

INTRODUCTION

This book explores the dynamics that inform the demand for in vitro fertilization in Turkey. To this end, I examine women's experiences of childlessness and the greater conceptual significance of children in their lives. I explore the influence of social relationships on childless lives. I focus on the experience of childless women before they start the treatment, rather than during or after the treatment.

The research was conducted in the northwestern part of Turkey. The first part of the research was undertaken in two IVF clinics, in Istanbul and in the outskirts of Istanbul. I interviewed women undergoing IVF (133 interviews in total ranging from a few minutes to two hours) as well as the medical IVF staff. The second part of the research took place in two villages about three hours by car from Istanbul. In the villages I had the chance to observe the implications of childlessness in the context of social relations.

Infertility and Assisted Reproductive Technologies

The definition of infertility is ambiguous (Sandelowski 1993: 55) if not self-imposed (Pfeffer 1987: 83). Infertility had at one point been defined by the WHO (World Health Organization) as 'the inability to conceive within two years of exposure to pregnancy'.¹ In November 2009, the WHO altered this definition, and in *The Revised Glossary for Assisted Reproduction Technology (ART) Terminology*, recognized infertility as a 'disease':²

Infertility (clinical definition): a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after twelve months or more of regular unprotected sexual intercourse.

As the WHO also makes explicit this time, the definition is a clinical one. It is predicated upon biological incapability, and so falls short of acknowledging a whole range of critical issues that derive from the social experience of being infertile, as my research shows, as does other research on infertility in Egypt (Inhorn 1994, 1996), in Lebanon (Inhorn 2004, 2006b, Clarke 2008, 2009), in Israel (Birenbaum-Carmeli and Carmeli 2010, Birenbaum-Carmeli and Inhorn 2011, Haelyon 2006, Inhorn and Birenbaum-Carmeli 2009a, 2009b, Kahn 2000, Soffer and Birenbaum-Carmeli 2010), in Iran (Tremayne 2006) and in India (Riessman 2000a, 2000b) as well as in Turkey (Gürtin 2009, 2012a), among others.

In Turkish, *kısır* means infertile or barren. For many people it is a humiliating word. I have encountered the word sixteen times among 133 interviews. Only two childless women used the word to describe themselves. For some people, only permanent reproductive incapacity may imply infertility. Couples who pursue IVF may not consider themselves infertile, for they still have a chance to conceive, whereas others may consider anyone who seeks a cure from IVF to be infertile.

Infertility has a variety of implications for couples. The gender identities of men and women can be contested due to infertility. For some, childlessness may also connote unrealized life goals, or a life of emotional suffering. However, in stark contrast, some couples in my research consider infertility to be a test given by God, and thus welcome the opportunity to prove one's faith in God's will (as also seen in Inhorn's research with the urban, poor infertile women in Egypt, 1996).

Infertility has been approached from a variety of perspectives in anthropological literature. The influence of religion on the conception of infertility and on the treatment of infertile people is one of them. Religious beliefs can inform the interpretation and experience of infertility that may lead to social exclusion of the infertile woman (N. Price 1998), denial of after-death rituals (Ebin 1994), or aggravation of the stigma based on promotion of motherhood (Inhorn 1996: 83, Kahn 2000). In Islamic countries, having children is also seen as a religious duty, whilst motherhood is sacred by nature (Inhorn 1996). Clarke (2008, 2009), Inhorn (1996, 2003a), Kahn (2000) and Tremayne (2006) reveal the ways in which religion can inform the discourses and practices related to IVF in ethnographies from the Middle East. A critical evaluation of religious discourses (and the pertinent literature) in the context of this research will be provided in the second chapter of this book.

Ethnographies of infertility emphasize stereotyping related to infertility. Selfishness is one of the stereotypes about childless women that I have encountered in my research. Infertility may signify misfortune (Feldman-Savelsberg 2002 on the Bangangté of Cameroon, Neff 1994 on the Nayars in South India), sometimes caused by witchcraft, envy or the evil eye (Inhorn 1996 on Egypt, Mitchell and Georges 2000 on Greece) or misfortune as God's will (Thiessen 1999 on Skopska Crna Gora, Macedonia, Inhorn 1996 on Egypt). There is no uniform way of looking at infertility as misfortune in Turkey, where it is possible to perceive infertility both as misfortune given by God and misfortune due to envy or the evil eye.

Metaphors about infertile people also offer insights as to how infertility is interpreted. A metaphor for the infertile may connote uselessness, a waste of resources and failure to realize the aim of life. A childless woman can also be called 'an empty basket' among the Lazi in Turkey (Beller-Hann 1999, Beller-Hann and Hann 2001),³ a cow which does not give milk or calves (Inhorn 1996: 59) or a tree that does not bear fruit in Egypt (Inhorn 1994, 1996). As I discuss in the next chapter, a childless woman in Turkey can also be referred to as a fruitless tree.

In this book, I will use the term assisted reproductive technologies (henceforth ART). Turkish terms are: *yardımcı üreme teknolojileri* (assisted reproductive technologies) or *üremeye yardımcı tedavi metodları* (treatment methods for assisted reproduction). The use of acronyms for ART is not common in Turkey except in legal documents.

Just a few years since the completion of my research, IVF is no longer perceived as a novel technology. As I discuss below, IVF has gone through a normalization process, which may have increased its acceptance while decreasing its popularity in the media. It does not engender the type of questions and concerns that it had before. During my research, IVF-related news appeared on television almost every day and one newspaper had a daily corner about IVF. After a few years, herbal healing became a more popular topic, as IVF experts were replaced by experts in herbal healing and nutrition. Newspapers followed the same trend as well.

The people I met in the IVF clinics and the two villages where I conducted research used the term *tüp bebek* (test-tube baby) to refer to IVF, as is common throughout Turkey. Everyone I met in the IVF clinics including the medical personnel and the interviewees used the terms 'sperm' and *yumurta* (egg) to refer to gametes. In the villages I saw that the media popularity of IVF had familiarized people

with 'sperm' and *yumurta* as essential components for conceiving a baby. To refer to sperm, the word *döl* was sometimes used as well as 'sperm'. They used *yumurta* in reference to ova.

In vitro fertilization (IVF) refers, in brief, to any assisted reproduction treatment that involves the conception of sperm and ova outside the body (as opposed to *in vivo*, in the body). This is so concise a definition that it is inevitably misleading. I provide a summary of the procedure below to give an idea of how much is obscured in this definition.

The IVF Process in Brief

In the first stage of the process, there is an introductory meeting (*ön görüşme*) with the IVF physician,⁴ where a couple learns about the treatment and the clinic, and the physician learns about the couple's reproductive history (involving when they first tried to conceive and what happened after that, including all the treatments undergone and tests taken), habits such as smoking, and the start date of the next menstrual period.

A variety of drugs are used in IVF treatment, along with two 'protocols' (short and long). The preference for a protocol is made mainly depending on the age of the patient. Most of the treatments I observed were long protocols, which lasted about three weeks. The short protocol, which involves intensive hormone intake over ten days, is preferred for women who are forty years old and more. The process I describe here reflects the long protocol. During the treatment, women attend the clinic about 4–5 times for monitoring (*takip*), once for oocyte retrieval and once for embryo transfer within three weeks. The treatment from the first day of using drugs to the day of the pregnancy test is called a 'cycle' in the medical terminology. In Turkish, this word is *siklus*, but its use is limited to medical professionals.

The first part of the cycle is called 'superovulation (follicular stimulation) and monitoring'. A female body has two ovaries and in each ovary (*yumurtalık*) there are follicles, each of which contains one oocyte (egg, *yumurta*). Normally a number of follicles start growing each month but only one of them reaches the mature stage and releases its oocyte (ovulation). With superovulation, the development of several mature follicles is intended.

Superovulation has two phases. The first is called 'down regulation' (*hormonların baskılanması*) and the second is 'stimulation' (*hormonların uyarılması*). During the down regulation, women are given GnRH (gonadotropin-releasing hormone) analogues in order

to prevent the ovarian production of endogenous hormones that can interfere with the production of follicles. This drug is taken every day by injection or nasal spray. Depending on the type of drugs used, women have intramuscular injections or they administer the injections themselves subcutaneously two fingers below their belly button using an auto-injector. During this phase it is important that ovaries are kept inactive. To check this, women undergo a vaginal ultrasound about 12–14 days later.

During the stimulation (or monitoring) phase, which lasts 10–12 days, women also inject themselves with drugs containing FSH (follicle-stimulating hormone) and LH (luteinizing hormone) every day in order to stimulate the production of several follicles. They decrease the dose of the GnRH analogue, but continue to inject it daily. Thus, women may have to administer injections to themselves twice or three times a day during this period. During this phase women go to the IVF centre every other day to monitor the growth of their follicles.

When the follicle size and oestrogen levels are ideal, the next step is the final maturation of the follicles. Women stop the injections they have been taking so far. They are given a different injection, of human chorionic gonadotropin (hCG).

After 34–36 hours, couples visit the IVF centre for the oocyte retrieval operation and semen collection. Oocytes are aspirated from follicles through the vagina with ultrasound guidance while women are under sedation. Oocyte retrieval lasts about twenty minutes and women rest for thirty minutes to two hours after the procedure. Women sometimes experience abdominal or pelvic pain. Men provide a sample of semen by masturbation at this time. Embryologists clear the sperm from the semen, and the oocyte from the follicular liquid. They perform tests on the sperm to choose the fastest ones with normal shape and movement.

In conventional IVF, which is almost never employed in Turkey any more, a few thousand sperm with one oocyte are placed in a petri dish in a culture medium – hence the name *in vitro*, meaning ‘in glass’. Fertilization is expected within eighteen hours.

An alternative technique is Intracytoplasmic Sperm Injection (ICSI), in which each oocyte is injected with a single sperm by an embryologist. This technique, which has turned out to be a great advantage in male infertility cases, has widely replaced conventional IVF in Turkey. This is mainly because IVF clinics, which want a high rate of ‘success’, want a lower risk, and so prefer that at least the penetration of the egg be guaranteed.

Couples are informed about the fertilization the day after the oocyte retrieval. The embryo transfer is made usually on the second or third day after the oocyte retrieval (these days, blastocyst transfer on the fifth day is also widespread). Embryo transfer does not require sedation for women who are able to undergo gynaecological examination. In Turkey, the maximum number of embryos that can be transferred is now one (at the time of the research it was three). Twelve days after the embryo transfer, a pregnancy test – measuring the BHCG (beta human chorionic gonadotropin level) in blood – is performed.

The summary given here is still too succinct to give an overall picture of the IVF treatment. The process from the beginning to the end can vary according to the drugs and methods used, health complications experienced and possible failures at each stage. Fear and frustration, as well as hope and joy, are also part of the treatment for many.

IVF in Turkey

Since the birth of Louise Brown, the first IVF baby in 1978, four million IVF babies have been born worldwide (Russell 2010). IVF arrived in Turkey in 1987 and the number of IVF centres in Turkey significantly increased in one decade, from twenty-two in 1998 to ninety-three in 2008.⁵ The Turkish Ministry of Health does not disclose any statistics regarding IVF to the public (except the names of active IVF clinics). The ministry refused to answer my questions regarding the number of IVF cycles and the number of IVF babies born to date. The only information they did provide me with was the yearly growth of the number of IVF centres in Turkey. According to a newspaper article (Çelebi 2011), it is estimated that over 50,000 IVF babies have been born in Turkey, and Turkey is the seventh country in terms of the number of IVF treatments performed after Israel, France, Spain, the United Kingdom, the United States and Germany. The total number of IVF cycles per year is over 40,000. However, the article mentions that according to Bahçeci, a well-known IVF specialist in Turkey, there are 500,000 people who are in need of IVF, a statistic that indicates that state financial support for IVF is insufficient (just one of several reasons for not opting for IVF, which this book elucidates).

In Turkey, IVF is available only to heterosexual married couples. Third-party assisted reproduction treatment is illegal. Unlike for the Shia Muslims in Iran and Lebanon (Clarke 2006a, b, 2007 a–d, 2008, 2009, Inhorn 2004, 2006b, Tremayne 2006), gamete

(sperm or ova) donation and surrogacy are not possible in most of the Sunni Muslim world. The Turkish Republic of Northern Cyprus is a notable exception and is preferred by Turkish couples who seek IVF via donated ova, sperm, embryo or surrogacy. Greece and Israel are among the other favourite destinations for 'reproductive tourism'.⁶ Turkish law permits freezing embryos for five years with the consent of both spouses. In the case of death of a spouse, frozen embryos are destroyed.⁷

The latest legislation in Turkey, as of 6 March 2010 brought enormous changes regarding the use of ART. Now not only the practice of IVF using donor gametes or embryos is illegal, but even referring patients to such practices abroad, or informing patients about such treatments is not allowed anymore (Gürtin 2010, 2011). The head of South Clinic (pseudonym) where I did research told me that he would not even mention a word to anyone about those practices anymore, now that it could be considered a criminal act. An IVF clinic can be shut down for three months if any IVF physician is found to refer couples to donor IVF (a second occurrence of such an act can result in the total termination of the clinic). All people involved in such acts including physicians, gamete/embryo recipients and gamete/embryo donors are prosecuted. I hope the later parts of this introduction on the government's strong support for the ideology of the 'sacred family' will make the incentives for such legislation a bit more understandable. However, this is not to say that the reasons underlying such forceful laws are understood or approved by the thousands who are in need of donor gametes or embryos.

Another major change in the practice of IVF in Turkey, brought about by the same legislation, is about the number of embryos that can be transferred to a woman's womb. During the time of my research, it was possible to carry out embryo transfer with up to three embryos. For those who had a history of failed IVF cycles or who were above thirty-nine years old, four embryos could be transferred.⁸ This new legislation introduces the practice of 'single embryo transfer' (SET) to Turkey. The transfer of only one embryo is allowed for women under the age of 35 for the first two cycles. Women under 35 who have had two failed cycles of IVF and women above 34 – in each cycle – can undergo IVF with a maximum of two embryos. This law is justified with the increased health risks associated with multiple pregnancies. Since the legislation came into force long after this research took place, the book will not reflect on the current laws.

Married women must be over twenty-three and under forty years old in order to be eligible for funding via the state's social security

institutions,⁹ they should have been insured for at least five years by one of those social security institutions, and should have failed to conceive for three years. Childless couples who meet these conditions can get a medical report from a teaching or research hospital.¹⁰ The cost of treatment at the time the research took place (depending on the quantity of drugs a woman needed, as well as on the clinic) was around 3,000–4,000 U.S. dollars or 5,000–6,000 Turkish liras, including the drugs. In a teaching or research hospital, a couple with a medical report (mentioned above) could have treatment for as little as 410 Turkish liras and pay half the cost of the medicine (for two cycles of IVF).

Mass media was the medium through which ‘truths’ about IVF were generated during my research. IVF was known to everyone, but there were alternative truth claims for IVF. Many people assumed that IVF was implemented with the sperm of a third party. This was because of the sporadic appearance of news in the mass media about the illegal use of third-party sperm in IVF or artificial insemination (with or without the knowledge of the couples).¹¹ Paternal relatedness in these narratives was reckoned genetically, and the man whose wife underwent IVF was suspected of not being the ‘real father’ of the IVF child.

During this research, a newspaper (*Posta*) had a daily corner about IVF. Television programmes had IVF specialists who provided information about the treatment. Sometimes religious specialists, nutrition experts and celebrities joined these discussions. All of these people contributed to the formation of discursive truths about infertility, IVF and motherhood. For example, IVF specialists stressed that ‘men, too can be infertile’, nutritionists underscored that ‘overweight people have problems related to fertility’, while religious specialists warned against ‘committing a sin by having a child in unconventional ways’ (such as surrogacy). Celebrities making claims about adoption as a more ‘appropriate’ solution (compared to IVF) for having a child marginalized certain treatments and the people who underwent them.

Some of these programmes also featured members of the public. For example, one daily programme hosted about a hundred guests who went to watch the show and take advantage of the gifts distributed on the programme.¹² These gifts ranged from household appliances and furniture to funding for an IVF cycle. Another daily programme sponsored unlimited cycles of IVF for women.¹³ IVF emerged as a pop culture artefact during my research that attracted popular attention, was distributed as a postmodern gift, and which

created a gamut of truth claims about the people who underwent it. Childless women participated in creating these truths by narrating their childless lives and by representing a needy self to convince the programme hosts to give them the 'gift'. As a pop culture artefact, the popularity of IVF in the media later diminished, despite its enduring significance for millions of childless couples and their families.

During this research there was a television series called *Bebeğim* (My Baby) about a woman who had a child via surrogacy.¹⁴ This series precipitated a debate in the media by journalists, sociologists and viewers of the series. The fact that surrogacy is a reality in Turkey despite its illegality and controversial image became apparent in daily television shows, in which couples who commissioned surrogates as well as surrogate mothers participated. Discourses about the 'natural desire' and 'natural need' for motherhood as well as the 'natural way' (or appropriate ways) to be a mother were repeatedly reproduced in discussions pertinent to IVF.

An interesting aspect of these appearances of IVF in the media and of the discussions that took place around them was the normalization of IVF (Thompson 1998, 2005: 79–115). Childless couples participated in this normalization. A woman could ask for a sofa along with IVF as a gift in these programmes. Infertility, once always concealed (and still concealed by many), could be normalized in a Foucauldian manner via medicalization, by defining it as a disease, or by presenting it as a financial problem compared to the lack of money to buy a sofa.¹⁵

While infertility is medicalized, IVF is socialized. For example, the fact that the practice of polygyny¹⁶ has diminished due to the increasing use of IVF is a recurrent discourse in newspaper articles, including the internet and religious newspapers. First, this discourse presents polygyny as a social problem. Then the claim that men who can now have a child via IVF do not need a second wife (*kuma*: concubine) presents IVF as a solution to this social problem. Another common narrative in news articles about IVF is the presentation of childlessness and of not having a son as social problems, and the presentation of IVF as a solution to these problems.

In these newspaper articles, claims that polygyny was the cultural solution to childlessness or not having a son before IVF make reference to a specific region in Turkey: the 'southeastern' part. In these articles, it is the southeastern (or eastern) region where husbands take a second wife (*kuma*) when they do not have a son, and it is women from the east/southeast, who do not want a *kuma* in their homes, who subsequently fill up IVF clinics. This narrative,

by localizing childlessness or sonlessness¹⁷ and its allegedly inevitable consequence, polygyny (taking a *kuma*), essentializes the 'culture' of people of a certain place and also normalizes IVF.

De Kok (2009: 211) warns against the normalization of certain practices as 'cultural' by people who want to legitimate them. Based on his research on opinions of infertility in Malawi during 2002–2003, he shows how:

respondents account for responses to infertility, such as engaging in extramarital affairs or polygamy, by mobilizing a cultural norm according to which bearing children is expected or required. These accounts construct the aforementioned practices as reasonable, practical solutions for fertility problems, and as scripted, that is, widespread and recurrent. Consequently, respondents normalize practices and play down people's accountability for them.

The Turkish media, in a similar vein, normalizes polygyny in the context of the southeast part of Turkey, but cannot normalize it for others for whom polygyny is considered a social problem. The narrative of before and after the advent of IVF resolves this conflict. Before the advent of IVF, polygyny is justified with reference to having a son as the 'cultural norm' (but only in the 'southeastern culture'), while after the arrival of IVF, pursuing IVF is normal (still in the context of those cultural norms that compel one to have children or specifically sons).

Another newspaper article about surrogacy appeared amidst the discussions triggered by the television serial, *Bebeğim*, mentioned above. Okyay, the consultant on the film, commented upon surrogacy:

Turkish society is already open to this topic and ready for it. Because especially in Anatolia, when the fertility of a woman is not considered enough, the problem is solved by a *kuma* (a second wife via religious marriage). Furthermore, the babies born to the *kuma* are registered as the children of the wife who is married to the man with a civil marriage. In the serial, this problem is solved by finding a surrogate and getting pregnant with IVF.¹⁸

For Okyay, Turkey is ready for surrogacy, which has similarities to polygyny (already practised by some people in Turkey). This association of established cultural practices with new ones provides a creative way to normalize a practice such as surrogacy. By 'piggybacking' surrogacy onto polygyny, surrogacy also becomes culturized.

Literature on IVF and Infertility in Turkey

In anthropological literature around the world, IVF has created debates on a variety of critical issues, ranging from unequal access to the treatment, to the bioethical or biopolitical considerations with regards to its use, objectification of the female body, commoditization of body parts in the form of gametes, reproductive tourism, transfer of technologies (and ideologies) to different cultures and the status of the woman versus the embryo. It has raised concerns over the ideology of the sacred family in religious or state ideologies.

The Humboldt University carried out a collaborative research project in Germany and Turkey to investigate the implications of ART and adoption on kinship, entitled 'Kinship as Representation of Social Order and Practice: Knowledge, Performativity and Legal-Ethical Regulation'. It was a long-term project conducted during 2004–2012. The results of the research can be found in an edited collection, *Reproductive Technologies in Global Form* (Knecht, Klotz and Beck 2012).

Gürtin conducted comparative research on IVF in Turkey and England within IVF clinics during 2006–2007 for her PhD dissertation at the Centre for Family Research, University of Cambridge, entitled 'The ART of Making Babies: Social Constructions of Turkish IVF'. She conducted interviews with patients, practitioners and experts, both inside and outside clinics. Her interest lies more in the experience of IVF and third-party IVF. By comparison, this book is focused on the pre-IVF experience of infertility.¹⁹ Gürtin (2009) also provides an account of Turkish immigrant women's experiences of childlessness and IVF in London.²⁰

In addition, a recent medical journal article investigates public opinion on oocyte donation in Turkey (Işıkoğlu et al. 2006). It is the first investigation into the topic to be conducted in a secular Muslim country. The data from four hundred interviews with women and men in rural and urban districts of Antalya (a large city on the Mediterranean coast) shows that most of the participants did not have objections to oocyte donation. Only fifteen per cent totally objected (It would be useful to know the same population's response to the use of donor sperm). This positive attitude towards oocyte donation in Antalya, however, should not be taken as representative of Turkey. Another study (Baykal et al. 2008) examines the opinions of infertile Turkish women on gamete donation and surrogacy. 23.1 and 15.1 per cent of the respondents of the study would accept oocyte donation and surrogacy respectively if they needed (the acceptance rate for sperm donation is only 3.4 per cent).

Research has also been done on the psychiatric implications of infertility. Özkan and Baysal's (2006) research with fifty infertile and forty fertile women revealed that infertile women, especially the ones with lower rates of employment, education and economic status and longer experience with infertility, suffered severely from depression.

IVF is also becoming a prominent theme for popular non-academic books in Turkey. There are now two books published by medical experts as guidance for women who want to pursue IVF (Bahçeci and Aktan 2007, Gülekli 2006), a book written by a journalist – again as a guidebook – who went through the treatment herself (Aydın 2009), a novel about a woman who undergoes IVF with sperm from her fiancé who is in a coma (Kefeli 2008), as well as a book about the Koran's view of IVF (Duman 1991).

It is important to note that despite the pivotal place of children in Turkey, and despite the significant ramifications of childlessness (on women, men and families), there has not been much anthropological interest in the issue of not having a child. The patrilocally extended family versus nuclear family type was once a source of interest for sociological and anthropological accounts of the family. The patriarchal structures inherent in virilocal households and the contemporary changes in those structures were often analysed (Duben 1982, Ilcan 1994b, 1996, Kağıtçıbaşı 1982b, 1982c, Rasuly-Paleczek 1996, Vergin 1985). Regarding kinship and gender, marriage practices have also been explored (Bates 1974, Hart 2007, Ilcan 1994a, 1994b, 1996, Kudat 1974). Gender is often investigated through the framework of patriarchal relationships in the household. Ethnographic accounts tangentially touch on infertility as an unfortunate circumstance for women. Since patriarchy remains the focus for most anthropological research, the failure to have a son has raised more interest. In a similar vein, kinship has been analysed in terms of the significance of having a son in the negotiations for patriarchal power (e.g. Delaney 1991, Ilcan 1996, Stirling 1965: 42, White 1994). This is the first anthropological manuscript on Turkey with regards to infertility and ART.

Places and Persons

Defining the field site is a matter of scale and choice. Because of its geography, history and varied cultural influences, it remains difficult to determine whether Turkey is part of the Middle East

the Mediterranean or both. It can also be considered European, Western, non-Western or an amalgam of them all. These field site decisions matter because they inform our theoretical frameworks. Bonaccorso's (2009: xvii) objection to the boundaries of 'Euro-America' (which indicates the discourses relevant to North America and Northern Europe) and Italy's place in relation to it is a case in point. Italy, as a southern European country, is outside the theoretical field of 'Euro-America'. However, Bonaccorso's discussion of kinship reveals important similarities between her field site and 'Euro-American' discourses about the implications of assisted reproductive technologies on kinship.²¹

The reasons behind conducting this research in Turkey were based on its contrast to the broader fields in which Turkey is found. Primarily, Turkey has a distinct place in the Middle East for being the only country with an Islamic population that has a secular civil constitution, and powerful religious authorities (such as the *ulema* or *mullahs* in Iran or Lebanon) do not exist.²² On the other hand, the state is not totally independent of religious influence. The laws pertaining to assisted reproductive technologies are consistent with the opinions and suggestions of the Presidency of Religious Affairs (*Diyanet İşleri Başkanlığı*). As such, there is 'harmony between secular legislation and religious opinion' (Gürtin 2012a: 286). Among Turkish people there is a growing tendency towards Islamism or at least towards more conservatism, but secularism, the founding ideology of the Turkish Republic, is still reflected in the lives of many Turks. Between the two extremes – from the most secularist to the Islamists, a range of discourses and practices regarding infertility and IVF exists, informed by a range of values, lifestyles and ideologies. As Gürtin (2012a: 286) states, 'as a staunchly secular nation with a Muslim population, as well as a country with great regional variation and enormous socioeconomic divisions, Turkey often represents paradoxes and hybrids for researchers'.

The majority of Turks are Sunni Muslims (the largest sect of Islam) with a minority of Alevi (a Shia group of Islam of most of whose adherents live in Turkey). Turkey's legislation on IVF reflects the Sunni consensus, which bans third-party gamete donation, surrogacy and limits IVF to married couples only. These prohibitions by the Sunnis aim to protect patrilineage (Inhorn and Tremayne 2012: 5, Clarke 2009). Turkish legislators, despite the similarity of their legislation on ART with that of other Sunni communities, do not accept the influence of religion on legislation. As Gürtin states, they may rather justify this similarity with an explanation based on

'culture' rather than 'religion': 'Although it may not be practically possible to disintegrate "culture" from "religion" within the secular politics of Turkey, the latter is unacceptable as a causal explanation of state regulation, whereas the former can be used to mobilize democratic aspirations' (Gürtin 2012a: 304).

As well as being Middle Eastern, Turkey, as Navaro-Yashin (2002: 9) argues, has always been European. As far as IVF treatment is concerned, the motivation of achievement underpins people's persistence with the procedure, just as in England (Franklin 1997). At the same time, an Islamic Middle Eastern approach also informs the attitude towards conception via IVF: the rhetoric of God's will.²³ Thus Turkey, as an Islamic-European site with similarities to the European and American discourses, proves to be a unique field for the study of infertility and IVF.

The research for this book was undertaken in the northwestern part of Turkey, in Istanbul and a neighbouring city. Doing research in the western part of Turkey was a deliberate choice. Stereotypes of social conditions (especially regarding gender and kinship) exist in the eastern (or southeastern) part of Turkey. Honour crimes, bride price, extreme son preference, and polygyny are among the practices typically attributed to the 'easterners' of Turkey. These practices were indeed more common among the people in my research who hailed from or were living in the east. The importance of having a son was more explicit among them than any other group. But still, these practices are in no way restricted to the people who live in the east, nor are they common to everyone in the east.

Whenever I explained my research topic to a Turk, the same question often followed: 'Why don't you do your research in the east/southeast?' This implied that in the east/southeast, gender inequality was so acute that richer data regarding the suffering of the infertile could be available. I was not after suffering, and if there were any, I would rather show that it was not confined to the east. The question above justified my decision to conduct research in the west. I was never concerned about 'representing Turkey' but I wanted to avoid 'representing the east' while excluding others in Turkey. My research shows that stigma attached to infertility exists and is not confined to the east. It is prevalent in varying degrees and forms among people I have met from all over Turkey. There are many women who suffer from the pressure to have a baby (or even a son) in both Istanbul and in the villages where I did research.

The IVF Clinics

As I have stated above, my ethnography was divided between the observation of IVF clinics and of family life in villages. First I did research in IVF clinics for about six months. I call these IVF clinics the North Clinic, and the South Clinic.²⁴ The North Clinic is on the European side of Istanbul, in a quarter inhabited by working-class people as well as the wealthy. The South Clinic is located in the outskirts of Istanbul, on the Asian side. Long before any fieldwork took place, while drafting my research proposal, I was able to arrange to visit these two IVF clinics for my research. A family friend owned the hospital where the North Clinic operated, and the head of the South Clinic was a friend of mine. I was welcomed at both clinics, and the IVF physicians were often supportive. There was no unease due to my presence in the clinics – unlike for example Bonaccorso's (2009: 19) research experience in IVF clinics in Milan.

I went to these IVF clinics five days a week, from morning to evening. I conducted interviews with women who were undergoing IVF as well as the IVF physicians. I also had many informal conversations with the physicians, nurses, secretaries and cleaning staff. I recorded the interviews when the women gave permission. Women were interviewed only in privacy, without their partners or others present. There were only a few times when their husbands or mothers attended the interviews, but this was always after an interview with them alone. I sometimes chatted with their kin (including mothers-in-law) in the waiting room. The interviews always took place in Turkish.

The North Clinic was located on the European side of Istanbul, in a district populated mostly with migrants from all over Turkey, as well as from the Balkans. Sixty-four per cent of women were primary school graduates and I met only one university graduate among them. Most of them lived in various parts of Istanbul, while a third of them were living in other parts of Turkey. There was a Turkish woman among the interviewees who came from Germany. The average length of marriage was nine years among the women I interviewed. There were six women married for 17 years. Eighty-five per cent of women were housewives.

The South Clinic was on the outskirts of Istanbul. It was part of a new hospital with imposing modern architecture, which stood in strong contrast to the shanty town surroundings. The hospital was close to an industrial zone, and so factory workers visited the hospital as well as affluent people who wanted access to the latest technology. The IVF unit also had a branch in an elite quarter

of Istanbul. However, all the women who underwent IVF there had embryo transfer and oocyte retrieval operations in the central hospital.

In the South Clinic, I had the chance to meet IVF patients of a higher socioeconomic status than in the North Clinic. The number of women who had university level education (38 per cent of women) was greater than the number of women who had only primary school education (31 per cent of women). This was also the case with their husbands. Half of the women were housewives. Five of them came from distant parts of Turkey. The average length of marriage for the women was eight years.

I was not denied access to the women in either clinic. The physicians were never concerned about whom I interviewed. They did not care if women spoke negatively about the treatment. Access was not negotiated based on whom to interview, but on the stage of the process during which I would do the interview.

In the North Clinic, the head of the IVF unit allowed me to talk to the women only at certain stages of the IVF process. In the beginning of the research, I could talk to women only after the initial meeting (*ön görüşme*) with the physician. This was certainly the worst stage for conducting an interview with the women. In their first meetings, they had so many questions on their minds about the treatment, the physician and the clinic that they found it hard to concentrate on my questions. I often felt I was disturbing them when they were looking forward to leaving the clinic and talking to their husbands about their first meetings. After a few weeks I persuaded the physician to let me interview the women at later stages of the process. I could then talk to them at the 'follow-up' (*takip*) stage (this is the superovulation and monitoring stage), but never during the days they had oocyte retrieval or embryo transfer. I was told that the women needed rest instead of discourse for those two days. Still, interviewing women during the later stages of the process proved extremely fruitful for me. The interviews could continue much longer, and the women felt much more comfortable (as did I). At these stages, they had often already seen me a few times in the clinic and sometimes had already spoken to me.

In the South Clinic, the physicians never interfered in the research process. The head of the IVF unit told me that I could talk to anyone I wanted. He suggested that I talk to women on the days of the oocyte retrieval and embryo transfer. On those days, women had plenty of time for the interview since they were waiting for their turn for hours before the operation, and they were resting

after the operation. The women were often willing to talk to me, because most of the time they were bored and anxious while waiting.

In addition to the head of the clinic, there was an additional IVF physician in the North Clinic. Both of them were in their forties. In the IVF unit, there was a large waiting room where the reception area was located. The physicians' offices were at one side of the room. The operating room was separated from the waiting room with sliding glass doors. On one side of the doors, there was a small corridor that led to the operating room and recovery room. People who were going to the operating room had to remove their shoes at that corridor and wear flip-flops. There were also blue gowns to put on.

The waiting room was almost always packed with women. Their husbands usually accompanied them for the initial meetings, and during embryo transfer and oocyte retrieval. For other scheduled visits, the women would often visit the clinic alone or with a female relative or friend. Two secretaries and the nurses would gather around the reception table when they had no other work to do. I too would join them and chat when I could not otherwise conduct an interview.

During the first weeks at the North Clinic, the head of the IVF unit used to call me into his room when there was an introductory meeting. He introduced me as a researcher who was interested in hearing why they were there and who had some questions to ask. He encouraged the couples to speak to me. When I started to interview the 'follow-up' patients, the nurses and secretaries became my sources of support. They introduced me to women, and provided me with their brief histories. I sometimes approached women myself, but more often I was introduced to them at the reception desk.

For our interviews, I took women through the glass doors to the corridor leading to the operating room. There were two chairs in that corridor on which we could sit. There was not enough privacy there, since it was possible for noise to pass through the glass doors. Passers-by were also disturbing. However, there was no other place for interviews, since I was not permitted to interview post-operation patients in the recovery room. A few times I interviewed women in the physicians' offices when they were available. The improvement in comfort and privacy was clearly reflected in the depth and length of the interviews.

Since the head of the South Clinic was familiar with social anthropology (he had taken social anthropology classes), he was sympathetic to the research requirements. He did not introduce me to

any of the women. Instead, I was given access to the recovery room where I introduced myself, asked for permission from the women, and then conducted the interviews. The recovery room housed six beds aligned into two rows of three. The beds were separated from each other by plastic privacy curtains. I sat on a stool near the beds when I interviewed the women. There was a small plasma TV hanging from the ceiling in front of each bed. The conditions at this IVF unit reflected the 'modernity' of the hospital, as the women described it. This environment was confusing to some of the women who came from remote rural areas. The environment, so different from their everyday experience, enhanced the liminality of their IVF experience. The interview conditions at this clinic were much better compared to the other one, allowing me to do more recorded interviews.

In both clinics, the physicians favoured the vernacular of the couples. For instance, to refer to a menstrual period, they did not use the words *periyod*, *menstruasyon* or even *regl*, common among the doctors or educated elite, but rather they used the word *adet*. In contrast to the distance (which implicates authority) deliberately created by physicians using medicalized language (Bonaccorso 2009: 79–81), these physicians were inclined towards creating a sense of trust with their patients. A similar attitude by Turkish physicians towards couples seeking IVF was also noted by Grtin (2012b): 'Many practitioners, dealing with a diverse range of patients, perceptibly varied their choice of words and general demeanour to facilitate a "dialogue" and to enable better communication with each and every type of patient'. In the spirit of disclosure, the physicians were always explicit about the risk of failure. Nonetheless, they also stressed to most couples that IVF was their only option for conceiving a child.

The interactions of the nurses with women undergoing IVF in the North Clinic were also based on creating warm relationships. In the South Clinic, however, nurses could sometimes be impatient or even arrogant. I witnessed two of them giving only brief explanations of the treatment, and occasionally responding to women's questions as if they were not intelligent enough to understand the treatment. These nurses were uncomfortable with me witnessing their unkind treatment of the women.

My interactions with women undergoing IVF were better than I had expected. Since infertility is a delicate topic which people often conceal and which also can be traumatic, I assumed that women would be reluctant to talk to me. Contrary to my expectations,

I was almost always welcomed, and women at various times remarked that talking to me about their experiences and emotions made them feel better. According to the head of the South Clinic, the women (and therefore the physicians) were pleased to have a sympathetic ear: 'It is good for them to be listened to'. Bonaccorso's (2009: 25) experience with women in IVF clinics is very similar to mine:

[A] part of me is still surprised at the depth and openness with which couples spoke to me, an absolute stranger. But possibly this occurred precisely because I was an absolute stranger, not unlike an encounter on a train. It is not unusual to share very personal life histories with strangers, one can be honest and direct as there are no implications.

The same applies to the interactions I had with the couples. And it was confirmed during unpleasant encounters when I crossed the boundaries of being a stranger, or perhaps even violated the borders, and told a woman, for example, 'my family hails from the place where you live. We are from the same village.' Uneasy looks and silence followed such impertinent remarks from me. It was even uncomfortable when I once told a woman that like her I had also worked as a product manager. This happened during an interview with Ela at the South Clinic, a 37-year-old woman with a career in marketing. I told Ela that I too had worked in marketing for a time. Before I said that, in her eyes, I was a researcher she met in a clinic. The moment I said I had been a product manager was the instant I moved out of that sphere. Where I belonged shifted, along with the woman's presumptions about me. On these occasions, women could no longer count on the privacy of the encounter. These encounters seemed to be confusing and possibly bothersome for the women.

Despite the importance of providing contextual information about the author (e.g. Edwards 2000: 18) as well as the narrator and the interview environment, I do not provide this for each interview in the book due to space limitations.²⁵ In addition, similar to Bonaccorso (2009), I aim to underline the repeated patterns or discourses in these narratives by providing as many of them as I can.

The Villages

For the second half of my research I stayed in two villages that were near one another. My main reason for continuing the research outside the clinics was to understand the impact of childlessness on social relationships. I had acquired pertinent insight from the

interviews, but a village setting afforded me the opportunity to observe how the politics of childlessness emerged in extended families and among close friends.

Inhorn (2003a: 27), who has worked on IVF and infertility in Egypt for almost twenty years, expressed her regret at not having done participant observation outside the clinics, which constrained her study. In anthropological studies on assisted reproductive technologies, research outside IVF clinics is less common. An exception is a study of fertile people outside clinics by Edwards (2000). Clarke's (2009) work in Lebanon derives from ethnography outside IVF clinics, but it was carried out with Islamic authorities and philosophers rather than childless women themselves. Another notable exception is an ethnography by Kahn (2000) concerning infertility and the Rabbinic discourses and practices related to IVF in Israel.

The villages in which I worked were attached to a small coastal town, three hours away from Istanbul by bus, in the northwestern part of Turkey. There was a minibus service to the coastal town from both of the villages every hour. These villages will be called Village Dere (Stream) and Village Tepe (Hill). The house where I lived was on the outskirts of Village Dere and was also about thirty minutes away from Village Tepe on foot. Dere was a hillside village a fifteen minute walk away from the coastal town, which had schools, small retailers, a hospital, post office, banks, parks, cafes, restaurants and such.²⁶ Tepe was further up the hill, an hour's walk from the same town.

I started research first in Village Dere, which was closer to where I was living. Most of the inhabitants of Dere were native to the region, but some had migrated from northeastern Turkey. A small minority came from eastern Turkey. A few of the families owned large fruit gardens where other villagers could work to earn daily wages. Since this was far from sufficient, sons were moving out of the village to find jobs elsewhere. Daughters usually married out, so when they married, they left the village as well. This is why most of the inhabitants of the village were elderly people with unmarried daughters. This context was valuable for observing the pressure to get married and have children.

In Tepe, most of the inhabitants were bilingual (Turkish and Bosnian). The first settlers of Village Tepe were Muslim Bosniaks (*Boşnak*) who migrated from Bosnia after Bosnia's separation from the Ottoman Empire at the end of the nineteenth century.²⁷ More than 90 per cent of the households had Bosniak family members.

Cattle raising was the major income-generating activity and most of the families had fruit gardens. Many villagers owned small-scale businesses in the nearby town centre. The inhabitants of Tepe were wealthy enough to afford to live in patrilineally extended houses. It was thus possible to observe the ways in which the relationships in extended families informed the experience of childlessness.

I was living in Dere with the parents of a friend and her aunt. The first reason I chose to stay there was that I had a limited time (six months) and this family would help me meet people and be welcomed in a shorter period of time. I refer to my friend as Idil, and her parents as Elif and Osman in this book. I call her aunt, who also lives in the same house, Selin. Selin spends the whole year there, while the others live there for only half of the year. In winter, Idil's parents go back to their house in Istanbul. All the members of the family did their best to support my research. They answered all of my questions patiently, they introduced me to the people they knew in Village Dere and around it, and they accompanied me on my visits to houses in Dere during the first weeks. Then I decided to continue doing research in Tepe as well, where they hardly knew anyone. Elif and I visited houses together and introduced ourselves. Having Elif with me made my acceptance to the village much easier.

In Tepe, I initially knocked on doors of houses with Elif in an attempt to establish friendships once we were invited in. A Koran course started in the village, which the local women started to attend. This was fortunate because women aged between 27 and 60 were attending this course to learn the Koranic script.²⁸ In villages usually children take Koran classes in the mosques during summer holidays. Every morning there was a class for children in the mosque of the village's 'middle quarter'. They learned the principles of Islam and memorized *suras* (certain sections of the Koran under separate names). After the children's class, the women's class would take place. There were nine women including Elif and me. Sometimes the number was higher when others came to practise their reading skills. Thanks to the Koran course, I had the chance to improve friendships with the women. The common experience of being classmates together became the foundation of these relationships.

Idil had been married for four years during my research and she was voluntarily childless. For the people in Dere and Tepe, voluntary childlessness at thirty years old was not easily comprehensible. When Idil was around, I had the chance to observe people's reactions to childlessness as well as the pressure she was encountering from family and friends.

I always spoke in Turkish in both of the villages. Elderly people in Tepe always speak to each other in Bosnian (*Boşnakça*), but in my presence they spoke Turkish, too. Unlike in Village Dere, there were people who were involuntarily childless (five women) in Tepe. This facilitated my research to a large extent by giving me the chance to observe the lives and relationships of childless women. I got close to one of these childless women (Kerime).

There were no schools in Dere, which was closer to the town; students could easily get to school in the nearby town on school buses. There was one mosque. In Tepe there were three mosques, one in each *mahalle* (quarter or neighbourhood), and one primary school (in the whole village) for primary education until the fourth grade. In both villages there were both girls and boys who were receiving university education in various cities in Turkey from Edirne to Istanbul and Izmir.

Both villages were divided into quarters, with names. In Tepe, since it was a larger village, quarters were more important in terms of people's social lives. The closest friendships were within the same quarters. The people I became close to were all living in the same quarter, the 'middle quarter' (*orta mahalle*). There was also an 'upper quarter' (*yukarı mahalle*) and a 'lower quarter' (*aşağı mahalle*).

Life in the two villages was very similar. In both villages, religion remained significant. In both Dere and Tepe the day typically started with practising the morning prayer (*sabah namazı*). Breakfast was followed by domestic and garden chores. Women visited each other in their houses and often did needlework during these visits. In Tepe when they gathered together, they sometimes made *pita börek* otherwise known as *Boşnak böreği* (a kind of pastry common among the Bosniaks, filled with cheese, potatoes or vegetables). In Tepe, women who attended the Koran course also practised reading the Koran together. After dinner, it was common in both villages for families to visit neighbours' houses. If the husbands were not at home, the women would make the visits without them. In both villages, children were sent to Koran classes in the summer to learn about religion. The Bosniak ethnic identity did not seem to have a major influence on the way of life in Village Tepe. Other than the differences specified here (and in Chapter 3 regarding marriage practices), the residents of both villages had similar lifestyles.

Persons

Below is information about the people with whom I developed the closest relationships in the villages, and who consequently appear

prominently in this book. There were many houses spread out over a large area on the outskirts of Village Dere in addition to houses inside the quarters of the village. Elif and Selin with whom I was living were always my greatest support; they did their best to help my research in every way. They had strong neighbourhood relationships with a few of the families living on the outskirts of Village Dere. Three of those families in particular became enthusiastic supporters of my research, inviting me every day to their houses in order to 'teach me their way of life'. One of those women, Saadet had a child after sixteen years of marriage. She was over fifty years old and her elder daughter was eighteen years old. She was reluctant to talk about those sixteen years, but she and her husband still shared a lot with me about that time.

Hatice and Yasemin were my dearest friends in Village Dere. They were both single and around thirty years old. Religion was central to Hatice's life. She practised all the compulsory prayers and wore Islamic attire.²⁹ Her opinions on almost everything were grounded in religion. She often talked about the life of the Prophet and suggested the names of religious books for me to read. Although she wanted to continue school, she had left school at an early age according to her grandmother's wishes. Her twenty-year-old sister Esra was not so pious. She did not wear Islamic attire; indeed, she used to wear knee-length skirts and sleeveless shirts. She was studying media at a university in Izmir, a metropolitan city on the west coast of Turkey. Yasemin's sister, who was getting married to Hatice's brother, was a pious practising Muslim like Hatice. Yasemin did not wear Islamic attire, and she pursued a comparatively independent life. On weekdays she stayed in a town close by (forty-five minutes by car) where she was working. Hatice and Yasemin were close friends and they both cemented a friendship with me.

Kerime's name appears frequently in the book. A 37-year-old involuntarily childless woman, Kerime was my closest friend in Village Tepe. She was one of the attendees of the Koran class. She knew how to read the Koran but she was there in order to improve her reading skills.

Kerime was living with her husband and her husband's elder brother. She had been married for twelve years, and had lived with her mother-in-law until her death two years ago. Kerime worked gathering fruit for daily wages, as well as in her own olive garden. Her husband managed a *kahve* (local coffee shop for men) in the village. They could hardly make ends meet. Kerime had been

having hormonal treatment for infertility after her mother-in-law's death. Although one of her fallopian tubes was blocked, Kerime seemed reluctant to try IVF, unlike the ambitious women I had met in the IVF clinics. This was partly due to financial reasons, as well as her husband's objection to IVF.

Kerime was a very friendly woman who loved to spend time with friends, including me. We kept in contact after the fieldwork was over, and she still replies to my questions readily and does her best to be of help to me. She and her husband appeared to love each other, and Kerime confirmed this to me when she talked about their relationship.

Cevriye, a lovely 54-year-old woman with three sons and a daughter, was another one of my Koran classmates. Two of her sons were married, one of whom had a child. Her childless son did not want to undergo IVF. Her other son had only one child, which distressed her: 'I tell them to go to a doctor if they have a problem. One child is not enough in this world.' Although she was encouraging her sons to seek treatment, she didn't pressure them. This was obvious, because Cevriye had a very docile, gentle character and her childless daughter-in-law was fond of her. Cevriye had suffered difficulties with her own parents-in-law – with whom she had lived for sixteen years – but she was not authoritarian to her daughters-in-law. She was also very supportive of me and my research.

Throughout the book, my encounters in the field and information about the interviews are sometimes in the debated 'ethnographic present', despite the fact that they happened six years ago.³⁰ Sometimes they are in the past tense, even though it is at this moment that I am reproducing them in theoretical frameworks unfamiliar to the persons with whom they were produced initially. As Hastrup (1989 n.d.: 28) notes, 'The dialogue was "then", but the discourse is "now". There is no choice of tense' (cited in Strathern 1991a: 48).

The 'field' was not only composed of the IVF clinics and the villages along with the persons I met there. The Turkish television serials I was watching at home, and even chats with my friends and family, had suddenly become a means of observation from the day I arrived in Turkey as a researcher. The place and the persons were the same to an extent, but it was I who was different. I was a part of my field (Hastrup 1990: 46) and have since been 'no longer the same' (1990: 50).

A Brief Literature Overview on Infertility and ART

A summary of the anthropological and sociological studies as well as the feminist literature on infertility and ART is now available from many sources (for example: Bonaccorso 2009: 2–7, Inhorn 2007c: 1–43, Thompson 2005: 51–75, as well as Clarke 2009 on ‘new kinship’; Inhorn and Tremayne 2012 on Islam and ART, and Inhorn et al. 2009 for ART and masculinities). Some ethnographies concern women’s subjectivities and experiences related to the IVF treatment rather than making a broader evaluation of infertility. The experiences of women who undergo IVF are studied in the works of Becker (1990, 1994, 1997, 2000) and Franklin (mainly 1997, besides 1988, 1990) whose ethnographies are from the United States and England respectively. Following other feminist writers, Franklin aims to dispel doubts over the devastating consequences of IVF. The overwhelming nature of the treatment is emphasized by focusing on infertility (Becker) or IVF (Franklin).³¹ A monograph by Bonaccorso (2009) also investigates the experience of people who underwent IVF in Milan, Italy. Like Franklin, she also provides excerpts from the narratives of people’s experiences. Unlike Franklin, she does not make a political statement in opposition to IVF. She inquires about the views of gay couples as well as heterosexuals and couples without vested interest. Bonaccorso looks at IVF via gamete donation for an understanding of ‘Italian kinship as a cultural form’ (2009: xvi).

By providing narratives of donor women, Konrad (2005) shows that oocyte donation is a complex process whereby donors go through intensive treatment that is neither risk-free for their physical health, nor straightforward in emotional terms. She therefore argues that ova donation is tremendously different from sperm donation. For the surrogate mothers in the United States, who are paid for their ‘service’ (Ragone 1994), and for the ova donors in the United Kingdom, who are not paid (Konrad 2005), helping women to have children is a common rhetoric in their decision to donate.

Ethnographies of experiences with prenatal diagnostic procedures such as amniocentesis (Rapp 1999), ultrasound imaging (Mitchell and Georges 2000, Morgan 2000), and fetoscopy (Blizard 2000) show that these treatments cause anxiety in women beyond the possible health risks for the women or babies. However, due to the excitement of ‘seeing the baby’ or ‘knowing it is all right’ the procedure is nevertheless pursued. ‘Scientific knowledge’ takes precedence over gestational embodied knowledge.

These few examples of ethnographies above concern women's experiences of assisted reproductive technologies. The motivation of the couples who pursue treatment, their physical and emotional states of being during treatments, disruptions that occur in their lives, the risks involved with the use of these technologies, and the governance of the female body are explored within the context of treatment narratives. Alternately, I rather focus on the experience of women before they start the treatment. I have included these examples to be able to locate my research in a larger picture of the ethnographies regarding IVF. My approach is to investigate infertility in various contexts from religious discourses to conflicts in extended families. My focus is on social relationships. I explore the ways in which social relationships influence childless lives, the attitudes towards procreation and assisted reproduction.

Theoretical attention to ART (more than infertility) emerged mostly in studies of kinship and technology in England and North America. Following the strong feminist objection to ART for being an invasive technology and a new means of male biopower on women's bodies in the 1980s (Arditti et al. 1984, Corea 1985, Crowe 1985, Franklin and McNeil 1998, Holmes et al. 1981, Klein 1989, Terry 1989), the 1990s saw a more balanced style of investigation of ARTs and infertility, as well as theoretically rich anthropological work.

Research in the domain of kinship since the advent of ART (although rising divorce rates and gay relationships are additional factors, as is rising academic interest in North America and Europe), due to a resurrection (Patterson 2005) or renaissance (Carsten 2004: 20, Clarke 2009: 2) in kinship, has been called 'new kinship studies' (Carsten 2004, Clarke 2008, 2009, Edwards and Salazar 2009, Patterson 2005, Strathern 2005). 'New kinship studies' scrutinize the ways in which ART lead to new ways of thinking about kinship (Strathern 1991b, 1992b, 1992c, 1994, 1995). Strathern (1992a, 1992b, 1992c) and Franklin (1988, 1997), following Schneider's (1968) analysis of American kinship, explored the ways in which kinship was reckoned biologically through the act of procreation (by blood or genes) in England. It was 'nature' which enabled procreation and which provided the 'facts of life'. These ethnographers drew attention to what happened to conceptions of kinship when faced with technologies that created kinship, and which shattered the entrenched assumptions about procreation and nature.³² Franklin (1995) called the change in the perception of kinship and procreation a 'paradigm shift'. Nature seemed to need the helping

hand of the 'enabling technology' (Strathern 1994). Science that was considered to bring 'miraculous reproduction' to 'desperate couples' could seem to provide new grounds for the facts of life (Franklin 1988, 1990, 1995, 1997).

Throughout the Middle East, there were no studies of this 'new kinship' until embryo and gamete donation as well as surrogacy became permitted practices in Lebanon (by religious authorities, Clarke 2006a, 2006b, 2007c, 2007d, 2008, 2009, Inhorn 2004, 2006b) and Iran (by civil authorities, Abbasi et al. 2008, Inhorn 2006b, Tremayne 2006). In Turkey (similarly to other Sunni Muslim countries), since third-party assisted reproduction is not allowed, the advent of IVF has not led to questioning the concept of kinship and the sources of knowledge for the facts of life. The law that bans third-party assisted reproduction aims to constrain practices that might threaten the 'sanctity of family' or the 'unity of the family'. Therefore the main focus of this research is not about the change in the perception of kinship in Turkey. The focus on kinship in this book lies on the social relationships among extended family members, which inform the experience of childlessness, rather than on the idea of biological relatedness and the recent changes in the definition of kinship.

About the Book

Today we are discussing a very important topic that seems scientific, which is indeed scientific but which interests all of society, everyone, even the future of humanity as well as the academic circles: test-tube-babies. ... This is a very important subject. It involves everyone. Some people are not directly related. Yet it concerns everyone in every aspect, whether it be ethical, religious, social or individual.³³

The preceding words belong to the host of a weekly television debate programme with a wide viewership in Turkey. The host, Ali Kirca, strongly emphasizes the importance of *tüp bebek* (test-tube baby) for 'everyone' and 'humanity' in 'every aspect' in his introduction of the topic. The programme reflects the contested nature of IVF in the media and draws attention to the fact that there is 'a range of social, ethical and legal questions raised by new [reproductive] technologies' (Stanworth 1987: 2).

In approaching my research, I first sought to understand why people undergo IVF treatment. My initial question – which is the subject of the next (the first) chapter – was why they desired a

child in the first place. Since, in many cases, a very fine line exists between desire and obligation, this inquiry at times turned into an exploration of why people feel obliged to have a child at all, a theme further elaborated on in later chapters. This question (why do people want children?) also challenges the 'naturalness' of the desire for a child.

The role of religion on the desire for IVF is the topic of the second chapter. I observed the prevalence of discourses on God's will in the narratives of childless lives in IVF clinics. Religion was also predominant in the daily lives of people I lived with during the second half of my research (in the two villages). These research experiences revealed the importance of scrutinizing how religious discourses and practices inform the experience of childlessness. The ways in which childless couples resort to religious rhetoric in order to constitute complete and normal gendered selves are also explored in this introduction.

The television discussion programme mentioned above featured a couple who had a child born with IVF. The programme host, Kirca, asked the couple if they reflected much before going for IVF. The response of the woman to the question was quite revealing:

Yes, of course we thought it over. We were concerned about what others would say about it, what would the neighbours say, what would the relatives say. We considered its appropriateness by religion.

As is seen in the response above, the decision to opt for IVF involves checking its appropriateness with many sources. Religion is one of these.³⁴ It is also important that one's kin and friends find this decision appropriate. In addition to one's family, one's perceived social milieu directly influences the infertility experience.³⁵ Friends and acquaintances can be of support to childless couples for assisted conception treatments by providing them with names of IVF specialists or simply by encouraging them to get treatment. However, it is not uncommon for friends to be a source of pressure and suffering for childless couples. Childless people sometimes endure humiliation and ostracism, if not discrimination, brought on by prejudices and failure to meet social conventions. The third chapter explores the place of social relationships in the experience of infertility. Looking at the negotiations necessary to create complete adult identities and power in kin-neighbour social circles, I discuss the ways in which these negotiations impinge upon the 'quest for conception' (Inhorn 1994).

The next question Kirca asked the childless guests highlights another important field in this research:

In Turkey people have certain presumptions about male infertility. Did you feel concerned about this; did you have unpleasant experiences when you decided to have IVF?

The husband of the woman who responded earlier replied that they did not have such worries and that they did not encounter any unfortunate incidents. The subtleties of the subject would make it difficult to say otherwise. The fourth chapter explores social relationships among men. The question posed above by Kirca reflects on the conflation of male infertility with sexual impotency. The chapter investigates the influence of manhood ideologies on men's and women's experiences of childlessness as well as on the decision to have IVF. Women may encounter social suffering due to infertility. Despite this, they very often take pains to shoulder the blame of infertility when their husbands have a fertility problem (Inhorn 1994, 1996, 2003b, 2004). I look for the possible reasons for such an endeavour by women.

Up to the fifth chapter, many of the possible reasons for conceiving a child *in vivo* (in a living organism, here in the female body) or *in vitro* (in glass, here via IVF) are discussed. In the fifth chapter the focus is on the demand for *in vitro* conception. The chapter investigates why people (women, especially) pursue endless cycles of IVF, and what kinds of insights this persistence in IVF treatment can give us about the lives and motives of the women who pursue them.

Another topic of inquiry in this book is the anthropological views on procreation. The gendered attitude to procreation and its influence on the decision to have IVF are key aspects of this study.

These are the key questions of this book. Yet they cannot be answered as if most women formed a homogenous category and as if ideas of parenthood were the same for everyone. For instance, social suffering due to childlessness is less common in the elite strata, such as the case in India described by Riessman (2000a, 2000b).³⁶ This is partly why working-class people who can hardly afford IVF were present in greater numbers in the IVF clinics (where I did research) than the more financially advantaged. The political economy of procreative decisions and attitudes is informed by a variety of factors. These factors, such as the nature of relationships in extended families, religion and hegemonic femininities and

masculinities along with their subversions, are explored throughout the book.

It is also crucial to note that these factors not only indicate a variety of contexts, but also, perhaps more importantly, signify inequalities. A working-class woman who is in an IVF clinic may have overcome not only a financial challenge (which also marks inequality); she may also have a husband who is more influenced by manhood ideology, that complicates the decision to opt for IVF. She may also be living in an extended household under the authority of her mother-in-law, who objects to IVF. Her sisters-in-law may be making her feel incomplete and undesirable in the family because of childlessness. She may have no other route to a position of influence and respect without a child. These are only a few of the power inequalities she may want to overcome and need to negotiate in order to end up in an IVF clinic. They all indicate inequalities compared to the more elite, and compared to others in her social network who have children.

This book will underscore the explanations that figure prominently in the experience of childlessness (and in the decision to have or not to have IVF). I will identify repeated discourses, make explicit the influential ideologies, and uncover the relevant implications in the decision-making process for IVF. However, in the end, the book will reflect what I find most important, puzzling and prevalent regarding the experience of infertility and IVF in Turkey.

Notes

1. WHO 2004, DHS Reports 9.
2. The revised glossary is prepared by the WHO and The International Committee for Monitoring Assisted Reproductive Technology (ICMART). It is published in *Fertility and Sterility* 92:5, November 2009 and *Human Reproduction* 24:11: 1–5, 2009.
3. Lazi (*Laz*) are a minority living in the northeastern Black Sea region of Turkey. They speak Lazi (*Lazca*), as well as Turkish.
4. In fact, an important phase is deciding on an IVF specialist or IVF centre. This usually involves watching programmes and news about IVF on television, reading the relevant articles in newspapers, searching the web and listening to suggestions from friends and kin. Word of mouth is influential in such a decision. The cost of the treatment and the promotion of 'novel' procedures by different clinics also inform the final decision.
5. There were 122 IVF centres in twenty-two cities in Turkey, as of January 2010.

6. All the details about the legal practice of IVF and state funding in the book will reflect the conditions of the time when the research took place – despite the use of the present tense. This aims to give a relatively coherent picture of the research context and to prevent confusion.
7. Article 17 of the By-law for Centres for Assisted Reproduction published in the Official Gazette, 19.11.1996: <http://www.mevzuat.adalet.gov.tr/html/20272.html>.
8. For a thorough discussion regarding the number of embryos that can be transferred during IVF, please see Gürtin 2012b.
9. These three national social security institutions are *Bağ-Kur* (for employers, artists and tradesmen), *Emekli Sandığı* (for civil servants and military personnel) and *SSK* (for employees) which are attached to the Republic of Turkey Social Security Association (*SGK*).
10. See the website of the Prime Ministry for the pertinent legislation, as of 29 September 2008: <http://rega.basbakanlik.gov.tr/eskiler/2008/09/20080929M1-1.htm>.
11. For example in November 2006, news articles with titles such as ‘*Spermci Profesöre Hapis Cezası*’ (Sperm-Swapping Professor Gets Prison Sentence) appeared in newspapers as well as on TV. A physician from a university hospital in Adana (The University of Çukurova) was found guilty of using his assistants’ sperm to artificially inseminate women with infertile husbands. See for example, the article on <http://www.milliyet.com.tr/2006/11/24/son/sontur26.asp> dated 24 November 2006.
12. ‘*Sabah Sabah Seda Sayan*’ (Seda Sayan in the Morning), appeared on weekday mornings on the TV channel *Kanal D*.
13. ‘*A’dan Z’ye*’ (From A to Z), appeared at 3.15pm on weekdays, on the TV channel *ATV*.
14. ‘*Bebeğim*’ (My Baby) appeared on a popular TV channel *ATV* from 21 December 2006 to 14 June 2007 every Thursday night. Despite the controversies it triggered, it never got high viewer ratings.
15. Another normalization practice is via religion. This is the subject of Chapter 2.
16. Polygyny is practised by some people despite its illegality in Turkey.
17. Not having a son is a strong drive for IVF for many reasons which will be discussed later in the book.
18. ‘*Meral Okyay’la Söyleşi*’ [An Interview with Meral Okyay], was available at http://www.vatanim.com.tr/root.vatan?exec=cikolata_detay&hkat=1&hid=10477 on 23 March 2007.
19. See Gürtin (2009, 2010, 2011 and 2012a).
20. Gürtin (2009) also includes an overview of studies on the infertility experience of immigrants in Germany and the Netherlands. See for example Gacinski et al. (2002) for Germany and Van Rooij (2006, 2007) for the Netherlands.
21. Another pertinent argument Bonaccorso (2009: 11) makes is in regard to the problem of defining the Mediterranean as a ‘cultural area

- construct': a unified stereotypical presentation of the Mediterranean societies as pre-modern (Herzfeld 1987), marked by the honour and shame syndrome (Peristiany 1965, Pitt-Rivers 1965, 1977, Gilmore 1987). See also Herzfeld (1980, 1984), Llobera (1986) and Pina Cabral (1989) for critiques of a uniform Mediterranean cultural unit for anthropological analysis.
22. Scholars trained in Islam or a council of men with authority in the matters of Islamic law.
 23. This will be discussed in Chapter 2.
 24. The names of the people and places are pseudonyms.
 25. See: Behar (1990, 1993), Behar and Gordon (1995), Bell (1988), Bertaux and Kohli (1984), Brody (1987), Bruner (1986), Crapanzano (1984), Cruikshank (1998), Frank (1979), Mishler (1986), Riessman (1987, 1988, 1993) and Robinson (1981).
 26. The population of the coastal town was around 50,000 according to the 2000 census. Village Dere had 110 households whereas Village Tepe had 210 during my fieldwork.
 27. Although Bosniaks are found in Turkey from the west to the east, most of them live in the northeast (Marmara region) of the county where Village Tepe is located.
 28. The Koran is written in Arabic, so what I really refer to here is Arabic script. However, I want to emphasize that the intention was not to learn Arabic but only how to read the Koran.
 29. Islamic attire here implies wearing a headscarf, as well as long-sleeved shirts and ankle-length skirts. Outside the home, it also involves wearing a long loose jacket. This was the dressing style of most of the village women.
 30. See Fabian (1983) for a definition of the ethnographic present and his caution against denying the 'coevalness' of the ethnographer and the 'other' via using the ethnographic present, and a call by Sanjek (1991) for an 'ethnography of the present' or by Hastrup (1990) for the 'ethnographic present'.
 31. It is important to note that these examples from ethnographic literature were published when IVF treatment was more physically demanding and time-consuming and less successful.
 32. It is important to note that these views were expressed by these anthropologists around the time of the first UK legislation on assisted reproductive technologies (Human Fertilisation and Embryology Act) that took place in 1990. Thus, the debate should be evaluated with the time framework in mind.
 33. The programme '*Siyaset Meydanı*' (Forum for Politics), on 26 April 2006, on the television channel ATV. This week's debate was on *in vitro* fertilization thanks to the second international conference titled 'Science and Moral Philosophy (Ethics) of Assisted Human Reproduction', which was held in Istanbul that week. One of the organizers of the

- conference, Prof. Robert Edwards, the pioneer of IVF, was also present on the programme as well as other organizers. See Grtin (2012a) for a discussion of this programme as well as the conference.
34. See Clarke (2007b, 2008 and 2009) for a discussion of moral propriety with regard to conception via IVF in Lebanon.
 35. See Jenkins (2002) for an ethnography of childlessness in Costa Rica, which reveals the utmost pressure from friends and even from casual encounters to have a child. The voluntarily childless couple mentioned in the article feels compelled to have a child only to bring an end to incessant remarks about their childlessness.
 36. Riessman (2000a, 2000b: 114–120) shows that in India, people of a higher socioeconomic class do not encounter stigma attached to infertility as much as women of lower economic classes.