identities and that the operationalization of subjectification is achieved through a particularistic discursive structure that signifies a "regime of truth". The regime of truth enraptures different capacities, rights and needs of recognition within the society and

the relationships between power, truth, gender, medicine, illness and discourses as a unified contested site, which influence our understanding of self within the medical practice. In this site of contested meanings, media creates a space of participation of patients- a space where they can get information and a space where they can shape the information. Consequently, patients, who are governed, become the active members of the governing system, participating in the discursive practices, forming bonds and attempting to individuate themselves within the resistant points.

In this regard, bio-power becomes an integrated part of self realization and action within the medical practises, whereby gender, race, ethnicity, health, infertility are constantly reminders of their governance. The power structures present at the most fundamental level deposit individuals as political creatures and shape their choices in any medical procedure in a totalizing manner. Combining Foucault's insights in focusing in "what is not being said", along with "what is being said" and feminist theory, I have observed that new reproductive technologies are represented within a stubbornly persistent aspect of patriarchal, traditionalist and nationalist views.

Firstly, IVF is constructed in a highly militarised, nationalist discourse. Infertility, which is constructed as a disease, is fought against at various levels- it is fought against at clinics, with sophisticated "weapons" such as IVF by specially trained 'soldiers", i.e. doctors; the "bravery" and "persistence" of the patient is required in order to "win the war" to get pregnant. Similarly, at the international level, infertility is fought among nation-states, where the ones with most sophisticated "arms", i.e. techniques and with most amount of experience, i.e. number of IVF cycles per year become the new norms of "arms-race" or "technology wars" in the area of reproductive technologies. While doing so, the intricate bonds between knowledge and power are formed and reformed. Doctors appear as powerful as soldiers, for having and knowing how to use the "weapon". Although the success depends on individual variance and their commitment to IVF, public is constructed as "ignorant and emotional" and need to be enlightened by the agency of medicines.

Secondly, the ultimate success in war, which is to get pregnant is also a problematic area. Just like narrating nationalist history, the victory is glorified, without making a note about how much people actually suffered during the war. Same analogy

with IVF, through out the media, people's experiences, hopelessness, social relationships, stress are not mentioned, or vaguely mentioned to develop 'strategies" (again a militarist term) against those experiences of ambiguity. In a way, it is expected that "the end justifies the means" – the main focus of IVF, as constructed in media- is to succeed, succeed at the clinical level (birth rate), to succeed at the national level (political campaigns and new introduction of free IVF treatment to health services), to succeed at the global level (health tourism).

Thirdly, doctors play a crucial role in constructing IVF in Turkish press and they are the primary loci of the relationship between power and knowledge. As they are seen as the only legitimate source of knowledge, their power is three fold: informative, representative and authoritative. They have the power to represent the truth about IVF (i.e. 'success numbers" and techniques), hence they are at the first level informative. They represent their nation (i.e. 'stars of IVF), and they are representative. Thirdly and more importantly, they govern their patients" decisions, even under conditions where risk is high, hence they are authoritative. Those, who neither obeys enough to doctor's power nor applies their knowledge for personal decision making on IVF, has no chance to survive in the war- babies are death and doctor can display them as the moral of the story.

Fourthly, religious authorities have the power to appropriate who should be allowed to become parents, traditional family bonds, established ideas about ethnicity and race can fuel this authority. Reproductive technologies or the process of undertaking IVF, which might seem as an innermost part of private life, becomes public territory, where human dignity, moral responsibility and religious bonds rise at stake.

CHAPTER 7

SURVEY STUDY

This survey was an attempt to demonstrate the way information and regulatory channels, namely mass media and legal institutions, shape the minds of individuals undergoing IVF. The survey was highly influenced by the questions raised in a 1982-Australia based survey, which indicated that societal norms and media coverage are inherited in patients" decision making processes (Littlejohn, 1982). In this regard, the survey aims to "measure" to what extend discursive practices of Turkish regulatory texts and newspapers managed to survive in the way people think.[240] Through out this section, the following abbreviations used: T: Total number of participants (=106), W: Total number of women (=55), M: Total number of men (=51), w: Number of female respondents, m: Number of male respondents

[240] I recognize that survey studies have their own limitations: Since every individual's experience would be different while undergoing IVF and without conducting qualitative interviews or focus group studies with patients, it is merely impossible to identify these differences.

1- Socio-Economics

In the first part of the survey I had conducted, I wanted to map "who" was being treated in these hospitals. Socio-economic factors are one of the most debated subjects in this area, as the price of IVF treatment is incredibly high and unaffordable for many people. In this regard, I collected two types of data: Firstly the age-demographics, for IVF had been recently added into the social health care system in Turkey, for women under 40. I aimed to see what type of effect it had on the demographics of IVF.

Table- S.I- IVF Demographics: Age

Age	20-30	30-35	35-40	40-45	45+	Not answered
Women W=55	11	21	20	2	0	1
Men M=51	10	15	16	9	0	
%total	20.5	38.5	23	17	-	1

The data suggest that most people who are on the IVF programme are around their 30-35, the age difference between men and women are not so high in each age groups, except in 40-45 phase, where the percentage of male participants in more than three times bigger than the percentage of female participants to my survey. After I had done the age-plot, I had re-analyzed if there were large age differences in marriages, where women were physiologically coerced into IVF, because her husband was old and possibly with fertility problems. That was not the case. Then I suspected the sudden drop of number of women in 40-45range is due to the public health policy, in order to get free IVF treatment, women are expected to be below 40 in order to use free fertility treatment service.

Although the government subsidizes about 1000 dollars for one IVF cycle, the prices in the private clinics, for many individuals, are still too high to be afforded; hence for many people who are on IVF are dependent on the state owned hospitals. I have checked my data, if the women over 40 years old were more likely to be seen in the private clinics- and my data suggested so. Although the sample size is small, so any

grand theory generalizations would not hold, one can still see that there is a tension around how much people could spend on IVF and how much is demanded and those who are over 40, being not subsidized by the government, do not see much point in being treated in state owned hospitals –as long as they could actually afford the private clinic surely.

Second part of the socio-economic data was about people's education levels and their status of employment. Previous Anglo-American studies had implied that IVF was more likely to be a middle class phenomenon, so my question derived from this literature, but with a critical question in mind. Does the socio economic status of IVF in Turkey, similar to those of Anglo-American clinics? And if so, how could one explain such effect? My question was straight forward, in the survey I asked them what the highest level of education they had completed was. According to the data I had received, the results were as follows:

Table-8-2: IVF Demographics: Education

	Women (W= 55)	Men (M=51)
Primary School	w=11, w/T=10.38%	m=11 m/T=9.44%
Secondary School	w=13 w/T=12.23%	m=16 m/T=15.09%
Graduate	w=29 w/T=27.35%	m=24 m/T=22.64%
Post-graduate	w=1 w/T=1%	m=0 m/T=0.00%

Table-8-3- IVF Demographics: Occupation

	Men (M=51) %	Women (W= 55) %
Not working/retired	m=21 m/M=3.92 %	w=12 w/W=30.99%
Professional	m=18 m/M=35.29%	w=22 w/W=40.14%
Government official	m=15 m/M=29.41%	w=15 w/W=27.27%
Worker	m=3 m/M=5.88%	w=1 w/W=1.8%
Own business	m=13 m/M=23.52%	w=3 w/W=5.88%
Student	M=0 m/M=0%	w=2 w/W=3.6%

Most of the people on IVF programme are indeed in the middle-class (in terms of economics) –this should not be much of a surprise. As I had shown in the section related to Economics of IVF, the data suggested that a person with minimum wage could not possibly be able to afford IVF, unless of course s/he receives funds from friends and family or sacrifices her/his essential needs to survive. Indeed, my data showed that most people are professionals or government officials- with a stable job, if not very high paying.

2- Decision Making: Religion and Information Channels

The section of the survey was intended to identify if the people I had surveyed were possible targets of the ethical debates led by some of the institutions, such as

religious institutions, mass media, and internet self help groups or if they were more reliant on the expertise knowledge of their doctors only.

The initial questions I had asked were “Do you belong to any organized religion?” Although “organized religion” is a largely defined term referring to monotheistic religions, the term still defines a territory, in which arguments about human dignity, foetal rights, prenatal diagnosis holds. The problematization of foetus as an independent human being derives from the religious texts, especially those of Augustine, who describes prenatal life as a state of developing a natural person, elevating all its vital needs so that it could develop its capacity to a full human being. Herewith the protection of prenatal life exceeds the will of mother. The traditional proposal is also conserved for the Muslim population and it was earlier indicated, the religious stance was once of the exceptional representations that often occurred in the media coverage. Consequently, faith and the extent of religious practice of individuals undergoing IVF treatment become particularly important to detect so as to relate their decisions through out the process. The second question was more at the practical level of religion, asking them if s/he would consider her/himself as a religious person- because if that is the case, I would expect a continuity with the arguments raised by the religious authorities and her/his way of constructing IVF debate.

Table-8.4- Religiosity

	Do you belong to any organized religion?		Would you consider yourself as a religious person?	
	Women (W=55)	Men (M=51)	Women (W=55)	Men (M=51)
Yes	42 w/W=0.7666 w/T =0.3962	33 m/M=0.6470 m/T=0.3113	18 n/W=0.3272 n/T=16.98	16 n/M=0.3137 n/T= 0.1509
No	12 w/W=0.2181 w/T=0.1103	17 m/M=0.3333 m/T= 0.1603	36 n/W=0.6545 n/T=0.33962	34 n/M= 0.6666 n/T= 0.3207
Not answered	1	1	1	1

The data I had collected suggested that an average of one third of participants defined themselves as religious. However it is important to note that I had not included criteria of religiosity, so my assumption here is that the way people would identify themselves would mark their behaviour and mind set. The following sections would show if that is or not the case.

Second piece of information I had collected was formulated as: “which information channels have you used prior to applying to an IVF programme?” This was a multiple choice question and I had asked the participants to check whichever applied to them.

Table-8.5- Information channels

	Women W=55	Men M=51
Mass media (Newspapers, TV, magazines)	w=49 w/W=89% w/T=46%	m=43 m/M= 84% m/T= 38.67%
Internet	w=4, w/W= 7,7% w/T= 3.77%	m=7 m/M= 13.75% m/T= 6.6%
Doctor	w=33 w/W= 60% w/T= 31.13%	m=15 m/M= 29,4% m/T=14.15%
Friends and family	w=15, w/W= 27.22% w/T=14.15%	m= 4, m/M= 7,84% m/T= 3.77%

At this instance, the question relates to Foucault's notion of "episteme"[241] by which I mean the popularization of a particular collective scientific subject in the ranks of lay people and its transformation with a pre-defined set of discursive relations without their "expertise" knowledge of the subject. Episteme therefore, from a Foucaultian perspective is employed in order to map the relations that structure knowledge within the scientific field. Also with this particular question, we are doing a cross check to see if our initial assumption of social actor network holds correct. This is to identify, whether our target population is appropriate to study the formation of common discourse in the light of given discourse analysis of media coverage. Participants answered that mass media, by a large percentage of 85%, is one of the key elements of obtaining information: thus answer indicates that our initial proposition that individuals are governed by the certain rules which are established by the norms of

[241] Foucault, M, *The order of things.* (New York, NY: Vintage Books, 1973).

truth- formulated by the common practices of discourses- hold a significant account in their decision making process.

The interest in mass media is larger than the interest in obtaining initial information from a doctor- the expert-. Hence once could conclude that authoritarian discourse that is dictated by the truth of discourse of modern bioscience and technologies of modern knowledge-power support system decreased, by taking away the authority partly away from expertise. This in turn means that problematization of life itself is not solely dependent on the monopolized practices of the State and even of doctors; but it is vastly integrated in mass media channels. Then again, it would be naïve to expect that these issues on news articles are not related to the mentalities of government, medical practices or of any other political or religious doctrine, rather it suggests that the scientific debate has penetrated to the public through mass media channels, which displays a discursive consistency as described in previous chapter.

Another interesting statistics that can be dwelled from the above data is that women are more likely, in fact two fold more likely than men, to consult their doctors prior to making their decisions in IVF – this might suggest that the "medical gaze" on women's bodies is experienced at an earlier stage, in the form of control or by simple advices. Although, women's interest in seeing the doctor is meaningful, after all those are the providers of IVF and women are the ones who are actually going to embody the IVF process, both physically and psychologically most.

3- Reasons to Desire Children

In this section, participating individuals were asked what societal and psychological factors had motivated them to take part in the IVF programme, they were asked to choose and mark all those conditions which applied as important to them. The feminist claim that motherhood myths and ideologies emerge from the patriarchal society and their critique of being a proper and good mother are of our research question. I, here, aim to find answers to the ways women are trying to achieve their role

of motherhood (and men to fatherhood) by the implementation of IVF. Therefore, the questionnaire followed a particularistic discursive approach in order to detect the presence of traditional values that structure motherhood/ fatherhood.

So the question was formulated as: "Which of these below statements are relevant in explaining why you desire to have a child? Please check all that apply."

Table-8-6- Reasons to desire a child

	Number of respondents indicating as an important reason (Women) W=55	Number of respondents indicating as an important reason (Men) M=51
Having children was the reason you were married	w=6 w/W=0.1099 w/T=.0566	m=8 m/M=0.1568 m/T=0.0754
Your suppose wants a child	w=34 w/W=0.2264 w/T=0.7547	m=31 m/M=0.6078 m/T=0.2924
To inherit the family name	w=6 w/W=0.0566 w/T=0.0188	m=11 m/M=0.2126 m/T=0.1037
A child is a must for happy marriage	w=8 w/W=0.1454 w/T=0.0754	m=8 m/M=0.1568 m/T=0.754
To prove you were able to have a child	w=2 w/W=0.363 w/T=0.0188	m=3 m/M=0.0588 m/T=0.0238
Life is incomplete without a child	w=20 w/W=0.3636 w/T=0.1886	m=10 m/M=0.1960 m/T=0.0943

Table-8-6- Reasons to desire a child, continued.

	Number of respondents indicating as an important reason (Women) W=55	Number of respondents indicating as an important reason (Men) M=51
You feel useless without a child	w=3 w/W=0.0545 w/T=0.0238	m=0 m/M=0 m/T=0
You feel selfish without a child	w=9 w/W=0.1636 w/T=0.8490	m=5 m/M=0.0980 m/T=0.0476
It is a natural instinct to want a child	w=24 w/W=0.4363 w/T=0.2264	m=2 m/M=0.0392 m/T=0.0188
All women should experience pregnancy and birth	w=14 w/W=0.2545 w/T=0.1320	m=11 m/M=0.2156 m/T=0.1037
Pressure from parents	w=5 w/W=0.0909 w/T=0.0471	m=7 m/M=0.1372 m/T=0.0660
Pressure from friends	w=1 w/W=0.131 w/T=0.009	m=0 m/M=0 m/T=0
All your friends have children	w=5 w/W=0.0909 w/T=0.0471	m=0 m/M=0 m/T=0
You have a strong desire to have a child.	w=48 w/W=0.8727 w/T=0.4528	m=47 m/M=0.9245 m/T=0.443

The first four questions aim to identify individuals" perceptions of marriage as an institution to raise a child and a way to continue their family name. According to the answers given to the survey, ideas of "inheritance of family name" or "marriage to reproduce" are largely limited to a restricted 11-17% range. This is, interestingly, close

to the number of people who have avowed that they would consider themselves as "religious individuals" and SPSS data reveals that those who understand family as a child-baring institution largely corresponds to those who consider themselves as "religious".

What is more interesting in this particular data is that a significant 65% claim that one of the most important reasons they wanted to have a child was supposes" wish to have a child and this statement. 34 women out of 55 and 31 men out of 51 responded that their desire to have a child was influenced by their partner; this may be seen as a mutual interest in constructing family as child bearing institution but more interestingly, this result displays the inescapability from social and cultural pressure on women to be parents- reciprocally constructed on men by women and on women by men.

Again to the statement "life is incomplete without a child", both men and women displayed a keen interest, whereby 36.6% of women and 19.6% of men claimed that their life would be incomplete without a child. This statement was followed by "feeling of nothingness" which was displayed by three women and no men. Although it might be suggested that 6%, especially in such a small sample of 106 people may not accurately display a coherent and significant dis-valuation; but I suggest that significance is of "quality of the experience" not of "quantity". There are still individuals, all of whom are women, not men, who try to construct their identity fully on their motherhood. It is therefore important to identify how IVF is contributing to these facts- it is possible to assert that IVF by providing the hope to become mothers "despite biological constraints", act as a powerful agent to impose this traditional strategy of "self-making."

Another appealing result is that women suggested that the desire to have a child was "natural", 12 fold more than men. If the desire is instinctual and purely biological, the question of how did women become much significantly aware of this "nature" remains unclear. Indeed, the idea is consolidated with the following statement that "all women should experience pregnancy and birth"- which was agreed at a total of 12% in the entire population sample, almost equally constructed both by men and women. The

collection of these two statements and the coherence among them suggests that the "nature" to desire a child is in fact "socially constructed."

I also tried to identify where this social pressure on infertility is originating or if not practiced more widely. Hence I asked them if there was any significant pressure they had experienced from their parents, friends or simply by the fact that "their surrounding" consisted of families with children. The recognition of pressure from friends and family is low- although one appealing suggestion that comes from the data is that only women, and again not men, stated that the fact their friends had children, motivated them to have children of their own. Once again, this might be seen as an attempt to construct self as "mother" to fit in the social roles "everyone else is inclined to fit in".

Finally, I placed a statement that reasons the desire to have child because they have a strong desire to have a child. This was a theoretical strategy, to check if there is a talk of "desire to have a child" but it is not explicated further- "it is an instinctual desire and it is strong" is the only claim that holds. The result was fascinating, 90% of the participants suggested they "desired to have a child" because "they had a strong desire to have a child." The almost adolescence reasoning such as "I want to because I want to" is consistent in their experience.

That is to say, "will to have a child" is not a simple construct, but of biological-determination conception relating to "bio-power" -which is a term that encapsulates various forms of power varying from conceptions of biological diversity- such as race, gender and health. Reframed in this context of biopower and/or biopolitics specifies, organizes, targets and controls those biological traits that are not accepted as "proper" in the society (Foucault,1975). Despite the risks associated with IVF and its high cost compared to other techniques, IVF remains as the most utilized technique of reproductive medicine and this is, data suggests, due to the emphasis of genetic, if not possible gestational, relatedness.

4- Alternative Methods to IVF

In this section of the survey, I aimed to compare how IVF was understood in comparison to other ways of having a child. After all, adoption, despite the red tape around it, offers an alternative solution for those couples who would like to raise the child of their own. I have then asked in the survey "Have you or would you consider any of the methods below as a good and ethical alternative(s) to IVF?"

Answers are schematized in the below table.

Table-8-7- Alternative choices to IVF

		Adopt a healthy Turkish baby	Adopt a Baby with disability	Adopt anlder child with	Accept ova transfer, fertilized with	Accept AID -if available in
W=55 Women	Yes	w=24	w=4	w=1	w=15	w=6
		w/W= 0.4545	w/W= 0.0888	w/W= 0.0181	w/W= 0.2727	w/W= 0.1090
	No	w=27	w=43	w=49	w=38	w=44
		w/W= 0.4909	w/W= 0.7818	w/W= 0.8919	w/W= 0.6909	w/W= 0.800
	Undecided	w=4	w=8	w=2	w=1	w=5
		w/W= 0.0888	w/W= 0.1454	w/W= 0.03636	w/W= 0.0181	w/W= 0.0909
	No Answer	w=1	w=1	w=2	w=3	w=0
		w/W= 0.0181	w/W= 0.0181	w/W= 0.0392	w/W= 0.0545	w/W= 0
M=51 Men	Yes	m=21	m=3	m=1	m=13	m=4
		m/M= 04117	m/M= 0.0588	m/M= 0.0196	m/M= 0.2549	m/M= 0.0784
	No	m=28	m=43	m=46	35	m=39
		m/M= 0.5490	m/M= 0.8431	m/M= 0.9019	m/M= 0.6862	m/M= 0.7647
	Undecided	m=2	m=2	m=2	m=3	m=5
		m/M= 0.0392	m/M= 0.0392	m/M= 0.0392	m/M= 0.0588	m/M= 0.0980
	No Answer	m=0	m=1	m=1	m=0	m=3

Responses to the first question which compares adopting a "Turkish baby" rather than having an IVF baby was in fact seen as an alternative by 42% of the participants, equally female and male –and for the other 42% it was a "definite no." The contestation became more apparent with the second question that raised if they would adopt a baby with disabilities and this suggestion was rejected by 86 participants, equally men and women. What this data suggests is that for some patients, IVF is a way to have their own biological baby, who can not be "substituted by" adopting a baby. Hence "the experience of pregnancy is used si as to establish the material bonds with children. Still, for others, as long as the baby is "healthy", they could consider the option to adopt a child. Yet, it is well known that IVF in itself involves some risks, especially when a person is treated wrongfully. However, the "possibility of risk" is overcome by the actual or "visible" risk –that is "disability". In other words, significant amount of people who apply for IVF are not only interested in their own "biological baby" but also one that is healthy.

A second level of analysis is in order to compare the gestational processes with actually raising a child. In the third question, I had asked if they would consider adopting an older child with disabilities, and significantly the number dropped to 2 individuals (one man and woman, whom I had found out that they were actually married- and probably filled out their questionnaire together). So the survey implies that individuals prefer their "own" off-spring, experience stages of pregnancy and if not at least be a spectator for the growth of their child, rather than adopting an older child.

The third question was if couples would accept ova transfer, fertilized with the husband"s sperm (although technique is not available in Turkey, due to the prohibition of egg-sperm donation. I compared this result with the level of acceptance of AID in Turkey. The results indicated that ova transfer and even artificial insemination are not seen as legitimate means of techniques. 67,8% of the population refused the use of ova transfer and even a larger population, 78,8% refused sperm donation. AID was in fact rejected more than ova donation. This is unlike the previous studies that were held in the American-British contexts and they are critical in terms of highlighting the fact that the acceptance of technologies is culturally bounded.

That is to say, "will to have a child" is not a simple construct, but of a biologically-determined conception relating to "bio-power" -which is a term that encapsulates various forms of power varying from conceptions of biological diversity- such as race, gender and health. Reframed in this context of biopower and/or biopolitics specifies, organizes, targets and controls those biological traits that are not accepted as "proper" in the society.[242] Despite the risks associated with IVF and its high cost compared to other techniques, IVF remains as the most utilized technique of reproductive medicine and this is, data suggests, due to the emphasis of genetic, if not possible gestational, relatedness.

5- Openness about IVF

In this section of the questionnaire I aimed to uncover the relationship between those undergoing IVF and their family and friends. I asked them "Have you told any of the below people that you were going to take test tube baby treatment?"

Table- S. 8. Openness About IVF Programme

	Women W=55		Men M=51		
	Yes	No	Yes	No	Not answered
Have you told your parents you are on the IVF programme	w=45	w=11	m=39	m=11	m=1
	w/W= 0.8181	w/W= 0.2156	m/M= 0.7647	m/M= 0.2156	m/M= 0.0196
Have you told all members of your family you are on IVF programme	w=27	w=29	m=27	m=23	m=1
	w/W= 0.4909	w/W= 0.5272	m/M= 0.4909	m/M= 0.4509	m/M= 0.0196

[242] Foucault, et. a. 1975

Table- S. 8. Openness About IVF Programme, continued

	Women W=55		Men M=51		
	Yes	No	Yes	No	Not answered
Have you told your close friends you are on IVF programme	w=48	w=8	m=32	m=18	m=1
	w/W= 0.8272	w/W= 0.1454	m/M= 0.6274	m/M= 0.3529	m/M= 0.0196
Have you told most of your friends you are on IVF programme	w=13	w=41	m=11	m=39	m=1
	w/W= 0.2363	w/W= 0.7454	m/M= 0.1607	m/M= 0.7647	m/M= 0.0196

The data at first sight indicates that most of the participants who have undertaken this survey have shared their participation to the IVF programme with their parents or with close friends. Our results are also consistent with the analysis of Whitehord and Poland, who claimed that people who have gone undergone IVF are unlikely to hold a secret, so as to keep their friends and relatives in close-contact as a safety net.

Nevertheless, when I took a closer look on the inconsistency around the first question, meaning 45 women versus 39 men claiming they had told their parents, I decided to investigate further, to check if couples were narrating different stories. Indeed that was the exact case: four women claimed they had told their parents but their husbands were claiming just the reverse. Perhaps, the mechanism is that women told their "own" parents but not their "mother/father in laws" in order to "protect" his "masculinity" – since the expectancy from men is to reproduce, is it possible to claim that any men failing to do can be "seen as" "less men"? This convoluted mechanism of secrecy is quite intriguing, however without having "qualitative interviews" and some more in-depth narratives pointing out to this event, it is impossible to "map" it in all its entirety, still even pointing out to the fact that there is an elaborate contested site for men through IVF is worth while to investigate in some future study.

6- Appropriation of Parenthood

In Turkey, laws governing the status and availability of ART only allow married heterosexual couples to have a child and National Health and Social Security system can pay only for one child. In this section, we investigated whether legal proceedings were representative of people's opinions. There seems to be only a small percentage of discrepancy among what Turkish law suggests and what participants suggested, unmarried couples, single/lesbian mothers are seen as "not so good" mothers. This view, I suggest, is a result of "neo-institutionalism", whose major goal is "to save all that can be saved of traditional family structures, opening them to partially to the technological developments, in a sort of institutional surviving adaptation of traditional family.

In the survey, I wrote: "Below is a case study exercise: Imagine you were able to decide who should be able to have test tube babies and these hypothetical people applied for the treatment. Who would you allow/ who would you not allow have test tube babies?"

These responses are outlined in Table- S 9- Opinions on Parenthood.

Table- S- 9- Opinions on Parenthood

	Women W=55						Men M=51			
	Married couples without a child		Married couples with only one child		Married couples with two or more children					
	w/T =0.5188	w/W =100	w/T =0.943	w/W=0.1 818	w/T =0.179	w/W=0.3 09	w =17	m/T =0.4811	m/M =100	Yes
	w/T =0	w/W = 0	w/T =0.349	w/W=0 .672	w/T =0.292	w/W=0.6 72	w =37	m/T = 0	m/M =0	No
	w/T =0	w/W = 0	w/T =0.056	w/W=0.1 090	w/T =0.009	w/W=0.0 18	w =1	m/T =0	m/M =0	Undecided
	w/T =0	w/W =0	w/T =0	w/W=0	m/T =0	w/W=0	w =0	m/T =0	m/M =0	Not Answered
	m/T =0	m/M =0	m/T =0	m/M = 0	m/T =0	m/M =0.372	m =19	m/M =0.2156	m/M =100	Yes
	w/T =0	w/W =0	w/T =0	w/W=0 .672	w/T =0	w/W=0.6 72	w =37	m/T =0	m/M =0	No
	w/T =0	w/W =0	w/T =0	w/W=0.1 090	w/T =0.292	w/W=0.0 18	w =1	m/T =0	m/M =0	Undecided
	w/T =0	w/W =0	w/T =0	w/W=0	w/T =0	w/W=0	w =0	m/T =0	m/M =0	Not Answered
	m/T =0	m/M =0	m/T =0	m/M = 0	m/T =0.009	m/M =0.0196	m =1	m/M =0.0588	m/M =0	Yes
	m/T =0	m/M =0	m/T =0	m/M = 0	m/T =0	m/M =0	m =0	m/M =0	m/M =0	No
	m/T =0	m/M =0	m/T =0	m/M = 0	m/T =0	m/M =0	m =0	m/M =0	m/M =0	Undecided
	m/T =0	m/M =0	m/T =0	m/M = 0	m/T =0	m/M =0	m =0	m/M =0	m/M =0	Not Answered

Table- S- 9- Opinions on Parenthood – continued

				Women W=55					Men M=51			
Any couple who asks for it			Unmarried couples who have a stable relationship, with child(ren)		Unmarried couples who have a stable relationship, without a child							
w/T=0.122	w/W=0.236	w=13	w/T=0.16	w/W=0.309	w=17	w/T=0.179	w/W=0.345	w =19	Yes	m=17	m/M =0.333	Yes
w/T =0.377	w/W =0.727	w=40	w/T=	w/W=0.618	w=34	w/T=0.3207	w/W=0.618	w =34	No	m=32	m/M =0.6274	No
w/T =0	w/W =0	w=0	w/T=0.009	w/W=0.018	w=1	w/T=0.018	w/W=0.036	w=2	Undecided	m=1	m/M =0.0196	Undecided
w/T =0.018	w/W =0.036	w=2	w/T=0.028	w/W=0.054	w=3	w/T=0	w/W=0	w=0	Not Answered	m=1	m/M =0	Not Answered
m/T =0.113	m/M =0.235	m=12	m/T =0.122	m/M =0.2549	m=13	m/T =0.131	m/M =0.333	m=17	Yes			
m/T =0.348	m/M =0.725	m=37	m/T =0.283	m/M =0.588	m=30	m/T =0.3018	m/M =0.6274	m=32	No			
m/T =0.0094	m/M =0.019	m=1	m/T =0.471	m/M =0.098	m=5	m/T =0.0094	m/M =0.0196	m=1	Undecided			
m/T =0.0094	m/M =0.019	m=1	m/T =0.0283	m/M =0.0392	m=3	m/T =0.0094	m/M =0	m=1	Not Answered			

Table- 8-9- Opinions on Parenthood – continued

	Women W=55				Men M=51			
	Yes	No	Undecided	Not Answered	Yes	No	Undecided	Not Answered
Women without a male partner (donor sperm will be used)	w= 12	w= 36	w= 1	w= 1	m= 14	m= 35	m= 0	m= 2
	w/W=0.2 18	w/W=0.6 54	w/W=0.0 18	w/W=0.0 18	m/M =0.274	m/M =0.686	m/M =0	m/M =0.039
	w/T=0.1 13	w/T=0.3 39	w/T=0.0 09	w/T=0.0 09	m/T =0.132	m/T =0.330	m/T =0	m/T =0.011
Lesbians or other women who wish not to have a sexual relationship with men	w= 8	w= 44	w= 2	w= 1	m =6	m =42	m =2	m =0
	w/W=0.1 45	w/W=0.8	w/W=0.3 63	w/W=0.0 18	m/M =0.1176	m/M =0.8253	m/M =0.039	m/M =0
	w/T=0.0 75	w/T=0.4 15	w/T=0.0 88	w/T=0.0 09	m/T =0.056	m/T =0.3867	m/T =0.0188	m/T =0

The results were equally distributed between men and women – the extend to which current legislative discourses penetrate into the daily thinking was more or less same for both men and women. The legitimate parents, on which there is one consensus, is the heterosexual married couple, the consensus decreases as the suggested "family" diverges from the traditional model. Finally, lesbians who "refuse" to have relationship with men are seen as individuals who deserve parenthood the least. Here, we see again an emergence of governance of bio-power, where some biological, physical or mental traits are accepted as proper, good and benevolent; where others are stigmatized .As Foucault describes, "the biological traits of a population organize them through an apparatus that not only assured the constant maximization of utility but also of their subjectification"[243], homosexuality is still not an accepted form of relationship and it is not seen as a "proper" space to raise a child. What Foucault traced as an "apparatus", in this case explains the role of law in terms of depositing certain logic and a tactical economy of domination operating within a discursive structure.

7- Economics

In this section, I aimed to see if the recent developments that had taken place during AKP government were seen as legitimate and ethical by the people who are governed by it. I wrote: "Imagine a purely hypothetical situation, in which you are eligible to decide how to distribute IVF services. Using your own insights, please select the option that is closest to what you might suggest." Then there were three questions:

a) Do you think all costs on IVF should be repayable as with other medical costs? Results are outlined in the below table.

[243] Foucault, et. al.1975:23

Table-8-10-Ethics: IVF cost

	Yes	No	Not answered
Women W=55	w=51 w/W=0.9107	w=3 w/W=0.0545	w=1 w/W=0.1818
Men M=55	m=46 m/M=0.9019	m=5 m/M=0.0980	m=0 m/M=0
Total T=106	(w+m)/T=0.9150	(w+m)/T=0.7547	(w+m)/T=0.009

b) If you were to ethically choose the number of cycles that will be covered by the health insurance, what would that be? Results are outlined in the following table.

Table-8.11- Ethics: IVF cycles

	None	1 treatment	2-4 treatments	No upper limit	Not answered
Women W=55	w=2	w=9	w=39	w=5	w=1
Men M=51	m=2	m=7	m=37	m=5	m=0
Total T=106	t=4	t=16	t=76	t=10	t=1

92% of the participants stated that all costs would be paid as with the other medical costs, which is formulated as a basic “welfare right” in this context. However, there is an accompanied discomfort that the number of cycles should be restricted to only a few cycles so as not to lessen the available fund for other treatments. In fact, as I had discussed in previous sections, the “optimum” IVF was three- as most couples got pregnant at the third stage (certainly, there are exceptions). This “scientific fact” corresponded to their assertion to limit the number of cycles to 4.

There is also 10% of the population sample, who demanded no upper limit for the amount of money the government should spend. Response is understandable: Although IVF offers a hope to replace infertility, it does not guarantee the pregnancy. There is nothing more reasonable for people who undergo this treatment to demand for more.

The third question I had asked them was to see if their "ethical world" translated into their actions. I asked them:

c) "How many IVF treatment cycles have you attempted so far?"

Table-8-12- Number of IVF cycles

	0	1	2	3	4	more
Women W=55	w=11	w=25	w=7	w=6	w=4	w=2
Men M=55	m=13	m=21	m=4	m=4	m=2	m=2

The actual data of how many cycles they had selected is also consistent with their "ethical world". Less than four percent of the patients tried IVF treatment for more than four times. However, there is again the issue of "finances" in shaping their decisions. As the cost per cycle is high, there is a limit (for most people) to the number of IVF cycles they can actually afford.

8- Ethics and prospective technologies

Table-8-13- Ethics and Prospective Technologies

	Women W=55				Men M=51			
	Yes	No	Unsure	Not answered	Yes	No	Unsure	Not answered
Would you like the scientist to be able to select the sex of embryo before transfer?	w =10	w =38	w =4	w =1	m =13	m =36	m =2	m =0
	w/W = 0.818	w/W = 0.690	w/W = 0.727	w/W = 0.018	m/M = 0.254	m/M = 0.705	m/M = 0.039	m/M = 0
	w/T= 0.094	w/T= 0.358	w/T= 0.037	w/T= 0.094	m/T= 0.122	m/T= 0.339	m/T= 0.018	m/T= 0
Do you think work should be done in order to develop embryo outside the body? If this is possible, do you think it is desirable?	w =7	w =42	w =3	w =3	m =5	m =39	m =0	m =5
	w/W = 0.127	w/W = 0.763	w/W = 0.054	w/W = 0.545	m/M = 0.980	m/M = 0.764	m/M = 0	m/M = 0.098
	w/T = 0.047	w/T = 0.369	w/T = 0.283	w/T = 0.283	m/T = 0.047	m/T = 0.267	m/T = 0	m/T = 0.047
Should surrogate mothers be allowed if the genetic parents cannot have a child in any other way?	w =37	w =13	w =2	w =1	m =33	m =14	m =2	m =1
	w/W = 0.672	w/W = 0.236	w/W = 0.036	w/W = 0.018	m/M = 0.647	m/M = 0.274	m/M = 0.039	m/M = 0.196
	w/T = 0.349	w/T = 0.122	w/T = 0.018	w/T = 0.009	m/T = 0.331	m/T = 0.132	m/T = 0.018	m/T = 0.009

Table-8-13- Ethics and Prospective Technologies

	Women W=55				Men M=51			
	Yes	No	Unsure	Not answered	Yes	No	Unsure	Not answered
Should surrogate mothers be allowed if the genetic parents can have a child in the ordinary way but prefer not to?	w =1	w =50	w =2	w =2	m =3	m =45	m =1	m =2
	w/W = 0.018	w/W = 0.909	w/W = 0.363	w/W = 0.363	m/M = 0.588	m/M = 0.882	m/M = 0.019	m/M = 0.039
	w/T= 0.009	w/T= 0.471	w/T= 0.018	w/T= 0.018	m/T= 0.028	m/T= 0.424	m/T= 0.009	m/T= 0.018
Should surrogate mothers be paid for their services?	w =42	w =9	w =3	w =1	m =38	m =8	m =2	m =3
	w/W = 0.763	w/W = 0.163	w/W = 0.545	w/W = 0.018	m/M = 0.745	m/M = 0.156	m/M = 0.039	m/M = 0.058
	w/T= 0.369	w/T= 0.084	w/T= 0.283	w/T= 0.094	m/T= 0.358	m/T= 0.075	m/T= 0.018	m/T= 0.028
If surrogate mothers are able to charge for their services, should it be a set fee?	w =33	w =12	w =4	w =6	m =33	m =8	m =1	m =9
	w/W = 0.6	w/W = 0.218	w/W = 0.072	w/W = 0.109	m/M = 0.647	m/M = 0.156	m/M = 0.019	m/M = 0.176
	w/T= 0.311	w/T= 0.113	w/T= 0.037	w/T= 0.566	m/T= 0.311	m/T= 0.075	m/T= 0.009	m/T= 0.084

Attention to social, legal and ethical consequences of reproductive technologies and “choice” focuses on the possibility of human embryo sex selection. One of the poles within the medical and scientific debate advocate that sex selection as a right to choose, where as the other pole describes it as an unacceptable form of “eugenic” practices. The Turkish Law on Biomedicine (1998) all ban the sex selection process and The Human Embryology Act (1990) ban the sex selection unless there is a certain genetic condition related that would effect the offspring. The regulation can be seen as a limitation to the free IVF market economy, where non-negligible number of

consumers, 23% in this case, “demands” to run this procedure. This is not to suggest that IVF centres are capable of providing this service at the micro-level, without the control of the state; nor that IVF centres would be able to profit more -even if their success rates were lower- but only that there is a regulated consumer demand in this area.

Secondly, participants answered if they thought work should have been done in order to develop embryo outside the body and if they would desired such work. Most of the media coverage use the metaphor of “designer babies” with a reference to Aldous Huxley’s Brand New World, where developing embryos in vitro are portrayed as developing in “test-tubes”. This conceptualization of reproduction science and cloning fiction were used over and over again in modern reproductive medicine discourse. The overuse of this image, I suggest, resulted in the conceptualization of ex-vivo treatments as highly undesirable; this in turn indicates that similar to the suggestion boundaries between fiction and non-fiction blurred in the representations of medical sciences. Nonetheless, 12,26% of the remaining population expressed that they would support the development of ex-vivo technologies, which might act as a “resistance point” in which conventional conception of “women as vessels” can be broken.

Third section also relates to the conceptualization of “women as vessels”, here participants verbalized their views on surrogate motherhood. Although Turkish law does not allow surrogate mother arrangements, 68% of the participants showed an interest in a surrogacy arrangement. This brings us to the initial argument made by Snowden that surrogacy procedures made being fertilized by someone else socially acceptable by eliminating the “sexual intercourse” from its description (Snowden, 1983). However surrogate mothers are seen legitimate only when the “ordinary way” is not possible to achieve; such opposition evokes that women are expected to give birth and their straight arrangements is seen as a form of “exploitation.”

9- General Aspects of Tube-Baby Treatment

This last section of the survey was designed in order to measure some common recurring themes surrounding debates about IVF. In the survey, participants were asked to answer three brief yes/no questions. Below is the data of the last set of questions:

Table-8-14- General Aspects

	Women W=55			Men M=51		
	Yes	No	Unsure	Yes	No	Unsure
Do you feel adequately informed on all the IVF procedures that are carried out?	w=36	w=19	w=0	m=50	m=5	m=0
	w/W= 0.6545	w/W= 0.3454	w/W= 0	m/M= 0.9880	m/M= 0.0196	m/M= 0
	w/T= 0.3396	w/T= 0.1792	w/T= 0	m/T= 0.471	m/T= 0.094	m/T= 0
Are you worried that IVF procedures might result in an abnormal child?	w=10	w=45	w=0	m=9	m=42	m=0
	w/W= 0.1818	w/W= 0.8181	w/W= 0	m/M= 0.1764	m/M= 0.8235	m/M= 0
	w/T= 0.9443	w/T= 0.4245	w/T= 0	m/T= 0.0849	m/T= 0.3867	m/T= 0
Would you agree to termination of pregnancy if tests indicated the foetus was abnormal?	w=41	w=10	w=4	m=39	m=8	m=4
	w/W= 0.7457	w/W= 0.1818	w/W= 0.7272	m/M= 0.7647	m/M= 0.1566	m/M= 0.0784
	w/T= 0.3867	w/T= 0.9448	w/T= 0.377	m/T= 0.3679	m/T= 0.0754	m/T= 0.0377

In the first question, which questioned if they thought they were adequately informed had a good turn up rate, in which 86 out 106 patients confirmed that they had been informed. My concern was the remaining 24 people who had not received enough information. In order to understand the mechanism behind, I had looked at where their data was coming from- my question was if state owned hospitals or ivate clinics were better in terms of their efficacy to convey information. SPSS analysis did not imply any significant distinction between private and state owned hospitals. Secondly, I asked if "the level of education" patient has could influence the amount of information s/he could get in an understandable manner. Education level did not create significant change in terms of constructing the informed consent, apparently medical personnel have been able to convey information to people, no matter what their education level was. There is then no other correlation about level of "informed consent" apart from the

obvious gender difference. Women participants, who claimed that they had not been sufficiently informed, was twenty-fold more than men, who claimed the same.

Respectively, only 15 % of the participants stated that they were not worried that IVF procedures might result in an abnormal child, Although the trust built between the physician and patient is important, it remains a question whether they were actually aware of the risks involved, such as respiratory distress and haemorrhage or long term effects of premature births, which are widely observed in IVF babies, due to multiple pregnancies. Hence the risk present and risk perceived are significantly different in the eyes of people undergoing IVF.

Third question was aimed to answer if the growing market in prenatal diagnosis (PND) had found a significant response in patients" views. As the data indicates, PND is seen a legitimate source of intervention to the foetus and both men and women agree on this issue.

11- Conclusion and Discussion

The survey study conducted highlights some of the key discursive practices that have been embedded in legal and popular media and demonstrates that these practices translate into patients" experiences while undergoing IVF. The survey demonstrated that IVF programme is indeed constructed as a middle-class phenomenon. The survey also demonstrated that the mass media had become one of the most powerful "apparatus"es through which technologies were introduced, information conveyed and identities are formed. This in turn implies that problematization of life itself is not longer solely dependent on the monopolized practices of the State and even of doctors; but it is vastly integrated in mass media channels.

The survey showed that there is a significant difference between the way women and men make sense out of infertility, along with their fertility treatments. Their experience is moulded by the cultural values, which were based on the solidified meanings of motherhood, maternity and kinship. It was demonstrated that individuals"

desire to have a child through IVF does not have a coherent narratives, most of them verbalize their interest in IVF as "just because" or as "instinctual." As the implications of these "biological" signifiers increase, the boundary between nature and culture gets more blurred. The supposes" wish to have child, along with pressures of leading "meaningless lives" are operational at the other end of the spectrum.

The sense of ambiguity is also fuelled by the construction of kinship or family through "biological causes." A majority of the participants in the survey claimed their preference of fertility treatments over adoption, especially when the adopted child has disabilities or older –meaning not a baby-. Moreover, there are some cultural variations among the embodiment of technologies, for instance in Turkish case, AID and ova donation were not seen as legitimate actions, unlike the Anglo-American conceptualizations.

Parenthood is also appropriated, along with the nature of the child; what is left except the heterosexual married couple is stigmatized; the bio-power in this sense is integrated in the "making of selves"- in the making of "making of parents."

A tertiary effect of biopower, that is economics of IVF, seems to manufacture people's ethical conceptions of IVF. Although news articles display the irrational behaviour and inclinations to have children, the survey results suggested that patients can in fact rationalize their actions in the IVF market –optimizing the number of cycles that can be affordable by the State for instance.

Conceivably, the emergence of new technologies is now regulated by various resources and patients are the fundamental domain providing this governance. Although there are still issues surrounding informed consent, gender bias, access to services – which are results of or continuations of already existing power structures- there is a conceivable change in the way reproduction is conceptualized. The domain of biology (nature) (infertility) is intermingled with culture (society) and the identities and interests are formed in a bidirectional process- on the one hand, IVF challenges the way people make sense of their infertility, on the other the understandings of maternity, gender and parenthood are appropriated to the regulations of technology. Overall, the survey displays to what extend these changes are afforded by the people who are both

subjects and creators of it and it is unique in its attempt to display this interplay in a non-AngloAmerican context.

CHAPTER 8

SUMMARY AND DISCUSSION

Through out this thesis, my aim was cooperate Foucault"s biopower in three layers–that is co-production of nature and culture, construction of new forms of spaces of governance such as new definitions of race, gender or religious domains and new modes of subjectification in relation to truth discourses – on the political and cultural construction of in vitro fertilization technique. I claim that production of discourses in legal institutions and media and their interactions with existing social values based upon gender, ethnicity and race found a substantial domain in which people (patients) set their standards to make sense out of IVF technologies and by doing so they become both the producers and the subjects through out their (bodily or visually) experience of IVF.

The analysis was initiated with historization and discussion of economics of IVF in both British and Turkish settings. I have demonstrated that IVF stands as an expensive medical technology, where individuals' participation is determined by their economic class status. Individuals, who do not have previous savings and/or financial support from their friends and family, are at average faced with the dilemma of sustaining their lives over choosing to undergo fertility treatments. The cost of IVF in Turkey, still, remains lower than the numbers reflected in the UK. As rational actors, most of who are deprived of services in their home countries chooses to take "health tourism" route and have IVF treatments where the cost would be lower. This rational decision ultimately results in what might be called as "reproductive tourism", with package programmes of IVF and holiday in Turkey.

It was interesting to find out that both Turkish and British governments chose to provide public funds for IVF programmes. If one ignores the feminist literature that analyzed the psychological effects of infertility and social forces –that is the demands and expectations of family and friends- which urge "the rush to reproduction" for a moment, and rather adapts a purely economic welfare point of view, infertility treatments seemingly are not obligatory. Hence the question of "why states chose to fund these expensive fertility treatments" was intriguing to resolve. I argued that the state funding of IVF in the UK aimed to eliminate the future financial problems associated with aging population. The aging population means that healthcare and pension costs will significantly increase and in order to avoid the larger cost posed by aging of the population, IVF was placed strategically to contribute to increase the population size. What British government calculated in terms of its population management programme became centralized through an introduction of reproductive technologies. However, the same figures do not hold for Turkey. According to July 2006 estimates, the current population size of Turkey is 70,413,958, with a median age of 28. The rate of population increase is 1.06%, which means population increases by one million each year. In order to understand the rationality behind the policy making in Turkey, I argued that the political ideology of AKP government needs to be revisited. I suggested that the particular stipulation on IVF is combined with the pronatalist discourse of AKP government. The legitimization of their interest to strengthen "integrity of family" is further manipulated by the use of reproductive technologies.

Following the historization and investigation of current legislation on IVF, I have concluded that the meaning of infertility was attempted to be fixed within the boundaries of medical knowledge. In other words, the normalization of IVF as a procedure and its acceptance by public are facilitated through remedial constructions. It is often the case that "infertility" is positioned in opposition to "fertility" as the lack of capacity to generate offspring of one's own, as well as the aptitude to cultivate family of one's own, consequently any "assistance" to solve the problem of infertility is mediated as desirable objectives within the society. In this regard, I argued that the technology itself is based on the "fixation"[244] to the "normal, healthy, and fertile."

[244] Clarke, Adele E. *Disciplining Reproduction: Modernity, American Life Sciences, and the Problem of Sex.* Berkeley: University of California Press (1998)

Moreover, the increasing interest in combining genetics and germ line gene therapies with IVF are increasingly implies that offsprings are understood in the domain of "enhancement." In this sense, I argued that the economics of IVF limit the number of its participants to only who can afford going under treatment; as a result on the one hand competitive economic forces prosper economic injustices in terms of the availability of services and on the other promote the technocratic mentality for those who can afford it.

In opposition to the biologically determined meanings of infertility and fertility, I have introduced the anthropological studies as "resistance points." I argued that discursive practice of infertility is deeply entrenched in the cultural norms and societal exercises for centuries. Deriving from Delaney's work, I proposed that procreation is formed within a complex set of cultural relations, where feminine role is passively defined, as the provider of nourishment and masculine role is defined as the provider of seed and this particular bias on women's bodies resulted in the partial understanding of women's sexuality and identity. Possibly, the emergence and even more the spread of reproductive technologies contribute towards altering our discernment about fertility and infertility. It is no longer possible to situate procreation as a neutral cultural process, where men and women are free from the culpability of their generation or from their incapacity to conceive an offspring. The convergence of medical and cultural boundaries distorts the way we make sense out of our bodies and they alter the familial relationships. The duality between culture and nature now need to be reinterpreted within the domain of social sciences; as a consequence, the ever growing literature provided by the studies of cultural feminists can be seen as attempts to overcome this dichotomy.

It became lucid that relation to self and family are mutually constructed at several domains, where imaginaries of motherhood are defined in essentialist feminine roles. Scientific domain can said to be found the conceivability of such images. That is to say, new technologies, which can offer change, are appropriated within the already conceived understandings of parenthood and familial relationships, and legal and medical documents form the basis of legitimization for such emancipation. What

immediately derives from this fact is the hinderance of permitting homosexuals, old and single women in the sphere of justified parenthood.

Legal documents in this regard are supporters of Foucault's description of "governmentality"[245] through statistics. Foucault argues that statistics eliminate the possibility of individual differentiation, decentralizes the focus on choices made at the level of family; but centralizes the role of economics, i.e. economics of economics of life, mortality, births. That is not to say however, family is no longer "governed"- in fact, just the opposite: "what now emerges into prominence is the family considered as an element internal to population, and as a fundamental instrument in its government." [246] IVF regulations contribute towards the construction of this cyclical power relation where biopower finds a space to operate. Precisely, IVF requires legislation, legislation is made up from the societal values they emerge in, but the legislation itself utilizes 'scientific facts" for legitimacy. So the power of legislation is not "biological" in the restricted sense of the discipline but it is a hybrid biological, sociological and demographical mobilization that requires "biological facts" in its core. Moreover, legal documents constitute means of intervention upon collective decisions under the name of medical intervention. Thirdly, legislation promotes the societal values whilst describing IVF as in pure medical terms and the availability of these medical services substance the subjectification of homosexuals and women, -particularly if they are single, middle age. These subjectified individuals are brought to work on themselves in the name of their own life.

Similarly, media coverage of IVF imposes certain subjectification on top of state centric regulations. Media in this regard become part of the signifiers of "regime of truth", which captivate different capacities, rights and needs of recognition within the society and the relationships between power, truth, gender, medicine, illness and discourses. In the way it perpetuates the multiplicity of meanings, media creates a space of participation into the governance of bodies, it becomes a source of information and

[245] Michel Foucault, "Governmentality" IN Graham Burchell, Cikin Gordon and Peter Miller, *The Foucault Effect: Studies in governmentality,* (Chicago: University of Chicago Press, 1990)

[246] Michel Foucault, et. al. 1990: 19.

self identification. As a result, governed bodies become the active members of the governing system, participating in the discursive practices, forming bonds and attempting to individuate themselves within the resistant points. In other words, bio-power becomes an integrated part of self realization and action within the medical practices, whereby gender, race, ethnicity, health, infertility are constantly reminders of their governance. The power structures offer the accreditation of individuals as political beings and motivate them in making their choices to undergo fertility treatments

Media achieves this objective at multiple levels. First, IVF is constructed in an extremely militarised, nationalist discourse. Infertility, which is constructed as a disease, is fought against at various levels- it is fought against at clinics, with sophisticated "weapons" such as IVF by specially trained 'soldiers", i.e. doctors; the "bravery" and "persistence" of the patient is required in order to "win the war" to get pregnant. Similarly, at the international level, infertility is fought among nation-states, where the ones with most sophisticated "arms", i.e. techniques and with most amount of experience, i.e. number of IVF cycles per year become the new norms of "arms-race" or "technology wars" in the area of reproductive technologies. Doctors become soldiers, using "weapons" of treatment and ultimately women's bodies literally became the battlefields in the wars of sovereignty. Secondly, the ultimate success in war, which is to get pregnant, becomes glorified. Pregnancy, as an end, justifies the means of suffering, risk and inconvenience. Through out the media people's experiences of hopelessness, social relationships, stress are not mentioned, or vaguely mentioned to develop 'strategies" (again a militarist term) against those experiences of ambiguity. Thirdly, doctors play a crucial role as the primary loci of the relationship between power and knowledge. Doctors are legitimized at three levels; they are informative, representative and authoritative. They have the power to represent the truth about IVF, their nation and they govern their patients' decisions, even under conditions where risk is high. In this regard, doctors become the source of providing the moral guidelines in IVF. Fourthly, religious authorities have the power to appropriate who should be allowed to become parents; and traditional family bonds, established ideas about ethnicity and race can fuel this authority. Bodies become a public territory, where individuals are expected to act in accordance with the moral objectives of human dignity, moral correctness that are previously defined in the religious domain.

The final section of my analysis was to measure how these key discursive practices became efficient in terms of patients' construction of self identity, in other words, the survey was an attempt to demonstrate the level of discursive penetration in actual experiences of IVF. The survey study showed that IVF is indeed constructed as a middle class phenomenon, since most of the participants in my study were members of middle class. The participants also implied that their primary information channel remains as media, although the trust built into this resource can be contested. . Tis in turn implies that problematization of life itself is not longer solely dependent on the monopolized practices of the State and even of doctors; but it is vastly integrated in everyday discursive practices that imply the multiplicity of truths.

The survey showed that there is a significant difference between the way women and men make sense out of infertility, along with their fertility treatments. Individuals' sense and experience of treatment is shaped by the cultural values, which are based and promoted on the grounds of traditional families, motherhood, maternity and kinship. In a way, the boundaries between medical practice and societal values become blurred in their expression of "self." For instance, women's relationship with their husbands, mother/father in laws, interactions with their friends constitute the foundation of their decision to accept IVF as treatment. Their self identification and meaning of life, as the survey, demonstrates are bounded within these inter-relations and pressures that derive from these relations. Furthermore, there are some cultural variations among the embodiment of technologies: for example unlike Anglo-American studies show, artificial insemination by donor sperm is not seen as justifiable means of conception for various couples in Turkey. The multiple levels of "bio-power" is integrated in the making of selves, along with the making of "making of parents." Another effect of biopower, that is economics of IVF, also is shown to manufacture people's ethical conceptions of IVF. Although news articles display the irrational behaviour and inclinations to have children, the survey results suggested that patients can in fact rationalize their actions in the IVF market –optimizing the number of cycles that can be affordable by the State for instance.

In its entirety, I suggest that in the 21st century, IVF remains as a powerful technology, which influences how we make sense out of our sexuality and reproduction. It interacts with several domains of power and founds the power of its

own. The reproductive technologies are regulated by various resources and patients are the fundamental domain providing this governance. Although there are still issues surrounding informed consent, gender bias, access to services –which are results of or continuations of already existing power structures- there is a conceivable change in the way reproduction is conceptualized. The domain of biology (nature) is intermingled with culture (society) and the identities and interests are formed in a bidirectional process- on the one hand, IVF challenges the way people make sense of their infertility, on the other the understandings of maternity, gender and parenthood are appropriated to the regulations of technology. These identifications of decision making processes also signify cultural-bounded-ness. It is clear that although means of making self are similar between British and Turkish cases, there is always some space available for the reconstruction of value systems. This might in turn suggest a resistance point in itself; the technocratic societies can be resisted with the multiplication of experiences of individuals as well as collective cultural differences.

APPENDIX

Tup Bebekle Ilgili Yaklasimlar Anketi

Eğitim düzeyiniz:	
Lise öncesi	
Lise mezunu	
Üniversite mezunu	
Yüksek lisans	

Asagidaki tanimlardan hangisi dine yaklasiminizi iyi tanimliyor?	
Müslüman	
Hristiyan	
Musevi	
Ateist	

Kendinizi dindar olarak tanımlar mısınız?	
Evet	
Hayır	
Günlük yaşamınızda kararlarınızı verirken din alimlerinin sözlerini dikkate alır mısınız?	
Evet	
Hayır	

Tedavilere basvururken temel bilgilerininizi hangi kaynaklardan aldiniz?	
Doktor	
Medya (gazete, televizyon)	
Tedavi gören yakınlarınız	
Aile, akraba, arkadaşlar	
Internet	
Diğer	

Kaç aydır IVF bekleme listesindesiniz?	
6-- 12	
13—18	
19—24	
25—30	
30—36	
37 ay ve/ya daha uzun süredir	

Şu ana kadar kaç tane IVF denemesinde bulundunuz?	
0	
1	
2	
3	
4	
5	
6 veya daha fazla	

	Evet	**Hayır**	
Sizce IVF sosyal hizmetler kapsamında bulunmalı mı?			
Sağlık sigortanız olmasaydı kaç IVF denemesinde bulunabilirdiniz?			
Hiç			
1			
Sınırlı sayıda			
Maddi engelim yok			
Aşağıdaki bilgilerden hangileri sizin için geçerli?	**Evet**	**Hayır**	**Kararsız**
Çocuk sahibi misiniz?			
Tüp bebek programında olduğunuzu ailenizle paylaştınız mı?			
Tüp bebek programında olduğunuzu yakın arkadaşlarınızla paylaştınız mı?			
Tüp bebek programında olduğunuzu tüm arkadaşlarınızla paylaştınız mı?			
Tüp bebek programında olduğunuzu iş arkadaşlarınızla paylaştınız mı?			
IVF yoluyla doğmuş çocuklara sizce tüp bebek olduğu söylenmeli mi?			

Aşağıdaki seçeneklerden hangileri çocuk sahibi olma isteğinizin nedenini iyi acikliyor?	**Evet**	**Hayır**	**Kararsız**
Çocuk sahibi olmak için evlendim.			
Eşim çocuk sahibi olmak istediği için.			
Soyadımızı devam ettirmek için.			
Mutlu evlilik için çocuk sahibi olmak önemli			
Arkadaşlarımdan gelen baskı dolayısıyla			
Ailemden gelen baskı dolayısıyla			
Çocuk sahibi olabileceğimi kanıtlamak için.			
Hayatın çocuksuz anlamı yok			
Çocuksuz bir hayatin bencilce olduğunu düşünüyorum.			
Çocuksuz bir hayatın anlamsız olduğunu düşünüyorum.			
İyi bir ebeveyn olacağıma inanıyorum			
Bütün kadınların hamileliği ve doğumu deneyimlemesi gerektiğine inanıyorum.			
Çocuk sahibi olmayı çok arzuluyorum			

Çocuklu bir aile kurmak için aşağıdaki alternatiflerden hangilerini kullanabilirsiniz?	**Evet**	**Hayır**	**Kararsız**
Sağlıklı bir Türk bebeği evlat edinmek?			
Engelli bir bebeği evlat edinmek?			
Yaşı büyük engelli bir çocuğu evlat edinmek?			
Suni döllenme yoluyla bir sperm bağışlayıcısının spermini kullanarak?			
Kendi embriyonuzu taşıyacak bir taşıyıcı anne kullanarak?			

Sizce kimler tüp bebek tedavilerinden yararlanabilmeli?	**Evet**	**Hayır**	**Kararsız**
Evli, çocuksuz çiftler			
Evli, tek çocuğu olan çiftler			
Evli, iki veya daha fazla çocuğu olan çiftler			
Evli olmayan ancak kalıcı beraberlikleri olan çiftler			
Evli olmayan ancak kalıcı beraberlikleri olan, tek çocuklu çiftler			
Evli olmayan ancak kalıcı beraberlikleri olan iki veya daha fazla çocuğu olan çiftler			
Çocuk sahibi olmak isteyen her çift			
Bekar ve şu an bir erkekle beraberliği olmayan kadınlar (donor spermi kullanarak)			
Lezbiyenler veya bir erkekle cinsel ilişkiye girmek istemeyen kadınlar			

IVF işlemlerine yaklaşım:	**Evet**	**Hayir**	**Kararsiz**
IVF işlemleri hakkında yeterli bilgileri edindiğinizi düşünüyor musunuz?			
IVF işlemleri sonucunda anormal bir çocuğa sahip olacağınız endişesini taşıyor musunuz?			
Testlerde fetusta anormallik tespit edilmesi halinde hamileliğinize son verir misiniz?			
Kullanılmayan embriyolar üzerinde araştırma yapılmasını onaylar mısınız?			
Kullanılmayan embriyoların yapay organlar üretilmesi için kullanılmsını onaylar mısınız?			
Kullanılmayan embriyoların klonlama işlemlerinde kullanılmasını onaylar mısınız?			
Kullanılmayan embriyoların doğan çocuğunuzun sağlık problemlerini gidermede kullanılmasını onaylar mısınız?			
Bilim insanlarının embriyo transferi öncesinde cinsiyet seçimi yapmalarına izin verilmeli mi?			
Embriyonun tamamen insan vucudu dışında gelişmesini sağlayacak bir teknoloji olsaydı, bunu destekler miydiniz?			
IVF tedavisinden geçen çiftler sizce embriyolarını başkalarına satabilmeli mi?			
Bir kadının yumurtasını satmasını onaylar mısınız?			
Bir erkeğin spermini satmasını onaylar mısınız?			

Taşıyıcı anneler ile ilgili sorular:	**Evet**	**Hayir**	**Kararsiz**
Eğer çiftin başka bir seçeneği yoksa taşıyıcı anne kullanılmasını onaylar mısınız?			
Eğer çift sıradan yollarla da hamile kalabiliyor ama bunu tercih etmiyorsa, taşıyıcı anne kullanılmasını onaylar mısınız?			
Taşıyıcı anneler verdikleri hizmetin karşılığında para alabilmeli mi?			
Taşıyıcı anneler verdikleri hizmetin karşılığında para alabilse bu sabit bir ücret mi olmalı?			
Taşıyıcı anne doğumdan sonra bebeği elinde tutma hakkına sahip olmalı mı?			

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