

**ASSISTED REPRODUCTIVE TECHNOLOGIES: THE DISCOURSES OF  
MOTHERHOOD AND CHILDLESSNESS IN BANGLADESH**

**MST SHAHINA PARVIN**

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MST. SHAHINA PARVIN

Date of Defence: March 18, 2016

Dr. Claudia Malacrida  
Thesis Supervisor

Professor

Ph.D.

Dr. Suzanne Lenon  
Thesis Examination Committee Member

Associate Professor

Ph.D.

Dr. Kara Granzow  
Thesis Examination Committee Member

Assistant Professor

Ph.D.

Dr. William Ramp  
Chair, Thesis Examination Committee

Associate Professor

Ph.D.

## **Abstract**

By employing Foucauldian and post-structural feminist theories and the method of discourse analysis, this research examines Bangladeshi media and fertility centres' truth construction process in regards to motherhood, childlessness, and ARTs. My research shows that the examined texts construct ARTs as desirable in Bangladeshi couples' lives in four ways. First, they produce the 'truths' that motherhood is a necessity for Bangladeshi women's lives, and childlessness is a 'defect' that causes grief. Second, they construct the 'truths' that ARTs are a significant sign of the progress of medical science, and modern treatments are available in Bangladesh in order to fulfill childless Bangladeshi couples' need. Third, they suggest that IVF (In Vitro Fertilization) children are as 'normal' as children conceived without medical interventions. Finally, they produce the 'truth' that Bangladeshi fertility clinics reconcile Islamic principles in providing fertility treatments, making them acceptable for childless couples to pursue.

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## **List of Abbreviations**

ART	Assisted Reproductive Technology
BRAC	Bangladesh Rural Advancement Committee
ICPD	International Conference on Population and Development
ICSI	Intracytoplasmic Sperm Injection
FET	Frozen Embryo Transfer
IVF	In Vitro Fertilization
NCP	National Congress Party
NGO	Non-Government Organization
NRT	New Reproductive Technologies
RT	Reproductive Technologies
UNFPA	United Nations' Fund for Population Activities
UN	United Nations

## **Chapter 1: Statement of the Problem, Rationale of the Research and Literature Review**

### **Introduction**

This research examines how Bangladeshi media and fertility clinics construct knowledge about motherhood, childlessness, and ARTs. My interest in ARTs developed following the conception of the first Bangladeshi triplet test tube babies in 2001, when the Bangladeshi media began to produce the ‘truth’ of the necessity of fertility treatments in childless Bangladeshi couples’, in particular women’s, marital and social lives (Sultana, 2014). In addition, around this time Bangladeshi media began to circulate medical and scientific knowledge about women’s bodies, highlighting the necessity of motherhood for women’s wellbeing as part of fertility clinics’ advertisements.

While Bangladeshi women’s fertility is the subject of Bangladeshi government and development partners’ population control programs, infertility has become a matter of business for some clinics and doctors of Bangladesh after 2001 because only private clinics provides ART treatments (Akhter, 2010a). In this sense, dual positions are reflected in Bangladesh; on the one hand, Bangladeshi media circulates the knowledge that overpopulation is one of the main reasons for its poverty, and that therefore Bangladeshi women’s, and in particular poor women’s, fertility should be controlled (Akhter, 1992). On the other hand, the media focuses on the necessity of children in every Bangladeshi couple’s lives regardless of their class status when they speak about ARTs. These dual positions reflect how the knowledge construction of women’s bodies is contested and political.

Many feminist scholars critique ARTs because they are potentially harmful to women's bodies, and work as a technique of governance to monitor not only childless women's, but rather all women's lives (Akhter, 2010a; Shildrick, 1997; McWhorter, 2010). Further, some feminist scholars argue that ARTs have become the most profitable business in the world, wherein body parts, mostly those of women, are "commercial property" (Basen, 1993, p. 25), a process which further establishes medical and social control by replacing women's own control over their bodies (Akhter, 2010a; Lippman, 1995; Corea, 1993; Rowland, 1987; McWhorter, 2010). As Bangladeshi women's bodies have been a site of Western modern medical control for a significant period of time (Akhter, 1992; Sultana, 2014), I anticipate the growth of ARTs in Bangladesh will work to further establish the medical and social control of Bangladeshi women's bodies in order to expand the commercial reach of ARTs. In these contexts, this issue is important to explore.

### **Statement of the Problem**

Bangladesh<sup>1</sup> is a Muslim majority country of the global south, and has the highest population density of any country in the world (Rabbani, et al., 2015). In mainstream discourses, overpopulation is generally seen as the reason for its economic and political problems, and as a barrier to its economic development (Akhter, 2010a). Since 1974, the United Nations' Fund for Population Activities (UNFPA) has played a key role in ensuring the availability of contraceptives in Bangladesh. UNFPA also plays an

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<sup>1</sup> Before 1971, Bangladesh was a part of British Raj and pre-Independence India. In 1947, India was divided into India and Pakistan – Pakistan was composed of two provinces, West and East Pakistan (Bangladesh was East Pakistan) based on religions Hindu and Islam respectively.

important role in making decisions related to population control programs in Bangladesh (Akhter, 1992). The government has door-to-door fertility control services, and even offers small amounts of money to people for using long-term contraception (Akhter, 1992; Parvin, 2006). Since its inception, Bangladeshi women's bodies, in particular poor women's bodies, have been the primary sites of focus for the population control programs; some women were even used for contraceptive experiments<sup>2</sup>. However, in mainstream development discourses, this reproductive control is generally discussed and positioned in terms of women's reproductive freedom.

The conceptualization of contraceptives as key to women's freedom, empowerment, and sexual rights is linked to the United Nations' Decade of Women, which occurred from 1975-1985. During this period, women's empowerment issues received attention from international development planners, through the argument that because women were not incorporated into development programs, they did not benefit from overall development. Four world conferences were held during this decade on the themes of women's equality, peace, and development. Since the Decade of Women, women's empowerment, health, and sexual rights have increasingly been represented as

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<sup>2</sup> A five year, long-term and provider-dependent Norplant contraceptive was implanted into poor Bangladeshi women's bodies on a trial basis beginning in 1985. The women were not told that the contraceptive was implanted as part of a clinical trial. Many of these Norplant test-subjects suffered negative side effects, but the concerns were not addressed by Bangladeshi doctors. Instead, the Bangladesh Institute of Research for Promotion of Essential & Reproductive Health and Technologies states in its research related to the trial that most of the Bangladeshi women were satisfied with Norplant. This result ultimately helped the Food and Drug Administration approve Norplant for the broader market in 1990. Many feminists worldwide protested this trial, but UNFPA and the Bangladesh government continued to provide Norplant in Bangladesh until 2004. This arguably reflects how certain aid agencies ultimately work primarily for pharmaceutical companies' benefits, and play a key role in connecting the global and local economy (Akhter, 1995).

key in the development of gender equality, which has prompted most national and international agencies to include women in their development discourses (Kabeer, 2000). The third United Nations' decennial conference, the International Conference on Population and Development (ICPD), held in Cairo in September 1994 developed "a new definition of population policy," which particularly focuses on women's reproductive freedom, health, and sexual rights (McIntosh & Finkle, 1995, p. 33).

The UN conferences had a significant impact on women's development programs in Bangladesh; following the Decade of Women, foreign donors began to allocate aid for women's empowerment issues. This resulted in both government and non-government organizations focusing their work on the issue of women's right in order to access financial aid. After centuries of subordination under British and Pakistani rule, and nine months war with West Pakistan, Bangladesh achieved its independence in 1971, and since then has been overwhelmingly reliant on foreign aid. However, it is important to note that aid is a highly political resource, for both donors and recipients (White, 1992). In 1980, 55% of funds allocated for women's empowerment was invested into women's use of contraceptives in the name of women's empowerment (White, 1992).

Bangladeshi doctors have also begun to produce the 'truth' that using ARTs is a childless woman's right, as ARTs will help establish these women's wellbeing. As the Bangladeshi government's aim is to control fertility, it does not focus much on fertility treatments. Thus, in Bangladesh it is primarily private clinics that provide fertility treatments, along with a few government hospitals which provide a limited number of fertility-related treatments in Bangladesh (Akhter, 2010a). Government hospitals do not provide IVF services; therefore, patients rely solely on the private sector for IVF

treatments (Sultana, 2014). Approximately twenty fertility clinics provide fertility treatments in Dhaka, capital of Bangladesh (Sultana, 2014, p. 7). Until June 2014, only clinics in Dhaka were able to provide test tube babies to childless couples. On June 10, 2014, *The Daily Star* published news of Bangladesh's second largest city, Chittagong, producing its first test tube baby (Staff Correspondent, 2014). According to Akhter, two other districts, Comilla and Sylhet, also have a small number of clinics which offer fertility treatment services (Sultana, 2014, p. 232).

Most of the people of Bangladesh are poor and depend on public health care, because the public sector provides services at a lower cost. Middle and upper class Bangladeshi people generally use private sector health services because they do not find the treatments of the public hospitals "to be high standard" (Sultana, 2014, p. 6). Although a very limited number of Bangladeshi people can feasibly afford the treatment costs associated with IVF children, the increasing number of fertility clinics and IVF children reveals that nonetheless more and more Bangladesh people are spending money in order to have biological children through artificial means (Sultana, 2014).

It can be speculated that Bangladesh as a whole is in favour of expanding access to ARTs, as Bangladeshi society is largely understood to be pronatalist<sup>3</sup>; reproduction is often considered to be the primary goal of married life, and it is seen as one of the necessities required to continue a marital relationship (Sultana, 2014, pp. 1, 4; Nahar, 2012, p. 23). Even before marriage, women, men and their parents select marriage

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<sup>3</sup> According to Rich et al. (2011), pronatalism is "an ideology that incorporates beliefs, attitudes, and actions that implicitly or explicitly support parenthood and encourage fertility" (p. 228).

partners who they believe will be good parents in the future (Sultana, 2014). From adolescence, mothers and other family members teach girls about ‘womanly’ behaviours so that they can be ‘good’ daughters and daughters in laws. They are taught to be quiet, softly spoken, polite, caring and sacrifice-minded for the wellbeing of their husbands and families (Kotalova, 1993, p. 73). These qualities are understood as key to being good wives and mothers, thus, parents and men like to select daughters-in-law and brides who have these qualities. On the other hand, a ‘good’ son-in-law often is understood as one with a handsome income for taking care of family and children. Marriage is almost synonymous with parenthood, and perhaps even more so, womanhood is associated with motherhood. In Bangladesh, after 1980, due to the structural adjustment program of the World Bank and the International Monetary Fund, industry and the national and multinational corporate sectors have expanded, leading to women’s increased participation in employment sectors and bringing changes in women’s lives. Nevertheless, even though women’s perceptions about marriage and motherhood vary on some points, most still interpret marriage and motherhood as an essential state in their life cycles, and motherhood is considered to be their ongoing responsibility (Sultana, 2014).

Although the Bangladeshi government’s main focus is on population control program, it also strives to preserve women’s subject position as mothers, in particular suggesting that ‘perfect’ mothering involves producing patriotic children for the development of the nation. Nationalism as a political movement was primarily developed to challenge the colonial British raj in colonial India. In India during this period, formal education for girls was permitted because of its role in producing ‘patriotic’ children who were willing to challenge colonialism and work to free the motherland from the

colonizers, contributing to national development (Loomba, 2005). The same philosophy was also used for building the Bangladeshi nation; after the end of the British colonial period, Bangladesh (at that time known as East Pakistan) was colonized by West Pakistan, and the notion of Bangladeshi nationalism was developed to challenge colonization in order to achieve autonomy. Such contexts of nationalism assist in explaining how IVF proponents work to produce the ‘truths’ of the necessity of motherhood in Bangladeshi women’s lives, and encourage childless Bangladeshi women to use ARTs.

### **Rationale of the Research**

Many sociological and feminist researchers worldwide explain that despite the reality that ARTs pose tremendous harms, and are a vehicle for the medical and social control of women’s lives, fertility clinics continue to encourage women to use these treatments. Researchers argue that health professionals generally draw upon existing circulating normative discourses of motherhood and childlessness to produce the ‘truth’ that ARTs are a necessity in women’s lives, and these ideas are often echoed in media (Sultana, 2014; Akhter, 2010b; Shildrick, 1997; Franklin, 1990). These discourses of motherhood and childlessness have negative effects on not only childless women, but on all women’s lives because they are often used to judge, discipline, control, and monitor women’s lives, placing childless women in an ‘othered’ category, and by extension, positioning all women as necessarily motivated to be mothers (Sultana, 2014; Malacrida & Boulton, 2013; Sha & Kirkman, 2009; Maher & Saugeres, 2007; Franklin, 1990).



Although Bangladeshi childless women may suffer from this ubiquitous construction of motherhood as ‘natural’, very few Bangladeshi social scientists and feminists are critical of this construction or of ARTs. Instead, social science researchers and feminists often concur with the notion that motherhood is necessary in Bangladeshi women’s lives, going on to propose a health policy for democratizing fertility treatments services (Nahar, 2012, p. 24).

My research takes an alternative approach in its interrogation of Bangladeshi media and fertility centres’ constructed knowledge of motherhood, childlessness, and ARTs. I undertake a Foucauldian analysis because it provides a model by which to examine how Bangladeshi media and fertility clinics construct ‘truths’ about motherhood, childlessness, and ARTs, and how health professionals’ power works on human bodies. A Foucauldian approach provides me with the tools to examine how the human body is both a site of power and a cultural construct; how people are formed, regulated, and take up these norms; and how socially normative behaviours act as a site of social control by encouraging people to follow these norms. I utilize a feminist post-structural approach because this approach does not presume that human beings’ identities are ‘natural’, but rather informs us that human beings’ identities are historical, economic, and political constructions (Butler, 1999, p. 3). This approach further sustains the position that medical science is a site for the material and discursive production of gendered bodies (Shildrick, 1997). Given these approaches, discourse analysis is an appropriate method to examine the discursive construction of knowledge about motherhood, childlessness, and ARTs. This research will further develop our understanding of the representation of, and construction of knowledge about women’s bodies, the social regulation process, and

women's social status in Bangladesh, which are all areas where current research is lacking.

## **Literature Review**

My research has been informed by literature about representation, motherhood, childlessness, and ARTs from both Bangladeshi and international contexts. This literature encompasses discussions of how national, religious, and cultural aspects are embedded in the representations of motherhood; how motherhood is imperative for the continuation of lineage; how a biological child is seen as necessary in conjugal lives; economic aspects of motherhood and childlessness; why childlessness is stigmatized; how motherhood is constructed as the fulfillment of heterosexual women's lives and how this materializes women's own self-policing and desire; how childless women resist and cope; and how ARTs potentially cause harms to women's bodies. These considerations are crucial in developing my research questions - which I will outline later in this chapter in my research question section - and I will discuss each of them in turn.

### **National, religious, and cultural aspects of representations of motherhood.**

A significant number of researchers have argued that understandings and representations of women's subject position as mothers serve the state's interests (Loomba, 2005; S Anandhi, 1998; McClintock, 1995). Remennick (2000) and Haelyon (2006) explain that in Israel women are highly encouraged to reproduce because of the settler colonial imperative of the Israeli state. Remennick notes that childless Israeli women often leave their jobs and may continue fertility treatments for a long while for

the sake of genealogy and the nation. Haelyon in her study found that in addition to cultural ideologies, myths, and religious texts, Israel's policies reflect a reproductive imperative for heterosexual women because, "Israel is the only country in the world" where all kinds of New Reproductive Technologies (NRTs) are subsidized by "the national health insurance system," and "every woman, regardless of her marital status, is eligible for unlimited rounds of IVF treatments free of charge" (p. 181).

Loomba (2005) examines how Indian national leaders tried to preserve women's subject positions as wives and mothers when the British administrators attempted to impose their cultural systems by banning sati and introducing women's education in India. She notes that, while colonial administrators introduced girls' education systems, many Indian national leaders protested against women's education in the beginning because they perceived that educated women might ignore their household and motherhood responsibilities. Conversely, women's rights to education were granted by arguing that it might help women to be good wives and mothers, as Indian nationalist leaders often believe that good wives and mothers are the characteristics of Indian 'ideal' women (Loomba, 2005).

In post-colonial India, motherhood is still understood to be women's main responsibility. In this regard, S Anandhi (1998) discusses that in India, when the Malthusian League<sup>4</sup> introduced a population control program in 1960, there was

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<sup>4</sup>The Malthusian League, a British organization, warned people about the dangers of population growth in the world. According to Malthus, population growth is faster than food supply; therefore, there should be a balance between population growth and production of food in ensuring food security and reducing poverty in the world. In the beginning of the twentieth century, many western-educated indigenous elites of India introduced Malthus' theory to construct fear of over population in India and they

significant debate and protest from the Indian National Congress Party<sup>5</sup> because the party focused on self-control and Brahmanic rules as control of fertility. Their opinion was that women's sexuality is only for reproduction and not for sexual enjoyment. By being good mothers, women would be ideal and would become Goddesses. If they used contraceptive methods, they would be like prostitutes. Puri (1999) also explains that women in Indian culture still attain 'good' girl status through marriage and motherhood. Marriage is considered as a woman's responsibility for her family and for the nation, and women often give birth within a short time after marriage. Women's security mostly depends upon their marital and motherhood status in their in-laws' house, and they are often pressured to engage in mothering and household care instead of concentrating on their careers.

The mythical elements of Hinduism in India also highlight motherhood as a divine virtue. Bradley (2011) examines the religious mythical texts of three Hindu missions and argues that the Hindu missions often focus on women's mothering and other domestic responsibilities through their education curricula and religious mythical texts. The aim of the missions is to educate women because they believe that women's education is the key to educating the whole nation and promoting the Indian culture and religion. Mothering and nurturing are understood as important for "the next generation of Hindu nationalists who will fight for a unified India" (p. 162). Bradley argues that the

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prescribed birth control method as a solution to control over population and for their food security and poverty reduction (S Anandhi, 1998; Nangia & Jana, 2010).

<sup>5</sup> The Indian National Congress Party led the movement against British colonization.

missions portray motherhood as a divine characteristic which includes caring and nurturing qualities, and proclaim that, through motherhood, a woman can be a Goddess.

The preceding discussion about motherhood, nationalism, and religion in the Indian context is pertinent to understanding the context of Bangladeshi women's lives, social status, and normative responsibilities because Bangladesh was a part of India until the end of the British colonial period, and people of Bangladesh are attached to India politically, economically, and culturally. Similar to Hinduism, Islam encourages motherhood by giving high status to mothers in Bangladesh. In Islam, offspring are instructed to love and respect their mothers in order to enter Heaven. There is a belief in Bangladesh that women whose three infants died will enter Heaven.

In Bangladesh, women's maternal nature and sacrificing image are highly valued. The socialization process encourages Bangladeshi women to be patient and calm, and do their best for their husbands' wellbeing; these are usually formulated as 'ideal' virtues of women. Girls are generally taught from their childhood that their status is inferior compared to boys, and their security is often ensured by their husbands or their nearer male relatives, which leads them to be dependent on men mentally and socially (White, 1992; Chowdhury, 2004; Nahar, 2012; Kotalova, 1993). Bangladeshi people often believe that women's economic and social security is ensured by their marriage and that women should get married at least once in their lifetime. To indicate how deep this belief goes, girls with severe disabilities are often married at least once and widowers and extremely poor men are selected to marry girls with disabilities (Kotalova, 1993). In this way, marriage to someone deemed socially undesirable is seen as preferable to remaining single for women. If adult daughters remain unmarried, parents and unmarried adult

daughters often feel guilty. Bangladeshi people generally believe that arranging marriage for girls is “a divine command” and if girls are not married they are understood as immoral (Chowdhury, 2004, p. 247).

Although overall residence patterns have changed in Bangladesh due to urbanization after 1980, in that many couples now relocate to urban areas to find jobs and establish nuclear families, after marriage Bangladeshi women are still generally shifted to their husbands’ houses (Chowdhury, 2004). These situations make women socially dependent on their husbands and lead them to follow their in-laws and husbands’ directions in order to make them happy. It is often argued that Bangladeshi women should do everything to ensure the continuation of their marriage. There is a proverb in Bangladesh that it is a woman/bride who can make a family happy, and the continuation of marriage is mostly dependent on women’s virtues. Even if a husband exploits wife, it is said that the wife should have tolerance. Divorce is not seen as positive in women’s lives because it indicates a woman’s failure and a divorced woman often becomes more economically and socially vulnerable (Parvin, 2015).

After marriage, women are often seen as strangers in their in-law’s houses. Women need to prove their potentiality for bringing prosperity to the house, and the best way of proving their usefulness is by giving birth to a child. If they fail, they become permanent strangers (Kotalova, 1993). In rural areas, if women are incapable of giving birth to a child, their husbands often divorce them, or bring in co-wives. In that case, the childless women do not have any authority in the house; generally, they do not have sexual relations with their husbands and their husbands do not like to bear their living costs (Nahar & Richters, 2011, p. 335). Urban childless women often do not face marital

disruptions and physical torture, but they also have fear of abandonment because there is the pressure of the extended family on their husbands to marry a second wife in order to have children. These factors exert tremendous pressure, making women desperate to be mothers.

### **The imperative of motherhood for lineage.**

In addition to the necessity of preserving culture and nation, motherhood in Bangladesh is often seen as vital for the continuation of lineage (Geest & Nahar, 2013; Sahinoglu & Buken, 2010; Inhorn, 2011). In this regard, Geest and Nahar (2013) state that people in Ghana and Bangladesh want children because they wish to stay alive after their death through their children; they think that their children are their “successors who carry [their] objects and thoughts into the future” (p. 6). Thus, childlessness is understood as a threat to the continuation of lineage.

The authors argue that in both Ghana and Bangladesh children give meaning to couples', and particularly to women's lives. In Ghana, if a couple is not able to have children, the husband and wife permit each other to try elsewhere. Conversely, Nahar and Geest (2014) state that even though Bangladeshi childless women are permitted to divorce, women are unlikely to leave their husbands and remarry to reproduce. Women often stay with their infertile husbands and hide their husbands' incapability to produce children. The authors suggest that women often stay with their infertile husbands because wifehood gives more prestige to women than abandonment or divorce. Ghanians have another solution for the childless couple, in that the sister gives one or two children to the childless sister and the children discover this much later in their lives. There are many

stories about good relationships between children and their foster mothers. In Ghana, this next-of-kin adoption is possible because biological connection is deemed to be less central than in Bangladeshi society. However, like in Bangladesh, childless Ghanaian women also interpret their lives as barren and empty, and often feel loneliness (Nahar & Geest, 2013).

Sahinoglu and Buken (2010) also discuss the importance of the process of lineage in the context of Turkey, another Muslim-dominant country. They argue that if Turkish women are not capable of conceiving, their traditional practice, the “kumalik” system, gives men the right to take a second wife for the purpose of having a child. This system places significant pressure on women, because they often feel they must permit their husband to re-marry for the purpose of having children. In this regard, Sahinoglu and Buken suggest that ARTs are a better solution for infertile women, but the law and regulation of ARTs is often a barrier for women who wish to access the services. In Turkey, only married couples can access ART services, and further, “it is forbidden to store fertilized cells and gonadal tissue except when it is medically necessary to do so” (p. 228). Moreover, as the genealogy of a child is legally significant, sperm donation is prohibited. Overall, the health insurance system of Turkey does not encourage women to access ARTs, and ultimately few people receive benefits to access the treatment services.

Sahinoglu and Buken (2010) argue that ART laws and regulations are problematic because they do not help all women fulfill their desire to have children. They suggest that not only married women, but also single, unmarried women who wish to access ARTs should have access, because this availability works to further establish human rights and reproductive justice. The aforementioned discussions reflect how discourses on ART



access can work to produce the ‘truth’ that women’s fulfillment depends on producing biological children. Given this context, in my research on Bangladeshi discourses relating to ARTs, I examined how Bangladeshi doctors convey the importance of lineage, and deploy discourses of human rights and reproductive justice issues, in encouraging ARTs.

Inhorn (2011) discusses how the continuation of lineage is important, and how it is maintained in Iran and Lebanon even when ARTs are used by a childless couple. She notes that, in Iran, there are two divergent sects: Shia and Sunni. The Sunni Islamic position permits in vitro fertilization (IVF) within a husband-wife relationship, but no third party is allowed into the marital functions of sex and procreation for “providing sperm, egg, embryos, or a uterus (as a surrogacy)” (p. 95). Sunni Muslims adhere to the religious prohibition on gamete donation because they believe that it may create “half-sibling incest” and most importantly, it “confuses the kinship, paternity, descent, and inheritance [of ] the patrilineal societies of the Muslim Middle East” (p. 95). The argument continues that this type of intervention is considered “immoral” and “psychologically devastating,” and the child may “be deemed illegitimate and stigmatized in the eyes of its own parents, who will lack the appropriate parental sentiments” (p. 95). These authors argue that Arab men believe that, like adopted children, the donor child would not be of their own paternity.

Many Shia religious authorities support the majority Sunni view, but, in Iran, where the majority of Muslims adhere to Shia Islam, the Supreme Leader of the Islamic Republic of Iran began to permit donor technologies in the late 1990s. Nevertheless, the donor and infertile parents must abide by strict religious principles regarding parenting so that the inheritance will go to the donor of the egg and the infertile couple are interpreted

as “adoptive parents” (Inhorn, 2011, p. 95) and in addition, the donor child is mostly perceived as socially unacceptable. Iran does not allow sperm donation, but surrogacy is permitted and widely practiced. In order to get access to sperm, Iranian women temporarily divorce their infertile husbands and marry the sperm donor. After having a successful pregnancy, they end the temporary marriage and remarry their infertile husbands. The donor technology is described as a “marriage savior” as it helps the couple avoid marital and psychological disputes (p. 96). Lebanon is another country in the Muslim world where these practices are allowed. The aforementioned discussions reveal how ART discourses and practice draws upon religious doctrine concerning birth and lineage, taking up and reproducing the normative ‘necessity’ of maintaining couples’ lineage. The ‘truth’ that it is women’s responsibility to save marriage is also implied in this discourse. Moreover, the prohibition of sperm donation produces the ‘truth’ that patriarchal lineage is critical in Iran and Lebanon.

Similar to Inhorn (2011), Sultana (2014) discusses the practices of egg and sperm donation and surrogacy in the context of Bangladesh. Sultana (2014) notes that her respondents do not want to use a donor or surrogate as they perceive that children born through these means are akin to adopted children, and will not be their own biological children. Bangladeshi women often perceive that taking donor sperm is like “committing ‘infidelity’” (Sultana, 2014, p. 215). They do not like that their husbands’ sperm enters into other women’s wombs, and they are not comfortable with the idea that their children gestate in other women’s wombs. Sultana (2014) explains that these perceptions come not only from a religious prohibition, but also from social conventions that offspring should not be born outside of the marital relationship; most of her respondents affirmed

this socio-religious discourses of marriage and parenthood (pp. 215, 216). Sultana's research also shows how producing one's own biological traits and the continuation of lineage are considered critical in Bangladesh. In my study, I specifically examined the ways that lineage is used to support the idea of ARTs in newspaper articles, video clips, and ART client information packages.

### **Economic aspects of motherhood and childlessness.**

While my approach is not Marxist, it is important to explore the potential ways that economic and productive ideas about children might play into the discourses deployed in support of ARTs. Friedrich Engels (1909) discussed the economic imperatives attached to having a biological child in a capitalist system, arguing that the introduction of private property emphasized the necessity of the biological child. Engels notes that, in the absence of private property, women's and men's work supposedly had equal social value and worth; their domains might have been separate, but this did not mean that one was more highly valued than the other. He argues that the domestication of animals and the development of agriculture originated the possibility of surplus and this was concentrated in the hands of men, who then started to transfer their property to their male offspring. Thus, the monogamous family became essential to ensure the paternity of children.

Roy (1998) discusses how women's mothering and nurturing roles benefit capitalism in the context of India. He examines the political and economic aspects of advertisements on Indian main television channels, and claims that capitalism targets women as its prime consumers. Roy argues that the advertisements construct the

ideological split of private and public domain wherein the public domain of work has been constructed as the space of masculinity and power, while the private domain of the household is constructed as associated with femininity, moral value, and support. The advertisements propagate the idea that women are more nurturing and caring than men and have a 'natural' talent for mothering and managing the home (Roy, 1998, p. 130). In the advertisements, women are represented as holding power in the household sphere; they are the planners for buying a variety of products and are very fulfilled by their status. Roy suggests that the repetitive representations of women's subject position as housewife and mothers encourages viewers to accept these images beyond question, which ultimately helps capitalism because women's mothering role ensures the reproduction of labourers, while domestic work supports husbands for the workplace (p. 131). The above discussions are crucial in understanding how economic aspects of advertising might be used in the discursive constructions of the imperative of motherhood in women's lives.

Nahar (2012) also explains some of the economic aspects of motherhood and consequences of childlessness in rural poor and urban middle class Bangladeshi women's lives. She argues that after marriage Bangladeshi women's potentiality mostly depends on giving birth to a child in both the poor and middle classes; however, childless rural poor women encounter more consequences than childless middle class women (p. 335). If rural women are incapable of giving birth to a child, their husbands often divorce them because childless wives are considered to be an economic burden to their husband as well as their parents. The abandoned women usually go back to their parents' houses; therefore, the parents' economic investment (e.g. dowry) for their daughter's marriage

comes to be seen as a waste. If their parents want their daughters to remarry, they must often invest more money for their divorced daughters than their unmarried daughters. Moreover, the custom in divorce is that husbands return the dowry, but in the case of childless women, husbands are not obliged to do so. It is understood that, as the wives are considered to be lacking, the husbands are able to remarry, and it is not seen as a crime to keep the dowry.

Nahar (2012) discusses that childlessness can be the cause of poverty in rural areas because in the family husbands are often the main earners, and children, particularly boys, are parents' supplementary earning hands. Childless couples lose this earning source and rural childless women are restricted in their contributions because women's work outside the house is understood as a matter of shame for husbands. Additionally, husbands do not like childless women to work outside the home as they often believe that other men can approach childless women because infidelities can be hidden more easily than with fertile women. It is hard for childless rural and poor women to get economic support from their relatives, and even to get a loan from the bank. Their status is understood to be so vulnerable at the institutional level that they are often refused micro credit. The institutions discourage childless women from taking loans as they think these women may be abandoned by their husbands at any time, and may default on their loans. Conversely, childless men often lose interest in bringing prosperity to their lives, as they think that without children there is no meaning to wealth, and they often ignore their responsibilities to provide food to their house. However, urban middle class women's husbands sometimes become more dedicated to their work so that they can pay the cost of fertility treatments.

Nahar's (2012) research findings are rich in insights about the patterns and variations in the economic consequences and experiences of childless Bangladeshi urban and poor women and men. However, most of her analysis is descriptive. When she uses theory, Nahar's analysis mostly follows development theories, and she posits that motherhood is necessary for women's lives, and children benefit women and couples economically. Conversely, my research has examined how economic aspects of ARTs are associated with the 'truth' construction that motherhood is essential for Bangladeshi women's lives.

### **Childlessness as a matter of shame and stigma.**

In a foundational study of childlessness, Jean Veevers (1980) argues that childlessness was understood as problematic in North America because the traditional belief was that giving birth to a child is "a duty to God, church and country" (pp. 4-5). Subsequently, childless couples were treated as immoral and irresponsible, and they were seen to lack 'normal' mental health, maturity, and wholeness. All these constructions of childlessness as lacking and problematic generally justified a wide range of negative reactions to the childless couple in North America (Miall, 1986). These beliefs influenced childless women particularly to think that they were physically, psychologically, morally, and emotionally inferior to others (Miall, 1986, p. 395). In her foundational work on the topic, Veevers (1980) argued that childless North American women generally felt inferior to others, they often avoided social gatherings and became lonely, isolated and increasingly focused on their misfortune.

However, the experience of childlessness was not homogenous. Miall (1986) notes that women sometimes faced fewer challenges if their husbands had infertility problems. If women were infertile, they often faced extreme negative attitudes such as physical violence from their partners. On the other hand, some scholars state that women are often blamed for the cause of infertility, even if the male partner is infertile (Rich et al., 2011; Remennick, 2004; Nahar & Richters, 2011). Women are blamed because they often do not want to disclose their husbands' problems since sexual potency is a negative reflection on men's ego and masculinity, and men's infertility is more stigmatized than women's (Miall, 1986; Remennick, 2004; Nahar & Richters, 2011). Moreover, men's damaged masculinity also causes stigmatization to women. In this context, women are understood as liable for their male partners' mental well-being (Remennick, 2004).

Although Miall (1986) and Veevers's (1980) studies were conducted over thirty years ago and they discuss stigma and experiences of childlessness in the very general context of North America their discussions are informative to my research to explore what reasons doctors depict to explain childless Bangladeshi women's stigmatization. Nahar and Richters (2011), who research Bangladeshi childless women, argue that in rural areas Bangladeshi people often do not like to start their day by seeing childless women's faces as they are interpreted as a sign of bad luck. In rural areas, poor, childless women are not allowed to go outside the house, even if they need to urinate in the morning, and they are not allowed to attend certain ceremonies. There is a proverb in Bangladesh: "Even a fox or a dog does not eat the dead body of a childless woman" (p. 331). These authors state that in Bangladesh, childlessness is often understood as God's punishment, and this belief leads women to feel helpless because they often perceive that

no one is with them, and Bangladeshi women often encounter physical or verbal violence from their partners and in law (Nahar & Richters, 2011).

### **Motherhood, fulfillment of women's lives, and self-policing.**

Some researchers are critical about the media's representations of the naturalization of motherhood in women's lives (Hadfield et al., 2007; Sha & Kirkman, 2009; Douglas, 2005). Hadfield et al. (2007) and Douglas (2005) examine the media's representations of motherhood and childlessness in the context of the United Kingdom and America, arguing that the media has not moved away from normative cultural discourses associated with femininity and motherhood. The media still highlights motherhood as women's 'natural' and 'normal' desire and portrays childless women as 'selfish', and 'irresponsible'. Douglas (2005) explains that, in America after 1970 the media has highlighted the notion of "new momism," which includes a set of standards, norms and performances that communicate messages about an intensive motherhood that occupies a "higher moral ground" (p. 12), that pushes a woman to compete with other women and excludes those mothers who do not follow the 'standard' behaviours of a mother. Magazines also emphasize celebrity women and give the message that celebrity women's lives are fulfilled by giving birth to a child, and that having "children is the most joyous and fulfilling experience in the galaxy" (Douglas, 2005, p. 8).

Malacrida and Boulton (2012) discuss that the discourses of motherhood not only affect child rearing, but they also intersect with pregnancy by prescribing how pregnant women should maintain a healthy mind and body, and be informed and vigilant to ensure a safe pregnancy. These discourses not only disciplines pregnant women but also post-pubescent girls' lives, as doctors often prescribe post-pubescent girls vitamins that



include folic acid and caution them to avoid smoking and drinking, telegraphing that all women are “perpetually potentially pregnant” (p. 750). Taking good care of one’s body during pregnancy is also connected with the notion of ‘good’ and ‘bad’ pregnant women. Women often are influenced by the discourses of ideal, safe, and ‘perfect’ motherhood, which leads to self-policing. Sha and Kirkman (2009) state that in Australian media, motherhood is not only portrayed as a ‘natural’ and ‘normal’ necessity of women’s lives, but also as women’s social destiny and national duty (p. 365). Similar to Malacrida and Boulton, Sha and Kirkman note that women’s asexual appearance, modest dress, family bonding, and heteronormativity are also discussed and policed during pregnancy.

From the above discussion, we can see that pregnant women are often not considered to be individuals, but rather as carriers of the foetus. This perspective not only neglects women’s needs, but also suggests that women may be penalized if they refuse obstetric care or are involved any kind of activities that may hamper the growth of foetuses. In order to be assured of the foetuses’ ‘perfect’ growth, screenings - some of which are harmful for mothers and foetuses’ health - are often prescribed for pregnant women (Lupton, 2012; Mutman & Ocak, 2008). In my research, I discuss how certain Bangladeshi media and fertility centres represent heteronormativity when they encourage ARTs. I also discuss the ways certain media and fertility clinics emphasize women’s maternal destiny, ignoring the risks attached to motherhood and to medical interventions such as ARTs.

### **Childless women's agency.**

Nahar and Geest (2014) discuss Bangladeshi childless women's agency, resilience and resistance in their study. They define agency as an individual's ability to position themselves against structure, resilience as an individual's ability to cope with their marginalized situation, and resistance as the active response to their adverse situation. Resistance and resilience are considered parts of the individuals' agency. They explain that childless poor Bangladeshi women face various obstacles from their husbands and in-laws in accessing infertility treatments. For instance, childless poor Bangladeshi women's mobility is highly restricted in their in-laws' houses; husbands and in-laws often do not want to bear the cost of infertility treatments, and they often abuse these women. However, childless poor Bangladeshi women often secretly save and sell food for the cost of their treatments which indicates their agency, according to the authors.

As discussed earlier, Bangladeshi men often remarry and divorce if their wives are not able to conceive. Due to fear of abandonment from their husbands, childless poor women are often silent about their oppression because their silence often preserves their right to stay in their in-laws' houses. Nahar and Geest (2014) understand these attitudes as women's coping strategies in their vulnerable situations. The authors explain that childless poor women often go to traditional healers for their treatments, which benefits women by providing hope that the childless women may conceive. In turn, the childless women tell their husbands that the healers have given them hope that they may have babies, which is used to discourage the husbands from remarrying and divorcing them. The authors define these activities as the women's agency.

Nahar and Geest (2014) explain that childless women also use their agency by involving themselves in socially-valued caring work, such as, cleaning, cooking, and taking care of elderly relatives and neighbours. Additionally, childless women also actively resist the negative attitudes towards them by ignoring people and their comments about their childlessness. The authors follow James Scott's (1985) concept of "weapons of the weak" to analyze childless poor women's resistance, noting that these actions may not change the women's life status, but they may help them to cope. Conversely, they discuss that although middle class women dedicate themselves to attempted motherhood for the first few years of marriage, if they are not successful, they are able to involve themselves in their careers in order to cope with the situation, and they also build personal strategies to avoid questions from people regarding their childlessness (Nahar & Geest, 2014).

Sultana (2014) also found that, in Bangladesh, the discourses of marriage are linked with motherhood; middle class women often interpret that motherhood is a 'normal' expectation within marriage, and women often use infertility treatments. Nonetheless, she observed different attitudes of couples in their marital lives. A few of her respondents explain that they did not prioritize having children for the first few years of marriage for various reasons, such as the husbands' family responsibilities, the couples' financial status, and also because of their career paths. A few childless women even mentioned that they were childless not for biological reasons but because they did not have good sexual relationships for various reasons, including the interference of in-laws. They mention that, without sexual satisfaction, they did not want children. Sultana notes that these women are not victims in their conjugal life, and "they challenge the

normative understanding that having children strengthens the marital bond” (p. 152). Nevertheless, these women could not divorce their husbands as they have some duty to their extended families. Sultana explains that this tendency indicates that they prefer to “reiterate the normative gender roles of wife, daughter and daughter in law” (p. 151).

A number of researchers also discuss women’s agency and choice in using Reproductive technologies (Sultana, 2014; Malacrida & Boulton, 2013; Thorsby, 2004) Thorsby (2004) examined the relationship between gender and technology, and found that although ARTs are not neutral – they can and often do have subjugating and disciplining effects on women bodies – women are not passive, but rather they actively select ARTs within available options. In line with Thorsby, Sultana (2014) also explains that Bangladeshi women are not simply objects of medical science, but rather they use technology actively despite its potentially disciplinary function. Nonetheless, Sultana also notes the complete medicalization of reproduction, which draws on, affirms and naturalizes the construction of women’s desire for motherhood status, including their use of ARTs.

Malacrida and Boulton (2013) also discuss how medical science influences women to be active in gathering and assessing the available information about pregnancy. They argue that women in many Western countries are responsible for choosing a birthing model – either medical or natural – and they are charged with collecting and assessing vast information about the risks and solutions attached to those choices. The notion of risk during pregnancy leads women to go to the hospital, yet once they enter into hospital, they often are made to choose serial interventions despite their originating wishes to avoid intervention. The women in their study agreed to follow their doctors’

intervention for the well-being of their babies, but they were provided little real information during their decision-making process. The authors, therefore, posit that it is problematic to assume that women have real autonomy during their labour. Rather, women are responsible for well-informed choice and risk management within a closed medical system, and informed choice and risk are used as tools of bio-power. This argument is crucial for my study in understanding how Bangladeshi health professionals encourage women to be active consumers in the modern medical system, and how the Bangladeshi media conveys messages about women's choice and freedom about their reproductive health.

### **Representations of ARTs and motherhood.**

Medical professionals' roles and strategies for expanding ART usage have also been explored by researchers in terms of how medical and psychiatric publications act to pathologize decisions to remain childless, portraying infertility as 'failed femininity', and something that will cause great sorrow or frustration (Hadfield et al., 2007; Okaly, 1980; Franklin, 1990). Franklin (1990) discusses how, in England, the media has discursively been producing knowledge regarding infertility to encourage childless couples to use ARTs. She argues that discursive claims are selective and they shore up the normative gendered order, where women are naturally meant to desire children and children are naturally positioned as the progeny of heterosexual, married couples. Franklin argues that the media and gynaecologists emphasize biological kinship and family, construct infertility as a biological problem, and place the solution to this problem in the hands of gynaecologists and other specialists. Popular media and health professionals also convey messages about when and how people should reproduce and which genetic characteristics

they should reproduce, which influences people's perceptions. Lippman (1993) in this regard explains that medical professionals categorize the notion of the 'normal' and 'abnormal' body, they then develop technologies to fix the perceived 'abnormality', and these technologies influence individuals' values and attitudes regarding health and diseases. The author addresses this process as "geneticization," which is expanded by prescribing genetic screening and ultrasound examination to check the 'abnormalities' of the foetuses (Lippman, 1993, p. 42). Lippman argues that all these technologies are imposed on women's bodies and are painful for women's lives.

McWhorter (2010) argues that Reproductive Technologies (RTs) such as prenatal screening and ultra-sonograms are used to select for certain gendered and ableist traits in offspring. Counselors provide information to pregnant women about the probable disadvantages of babies with disabilities. They encourage women to use prenatal screening and ultra-sonograms, conveying that woman can give birth to a 'perfect' and desired child through this technology. McWhorter discusses that in a neoliberal economy, children can be interpreted as a commodity who will contribute to their parents' utility by serving their pleasure and security in their old age (p. 58). This expectation may lead parents to use reproductive technology to enhance their children's intellectual and physical ability in similar ways to how they seek to develop their children's skills by investing in their education and training for the market economy. In Bangladesh, children's success is also interpreted as the parents' – and specifically women's – success, and women thus work hard to invest in their children's skill development. Moreover, as the Bangladeshi government does not provide support to people in their old age, and, culturally, children – specifically, male children – are expected to take

responsibility for their parents and parents often depend on their male children in their old age (Nahar & Richters, 2011). In this context, male children are often desirable to parents. Although male children do seem to be more highly-valued in Bangladeshi culture, Bangladeshi media and fertility clinics' discourses were, in my research, surprisingly gender neutral, implying that *any* baby has the capacity to enrich women's lives.

### **Critiques of ARTs.**

A significant number of feminist scholars critique the encouragement of ART access because ARTs are potentially harmful to women's bodies and the treatments are costly and involved (McWhorter 2010; Akhter, 2010a; Shildrick, 1997; Corea, 1993; Lippman, 1993). Feminist scholars argue that many poor women's body parts are used and sold in the open market of ARTs, and realistically, few women are financially able to bear the cost of the treatments (Akhter, 2010a; Corea, 1993). Corea (1993) argues that pregnancy becomes commercial in modern societies because women's desire for having children is used to create profits by offering selective and desired characteristics of babies in addition to curing infertility, and it justifies all types of experimentation on women's bodies. Corea explains that individuals cannot decide the process, but rather, "doctors, scientists, lawyers, politicians and ethicists" monitor the use of these technologies, including who can use those technologies, and when and how can they be used (p. 28).

Corea (1993) and Lippman (1993) are critical of New Reproductive Technologies (NRTs) because these technologies are used to select who will be born in the world, eliminating the fetuses deemed as unworthy. Corea (1993) argues that the goal of

providing prenatal care for all women still has not been achieved, whereas screening for “all fetuses with Down syndrome” has become key in medical science (p. 18). Corea claims that “the public discussion of the NRTs and of genetic engineering is also engineered” because industry has become very successful in controlling this information (p.18). The medical interpretations of NRTs do not include detailed information about the ethics and risks of this technology.

Corea (1993) further argues that IVF is very harmful for women’s bodies; it is a kind of technological experiment and the failure rate is high. In her estimation, this technology damages women not only physically (she notes that due to super-ovulation, many women have died), but also emotionally. However, when ethical issues related to IVF are discussed publicly, women’s suffering is not taken into consideration, in part because in the United States and Britain, public discussions around ARTs are controlled by the reproductive industry. Corea further argues that, rather than understanding ARTs as abusive and experimental, they are promoted as treatments and the manipulation of eggs and embryos is promoted as “care and cure” (p. 24). The limiting of this kind of information is problematic in terms of “informed choice”, and Corea wants to disrupt this technological intervention on women’s bodies to protect women (p. 21).

Shildrick (1997) and McWhorter (2010) are also critical of ARTs, arguing that they are harmful for women’s bodies. They explain that ARTs – particularly IVF – can cause ovarian cancer due to super-ovulation, infection, bleeding, and punctured fallopian tubes. They argue that it also encourages women’s imperative to procreate and re-establishes gender responsibility in the name of women’s wellbeing. They criticize the idea that IVF can cure women’s infertility problems because they claim that it is often



women who are fertile who conceive through IVF because this technology helps weak sperm to penetrate an egg. Thus, the typical narrative of medical science that IVF cures women's infertility is actually sexist and obfuscating. Raymond (1987) also argues that, in the name of women's choice and benevolence, reproductive technologies confirm women's reproductive subject position. Raymond notes that the message about ARTs as beneficial for women is confusing because once women enter into fertility treatments, their bodies undergo lots of invasive and painful tests. Raymond discusses that ARTs ensure and extend medical intervention in women's bodies, which has "begun with the nineteenth-century establishment of the specialities of gynaecology" (p. 12).

Similarly, Rowland (1987) notes that within the context of a complete medicalization of reproduction, it is hard for women to say no to reproductive technologies, which eventually proliferates men's control of the reproductive process. She argues that medical science often possesses and extends the patriarchal ideology of the necessity of motherhood in women's lives, as new reproductive technology mostly focuses on women's reproductive capabilities. In my study, I explore how Bangladeshi media and fertility centres take up or undermine patriarchal norms. I will also examine how Bangladeshi media and fertility centres convey their messages about IVF, its potential benefits and harms, and how these messages address or elide discussions of risk and danger.

## **Research Questions**

In my exploration of the ways Bangladesh's fertility centres and media discursively construct motherhood, childlessness, and ARTs, my key questions draw and expand upon the above literature. This research asks:

1. How is the 'truth' of the necessity of biological children in Bangladeshi women and couples' lives produced in the examined research newspaper articles, video clips, and ART client information packages?
2. How is the stigma and grief associated with childlessness used in this discourse?
3. How is knowledge constructed about male and female infertility?
4. How are the costs, potential harms, and benefits of ARTs in women's and couples' lives constructed and conveyed?
5. How are national, religious, and cultural aspects deployed in the discourses of motherhood?
6. Finally, how are the political economy and entrepreneurial aspects of ARTs constructed?

## **Conclusion**

In Bangladesh, marriage is generally understood as women's destiny, and the continuation of marriage often depends on motherhood. Bangladesh is a patriarchal and Muslim-dominant state where capitalism and the paradigm of medical science have been flourishing. Islam, capitalism, and medical science all together normatively coalesce to

affirm the necessity of motherhood in women's lives. This places childless women as the 'othered' category and results in tremendous suffering in women's lives. In the literature, it is clear that ARTs contribute to and strengthen the discourses of the necessity of motherhood in women's lives despite being costly, harmful, and painful, and contribute to sustaining gendered inequalities. In my research, through an examination of Bangladeshi newspaper, television and fertility centre discourse, I interrogate how these cultural and normative orders are used to discursively construct knowledge about motherhood and childlessness. In so doing, I employ Foucauldian theory and post-structural feminist theory. In the next chapter, I will discuss how Foucauldian and post-structural feminist theory has helped me to understand the constructed and political nature of motherhood and childlessness. Furthermore, the next chapter will address the methodology of my research.

## **Chapter 2: Epistemology and Methodology of the Research**

Epistemology “is a process of thinking. The relationship between what we know and what we see. The truths we seek and believe as researchers” (Lincoln, Lynham & Guba, 2011, p. 103). In order to answer my research questions and analyze the data, I have employed Foucauldian and post-structural feminist theories because these theories identify the body as a site of power and as a cultural construct, focusing on micro-level, intimate operations of power in day to day life. Furthermore, these theories explain how reality is constructed, how it is presented to us, how we are produced by and contribute to it, and how discourses have the capacity to produce and reproduce certain normative values (Foucault, 1972; Mills, 2004).

### **Foucauldian Theory**

Foucault’s (1972) discussions about ‘truths’ help me to understand the ways Bangladeshi media and fertility centres rationalize ‘truths’ about motherhood and childlessness in ART news. Following Foucault, I understand that the ‘truth’ about the necessity of motherhood in women’s lives is a political construct, a result of the complex historical process and socially constructed rules through which this idea comes to be understood as true. Foucault (1972) explains that both the production of truths and their effects are complexly intertwined with power relations. Foucault argues that facts cannot tell us about truth and falsehood because what is deemed a fact is shifting in nature because it is determined by its particular domain (Hall, 2007).

Foucault’s (1972) theorizations of power as that which works in local, micro level interactions and is dispersed throughout the social systems is informative for my

research. Following this, I understand that the ways that health professionals construct knowledge about women's bodies, gender identity, and norms of society and the dispersal of these ideas through discourses operates as a form of power relations that elevate health professionals while maintaining women's normative subordination.

Foucault's (1995) notion of panopticism is informative in understanding the social surveillance of childless couples which motivates them to pursue fertility treatments. He examines the changing pattern of punishment for violation of the social norms, noting that, in the medieval period, punishment was physical and displayed publicly so that other individuals would be warned to follow the law and maintain the status quo. Conversely, in modern Western cultures, disciplinary power encourages citizens to internalize social surveillance which will control their future performances/actions. Foucault (1995) suggests that disciplinary power is dispersed on the whole population, and that the disciplinary system that works in prisons is present in other institutions, such as the school and the home, so that individuals internalize and take up self-discipline (pp. 208-209). If individuals are not able to discipline themselves to achieve a certain normativity, instead of questioning those norms, they often confess their incapability (Butler, 2004). Disciplinary power circulates through language, and thus it will be important to attend to the discourse of ARTs in Bangladesh, and particularly, how this discourse is used to convey the imperative of motherhood and normalize the stigmatization of childlessness in disciplining ways.

Foucault's (1984) discussions of how health professionals function as a site of bio-power by using various techniques in order to discipline a population are informative for my research. According to Foucault (1995), bio-power is not coercive, but rather it is

a constructive machinery of power over life, through the regulation of birth, health, morality, and sex. Foucault argues that in modern life, the mechanism of disciplinary power produces subjects, and it influences individuals through their self-understanding, producing desire, which often comes to people as norms and practices of self-constitution. These insights are crucial for my research and will inform my analysis of how health professionals produce disciplined and self-disciplining bodies by deploying a normative desire for motherhood.

Foucault's (1984) discussions of the power of medicine also guide me to examine how medicine has a fundamental role in the formation of the self. For Foucault, medicine works as bio-power because it disciplines individuals through continuous surveillance over the population in their everyday lives. However, medicine is not coercive in the vicious and controlling sense because its character is often disguised by its apparently benign involvement in people's troubles. Medical clinics exercise and legitimize their power by defining individuals as 'normal' and 'deviant' or sick and healthy and prescribing the solution for the sickness, 'abnormality' or 'deviance'. Drawing on these insights, I will be critical of health professionals' production of 'normal' and 'deviant' bodies in the discourse, and how health professionals' categorization about motherhood and childlessness exercise normative power.

### **Post-structural Feminist Theory**

Foucault's discussions about the body and power are important in understanding how the 'ideal' notion of the body is constructed through power relations and how this notion encourages self-surveillance. However, Foucault did not discuss how power in

fact produces gendered bodies, and how these constructions are connected with patriarchy. Conversely, post-structural feminist theories, in particular Margrit Shildrick's (1997) discussions about medical science's construction of knowledge about the functions of male and female bodies, assist me in examining how Bangladeshi fertility clinics discuss male and female bodies.

Shildrick (1997) has used Foucault's idea of the body as a site of modern social control, and moves from the belief that the body is a "naturally existent material," seeing bodies as discursively and culturally constructed (p. 14). However, unlike Foucault she has elaborated her discussion of the body by including gender and other intersections, such as class, ethnicity, and (dis)ability (p. 47). She argues that while Foucault was concerned about the institutional structures of bodies such as the school, the clinic, and their disciplinary power, he did not address that those structures are gendered.

In order to analyze "the discourses around the female body," Shildrick (1997) not only focuses on healthcare, but also examines the "general cultural representation" of the female body (p. 22). Shildrick further explains that representations of female bodies in medical science position women as reproducers, as well as "deficient and existentially disabled" (p. 14). This argument prompted me to examine my data for the ways in which ART discourses produced bodies as normatively 'male' and 'female'.

Further, Shildrick (1997) explains that the development of empirical methodology in medical science has heightened health professionals' authority and opportunities to construct knowledge about female bodies. In addition, historically, medical constructions of the female body are entirely engaged with men's philosophical status, but the

seemingly neutral and natural ways this knowledge is conveyed obfuscates the masculine privilege embedded in medical science. In her critique, Shildrick aims to disrupt masculinist knowledge of medical science and explain the morphology of medical power. She notes that in modern society, health professionals' power works "within a system of normativities" which are not seen as imposed, but this normativity encourages "self-generated and self-policed behaviours" (p. 54). Drawing on Foucault, Shildrick notes, "these internalized procedures [work as] the technologies of the self" where individuals take up and modify themselves to normative ideals in order to achieve "a state of perfection and happiness" (p. 55).

Shildrick (1997) explains that ARTs work as a technique of regulation of women's bodies, because they influence women to be mothers and mostly focus on women's reproductive capabilities, and women are thus produced through these discourses of social and medical control. She goes on to explain that in Great Britain during the late twentieth century a new consumer culture has been developed, such that most fertility clinics emphasize men's responsibilities for reproduction alongside women, and encourage women to attend clinics with partners. Shildrick posits that although men are encouraged to visit the clinic with their partners, and infertility is considered to be a joint problem, women generally undergo the most invasive examinations (p. 24).

Shildrick's arguments assist me in examining how the doctors in my data produce knowledge about male and female reproductive bodies and responsibilities, and ultimately work to produce gender differences; in essence, medical science can be viewed as a powerful site of the production of societal norms, which often encourages women to police their bodies and be proactive in order to be 'good' mothers.



## **Why I Chose Discourse Analysis**

There are three possible stances in research: ventriloquy, voice-centered, and activist (Fine, 1992). Ventriloquy follows a positivistic stance, seeks universal truth, and does not raise questions about the ways in which research texts are created by researchers. Thus, researchers speak about ‘truths’ without mentioning their authority, gender, and race in their writing, and emphasize the notion of personal and political neutrality, and detachment, which wants to understand through Haraway’s term “God trick” (Fine, 1992, p. 212). The voice-centered method seems to include the voices of marginalized individuals and local meaning, and scholars seemingly get an opportunity to write “critical and counter hegemonic analysis of institutional arrangements” (p. 215), but actually some of the problems of ventriloquy persist here, when researchers fail to identify their own positions, or distort the voices of others.

Fine (1992) discusses three problems of incorporating the voices of the research subjects: one is that the respondents’ voices have often been selected by the authors to broaden their arguments, and support their claims by selectively using respondents’ voices. The second is that using individuals’ voices to represent group behaviour does not focus on the intersection and context of the respondents, and depoliticizes their perspectives (Fine, 1992). The third problem is that researchers often romanticize and handle the data uncritically, or unevenly, and often refuse subtly to explain their “own stances and relations to these voices” (p. 218). For example, researchers often think that poor women are free of power relations, and mystify the ways they select, use, and exploit their voices. Voices are used “as isolated and innocent moments of experience” to organize the research texts (p. 218). Due to this reason, researchers have failed to

understand the applicability and limits of the methodology, and how to move from their “own political responsibilities to tell tough, critical and confusing stories about the ideological and discursive patterns of inequitable power arrangements” (p. 218).

The third approach is to take an activist stance, which focuses on breaking an unjust social order. Three distinctions of activist scholarship are as follows: the researchers should indicate the explicit theoretical and political stance of the research, even if the stance is various, fluid and mobile; they must analyze and present “social arrangements and their ideological frames” critically, and finally, they should discover and “interrupt new frames for intellectual and political theory and change” (Fine, 1992, p. 202).

I have followed a critical and activist stance in my research because I want to disrupt the idea that motherhood is a ‘natural’ state in women’s lives, and that childless women are not complete women. I intend to examine the social arrangements that construct some characteristics as ‘natural’ for women, and I find the method of discourse analysis is an appropriate approach for my research. Discourse analysis will help me to unpack how ‘truths’ about motherhood, childlessness and ARTs are produced, and which normative orders are sustained through this deployment. It also helps me to understand how the realities of gender and fertility are constructed in Bangladesh insofar as the discourses structure the way that people perceive reality (Foucault, 1972).

Foucault (1972) explains that human beings are produced through discourses, and discourse presents an issue in a particular way. For Foucault, human beings and institutions create ideas and practices in a particular way and, subsequently, ideas and

practices constitute a constructed and political reality. Foucault argues that people apprehend reality through discourse, and that when people apprehend this reality they often categorize and understand their involvements, experiences, practices, and insights according to social structures, although they are not always aware of the ways that discourses structure individuals' understanding (Mills, 2004, p. 49).

Further, Foucault (1972) states that discourse is about the production of knowledge and concept through language, and a number of statements work together to construct knowledge about a topic and offer a limited language for speaking about an issue. Foucault argues that statements are not only textual, but can include images; yet all statements do not share a similar status, some are more authorized than others and not everybody is authorized to make statements. In other words, not everyone's statements are considered important. Following Foucault, it could be read that fertility medicine is an authorized voice when it comes to discourses about the body, and particularly, about the gendered body.

Foucault (1981) also argues that discourse restricts other ways of constructing 'truths'. He states that:

In every society the production of discourse is at once controlled, selected, organised and redistributed by a certain number of procedures whose role is to ward off its powers and dangers, to gain mastery over its chance events, to evade its ponderous, formidable materiality. (Foucault, 1981, p. 52)

These discussions have prompted me to examine images in addition to textual materials concerning discourses of motherhood, childlessness, and ARTs. Further, these arguments have prompted me to explore whose statements concerning ARTs are given priority in the media; how different statements work together to construct a discourse of

motherhood and childlessness and how motherhood and childlessness are given meaning in Bangladeshi media and fertility centres' pronouncements concerning ARTs. Foucault's argument of authorized voices in a discourse also has assisted me to explore how the discourse authorizes health professionals' knowledge, establishes their knowledge as truths, gives them power to speak these truths about childless men and women's lives, and permits them ultimately to exercise their power through human bodies.

A Foucauldian approach to discourse analysis, in combination with feminist theory, helps me to examine how medical science represents the discourses around male and female bodies, and how they produce and sustain norms of masculinity and femininity. I ask, what evidences the research clinics and media have used for claiming 'truths' about these issues? What identities, norms, and practices have been made desirable, and what have been problematized? What interests have been mobilized in the research articles, video clips, and ART client information packages?

Furthermore, a Foucauldian approach to discourse analysis helps me to understand the unspoken, covert, and contradictory issues embedded in the texts I examined. Foucault (1990) explains that what is said about one particular issue "must not be analyzed simply as the surface of projection of these power mechanisms .... we must conceive discourse as a series of discontinuous segments whose tactical function is neither uniform nor stable" (p. 100). He argues that we must understand discourse "as a multiplicity of discursive elements that can come into play in various strategies" (Foucault, 1990, p. 100). Instead of accepting at face value the 'truth' about the positivity of motherhood and ARTs that doctors try to convey, this method has given me the tools

to explore the exclusionary and pathologizing messages about childlessness that underpin these documents in a critical way.

I also examine how different themes arise in media and fertility centres' discourses about motherhood and childlessness. These include the necessity of offspring for married heterosexual couples' lives, childless women's naturalized suffering, and the unquestioned benefits of ARTs. Here, a Foucauldian method of discourse analysis in combination with feminist theory helps me to understand how health professionals and religious scholars collectively produce the discourses of motherhood, childlessness, and ARTs. These examinations help me to understand how these representations play a fundamental role in producing limited and limiting perceptions about motherhood and childlessness.

### **Data Sources**

My data sources come from media representations and fertility clinic information packages pertaining to ARTs in Bangladesh. I have chosen popular media representations as they are crucial in illuminating the cultural temperature of a society. Hall (1977) explains that popular media's communication is connected with power; in other words, individuals who hold power in a society inform what issues and in what ways they can be presented through popular media, and these media play a fundamental role in reflecting and shaping people's views. I examine the coverage of ARTs in Bangladesh's two leading and widely circulated daily national newspapers, *The Daily Star*, and the *Prothom Alo* during the period from 2001 to 2015. I have selected this time frame because in Bangladesh, the first triplet IVF babies were born in 2001. The news received

tremendous attention in Bangladeshi media; prior to 2001, Bangladeshi media did not focus on infertility issues. Focusing on these two newspapers is important because it is my perception that Bangladeshi middle and upper class, educated people – who are the people most likely to actually avail themselves of ARTs in Bangladesh – often take the news, which comes from these newspapers, as ‘true’ and ‘valid’.

In addition to newspaper sources, I focus on five video clips from Bangladeshi television talk show news on the subject of ARTs. I choose to focus on television because television is accessible for all classes of Bangladeshi people. Poor Bangladeshi people do not have the ability to buy newspapers, and most of them are illiterate and unable to read the newspapers which are displayed in public places. They thus mostly rely on television channels for the news and their entertainment. I examine four Bangladeshi television channels, ETV, NTV, Boishakhi and Banglavisión, because in my search on-line for Bangladeshi video clips on ARTs, I found that these four channels were the ones that actually had programming about ART information, and all four of these TV channels are popular and well-established in Bangladesh, and each enjoys a wide circulation.

The length of these videos varies; the first two clips are around four minutes long, with one focusing on a male doctor’s discussion about ARTs (Siddiqui, 2014), while the other highlights successful couples’ experiences and test tube babies’ ‘normal’ development (Romel, 2014). The third clip is a nearly eight minute long discussion by a religious scholar of Islam who talks about the Islamic rules of using ARTs (Hasan, 2009). The fourth and fifth video clips are thirty-nine and twenty-one minutes long respectively, and they focus on discussions by renowned doctors who explain and answer members of the general public’s questions relating to ARTs (Uddin, 2014; Amin, 2014). Although the

video clips are not in English, many of the themes of scientific knowledge, Western medicine, the role of religion in framing motherhood and womanhood, and heteronormative family and gender ideals are visually present even without knowing the language.

Although I did obtain some other video clips on ARTs, I have found these five to be the most relevant to my study focus as they encompass discussions of ARTs from multiple crucial angles, including those of doctors, couples who have IVF children and religious leaders (Muslim Imams). They include local explanations about the problem of infertility, the obstacles of using ARTs, religious principles of using ARTs, and how ARTs are understood as beneficial for infertile couples and women, in particular. Additionally, the doctors and the Imam in these video clips answer Bangladeshi people's various questions about using ARTs, which has given me insights to understanding Bangladeshi people's attitudes towards ARTs, and how these professional discourses are taken up and responded to. Imams' discussions are important for my research as Bangladeshi people often understand that infertility is not only a physical problem, but is also seen to be the result of sin, Allah's wishes, and the effect of supernatural beings' interventions. Therefore, infertile couples and even their relatives will try to please Allah/God by following traditional ways in hopes of a divine solution to their problem. Women often incorporate these spiritual methods alongside modern medicine in hopes of having children. Hence, the discourses of infertility and fertility treatment are diverse in Bangladesh. While health professionals promote ART services, Imams emphasize Allah's wishes. However, today many Imams also perceive ARTs as an important treatment for couple's infertility and their religious interpretations, like those of modern

medicine, focus on the importance of motherhood and women's (and to a lesser extent, couple's) hopes of having children (Sultana, 2014). In addition, health professionals also reconcile medical knowledge and religious discourses in encouraging and providing ART treatments in Bangladesh.

Finally, I explore four fertility centres' ART client information packages because I aim to understand how Bangladeshi health professionals construct truths about motherhood and childlessness in their ART information packages. According to an informal 'survey' of family, colleagues and friends, the Labaid Fertility Centre, the Square Fertility Centre and the Apollo Fertility Centre are well known fertility clinics in Bangladesh. Therefore, in my research, I have selected these three fertility clinics. Wealthy and middle class people often seek health services from these centres because they perceive that these hospitals provide high quality services and they have modern advanced technological support for their patients. The Square Hospital presents itself as the best service provider in Bangladesh; it appoints high profile doctors who are reputed to show friendly attitudes toward their patients, it maintains a high standard of hygiene, has a modern building structure and employs modern technologies and standards (Square Fertility Centre, 2015). Unsurprisingly, the cost of overall treatments at the Square Hospital is higher than most of the hospitals in Bangladesh. In the case of IVF treatment, the clinic charges approximately \$2500 (CAD) per course of treatment (Salahuddin, 2003).

I also am familiar with and have been able to observe the treatment system of the Labaid Hospital, as my sister's baby was in an incubator at that facility for six days. I do not have any experience of taking services from the Apollo Hospital in Dhaka, however, I



have often heard through my personal networks about its high reputation. These contacts often posit that the Apollo Hospital has the best technological supports, as well as doctors, even when compared to the Square Hospital. This hospital has ties with Indian doctors who come to Bangladesh to perform complicated surgeries. I have examined the Apollo Fertility Centre's website, and found that it has extensive and organized information about ARTs (Apollo Fertility Centre, 2015).

In addition to the aforementioned three clinics, I also looked at the Harvest Infertility Care Ltd. Clinic's information package and website because they have an established reputation as an ART provider, having already celebrated 100 test tube babies' births by 2009. Moreover, I am interested in looking at this clinic's information as it claims that they are the pioneer of frozen embryo babies in Bangladesh.

I found that they have visual rich information and advertisements on their website that speak to the naturalness of motherhood in women's lives, the desires of couples to have babies, the curse of not having a lineage of descendents, the distress and emptiness in childless couples' lives, and their desperation to have a child (Harvest Infertility Care Ltd. Clinic, 2015a).

They also describe how science has brought a solution for infertile couples' plight, how the Harvest Infertility Care Ltd. Clinic provides high standard fertility treatments while maintaining Islamic principles, how ARTs are virtually safe for women's bodies, and how the test tube baby is a 'normal' or 'natural' process. This site conveys messages that childless couples are unfortunate and excluded from many opportunities and the Clinic has thus worked hard to reduce the costs for ART treatments compared to other service providers, in order to bring hope and happiness even to less

financially solvent childless couples. The Clinic charges approximately \$1200 (CAD) for the first cycle of IVF treatment. It is important to note that neither clinic mentions the treatment cost on its website or in client information packages. I received information about the IVF treatment cost of the Square Fertility Centre from one article (Salahuddin, 2003), while my husband collected information about the IVF treatment cost of the Harvest Infertility Care Ltd. Clinic via phone. However, I was not able to collect information about the treatment cost of the other two fertility clinics whose websites and client information packages I examined because the clinics did not want to disclose their prices over the phone; they would only state that the cost depends on patients' infertility problems.

### **Collection of Data**

I have collected newspaper articles and video clips through the internet, given my location in Canada. In collecting articles from the English newspaper *The Daily Star*, I used search terms such as: test tube baby, infertility, motherhood, and childlessness, while I used the words “*bondhatto*” (infertility), “*matrito*” (motherhood) and test tube news to collect data from the Bengali newspaper *Prothom Alo*. In addition, I located an article which is not on ARTs, but about the joy of ‘perfect’ mothering. The article is about an award program honouring the ‘best’ mothers in Bangladesh. I chose to include this article as it is relevant to understanding how motherhood is constructed as a Bangladeshi woman’s major identity and achievement, and how it might encourage women to be a mother at any costs. In total, I have collected 12 articles from the newspaper *Prothom Alo* and five articles from the newspaper *The Daily Star* (see, Appendix-A, the list of the newspapers’ articles).

In the case of collecting video clips, I used the search terms test tube, new reproductive technology and ART, and through my search, I found three video clips for my research. My supervisor, Dr. Claudia Malacrida helped me by finding a further two video clips for me. Furthermore, I have collected four fertility centres' pamphlets, publications and other visual imageries in relation to ARTs. My husband went to the above mentioned four clinics in Bangladesh to collect the centres' client information packages. He also took some pictures of ART-related promotional materials from those centres' walls and display stands. I have also collected data from the centres' websites (Apollo Fertility Centre, 2015; Harvest Infertility Care Ltd. Clinic, 2015; Labaid Fertility Centre, 2015; Square Fertility Centre, 2015) and I found that among the four, the Apollo Fertility Centre's and the Harvest Infertility Care Ltd. Clinic have the most detailed information about their ART services compared to the Labaid and Square fertility clinics.

## **Analysis**

To begin my analysis, I read all related newspaper articles and fertility clinics' client information packages, and watched the video clips in order to understand how motherhood and childlessness were discussed, which themes were focused on, which topics were not covered, and who was speaking and from what philosophy he/ she was speaking. Reading these documents helped me to get a sense of possible themes for the interpretation of my research data. First, I sorted the issues that were discussed frequently in my data, and developed the following codes: "Motherhood and Fulfillment of Women's lives," "Portrayals of Heterosexual Couples with IVF Babies," "Motherhood and Inheritance," "Stigma and Grief of Childlessness," and the "Desperation of Childless Women to Give birth, and the Beneficial Aspects of ARTs."

Further, I analyzed the images following Foucault's assertion that discourses are a series of statements which not only include texts, but also images (Mills, 2004). I noted some important constructs are conveyed in the images, including: the notion of Western progress and of Western people as positive and modern, expressions of nationalism, men's masculine image, and women's 'natural' ties with children.

Along with searching for these frequently addressed issues, I also sorted the issues which were seldom discussed in the research media and fertility clinics. I observed that in their discussions of fertility treatments, Bangladeshi media and fertility clinics mostly focus on the benefits of the treatments, and rarely discuss the harm and pain that may occur as a result of undertaking them. Another issue that is rarely discussed in the research media is women's alternative subject positions as, for example, living full lives while remaining childless. This tendency reflects Foucault's (1981) idea that production of discourse is at once controlled, selected and redistributed through different procedures (p. 52), and the notion that discourses restrict other ways of constructing a topic (Hall, 2007).

Further, I sorted the contradictory statements and issues embedded in the discourse, as Foucault (1990) suggests that the segments of a particular discourse might be contradictory and discontinuous, and the tactical functions of the segments might be inconsistent and unstable (p. 100). When I was reading my data, I observed that health professionals frequently state that males and females are both responsible in a similar way for infertility; many of their portrayals, however, still sustain the idea that infertility is a woman's problem. I discuss this inconsistency under the theme "Constructions of Male and Female Infertility."

I also developed themes based on less overt messages, such as the entrepreneurial aspects of ARTs, as Foucault (1990) recommends exploring the covert messages in a discursive formation. I noted the covert desire of health professionals' to facilitate their ART business while participating in the formation of discourses of motherhood and childlessness in relation to ARTs. The doctors do not state that the expansion of ARTs will benefit them materially, or acknowledge that increased ART business is connected with their personal profit. Instead, they focussed on producing the notion that ARTs are solely beneficial for childless Bangladeshi women. These themes are further explored in the sections, "Entrepreneurial aspects of ART in Bangladesh," "The Normalization of IVF Treatment, IVF Babies and Treatment Cost," and "Reconciling Islamic Principles in Using ARTs in Medical Science."

Further, I analyzed who spoke the most, from which stances they were speaking, and whose voices carried authority, as Foucault explains that not everyone is authorized to make statements and not all statements share a similar status; rather, some are more authorized than others (Mills, 2004). I found that health professionals' knowledge was mostly emphasized in the media, but childless couples' voices were seldom presented there. Additionally, Imams' (Muslim religious scholar) voices were also authorized in describing the principles for using ARTs. Along with focusing on who has authority to speak, I focused on identifying the gender of the speakers; I found that the majority of speakers are male, but when health professionals discuss childless couples' sorrow, they often explain only women's grief over not having children. Thus, in this discourse, it seems that men are subjects, while women are normatively produced as objects of both religious and medical pronouncements.

## **Reflexivity as Ethics**

There are two types of ethics; one is procedural ethics, which refers primarily to processes of approval through a relevant ethics institutional board to conduct research on human beings. The other is ethics-in-practice which emphasizes the everyday practice of ethics during the whole period of research (Guillemin & Gillam, 2004). In the case of my research, I did not go through the University of Lethbridge's Office of Research Ethic's Human Subjects Research Committee approval because my research does not directly engage with human subjects. However, I agree with Guillemin and Gillam's (2004) argument that researchers' attitude and personal history affect the research, and thus that even without human subject involvement, reflexivity is important in contributing to the practice of ethics by clarifying the researcher's position on the research issues and context. Guillemin and Gillam (2004) explain that reflexivity in research is "an active, ongoing process that saturates every stage of the research," and this requires researchers' continuous "critical scrutiny and interpretation" (pp. 274, 275). Being reflexive enhances researchers' capacity to be concerned about ethical issues since reflexivity develops "a means of addressing and responding to ethical concerns if and when they arise in the research" (p. 276). Guillemin and Gillam posit that reflexivity encourages researchers to develop skills to respond to emerging situations appropriately.

To me, reflexivity means following those practices which will assist me to be transparent and honest in my research. In my research, I have been very careful while translating my data because I felt that this was the most ethically tense part of my research. Most of my research articles and all conversations of my research video clips are in Bengali language. I translated all Bengali articles line for line in English since I am

doing a Master's degree in an English speaking country, the language of my thesis is English, and most of the readers of my thesis are English speakers in Canada.

When I was translating my data, I sometimes felt that it is not possible to translate the exact meaning and feelings of statements from one language to another and I was reminded of Talal Asad's (1986) discussions of translation. Asad (1986) explains that when British ethnographers went to other societies seeking to learn their ways of lives, they often had to learn the language. However, ethnographers often wrote ethnographies for English readers, and when they translated other cultures in the English language, they often chose words which were understandable to their English speaking readers. Similarly, while I was translating my culture in English, I had a feeling that I was trying to translate my data in such ways so that those would be understandable for English speakers. However, I did my best, and I remained conscious while translating of being as true to the text as possible. Further, when I did replace terms, these replacements didn't change the meanings, but just the syntax.

### **Reflexivity in Data Analysis**

There is a vibrant discussion about the political aspects of analysis and interpretation of data in the social sciences. Until 1980, the positivistic paradigm was prominent in social science research; notions of neutrality, objectivity, and detachment from the 'other' were considered necessary for producing a more 'accurate' representation of the data (Denzin, 1998; Mauthner & Doucet, 2003). These notions of neutrality and objectivity were criticized by feminists, post-structuralists, post-modernists, and critical theorists who recognize that "knowledge and understanding are

contextually and historically grounded, as well as linguistically constituted,” that theory is also embedded with culture, society and history and thus, research analysis is accomplished through “‘situated knowledge’ and is a ‘social activity’” (Mauthner & Doucet, 2003, pp. 416-417). In order to improve researchers’ accountability, a significant number of scholars argue “for an ethical approach” (Malacrida, 2007, p. 1330) which will acknowledge researchers’ motivation, preconceived notions, assumptions, power, biases, and privilege. In other words, taking a critical look at all aspects of their activities in their research (Malacrida, 2007; Guillemin & Gillam, 2004), these scholars see reflexivity as “critical element” in research (Malacrida, 2007, p. 1330).

My research does not follow the notion of neutrality and objectivity, but rather my subjective understanding, developed through my study and my life experience, is the basis of my interpretation of data. I have reflected while undertaking this project upon how my academic and personal biography prompted me to explore media and fertility centres’ representations of motherhood and childlessness (Mauthner & Doucet, 2003). In my academic career, I have learned through Foucauldian and post-structural feminist theories that women’s bodies and sexuality are sites of social control, and that knowledge regarding women’s bodies is not ‘natural’, but rather constructed, and medical science and the media play crucial roles in constituting knowledge about women bodies and identity. My academic career has helped me to interrogate the stigmatization of Bangladeshi childless women and the promotion of the necessity of having babies in couples’ lives that is naturalized in ART discourses. My sister’s vulnerabilities influenced me as well to question the stigma attached to childlessness and the oppressive aspects of medical systems.



I do not claim that my reading of my data is the only possible interpretation. Instead, my position follows post-structuralist notions that my account of my research is one reading of many other possible readings. However, I have been very careful to interpret the discourses ‘accurately’ and I went through critical readings of them again and again to better my understanding.

## **Conclusion**

In this chapter, I have outlined the epistemology and methodology of my research. Foucauldian and feminist post-structural theories have guided my inquiries, and I have employed the method of discourse analysis to examine the discursive construction of knowledge about motherhood and childlessness in relation to ARTs. In the next chapter, I will address how Bangladeshi media and fertility centres construct ‘truths’ about the necessity of children in married heterosexual women’s and heterosexual couples’ lives in their discussions about, and representations of, infertility treatments.

### **Chapter 3: Discourses of Motherhood and Parenthood**

My data shows the overall focus of the research articles, video clips, and ART client information packages to be producing a narrative of childbearing and pregnancy as key sources of happiness in married heterosexual couples' lives, with these narratives consistently highlighting women's desire for and happiness as a result of having children (Romel, 2014; Uddin, 2014; Based, 2015; Purabi, 2015). While these discourses may at some level be simply marketing techniques for clinical services (Franklin, 1990; Akhter, 2010; Sultana, 2014), it is nonetheless remarkable how coherent these are in terms of framing marital happiness and the fulfillment of women's lives as impossible without the presence of children (Romel, 2014; Uddin, 2014; Based, 2015; Purabi, 2015). In this chapter, I examine how the discourses of motherhood and parenthood have been illuminated in my selected ART discourse.

The first section of this chapter addresses Susan Sontag's (1977) and Roland Barthes' (1981) discussions on the functions of images, employing their analyses to clarify my examination of images used by the research newspaper articles, video clips, and ART client information packages. In the second section of the chapter, I discuss how the 'truth' of the necessity of motherhood in women's lives has been produced throughout these materials. The third part of this chapter examines how parenthood within married heterosexual relationships has been emphasized in the ART discourse. The fourth section outlines how the 'truth' about the necessity of continuation of lineage has been produced in the researched ARTs discourse.

## Functions of Images

It is worth noting that much of my analysis arises from the photos that newspaper articles, video clips, and fertility clinic pamphlets utilize alongside their discussions of the desire to have children and the happiness that will result (Staff Correspondent, 2009; Based, 2015; Purabi, 2015; Harvest Infertility Care Ltd. Clinic, 2015a). It is important to consider the ways in which imagery can be interpreted. Susan Sontag (1977) argues that people often read photos based on personal ideology; in that sense, photographs do not constitute meaning by themselves, but rather work as part of a certain knowledge system. Thus, it is important to know when and in what context photos are taken and used. She goes on to explain:

Socially concerned photographers assume that their work can convey some kind of stable meaning, can reveal truth. But partly because the photograph is, always, an object in a context, this meaning is bound to drain away; that is, the context which shapes whatever immediate. (Sontag, 1977, p. 106)

Following Sontag, I argue that photographs are objects that do not convey a stable meaning; rather, interpretation of a photo depends on a viewer's knowledge and cultural location. In my research, my reading and conceptualization of images is dependent upon the perceptions and knowledge I have developed through my academic study and personal life experiences.

Roland Barthes (1981) proposes an effort to understand photographers' "studium," in photography; he aims to uncover the information the photographers want to convey through photographs, despite his perception that viewers have freedom in interpretation. Following Barthes' notion of studium, I consider that the images produced and presented by Bangladeshi media and fertility clinics rely heavily on the assumption

of the naturalness of reproduction, in particular for women, and the understanding that children animate and fulfill couples' lives. Moreover, these photos are used to attract readers by appealing to their normative conceptions of family, children, and what is valuable to social life.

### **Normative Notions of Motherhood**

Much of the material I analyzed from Bangladeshi media and fertility clinics begin their discussions with childless couples' desire for having children, but they more often than not end their discussions suggesting that women desire children more than men do (Based, 2015; Purabi, 2015; Uddin, 2014; Imam, 2013). For instance, Dr. Purabi wrote an article entitled "Know the Reasons of Infertility" in the weekly health page<sup>6</sup> of *The Daily Star* newspaper, in which she states:

In married life children are like an anchor between the father and mother. A woman possesses a dormant desire to be a mother. In most cases, this desire exceeds everything including her career development or physical beauty. In case of a man the outer expression can be less but he also wants to live through his children. (Purabi, 2015)

This vignette draws upon existing circulating discourses relating the significance of having children in a couple's life and produces the 'truth' that heterosexual women's desire for having children exceeds everything else in their lives, and is fundamentally more intense than men's desires could ever be. Nevertheless, Purabi does present men's desire to be fathers, which may be a new strategy in encouraging ARTs. It is important to

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<sup>6</sup> In *The Daily Star* there is a weekly health page, in which doctors from different well-known hospitals write about health and diseases to raise people's awareness in Bangladesh.

note that the discussion of fatherhood was seldom raised in my research, producing and reproducing the notion that fatherhood is not the primary goal of men’s lives.

The Harvest Infertility Care Ltd. Clinic also represents a similar message on its website. Under the tab “Success Stories,” the centre has published the experiences of three anonymous women who have undergone IVF treatment through the centre. These narratives describe how the women desired children and attempted pregnancy, and discuss why having children is a crucial aspect of women’s lives (Harvest Infertility Care Ltd. Clinic, 2015c). The centre also published the following photo on the website:



Figure 3.1: (Harvest Infertility Care Ltd. Clinic, 2015a)

This photo represents the ‘truth’ of women’s joy, affection, and ‘natural’ ties with their children, with a mother, depicted alone with her child, engaged in an ecstatic embrace, and representing a complete and joyous connection. It is important to note that this image does not resemble the majority of Bangladeshi women; instead this photo portrays this ideal and happy duo as white, drawing upon existing discourse in the Bangladeshi context that whiteness is sign of beauty and progress, and success to be emulated by the clinic’s potential consumers (Sultana, 2014). Although the clinic publishes a significant number

of photos focusing on women's enthusiasm regarding children, it does not publish photos attempting to show men's desire to have children. This absence constructs women's desire to be mothers as central and also conveys the 'truth' that women are solely responsible for reproduction.

In its attempt to convey the normative qualities of motherhood, a clip from the Ekushey Television channel (Romel, 2014) employs an image of a celebrity woman's joy in motherhood. The clip subtly conveys the idea that even famous women with wealth and success are only fulfilled and experience bliss by giving birth to a child. The video clip represents the happiness of a famous actress, Shahanaz Haque, and her delight in having a child with the assistance of ARTs. Arguably, drawing on discourses of both science and religion, the aim of this clip is to construct ARTs as reliable and acceptable to Bangladeshi people. The clip focuses on the happiness and bond between the actress and her daughter, highlighting that "after many years of prayers, the actress got her daughter, Aini Zaman, through the test tube method. The friendship with her daughter, who is a class three student, indicates how science has brought hope and joys for frustrated people" (Romel, 2014). Further, because Haque is a prominent and admired Bangladeshi woman, her story serves as a powerful symbol that it is acceptable for Bangladeshi woman to pursue motherhood through ARTs, and through this pursuit, to achieve the ultimate joy of the maternal-child bond.

The following example demonstrates how the construction of the 'truth' of the importance of motherhood in women's lives occurs, arguably also revealing the overall attitudes of Bangladeshi society towards women. On 10<sup>th</sup> May, 2015, the newspaper *Prothom Alo* published a story on the celebration of the best mothers of Bangladesh. The

article states that since Mother’s Day 2003, Bangladeshi women with multiple well-established children are acclaimed as a “Ratnagarbha<sup>7</sup> Ma” (literally, a “mother with a diamond womb,” or more colloquially, a mother of talents). It goes on to explain that:

Ratnagarbha Ma', an award initiated to honour successful mothers across the country, has been conferred on 25 mothers this year ..... After receiving the award, Gulnahr Lutfе Ara told *Prothom Alo*, "This recognition, I think, will encourage my children to become more dedicated and responsible for the country." (Staff Correspondent, 2015b)



Figure 3.2: (Staff Correspondent, 2015b)

This article produces the notion that motherhood is not only a source of women’s honour and happiness, but that the connection between ‘perfect’ motherhood and the wellbeing of the nation is broadly conveyed. The article suggests the Bangladeshi nation itself is interested in women’s subject position as mothers and encourage women to be ‘good’ mothers. As well, the mother herself seems to adhere to this notion that having children is not ‘selfish’, but instead is a contribution to the nation and its future. It is noteworthy that these messages are circulated even while the state simultaneously supports population

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<sup>7</sup> “Ratna” means diamond and “Garbha” means womb.

reduction programs. The celebration of mothers who have multi-talented children including doctors, engineers, scientists, and academics on the one hand, and the controlling of poor women's fertility on the other reveals an ambiguous tension in the Bangladeshi discourses concerning motherhood, population, and development. The focuses on women's responsibilities for producing economically 'productive' children and 'good' citizens of Bangladesh is linked with the circulating discourses that women are spirits of the nation, and bearers of national identity through their children (Yuval-Davis, 1993). Although women are given responsibility for producing 'good' citizens, the state produces and extends male power and privilege because male power is circulated through families in Bangladesh (McClintock, 1995).

In Bangladesh, most households are represented by men, and women are often represented in public through their husbands and fathers. After marriage, producing children is seen as a main responsibility of women, which certifies their rights in their husbands' households (Nahar, 2012). Before 1980, Bangladeshi people were mostly dependent on agriculture, and producing children was important as children were considered as extra hands of parents (Akhter, 2010). However, since 1980 and in the neoliberal economy, not only producing children, but producing economically productive children has become important for the economic and social development of the nation. Here, Bangladeshi women are responsible for and encouraged to produce 'good' citizens by the power of their 'perfect' mothering.

With this in mind, the public valuing of motherhood can be seen as linked with the broader political and economic systems of Bangladesh. The celebration of 'best mothers' constructs women's subject position as nation-builders and heritage-bearers,



which also produces the notion that women's lives become meaningful through their 'perfect' mothering. These practices reflect the ways in which Bangladeshi women's honour mainly depends on their successful participation in motherhood, arguably suggesting that they may be prompted to police their behaviours to be not only mothers, but to do everything in order to achieve 'good motherhood'. In this context, it is easy for IVF proponents to deploy conceptualizations of women's motherhood identity to encourage women's willingness to use ARTs.

### **Discursive Construction of Parenthood within Heterosexual Couples**

As noted, in the materials I analyzed, there was a consistent and insistent claim concerning a universal desire for children in the happy, heterosexual couple's life (Romel, 2014; Uddin, 2014; Based, 2015; Purabi, 2015). For example: in the newspaper *The Daily Star*, Dr. Purabi (2015) presents an article on infertility accompanied by the following image. The article itself describes how children ensure happiness in a couple's life, portrayed in an accompanying image of a heterosexual couple observing confirmation of pregnancy.



Figure 3.3: (Purabi, 2015)

Both of the prospective parents focus on the promise embedded in the pregnancy test results, but in addition, the picture suggests the husband, with his arm firmly around his wife, is the protector of the future family, constructing his power and primacy in the marital relationship. In this image, as in many similar images, the woman's clothing is not typical of Bangladeshi people, but rather appears quite Western. In Bangladesh, "Sari"<sup>8</sup> is often considered to be married women's dress. Bangladesh is a Muslim majority country and, culturally as well religiously, showing body parts is unacceptable and shameful. A dress that shows arms and legs of a woman is often interpreted as Western women's style. In Bangladesh, this type of dress can have two meanings; on one side, showing body parts is interpreted as sign of an 'immodest' girl (Naher, 2005) as well as an aspect of polluting Bengali culture<sup>9</sup>; on the other side, wearing Western dress and following Western life style also often understood as symbols of smartness and progress. These symbols are materialized in this photo to produce a normative subject who on the one hand is heterosexual, married and 'proper' as signified by her partnerships, and on the other is modern, progressive and in control, taking up modernity by embracing the Western Technologies.

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<sup>8</sup> Sari is a traditional garment of Bangladeshi female, which consists five to eight meter long and two to four feet wide piece of cloth.

<sup>9</sup> Said (1993) states that "culture is a concept that includes a refining and elevating element, each society's reservoir of the best that has been known and thought. People bring the notion of culture in order to show their society, tradition at their best, and use some parts of the other culture to make [the] other inferior" (p. xiii). Said argues, thus, that "culture comes to be associated, often aggressively, with the notion of the state; this differentiates 'us' from 'them', almost always with some degree of xenophobia" (p. xiii). Culture is a sense of identity, and "culture is a sort of theater where various political and ideological causes engage one another" (p. xiii). In accordance with Said, I perceive culture as problematic.

In this photo, using the Human Chorionic Gonadotrophin (HCG) strip as symbol of pregnancy reflects the ongoing medicalization<sup>10</sup> of reproduction in Bangladesh; traditional<sup>11</sup> Bangladeshi media usually focuses on woman's vomiting and eating sour fruits to portray and convey signs of pregnancy. This image, with its modern, Western iconography moves away from the traditional. Following Sontag's (1977) assertion that reading the meaning of the photo depends on viewers' knowledge, this photo appears to be directed to the educated individuals who have the knowledge of what the woman is holding (a pregnancy test) and who can thus appropriately read the image 'appropriately'.

Modern medical science's gaze and authority over diseases and health was introduced in Bangladesh through the British colonial rulers during the nineteenth

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<sup>10</sup> In this regard, Foucault's (1984) discussion about medicalization is informative. He discusses that from the sixteenth century, medical science has been constructing medical gaze and 'truth' of diseases, and replacing other knowledge systems about diseases and health in Western countries. Before, people used to go to the priests and followed their suggestions for their recovery from illness. In the nineteenth century, health professionals have become the authorities and experts to speak about diseases in Western countries. In addition to that, medical science has constructed knowledge about every aspect of human life, such as food habits, dressing 'properly', and housing planning in the name of healthy life.

<sup>11</sup> The terms, 'tradition', 'traditional' are also problematic because they are often considered as timeless and immutable past, and hide the notion that tradition is shaped by the political and economic interests of powerful people of the society. For instance, in colonial India, the British colonizers identified some practices - widow burning - as traditions in order to prove the notion that Indian culture is barbaric and oppressive for women. On the other hand, when 'post' colonialists deconstruct history, they "persistently emphasize their difference from the imperial masters," by showing some practices as their traditions. Women's roles and behaviours were often used as key markers of tradition in both colonial and nationalists' interpretations of tradition (Loomba, 2005, p.192). This tendency is problematic as both the colonizers and anti-colonial nationalists have casted "certain values and practices as 'constitutive and central elements' of the culture in order to distinguish it from 'other culture'" (Narayan, 2000, p. 87). In my research, following Loomba, I argue that traditions are political and economic construct of the society and not timeless and immutable past.

century. Since that period, medical science has been replacing other healing systems in India<sup>12</sup>. It is argued that medical science was used as one of the tools<sup>13</sup> of British colonialism (during the colonial period, Bangladesh was a part of India, as noted earlier in the first chapter), and medical science helped to shore up the authority of colonial rulers over the Indian people (Prakash, 1999). The following portrayal comes from the Square Fertility Centre also shows the ongoing medicalization of reproduction in Bangladesh.

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<sup>12</sup> Previously, sin was often interpreted as a reason for diseases in India; thus, sick persons as well as other people of the community often went to priests and performed rituals for recovering from the sickness (Guha, 1998).

<sup>13</sup> During the early nineteenth century, India was colonized using empirical science, modern institutions, modern infrastructures, modern knowledge and practice to deepen India's economic links with the global capitalist economy: Medical doctors and scientists endeavoured to control epidemics and took care of people's bodies to increase productivity. However, it was not easy for the colonizers to reach all parts of India and bring colonial people under their sovereignty because of its cultural, territorial and language diversities. In order to facilitate the notion of progress and Western knowledge, Western education systems were introduced and Western educated indigenous elites were produced, who translated the Western knowledge to the indigenous people. The Western educated indigenous elites started to work as reformers of culture, and they reformed the culture in such a way to appear as if they produced the scientific Indian tradition and culture for the wellbeing of Indian people, and they became a part of colonial power and discourses, who started to determine which traditions should be continued and which should be revised and in which ways (Prakash, 1999). In this process, medical doctors simultaneously played a significant role in introducing Western medical knowledge and continue to do so.



The caption of the photo states:

Like us, secure your opportunity. We also have suffered due to our childlessness. However, we became successful when we went to the Square Fertility Centre. We have achieved our greatest happiness through its experienced doctors and its world class fertility treatments. (The Square Fertility Centre, 2014)<sup>14</sup>

Figure 3.4: The photo was taken by Iftekhar Khalid, 04. 04. 2014

The Square Fertility Centre displays this image at their clinic. Following Barthes' explanation about the function of photos, I argue that the intention of displaying this photo in the centre is to represent the 'truth' about how ART users experience a sense of serenity following the birth of their child, as a means of appealing to childless couples. Furthermore, this photo produces the 'truth' of the centre's ability to assist heterosexual couples in producing a family through modern medical means. In this photo, man's masculine image has been represented through his confident and protective appearance to his wife and child. The woman's caring role and the idea of the 'natural' connection between mother and baby are produced through both parents' positions in the photo. The

<sup>14</sup> The Publication date is not provided, but Iftekhar Khalid collected this brochure 04.04.2014.

dress of the woman indicates it is likely that she is still in the hospital; however, any symbol of pain from delivery or the use of fertility treatments has not been shown. At the same time, the photo and its caption subtly convey the notion that individuals should undertake any and all technologies, regardless of how painful or harmful, in order to achieve offspring and experience happiness. Furthermore, the absent messages regarding women's experiences of childbirth (as opposed to the abundant portrayals of the agony of childlessness) normalize medical science's ability to understand and fulfill heterosexual women's needs.

The caption, through its invocation of success, conveys the fulfillment of giving birth as truth, producing the narrative of the couple in terms of success, happiness, and joy, but never in terms of financial costs, potential for failure, or health risks to women using IVF. This text constructs the idea that children are risk and cost-free assets that provide security in Bangladeshi couples' lives, since children in Bangladesh, particularly boys, are interpreted as parents' supplementary earning hands and security in old age. Therefore, childlessness is interpreted as couples' loss of an asset (Nahar, 2012). Further, the statement in the caption regarding the centre's 'world class treatment facilities' highlights the focus on technological expansions of Western medical science in Bangladesh.

The above portrayals suggest IVF clinics and health professionals are likely to utilize images of light-skinned, attractive, seemingly Westernized individuals in order to produce the perception of ARTs as modern and acceptable to Bangladeshi people. Further, these representations produce Bangladeshi people's desire to adapt to Western

lifestyles, normalizing ideas of the racial superiority of light-skinned people, and equating whiteness with progress.

Historically, the notions of racial and cultural superiority of White Western people were produced during the colonial period in India. Colonial rulers constructed ‘knowledge’ about Indian people’s racial inferiority and the supposed backwardness of their culture in order to prove Indian people’s incapability to govern themselves; in turn, this construction provided colonizers with a justification for their imperialism (Chakrabarti, 1997). The ART portrayals discussed here arguably demonstrate that Bangladesh is not as ‘post’ colonial as many Bangladeshi people would like to think. The portrayals of medical science’s progress parallel to images of light-skinned couples suggests colonialism is still rampant in Bangladesh, despite the argument by some authors that Bangladeshi people strive to preserve traditional culture in order to distance themselves from Western society (Loomba, 2005).

### **Discursive Constructions of Real Bangladeshi Parents and IVF Children**

My research indicates that prior to 2012, daily newspapers seldom published photographs of IVF babies and their parents. Dr. Begum, one of the most well-known gynecologists in Bangladesh, states in a video clip from the Banglavisision television channel that Bangladeshi people still have misconceptions about IVF babies (Uddin, 2014). Begum points to an underlying fear that doctors may fertilize a woman’s egg using sperm that does not belong to her husband, violating Islam. As such, couples have worried that babies conceived through IVF may be deemed illegitimate in the eyes of Bangladeshi people, and are hesitant to publicly admit to ART use (Uddin, 2014). A

possible indication that this concern is subsiding and ART acceptability is growing, is that Bangladeshi media and fertility clinics started to publish photos of parents and IVF babies post-2012 (Romel, 2014; Staff Correspondent, 2014a).

The June 10, 2014 edition of *The Daily Star* published news of the first test tube<sup>15</sup> baby in Chittagong, a large Bangladesh city, accompanied by the following picture:



Figure 3.5: (Staff Correspondent, 2014a)

This image significantly, and in multiple ways, contrasts the promotional media featuring happy, Westernized, light-skinned couples that I discussed previously in the chapter. The woman's *bindi*, *sindoor*, and *shakha*<sup>16</sup> indicate that they are a married Hindu couple, and her sari reflects the traditional dress of Bangladeshi women. Though appearing happy, the

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<sup>15</sup> In the case of the first baby conceived through IVF, Louise Brown, the embryo was formed in a test tube. Today, the ovum and sperm are typically placed in a dish to form an embryo, and the embryo is then inserted into a patient's uterus. Because Bangladesh doctors before used test tubes rather than dishes, Bangladeshi people still typically use the term 'test tube babies' to refer to babies conceived through IVF (Siddiqui, 2014).

<sup>16</sup> As a symbol of marriage, Hindu Bangladeshi women are often expected to wear red dot (*bindi*) on their forehead, red powder in the partings of the hair (*sindoor*), and white conch shell bracelet (*shakha*) on their wrists.



couple also clearly looks tired. The article accompanying this photo explains that the couple initially travelled to India for ART, but were unable to continue treatment outside of the country because of prohibitive costs. The underlying message of this couple's story, and the visual proof provided through the picture of their new baby, is that even couples without vast wealth can, and should, persist and find a way to work within their means and eventually have a child. It also produces the 'truth' that Indian technology is no longer needed because modern, effective services are obtainable at home. The image continues to portray women in their 'proper role' as primary caregivers since the baby is in the mother's lap. This picture represents a normative message that managing babies is a woman's role (Sultana, 2104), and propagates the idea that women are more nurturing and caring than men because of their 'natural' talent for mothering (Roy, 1998).

The themes I have located and addressed in the previous sections reflect Franklin's (1990) discussion of how the media draws upon normative notions of national identity, heteronormativity, western progress, and the imperative of motherhood in promoting ART use. Franklin (1990) suggests that in England, the media portrays biological parenthood as necessary to fulfill women's lives, but notes that when single, lesbian, or gay parenthood is discouraged, the narratives of fulfillment become contradictory, expressing the broader socio-political ambivalence over non-heterosexual, non-biological parenting. Franklin points out that inheritance, descent, and biological kinship are important in British culture and supported in medical science discourse; thus, other forms of parenthood, such as adoption, are not encouraged. The research newspaper articles, video clips, and ART client information packages I examined also focus on the

importance of biological children because they ensure the continuation of heredity and descent.

Franklin (1990) discusses how parenthood in England is only encouraged through representations of heterosexual relationships. Similarly, the ART discourses I examined emphasizes only heterosexual couples, but they also stress that these couples are married because Bangladesh is a Muslim majority country, and Islamic principles only permit sexual relationships within marriage; conception outside of marriage is interpreted as “haram” (prohibited in Islam), and the baby is labeled the product of sin (bastard).

### **Discursive Construction of the Necessity of Continuation of Lineage**

Discussions of patrilineal lineage are not frequently addressed in the ART discourse, but this issue is nonetheless present, and significant, in depictions of ART. As previously discussed, well-known Bangladesh gynaecologist Dr. Begum identified misconceptions about IVF related to potential mix ups in sperm that could ultimately violate Islam. Though not explicitly addressing the issue, the doctor points to tensions associated with the confirmation of patrilineal lineage. Sultana (2014) explores this issue, suggesting childless Bangladeshi couples often decline ART involving sperm donation because they believe children produced through such means cannot pass couples’ biological traits and lineage to offspring. In a similar vein, Inhorn (2011) explains that in Iran, Sunni Muslims adhere to the religious prohibition on gamete donation because they believe that it “confuses the kinship, paternity, descent, and inheritance [of] the patrilineal societies of the Muslim Middle East” (p. 95). This type of intervention is

considered “immoral” and “psychologically devastating,” (p. 95) and Arab men believe that, like adopted children, the donor child would not be of their own paternity.

Despite these reservations about the disconnect ARTs seemingly create in terms of patrilineal descent, some medical experts attempt to refocus ART as fundamentally a method of natural biological reproduction, in spite of the actual reliance on technical intervention. A clip from a Banglavisión Television channel talk show addressing ARTs features two famous Bangladeshi infertility consultants; in the clip Dr. Farhad Uddin (2014) claims biological reproduction is key to continuing not only family line, but the human species. He begins by discussing Darwinian theory:

According to Darwin, all species try to survive, which has two goals, one is survival for the individual, and another is survival for the species. [...] we want to procreate to expand our lineage, and our inability of procreation abolishes our species. (Uddin, 2014)

Drawing on one of the most familiar names in Western scientific knowledge to legitimate his claim, Dr. Uddin (2014) claims the ‘truth’ that procreation and expansion of lineage are human beings’ ‘natural’ desires, asserting infertility is a ‘problem’ to continuing those desires. Throughout the program, Dr. Uddin and other invited experts explain the desire of childless couples, in particular the women in these relationships, to have children.

Uddin (2014) ends the program by featuring the stories of three childless couples unable to access ARTs. Here, he discusses the underlying barrier of providing ARTs in Bangladesh as rooted in the cost of medical treatments<sup>17</sup>. Uddin goes so far as to request

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<sup>17</sup> As a Bangladeshi, I have personal experience with prohibitive medical costs and doctors who prefer to provide treatment in private clinics, where they often charge a large amount of money and suggest unnecessary tests. In Bangladesh, doctors often receive a percentage from the diagnostic laboratory of the costs of tests they prescribe to patients. In my experience, doctors often do not care about patients’ finances, and prescribe many

infertility specialists provide these couples with access to ARTs, ending the program by praying that “every childless couple have their invaluable asset” (Uddin, 2014). This message highlights the notion that every couple, regardless of their financial situation, should attempt to have children in order perpetuate ideals of family lineage and inheritance; Uddin appears to suggest that no sacrifice is too great when it comes to having children, and his use of prayer solidifies the sacred, cultural aspect of family life. His recommendation that all individuals should have access to ARTs essentializes procreation as natural and deserved, simultaneously reinforces cultural norms about parenthood, and produces the use of technology as an acceptable part of the traditional fabric of Bangladeshi life.

Similar to Dr. Uddin’s statements, the Harvest Infertility Care Ltd. Clinic focuses on the rights of every couple to have children. In establishing their position, the Clinic acknowledges both the notion of overpopulation in Bangladesh and the cost of ARTs on their website under “Frequently Asked Questions.” In response to the question featured in this section, “Should Bangladesh offer infertility treatments as it may exacerbate the population problems?” the Clinic states:

The right to have children is a fundamental right of every human being and a very basic biological urge. Just because a neighbour has too many children

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medicines and tests. Moreover, the results of diagnostic tests often vary from one laboratory to another. For example, I went through two ultrasound scans of my uterus at two different laboratories within a short period of time; one laboratory identified a cyst in my uterus, while the other did not find anything. However, I was privileged in comparison to the couples highlighted in this television clip, because I received treatment services from one of my relatives (a well-known gynecologist in Dhaka city) without fees. Furthermore, I often paid 20% less for the tests, as my relative specified in the prescription to not charge the 20% fees that the diagnostic centre provides to doctors.

should not deprive the infertile couple of their right to have their own.  
(Harvest Infertility Care Ltd. Clinic, 2015b)

This statement is interesting, as poor women's fertility is often controlled by the Bangladeshi population control program (Akhter, 2010). Rather than adhere to ideas of overpopulation and population control, the Clinic characterizes having children as a right, drawing on the discourses of democracy, individualism, and the rights of citizens, which is a particularly western approach. Neither self-indulgence, tradition, nor even duty is invoked as the 'real' reason for having children or accessing this technology – it is a specific, rights-based discourse, which is perhaps attached to the new international economic order developed in the early 1980s<sup>18</sup> (Nyamu-Musembi & Cornwall, 2004). Drawing on an equally Western, economic, individualistic discourse, the Harvest Infertility Care Ltd. Clinic justifies the cost of IVF stating:

IVF and related technologies are undoubtedly expensive, but, then, so is heart surgery. Yet no one objects when over Tk. 1 lakh are spent to try to salvage the heart of a 70 year old man (whose life expectancy in any case is only about 5 years and is not extended by the surgery). Why then should medical technology not be used to help couples in their thirties (with their whole lives ahead of them) have their own baby? (Harvest Infertility Care Ltd. Clinic, 2015b)

This argument raises the question of the value of a child as compared to the value of an elderly individual; ultimately this question is about the future as opposed to the past – a

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<sup>18</sup> In 1986, there was a declaration from the United Nations on “the Right to Development,” in which the Global South's social, cultural and economic development received attention (Nyamu-Musembi & Cornwall, 2004, p. 8). This new declaration refines the “understanding of rights as being about state-citizen relations,” and focuses on the global dimension (p. 8). It emphasizes “the collective obligation of all states to create an equitable international environment” by pointing out the inequalities between the global North and South (p. 8). In order to facilitate the social, cultural and economic rights, aid was and has been provided to global South countries, and the government of aid-recipient countries were and have been obliged to ensure that the aid is used to fulfill the rights of their citizens (Nyamu-Musembi & Cornwall, 2004).

‘progress’/future narrative that is particularly interesting when one thinks about it as an argument against the Bangladeshi values of respecting one’s past/elders.

## **Conclusion**

In this chapter, I have highlighted how ‘truths’ about motherhood, parenthood, and lineage are produced in order to encourage ART usage in the research data. I have outlined that the research newspaper articles, video clips, and ARTs client information packages represent women’s happiness with their children as normative, perhaps even imperative, and explained how motherhood is depicted and equated with honour. I have also addressed how the research data represents imagery of women’s delight with children, primarily by focusing upon seemingly ‘natural’ ties between mother and child in their representations of motherhood and parenthood discourses. Multiple sources of imagery simultaneously present both light-skinned, Westernized couples to promote progress and images of actual Bangladesh couples who have used IVF, demonstrating a broad attempt to normalize ART use. Further, this chapter has discussed how the newspaper articles, video clips, and ART client information packages construct the ‘truth’ that the marital happiness of heterosexual couples is impossible without biological children, also representing traditional, normative notions of masculinity and femininity. Finally, I have discussed how the focus on motherhood within marriage and birth of biological children is connected with the notion of continuation of inheritance, and how these ideals are linked to the concept that having children is a fundamental, albeit westernized right of all couples. In the next chapter, I will show how the research newspaper articles, video clips, and ART client information packages produce the ‘truth’ that childlessness is a problem.

## Chapter 4: Discourses of Childlessness

The research newspaper articles, video clips, and ART client information packages I examined suggest that many Bangladeshi doctors put considerable effort into constructing the ‘truth’ that infertility is not only a woman’s problem, but that men may also be responsible for infertility; this is a notable claim, in that normatively, Bangladeshi people have a belief that infertility is solely caused by women, who are stigmatized and suffer due to this belief (Zaman, 2009; Amin, 2014; Uddin, 2014; Based, 2015; Purabi, 2015). However, even though Bangladeshi media and fertility centres may offer a countervailing cultural narrative concerning male infertility and male use of fertility treatments, this narrative is undermined because the grief of childless women and their desperation to become mothers is so central in these constructions (Amin, 2014; Uddin, 2014; Based, 2015; Purabi, 2015; Romel, 2014). For example, it is argued that men should use fertility treatments to remove stigma towards a woman and heal her grief, rather than to fix their own reproductive failings (Amin, 2014; Uddin, 2014; Zaman, 2009). Although doctors’ focus on men in infertility discourses seem to soften the responsibility placed on women, the constant reintroduction of the ‘issues’ women suffer as a result of childlessness sustains the notion that childlessness is a woman’s problem and perhaps even a woman’s responsibility regardless of the biological underpinnings for infertility.

In this chapter, I examine how the newspaper articles, video clips, and ART client information packages deal with the stigma and grief associated with childlessness, discourses of male and female infertility, and the all-encompassing desperation of

childless women in order to encourage childless couples, particularly the women in these relationships, to be active users of Assisted Reproductive Technologies (ARTs).

### **Stigma and Grief of Childlessness**

Shahaduz Zaman is a doctor, medical anthropologist, and famous writer in Bangladesh. He is also the coordinator of the Masters of Public Health programme at the James P. Grant School of Public Health at BRAC University in Bangladesh (Zaman, 2015). In an article from the Bangladeshi newspaper *Prothom Alo*, Zaman (2009) explains that in Bangladesh childless women, particularly poor rural women, are often vulnerable because people perceive that infertility is their fault. He declares:

In Bangladesh, only one term, “Atkure,” is used for male infertility while 18 terms are used to address a woman, such as “Banja,” “Poramukhi,” “Pjatra,” “Moilla.” ... The husbands often leave poor childless women.... It is observed that a higher-educated, jobholding childless woman also suffers an inferiority complex for not having children.

In this vignette, Dr. Zaman draws upon the circulating normative notion of gender and discourses of stigma associated with childlessness, and the effects of childlessness in Bangladeshi women’s lives to formulate an argument that because of this stigmatization, ART is necessary, and will in fact, save women from this kind of stigmatization.

Dr. Zaman (2009) goes on to add further examples to describe the reasons for women’s grief, drawing not only upon normative notions of womanhood, but also on circulating discourses about modernity and science as appropriate responses to the stigmatization and social exclusion of infertile women. He states:

Due to the lack of fertility treatment services in Bangladesh, many people, particularly in rural areas, are dependent on traditional fertility treatment systems. In traditional treatments, there is no way to do a checkup to identify



the fertility problems or who is responsible for infertility. Therefore, people often point to women as infertile. .. After marriage, the family eagerly anticipates the new bride's conception. If this does not happen accordingly, the bride is defined as "Bondha" (infertile) without any examination, and this causes physical and psychological trauma. (Zaman, 2009)

The text produces the 'truths' that poor rural childless women suffer more due to their lack of wealth, location in rural areas, and lack of access to modern treatment systems than do urban, wealthy and literate women. This argument conveys a sense that poor rural childless Bangladeshi women suffer deeply because of their lack of access to modern medical treatments, which are positioned as holding the ultimate ability to solve childless women's problems. In this deployment, the ostracization and punishment of childless women is not positioned so much as a problem of patriarchy, but rather as a problem of traditionalism and lack of access to western medicine. The doctor goes on to explain:

Government and non-government organizations do not think that infertility is also a problem, which has social, psychological and economic impact. As policy makers do not have any consideration of this issue, the rural childless women are often cheated while they take useless traditional treatments for infertility. Due to a lack of information, they spend huge amounts of money and become more poor. (Zaman, 2009)

In this positioning, it is knowledge – or its lack – that is the basis of women's problems. I argue that the doctor's stance takes up imperialist claims as to the superiority of western knowledge systems in order to expand the purview of Western modern medical treatments in Bangladesh, and it does this by characterizing traditional healing systems as harmful and expensive to women, implying that ARTs are neither.

White's (1992) arguments regarding women's bodies as a site of knowledge construction in development programs in 'post –colonial' Bangladesh assist me to understand the doctor's position because, like other development planners, Zaman constructs the modern medical system as a way to establish women's empowerment and

rights. However, he remains silent about how poor women's grief is embedded in poverty that is connected to global capitalism and in patriarchy that ART technologies will do little to address.

In the *Prothom Alo*, a doctor presents the following mythical, traditional story, drawing on normative formulations that naturalize Bangladeshi childless women's grief, to shore up the availability of ARTs for rural women:

A king, who had many assets, did not have peace because he could not have a child. The six queens of that king were not able to give the king any offspring. At last the seventh queen gave the king a prince by the grace of a saint. We know this story and we know that king started to live with the seventh queen very peacefully after having a child, and sent the other six queens to the forest. However, we do not know what happened to those six childless queens in the forest. We also do not know how childless Bangladeshi women live their lives like the queens who were left in the forest. (Zaman, 2009)

This myth conveys the message that even for a king, no possession is greater than having children. It also alludes to the security, and protection that the successfully reproductive woman will enjoy, and the desperate circumstances that – seemingly since time immemorial – non-reproductive women in Bangladesh will naturally have to endure. The story draws uncritically on circulating ideas of the appropriateness of serving men's 'needs' for lineage, and constructs violence, abandonment, and stigmatization against childless women as unproblematic, indeed positioning childlessness as reasonable grounds for that violence within an historical, traditional narrative. It further draws on women's subordinate positions in society to legitimate the growth of modern medical intervention in the form of ARTs by suggesting that women should achieve motherhood at any cost to secure their subjectivities as wives.

Somewhat ironically, in addition to arguing for the necessity of ART treatments for poor rural women, Dr. Zaman's (2009) proclamations include an attempt to change these social opinions about women's lives:

Policy makers should raise people's consciousness of this issue, and people need to change their mentality that motherhood is not the one and only identity of a woman, and this is not the main job and capability of women. There are many famous women are around the world who have not given birth. A woman can live a glorious life only playing one of her roles.

This is the only article within my research that actually proposes the possibility of an alternative subject position for women that could include childlessness. Nonetheless, Dr. Zaman's position is contradictory; on the one hand, he proposes an alternative subject position for women, mentioning that "the tree does not grow only for giving fruits; it gives us shade, medicine, and many other things. It can live a glorious life only playing one of its roles," while simultaneously recommending that all women should have access to ARTs as a means of improving their lives. In similar ways to most of the ART discourses I have examined, Dr. Zaman draws upon normative, pronatalist Bangladeshi discourses of motherhood in support of market expansion, this time to rural women. In this light, it is difficult to take seriously his argument for the establishment of an alternative subject position for women while he simultaneously argues for the expansion of ARTs.

Similar to Dr. Zaman, Dr. Rashida Begum, who is the pioneer of successful frozen embryo transfer (FET)<sup>19</sup> procedures in Bangladesh, and well-known Bangladeshi infertility specialist Dr. Morium Shati in a video clip about ARTs, deploy an argument

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<sup>19</sup> Frozen embryo transfer (FET) utilizes a cryopreserved embryo generated from a previous cycle of IVF, which is thawed and transferred into the uterus.

about the naturalness of stigmatization to support the use of ARTs. They claim that childless Bangladeshi women are more stigmatized because people assume that women are solely responsible for infertility because they bear the child and give birth, and are unaware that men's infertility is even a possible issue (Amin, 2014; Uddin). In discussing the importance of ARTs for Bangladeshi women, Dr. Begum and Dr. Shati explain that although today's husbands are becoming more supportive if their wives experience fertility problems, mother-in-laws still often harass brides. In a video clip, Dr. Shati explains one of her patient's dilemmas:

The patient's husband lives abroad and he came home to visit her for two months. The patient said that one day while she was in prayer, her mother-in-law told her, pray more to please Allah so that this time you will conceive. Otherwise, I will have my son remarry, and I have already chosen three girls this time if you fail to conceive this time. The patient was crying while she explained her experience of childlessness. (Uddin, 2014)

Dr. Begum adds that a "more interesting thing is that in some cases, in-laws want to remarry their sons even if their sons are infertile" (2014). She states:

I had a patient whose husband had three wives before he married the patient. Her husband divorced them as none of them gave birth to a child. However, after using fertility treatments, the patient learned that her husband had fertility problems. She was so angry to know that. (Uddin, 2014)

These experts are seeking to resist normative gendered discourses by exposing the inequalities embedded in their patient's experiences. However, none of them suggest that childless women do not need be desperate to be mothers. Instead the stories construct the 'truths' that Bangladeshi women's security and rights in their husband's household depend on producing offspring, and reproduction is crucial for the continuity of marital relations. The texts also use these stories of how men exercise their power by

remarrying<sup>20</sup> and abandoning wives, in disciplinary ways, as they are offered as cautionary tales to childless Bangladeshi women, indirectly encouraging them to actively seek out ARTs. In addition, Dr. Begum specifically draws upon Bangladeshi understandings that pleasing Allah is important for childless women, braiding traditional and modern narratives together to naturalize the notion of seeking medicalization for all Bangladeshi women (Uddin, 2014).

Similarly, Dr. Shati superficially appears to resist typical woman-blaming norms by stating, “we become happier when our patients revolted against woman-blame and instead understood that they were not infertile” (Uddin, 2014). However, she also falls short of addressing women’s alternative subject positions, because she does not argue that women do not need to use ARTs. Instead she presents, like the others, her patients’ stories as evidence to make a claim that ARTs are a necessity in childless Bangladeshi women’s lives. These professionals’ stances appear to speak from the discourse of women’s empowerment, while they simultaneously work to instate the ‘truth’ that ‘fixing’ women’s infertility (or disciplining women’s bodies) is the compassionate and natural response.

In a final irony, Dr. Shati and Dr. Begum (2014) go on to explain that even if they are aware of it, ‘typical’ Bangladeshi women often do not disclose their husbands’ infertility, because they do not want to question their husband’s sexual potency, linked to their ego and gendered expressions of masculinity, in front of his family. In this way,

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<sup>20</sup> In Bangladesh, men receive multiple benefits by marriage, including dowry from the parents of bridegrooms. In addition, they receive new labourers, who reproduce more labours in families since most people in rural areas depend on agriculture, and children are considered as parents’ working hands (Nahar, 2012).

their arguments are linked to and supportive of the existing circulating discourse that Bangladeshi women are appropriately liable in protecting their husband's image and providing care for his mental well-being by hiding their husband's infertility (Sultana, 2014).

### **Constructing Male and Female Infertility**

As discussed above, many Bangladeshi doctors have been actively making efforts to produce the 'truths' that infertility is not solely women's problems, drawing attention to the fact that men may also experience infertility and be the determining factor in why a couple has been unable to conceive (Zaman, 2009; Amin, 2014; Uddin, 2014; Based, 2015; Purabi, 2015). For example, Dr. Mortayez Amin explains in a clip on male infertility that aired on the Boishakhi television channel that in 50 percent of cases, males are infertile but do not go for fertility treatments; consequently, women are blamed and suffer (Amin, 2014). He adds that this situation is not unique to Bangladesh, declaring that "in England, women also take the responsibility for fertility treatments," as they are blamed and more stigmatized than their husbands (Amin, 2014). Some doctors even suggest that men should seek fertility treatments simply because it will reduce women's burden and grief (Uddin, 2014; Amin, 2014; Zaman, 2009). This type of argument produces the 'truth' that children are a necessity in women's lives, and that even when men do engage in medical investigation and treatment, they are really properly doing this for the women in their lives.

In his video clip Dr. Amin (2014) even goes so far as to state that "men are more responsible for infertility in Bangladesh" suggesting that "every doctor should do semen

analysis at first because it is a very easy test and it saves money and other inconveniences to the couples, which in turn benefits doctors as the outcomes of treatments will be good, and doctors will achieve fame” (2014). This statement reveals the doctor’s interest in men’s fertility concerns as less concerned with issues of gender equity or changing attitudes towards infertility and more squarely centred on the financial and reputational benefits of expanding the disciplinary potential of medicalization and western ART services to men as well as women.

Further, it is not clear that shifting the focus to men’s fertility, even from a purely medical perspective, has the potential of reducing women’s engagement with ARTs. When doctors discuss male fertility treatments, they often focus on discussions of Intracytoplasmic Sperm Injection (ICSI), where a single sperm is injected into an egg, which they read as a major achievement in curing male infertility (Amin, 2014; Siddiqui, 2014). However, according to some feminists, ICSI is not sufficient to make conception by itself because women often simultaneously need to go for IVF treatment for doctor’s collection of eggs. When the sperm fertilizes an egg through ICSI and the embryo is implanted in a woman’s uterus all foetal developmental responsibilities remains the woman’s (Thorsby, 2004). Moreover, if conception does not happen through this treatment, the blame also often goes to the woman even if she may be perfectly fertile (Thorsby, 2004; Akhter, 2010). Therefore, doctors’ effort to expand men’s use of fertility treatments is connected with women’s uses of ARTs, and does little to shift existing gendered inequalities in the way fertility is understood or handled in the broader culture.

Moreover, my research shows that when health professionals discuss male and female infertility, they primarily emphasis women’s fecundity decreasing with age, and

associate this with their reproductive responsibilities (Purabi, 2015). For example, Dr. Purabi (2015), drawing on medical discourses of the female body as lacking and hence requiring intervention, notes in an article from *The Daily Star* that:

A woman is born with a specific number of ova. .. After crossing puberty, in every month some of these ova are spent. In this way these ova are completely finished at one point of time. In [the] case of a man, the sperm is produced constantly. As such, the influence of age is much more [acute] on a woman than a man. Even then it is assumed that fertility is reduced for a man after reaching the age of 40 years. And for a woman, this age is 30 years. (Purabi, 2015)

In this text, the medical discourse surrounding male and female fecundity decreasing with age shores up Bangladeshi people's commonly-held perception that women's age is a matter of consideration in terms of marriage and productivity (Field & Ambrus, 2008). Further, Dr. Purabi's truth claims about male and female's reproductive functions also reveal Shildrick's (1997) assertion that medical science's knowledge about women and men's reproductive functions is informed by cultural notions of male bodies as superior and female bodies as spaces of pathology and lack. For instance, in the discourses of male and female reproductive functions in medical science, the female reproductive functions are constructed as less worthy than the male body by claiming the 'truths' that men produce millions of sperm a day, signifying their continuous productivity, whereas women produce a limited number of ovum in their entire lives. These types of portrayals construct the 'truth' that women's bodies are less productive and worthy than men, and they legitimate medical control over women's bodies. The texts also support Shildrick's (1997) and McWhorter's (2010) claims the female body is conceptualized and valued in a different way than the male body; representations of female bodies position women as deficient, but doctors construct knowledge about male and female bodies in such a way



that it is difficult to identify the masculine dominance embedded in the medical sciences (Shildrick, p. 14).

The following poster from the Labaid Fertility Centre also reflects Bangladeshi health professionals' focus on women's infertility.



Figure 4.1: (Photograph by Iftekhar Khalid, 04. 04. 2014)

The caption of the poster begins from the position that normatively, women's fertility issues are those that matter, stating in large font: "Infertility is not only a woman problem." The small font below addresses men's fertility, stating, "Men may have infertility problems, and IVF resolves both men's and women's fertility problems and fulfills the desire of having a child." This suggests the focus of health professionals at this clinic to be focusing on women's infertility – even if the biological issues reside in the male – and then constructing ARTs as a solution to both parents' dilemmas.

## **Discursive Constructions of Women's Desperation**

The June 11, 2015 issue of the newspaper *Prothom Alo* published an article in the Science, Technology, and Information Research section on freezing ovary tissue. The article described how two women, one Belgian and another Congolese, became mothers through the re-implantation of tissue in the ovaries. Though the focus of this article seemed to be on describing a new progression of medical science, the sustained narrative focused on the women's desperation to give birth. This focus suggests the success of medical science is still measured in terms of the imperative of motherhood in women's lives.

The article describes the stories of two women who were diagnosed with cancer in their childhood, and underwent chemotherapy and radiation; because the treatments would effectively render the women sterile, their doctors froze and preserved ovarian tissue prior to treatment, with the intent of re-implanting the tissue during adulthood and facilitating conception.

The woman, who wanted to be anonymous, had sickle-cell anemia when she was five years old. She had bone marrow implantation at her age of 11. After implanting bone marrow and taking chemo and radio therapy, she took medicines for one and half years, which damaged her left ovary. After 10 years, the girl wanted to be a mother, and at that time, Domesto and some of his associates extended their assistance. They implanted four pieces of tissue in her left ovary and 11 in her right ovary. After five months she started to menstruate, but her partner started to face infertility problems. The couple tried for a baby through IVF, but that failed, and they broke up. After implanting tissues the woman conceived naturally at 27 years of her age. Her new partner is the father of the baby. The baby's weight was three kg and 100 g at birth. The ovary has been functioning normally, and some of its parts have been preserved. (Staff Correspondent, 2015a)

This story reflects Shildrick's (1997) idea that medical science constructs women's subject position as reproducers, and Foucault's (1984) declaration that the human body is

a site of doctors' power and that medical power is dispersed through the categorization of the 'normal' and 'productive' body. Following Foucault, I argue that these categorizations encourage women to actively pursue motherhood and surrender themselves to doctors' power since motherhood is seen as sign of women's 'normal' and 'productive' bodies.

By producing women's subject position as reproducers, these texts encourage women's self-regulation through the goal of reproduction, they position women's desperation to give birth as a 'natural' choice, and they construct medical compliance as a woman's 'natural' desire rather than evidence of doctors' power over women's bodies. In this story, information about women's pain resulting from the treatments is entirely absent; instead, the invasive and undoubtedly painful treatment procedures are described as though they are no problem for women's bodies to endure, which reflect Foucault's (1972) notion of discourse as a limited and limiting means of representing truths. In addition, these procedures are referred to as medical science's triumphs and successes, as finally the woman was made 'normal' again and had a child. Focusing on the 'normal' functioning of the woman's ovaries after surgery, and the healthy child produced, shores up the notion that medical sciences' mastery over women's bodies is desirable and helpful.

Further, technological intervention is interpreted as essential for women's wellbeing, and hides the control of medical science over women's bodies, reflecting Franklin (1990) and Shildrick's (1997) assertions that ARTs work as a form of bio-power. Franklin (1990) argues that doctors often represent discourses of social loss and biological destiny in order to stimulate childless couples to use ARTs, which produce

new and disciplining social opinions to guide people's behavior. In a similar vein, following Foucault (1995), Shildrick (1997) explains that ARTs work as bio-power because they employ and focus on a number of disciplinary mechanisms, such as heterosexual norms, women's motherhood identity, and the desire to have children, to achieve control of women's bodies, and ultimately, control of the population. Echoing Foucault (1984), Shildrick (1997) explains that health professionals' power is not violent, but rather is conveying knowledge to people as an expression of their own desire, supporting them to draw on religious and moral beliefs to govern their behaviour.

This particular narrative also reflects Franklin's (1990) discussion of how the popular media draws on notions of what is 'natural' and 'normal' in their discussions of women's grief due to childlessness in England by focusing on the natural and biological necessity of having children and a family. Franklin (1990) argues that narratives of the social and biological necessity of children work together to produce feelings of desperation in infertile couples, particularly in women, and in this context, the media portrays that the one and only resolution for desperate women is a medical cure. As infertility is seen as a biological problem, its solution is in the hands of gynecologists and other infertility specialists. These treatments are interpreted as achievements of medical scientists "in the battle to overcome the infertility" (Franklin, 1990, p. 210). The newspaper articles, video clips, and ART client information packages I analyzed follow a similar trajectory in encouraging ARTs in Bangladesh.

It is worth noting that the aforementioned news on freezing ovary tissues not only focuses on women, but also girls, positioning all females, however young, as fundamentally motivated to become mothers by stating:

[the invention of freezing ovary tissues] is a major development in medical science because this treatment will greatly benefit children. After identifying severe anemia of children, the treatment can be provided so that they can be mothers if they want to be in their adulthood, and freezing ovary tissues is the only way to be a mother. (Staff Correspondent, 2015a)

The text draws upon existing normative discourses relation to the ‘naturalness’ of women’s desire to have children into the future lives of young girls. Further, the interpretation of the invention of freezing technology as a critical consideration for children with serious medical issues carries with it the implication that such children should consider reproduction and the continuation of lineage in future, even while their own lives are at risk. To move briefly away from post-structural framings, it is worth noting that the representation of motherhood as women’s ‘natural’ desire also hides the political and economic interests of patriarchy, capitalism, and globalization that are linked to producing the discourses of the imperative of motherhood in women’s lives.

The Harvest Infertility Care Ltd. Clinic also published stories of three IVF cases treated at the centre to produce the ‘truth’ about Bangladeshi women’s desperation to give birth (Harvest Infertility Care Ltd. Clinic, 2015c). In one case, the woman’s dedication was represented as following: “my husband was the only child of his mother. So, the craving for a baby was more. I cried and prayed to Allah a lot,” (Harvest Infertility Care Ltd. Clinic, 2015c). This narrative draws on discourses of the important of lineage, paternity, and family, unproblematically claiming that her desire to conceive was greater because the genetic line of her husband’s family was in danger. The story describes the woman as praying to Allah while she went through three cycles of IVF. The first attempt was entirely unsuccessful; in the second attempt the woman suffered an ectopic pregnancy and lost one fallopian tube. However, the Centre constructs that the

woman was blessed with a healthy son “by the grace of Allah” in her third IVF attempt (Harvest Infertility Care Ltd. Clinic, 2015c). In this narrative, the woman is constructed as happy despite her lost fallopian tube and the considerable pain that would have accompanied this experience. This kind of representation establishes the notion that women’s value and indeed their happiness is produced through bearing children.

This message also produces the notion that it is a woman’s duty to do everything in her power to serve the needs of her husband and his family; essentially, the woman’s own sense of value is tied to her being a vessel to the man’s genetic material. Thus, these women’s bodies are represented in such a way that they are not for their own wellbeing, but considered in relation to others (Mutman & Ocak, 2008). Finally, the argument is posed drawing both on traditional, religious, and modern, medical narratives of saving women, either through divine or technical interventions.

Women’s dedication to perfect mothering during pregnancy is also constructed in a clip from the Ekushey Television channel, where the presenter focuses on three couples’ experiences of conceiving through IVF. One woman, Mitu, described her feelings about pregnancy with the assistance of IVF, stating:

I am so worried and very careful about all of my activities so that I do not do anything that causes harm to my baby. Thus, it is a joy on the one hand, and panic on the other hand. (Romel, 2014)

The portrayal of Mitu’s concerns about the wellbeing of her foetus suggests a normalization of the concept of ‘perfect’ and intensive mothering, because any developmental delay and or problems with a foetus are understood as a mother’s failure to provide ‘perfect’ care (Lupton, 2012, p. 331). It may be that Mitu’s concerns are

amplified because she conceived with the assistance of fertility treatments; therefore, losing the foetus represents not only the loss of a baby, but also all other investments including money, time, energy, pain, and harm inflicted on her body by the treatment.

Mitu's economic dependency is also implied in this video; when Mitu was describing her concerns and self-surveillance of every activity to ensure the wellbeing of her foetus, her husband explained the economic cost of having IVF babies. This could be read as reflecting her husband to be the earner and bearer of the cost of IVF treatments, resulting in Mitu's vulnerability, which may be increased through any perceived failure to engage in 'perfect' mothering. Thus, the text can be read as a disciplinary or cautionary tale; here, Mitu is positioned not as a woman vulnerable to gendered economic dependency and medical expansionism, but she is instead characterized as a woman-hero who works hard constantly to do the right thing not only for her fetus, but for her husband and his 'investment'.

My data emphasizes infertile women's dedication to having children (Staff Correspondent, 2015a; Romel, 2014; Uddin, 2014), while messages about infertile men's experiences are absent or downplayed. This absence produces the 'truths' that women desire babies more than men do; that women's bodies fail more than men's; thus, they should be proactive in achieving the desired result. In my research, only one article from the *Prothom Alo* discusses an actual infertile man's suffering (Imam, 2013). In this story, the man is characterized as kind, having lost his job and becoming dependent on his wife's earnings. In contrast, the wife is depicted as unkind and dedicated to her career, with poor connections and relationships with her husband and his family members. Unlike other stories that have been addressed in this research, the family members do not

criticize the bride, as they depend on her earnings; rather, the man is the one who experiences pressure from his family to have a child. In Bangladesh, kindness is understood to be a woman's virtue, and economic independence a sign of men's masculinity; however, in this story, the man and woman's characteristics are portrayed differently. In this narrative, the childless man is constructed as emasculated, and we can almost imagine that should he produce a child, he would then be reasserted as the head of his household. His suffering is depicted as a result of his economic dependence on wife, unlike women's suffering, which is typically portrayed as emotional and embodied through infertility. Moreover, this article produces the 'truth' that male infertility as unnatural and unmasculine. In this way, gendered norms and bodies are produced and sustained, even though the article depicts a man's infertility and his experiences.

This article goes on to further produce gendered bodies by focusing on the woman's dedication to pursue having a child. As with other stories, it is the woman who attends the clinic for a fertility checkup, indicating that it is she who assumes responsibility for reproductive outcomes. Only after learning that she is not the cause of the infertility does she suggest her husband to go for fertility tests, and finally, her husband's infertility was identified. Thus, although this story could be read as a reformulation of gendered bodies by exposing the possibility that men also experience infertility, other gendered norms are produced through the message that even though economic solvency may reduce some pains of women, it still does not change women's desire for motherhood. The story ends by explaining that the woman became sympathetic to her husband after learning of his infertility, telling her husband that "she will not leave



him” (Imam, 2013), drawing on normative claims about women’s natural, sacrificing role as ‘good’ wives.

## **Conclusion**

The aforementioned discussions reveal that the researched newspaper articles, video clips and ART client information packages often disproportionately represent the negative consequences of childlessness in women’s lives as compared to the benefits of motherhood, which produce the ‘truth’ of the necessity of children in women’s lives. This chapter has discussed how the discourses often exploit women’s grief and the stigma of childlessness in order to encourage ART usage. I have established that although it appears that there are some efforts being made to produce the ‘truth’ that men also have reproductive difficulties, much of the discourses nevertheless focus on the normatively gendered responsibility of women to investigate and resolve fertility issues. I have also outlined how the researched newspaper articles, video clips, and ART client information packages focus on only the benefits of ARTs, and remain silent regarding the potential harms and pain associated with fertility treatments; they even go so far as to describe the treatment procedures in such a way that convey the ‘truth’ that they are not difficult to access or use, have few or negligible side effects, and are highly likely to succeed. Women’s actual experiences of using the treatments are absent in most of the portrayals used by Bangladeshi media and fertility clinics. Instead, the media focuses on women’s overwhelming desire to have children, their commitment to this goal, and the tremendous rewards they experienced from using ARTs. Following Foucault (1984), I have argued that these presentations help doctors to extend their power over women’s bodies in the name of their wellbeing. In the next chapter, I will discuss how Bangladeshi media and

fertility centres reconcile religious discourses of giving birth within medical science in order to appear more promising to Bangladeshi childless couples, and how these constructions are connected with the doctors' entrepreneurial hope.

## **Chapter 5: Market of ARTs: Conciliation of Science and Religion**

Having analyzed how the research articles, video clips, and ART client information packages produce the ‘truth’ that children are a source of happiness for married heterosexual couples, and childlessness is defect and causes grief in Bangladeshi women’s lives, I will now analyze how the research data discursively constructs ARTs as providing hope for every childless couple. My enquiry in this chapter has been informed by Franklin’s discussions on the entrepreneurial aspects of ARTs. Franklin (2006) addresses ARTs as “hope technologies” that simultaneously materialize the imperative of biological reproduction and prompt childless couples to keep faith in “scientific progress” and “technological-enablement” (p. 549). Franklin (2006) further argues that these constructions of ARTs are connected with doctors’ entrepreneurial interests.

Similar to Franklin, my data from Bangladeshi media and fertility clinics indicates that in their construction of hope, besides materializing the social imperative of biological children (as discussed in the third and the fourth chapters), Bangladeshi doctors deploy a limited ‘truth’ about technological advancement in terms of ARTs in Bangladesh, encouraging childless couples to trust western medical treatment, to normalize the idea of fertility treatments and babies produced through IVF, and to construct an idea of IVF treatments as democratizing through the promise of lower costs (Kabir, 2007; Staff Correspondent, 2012; Romel, 2014; Amin, 2014). Finally, physicians draw not only on modern and democratizing discourses, but also on notions of medical adherence to Islamic principles in providing ARTs in order appeal to Bangladeshi couples in this Muslim majority country (Uddin, 2014; Amin, 2014). The doctors focus on this issue because there are continued tensions between the notion of progress, Western modernity

and Islamic principles, and many Islamic groups fear that Western countries only utilize the notion of modernity in order to implement their culture in Bangladesh and pollute the principles of Islam (Nahar, 2005). In this chapter, I argue that for Bangladeshi health professionals, these discursive constructions of ARTs are firmly aligned with their desires to increase the business of ARTs in Bangladesh (Franklin, 1990; Sultana, 2014).

### **Constructing Hope for Childless Couples**

This section is divided into three parts; the first part addresses how Bangladeshi media and fertility clinics construct ‘truths’ about the technological advancement of ARTs by working to engender feelings of hope in childless couples. The second part discusses efforts to normalize IVF by naturalizing the production of ‘healthy’ and ‘normal’ IVF babies, and producing the ‘truth’ that IVF treatment is simple to use. Finally, the third part addresses how Bangladeshi health professionals are attempting to appeal to couples by assuring them that they will be able to undergo IVF treatment at lower costs.

#### **Providing advanced fertility treatments in Bangladesh.**

All fertility centres analyzed in this research use similar tactics in describing their technological advancement to encourage childless couples to use their treatments; they deploy knowledge about their advanced technologies, skilled onsite doctors, and highlight their collaboration with expert doctors in other more developed countries, including India, Singapore, and Thailand. Nevertheless, some clinics take a more expansive business approach than others; for instance, the Harvest Infertility Care Ltd.

Clinic not only targets childless Bangladeshi couples who live within the country, but also couples who live abroad, through advertisements in the American-based online Bangladeshi newspaper *PBC24.com* (Faruque, 2013). As part of the centre's advertisements, the newspaper published the stories (and it published the same stories on its website) about a Bangladeshi ex-patriot woman living abroad, using her professed satisfaction with the clinic's treatment services to shore up their claims to modern, effective and inexpensive outcomes:

I was confused that being the resident of America, I am receiving such a sophisticated treatment from a relatively less developed country like Bangladesh. But the caring doctors and the fantastic environment they have created relieved me from all the agony. To tell the truth, I was so comfortable here that even in America I was not that comfortable. Don't you think that if you can describe your problem in your mother tongue, it is comfortable? I strongly believe that technical efficiency [and] the unique environment it has created is world class. (Harvest Infertility Care Ltd. Clinic, 2015c)

This text draws on normative understanding about the superiority of the west to argue for accessing these modern scientific treatments in Bangladesh. The text also encourages childless couples to use fertility treatments in one's native country by representing the benefits, including the comfort of expressing needs in one's native language and within one's familiar cultural norms. The text suggests these benefits, coupled with the lowered costs of service, to be so appealing that even couples living in England or the United States should travel home to Bangladesh when considering fertility treatments.

In addition to constructing the 'truth' of the benefits of receiving medical treatment in one's native country, the fertility clinics pamphlets, news articles, and video clips I examined shore up their claims to superiority by highlighting the potentially negative aspects of receiving treatment abroad, including failure rates, high cost of

treatments, hassles of traveling, and loss of productivity, in order to encourage childless couples to choose treatments in Bangladesh (Staff Correspondent, 2014a; Amin, 2014). In this way, the discourse of hopefulness formulates an argument that, on the one hand, ART services in Bangladesh are every bit as modern, effective, efficient, scientific and successful and those in the West (which remains positioned as the world leader in terms of medical and excellence). On the other hand, the argument positions these ‘just as good as’ services can be obtained at home without the attendant expense, discomfort and uncertainty of traveling to the West. In this way, the discourse both shores up normative notions about the West as the centre, and of Bangladesh as able emulate the west while not threatening its traditional roots.

The Square Fertility Clinic attempts to construct hope for childless couples in methods similar to the Harvest Infertility Care Ltd. Clinic. For example, one of its pamphlets states that “Now there is a hope for every childless couple,” because the Clinic employs highly-skilled consultants including embryologists from Singapore; has long term, experienced nurses; and has a dedicated staff with whom they have achieved world class success<sup>21</sup>. In addition, the Square Fertility Clinic declared in the newspaper

*Prothom Alo*:

Good news for the infertile couples, the Square Fertility centre is giving children as gifts to all of infertile couples. After 18 years of marriage at 37 years old, Mrs. Khan gave birth to a test tube baby in her first attempt under Dr. Zakiur Rahman’s treatments in the Square Fertility Centre. (Kabir, 2007)

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<sup>21</sup> The publication date is not provided, but Iftekhar Khalid collected the brochure on 04. 04. 2014.

This vignette claims the ‘truth’ that the centre has such highly skilled doctors that they are able to produce IVF babies in even a single attempt. The use of language “giving children as gifts” suggests that the centre is providing babies (treatments) without any cost, hiding the significant investments couples will have to make. The centre’s message about “good news” demonstrates an issue that Akhter (2010b) has discussed; while producing test tube babies may seem on the surface to be very good news for infertile couples, it is not good news for women because it again emphasizes their desperation to procreate in patriarchal society and reestablishes the ‘truth’ that women achieve their value by producing a child. Rather, it might simply be ‘good news’ for doctors because they can expand their business based on this value.

### **Normalization of IVF treatments and babies.**

Perhaps because many Bangladeshi people still believe that IVF babies are not ‘natural’ babies and are often born with physical and mental ‘defectiveness’, health professionals have begun displaying photos of IVF babies in fertility clinics in an effort to refute these beliefs (Uddin, 2014; Romel, 2014).



Figure 5.1: Wall displayed in the Square Fertility Centre, photographed by Iftekhar Khalid on 04.04. 2014

A clip from Ekushe TV illustrates how clinics work to make IVF children appear ‘normal’ like other children by showing how ‘average’ their daily lives are. The reporter in the video clip reporter explains that:

The couple had been trying for a child for a long while, and they got their baby Minhaz from one of the infertility centres in Bangladesh a few years ago. Minhaz is now KG student. He is doing well in his school and his naughtiness and continuous demands give the family life, and make the parents happy ever after. (Romel, 2014)

The descriptions construct the ideas that the IVF child is ‘perfectly normal’, and that scientific intervention is a safe – even guaranteed- means of producing a healthy, happy child. This story also draws upon the existing idea that ‘normal’ children are the source of happiness, despite the everyday ‘naughtiness’ of the ‘typical’ child. The video clip also features two children conceived through IVF reciting poems to prove their intellectual ‘normalcy’; in it, the mother of one IVF baby also explicitly explains that her child’s brain development is similar to ‘normal’ babies (Romel, 2014). The woman’s worries about the ‘normalcy’ of her child reveals Foucault’s (1984) assertion that constructions of ‘normal’ and ‘abnormal’ bodies and characteristics circulate in ways that invite people to respond with compliance, and to want to achieve ‘normalcy’.

Bangladeshi health professional’s efforts to normalize IVF treatments reflect Thompson’s (2005) explanations regarding the normalization and naturalization of ARTs in the United States. Thompson notes the notion of ‘natural’ is not static, but shifts in biomedical science through the efforts of doctors, medical staff, and counselors. Thompson argues that naturalization, or using the language of the natural, is an important way to normalize new technologies, and the process of naturalization can occur as use of a new technology increases. Thompson (2005) explains that, initially, fertility treatments



in the United States were originally addressed as “artificial insemination,” whereas today they are more accurately, and neutrally, referred to as ARTs. Thompson also notes that time is key in making the treatments seem ‘natural’ and ‘normal’, because “patients go through their own changes over time about what seems natural and acceptable and what seems frighteningly or impossibly unnatural” (p. 41). Thus, IVF was initially considered a highly unnatural means of conception, but public opinion has shifted as a result of large numbers of people employing the technology, and because a significant number of babies have been born through the treatment (Thompson, 2005). The same trajectory is seen in Bangladesh, as research indicates that the use and acceptance of IVF treatments has been steadily increasing (Romel, 2014).

In addition to displaying photos of IVF babies, all clinics included in my research publish images of treatment procedures in their brochures, such as the photo below:

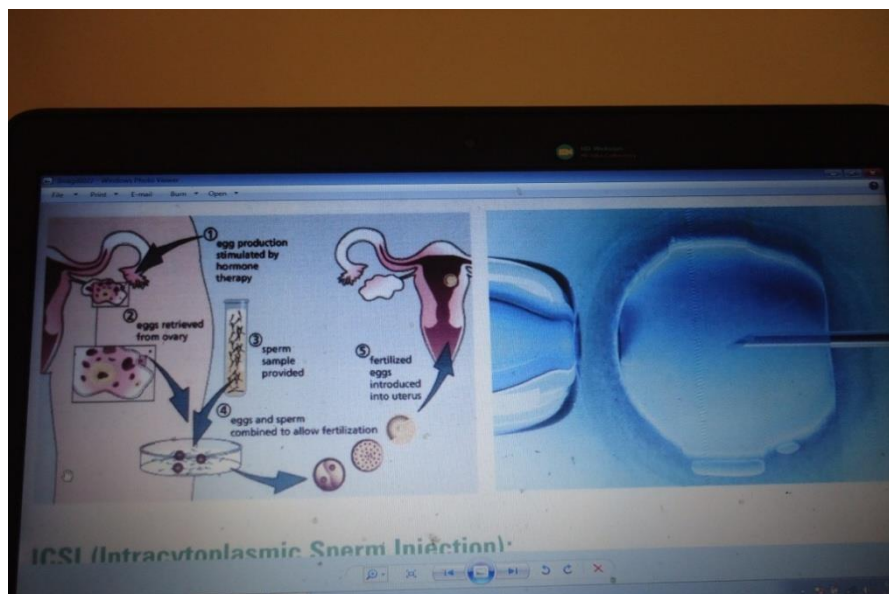


Figure 5.2: This image was collected from the pamphlet of the Labaid Fertility Centre. Scanned by Iftekher Khalid on 04.04. 2014

The above images are not realistic, rather they are used to illustrate the procedures of IVF treatment in considered ways; the right image shows how doctors inject a sperm into an ovum in IVF treatment in order to fertilize an egg, while the left image describes the entire cycle of IVF treatment. Both images convey the notion of ART as a remarkably disembodied procedure, obfuscating medicine's actual intervention in human bodies, while simultaneously coding how in modern science, disembodiment is idealized as neutral and objective (Haraway, 1991). Further, while the images convey the process as very clean and clinical, any sign of the messiness, pain or trouble of this treatment is absent, although the fact is that the treatment is complicated and painful (Shildrick, 1997). In this portrayal, IVF treatment is rendered as easy, painless, scientific and as one that indeed does not involve any body – either that of the woman, or of the doctor who 'penetrates' her. In this way, perhaps, traditional Muslim concerns about ART as a form of infidelity and as *haram* are preemptively dealt with.

Further, when doctors explain the IVF procedure, they often describe themselves as assisting the 'natural' process of procreation in the laboratory (Amin, 2014; Uddin, 2014). This claim is addressed by Franklin (2006), who asserts that since the origin of IVF treatment, doctors have claimed to only assist or help natural reproduction, when the fact is that the process quite invasively replaces women's reproductive cycles. For example, doctors need to inject the gonadotropin-releasing hormone to stimulate the growth of follicles in the ovaries (Sultana, 2014) which changes women's biology (Franklin, 2006); this treatment can cause ovarian cancer due to super-ovulation, infection, bleeding, and potential puncture of the fallopian tubes (Shildrick, 1997, p. 203; McWhorter, 2010, p. 50).

Nonetheless, the Labaid Fertility Clinic describes the pain associated with the treatment as a “mild discomfort” in its brochure, and the Clinic barely describes the potential harms and risks of the treatments. The following example from the Frequently Asked Questions on the Harvest Infertility Care Ltd. Clinic website also shows how the fertility centre downplays the potential harms of ARTs:

Questions from a patient: Are there particular health risks for women undergoing infertility treatment?

Answer of the centre: Along with their intended benefits, drugs used to treat infertility may seldom cause side effects. In ovulation induction, close monitoring of follicular growth is crucial to ensuring successful treatment. Monitoring techniques (such as ultrasound scan and blood tests) and adequate use of treatment protocols help the physician to avoid ovarian hyper stimulation syndrome (OHSS) and minimize the risk of multiple pregnancy. (Harvest Infertility Care Ltd. Clinic, 2015b)

The centre constructs ‘truths’ about its technological ability to reduce harm, monitor and manage risk, thus encouraging couples to keep faith in the ability of technological interventions. The centre also constructs super-ovulation as beneficial for childless couples, declaring:

Since most IVF/ICSI programs superovulate patients to grow many eggs, there are often many embryos. .. It is now also possible to freeze these embryos and store them in liquid nitrogen. .. so that [they] can have another embryo transfer cycle done without having to go through superovulation and egg collection all over again. (Harvest Infertility Care Ltd. Clinic, 2015d)

The text addresses frozen embryo technology as a convenient, one-time intervention that offers new hope for childless couples, attempting to normalize the regularly occurring failure of the first attempt of IVF, and encouraging couples to try unlimited cycles. These texts also arguably indicate that technologies are replacing the role of women in

procreation, with specialists becoming the authority in control of conception (Basen, 1993). These types of representations play a significant role in shaping people's view of ARTs as harmless, painless and risk-free (Sultana, 2014; Franklin, 1990).

The following question from the Harvest Infertility Care Ltd. Clinic Frequently Asked Questions section addresses how people categorize themselves as 'normal' or 'deviant':

Question from the patient: My gynecologist has done an internal examination and said I am normal. Do I still need to get tests done to determine why I am not conceiving?

Answer from the centre: A routine gynecological examination does not provide information about possible problems which can cause infertility, such as blocked fallopian tubes or ovulatory disorders. You need a systematic infertility workup. (Harvest Infertility Care Ltd. Clinic, 2015b)

These texts display normatively that ART practitioners are empowered beyond 'ordinary' doctors to identify what is 'normal' and what is 'deviance' and enforce the idea that the one and only solution for childless couples is undertaking increased technological assistance. The question from the woman reinforces the idea that women desire to be mothers, while the answer of the Centre encourages women to persist with a systematic (read: lengthy) series of medical investigations and treatments. This text reflects Foucault's assertion that medical science exercises and legitimates its power by categorizing individuals as 'normal' and 'deviant', and then prescribing the solution for the 'abnormality', which prompts people to actively position themselves within the discourses of normalcy and hide the technologies of medical science's power behind the screen of normality (Turner, 1997). Further, the utilization of only women's worries about their 'productive' and 'normal' bodies reflects Shildrick's (1997) assertion that

medical science produces women's bodies as deficient, and in need of doctor's assistance.

### **Treatment cost.**

The costs associated with IVF treatments are understood as one of the most significant barriers for its expansion in Bangladesh, since most people do not have the ability to bear the expense (Staff Correspondent, 2013a; Uddin, 2014). Therefore, health professionals publicly claim that they are trying to reduce the cost so that they can provide this service to a larger number of childless couples. However, they also mention that costs are not in their hands, and that they ultimately depend on the pharmaceutical companies' rates for producing medicine needed in the procedures, and on the government's tax rate for the medicine. They claim that if both pharmaceutical companies and the Bangladesh government lower their rates, then ART health professionals will be able to provide the treatments at lower costs (Uddin, 2015). Doctors' claim that the pharmaceutical companies of the Global North charge high rates for ARTs in order to produce the 'truths' that it is the companies that profit, not Bangladeshi doctors. Moreover, they explicitly leave out any information on their ties with the companies.

Recent news suggests the Bangladesh government has already started to build an IVF laboratory in one of the country's public hospitals in order to provide IVF treatment at a lower cost (Romel, 2014). An article from the *Prothom Alo* adds:

The researchers of the United States and Europe have been trying to find a kind of test tube technology which will cost less money, and it will cost only 256 US dollars per test tube baby, and this method can be a ray of light not

only for the childless couples of developed countries, but also for poor childless couples of developing countries. (Staff Correspondent, 2013a)

This news focuses on the involvement of European and American scientists because they are normatively seen in developing countries like Bangladesh as skilled leaders in discovering new technologies. The text further indicates how the invention of biotechnologies in Western countries is seen as globally beneficial rather than problematic. While this seems like an effort to democratize access to ARTs for poor people, in fact it will most likely do little more than open vast new markets and profits through increased sales.

### **Reconciling Religious Discourses of Giving Birth in Providing ARTs**

The news articles, video clips, and ARTs client information packages I analyzed show that many Bangladeshi doctors aim to produce the ‘truth’ that they maintain Islamic principles in providing fertility treatments. Doctors are particularly careful in terms of this issue because many Bangladeshi people still fear using ARTs; couples are concerned that doctors will use the wrong sperm to fertilize the egg, and violate Islam (Uddin, 2014; Amin, 2014). For instance, in the Harvest Infertility Care Ltd. Clinic’s ART pamphlets, it is explicitly written that “Treatments are regulated following Islamic principles.”<sup>22</sup> In their descriptions of the treatment procedures IVF and ICSI (Intracytoplasmic Sperm Injection), the Labaid Infertility Clinic uses the following language:

IVF: If the fallopian tube is blocked, this method is used. The ovum is collected from the ovaries through an operation, and then is placed with a husband’s sperm, and the embryo is transferred to the wife’s uterus.

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<sup>22</sup> The publication date is not provided, but Iftekhar Khalid collected the brochure on 20.04. 2015.

ICSI: If the quality and mobility of sperm is not good, this method is applied. Like IVF the ovum is collected from the ovaries, then the sperm is inserted with a special instrument. Then the developed embryo is placed into a wife's uterus.<sup>23</sup>

In this text, the centre is careful to use the words *husband* and *wife* instead of *men* and *women* when describing their fertility treatment services. Using the words husband and wife is important as these words draw upon the positive normative power of the marriage relationship in order to assure potential clients that the centre is not doing anything which is “haram,” or culturally unacceptable in Bangladesh. This representation in turn shores up the marriage system and discards other relations outside marriage. This strategy on behalf of the centre is can be read as an effort to be as trustworthy to Bangladeshi people and eliminate Bangladeshi people's skepticism and confusions about using ARTs by drawing on key cultural values about marriage, religion and lineage. The Labaid Fertility Centre, like the Harvest Infertility Care Ltd. Clinic, uses the terms husband and wife in their materials. Similarly, the doctors, reporters, presenters, and the Imam in the video clips used in this study all use husband and wife when they discuss fertility treatments. Their language affirms the cultural tradition that offspring is only possible within a marital relationship. Only the Apollo and Square Fertility Centres use the terms “men” and “women” when describing the procedures. However, the Square and Apollo hospitals are famous for their modern, world-class treatments in Bangladesh; thus, they may follow Western writing and representation styles without question.

Egypt, also an Islamic country, reflects a similar pattern; IVF is only acceptable within a husband/wife relationship, and donor insemination is prohibited (Inhorn, 2003).

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<sup>23</sup> The publication date is not provided, but Iftekhar Khalid collected the brochure on 04. 04. 2014.

Inhorn (2003) explains that Muslims in Egypt are strongly concerned with what is “haram” (prohibited in Islam) and what is “halal” (permitted in Islam). In Egypt, infertility is often understood as a result of sin or Allah’s punishment; thus, fertility centres are careful to address these beliefs, and use language that confirms they do not do anything which is prohibited in Islam. However, Inhorn (2003) explains that technologies also shape and are shaped by local culture; IVF was stigmatized in Egypt, but gradually doctors have been normalizing it through reconciling modernity and traditions. Inhorn (1994) explains that the first Egyptian IVF baby was born in 1987, and after this the Egyptian media began to telecast many programs on IVF in order to inform people of the treatment option. Discussions about the religious permissibility of IVF were also televised in order to increase IVF acceptability, greatly impacting the overall normalization of the process. Nonetheless, Egyptians still often rely on Allah’s will, and believe that Allah ultimately decides the result of IVF.

In a similar way, the Bangladeshi television channel NTV telecasts “Test tube baby: Islamic view,” as part of its “Life Questions” program, and features the Imam’s (religious scholar) opinions on the use of ARTs (Hasan, 2009). The religious scholar was invited to answer people’s questions about Islamic views on using IVF. In the clip, he explains:

IVF can only be approved within husband and wife relationships. If an embryo is implanted into an unmarried woman’s uterus and if sperm is collected from other than husband, these procedures will hurt the natural system. This is completely prohibited because these procedures violate Allah’s order and hurt Allah’s natural system. (Hasan, 2009)

This statement reflects the common Bangladeshi opinions that married relationships, and having children within this relationship, are ‘natural’, and these ‘natural’ practices should



be continued for the wellbeing of the world. Nonetheless, ARTs reflect Western beliefs and practices, and are interpreted as artificial; thus, using these technologies may pollute Allah's natural systems and Bangladeshi culture. Using these technologies may mean disobeying Allah and Allah's natural systems, and the experts are careful to caution that Bangladeshi people should be aware of this and work to straddle medical and religious imperatives. The imam goes on to explain that:

The collection process of the sperm also should follow Islamic principles. Any illegal way should not be used for ejaculation, so that the sperm should not be collected through masturbation, as it is unacceptable in Islam. Allah says that those who masturbate, their hands will be punished by conceiving, that means hands will conceive and will be ashamed in the Judgement Day<sup>24</sup>. In order to collect sperm, the husband and wife should go for sexual intercourse and the husband should ejaculate outside the vagina, from where the sperm should be collected. Moreover, only female gynecologists should take part in operations in order to collect eggs from women. (Hasan, 2009)

This statement sets highly proscribed means of bridging western medical practice with Islamic prescriptions, and holds heterosexual, marital intercourse as the only way to produce a child 'properly', even when that intercourse is embedded within a broader series of technological interventions.

Although the religious scholar focuses on Islamic principles when applied to ARTs, he begins his talk by claiming the 'truth' that the invention of ARTs is a significant sign of the progress of medical science in helping childless couples; as such, his talk suggests he is articulating the notion of progress in an Islamic way. Incorporating Imams' views in medical discussions in Bangladeshi media is a powerful strategy on

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<sup>24</sup> In Islam, there is a belief that one day the earth will be destroyed and all people "will be resurrected after death and judged on the basis of how they conducted their lives" (Sultana, 2014). On that day, people's actions will be shown to others, and people will be sent to Heaven or the Hell based on their beliefs and deeds.

behalf of medicine to increase the acceptability of medical treatments to Muslims. This also, however, suggests that doctors are not concerned about other religious and ethnic minority people in Bangladesh.<sup>25</sup> .

Further demonstrating the mixed interpretation of Islamic law, gynecologist Rashida Begum, a Bangladeshi pioneer of the successful implantation of frozen embryos, has frequently stated on Banglavisision TV talk shows that as Islam permits IVF only within married heterosexual couples, sperm donation is not acceptable in Bangladesh (Uddin, 2014). She also suggests surrogacy is prohibited, as it involves a third person in addition to a husband and wife (Uddin, 2014). Nonetheless, Dr. Begum frequently states that having a child – even if it involves the use of modern technological interventions

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<sup>25</sup> Bangladesh is the third largest predominantly Muslim country in the world, and is an aid dependent country. Since the independence in 1971, many Non-Government Organizations (NGOs) have been working for the ‘development’ of Bangladesh. During nineties some groups were critical of NGOs activities as they perceived NGOs to be the agents of Western imperialism. During this period, some fundamentalist groups burned down schools set up by NGOs, as well as NGO offices, as they perceived NGO activities as coming from the West with the intention of destroying ‘Islamic ideology’ and values of the country. They attacked NGO activities including family planning and health programs, micro credit, and women’s education programs, and harassed women who worked for NGOs. They also prevented women from obtaining health services from NGOs. On the other hand, Western donors have also become suspicious about the activities of ‘fundamentalist’ groups, and address them as ‘terrorists’ who are seen as threat to Western power and hindrance to their development projects (Naher, 2005, pp. 1-3). Therefore, development planners today are careful about religious sensitivity, and concerned about incorporating Islamic actors and representatives of traditional elites to make the development process succeed. They incorporate religious leaders from traditional organizations, such as Mosques, and Madrasah (schools for Muslim children) to make the development process acceptable to people in many Islamic countries including Yemen, Algeria, Egypt, and Jordan (Gatter et al., 2013). Recently, development planners from Germany argued that “Islam is not a monolithic construct” and “unchanging system of values and norms,” but it is often portrayed as rigid and unchanging (Naher, 2005, p. 06). Instead, Islam is shaped by a multiplicity of “religious currents and legal schools” and “its local traditions and political and historical experiences” (Naher, 2005, p. 07).

such as IVF – is a blessing of Allah, and without Allah’s grace nothing is possible (Uddin, 2014).

The fertility clinics are also careful about referencing Islamic principles when they describe their treatment procedures; for example, the Harvest Infertility Care Ltd. Clinic mentions that “general physical examination and gynecological examination will be carried out by our female doctors” (Harvest Infertility Care Ltd. Clinic, 2015d). The Centre further explains that for transvaginal ultrasounds, patients will be prepped by female doctors and fully covered before ultrasonography is carried out by specialists (Harvest Infertility Care Ltd. Clinic, 2015d). By drawing on Islamic understandings of propriety and sexuality, this discourse carefully presents a truth that the sanctity of women and their position within Muslim society is not threatened by the advancements of modern medical practice.

Among the four fertility clinics I researched, the Harvest Infertility Care Ltd. Clinic appears most concerned about Islamic principles. However, the centre’s answer to a patient’s question on the Frequently Asked Questions section of its website contradicts its position about religion. The patient’s question was: “My grandmother says that if I just pray and have faith, I will definitely conceive. How far is this true?” The centre answered that: “Believing in [G]od can help you to maintain a positive outlook – but sheer will and blind faith won’t overcome a physical problem like blocked tubes or absent sperms” (Harvest Infertility Care Ltd. Clinic, 2015b). This answer contradicts the popular opinion that IVF works if Allah wishes (Inhorn, 201, Uddin, 2014). Rather, in this response, the clinic clearly positions scientific knowledge over religious belief, and my extension, western thinking over Eastern faith. This discursive strategy can also

suggest that the centre's main purpose in stressing the compatibility of Islamic principles with ART practice is not preserving Islam, but rather simply materializing Islamic principles to support their business.

Inhorn (2011) states that before travelling to the Middle East to conduct research on ARTs, she believed that as Islamic countries, the regions she was researching would have different attitudes from Western countries towards the commodification and bodily transfer of human gametes. However, she observed that even "Islam encourages the use of science and medicine as solutions to human [procreation]" (Inhorn, 2011, p. 93). In this regard, Inhorn (2003) explains that most developed countries are the producers of technologies, while developing countries are the users. When new technologies are introduced in developing countries, their "local social arrangements" are imported to make the technologies relevant in that society (Inhorn, 2011, p. 2). In the discourses I examined, it was clear that because Islam is an important aspect of Bangladeshi culture, health professionals do import these local beliefs into their discourse and practice in their efforts to make ARTs acceptable and to expand their markets.

That said, in these materials, there are some contradictory messages about the approach of doctors towards third party involvement in IVF treatment, indicating that some physicians may be willing to permit. For example, in the research video clips, health professionals often maintain that like other Islamic countries, egg and sperm donations in Bangladesh are haram (Uddin, 2014; Amin, 2014). However, in one of these clips, Dr. Rashida Begum states that "there is an option of sperm donation, but the treatment is only provided with the consent of the patients" (Uddin, 2014). Another video

clip goes even further, to suggest sperm donation is be available through certain channels, “...with the help of the third party behind closed doors” (Romel, 2014).

Sultana (2014) also finds that most Bangladeshi doctors’ responses regarding the availability of egg donation, sperm donation, and surrogacy are ambiguous at best.

Sultana (2014) observed that doctors were hesitant to speak about these options. As there are no formally regulated guidelines in Bangladesh, IVF proponents often “follow their personal ethics” when providing services (Sultana, 2014, p. 303). However, they disclose that they fear “‘third party’ involvement in IVF procedures will be challenged fiercely by religious groups in Bangladesh” (Sultana, 2014, p. 304). Further, Sultana (2014) states that doctors feel “the government of Bangladesh will never permit the option of donor’s egg and/or sperm” (p. 305). Thus, it is important to maintain the *appearance* that health professionals are not “doing anything” which contradicts religion (Sultana, 2014, p. 305). This suggests that although health professionals might wish to provide these fertility treatments, the fear of criticism and being labelled as practicing something that is haram affects the type of services they ultimately provide.

This importance on the *appearance* of compliance to Islam is threaded throughout the discourses I examined. It is clear from these materials that many health professionals are trying to implement modern and scientific medical treatments. These professionals convey Western thinking, but often publicly express maintaining traditional values and independence from more ‘polluting’ or ‘decadent’ aspects of the West, in order to appeal to traditionalist groups that are worried about the negative influence of Western culture on Bangladeshi identity and society (Naher, 2005). This, in turn allows them to expand into a market that otherwise would be unavailable to them. In this regard, Douglas (1966)

is informative; she explains that every society has some key notions of purity and pollution that act to maintain a boundary between that society and others, and the leading members maintain the rules of purity and pollution to maintain norms and order in the society.

## **Conclusion**

This chapter has outlined how health professionals construct hope for childless couples, and how these constructions are connected with doctors' entrepreneurial endeavours. This chapter has outlined how the newspaper articles, video clips, and ART client information packages I analyzed often highlight the technological developments of ARTs, including focusing on skilled doctors, promoting collaborations with specialists from other countries, and advertising world-class treatment facilities. This chapter also addressed the various efforts of doctors and reporters in my data set to normalize ART treatments and IVF babies, through such methods as describing fertility treatments as simple to use and highlighting the production of 'healthy' IVF babies. Further, I have outlined how although the included newspaper articles, video clips, and ART client information packages construct hope for childless couples through their assertions of lower cost fertility treatments, doctors continue to operate their businesses in ways that fundamentally focus on their own benefit. Finally, I have explained how many Bangladeshi doctors in my data express their concern with maintaining Islamic values, while at the same time implementing bio-medical treatments in Bangladesh.

## **Chapter 6: Specificity to Bangladeshi Context**

This chapter reviews the specific ways the newspaper articles, video clips, and ART client information packages I analyzed have strived to make ARTs desirable to Bangladeshi people. First, I discuss how the discourses of motherhood and parenthood are present in my data. Second, I discuss how the included newspaper articles, video clips, and ART client information packages draw upon naturalized notions of grief and the stigma associated with childlessness to construct ‘truths’ about male and female infertility and women’s dedication to be mothers. Next, I outline how some Bangladeshi doctors draw on notions of progress and modernity in relation to ART treatments and how they aim to normalize the cost and potential harms of IVF treatments as well as IVF children. In addition, I examine how my data work to reconcile Islamic principles with medical science in making ARTs desirable to Bangladeshi Muslim consumers. I conclude by addressing the limitations of my study, and offer suggestions for possible future research.

### **Discursive Constructions of Motherhood and Parenthood**

The examined newspaper articles, video clips, and ART client information packages draw upon the discourses of women’s ‘natural’ desire of having children and produce the ‘truth’ that Bangladeshi women’s lives are fulfilled by motherhood (Romel, 2014; Uddin, 2014; Based, 2015; Purabi, 2015). They publish imagery as ‘proof’ of women’s delight with children, and even depict celebrity actresses’ joy and blissful lives in their aim to produce the ‘truth’ of women’s ‘natural’ desire of motherhood (Romel, 2014).

In addition, these ART discourses often take up and reproduce normative notions about the necessity of biological children in couples' lives, with a particular emphasis on couplehood and parenthood as proscribed within heterosexual marriage. In conveying this notion of the naturalness for the desire of parenthood and motherhood and their 'proper' position within heteronormative marriage, the analyzed newspaper articles, video clips, and ART client information packages use multiple kinds of imagery. On one side, they have published light-skinned and Westernized couples - whom are culturally linked with the notion of progress - to produce a normative subject who desires to use modern treatments (Based, 2015; Purabi, 2015). On the other side, they have published the images of actual Bangladesh couples who have IVF children – with whom local readers will presumably identify – to encourage Bangladeshi couples to use ARTs (Staff Correspondent, 2014). Regardless of the racialized aspects of the discourses of couplehood and parenthood, both sets of imagery draw upon and produce normative notions of masculinity and femininity (Based, 2015; Purabi, 2015; Staff Correspondent, 2014a).

As Bangladesh is produced and understood within discourse of international aid and development as an overpopulated country, and because local, national and international government and development organizations often focus on population control programs, population is an important issue in marketing ARTs in Bangladesh. Material from one fertility clinic included in this research strives to clarify the issue, aiming to erase people's hesitation to use ARTs by linking the concept of having children with every couple's "biological urge" and "fundamental rights" (Harvest Infertility Care



Ltd. Clinic, 2015b), thus erasing political and economic arguments through conveying the inevitability and universality of reproduction.

I was surprised by some of the themes in the discourse. Before collecting data, I had the belief that Bangladeshi doctors would only encourage wealthy childless couples to use ARTs, as these treatments are costly and poor women are strongly discouraged to reproduce (Akhter, 1992). However, in my data doctors also present the desperation in less wealthy couples' stories in order to encourage couples without vast wealth to seek IVF treatment (Uddin, 2014; Staff Correspondent, 2014a). Another surprising aspect of the data I analyzed is that doctors even present the value of spending money for IVF children in comparison to seeking treatment for other diseases, and strive to construct the 'truth' that spending money for having children is more worthy even than one's own, or one's elder's wellness.

### **Truth Claims about Stigma and Grief of Childlessness and Women's Desperation to Give Birth**

The newspaper articles, video clips, and ART client information packages I examined present the negative consequences of childlessness mostly in terms of Bangladeshi women's lives and desires, but not men's (Zaman, 2009; Amin, 2014; Uddin, 2014; Based, 2015; Purabi, 2015). They also produce the 'truth' that poor rural childless Bangladeshi women suffer more compared to wealthy and urban women due to the lack of wealth, their location, and lack of access of modern fertility treatments, in a way extending their potential markets, but also extending the potential reach of modern medicalization. The texts and media I examined even produce traditional fertility

treatments as detrimental in establishing women's rights, posing the modernity of medical intervention as something connected to gender emancipation rather than as a simple technology for sale. Further, they construct the 'truth' of the necessity of replacing traditional treatments with ARTs by inflating their descriptions of the beneficial aspects of ARTs in reducing childless Bangladeshi women's grief and simultaneously understating the risks and costs attached to ART treatments (Zaman, 2009; Uddin, 2014).

In my data, many doctors were shown to have been striving to construct the 'truths' that women are not solely responsible for infertility, but that men are in a similar way responsible for infertility in order to include them as consumers of ARTs. These doctors claimed that most Bangladeshi people still perceive infertility to be a woman's problem because they carry and give birth to the child, and that the doctors are striving to break this perception. In all video clips analyzed for this research, doctors encouraged men to use ARTs by using the argument that their use would reduce childless women's grief (Zaman, 2009; Amin, 2014; Uddin, 2014). I argue that this type of truth claim draws upon the circulating idea that children are more necessary for women's lives as compared to men's, and ignores the benefits and joy males receive from their children.

Further, I argue that the doctors in the examined discourse strived to construct the 'truth' that men and women are in a similar way responsible for infertility (Amin, 2014). While this may be physiologically true, nevertheless many of their claims still relied on and the 'truths' that women's bodies are less productive, potentially deficient, and in need of medical assistance. They also construct the 'truth' of childless Bangladeshi women's dedication and willingness to sacrifice themselves in order to use ARTs, and position women as reproducers. The invasive and often painful ART treatments were

described as ‘normal’, and technological intervention is interpreted as essential for women’s wellbeing in these claims. Health professionals’ power is constructed as anything but violent, and women’s surrendering to their doctors’ power gets glossed over in these discussions as women’s own desire and choice to be mothers (Shildrick, 1997). By discursively constructing women’s desire to be mothers as natural and universal, doctors in my data produce the ‘truth’ of advancing medical science as a significant method of progress in helping women to become mothers, and legitimizes doctors control over women’s bodies.

### **Reconciling Science and Islam**

Besides constructing the ‘truth’ of social imperative of biological children and normative notions of motherhood and parenthood, Bangladeshi doctors in my data represent discourses of ART technological advancement in Bangladesh to construct childless couples’ hopes of having children (Kabir, 2007; Staff Correspondent, 2012; Staff Correspondent, 2014a; Romel, 2014; Amin, 2014; Staff Correspondent, 2015a). I found that all fertility clinics analyzed in this research have similar messages about progress and their ART treatments. For example, they convey messages that they provide world-class treatment services, have skilled doctors, and collaborate with other skilled doctors from around the world. Some fertility clinics, including the Harvest Infertility Care Ltd. Clinic, show more aggressive business-oriented attitudes by simultaneously targeting childless couples who live in Bangladesh and who live abroad through advertisements in online newspapers (Faruque, 2013). The centre publishes real cases of immigrant women’s satisfaction with using the clinic’s treatment services to encourage other couples to use their services (Harvest Infertility Care Ltd., 2015c).

Further, and reflecting Foucauldian claims about medicine's role in relying upon and producing categories of normal and not-normal, the doctors cited in my analysis normalize or simply deny the harm of ARTs while naturalizing its possible results by displaying photos and telling stories about IVF babies that show their 'normal' growth and development, in efforts to counter the perception that babies conceived through IVF are 'unnatural'. Since high costs are seen as a barrier in accessing ARTs for many childless Bangladeshi couples, the newspaper articles, video clips, and ART client information packages I analyzed were all actively attempting to construct hope that in the near future doctors will provide IVF treatments at lower costs (Romel, 2014; Staff Correspondent, 2013). However, I found contradictory information in this discourse about the actual grounds for some of these high treatment costs, which suggested doctors only claim that fertility treatments are expensive because the costs of the medicine are artificially inflated and the Bangladeshi government charges unnecessarily high taxes on them (Uddin, 2014). Further, some of the discussion described how Bangladeshi doctors falsely profit from fertility treatments by prescribing unnecessary medicine to childless couples (Alam, 2014). These contradictions indicate that despite drawing on democratizing language promising low-cost access to infertile couples, medical greed and ambition is an active part of the discourse and its related practices.

In addition to conveying messages about the ways ARTs represent technological advancement, Bangladeshi media and fertility clinics actively seek to reconcile Islamic principles with using ARTs, as Bangladesh is a Muslim majority country and many aspects of ART stand in contradiction to Muslim beliefs (Uddin, 2014; Amin, 2014). There are continued tensions between the notion of progress, Western modernity, and

Islamic principles, since many Islamic groups fear that Western countries only utilize the notion of modernity in order to impose their culture in Bangladesh and pollute the principles of Islam (Naher, 2005). According to Imams (Islamic religious scholars), ARTs should be used only within married, heterosexual relationships, and no third party should be involved in order to adhere to Islam (Hasan, 2009). Doctors are aware of and concerned with this issue, and address that surrogacy, egg donation, and sperm donation are not typically available in Bangladesh since they are prohibited in Islam. Fertility clinics also explicitly and pre-emptively address their adherence to Islam in providing information about treatments to women (Harvest Infertility Care Ltd. Clinic, 2015d). Fertility clinics' concern about Islam is reflected in their ART promotional materials, in that in order to assure people that they provide treatments only within marital relations, they use the words *husband* and *wife* instead of *men* and *women*.

Nonetheless, I found contradictory evidence about the actual availability of sperm and egg donation in Bangladesh (Romel, 2014). These contradictory messages suggest that doctors' focus on religious permission in using ARTs is perhaps only a pragmatic means of making ARTs acceptable to Bangladeshi people, and they will participate in treatments that violate Islam under certain situations if their patients desire.

### **Further Research**

My research has used the method of discourse analysis which has assisted me to explore how discourse is used to convey stories about reproduction and technology and how the stories rely on normative notions of gender, religion, technology, bodily discipline, and western superiority. While this approach has assisted me to examine how

Bangladeshi media and clinics construct ‘truths’ about women’s bodies and ARTs, further research might use a political economy approach to explore the structural and economic relations in which childless women’s experiences are embedded. Further research might employ an ethnographic method in exploring childless women’s experiences from their standpoints. This approach might include examining how childless women face and cope with stigma and social pressure, consider whether they negotiate or resist the dominant discourses of motherhood, and examine the direct experiences of ART users.

In my research, I examined doctors’ opinions through media and clinics’ information packages, and found some doctors’ express contradictory opinions, or do not address certain issues at all. For example, health professionals only described how they follow Islamic principles in providing IVF treatments, but they did not convey any information on how they provide treatments to other religious groups and ethnic minority people. Qualitative interviewing methods might provide an opportunity to unpack these issues.

Other future research might focus on childless women’s experiences in different ethnic minority cultures in Bangladesh. For example, some ethnic minority communities in the country are matrilineal, and considering these cultures might provide us with insight into the differences and similarities between childless women in different cultures within Bangladesh. Comparative research might also provide insight into the different cultural meaning and practices of motherhood, childlessness, and fertility treatments. It

may also illustrate how seemingly ‘natural’ experiences of motherhood and childlessness are purely cultural practices.

I have also learned through my research that male infertility is an emerging issue in Bangladeshi media and fertility centres, and Intracytoplasmic Sperm Injection (ICSI) is interpreted as a huge development in terms of curing male fertility. Nevertheless, men still do not want to seek fertility treatments in Bangladesh (Amin, 2014; Uddin, 2014). Further research might explore male infertility and experiences from their standpoints. Further, in my research I have only focused on how *medical science* constructs knowledge about male and female infertility, but in Bangladesh, *traditional* fertility treatments are also available. Many people still go for traditional fertility treatments, sometimes alongside modern treatments, and many others depend only on the traditional healing systems (Zaman, 2009). This consideration of modern versus traditional treatment would be an interesting issue to explore.

Finally, during my research I came across a brochure from the Apollo Fertility Clinic regarding stem cell treatments at the Apollo Clinic in India. I have not examined whether or how genetic technologies are encouraged alongside assisting conception, but this would be an important research issue to consider because of the significant criticisms that these treatments and technologies are embedded in eugenic and sexist ideas that aim to create ‘perfect’ children and eliminate ‘disabled’ people (McWhorter, 2010). Future research might explore how and why health professionals provide genetic technologies, and why couples use these treatments; this may ultimately provide insight into the further biomedical control of Bangladeshi people.

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### Appendix A: A Chart of the Newspaper Articles

Source	Speakers	Date Published	Name of the Article
<i>The Daily Star</i>	Staff Correspondent	June 10, 2014	Ctg gets its first test-tube baby
	Doctor	January 11, 2015	Dealing with infertility
	Staff Correspondent	September 20, 2008	First frozen embryo baby born in Bangladesh
	Staff Correspondent	April 21, 2009	Twin test-tube boys born at Apollo Hospitals
	Doctor	June 07, 2015	Know the reasons of infertility
<i>The Prothom Alo</i>	Staff Correspondent	March 14, 2014	Fertility treatments in BSMMU 14 tests for everyone
	Staff Correspondent	September 20, 2013	Infertility and a tree of afternoon
	Staff Correspondent	September 24 2012	A new ray of hope to prevent infertility due to chemo therapy
	Staff Correspondent	August 26, 2013	Test tube babies with less cost?
	Staff Correspondent	May 12, 2014	The male infertility due to tooth pest, soap, and sunscreen
	Staff Correspondent	May 10, 2015	Mothers with diamond wombs conferred on 25 mothers
	Doctor	October 24, 2007	Happiness is seeing the face of the child
	Staff Correspondent	May 19, 2015	The Production of sperm in a Laboratory
	Staff Correspondent	June 11, 2015	First baby from frozen tissues of ovaries
	Staff Correspondent	September 14, 2013	When conception is an occupation
	Staff Correspondent	April 18, 2014	A New Era of Infertility Treatment
	Doctor	October 17, 2009	Infertility

