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**BIOPOWER AND PRECARITY:
MEETING EMBODIED SELF IN THE DISCOURSES OF
ASSISTED REPRODUCTIVE TECHNOLOGIES
IN UKRAINE**

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ABSTRACT

There is a large amount of research accumulated with regard to cultural, political and social aspects of assisted reproductive technologies (ART) in Western academia. However, the implementation of ART in Ukraine is left without deserved attention. Likewise, I am not aware of any reports about Ukrainian infertile women's experience of negotiating assisted conception. Thus, in this thesis I would like to examine the connection between rationalities of government and infertile women's subjectivation in the context of technologization of reproduction in Ukraine, where ART were introduced not so long ago, but have already become part of lived experiences of numerous women and heated a large debate in society about the nature of women, motherhood, national duty, citizenship and demographic crisis. Moreover, the study I accomplish is necessitated by the growing importance of Ukraine as a colonial market of cheap donor egg cells and as a target of transnational reproductive travel engendered by commercial surrogacy industry.

I applied the concepts of biopower and precarity to analyse the subjectivation of women who undergo in vitro fertilisation (IVF) and reveal which power rationalities and technologies act on their bodies and subjects. In order to give an account of a plurality of meanings that constitute the social reality of ART, I have analysed three discourses, in particular the discourses of the state, medical professionals in infertility clinics and IVF patients. To gather the necessary data I have conducted semi-structured interviews with directors of infertility clinics and women who completed IVF and considered articles in professional medical journals, ministerial programmes and orders, legal framework with regard to the use of ART.

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INTRODUCTION

The first “test tube baby” in Ukraine was born in 1991 under the treatment of the famous Ukrainian scientist in the field of cryobiology and cryomedicine Valentin Grishenko. Since then the introduction of Ukrainian society to the assisted reproductive technologies (ART) generated a wide variety of controversial accounts of assisted conception as both giving hope and endangering, as well as tangible transformations of social structures and material lives. At the same time, with the growing role of ART the individual lives of women’s bodies became inhabited with governmental and medical decisions. As a result, it becomes more and more important to interrogate these vulnerability and precariousness of matter as a space of power struggle, agency and solidarity.

The critical feminist perspective on the latest development of the technologization of reproduction in Ukraine requires from the researcher to accomplish the task of politicization of ART interventions into production and regulation of the female embodiment. In this thesis I explore how women’s subjects are constructed in the context of the implementation of ART in Ukraine, and how these new ways to manipulate the elementary components of life are socially and politically informed and related to the production of knowledge and exercise of different rationalities of government. I argue that the scholarly consideration of the politics of ART in Ukraine is particularly important since it reveals the emergence in the post-Soviet area of the new procreative imagery and new reproductive markets, which determine its position with regard to geopolitics of knowledge and transnational reproductive travel.

ART have been in the focus of feminist scholarly work for more than thirty years by now. According to Thompson (2002: 52), the main paradox in feminist research about ART is that while feminists recognize how involuntary childlessness endures the suffering of women, they are reluctant to fully endorse infertility treatment, since it often reproduces conventional gender expectations and structures of stratification. As a result, Thompson (2002) suggests dividing the evolution of feminist theory with regard to reproductive technologies into two distinct phases.

In 1970s and 1980s feminist scholars of the “phase 1” mainly saw in ART the means to subject women to greater patriarchal control. In this context, Martin (1987) and Terry (1989) developed a critic of ART as a part of the medicalization of reproduction connected to increase in surveillance of women's bodies. Due to its dangerous and experimental character, low success rates and high prices infertility treatment was viewed as reinforcing childbearing roles for women, supporting the superiority of the heterosexual nuclear family and bolstering class and race inequalities.

While feminists of the first phase leaned towards morally condemning “just say no” solution and questioned the maternal instinct of infertile women as an effect of patriarchy, there still was the alternative strand of thought aimed at valorisation of womanhood, in particular through reevaluation of motherhood as essential for woman’s identity (Thompson, 2002: 61). Under this influence in the 1990s the attention of the feminist scholars in the “phase 2” turned towards the women’s experience of motherhood and they became mainly “curious about ways women and men work with and against mothering stereotypes” (Thompson, 2002: 66). Many researchers started to focus on lived experiences of infertile women and men in complying and resisting the cultural accounts of normalcy and gender identity reproduced by ART. For example, Becker (2000) explored how the definitions of gender and kinship are reshaped because of the failure to fit into the existing one.

The elaborations within feminist science and technology studies and feminist anthropology, or new kinship studies, were largely conditioned by this opening. Anthropologists Marilyn Strathern and Sarah Franklin extensively studied the role of biotechnological advancement and reproductive medicine in reshaping procreative and kinship imagery of society, rather than in authorising structures of oppression (Edwards, Franklin, Hirsch, Price, Strathern, 1993; Franklin, 1997; Strathern, 1992). In their opinion, the problematization of nature by technology destabilizes and denaturalizes the status of “genealogical grid” and brings about the proliferation of kinship configurations, some of which have a potential to subvert conventional families and gender stereotypes (Franklin, 1997: 10). In turn, Ragone (1996) explored the social effects of the disintegration of motherhood into social, biological and genetic in the context of gestational surrogacy and egg donation.

According to Franklin and Lock, nature today represents a technique with the help of which the elementary components of “life itself” are modified and engineered. Consequently, they talk about capitalization of biology and “transformation of life and death into the means of (re)production” as a way to generate “wealth, agency and value” within an evolving global biological economy (Franklin and Lock, 2003: 13-14). The technologization and commodification of reproduction also presupposes the changing meaning of the nature-culture divide in context of global bioeconomy (Ibid, 2003). Franklin, Lury and Stacey (2000) argue that nature and culture become “isomorphic” due to the constant transactions between the two. In fact, according to Rapp living organisms start to be understood as programmed in accordance not to their genes, but rather “their computational sequences arranged and compared bioinformatically” (2003: 158). Therefore technology transforms life into the set of informational codes “programmed into the molecular grid of DNA” (Rapp, 2003: 130).

The boundary between “natural” and “cultural” was even more disrupted, when feminist inquiries into the role of reproductive technologies became a part of the larger debate within the field of science and technology studies (STS), asking how science and social relations are interconnected, how scientific knowledge is socially constructed and intertwined with power, and how scientific discourses take part in the construction of reality (Harding, 2004). In this context, the production of biomedical knowledge about ART was seen as forming and transforming the social and material reality of the body.

However, a number of theorists claimed that the social constructivist approach assigned to discursive practices the role of those objective and unquestionable natural facts which it promised to challenge and reproduced the nature-culture divide by assuming “human”/“discourse” as active agent in construction of social and material worlds and “non-human”/“matter” as passive surface of inscription (Barad, 2003). For example, sociologist Bruno Latour (2005) emphasized that making distinction between “social” and “natural”, as well as drawing any other boundaries and imposing explanations and categories on the social world, only precludes sociologists from tracing connections and associations of all sort of entities, including non-human, which are recognizable as social only when reassembled together. While feminist Donna Haraway (2003) elaborated on the concept of “naturecultures” that grasps nature and culture in their inseparability. In her writings she delineated how recent development in technosciences demands that human and non-human, organic and technological, material and discursive are to be understood together. As well Karen Barad (2003: 809) claimed that to give an account of “non-human” as well as “human” forms of agency” not only discourse, but also materiality must be understood in terms of agency as playing “an active role in the workings of power”. As a result, feminist STS theorists unravelled the links between power, knowledge and body, while at the same time called for agency of non-human agents, in particular technologies, in this process (Haraway, 1989).

In terms of the use of ART, the blurring of the distinction between discourse and matter, human and technology is extremely important, therefore in my analysis I am also trying not only to acknowledge the body and technology as effects of power and discourse, but also examine the possibility of their agential involvement in production of reality. The excellent example of such analysis is provided by Thompson (2005), who explores how the patterns of knowledge within the site of infertility clinic emerge to produce the identities of parents and children and enable their recognition as objects in the highly synchronised practice of treatment. Since the site of infertility clinic emerges as a result of regulated interaction between elements that are considered to belong to different ontological orders, Thompson (Ibid.: 8) suggests to grasp their joint action with the help of the concept “ontological choreography”, which indicates the “dynamic

coordination of the technical, scientific, kinship, gender, emotional, legal, political, and financial aspects of ART clinics”.

Another approach to ART, which I largely rely on, is concerned with the use of infertility treatment by the state for the sake of achievement of political goals. Different scholars would agree that in twentieth-century politics medicalization of reproduction and management of infertility played a role of the state's tool instrumental in establishing a control over population and maximizing its life processes (Foucault, 1978; Sawicki, 1991). The consequent development of the notion of the state and national interest in regulation of reproduction led to the necessity to look at reproduction from the perspective of transnational politics and acknowledge the uneven use of assisted reproductive technologies in different local contexts (Ginsburg and Rapp, 1995). Ginsburg and Rapp (1995) highlighted how ART services contribute to class, gender, age, race and able-bodiedness stratification as restricted to upper- or middle-class white married couples. Rapp (2001: 469) argued that since the 1970s “problematic reproduction” became crucial in disclosing “shifting norms of globalizing stratification” and contributing to the topics as diverse as “commodification, state surveillance, and the global economy”. Therefore, Rapp (2011: 703) suggested to analyse it across borders with the help of concepts “stratified reproduction” and “moral pioneering”.

The concept of “stratified reproduction” is called to characterize the tasks of physical and social reproduction as performed differently depending on the social inequalities, chaotic division of labour, exploitation and alienation of workers in capitalist economy (Colen, 1995: 86-89). Thus, this approach demonstrates how the global relations of power entitle certain categories of people to reproduce and nurture, while deprive others of this right. It became largely used by scholars to point at the discrepancies of the use of ART in different cultural and political settings situated within the global politics of gender, race and class inequalities (Ginsburg and Rapp, 1995)

Although the question of ART is excessively studied in Western societies, there is not so much academic research conducted in the context of reproductive politics of post-Soviet countries. Nevertheless, Rivkin-Fish (2013) writes on reproductive politics and the possibilities of feminist resistance in Russia. She acknowledges the inequalities propelled by neoliberal and unregulated character of commercial surrogacy market in Russia and envisions the feminist resistance strategies in this field as “addressing women’s multiple interests”, rather than “emphasizing individual autonomy or a private sphere” (Ibid.: 589). In turn, Zhurzhenko (2002; 2004) explores the post-Soviet ideology of the rebirth of the “traditional” family and thus reinforcement of control over sexuality. The group of Russian feminist researchers, consisting of Brednikova, Nartova and Tkach, develops the only scholarly inquiry into the implementation and

cultural reception of ART in Russia (Brednikova, Nartova and Tkach, 2009; Brednikova and Nartova, 2007; Brednikova, 2008a; 2008b; 2008c; Tkach, 2009; 2013; Nartova, 2008; 2009), while Schurko (2012) analyses ART as a part of pronatalist politics in Belarus.

Despite the aforementioned studies related to the use of ART in different post-Soviet countries, Ukraine remains a blind spot on the map of academic literature, since there has been very small amount of research done about assisted reproduction there. Galina Yarmanova discussed the question of the use of in vitro fertilisation (IVF) by homosexual couples in the context of a broader research on LGBTQ parenthood in Ukraine (Yarmanova, 2012). There are also some feminists who examine the notions of demography, family, motherhood and reproduction mainly with the help of discourse-analysis. In particular, Ludmila Males (2012) analyses the demographic situation in Ukraine and the way politicians exploit the concept of demographic crisis to force women into giving birth. Moreover, Olga Plakhotnik (2011) writes about discourse of family in Ukrainian gender politics and its conventional characteristics and Olena Strelnyk (2011, 2012) researches motherhood and disability.

Nevertheless, there is no research that accounts for the voices of Ukrainian women in articulating their experience of encounter with reproductive technologies. At the same time, Ukraine becomes an important country in the global bioeconomy by virtue of the colonial magnetism of the Ukrainian market of reproductive medicine, transnational travel of "Ukrainian" oocytes and reproductive tourism to Ukraine. Moreover, the study of the subjectivation of women who use IVF in Ukraine is important since Ukraine as a post-Soviet country provides the scholars with opportunity to explore in which rationalities of government the development of assisted reproductive technologies is embedded in political systems that differ from "advanced liberal democracies". Thus, I chose as my main research objective to explore *which **modes of subjectivation** are constructed for infertile women who undergo IVF in the discursive practices of ART and which **rationalities of government** are manifested through this construction.*

In order to understand with the help of which governmental technologies IVF patients in Ukraine are brought to work on their conduct and their bodies in a continuous manner, I give an account of three discourses about the phenomenon of ART: **state discourse, discourse of medical professionals in private infertility clinics and IVF patients.** To discover which modes of subjectivation are constructed for infertile women who undergo IVF on all three levels of analysis I rely on two concepts – **biopower** and **precarity**. I use the concept of **biopower** to analyse how different rationalities of government, in particular the techniques of **biopolitics** and "**advanced liberal**" **governmentality**, engender subjectivation. I implement the concept of **precarity** to analyse how subjectivation of infertile women who use IVF is enacted by virtue of

the **precarious conditions** produced by **biopower**. As I look for the connections between **biopower** and **precarity**, I would also like to discuss:

1. How the **precarity** of infertility works together with **biopower** to provide women who undergo IVF procedure with **modes of subjectivation** grounded in **motherhood** and **biological citizenship**;
2. How the **precariousness** of infertile women:
 - makes them adopt the **modes of subjectivation** based on **self-governance** complicit with the needs of the state and medical establishment;
 - helps them to envision new sense of ethical conduct towards the others and coalition-building based on shared vulnerability.

Since I share the Foucauldian idea that any truth claims are made intelligible only within certain regimes of truth, I chose not to rely on the rigorous formulation of research question that would demand the production of “true” and “objective” knowledge representing “some underlying reality” (Ramazanoglu and Holland, 2002: 86). On the contrary, I want to keep my account of reality open to constant rearticulation and shifting across difference, because rooting better access to “truth” in certain positionalities inevitably leads to naturalization and essentialization of one’s own perspective, as well as to exclusion of other positions as not valid and intelligible (Haritaworn, 2008). Therefore, bracketing the question of “objectivity” and being relativist about “truth” gives me the possibility to travel between different contingent and flexible foundations and not to ground myself in any of them. Here I agree with Judith Butler (1994: 21) that “there is more to learn from upsetting such grounds, reversing the exclusions by which they are instated, and resisting the institutional domestication of queer thinking”.

THEORY

I. BIOPOWER

To reveal in which way ART constitute part of the “distinctive art of government that historically emerges with liberal forms of social regulation and individual self-governance” and is directed at control of humans as living species, I incorporate into my theoretical framework the account of “biopower” (Lemke, 2011: 34). The concept of biopower helps me to acknowledge two distinct political rationalities that are at work in the discourses of state, medical professionals and IVF patients in Ukrainian context, in particular the 1) biopolitics or “power over life” of population that acts through society as a whole (normalization techniques); and 2) “advanced liberal” governmentality which acts on the choices of quasi-autonomous entities (techniques of responsabilisation). These two rationalities of government bring to the light which modes of subjectivation they provide for infertile women who undergo IVF procedure.

In Ukraine the state support of infertility treatment can be understood as instrumental in establishing a control over population and maximizing of its life processes. In particular, my analysis proves that the state discourse about ART is a part of a bigger discourse on the importance of population growth for the national security. Therefore, I have chosen to rely on the Michel Foucault’s (1998; 2003; 2009) concept of biopolitics to decipher the political rationality that constructs women’s subjects in the state discourse about ART. The main biopolitical techniques used by the state to regulate reproductive practices are normalisation of motherhood and precarization of infertility. As a result of these discursive strategies the only available mode of subjectivation for woman is “mother”. Since female subject is constructed as fulfilled only through motherhood, it further reinforces the precarization of infertile women due to the lack of recognition. I give an account of the joint work of biopower and precarity in the second half of the theoretical part.

At the same time, in spite of biopolitical ambitions in the realm of state discourse about infertility, on practice the state forwards responsibility for reproductive health to individual women, which can be seen in the poor material support provided by the state. In the agreement with these policies, the discourse of professionals in private infertility clinics articulates the treatment of infertility as a matter of consumer choice that should be left to private and autonomous actors. Since the main political rationality in the discourse of medical professionals about ART consists in acting on choices, I try to capture it with the concept of “advanced liberal” governmentality explored by Peter Miller and Nicolas Rose (Rose and Miller, 2008; 2010; Rabinow and Rose, 2006; Rose, 2007). Acting through autonomisation and

responsibilization it provides woman with a mode of subjectivation that is based on self-governance and somatic ethics, and can be called biological citizenship (Petryna, 2002; 2004; Heath, Rapp and Taussig, 2007; Rose and Novas, 2005). In the second half of the theoretical part I argue that precarization of infertile women smoothes the work of governmentality techniques and allows them to bring IVF patients in Ukraine to exercise regulated autonomy in mastering their conduct and optimising their bodies.

Therefore, both rationalities try to produce those subject positions that would fulfil their policies. In discourse of IVF patients biopolitical techniques and neoliberal governmentality work together with precarity to structure the experience of infertile women's encounter with the technology and impose on them the subject positions of "mother" and "biological citizen".

1. Biopolitics

a) Rationality of government

In Ukraine the biological life and health of the population are rendered amenable to the state intervention aimed at stimulation of birth rates both through extensive campaigns and regulation of human conduct. I use the theoretical elaborations with regard to the concept of biopolitics and governmentalisation of the state to argue that political rationality exercised on the level of the Ukrainian state "has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security" and is exercised on the level of the state thanks to the ensemble of means that Foucault calls "governmentality" (Foucault, 2009: 144). This rationality of government is enacted in the state discourses of ART and has big influence on the discourse of IVF patients themselves.

In his lectures *Society Must Be Defended* Foucault (2003) introduces the concept of biopower. Biopower operates in a productive, rather than in a repressive mode. If the sovereign power had the right to decide whether to take the lives of its subjects away, biopower aims at production and strengthening of the forces of subjects as biological beings through nurturing, multiplying and reinforcing their lives (Ibid: 242-243). In his lectures *Security. Territory. Population* Foucault (2009: 1) defines bio-power as a "set of mechanisms through which the basic biological features of the human species became the object of a political strategy".

Bio-power is exercised through accumulation of knowledge and generation of discourses about human life in two forms (Foucault, 1998: 139): 1) Disciplinary power (or anatomopolitics) appears in the 17th century and is concerned with supervision and control of individual bodies with the help of the technologies of discipline (Foucault, 1991); 2) Biopolitics develops in the 18th century and is concerned with control and regulation of the population as a "global mass

that is affected by overall characteristics specific to life (...) like birth, death, production, illness, and so on” (Foucault, 2003: 249) and seeks to secure the "the improvement of its condition, the increase of its wealth, longevity, health, et cetera" (Foucault, 2009: 140). It is exercised with the help of the technologies of security and liberal governmentality.

Two forms of biopower work simultaneously to control human both as individual body and as species (Foucault, 2003: 242–243). This joint action is especially relevant in context of control of reproduction, since sexuality “exists at the point where body and population meet” (Foucault, 1980: 145). The history of the female body as closely associated with the birth of dispositif of sexuality is a part of history of bio- and anatomo-politics. Medical practices in infertility clinics in Ukraine are based on techniques of anatomo-politics, which canalize the aspirations and actions of infertile women with the help of surveillance and discipline. Doctors have a monopoly on production and rational use of appropriate "discourse of truth" through which the scope of the female body and its procreative properties are identified and supervised (Foucault, 2003: 24).

But while disciplines of the bodies exist on the level of institutions, the reproduction is also a biological process of a population and thus is crucial for bio-politics on the level of the state (Ibid: 251–252). In Ukraine the infertility is identified as problem that has consequences for wellbeing of society and national security, thus state politics concerned with ART and management of reproductive health are embedded in strong pronatalist incentives with regard to all population. As a tool of biopolitics ART consolidate the power of society through the establishment of control over sexuality. We can also find evidence of this in its discursive practices, which determine the meaning of ART in terms of conservative sexuality, family health and population growth. Therefore, to accomplish my analysis on the level of the state I am exploring which technology of government was enabled by the emergence of the problem of population.

In his lectures *The Birth of Biopolitics and Security, Territory, Population* Foucault (2008; 2009) undertakes the analysis of the technologies of security and governmentality, which allows him to reformulate the concept of biopolitics within the problematics of the liberal art of government characteristic of this distinct form of power. According to Foucault (2003: 249), the biopower is being exercised through the apparatuses (dispositif) of security, which is not based on exclusion, but rather prevention of anything that can endanger society and its each individual member. Moreover, Foucault (2009:143) claims the emergence of population “as a field of intervention, and as the end of government techniques” made possible the extension of the concerns of rulers outside of the juridical framework of sovereignty and thus articulation of the new liberal art of governing human beings, which Foucault calls “governmentality”. The concept

of “governmentality” Foucault uses to indicate the political rationality that grounds the exercise of bio-power on the level of the state and operates according to the “nature of society that constitutes the basis and the border of governmental practice” (Lemke, 2011: 45). At the same time, he understands liberal governmentality as acting outside institutional framework of the state, which becomes “governmentalized” (Foucault, 2009: 144).

b) Mode of Subjectivation

Thus, governmental techniques are exercised “at a distance” and aimed at governing through society. Michel Foucault argues that the operation of the new methods of power is not ensured by “law” and “punishment”, but by “technique”, “normalization” and “control”, those methods are “employed on all levels and in forms that go beyond the state and its apparatus”. He stresses that the main feature of bio-power is that it is targeting the "norm" and provides the organization of "normalizing society" (Foucault, 1998). I apply the notion of normalisation to examine the interventions of Ukrainian state upon biological life and health of population. The modes of subjectivation provided by the state for the infertile women is based on the normalization of motherhood and construction of the infertile bodies as deviant, thus the main technology is shaping the conduct, educating desires and configuring habits, aspirations and beliefs of infertile women in relation to social norm of motherhood. This mode of subjectivation is constructed in the state discourses of ART and is adopted by IVF patients.

Medical interventions in the reproductive processes are also naturalized by virtue of attaching women to their “imperfect bodies”, having "natural" needs for assistance and not being complete without the interference of doctors on the level of the clinic. As a result, women’s bodies are disciplined and enhanced, as well as their conduct is engineered and normalised to correspond to the role of mother. In accordance with this, Thompson (Cussins, 1998) argues that the clinic is (re)produced in particular through normalization techniques which indicate the ways, in which “new data” are included into “pre-existing procedures and objects of the clinic”, as well as “the grid of what is already there is produced, recognized, reproduced, and changed over time” (Thompson, 2005: 80). Normalization techniques are based on strategies of routinization and naturalisation, providing routinization is a “skilled local knowledge that is exercised by practitioners and patients in conjunction with medical technologies”, while naturalisation specifies how “aspects of the site are rendered unproblematic or self-evident in the sense of seeming “natural” (Ibid.: 81).

At the same time, the subjectivities of women are produced to be active in their own government and even overcome all obstacles on their way to self-fulfilment in responsible motherhood. Otherwise, all women who are not capable to become intelligible subjects through

motherhood are made precarious and their lives are made un-liveable or less liveable than the lives of proper subjects.

2. “Advanced Liberal” Governmentality

a) Rationality of government

Nicolas Rose (2007) follows Michel Foucault in his ideas about biopolitics as technology that administers and enhances “vital lives” of citizens and constitutes a liberal art of government, but he claims that the current technoscientific advances together with neoliberal changes in rationalities of government led to the shift from biopolitical mechanisms of normalisation towards the technologies of responsabilisation and autonomisation. In the “advanced liberal” democracies the state was “degovernmentalised” and practices of government were “de-stated”, thus a variety of regulatory technologies previously exercised by the political apparatus were detached from the centre (Rose, 2008: 212-213). In particular, the responsibility for the human life and health was disassembled from the state and ascribed to the quasi-autonomous non-governmental entities, that include bioethics commissions, private corporations, organisations, groups of experts, communities and individuals, who now are supposed “to manage their own affairs, to secure their own security with a prudential eye on the future” (Rose, 2007: 4).

The analysis of rationalities of government provided by Nicolas Rose are problematic when applied across difference in political systems and cultures, thus I am interested in displacing and decontextualizing them through a comparison with post-Soviet states on the example of Ukraine. In the field of the infertility management in Ukraine, that does not constitute an “advanced liberal” democracy, these neoliberal governmentality mechanisms are exercised simultaneously with biopolitical one. Despite the pronatalist rhetoric of the state, the field of reproductive medicine in Ukraine is almost entirely governed by private clinics. I apply the concept of “advanced liberal” governmentality to the discourse of medical professionals in order to reveal the mechanisms with the help of which they exercise the government in the field of ART without a control or intervention of the state and construct the subjects of IVF procedure as active and responsible consumers capable of self-governance and self-knowledge.

At the moment there are only 6 state clinics, which provide the services of ART, and around 28 private infertility clinics in Ukraine. At the same time, the legal regulation of ART is underdeveloped and the private clinics don’t face major restrictions from the state in their activities. The financial support to infertile women provided by the state program for treatment of infertility is drastically insufficient, since the state funds less than 600 hundred cycles of IVF

per year for almost 12 million women of fertile age¹. As a result, the majority of women have to handle the high prices of private infertility clinics and adapt the subjectivities of responsible biological citizens provided for them by the medical discourse.

b) Mode of Subjectivation

“Advanced liberal” government does not have society or population as a target of rule, rather it is deployed through shaping of will of autonomous bodies and regulating choices of individual citizens (Rose, 2008: 216). The undoing of welfarist forms of regulation and the arousal of neoliberal agendas and policies resulted in construction of subjects with a presupposition towards the autonomy and self-governing, aspirations for self-actualisations and self-fulfilment (Lemke, 2011). As a result of these technologies of responsabilization, “the regulation of conduct becomes a matter of each individuals desire to govern their own conduct freely”, become responsible for their choices and management of their own affairs “in the service of maximization of a version of their happiness and fulfilment” (Rose, 2008: 215).

I rely on this mode of subjectivity to analyse how infertile women are subjectivated in the discourses about ART, in particular the discourse of medical professionals. From my interview material, it has emerged that IVF patients are urged to identify with certain kind of conduct, which satisfies the norms of “responsible” motherhood, and motivates them to take individual responsibility for their reproductive health. The medical discourse in Ukraine by virtue of normalization of motherhood and formation of somatic and consumer ethics constructs the subject of IVF as an active consumer capable of governing oneself, making independent choices and optimizing ones body. Except for being enacted in the medical discourse, this rationality of government has impact on the discourse of IVF patients. In order to endorse the self-governance they feel obliged to adopt the educated and knowledgeable relation to their bodies and act upon them in the caring manner. The subjectivation of IVF patients happens through problematization and optimization of the body, incorporation of biomedical knowledge about its functioning.

Thus, in the context of my research it is important to discuss how our biology understood in biomedical terms becomes who we are, what informs our hopes and expectations, unease and discontent, how crucial for the identity becomes ones knowledge and care about the body and how power is enacted through this mechanisms of subjectivation. The arterial assemblage between the biosciences and biotechnologies, the neoliberal political rationalities and formation of identity and self-hood effects the relations between individuals and society in a way that leads

¹ Ministry of Health of Ukraine Order # 651 “On approval of quotas of regions and distribution of drugs and small laboratory equipment for the treatment of female infertility with the help of ART, procured centrally by the State Budget of Ukraine for 2009. 2009. Available at: http://www.moz.gov.ua/ua/portal/dn_20090828_651.html [Accessed 5 March 2013]

to the new forms of political articulation grounded in informed care about one's biological body. These new modes of political activism and representation can be described with the concepts of "biological" and "genetic citizenship" (Petryna, 2002; 2004; Heath, Rapp and Taussig, 2007, Rose and Novas, 2005). In relation to my work I unite under the title of "biological citizenship" both responsibility to govern oneself and somatic ethics discussed above and use this concept as characteristic of distinct mode of subjectivation produced by "advanced liberal" governmentality and enacted in discourses of medical professionals and IVF patients.

In his discussion of biosociality Rabinow claims that taking into account the proliferation of bioscientific knowledge people start to understand themselves in bioscientific terms and form individual and collective identities on the basis of biomedical classifications (Rabinow, 1992). As a result, the demands for rights, recognition and belonging can be made on behalf of one's medical condition, as well as duties of humans are defined in relation to their bodily identities, which they are obliged to govern themselves. My interview material reveals how important for the identity of IVF patients is the successful management of infertility and how their embodied experience understood in accordance with biomedical classifications begins to provide a ground for the citizenship claims and new forms of democratic participation and coalition-building. Infertile women in Ukraine initiated the online forum, which allows them to share knowledge, life experiences and provide emotional support to each other. It can be understood as an example of self-help group whose members are not just passively anticipating medical care, but are rather involved in diverse social activities with regard to it. For example, they adapt the conduct of active biological citizens and conscious consumers, who educate themselves by finding all medical information on the internet, evaluate the opinions of doctors, fight with the monopoly of the medical authority on the knowledge of their bodies (Rose, 2007: 22).

II. PRECARIETY

To uncover how biological citizenship can be grounded in the constitutive vulnerability of women who undergo IVF in Ukraine resulting from a number of precarious conditions within which they are placed I refer to Judith Butler (1997; 2004; 2005; 2009). I analyse how the rationalities of government and the modes of subjectivation enacted by them reinforce the precariousness of infertile women, since they subjectivate women only as "mothers", thus exclude the subjectivity of the infertile as liveable. The experience of IVF procedure reveals to many women their precarious standing, which I see through the Butlerian lenses as constitutive vulnerability grounded in the "inappropriateness" of their bodies and their dependence on the precarious conditions of medical treatment and state politics they cannot control.

The state biopolitics and governmentality of medical professionals enacts the frames of recognition which render the lives of infertile women unliveable since they don't fit the norm of motherhood and fail to sustain the social conditions intended to protect these lives. Thus, apart from the existential precariousness of one's infertile body, the women in the practices of IVF treatment experience the precarity produced by biopower. They manage this precarity by adapting the responsible and self-governed subjectivity of biological citizens, establishing informed relationship with their bodies and building networks based on bodily condition.

Thus, I would like to discuss: 1) how precarity works together with biopower to provide a subject of IVF procedure with a ground for the formation of the distinct ethics of self-governance; 2) how these modes of subjectivation are serving the needs of the state and medical establishment; and 3) how the recognition of this precarity and limitedness of self-knowledge and self-control envisions new sense of ethical conduct towards the others and makes one sensitive to the limits the others encounter in their dependencies.

1. Precariousness

For Judith Butler there is no coherent, self-grounding and self-assertive subject that relies on positive nature of what it means to be human. In *Psychic Life of Power* she argues that the subject "is initiated through a primary submission to power" (Butler, 1997). In *Giving An Account of Oneself* Butler (2005) claims that we are given over to the other prior to the subjectivation and formation of the "I" in the same way as a child, from the start, is exposed to the other in its passivity and impressionability, helplessness and need. Thus, the subject is constituted only when addressed by the other and is dependent upon the work of power to persist as a social being. These constitutive dependencies of the subject from the social conditions reveal the common human vulnerability and precariousness (Butler, 2005).

In *Precarious Life* Butler (2004) contends that the desire to persist as a recognisable social being requires submitting oneself to the social norms, which condition the process of recognition and are never owned by the subject. Thus, to become intelligible we should fulfil "cultural norms that precede and exceed us", since we are "given over to a set of cultural norms and a field of power that condition us fundamentally" (Butler, 2004: 45). As well, the women who undergo the treatment of infertility are made precarious by their dependence on the norms of motherhood, which they are reinforcing and reconciling at the same time in order to become recognised.

According to Butler (2004: 28), "the disposition of ourselves outside ourselves" follows from "the social vulnerability of our bodies", which never belong to us and are constituted through social crafting. Butler (2009a: 23) defines "precariousness" as "the condition of being conditioned" that "relies on a conception of the body as fundamentally dependent on, and

conditioned by, a sustained and sustainable world” (Ibid: 34), “given over to modes of sociality and environment that limit its individual autonomy” and socially constituted by virtue of the exposure and vulnerability of bodily life (Ibid: 30). It differs from the concept of “precarity” since it is a “generalized condition” shared by all humans due to their primary sociality and public dimension of their bodies, physically vulnerable and finite, exposed “to the gaze of others, but also to touch, and to violence” (Ibid: 28). Butler (Ibid: 24) argues in *The Frames of War* that we can assume that “lives are by definition precarious”, since “they can be expunged at will or by accident; their persistence is in no sense guaranteed”. To say that life is always precarious implies the concept of life as a conditioned process, since “there is no life without the conditions of life that variably sustain life, and those conditions are pervasively social” (Ibid: 23). The experience of IVF reveals the ontological/existential precariousness of infertile body and the limits of knowledge with regard to its functioning.

2. Precarity

On the other hand, by “precarity” Butler introduces more specifically political concept that identifies those structures of power, including economic and social institutions, which are intended to maintain the conditions that make the life “liveable” and provide populations with the means to secure life. The life depends fundamentally on the social and political networks that sustain it, but this vulnerability is articulated differently, since while power assists certain human lives, it disregards others, encouraging and augmenting their precariousness. Thus, the precarity is allocated differentially and “designates that politically induced condition in which certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence, and death” (Butler, 2009a: 25). In my analysis I explore how political rationalities in Ukraine recognise some populations, while disavow others, in particular infertile women. With the help of this concept I explore how the existential precariousness of the infertile bodies is deepened due to the failure of the current rationalities of government to provide them with sufficient support. On the contrary, both state biopolitics and governmentality on the level of private clinics further engender a situation of precarity for infertile women.

The reason why some lives are treated as not worth support and are made precarious in their dependencies is because they don’t conform with certain norms that determine what a recognisable life is (2009a: 7). Butler discusses the role of “the differential operation of norms of recognition” (2004: 30) or the “differential allocation of recognisability” to highlight how only those lives that fit the norms that govern “the intelligibility of the body in space and time” are liveable and grievable, the rest are made even more precarious (2009b). This normative terms

condition in advance who does count as a subject, and who does not, and thus “what kind of life will be a life worth living, what life will be a life worth preserving, and what life will become worthy of being mourned” (Butler, 2009a: 54).

Thus in order to be recognised as a subject one has to be compliant with the norms, in particular the gender and sexual norms that condition eligibility for recognition. At the same time, "subjects" who are not conforming, are not “recognizable as subjects”, which “calls into question the viability of one’s life and makes one’s body to appear more precariously than others” (Butler, 2009a: 4). My analysis shows how different rationalities of government in Ukraine impose the identities of “mother” and “biological citizen” as the only possible modes of subjectivation for infertile women and thus neglect the life of the infertile body as such.

In Ukrainian context it seems that women can exist as intelligible subjects for the power only if they live out the norm of motherhood and modes of subjectivation provided by hegemonic discourse. Infertile women, who don’t fit the terms of recognisability enacted through the structures of biopower, find their bodies as not liveable, become precarious and disavowed within this given political rationalities. Both discourses of state and medical professionals doesn't provide infertile and childless woman with an intelligible subject position, quite the reverse she is always subjectivated through her desire to be a mother and is recognised by power structures only as fulfilled in motherhood. The omission of the infertile women in discourse of the state is an act of nation-building, since it signifies which bodies are liveable enough to constitute a nation, and how vulnerability should be distributed by the medical and welfare structures to make lives of “mothers” more secure and the lives of infertile women more precarious. Thus, infertile women in Ukrainian context become a precarious population that is not recognised as part of the nation, whose voices and visibility are regularly disavowed and who experience constant lack of support from the state and medical institutions.

3. Governmental Precarization

Moreover, precarization eases the work of biopower in construction of subjects of women. Since infertile women are not living gender norms in the way that is recognised by structures of power, they are exposed to all sorts of insecurity and the conditions on which they depend are turned by power to be extremely precarious and uncertain. Butler (2004) claims, that lives which are not first apprehended as living cannot be apprehended as injured or lost, as well lives of infertile women are not grievable, their pain is not acknowledged and their losses cannot be mourned.

The power not only makes some groups precarious, but also uses their precarious condition to govern. The precarious standing of infertile women makes them more open to intervention and harassment, as well as facilitates the work of power in shaping their subjectivities. In my

research women who understood their precariousness were eager to adapt the subjectivities provided by power in order to manage the state of precarity. The decision of my respondents to do IVF was conditioned both by the desire to fit the definition of normalcy, and by the responsabilisation techniques that promote the endless optimisation of the body for the sake of self-fulfilment. Since infertility is not considered liveable, they saw in “motherhood” the only chance to restore themselves in the status of intelligible subjects and manage the precariousness of state discourse. While they found the possibility to manage precariousness of medical treatment in adoption of the educated and knowledgeable relation to their bodies.

Therefore, the biopolitical and governmental techniques encountered a “fertile” ground in infertile bodies. I argue that the precariousness of infertile women eased the work of governmental techniques, which led to the formation of subjects capable of self-governance. Thus subjectivation in the examined discourse of IVF patients is enacted largely through the acknowledgement of one’s vulnerability and precariousness. As a result, their precarity becomes a norm itself through which power governs and can be called “governmental precarization”. Isabell Lorey (2011) claims that “precarization in neoliberalism is no longer perceived as a phenomenon of “exception”, but is instead in the midst of a process of normalization, which enables governing through insecurity”. According to her, the focus on the interaction between precarity and governmentality allows one to see the productive moments of precarization, “as they arise through techniques of self-government” (Lorey, 2011).

4. Ethics

At the same time, self-governance, self-education and self-treatment that my respondents adopted to manage vulnerability represents not only the form of biological citizenship triggered by the lack of support from the state and medical institutions and awareness of their precariousness as infertile women. It also reveals the agency of women in caring about themselves and organising with others through acknowledgement of the limits of their possibility to control their lives and be accountable for them. The awareness of their precariousness led them to the distinct ethics with regard to each other and coalition building. In this sense, the acknowledgement of vulnerability provided an opening for new liveable worlds by the virtue of impossibility to achieve the norm and constant inability to fully give an account of oneself and of the Other.

Butler tries to argue that due to the fact that the opacity of the subject originates from its primal relations with the others, it can sustain an ethical attitude towards the Other. Since I can’t fully give an account of myself, as I am founded on the loss, which I disavow, the recognition of the other is as opaque as my own reflexivity. This enables me to escape the demand to perform

coherent self-identity at any time, as well as it helps me to establish the ethical conduct towards the other: “one can give and take recognition only on the conditions that one becomes disorientated from oneself by something which is not oneself, that one undergoes a de-centering and “fails” to achieve self-identity” (Butler, 2005: 42).

For Judith Butler (2005: 19) the moral subject arises when it experiences the limits of what she can know about herself, when she acknowledges the limits of acknowledgement itself, in other words avow that she will never know her own essence and will always be dependent on conditions that can not control. I claim that the women who undergo IVF thanks to this experience acknowledge their own dependence on the Other and inability to be accountable for their opaque, fragile and incomplete bodies, and this gives them opportunity to understand the vulnerability of other women who have also faced their imperfect bodies.

METHODS

In order to answer my research question I have used both the elicitation methods to gather the necessary field data and evaluation methods intended to help in the analysis of collected data (Tischer, et al., 2000: 6). I took into account the constant discursive struggle between different discourses about IVF and selected for examination three discourses involved in it: the discourse of the state, discourse of medical practitioners and discourse of the IVF patients. I was conscious in excluding the mass media discourse, since it would make my research too broad to handle within the determined limits.

As my intention was to investigate what political rationalities and modes of subjectivation structure the social reality of infertile women in the discourses about IVF, it conditioned the necessity of direct involvement with the carriers of the discourses in question. I have preferred individual semi-structured interviews as a main field-research method of data gathering, because it was important for me to reach the situated perspectives of the main actors that produce the discourses about IVF. To examine the data collected with the help of interviews I have chosen to conduct discourse analysis. I have also conducted discourse analysis of generally accessible texts when I was lacking material from the interviews.

I. DATA GATHERING: INTERVIEWS

Initially I have planned to conduct interviews with state functionaries in the Ministry of Health of Ukraine, but I didn't manage to have the consent of any of them, therefore I had to analyse state legislation and programmes about ART (Appendix 1). To analyse the discourse of medical professionals I have conducted 4 interviews with directors of ART clinics in Kyiv and Kharkiv (Appendix 4). I had to compensate the small amount of respondents among medical professionals with articles of obstetricians and gynaecologists in Ukrainian medical journals (Appendix 3). To grasp the modes of subjectivation of women who undergo infertility treatment I conducted interviews with 10 women about their experience of IVF procedure (Appendix 7). On the preliminary stages of my research, I have also conducted 5 expert interviews with feminist researchers and activists who are engaged in debates on the politics and discourses about reproduction and infertility treatment in Ukraine to situate myself with regard to the research problem (Appendix 10).

I have decided to conduct qualitative interviews, because quantitative survey methods, like questionnaires, required larger sample and were inapplicable due to the small amount of respondents I have succeeded to get in contact with (Kirby, et al., 2010: 132). Moreover, as less interactive method of data gathering it wouldn't allow me to access the meanings carried by the

experiences of respondents (Ramazanoglu and Holland, 2002: 155). While organisation of focus groups with medical professionals was impossible due to the low participation as well, focus groups with IVF patients were problematic due to the ethical aspects of IVF treatment, in particular I was worried that it would be difficult for women to discuss their traumatic experience of infertility treatment in public (Kirby, et al., 2010: 146).

Another option in mapping the underlying mechanics of power and subjectivation would have been to choose the participant observation methods in private and state infertility clinics. That would enable me to investigate everyday verbal and non-verbal practices of medical professionals in managing infertility and of infertile women in undergoing IVF procedure. However, I didn't employ observational method, since I decided to focus on the discursive aspect of IVF, rather than on the behavioural patterns and lived experience of all actors involved in the procedure. Moreover, the fieldwork of this kind would require obtaining the permission to enter the site and developing contacts with the group (Kirby, et al., 2010: 147). Thus because of the lack of time and social connections it would be particularly difficult for me to observe the everyday functioning of infertility clinic, which represents relatively closed and exclusive institution in Ukraine.

Since I was conducting semi-structured life-world interviews "to obtain descriptions of the life-world of the interviewee with respect to interpreting the meaning of the described phenomenon", I have faced my respondents with an open set of questions and themes in order to better incorporate their insights and perceptions (Kvale, 2007: 52). I was changing the order and formulation of questions in the interview guide depending on the process of interaction. Some of the questions were added to the interview guide only after they were brought up by respondents. If I saw that there is a theme that emerges in conversations constantly, I would focus on it more during subsequent interviews. On the contrary, when I noticed that some of my questions didn't resonate with respondents, I would drop them off the list. In general, I was trying to give my respondents as much space as possible in articulating what is important for them and not to impose my perspective.

I have operationalized the notion of political rationalities and modes of subjectivation into a set of questions that differed depending on the group of respondents. I asked medical professionals how they see their role in infertility treatment and how they relate to the state politics with regard to ART and to women who undergo the procedure in their clinic (Appendix 5). Touching upon these themes allowed me to explore how they rationalise their own agency in the field of ART, how they see the role of the state and IVF patients, and how they construct professional discourse to reflect their vision. As a result, I was able to reveal the techniques of power they exercise and the subjectivity they construct for the patients.

Except for asking how the political rationalities on the level of hegemonic discourses shape the ways in which subjects would act on themselves, I was interested in how people are accommodating and changing this knowledge in order to relate to themselves. In interviews with IVF patients I focused on the experience of the IVF procedure and how my respondents understood their position as infertile women with regard to the state and medical practitioners. I asked women what they felt about their infertile bodies and how they understood the feelings of others about their infertility, how they encountered medical institutions and what was their way through the treatment, what was the impact of infertility and its treatment on their bodies and lives (Appendix 8). As a result I was trying to see which power techniques structured their experience, which forces they felt as acting upon their own lives and how they managed this situation, thus what mode of subjectivity they adapted and how they negotiated power and agency.

To find the respondents from the group of medical professionals, I have conducted preliminary research on the Ukrainian forum about IVF (<http://ovulation.org.ua/forum/index.php>) to find out which doctors are the most popular among women. As a result, I have contacted 10 infertility clinics asking for the interview with their specialists. In four ART clinics in Kyiv and Kharkiv the directors agreed for the interview. The interviews with them took from half an hour to hour and a half.

The same forum helped me to access 5 women with an experience of IVF procedure. I wrote them independently, but all of them knew each other either virtually or in real life. They recommended me to contact other 4 respondents. I have also allocated one of my respondents through my personal links. The interviews with women spanned from 2 to 4 hours and were anonymous.

All of my respondents did IVF between 2003 and 2010. Four of them had successful pregnancies and deliveries after the first cycle and the rest gave birth to children as a result of the subsequent cycles. One of my respondents has three children as a result of one cycle, three of them have one child after one cycle, and the rest have two children after one cycle. One of the women was in the process of her second cycle at the moment of the interview.

With regard to the age, all of my respondents were between 22 and 38 when they underwent IVF, but the majority were around thirty, which reveals how relatively early in their lives women in Ukraine decide to undergo the procedure. As for the marital status, 9 of my respondents were married and 1 was divorced. 5 of my respondents were working mothers, while the rest were housewives and totally dedicated to the needs of their children. While this brings to the light the middle class position majority of them occupy as supported by their husbands, only 3 of my respondents were not troubled by the price of the procedure and had the money needed.

The rest were either saving money, or borrowing from relatives, taking bank credits, which indicates how precarious is the position of the middle class in Ukrainian context.

The overall sample of my research isn't representative due to the snowball method, which allowed me to access only members of one social network, and also the difficulty in reaching larger amount of respondents with more diverse characteristics. Moreover, the qualitative interview in general doesn't provide the researcher with means of generalisation (Kvale, 2007). Although the group on the forum was formed as a result of the experience of IVF and could have been very heterogeneous, my respondents shared class, gender, ethnicity and marital status, which is largely determined by the nature of infertility treatment as targeted at the married women from the middle and upper classes. My research didn't account for the experience of infertile men, lesbian women, women and men of lower classes or people who don't suffer from infertility. Even if there are IVF patients among them, it is very difficult to access the respondents who represent these very small and exclusive groups.

II. ANALYSIS OF DATA: DISCOURSE-ANALYSIS

My material is textual, thus I am relying on methods of text analysis in my research. At the same time, I am not interested in the language per se, but rather in the relations between political rationalities, subjectivity and discourse. I am preferring to apply discourse analysis as a main evaluative method, because it offers the account of the interdependences between discourse, its social context and power relations that structure it. It helps me to unveil the investment of power in production of discourses and subject positions, as well as reveal the variety of ways in which discourse reproduces and alters social reality (Tischer, et al., 2000: 146).

In order to acknowledge with the help of which power techniques subjectivities of women are constructed I chose as a foothold the theory of discourse of Chantal Mouffe and Ernesto Laclau (1985). For Chantal Mouffe and Ernesto Laclau neither society, nor its divisions and identities, exist before they were articulated as objects of discourse, while Fairclough sees discourses as not only productive, but also determined by the larger social domain. Due to the epistemological assumptions of my analysis, I don't account for the discursive/extra-discursive dichotomy to the extent that would satisfy the requirements of the critical discourse analysis, therefore I don't use the method developed by Norman Fairclough (Jorgensen and Phillips, 2002). I will briefly introduce here the concepts I applied during analysis.

Michel Foucault emphasizes on the existence of certain rules, procedures, techniques, that result in the organization and production of utterances as true one (Foucault, 1972). As well Chantal Mouffe and Ernesto Laclau understand the relationship between signs and their meanings as determined in particular articulations by power. Thus, my methodological assertion

is that instead of being objective and autonomous representation of reality, discourse is produced by power and depends on particular politics of truth, that allow us to understand which statements should be considered true. To analyse the political rationalities that are enacted in Ukraine to construct the subjects of women who undergo IVF I explore the ways in which power and truth claims are intertwined in the discourses about IVF of the state, medical professionals and IVF patients.

To account for the concept of political rationality I examine which particular setting of the “chain of equivalence”, or organization of signs around the “nodal points” of discourse, is enacted by power to produce truth statements (Mouffe and Laclau, 1985). According to Mouffe and Laclau (Ibid: 112), discourse is a relational totality that is “constituted as an attempt to dominate the field of discursivity, to arrest the flow of differences, to construct a centre”, while “the privileged discursive points of this partial fixation” can be called “nodal points”. The “nodal points” acquire meaning not in a result of their relationship to reality, but in relation to other partially fixed signs, in other words through identification with certain “moments” of discourse and the exclusion of others from the field of discursivity (Ibid: 111). The process of attaching certain meanings to signs (articulation) is a result of establishing a certain type of hegemony (Ibid: 134).

Temporary fixation of any “element” into “moment” of discourse can always be subverted and destabilized by the interference of other meanings from the “field of discursivity”. Laclau and Mouffe (Ibid: 111) write, “we have referred to 'discourse' as a system of differential entities - that is, of moments. But we have just seen that such a system only exists as a partial limitation of a 'surplus of meaning', which subverts it. Being inherent in every discursive situation, this 'surplus' is the necessary terrain for the constitution of every social practice”.

Because of the relational character of identity and proliferation of signifieds in discourse, any articulation can never be complete. The articulation is possible because every “nodal point” is a floating or empty signifier that can acquire a multitude of meanings by virtue of being tied to differential positions. The emptiness of discursive centre and impossibility of an ultimate fixity of meaning enables discourse, while simultaneously conditions every discursive totality as non-complete (Ibid: 113). Laclau and Mouffe introduce the concept of floating signifier to name those signs, which have been contested in the struggle of different forces for hegemony in discourse. As any totality society as complete doesn't exist, thus those floating signifiers that refer to a society as a whole can be called “myths” (Jorgensen and Phillips, 2002).

To analyse the discursive construction of distinct modes of subjectivity I focus on those “nodal points” that articulate any identity as relational and partially fixed and can be understood as subject position in the discursive structures (Mouffe and Laclau, 1985:115). According to

theory of discourse, formation of “positive” and “complete” identity is a result of political struggle to fill the emptiness of discourse with a given content. For Mouffe and Laclau (Ibid: 111) the contingency of discourse can never be overcome, while the identity is always relational and grounded on antagonism. The non-complete character of all discursive fixations and polysemy of signifieds makes impossible the “society” as “suture and self-defined” totality. Discourse theory project is post-identical, as it does not presuppose a doer before the deed, denaturalizes those meanings and identities, which were perceived as reflecting reality, and demonstrates how identities were established through numerous exclusions. The subject is always fragmented, positioned differently in a number of discourses, or overdetermined – positioned in conflictual discourses at the same time.

III. REFLEXIVITY

It is also important for me to account for the feminist methodological approach that values researcher’s reflexivity, positionality and awareness that the ideal of scientific objectivity can serve as a tool to reproduce hierarchies in knowledge production and support social hierarchies in society (Ramazanoglu and Holland, 2002). When I reflect on my position in relation to participants of my research and my role in production of knowledge, I am aware of the implications of my power in formulating the research problem and deciding upon the theoretical and methodological framework, as well as in imposition of my own interests on the analyses, including one and ignoring others groups and social characteristics. Despite the fact that I aimed at incorporating the voices of infertile women into my study design and directing my research at promotion of positive changes for them, eventually the research wasn’t collaborative and participation of my respondents wasn’t sufficient, since I haven’t succeeded to get enough feedback from them with regard to the progression of research and didn’t agreed on interpretation of data (Kirby, et al., 2010: 39-41).

Although my research was driven by the solidarity with infertile women I felt myself as an “external insider”, or the researcher that comes from outside, but connects to the experience of the group under study (Banks, 1998). From one point of view, my social standing as a middle-class heterosexual Ukrainian woman eased my communication with participants, since we shared social background. At the same time, my young age, lack of experience with regard to marriage and motherhood and the fact that I never encountered the medical condition my respondents did, created the unequal dynamics, which I was struggling to negotiate. This embeddedness in social relations and relations of empathy towards the participants inevitably conditioned the partiality of my perspective and situatedness of knowledge produced from this specific location.

Thus, the main concern of feminist methodology is not to avoid power relations, but to make them as visible as possible and reveal how different social orientations influence the production of knowledge (Ramazanoglu and Holland, 2002: 158-159). Hence, the most important questions are “which politics advance and which obstruct the growth of knowledge; and, for whom (for which groups) does such politics advance or obstruct knowledge?” (Harding, 2004: 30-31).

In context of my research, reflexivity also means making clear what is my ethical stand towards the participants. The situation of the interview was traumatic for the IVF patients, since it touched upon the experience of emotional and physical suffering. I was constantly aware of this and tried not to ask questions which reinforced vulnerability of participants, as well as respected their right to stay anonymous and end interview at any moment they feel suitable (Kirby, et al., 2010: 89)

ANALYSIS

I. THE DISCOURSE OF THE STATE ABOUT ART

I analyse the discursive phenomena produced by the state with regard to ART, in particular women's subjectivation and rationalities of government that shape it, on the examples of state documents concerned with reproduction and assisted reproduction (Appendix 1). I claim that the state in Ukraine still employs biopolitical technologies of regulation of population through normalisation of motherhood. At the same time, the advance of neoliberal rationalities can be seen in forwarding the responsibility for health to quasi-autonomous private infertility clinics and individuals and government at a distance, which will be analysed later. My main argument is that discursive practices of the state with regard to reproduction of population incorporate the new reproductive technologies as a tool of biopolitics aimed at constructing women's subjects as mothers and precarization of infertile bodies.

While trying to answer what signs have the privileged position and in relation to which signs they are articulated I discovered that the discourses reproduced in the text strongly rely on the number of subject positions and nodal points that relate to society as a whole (myths). I examine the main nodal points of the state discourse and try to understand which chains of equivalence determine their meaning. I discuss the nodal points of "reproduction of the nation", "reproductive health", "infertility", "demographic crisis", "national security", "national development", "traditional family values" and the subject position of "mother" (Appendix 2).

1. Rationality of Government: Biopolitical Techniques

In the state documents the question of ART is framed with regard to "reproductive health" and "infertility", which constitute moments in the chain of equivalence with the nodal point "demographic crisis" or "decline in the birth rate". In "The Strategy of Demographic Development"² the privileged point of discursive fixation "demographic crisis" or "unfavourable demographic situation" is tied together with the nodal point "national security", thus decline in the birth rate is articulated as "danger for national security", while encouragement of higher birth rate as necessary for "national development and wellbeing". Moreover, the main state program that is concerned with the problematics of reproductive health bears the name "Reproductive Health of the Nation"³. As a result, discourses about reproduction and national security acquire

² Cabinet of Ministers Resolution on approval of the state program "The strategy of demographic development for the 2005-2015". 2006. Available at: <http://zakon4.rada.gov.ua/laws/show/879-2006-п> [Accessed 8 March 2013]

³ Cabinet of Ministers Resolution on approval of the state program "Reproductive Health of the Nation until 2015". 2006. Available at: <http://zakon4.rada.gov.ua/laws/show/1849-2006-п> [Accessed 8 March 2013]

meaning through the mutual determination and constitute the nodal points of one shared chain of equivalence with regard to “reproduction of the nation”. In such situation reproductive health becomes crucial for national development and reproductive technologies become a biopolitical and governmental tool that allows to mobilize one more demographic reserve - infertile couples.

The nodal point “demographic crisis” also brings about the nodal point “traditional family values”, since it is defined in the chain of equivalence with the moments “problems of family formation”, “problems of family functioning”, “the deterioration of family values”, “reduction of the demographic potential of the family”, “postponement of marriage and childbearing”, “single motherhood”, “childlessness”, “only one child”, “children out of wedlock”, “fall in numbers of registered marriages”, “increase in divorces”⁴. In turn, the nodal point of “reproductive health” is also defined through the chain of equivalence with “attention to the role of the family” and “preservation of traditional culture of relationships in the family”⁵. Instead of articulating the social-economic causes of “demographic crisis”, the discourse identifies the reason in the dissolution of traditional family values and gender roles. Therefore, encouragement of conventional reproductive practices is articulated as a solution to the problem of low birth rate and poor reproductive health. This fixation of discourse facilitates the work of biopolitical rationality in exercise of population control.

The processes of nation building in post-Soviet countries have contributed to the intervention of the hegemony of the discourse of the “traditional family values” as promising high birth rate and national prosperity. Reference to the tradition also makes explicit how current myth of society is produced as a result of manufacturing its past history. Zhurzhenko (2004) argues that it is an important element of an ideology of “post-Soviet traditionalism” that legitimizes the rhetoric of the rebirth of the nation by virtue of the appraisal of the traditional family values, which never existed in the same form in history, but were reimagined as an ideal model. That is why discourse of family and demography strongly relates to the discourse of national security and becomes articulated in concrete legislative initiatives.

The nodal point of “family” is defined through the chain of equivalence with the “cell of reproduction of population”, “women’s vacation”, “fulfilment of women”, “big families”, “registered marriage”, “union of man and woman”, and thus brings about “high rates of reproduction”⁶. While the field of discursivity excluded from the articulation process consists of queer kinship configurations, lesbian and gay couples, childless couples, single parenthood, civil

⁴ Cabinet of Ministers Resolution on approval of the state program “The strategy of demographic development for the 2005-2015”. 2006. Available at: <http://zakon4.rada.gov.ua/laws/show/879-2006-п> [Accessed 8 March 2013]

⁵ Cabinet of Ministers Resolution on approval of the state program “Reproductive Health of the Nation until 2015”. 2006. Available at: <http://zakon4.rada.gov.ua/laws/show/1849-2006-п> [Accessed 8 March 2013]

⁶ Cabinet of Ministers Resolution on approval of the state program “The strategy of demographic development for the 2005-2015”. 2006. Available at: <http://zakon4.rada.gov.ua/laws/show/879-2006-п> [Accessed 8 March 2013]

marriages, organised around the nodal point of “deterioration of family values” and “demographic crisis”.

Franklin (1995: 328) states that ART undermine those naturalized assumptions that define who has the right to be a parent, and who has not. However, in spite of the disappearance of natural referent, the traditional idea of nuclear heterosexual family as the necessary condition that legitimates the right of motherhood is still maintained. The state discourse about ART promotes this conventional notion of family, as natural and objective need situated above politics. At the same time, it articulates this need as crucial for national development. Its discursive practices determine the meaning of ART in terms of the nodal point "reproductive medicine" as included in the chain of equivalence with “safe motherhood, sexual health, family planning, family medicine, demographic growth”, and opposed to infertility, which is identified with the “infertile marriage”, “medical and social problem nationwide”, “tragedy”, “the perennial problem of humanity”. This fixation of discourse about ART is accompanied by restrictions and regulations of the use of ART and eventually works for the reproduction of the superiority of the normative families, rather than on the redefinition of the notion of the family itself.

The legal framework implicates that ART are to be used primary by heterosexual married couples. For example, the Art. 123 of the Family Code of Ukraine⁷ defines as parents of a child born in the result of application of assisted reproductive technologies “married couple (man and woman)” and in Art. 48 of the Law "Principles of Legislation of Ukraine on Healthcare"⁸ it is stated that the use of artificial insemination and embryo implantation can be carried out in case of “written consent of the spouses”.

If legal regulation contains no explicit prohibitions on the use of IVF by singles and unmarried couples with various sexual orientations, surrogacy is allowed only to heterosexual couples in registered marriages, precluding the legal possibility of married same-sex couples from abroad to be recognised as eligible. In the review of this law by parliamentary committee it is stated that “the bill proposes to clarify the concept of marriage for those couples who can use the results of assisted reproductive technologies. This will eliminate the use of the services of surrogate mothers, citizens of Ukraine, by foreign citizens who are in same-sex marriage.”⁹ Moreover, a number of recent law projects produce exclusion of citizens of the states where surrogacy is forbidden. Although the proposition to forbid couples from the countries where

⁷ The Family Code of Ukraine (art. 123) 2002. Available at: <http://zakon4.rada.gov.ua/laws/show/2947-14> [Accessed 7 March 2013]

⁸ Law "Principles of Legislation of Ukraine on Healthcare" (art.48) 1993. Available at: <http://zakon4.rada.gov.ua/laws/show/2801-12> [Accessed 3 March 2013]

⁹ Proposition of bill #8212. 2011. Available at: http://w1.c1.rada.gov.ua/pls/zweb2/webproc4_1?pf3511=39859 [Accessed 10 March 2013]

surrogacy is not legal to use surrogacy in Ukraine was vetoed by the President, it received a warm welcome from the professional community of doctors and society in general¹⁰. Moreover, the previous version of the same law proposed to forbid all foreigners to use assistance in reproduction in Ukraine.

As a tool of biopolitics discourse of ART consolidates and maximizes the power of society through the establishment of control over sexuality. By attaching identities to strict heterosexual matrix state institutions that produce these discourses determine how would look the “body of the nation” in the future. Nira Yuval-Davis explains why this dependence of national collectivity on women fertility and sexuality occurs. In case of nationalist and racist mythologies the only legitimate way to join collectivity may become “being born into it” (Yuval-Davis, 1997: 26-27). This explains a crucial role of women in maintaining a “common origin” as a cultural and biological reproducers of the nation.

2. Mode of Subjectivation: Subjectivity of “Mother”

The nodal points articulated in the state discourse about ART construct certain types of subject positions for those represented in discourse, in particular infertile women. The subject position of infertile woman in this discursive formation is defined within the chain of equivalence of their procreative function, traditional family and conventional sexuality and through the nodal point of “mother”. This subject position is naturalised, while all other possible subject positions are excluded, as a result of the intervention of the hegemony of the state discourse structured by the biopolitical rationality. The discourse of reproductive technologies aims “to help women fulfil their mission” and “realize their maternal instinct”.

The conjunction of discourses organised around “reproduction of the nation” and “traditional family values” articulates motherhood as prior mission of every woman, while all other subject positions are deemed not intelligible within this discursive formation. The potential antagonistic subject positions of infertile and childless women reside in the field of discursivity and lack sufficient resources to subvert the existing fixation of meanings. Construction of women’s subjectivity as fulfilled only through motherhood and focused primary on childbirth and childbearing allows for biopolitical regulation of population. Thus the main power technology is the normalisation of motherhood, which is achieved as a result of intervention of hegemony and organization of moments around the nodal point of “mother” and exclusion of infertility and childlessness as undesirable.

¹⁰ Proposition of bill #8282. 2011. Available at: http://w1.c1.rada.gov.ua/pls/zweb2/webproc4_1?pf3511=39973 [Accessed 10 March 2013]

Another power technology used to control the conduct and bodies of women is the individualisation of responsibility for giving birth and taking care of children and family. Motherhood is not only the main vacation of women, but women are also responsible for the decrease in birth rate, for which the state withdraws responsibility from itself. Women's identity is constructed through the notions of responsibility for the reproduction and guilt for not giving birth or not being a good/responsible mother. Construction of infertile women as responsible to handle their medical condition and ART treatment allows state to forward responsibility for reproductive health to private infertility clinics and individual women, while still achieving the objective of population control by virtue of the imposition of the norm of obligatory motherhood at a distance.

The responsabilisation of women is reinforced by the state discourse, which articulates the loss of "traditional family values", and thus problems with "reproductive health" and "demographic crisis", as conditioned by the improvement in social status of women. The causes of "demographic crisis" are defined through the chain of equivalence: "the change in the social status of women", "the expansion of their interests outside family", "higher education", "employment", "their desire to postpone or avoid marriage and childbearing", "divorces", "abortion", "the necessity to satisfy their educational and civil interests", "only one child"¹¹. Since within this discourse women are thought to bear responsibility for the maintenance of family values, reproduction and childbearing, the loss of "traditional family values" is equated with reluctance of women to become mothers and fulfil their traditional gender role.

Although childlessness and infertility doesn't provide legitimate subject position, it still becomes a nodal point of discourse on ART by virtue of stigmatization. As a result, the nodal point of "infertility" is constituted through the chain of equivalence "the decline of reproductive health because of women's diseases", "abortion", "women's illnesses", "couples infertile because of the women's diseases", "unrealized femininity", "wrong way of life", "irresponsible/bad mothers". Thus, powerful instrument to attach women to the desire to have children is their discursive condemnation for infertility. As a result a lot of women seek for technological assistance in order to give birth and resume themselves in the status of normal.

Therefore, according to this logic the return to traditional family values, which presupposes the return to traditional women's role centred on the family and reproduction, is desirable as a way to overcome the demographic crisis, which is the main aim of the state rhetoric. There is an endorsement of this idea in the "State strategy for demographic development", which defines its purpose as promotion of "the restoration of family values in

¹¹ Cabinet of Ministers Resolution on approval of the state program "The strategy of demographic development for the 2005-2015". 2006. Available at: <http://zakon4.rada.gov.ua/laws/show/879-2006-n> [Accessed 8 March 2013]

Ukrainian society, including the desire to have and raise children”, “preserving the traditions of large families where they still exist, and forming recommendations for parents to have two children”, “active propaganda through the media of family values”, “conscious attitude to family responsibilities”¹². As a result, the promotion of ART as a cure for infertile women who seek to fulfil their mission as mothers fits into the rhetoric of the return of women into the family and reproduction of their traditional gender role.

The discourse about ART even further stabilizes the subject position of “mother” since it allows women to struggle for being mothers, prove how fit they are for motherhood in overcoming major obstacles on their way and how they can do everything that they can in order to counter “infertility” and become “happy”. Therefore, in state discourse about ART the nodal point of “mother” is defined through the chain of equivalence with “safe”, “responsible”, “good”, “intensive”, “real”, “true” motherhood, according to which women identify themselves, structure and satisfy their desires. These norms reflect subjective positions in the discourse of ART. Moreover, to be approved as a candidate for assisted reproductive technologies woman has to be “infertile”, “officially married”, “heterosexual”, to support “traditional family values”, stand for a couple in treatment, exhibit “the desire to have children” and other conventional ethical characteristics that meet the requirements of “responsible” and “intensive” motherhood¹³. Thus, women discipline themselves according to the norms of “caring” and “loving” “mothers” and their manifestations through different social practices, including consumption of ART services.

But along with the construction of “responsible” motherhood the abnormality and deviation is being produced as excluded field of discursivity. According to the hegemonic discursive formation the selection of candidates for infertility treatment is based on racist, classist, heterosexist bias. Women who are excluded by it, particularly single women, healthy women, lesbians, poor women cannot qualify for approval.

Normalization of motherhood has the legal dimension that legitimizes many practices of exclusion. In Ukraine the right of unmarried women, lesbians and women who do not suffer from infertility to use assisted reproductive technologies isn’t secured at all. Moreover, tendency to make such services even less available to these groups and further limit their rights to motherhood becomes more obvious. According to the Civil Code of Ukraine (Art.281, § 7) “adult woman or man have the right for medical reasons to apply for assisted reproductive

¹² Ibid.

¹³ Ministry of Health of Ukraine Order #771 “Instruction on the use of ART” 2008. Available at: <http://zakon1.rada.gov.ua/laws/show/z0263-09> [Accessed 5 March 2013]

technology”¹⁴, this ignores the right of healthy women to use assisted reproductive technologies, and all those who need medical intervention not because of their physiological needs, but rather because of social and personal reasons, namely the lesbians and other women who would like to have a child avoiding heterosexual intercourse. Theoretically homosexual woman can take advantage of IVF, but as a single woman, and not as a lesbian, there is no official ban, but informally it is subject to condemnation, respectively lesbians prefer not to disclose their orientation (Yarmanova, 2012).

The commercialization of assisted reproduction in Ukraine and other reproductive services causes stratification of reproduction by class, as well as increases the role of class in the defining who has the right to be a mother. The majority of infertility clinics are private and the price of the services there can not be afforded by the working mother of low income, as well as the time needed for the procedure is available mostly to the unemployed women supported by their husbands. Thus, almost exclusively middle-class couples have access to the benefits of assisted reproduction.

The only support comes from the state program of IVF treatment, which exists since 2004 and provides infertile women in the age between 19 and 40 with one attempt of IVF, in case it is their first one¹⁵. At the same time my respondents among feminists claim that there is a discrepancy between the discourse of “traditional family values” and importance of motherhood for women and practical support with pronatalist policies, which can be seen in the lack of financial support of the initiatives with regard to the implementation of ART and corruption of state medical institutions, poor expert knowledge and bureaucratic obstacles created for private clinics.

The distinct feature of the state program is that it avoids negative results, therefore the criteria for candidates are very strict. Only women with the absence or obstruction of fallopian tubes and no serious diseases (perfect results of all analysis with regard to very wide range of diseases) are eligible, while male factor of infertility is excluded altogether. In case of absence, anomalies or synechia of uterus women can also apply for surrogacy. Medical documents are examined by the special commission created by the Ministry of Health and women have to wait for decision around 1-2 years. There are only 4 state centres where IVF can be made to the candidates accepted by the commission and the amount of cycles per year continues to be very limited: in 2009 there were 574 cycles planned for 11 960 858 women of fertile age and 42

¹⁴ The Civil Code of Ukraine 2003. Available at: <http://zakon4.rada.gov.ua/laws/show/435-15> [Accessed 7 March 2013]

¹⁵ Ministry of Health of Ukraine Order #579 "Procedure for referral of women with absolute indications for the first course of infertility treatment with the methods of Assisted Reproductive Technology for budgetary funds" 2004. Available at: <http://zakon2.rada.gov.ua/laws/show/z0224-05> [Accessed 5 March 2013]

thousands of registered infertile women.¹⁶ Moreover, almost for all services in state clinics physicians expect to receive an informal material reward from the patient. The money given for medications by the state is not enough, therefore even if your candidacy was approved, you still have to pay something and partly buy medications.

Thus, except for normalization of motherhood, stigmatization of infertility and individualisation of responsibility for the reproductive health and childbearing of women, the state also tries to fulfil its biopolitical objectives in growth of birth rate with the help of funding the state program on IVF, although unproductively. The conjunction of all these techniques leads women to the attempts to normalize their bodies with the help of IVF. Thus, IVF fits into the state discourse about rebirth of traditional family values, which defines women through fulfilment of their reproductive function and blames women for the low birth rate.

II. THE DISCOURSE OF MEDICAL PROFESSIONALS ABOUT ART

In this part I examine the discourse of medical professionals with regard to ART. I argue that political rationalities revealed in the discourse of the private infertility clinics entails “advanced liberal” governmentality techniques: action on choices, autonomisation and responsabilization (Rose and Miller, 2008; 2010; Rose 2007). Private infertility clinics view themselves as self-governed organizations and make all efforts to take the lead before the state in the process of decision-making with regard to implementation of ART and management of infertility.

At the same time the state is not always supportive of such autonomisation. My interview material allows seeing the perspective of medical professionals on the attempts of the state to regulate the field of ART with further legal restrictions, to exercise control over the clinics with the help of the examinations by the different state services, to impose difficult bureaucratic procedure of the registration of medications. As a result, the discourse of medical professionals discloses the antagonistic relations with the state and lack of trust on both sides.

There are several subject positions that determine infertile woman in this discourse, in particular of an active and responsible consumer, governing her life independently, and of a body of a patient that is incomplete without medical assistance and requires constant optimization. All other possibilities are excluded as a result of the process of hegemonic intervention of the professional medical discourses structured by neoliberal governmental rationality. I use the concept of biological citizenship (Petryna, 2002; 2004; Heath, Rapp and Taussig, 2007, Rose

¹⁶ Ministry of Health of Ukraine Order # 651 “On approval of quotas of regions and distribution of drugs and small laboratory equipment for the treatment of female infertility with the help of ART, procured centrally by the State Budget of Ukraine for 2009. 2009. Available at: http://www.moz.gov.ua/ua/portal/dn_20090828_651.html [Accessed 5 March 2013]

and Novas, 2005) to identify this mode of subjectivation based on self-governance and somatic ethics.

I examine interviews with medical practitioners (Appendix 3) and articles in two Ukrainian medical journals (Appendix 4) to see which nodal points have the privileged position and in relation to which chains of equivalence they are articulated, in particular I allocate the nodal points of “reproduction”, “state intervention”, “commercialization of ART”, “legal regulation”, “reproductive hooliganism”, “advance of ART”, “contractual relationship”, and subject positions of “consumer” and “patient” (Appendix 6).

1. Rationality of Government: “Advanced Liberal” Governmentality Techniques

The discourse about ART of medical practitioners positions itself as independent of political influences, natural and objective. This is confirmed by the fact that the nodal point “reproduction” is determined through the following chain of equivalence: “biology, preservation of species, procreation, natural function”.¹⁷ It is interesting that this chain also includes the following moments from the field of politics: “the nation's health, security, sustainable development of society”, which leads to the naturalization of its political traces.

The directors of the clinics I interviewed see the field of ART as completely dominated by private infertility clinics, which are the only agents that allow for positive change. They understand further “advance of ART” as possible only in case state structures don't intervene in the activities of private clinics and development of commercial infertility treatment. They recognize as negative the outcomes of the state interfering in the development of the field and define the nodal point of “state intervention” through the chain of equivalence with “rigid bureaucratic system”, “ineffective management”, “the ART develops not “thanks to” state politics, but “despite of” them”, “low purchasing power of the population”, “complete lack of governmental support”, “misallocation of resources”, “corruption”. The desirable role of the state is seen in not impeding in the “commercialization of the ART”, while providing “legal regulation” that would prevent “reproductive hooliganism”.

The nodal point of “commercialization of ART” is articulated together with the nodal point “advance of ART” in opposition to the nodal point of “the state intervention”. My interviewees think that the success of ART in Ukraine can be explained primary by the fact that it was commercialised, privatised and exists independently from the state health system. Moreover the functioning of the private clinics is more efficient than of the public health clinics and

¹⁷ Anon., 2007. Bezplidya: Odvichna problema ludstva. *Zinochiy Likar* [online]. 4, p. 4. Available at: <http://z-l.com.ua/ru/article/62> [Accessed 3 May 2013]

governmental institutions. The acknowledgement of inadequacy of state governing and management lead private clinics to seek further autonomisation in order to augment the success of their activities. The institutions that exist on the state budget are lacking necessary resources for the implementation of financially demanding ART. On the contrary, commercial clinics receive enough money from the patients to provide the procedure with “good level of equipment”, “good level of knowledge”, “good level of medical service”, “good level of materials”, “good level of environments”, which is the chain of equivalence for the nodal point of “commercialization of ART”.

Moreover, my interviewees evaluate the control that they accomplish themselves in their clinics as more efficient and decisive than the one that the state tries to exercise. Here the nodal point of “commercialization of ART” is defined through the chain of equivalence with “growth”, “control of the quality”, “audit”, “training”. They don’t estimate the control of the state as well-organized and successful, on the contrary they claim that their “inner control” is more important and it is the results of their inner checking they should take into account in developing solutions for the advance of their businesses.

For us how we control ourselves from inside is more important than who controls us from outside. Therefore, our task – self-control, first-class control (Doctor 3)

They also become autonomous through accomplishing education of doctors on the basis of clinics. Since the medical universities in Ukraine don’t teach reproductive medicine and embryology to students well enough, so that they can perform IVF. Thus the interviewees identify the lack of professionals as the biggest problem their clinics encounter. When gynaecologists, obstetricians, biologists come to the clinic, they need to be trained and prepared before performing their duties. They also fund the education of their employees abroad. Therefore, the clinic works as educational centres that create new professionals to hire.

As a result, the discourse of the medical professionals reveals the “advanced liberal” governmentality techniques. My respondents emphasize their desire to manage their activities without a control of the state and define their role as quasi-autonomous, self-governed and self-controlled private entities. Although they are still dependent on the state legislation, they accomplish self-governance within some determined limits of freedom.

Legislation is fragmentary, spread across different laws, doesn’t answer all questions important on practice. But you can’t say that we don’t have legislation at all. Nevertheless, it doesn’t influence the activities of the clinic a lot (Doctor 4)

Autonomisation of private medical institutions and distancing from the state can be seen in the following examples from the interviews that reveal the conflicts between UARM (Ukrainian association of reproductive medicine) and Ministry of Health. Since UARM is non-governmental

organisation it encounters the obstacles created by the state bureaucracy when it aims to defend its members in case of accreditation problems. UARM “is not treated seriously”, and is “not official really”, because “state government doesn’t interact well with non-governmental structures”.

All respondents admit that the cooperation with the state is problematic and “very difficult” issue due to a number of reasons. There is “a lot of obstacles” and situations of “conflict” between state and private medicine. First of all, due to the inadequacy and disorder of state governing. Secondly, due to the corruption of state institutions and their reluctance to work together with private clinics on the transparent conditions of partnership. Some of my interviewees argue that the cooperation with the state depends too much on the personal relationships.

One of my interviewees says that she always encounters obstacles in “the hospitalisation of difficult patients”, moreover the state ambulance service refuses to bring her patients to her clinic, since state medical entities don’t want to enter into agreements with private one. At the same time, “the patients are obliged to pay for the state services as for the private, although unofficially” (Doctor 3).

Nevertheless, there are realms where the “intervention of the state” is desirable. Due to the “low income of population”, the commercial interest of private clinics depends on the amount of financial support given to the people by the state.

The common quality of life of population limits their capacity to apply to the clinics, since the treatment is not cheap. Therefore, if the state supports the people at least partly they are going to have possibility to pay for the treatment (Doctor 1)

All my interviewees agree with the necessity of state support, but criticise the existing state program of IVF, since it requires treatment to be conducted only in state owned clinics, which don’t always provide patients with qualitative service. In their opinion, the existing budgetary money are spent with very low efficiency and represent “drop of water in the sea” with regard to the existing demand for infertility treatment in Ukraine.

In context of Ukraine it is a drop of water in the sea, it absolutely doesn’t meet the scale of the problem in the country (Doctor 4)

As a result, medical professionals suggest the state policies that would support people individually with money so that they can use IVF in clinics of their choice. State can pay for the financially insecure couples more than one cycle in different private and public clinics, or give credits to the people to do IVF.

The state institutions use money less efficiently than their private colleagues. It would be better to give money directly to people, so that they can use it in the clinics that are better than state owned (Doctor 1)

The “reproductive hooliganism” is another interesting nodal point of the medical discourse, which necessitates the “legal regulation” provided by the state. It includes in one chain of equivalence the moments 1) from the realm of medical practice: “the transfer to the uterus more than 2 embryos without medical evidence”, “the transfer to the uterus more than 3 embryos”, “carrying out more than 5 cycles without any correction of prescriptions”, “conducting stimulation cycles in obviously hopeless cases”; 2) from the ethical realm: “the use of donor sperm from a relative in the male line (non-anonymous sperm donation)”, “two surrogate mothers”, “surrogate mother, which is both an egg donor”, “embryo transfer to the woman and the surrogate mother at the same time”; and 3) the moments that define who is eligible to become a parent: “embryo transfer to the women beyond certain age”, “the treatment of homosexual couples”.

Certainly, there can be no rigid boundaries between these realms from the start, however their diffusion in the discourse makes more explicit the consensus between state and medical professionals with regard to the naturalization of the exclusion of those subject positions that question the normalized kinship configurations, in particular “mothers” who split the integrated concept of motherhood, mothers “beyond” certain age, homosexual parents. Such discursive practices can be understood as revealing “the ways in which scientific, biological, or “natural” idioms normalize and control the physically or socially deviant, pathological, and dangerous” and providing “filtering mechanisms that operate from within the infertility unit” to “restrict who can be infertility patients and how they can gain access to the site” (Thompson, 2005: 81), in particular mainly officially married¹⁸, heterosexual, infertile¹⁹.

Other moments in the chain of equivalence of “reproductive hooliganism” are connected to contracting Ukrainian surrogate mothers and obtaining Ukrainian egg cells by the couples coming from abroad, for example “the bad image of Ukraine in the world”, “a country where you should go for surrogacy and donor egg cells”, “Mecca of surrogate motherhood”, “the problems with registration of children”, “worsens the reputation of the country”. After a number of international scandals provoked by impossibility to determine the national belonging of the children born from surrogate mothers in Ukraine, a group of directors of infertility clinics that includes my interviewees gathered and made a decision not to provide surrogacy to the patients who come from the countries where it is illegal.

¹⁸ Girina, O., Bondar, V., Abrosimova, L. 2010. Prognosticheskaya cennost osnovnykh criteriev otbora I provedeniya vnutrimatochnoy inseminacii spermoy muza. *Zinohiy Likar* [online]. 1. Available at: <http://z-l.com.ua/upload/journals/27/1-2010site2.pdf> [Accessed 2 May 2013]

¹⁹ Yuzko, U., Yuzko, T. 2010. Zastosuvannya dopomiznih reproduktyvnykh tehnologiy pry likuvanni bezplidya v Ukrayini. *Zinohiy Likar* [online]. 2. Available at: <http://z-l.com.ua/upload/journals/28/2-2010site6.pdf> [Accessed 2 May 2013]

If we have foreign clients that apply for a service that impedes the reputation of Ukraine and influences other states as well ... we reject the questions of surrogacy motherhood with foreign clients principally, where it is forbidden (Doctor 3)

Other interviewees claim that they avoid international clients from the countries where surrogacy is banned, because they want to secure their reputation from the scandals.

The problem emerges when these people are trying to legalise their child on the territory of their country of residence (Doctor 1)

My interviewees claim to be main initiators of the law project with regard to restrictions of ART mentioned above in the discussion on the state²⁰, except for my interviewee Doctor 2, who is principally against any intervention of the state into the use of medical methods. This law proposal suggests to forbid the use of surrogacy to the citizens or residents of the countries, where surrogacy is illegal, as well as to forbid IVF to women above 51. The nodal point of “legal regulation” plays a role of “filtering mechanism” from the outside and is articulated within the chain of equivalence: “reputation”, “the clinics that respect themselves”, “the clinics that work adequately”, “the clinics that work in the legal field”, “civilized laws”, “to advance and support the ART”, “right image of Ukraine”, “expert knowledge”. My interviewees see these legal restrictions as necessary to protect their reputation and distinguish them from those clinics that benefit from such ambiguous treatments, as well as to protect the reputation of the country.

I would support the enactment of the law that would forbid foreigners from the countries where surrogacy is illegal to use it in Ukraine. This would lead to the formation of the right image of Ukraine (Doctor 1)

Moreover, my interviewees argue that the legislation on ART should be produced in accordance with their expert knowledge in order not to harm the whole field. They are afraid that without their participation in the creation of legal norms with regard to the use of ART the Ukrainian government can just ban ART as a whole to prevent any ambiguous situations and international conflicts in the context of surrogacy and ova-donation.

We are trying to take initiative, because if our deputies write the laws and instructions on the use of ART, this can mean the end to the whole field (Doctor 1)

2. Mode of Subjectivation: Subjectivity of “Biological Citizen”

The exercise of “advanced liberal” governmentality relies on the acts of choice of autonomous individuals who would govern themselves and manage their own affairs “in a variety of private, corporate and quasi-public practices from working to shopping” (Rose, 1999: xxiii). This

²⁰ Proposition of bill #8282. 2011. Available at: http://w1.c1.rada.gov.ua/pls/zweb2/webproc4_1?pf3511=39973 [Accessed 10 March 2013]

rationality of government requires the construction of subjectivities that would feel responsible to actively work on themselves in a continuous manner, to “enterprise themselves” through acts of choice, in order to improve and optimize their qualities of life (Rose, 2008: 214). As well, the discourse of medical professionals constructs the subject positions for infertile women that reflect this mode of subjectivation.

The subject of infertile woman is fragmented, since several not antagonistic subjectivities work together to bring it to life. Firstly, it is the subject position of active “consumer” responsible for her health and consumer choice. Secondly, it is the subject position of the “patient” whose body requires medical assistance and for whom optimising one’s bodily self and crafting its autonomous existence become necessary condition for self-fulfilment (Rose, 2008: 214). Since the discourse of medical professionals interpellates infertile women into biomedical perspective, which results in citizenship claims and collective activism on behalf of medical condition, I understand these two subject positions in infertility treatment as manifestation of biological citizenship.

With regard to the subject position of “responsible and active consumer”, it is articulated in the chain of equivalence with the nodal points of “free/informed/individual choice”, “contractual relationships”, “efficacy”, “the quality of the treatment”, and “evaluation upon the result”. The consumerist logic of the functioning of private infertility clinic constructs the patient as always “right” in her desire to use the medical service and evaluates the quality of the service upon the satisfaction of the demands of consumers. Thus, if the child was born as a result of IVF, the clinic is good, but even if it wasn’t, the clinic isn’t bad either, since the patient was informed about possibility of failure.

Our relationships with the patients are contractual. She is informed about cases of efficacy or inefficacy of the program. The patient understands what she is paying for and what she is going to get as a result, thus this is her choice. The patient comes to us for the child, not for the program. If I succeed to fertilise her, this is the main question – to give birth, if this happens, than I am a good doctor (Doctor 3)

But women don’t come into clinic already practicing the consumer ethics. They have different attitudes towards IVF: some of them don’t believe in treatment and don’t see a necessity in it. Therefore, in order to make them into autonomous and self-governed consumers, the clinic works as a centre of education of patients. My respondents think it is essential to inform and prepare future patients, provide them with training and knowledge, necessary to discover and consolidate their desire to have children through IVF. They provide “a day of open doors”, when “social consulting” is available free, as well as an “expert opinion about the medical condition of the couple”, so that they know “where are they and how quick they have to make decisions to solve the problem of childbirth, how to treat infertility, how to conduct IVF”.

The important question is the one of information, this is what we do - different social projects: “Discover your follicular reserve”, “Evaluate your parenthood potential”, “Be a mother”. Since the right moral preparation of the patient is also very important. Why to chose us, why we are more efficient, more tolerant. The patients love this, they become enlightened, the one who wants a baby will find the money and resources and will always get one (Doctor 3)

Some patients wait for the result to be guaranteed and thus blame doctors as responsible for every failure. Thus, another training accompanies psychological problems emerging from the failure and helps patients to overcome them and not to accuse the clinic. The one that would allow them to handle the treatment in the mode of continuous optimization of their body, in other words accept the failure, “not to lose hope”, acknowledge their own responsibility for continuation of treatment no matter what and “return to the clinic for the next cycle”. There is a psychological training of doctors as well, so that they know how to treat patients after failure in order not to lose them.

Another subject position provided to patients is attaching them to “infertile bodies” that naturally demand medical assistance and continuous optimization. Medical interventions in the reproductive processes are naturalized through representation of the body as having “natural” needs for assistance and not being complete without the interference of doctors.

Ukraine is the civilized country. The bodies demand assistance in civilized world. We all want to have children. Taking into account that every fifth family couple has potential deviations, either relative factor of infertility, or absolute, the new reproductive technologies help to overcome and treat severe forms of infertility (Doctor 3)

Therefore, IVF become self-evident “natural” solution to the problems that were previously constructed by specific representations of bodies and their inherent physiological defects and which are not treated as “hopeless” anymore. Franklin (1995: 328) discusses this topic in her article on assisted reproduction, where she argues that through different disciplining practices assisted reproduction aims to improve “nature” in a “natural” way.

The chain of equivalence organised around the nodal point of “infertile body” includes “genetically defective mothers”, “responsible and ready for pregnancy”, “surrogate mothers”, mothers, whose ovaries are “normal respondents” and opposite to them, the “mothers with poor response of ovaries”²¹, bodies that “are not socially ready for pregnancy”, “irresponsible mothers” who do not want to treat infertility, pass tests, the mothers with uterus that appears as “hostile environment for the fetus” and who can not handle pregnancy and are doomed to

²¹ Sudoma, I. 2005. Syndrom slabkoyi vidpovidi yayechnikiv u ciklah ekstrakorporalnogo zaplidnennya u pazientok iz adenomiozom. Ukrainskiy Medichniy Chasopis [online]. 2 (46), p. 92. Available at: <http://www.umj.com.ua/article/699/sindrom-slabkoi-vidpovidi-yayechnikiv-u-ciklax-ekstrakorporalnogo-zaplidnennya> [Accessed 6 May 2013]

“premature birth”, “the mothers with ectopic pregnancy”²², mothers who do not agree on abortion of “defective” fetuses, the prolific mothers who “create problems for obstetrics”²³.

This fixation on the body as imperfect and demanding assistance, as well as crucial for self-fulfilment, leads to the acknowledgement of the necessity of its optimization with the help of ART. Women are taught to see body as something to improve and treat autonomously, to obtain expert knowledge about, to be worked upon in order to become “happy” and fulfilled in motherhood.

As a result of the development of ART each married couple understand that they have a real chance to get a child, if something is wrong with them (Doctor 1)

A striking example of subjectivation through attachment to the naturalised medical procedures is the next chain of equivalence, which is determined by nodal point of “surrogate mother”. The peculiarity of it is that it includes at the same time such moments as “free, conscious and informed decision, intelligent responsible pregnant woman” and necessary medical practices, presented as rational and voluntary: “restraint of autonomy, examination, prenatal monitoring, abortion in case of malformation of the fetus, compliance with all advices, recommendations and caution in prenatal monitoring”.²⁴

III. THE DISCOURSE OF IVF PATIENTS ABOUT ART

In this part I would like to focus on the experience of IVF patients in Ukraine, in particular on the modes of subjectivation available to them and rationalities of government their experiences are embedded in. My research shows how individuals become more somatic and how biological body travels to the centre of subjectivity, when the identity depends on the bodily performance in accordance with existing gender norms. For my respondents care of the body becomes central to subjectivity due to their continuous failure to conceive. The stubborn manifestation of infertility triggers my respondents to focus almost exclusively on understanding and transforming their body. The women I interviewed during long period of time concentrate on enhancing their body

²² Mozgova, O. 2005. Kompleksna diagnostyka riziku ta poperedzhennya zagrozi pererivannya vagitnosti u zinok pislya ekstrakorporalnogo zaplidnennya. *Ukrainskiy Medichniy Chasopis* [online]. 2 (46), p. 102. Available at: <http://www.umj.com.ua/article/697/kompleksna-diagnostika-riziku-ta-poperedzhennya-zagrozi-pererivannya-vagitnosti-u-zhinok-pislya-ekstrakorporalnogo-zaplidnennya> [Accessed 4 May 2013]

²³ Sudoma, I. 2005. Chastota ta etiologichni faktori ektopichnoi ta geterotopichnoi vagitnosti pislya program ekstrakorporalnogo zaplidnennya. *Ukrainskiy Medichniy Chasopis* [online]. 4 (48), p. 99. Available at: <http://www.umj.com.ua/article/641/chastota-ta-etnologichni-faktori-ektopichnoi-ta-geterotopichnoi-vagitnosti-pislya-program-ekstrakorporalnogo-zaplidnennya> [Accessed 5 May 2013]

²⁴ Dahno, F. 2007. Surogatnoe materinstvo. *Zinochiy Likar* [online]. 3, p.15. Available at: <http://z-l.com.ua/ru/article/129> [Accessed 5 May 2013]

and find the meaning of life in its performance and successful pregnancy, while all other occupations become less important and relevant for them.

And now I wonder, what a fool I was. I nibbled myself. I needed to enjoy life instead. All this self-hatred. I regret that I did not notice whether it was fall or winter, everything that I thought about were children. I needed to enjoy life, to go for vacations. I had only thought about the children (Patient 9)

The subjectivation of infertile women is determined by several subject positions in discourses of state and medical professionals. Firstly, this fixation on the body is conditioned by the biopolitical technique of the normalisation of motherhood. Secondly, by the “advanced liberal” governmentality techniques that promote the ethics of self-governance and somatic ethics, in other word the endless optimisation of the body through the range of choices. In the discourse of IVF patients both biopolitical rationalities and “advanced liberal” governmentality are combined to provide the modes of subjectivation of “mother” and “biological citizen” to women that embark on infertility treatment.

The work of biopower is facilitated by the differential allocation of precarity. Since infertile women don't fit into existing subject positions and don't meet norms and frames established by power techniques, their subjectivities are rendered not recognisable and lives not liveable within both discourses of the state and medical professionals. As a result, they represent the group especially exposed to intervention of power. It is precisely the imperfection of the body and inability to live out the gender norms that deepens the precariousness of infertile women. A number of precarious conditions contribute to the fact that women realize their vulnerability and lack of control over their bodies and lives: precarious embodiment, distrust to the state and private medical institutions, lack of reliable expert opinion, lack of financial resources, insufficient support from the state. As a result, they adapt the subjectivation provided by biopower by virtue of the acknowledgement of one's bodily vulnerability. As a way to understand and manage these uncertainties they seek to fit into the structures of recognition, as well as establish informed and caring relationship with their bodies and adapt the ethics of self-government.

The normalisation of motherhood and stigmatisation of infertility pushes women to use IVF in order to become “mothers” and thus correspond to the definition of normal “woman”. As a result, overcoming the precariousness of infertility with the help of IVF evokes the precariousness of IVF pregnancy that doesn't fit into the idea of normal or “natural” pregnancy. According to Becker (2000: 240), ART can be seen as an “expression of how people attempt to live out gender expectations, reflect efforts to re-establish a sense of normalcy”. At the same time, the “normal” gender identity reaffirmed by this technologies is questioned by the virtue of

experience of infertility and its treatment that differs so much from taken for granted “natural” pregnancy. Thus, Becker (Ibid.: 240) claims, when as a result of successful procedure “people are able to re-establish a sense of normalcy in their lives, it is precarious at best”.

My analysis of the discourse of IVF patients also reveals how infertile women adapt the subjectivity of “biological citizens” that enterprised themselves and understand their embodied experience in agreement with biomedical classifications. According to this subjectivity women use IVF in order to regain control over their lives, make their own choices, work upon the body and construct informed relationship with it for the sake of self-fulfilment. Obtaining biomedical knowledge about one’s body, taking control over its treatment and organising into collectivities upon shared medical condition, are the distinct signs of the transformation of IVF patients into active and responsible for their body and health biological citizens. Construction of biological citizenship indicates the presence of the governmentality techniques, in particular governing at a distance through individualisation of responsibility and acting on the free will of individuals. Biological citizenship can be also identified in the process of lay people becoming experts and seeking optimisation of their bodies autonomously, independent from both state and private medical practitioners. As well, the practices of self-governance, self-education and self-treatment of my respondents is triggered by their uncertainty in the competence and honesty of medical professionals and awareness of their precarious social position as infertile women.

At the same time, acknowledgment of the vulnerability of each other and necessity of care conditions a certain way in which women start to relate to each other. I would also like to discuss how the awareness of ones bodily vulnerability and precariousness provides a subject of IVF procedure with a ground for the formation of the distinct ethics of care of the others and leads to building of friendship networks based on bodily condition and biomedical knowledge about it. However, I suggest that in context of Ukraine citizenship claims made upon medical condition by IVF patients and self-help groups organised by them do not acquire any political representation.

To examine which signs in the discourse of IVF patients have the privileged position and in relation to which chains of equivalence they are articulated, I allocate the nodal points of “infertility”, “inferiority”, “pressure”, “condemnation”, “prejudice towards IVF”, “IVF pregnancy”, “motherhood”, “body”, “trust in medical institutions”, “commercialization”, “fear”, “ignorance”, “failure”, “biomedical knowledge”, “control”, “forum”, “friendship”, and subject positions of “mother” and “biological citizen” (Appendix 9).

1. The Work of Biopolitics: The Subjectivity of “Mother”

The political rationalities of biopolitics provide the only intelligible subject position for women – the one of the “mother”. The normalisation of motherhood leads to the exclusion of subjectivities of infertile women as not intelligible. The women who don't fit into the categories established within the horizon of biological motherhood are confronted with strong moral condemnation in Ukrainian society, while the infertile bodies that refuse to fulfil their “biological function” are stigmatised. Their identity is not recognised and their lives are not liveable unless they are fulfilled in motherhood. Thus infertile women are produced as precarious population by the structures of normative motherhood.

The nodal point of “pressure” helps to reveal the work of biopower in imposition of the gender norms and articulation of the nodal point of “motherhood” as “normal/obligatory”. This “pressure” society puts on childless women, assuming their responsibility to give birth.

Our people aren't considerate enough. Going through all of it and being asked, a woman in her thirties, why don't you have kids? Usually those people are not close, I don't know why I reacted at all. People who are close to you support and help. The opinion of the strangers. Still unpleasant, hurts. Attitudes, public opinion, how is it in our country: you have to get married, and necessarily have children, how can it be without children? (Patient 9)

Within some narratives “pressure” is articulated together with “condemnation”. My respondents define the nodal point of “condemnation” in a chain of equivalence with “dangerous”, “leading wrong way of life”, “loosing friends”, “alcoholic”, “psycho”. Patient 3 mentions that after she had first ectopic pregnancy, when she was extremely stressed, her relatives started to question why she is not getting pregnant for the second time and why she is not doing anything about it, especially important role in this process played the mother of her husband. Patient 1 started to undergo IVF cycles when she was 27. When being asked what influenced her decision to undergo IVF treatment, she answered that she was pressured by close friends and relatives. Patient 1 “couldn't talk with anyone” about being infertile, since she encountered a strong “condemnation” of her friends.

Women are being put under pressure, I was pressured by all close people with questions: when, why, how long, and how you this and how you that. The pressure plays its role. We have very wild people still. When I was unable to get pregnant, my friend, I mean ex-friend now, knew that we are trying, but it doesn't work. And when his wife got pregnant, they started to say that my husband is an alcoholic, this is why we don't have kids. I had a depression because of it, and they started to say that I am dangerous, that I am not allowed to approach pregnant wife, because I can cause harm. I had a nervous breakdown than, people you trust, treat as friends, say things like that, that you can kill the baby, he is alcoholic, she is alcoholic, she is psycho (Patient 1)

As a result, in the discourse of IVF patients the nodal point of “infertility” is strongly attached to the nodal point of “inferiority” and articulated in the chain of equivalence with the moments “feeling different/abnormal/worse than other women” and “being guilty/being the one to blame”. For example, Patient 1 has a kid, who is three years old now and who was born as a result of IVF procedure in 2010.

The feeling that you don't have a baby, that you can't get pregnant like everyone else, leaves an imprint for the whole life, that you are different than everyone else. If the family doesn't have children the one to blame is always woman, psychologically this was eating me from inside (Patient 1)

The motherhood is so irreplaceable in order to have your identity as a woman complete that all my respondents define the “inability to give birth” through the chain of equivalence with “drown in the depressive states”, caused by the feeling of “handicap”, “self-hatred”, “diminished/unfulfilled femininity”. For example, Patient 9 had no children in the first marriage, after she divorced and got married for the second time she also had no children for 5 years. By that time she was 32. She compared herself to other women who don't encounter problems with conception and childbearing and thought that she is “defective”, “crippled”, as well as “not womanly/feminine”. She “put guilt on herself” because she couldn't get pregnant and she was feeling that “something is wrong with her”, that she is “not good enough”.

I also conclude that women in Ukraine start to be stigmatised for childlessness at a very early age. Some of my respondents were pressured to undergo IVF when they were 27, while at the same time they experienced condemnation much earlier in time. For majority of my respondents this happened as soon as they got married for the first time, which happened before 25 in most cases, except for Patient 4, who lived for 10 years in marriage without children and it didn't bother her. As a result a lot of women in order to become liveable need to adapt the subjectivity of “mother”, otherwise their precarious position makes them “inferior”. They seek for technological assistance to give birth and resume themselves in the status of normal. A lot of them articulate the nodal point of “IVF pregnancy” as their “only/last chance” to get rid of the depression caused by the haunting feeling of lacking the necessary attributes of normative femininity and don't expect it to be so “difficult” and “full of obstacles”.

But when women in their attempt to meet the norm of compulsory motherhood undergo IVF procedure, their pregnant body continues to be rendered precarious as not “natural”, meaning not “normal”. This stigmatization happens both in medical institutions and outside them. As a result managing the precariousness of infertility by virtue of adopting subjectivity of “mother” with the help of IVF evokes the precariousness of “IVF pregnancy” that doesn't fit into the idea of normal or “natural” pregnancy and is articulated through the chain of equivalence

with “miscarriage”, “uncertain”, “insecure”, “prejudice of medical professionals”, “overprotection by medical professionals”, “too old for pregnancy”, “multiple pregnancy”, “abnormal”, “children as artificial”, “complications in supporting pregnancy”, “medical surveillance”,

The majority of my respondents told that they were in more or less successful way persuaded into hospitalization by medical practitioners in the state institutions of prenatal care/maternity hospitals due to their status as IVF mothers. The attitude towards them was more on the alert in comparison to other pregnant women, since they were expected to be more likely to have pregnancy with complications and miscarriage. Their pregnancy was perceived by medical personal as more “uncertain” and “insecure”. In addition to being treated differently with regard to IVF procedure, women in my survey report that obstetricians saw their pregnancy as “problematic” since they were “in their thirties” and mostly had “polycyesis”. Therefore there was a complex set of norms about the age of the future mothers, the number of children, the means of conception, that came into play in articulating the IVF pregnancy as “abnormal”.

At the same time, my respondents thought that the IVF procedure itself didn't influence the character of their pregnancies. Moreover, some of them had very “easy pregnancies” and were surprised by the assumptions medical staff made about them being a “complicated case” and having “trouble with supporting pregnancy”. For example, Patient 3 shows irritation by the fact that the doctor in maternity hospital tried to convince her to stay under “medical surveillance”.

33 years old. In anamnesis: infertility, IVF and twins. She [the doctor] was kneeling in front of me and saying: “please, stay in the hospital, if you are not going to, I can be fired”. Because according to my indications, I was expected to lie in the hospital all the time. Although I had an excellent, exemplary pregnancy, during pregnancy I never felt bad, I had all analysis as a cosmonaut. I was going to work every day. They made me lie in the hospital, but I actually wasn't, I was just coming, sitting there, reading a book, while they had a check-up, and afterwards leaving (Patient 3)

With regard to how IVF pregnancy is treated in society, my respondents had diverse articulatory practices. From one point of view people who hide the fact that they underwent IVF attached it to “shame and embarrassment”, “keeping in secret”, “the prejudice and incomprehension”, “abnormality of IVF children”, “negative attitude towards IVF in society”, “a tag of artificial children”.

Part of women I interviewed claims that it was quite often traumatic to be met by “the prejudice and incomprehension”.

Since we have this attitude, you are like a derelict, it is very scary. IVF is everything at once: caesarean, too old for pregnancy, twins. Some people say that these children are not normal (Patient 9)

Patient 1 and her husband decided not to tell anyone that they had a child with the help of IVF, even their parents and closest relatives.

We hide it from everyone, from all our relatives and friends. If you go to ordinary hospital, people start to talk: some nurses can say that it is better to get a dog than a child like that. Our society is not grown-up enough to take it. Some people hide even from the doctors (Patient 1)

At the same time, part of my respondents convey that they never met people judgemental with regard to IVF in their life and articulate it through the chain of equivalence: “no negative emotions”, “connected to children”, “children always give happiness and gayness”, “no disapproval”, being “proud” of giving birth through IVF.

Another important factor that helps to sustain the negative attitude towards IVF in society is the “lack of knowledge among professionals and lay people”, “professional community as exclusive”. My respondents mention that physicians in state maternity hospitals and women's medical consultation centres are not competent and knowledgeable enough to support IVF pregnancies, as a result they induce a lot of myths about IVF. Moreover, infertility and assisted conception are silenced in mass media and state rhetoric unless they are concerned with international surrogacy scandals. Therefore the majority of women I interviewed admitted that they thought that this problem doesn't exist until they actually faced it by themselves, went to the clinic and saw “long lines” and understood how many women actually suffer. The absence of the open discussion in society about the question of infertility and ART only contributes to the bewitchment of their mechanism and lack of access for the ordinary women.

There are people on the periphery who don't know that these technologies exist at all (Patient 9)

Patient 9 adds that the community of medical professionals is not willing to reach the lay people and represent their interests, rather than interests of doctors and clinics.

Conferences are organized only for doctors, although I would go, even if it is the conference of reproductologists, but they can have three hours for ordinary women, questions explained to them, a lot of them don't understand what is where, a lot of them don't even know their own bodies. For whom those doctors write articles? For whom defend dissertations? (Patient 9)

To manage the precarity produced by the lack of recognition within existing frames, IVF patients make a big effort to normalise themselves and thus adopt subjectivities provided by power. They tend to present themselves as very “normal” women and especially fit for “motherhood”. They articulate the nodal point of “motherhood” within the chain of equivalence: “desire to become mothers”, “struggle to have children”, “caring/loving”, “belonging to certain social class”, “social stability”, “heterosexual marriage”, “stable employment/housing”,

“financial ability to support a child”, “focused on children during all their life”, “capable to be mother”, “deserving motherhood”, “good/protective/responsible mothers”, “genetic ties”, “children of a higher quality”, “selected biological material”, “pregnancy as a conscious choice”, “children as main vacation and responsibility of women”. The discourse of IVF patients reveals “intransigent and exhausting struggle for pregnancy” as the main rationale that proves women who treat infertility to be perfect candidates for motherhood and makes them different from those marginal childless women, who are blamed for being not caring and loving enough. As Thompson (2002: 65) argues, “infertility patients display exaggerated stereotypical gender attributes at appropriate times during treatment, perhaps to signal their fitness to become heterosexual nuclear parents and perhaps also to rescue gender and sexual identities compromised by the lack of fertility. Patients had to act out these roles emotionally, economically, and legally to have access to treatments, which if successful allow them to reassert their station in this normative social order”.

The women who I interviewed assumed that women with certain socially approved behaviour and class should give birth, rather than those who don't behave in the way appropriate for the “mother”. Patient 7 argues that the experience of the struggle with infertility proves how loyal are women to the idea of children and how many great qualities they have in order to care about their children. Thus, they are even “better mothers” than those, who get pregnant without an assistance of technology. So they must be especially supported by government, in case they can't support themselves financially, because they are perfect mothers for the “nation”.

People who go for IVF have problems, but they want children. They can save the money, they can take credit, they can have diverse financial sources. It is clear that some alcoholic is not going to do IVF, but she will give birth to the second child, third, forth. We have the 'normal' nation dying out, it is easier for us to give a right to give birth to some alcoholic than to the normal women, who want, but have problems (Patient 7)

The fact that parents made through IVF are very protective towards children can be proved by my interviews. Almost all women expressed suspicion towards kindergartens as too dangerous for their children and admitted that they don't trust pediatricians, since their prescriptions can be harmful for the child as well.

Another strategy that helps to normalize IVF and even make it supportive for the traditional kinship structures is the emphasis on the reinforcement of genetic ties that IVF provides. Becker (2000: 241) argues, that ART “signal a specific cultural ideology, the ideology of the biological child”, it upholds “the emphasis on biology, which underscores traditional images of women as conceivers and bearers of children” and makes it “more difficult for women and men contemplating parenthood to entertain nonbiological possibilities”. My respondents

emphasise the importance of the genetic connection with your own baby as the only “normal” ground for kinship, and reject adoption as the alternative, which reveals how all other parenting practices except for biological become the excluded field of discursivity.

I wanted only my children, I didn't want other people's children. Even if I would fail in IVF, I wouldn't go to the orphanage anyway. Would you relinquish having your own child? No. And I wouldn't. These adopted children, who gives the guarantee that they don't have some physical hereditary disease? If their mother was schizophrenic or paranoiac, it will appear sooner or later in the child (Patient 2)

The IVF practice also supports the placement of responsibility for the child on the woman. My interview material demonstrates that the female body is always standing for the couple in treatment. Even those my respondents, whose “inability to give birth” was determined by “the male factor” of infertility, were the one to struggle and expose body to the IVF procedure. All women claim that it was difficult to persuade their husbands to go to the clinic, since for them it was difficult to realise that they can have problems with fertility. They also claim that with no regard for the actual reason of childlessness, their surroundings saw them as a cause of the problem. Moreover, only women communicate on the forum about IVF and thus “couples” became, disproportionately, the female partner” (Thompson, 2005: 93).

2. The Work of Biopower: Producing Precarity

When the normalised gender performance fails, the one that grants the secure status in society, the precarious conditions emerge. The precarity of infertile women is produced by different power structures that deprive them of support because their bodies don't meet the norm of fertility. My interview material reveals four precarious conditions within which infertile women find themselves and which make them adapt to the modes of subjectivity provided by power structures: precariousness of the body, precariousness of the medical treatment, precariousness of commercialization, psychological precariousness.

a) Precariousness of the body

I would like to discuss the first condition that makes infertile women precarious and eases the work of power upon their conduct. They discover the uncertainties and opacity of their own physical organization in their struggle to take under control their lives. In the discourse of IVF patients “body” is articulated through the chain of equivalence: “imperfect”, “derelict”, “difficult pregnancy”, “lack of control”, “disobedience”, “precariousness”, “vulnerability”, “fear of loosing a baby”, “irresponsible body”, “disabled body”, “body incapable to do what is expected from it”, “anxiety because of the body's failure”, “miscarriage”, “uncertainty”, “unexplained reaction”, “lack of knowledge about the body”, “unknown reasons of failure”. The experience of

infertility is the perfect example of body acting in the way that “can not be fully controlled”. The inability of the body to perform its reproductive function questions the identity of woman and her confidence in the fact that she knows and understands her body. On the contrary, she understands the limits of her knowledge with regard to the precariousness, fragility and opacity of her biology.

The majority of women I talked with were going into IVF procedure without a clear understanding of what to expect from their bodies. They also were lacking the knowledge about their own body map, as well as medical knowledge that would help them to figure out what actually is happening to them and why. The lack of knowledge had as a result the lack of control over situation and helpless exposure of one's body to the medical practitioners. The opacity of the body increases with the repetition of failures for the unknown reasons. Except for the fact that unexplainable negative results make you more vulnerable, it becomes especially traumatic to accept failure in treatment, when you don't know what to expect from the procedure.

In majority of occasions the body acts against infertile woman, becomes an enemy she struggles with, while in other occasions it requires protection from incompetence of doctors, loving and caring treatment. Patient 7 discovers her body's agency and her inability to control it as a very traumatic experience.

It was always difficult for me: each month when my menstruation started it was hard to take. Really. Maybe you can just let it be the way it is or you can think if it didn't happen this time, it will happen next time. I don't know. But for me, it was always extremely painful, since I always wanted children. I never imagined my life without children (Patient 7)

Instead of taking the body for granted, she accounts for its great vulnerability and imperfection, the fact that it can bleed, hurt, lose its constitutive parts, rebel and disappoint. Acknowledging this precariousness is the occasion for the woman to meet with her own body. If before she perceived body as whole and complete in its normalcy, it is infertility that makes her look at it as different from the norm, to understand it as disabled, not performing certain conferred functions often for unknown reasons.

As well it is the occasion to start to see the body as something to be worked upon. My respondents think about their embodied selves as not only crucial to who they are, but also open to modification. They are constantly optimizing their physical state, since in the age of biotechnology it becomes more and more open to choice and experimentation.

Trying to get pregnant is an extremely exhausting and painful process, but for a lot of woman pregnancy is not easy either because of the fear that they will “lose the baby”. Trying to save the baby presupposes being nervous all the time, disciplining the body, controlling each symptom and reading each small sign it gives you.

I had a difficult pregnancy, with risk of miscarriage, after IVF I practically only laid down, on the 7th week I left work, periodically showed up before, but afterwards wasn't present anymore, had bleeding, laid in hospitals and at home, when children were born, they were premature, in general pregnancy was difficult (Patient 9)

Women who try to succeed in conception work intensively on themselves in order to reconcile their identity with gender norms and perform their gender in the socially approved way. At the same time, they redefine normalcy when they call into question the existence of the normal healthy body as a full unattainable ideal. G. Becker (2000: 238) is explaining, how infertile couples reconsider their gender identity after their negotiating with cultural norms and expectations fails. Their inability to rely on the body as a normal and functional, and on the social structure's support in dealing with its dysfunctional performance, infertile women manage through self-knowledge, self-treatment and self-understanding, in other words through the construction of biological citizenship.

b) Precariousness Of The Medical Treatment

When appealing to doctors for help my interviewees encountered the precariousness of medicine. In the Ukrainian context of the widespread distrust to medical institutions the appeal to a doctor does not allow patients to absolve themselves of responsibility for learning, instead it creates even more precariousness, because the woman is faced with unprofessional medical workers, their desire to earn money by inappropriate means, she has no confidence in their knowledge of her body.

All my respondents show a low degree of “trust in medical institutions” that treat infertility and provide IVF procedure, both state and private. They articulate the nodal point of “medical treatment” in the chain of equivalence with “feeling helpless and powerless”, “doctor's mistakes”, “failure of treatment”, “bad diagnosis”, “disappointment”, “low qualifications of doctors”, and “low quality of treatment”.

The situation of IVF patients can be understood as very ambivalent. From one point of view, they felt “helpless and powerless”, since to a large extent their pregnancy depends on the decisions of doctors, who were more competent in the issues at stake. But on the other hand, they were aware of the “lack of professionalism” of medical practitioners and attempted to take the treatment under control, protect their bodies from unnecessary and harmful medical intrusion.

My respondents also had to learn how to make “right informed choices” between the doctors and clinics, since in the context of “uncertain Ukrainian market of medical services” the risks of irresponsible consumer conduct are high. Thus, the “medical treatment” is also defined through chain of equivalence with “change of the doctors”, “choice between doctors”, “recommendations”, “and the risk of wrong decision”. My interviewees have changed their

doctors numerous times during treatment: they were doing different procedures with different doctors in different clinics (infertility treatment, artificial insemination, IVF cycles, screening). They were never observed by the IVF clinic after they got pregnant. Mainly afterwards, they all went to different state medical institutions of prenatal care.

The overall feeling women got from their encounter with the medical institutions in Ukraine is that rarely someone there is actually interested in their health and wellbeing. The chain of equivalence is being built with “prejudice towards IVF”, “conveyor”, “indifference towards all patients”, “long lines”, “feeling neglected”. Patient 8 claims that in state institutions the attitude is: “Here, take it, just stop bothering”. While Patient 1 says, “in the private clinics I was feeling myself on a conveyor”. When Patient 4 came pregnant to the state maternity hospital, the doctor, who told her, that her twins are too small and are not going to survive, denied her treatment. The same story happened to Patient 1.

I went to the ordinary women's medical consultation on a residence, and they told me: “IVF? I am not going to take you, I don't know what to do with you”. I went to the head of the department: “You go there where you got pregnant, who knows whether the child is going to live” (Patient 1)

The women don't trust doctors and have a negative attitude towards them partly because they see how medical professionals are driven by their material interest at expense of the health of the patients. Thus this chain also includes “material interest of doctors”, “expensive procedures”, and “fraud”.

Everything is directed towards making money, this is what we used to, people earn small salaries, doctors in particular, they need to live somehow, this I understand, but anyway, a human must stay human (Patient 9)

Women argue that some doctors prescribe unnecessary but more expensive pills or analysis, because they have the agreements with different pharmaceutical companies and medical laboratories that will pay them for attracting clients. While others conduct a number of cycles without any change of prescription for the sake of earning money. Patient 7 had 10 unsuccessful cycles with a doctor who did only minor changes in the treatment from cycle to cycle and, in her opinion, haven't searched for the reasons of her problem.

Another precarious ground in the treatment is the amount of embryos transferred and the necessity to make a reduction. The fear of failure in conception is so strong, that patients usually agree for the transfer of a big amount of embryos without thinking about consequences. Many women want to get pregnant so desperately that they agree for the transfer of 6 embryos. For example, 2 my respondents had 6 embryos transferred, and 1 had 4. Patient 3 had to do a reduction of 2 embryos since 6 embryos were transferred and 4 embryos implemented.

With regard to state program the chain of equivalence is “discriminatory criteria of admission to the program”, “bribes”, “bad treatment”, “refusal”. I conclude that it isn’t successful enough in reaching infertile women, shaping their subjectivities and achieving its biopolitical goals, since all women I interviewed have very skeptical opinion about it due to the “long waiting time”, “strict criteria of admission”, “corruption”, “low quality of treatment”. Even those of them who met very exclusionary requirements of the program either didn’t apply (2 respondents) or were not admitted due to some reasons (2 respondents).

State program, you know, why it doesn't work for a lot of people, including me, because doctors who do it are also commercialized, I haven't agreed on any bribes, but I think that a doctor who refused me on the state program, was waiting for money, I have a very bad opinion about her, she treated me badly (Patient 3)

As a result the lack of qualified help only further deepens the precariousness of infertile women and encourages them to educate themselves, control their treatments and manage their bodies independently. To escape full dependency from the doctors who they don't trust, my respondents aimed at responsabilization, autonomisation and self-government.

c) Precariousness of Commercialization

The absence of money is one of the most widespread reasons why my respondents haven't undergone IVF earlier in their life.

I didn't have stable material conditions, everything ended up in money issue. I think we would do IVF much earlier otherwise (Patient 9)

According to my research the social class of the IVF patients is very diverse, as well as the resources they use to financially support themselves in doing IVF. They are coming both from the most wealthy segments of society who can easily afford the procedure and from the lower middle class, for whom the nodal point of “commercialization” is articulated through the chain of equivalence: “to save from the salary”, “take credits”, “spend less”, “spending all money on IVF”, “austerity”, “necessity of financial support”. Patient 7 had to spend all her salary on doing 11 protocols during 7 years of IVF treatment.

And to live all the time with the thought that you have to save this money and that there is no one to help, neither my parents, neither my husband's parents couldn't help. I was not going for vacation anywhere, I couldn't afford it, because my first thought was that I couldn’t spend this 5 thousand on vacation, if I can go for the protocol for the same money. I wasn't going anywhere, wasn't traveling at all. I was just going to my aim (Patient 7)

All my respondents agree there must be some state support of IVF treatment. They see the contradiction in the fact that state actualizes the rhetoric of “our birth rate falling”, but sees infertility as “private problem” and doesn’t help “people, who can’t have children”(Patient 9).

The state must support women, if I could pay all this money, than you should make some state institute, state clinic, where other women can do it free, because, you should forgive me, but these medications cost a damn pot of money. This is unreal (Patient 2)

d) Psychological Precariousness

Another condition for the precariousness is articulated through the nodal point “fear of losing a baby” and chain of equivalence “inferiority”, “nothing gives joy”, “last chance”, “fear of miscarriage”, “necessity to control the body all the time”, “unexplained reasons of failure”, “distrust and fear with respect to the unknown medical treatment”, “losing hope because of constant failure”.

Patient 7 decided to make IVF when she was 32 after trying to conceive independently for 8 years and going through one year of infertility treatment. The reason she was advised to try IVF was because she had obstruction of the fallopian tubes. She became pregnant with twins after her first cycle, but lost the children on the fifth week without a clear reason. Afterwards she experienced 9 unsuccessful cycles, when the pregnancy didn't occur at all and no one from medical practitioners could explain why. She gave birth to twins thanks to the 11th cycle on the 7th year of IVF treatment.

I was extremely scared, I was so scared, this fear, I have it even now. Now I am afraid that something can happen to children, to their health, to their life. And during all pregnancy I had this panic fear. When I recall it know, I wasn't enjoying pregnancy like other girls, the moving inside, the punching, I didn't have all this (Patient 7)

In the case of Patient 2 the fear that she will lose the baby made her lay for nine month in the hospital since after she was trying to get pregnant for 10 years, she didn't want to risk at all. As a result IVF pregnancy becomes extremely precious and women put so much pressure on themselves trying to save it. Many treat IVF as their “last” and “only chance” and think that everything will crush if she is not having this baby, although she put so much effort in it.

When everything came in a row, and each time was failure, I was already getting crazy, I was crying all days and nights, I didn't believe in anything anymore (Patient 8)

A lot of my respondents said that except of the fear of the failure, they had distrust and fear with respect to the unknown medical treatment, the procedures they had no idea what to expect from. Patient 9 had very complicated pregnancy with occasional bleeding. She felt depressed, her nerves were exhausted because of physical pain and constant fear of miscarriage. In this precarious psychological situation she needed psychological support in the clinic, someone in the hospital to explain to her that her life is not going to end if she will not have the baby, as well as provide a hope for her, but it wasn't available.

I really needed psychological support. Even here in this clinic, there wasn't a psychologist. And I regret I didn't understand that I need help, did not go to a psychologist, therapist, it is very hard. To see young children, to understand all my inferiority, maybe someone is calm about it, I felt that something was wrong, nothing gave me joy. When I got to the clinic bleeding on the 7th week, I just could not imagine if they will clean it up, how would I continue living, because the money was borrowed and I got used to the thought that I am having children, I already told everyone (Patient 9)

3. The Work Of “Advanced Liberal” Governmentality: The Subjectivity Of “Biological Citizen”

To minimize precarity my interviewees learned how to govern themselves, control their treatment and become independent from social structures that endanger their lives. Thus, they adapted the subjectivity of biological citizenship. The lack of support from the state and medical structures led them to realize their responsibility for optimisation of their own health and bodies and normalise their precariousness, in other words their precarious standing allowed governmentality to act on them more easily. However, recognition of shared vulnerability also enabled them to develop a certain ethics towards each other, form a solidarity networks based on their medical condition and opacity of their bodies.

Those respondents who did a number of IVF cycles and wasn't lucky enough to get pregnant after the first cycle, started to see IVF procedure as a “set of challenges”, which you have to be prepared to overcome. As well, women in the research done by Sarah Franklin (1997: 10) described experience of IVF as an “obstacle race”, which is full of failures and which “takes over” and becomes “a way of life”, because demands from you accomplishment of the whole set of different tasks, from disciplining the body and physical demands during procedures to adjusting your schedule and even leaving work in order to release the required for the IVF time. In particular, you have to adjust your expectations to the reality of the low success rates and acquire the necessary knowledge of your body and medical manipulations with it.

After the failure doctors say: “We don't know the reason, you should check this analysis and pass these additional tests”. I have learned a lot during these protocols, I come sometimes to the physician, she asks me if I have a medical education, I answer: “With our medicine, even if you do not want to, you will become a physician anyway”. But the first time I was going like a dumb, you understand that they take advantage of you, but you don't know how exactly. (Patient 1)

My interviewees managed their precarity and distrust in medical expertise with the help of getting into the details of medical treatment, obtaining knowledge about their body and its physical processes, attending to the lived experiences of other women. They learned to control

their own analysis, drug doses, check the reviews and notations of medications, prescribed to them, as a result to challenge the authority of the doctors. The narrative of Patient 7 shows how sculpting autonomous treatment and enacting biological citizenship are triggered by the desire to regain control over one's body and escape precariousness. When Patient 7 describes her experience of the first IVF cycle she mentions that she was behaving as a 'fathead': she lacked necessary knowledge about her body and its medical treatment, didn't have any initiative and relied strongly on the opinion of the doctors in the clinic. During seven years and 10 unsuccessful cycles she learned perfectly how to decipher what is going on with her body in medical terms.

I was not just sitting and listening in the consulting room, I was reading a lot on my own, I was reading dissertations, articles in the Internet, buying books. I was passing hormonal tests on my own, controlling my estrogen, progesterone, going to the laboratory as if I was working there. Everyone knew me there. I was coming to control my HCG every two days (Patient 7)

My interview material reveals, how the nodal point "medical knowledge" and the chain of equivalence "medical literacy", "self-education", "checking prescriptions", "deciphering analysis" are defined through the equivalence with the nodal point "control over medical treatment", or "control over pregnancy", while the "lack of knowledge" is equalled with the "lack of power". Thus, the nodal point that reveals the work of "advanced liberal" governmentality in constructing women as autonomous and responsible for their bodies is "control over medical treatment".

According to Rose and Novas (2005: 450), they can be called "moral/ethical pioneers of a new kind of active biomedical citizenship", or "new informed ethics of the self", a set of techniques of managing everyday life and exercising agency in relation to medical condition and in relation to expert knowledge about it. The concept of "moral pioneering" was suggested by Rapp (2011: 703) to explain how women and men in different contexts assess their encounter with new medical technologies through the lenses of existing social relations. Part of the obligation of biological citizenship is activism and responsibility: biological citizens are obliged to inform themselves and make claims on decisive power. Similarly, my interviewees try to act on behalf of their medical condition and treat themselves independently from medical professionals with the help of acquired knowledge. The chain of equivalence organised around the nodal point "control over medical treatment" includes "becoming independent from doctors in treatment", "increasing the doses of hormones", "self-treatment", "experimental treatment", "trying different medications", "self-prescribing medicine". After having 10 unsuccessful IVF cycles Patient 7 was taking different medications without prescription, hoping that it will help her to get pregnant.

Afterwards I prescribed myself a scheme. I also found it somewhere on the Internet. When I showed the list to my doctor, she looked at me and asked: “Oh, my God, how do you endure all this?”. In other words, I was making injections, taking medicine, everything I could shove inside my body, I tried. I still don't know what actually helped me.

The case of Patient 8 can be seen as an example of “self-made” pregnancy. Two years after giving birth as a result of IVF procedure Patient 8 had two natural pregnancies, which ended in miscarriage. Patient 8 started to support her third natural pregnancy with hormonal treatment as in IVF protocol, because she was afraid that she could lose the child without progesterone. No one from her physicians knew that she is taking hormone without prescription.

I started to do the tests very early, and the moment I saw a ghost of a ghost (the magnifying glass was necessary to see), but there was something, I started to make injections (Patient 8)

Patient 9 obtained enough knowledge to perceive the help of medical practitioners as pointless.

Attending doctors, neither fish nor fowl, they told me it is necessary to lie in the hospital, and why, for what? I can put a drip myself at home (Patient 9)

According to Petryna (2004: 265), in Ukraine both scientists and victims of Chernobyl adapt a form of biological citizenship grounded in radiation-related illness in order to demand a redress from the state, negotiate “public accountability, political power and further state protection, in the form of financial compensation and medical care”. I argue that in the field of IVF the opposite happens, since my respondents do not demand redress, but develop self-care attitudes, strive for autonomisation from the state and private medical institutions, organise into collectivities and feel obliged to obtain self-knowledge in order to fight with authority of medical professionals.

I understand community of infertile women who undergo IVF treatment in Ukraine as an example of biosocial collectivity. Biosociality partly signifies those collectivities that are organized on the basis of the shared biological condition and its biomedical classifications and include self-help groups and patient organisations (Rabinow, 1999). All my respondents know each other, regularly meet online and in the real life, celebrate the birthdays of their children together, organise charity events to help children with severe medical conditions, collect money to assist women who cannot afford IVF. They meet and communicate to share their experience of treatment and provide emotional support to each other in the situation of the overall silencing of their histories by society.

I found my respondents on the Internet forum. They all answered me independently from each other, but a lot of them mention each other in a very positive way in conversations with me. Rapp, Heath and Taussig (2007: 155) indicate how important in context of geneticizing of

citizenship claims are those “translocal engagements and intimacies” that arise on the web due to the sharing of biomedical knowledge and life experiences, establishing new entanglements and coalitions on the ground of common bodily condition. Thus, this community exists both on the web and outside it and its main role is in enhancing the medical knowledge of its members, helping them negotiate and normalise their bodily condition and learn how to govern and take care of their bodies with regard to disability.

In the narratives of respondents the nodal point “forum” is determined through the chain of equivalence with “friendship”, “emotional support”, “the only people who understand”. The chain of equivalence also includes “overcoming depression”, “feeling not alone”. “Forum” played an important role in treatment of infertility and provided psychological support that was crucial in managing precarity, since everyone there was going through the same traumatic experience and shared their feelings and knowledge about it. Because of social stigmatization of childless women, some of my respondents could communicate about IVF only with those who go through the same experience.

I became a user on a forum, there are people with similar psychological problems and this saved me. At that time my husband and I have isolated from everyone else, lived alone, only two of us. Couldn't communicate with anyone. And I saw on the forum women who are already 46, I knew that I am not alone, that people are even older, they go to their goal, anyway, they achieve it. It allowed me not to give up, it gave me the ability to control the mistakes of doctors, because a lot depends on the patient (Patient 1)

Therefore, the nodal point “forum” is also articulated with the moments “seeing actual results of IVF”, “knowing what to expect”. It shows how important it is for those women who only plan to do IVF to connect with someone more experienced, so that they can believe that it works and see its actual results, which eliminates the obscurity of future IVF treatment and gives a sense of awareness and certainty.

It's much easier to sit here and read that someone already had puncture and someone already had a positive pregnancy test, this also gives strength (Patient 5)

The nodal point of “forum” is also defined through the moments “source of information”, “sharing experience of the procedure and body change”, “identifying mistakes of doctors”. In the situation of the absence of trust, it is possible to cope with precariousness by virtue of sharing on the forum the opinion about doctors, clinics, and medical articles. Therefore, the forum becomes not only the foundation of emotional connections and support, but also helps with management of the distrust regarding medical system and the general precarity of infertility. The subjectivity of biological citizenship produced as a result of precarity makes women into conscious consumers of the services of IVF.

Girls are telling everything, in which way they are supporting pregnancies, which prescriptions from the doctors they have. Everyone is adjusting doctor's prescriptions for themselves, especially in the supporting medications, because of the fear that something will go wrong. It is scary, and even more so when you read that the rest are on progesterone to 12 -15 weeks, and why not me? (Patient 8)

The information received from the other women helps to handle fear and uncertainty and gain more control over IVF treatment. The sharing of experience also leads to obtaining medical knowledge and thus allows blurring the distinction between lay people and medical experts. As autonomous and self-governed individuals, the users of forum challenge the authority of the doctors, adjust their prescriptions and decide which treatment is more appropriate in accordance with their shared experience. At the same time, by exposing their body to all kind of experimental self-treatment practices and continuing its optimisation until achieving pregnancy, they endanger its health and wellbeing.

Another function of this biosocial collectivity based on shared vulnerability is in the new sense of ethics that it uses as glue. This awareness of the physical deficiency of their own body and psychological uncertainty they face during attempts to conceive and gestate the child, gives them the ability to understand other people's vulnerability and impetus to build friendship with those women, who experience the same problem of the clash with the reality of their own body and its non-compliance to the norm. This coalition allows women to understand the vulnerability of each other, share the information, regain confidence and enjoy emotional support.

According to Butler's (2004) line of argument, it is ethical not to demand the self to be responsible for the actions, which can never be fully knowable, and for identity which can never be complete. In the same way my respondents acquire ethical agency that fosters greater tolerance and compassion for the weaknesses of others, makes it possible for them to understand the imperfection of the world and not to stigmatize people that do not meet illusionary standards of normalcy. Since they don't thoroughly account for themselves, they don't ask the Other to be accountable and responsible as well, leaving the process of identity formation open. They acquire the capacity to build coalitions based on shared vulnerability.

I conclude that those IVF patients, that I succeeded to interview, are going through an experience that makes them able in the future to join with others for political goals, such as minimization of precarity of infertile women in the realm of reproduction and public health in Ukraine. However, their biosocial collectivity does not have any political consequences yet. After being involuntary childless for so long and finally achieving pregnancy through IVF treatment, my interviewees tend to radically reduce their lives to private issues and become disinterested in public activities, spending most time with their children and lacking awareness about their collective interest and the need for collective action.

CONCLUSION

In Ukraine infertile bodies are extremely diminished under the normalizing gaze, while treatment of infertility is accompanied with the growth of precariousness of reproduction due to the lack of trust in the state and private medical institutions and shortage of financial opportunities. The discourses about ART reveal different types of political rationalities that work to govern the conduct of infertile women who undergo IVF through construction of certain modes of subjectivity.

The state discourse about ART constitutes a part of pronatalist strategy, that aims at control over female body and reproduction. While the state continues to exercise the biopolitical techniques such as regulation and maximization of the life processes of population through normalisation of motherhood and precarization of infertility, the advance of neoliberal rationalities can be found in forwarding the responsibility for reproductive health to quasi-autonomous private infertility clinics and individuals, that are engendered to practice controlled freedom and choice.

I conclude that on the level of the state the mechanisms of biopolitics construct the subjectivity of infertile women who undergo IVF treatment as “mothers”, that are supposed to reproduce the “nation”. The structures of biopower produce the norms of motherhood, which infertile women can’t satisfy. The lack of recognition and non-compliance with the gender norms makes the lives of infertile women less liveable as situated in precarious conditions enacted by biopower.

On the level of medical professionals, the “advanced liberal” governmentality techniques based on individualisation construct women who do IVF as “biological citizens”, adopting ethics of self-governance and optimisation of the body. The discourse of medical professionals about ART reveals that both individuals and private clinics try to be independent from the state and shape an autonomous conduct.

The biopower and precarity work together to ease the government of infertile women who become IVF patients and their reproductive practices. The experience of IVF procedure reveals to many women their precarity grounded in imperfection of their bodies and lack of recognition and support from the power structures. The subjects formed in the practices of IVF are brought to understand and manage these uncertainties by adapting the modes of subjectivity provided by biopower. As a result, in the discourse of IVF patients both biopolitical mechanisms of normalisation and governmental mechanism of responsabilization and individualisation find their place and bring infertile women who undergo IVF to subjectivate as “mothers” and “biological citizens”. Thus, their decision to do IVF is largely conditioned both by their desire to re-establish

themselves in the status of normal “women”, which within the given frames of recognition means to fulfil themselves in “motherhood”, and by the promotion of the endless optimisation of the body through governance of one’s freedom. The central to the subjectivation of women who undergo IVF treatment is acknowledgement of precariousness of their body, control and care over living and functional body, procurement of biomedical knowledge about it. As a result, they seek to establish independent governance over their biological lives and act on behalf of their medical condition.

Another effect of the precarious standing of infertile women is that realization of their corporeal vulnerability and inability to fit the gender norms leads them to build coalitions with other women placed within similar conditions of precarity and erecting biosocial collectivities based on bodily illness. Infertile women realise that they don't fit the norms, on which they depend to be recognised, that they don't control their lives and can't explain the way their body acts. Since they can see the limits of their own self-knowledge, and impossibility to be fully accountable for themselves, this grounds the possibility of ethical conduct towards the other women, who share the same uncertainties.

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Appendixes

Appendix 1. State Documents

1. The Family Code of Ukraine (art. 123) 2002. Available at: <http://zakon4.rada.gov.ua/laws/show/2947-14> [Accessed 7 March 2013]
2. The Civil Code of Ukraine 2003. Available at: <http://zakon4.rada.gov.ua/laws/show/435-15> [Accessed 7 March 2013]
3. Law "Principles of Legislation of Ukraine on Healthcare" (art.48) 1993. Available at: <http://zakon4.rada.gov.ua/laws/show/2801-12> [Accessed 3 March 2013]
4. Ministry of Health of Ukraine Order #771 "Instruction on the use of ART" 2008. Available at: <http://zakon1.rada.gov.ua/laws/show/z0263-09> [Accessed 5 March 2013]
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Appendix 2. State Documents: Coding

Nodal Points	Chains of Equivalence
reproduction of the nation	national development and wellbeing, reproductive health, national security
reproductive health	attention to the role of the family, preservation of traditional culture of relationships in the family
infertility	demographic crisis, infertile marriage, medical and social problem nationwide, tragedy, the perennial problem of humanity, the decline of reproductive health because of women's diseases, abortion, women's illnesses, couples infertile because of the women's diseases, unrealized femininity, wrong way of life, irresponsible/bad mothers
traditional family values/family	cell of reproduction of population, women's vacation, fulfilment of women, big families, registered marriage, union of man and woman, high rates of reproduction, reproductive health
demographic crisis	danger for national security, problems of family formation, problems of family functioning, the deterioration of family values, reduction of the demographic potential of the family, single motherhood, childlessness, singlechildness, children out of wedlock, fall in numbers of registered marriages, increase in divorces, the change in the social status of women, the expansion of their interests outside family, higher education, employment, their desire to postpone or avoid marriage and childbearing, abortion, the necessity to satisfy their educational and civil interests
reproductive medicine	safe motherhood, sexual health, family planning, family medicine, demographic growth
Subject Positions	Chains of Equivalence
mother	safe/responsible/good/intensive/real/true motherhood, officially married, heterosexual, to support traditional family values, stand for a couple in treatment, exhibit the desire to have children, caring and loving

Appendix 3. Medical Articles

From Ukrainian Medical Journal [Український Медичний Часопис] and Woman's Doctor [Жіночий Лікар], published between 2005 and 2010.

1. Girina, O., Bondar, V., Abrosimova, L. 2010. Prognosticheskaya cennost osnovnyh criteriev otbora I provedeniya vnutrimatochnoy inseminacii spermoy muza. Zinochiy Likar. [online]. 1. Available at: <http://z-l.com.ua/upload/journals/27/1-2010site2.pdf> [Accessed 2 May 2013]
2. Yuzko, U., Yuzko, T. 2010. Zastosuvannya dopomiznih reproduktyvnyh tehnologiy pry likuvanni bezplidya v Ukrayini. Zinochiy Likar. [online]. 2. Available at: <http://z-l.com.ua/upload/journals/28/2-2010site6.pdf> [Accessed 2 May 2013]
3. Anon., 2007. Bezplidya: Odvichna problema ludstva. Zinochiy Likar. [online]. 4. Available at: <http://z-l.com.ua/ru/article/62> [Accessed 3 May 2013]
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Appendix 4. Interviews with medical professionals: Demographics

Name	Gender	Position in the clinic	Location
Doctor 1	M	Director	Kharkiv
Doctor 2	M	Director	Kyiv
Doctor 3	F	Director	Kyiv
Doctor 4	M	Director	Kyiv

Appendix 5. Interviews with Medical Professionals: Questions

1. What is your opinion about the level of development of ART in Ukraine?
2. What are the main problems and challenges you encounter in the field of ART in Ukraine?
3. What is your opinion about the existing legislation of ART in Ukraine?
4. What are the shortcomings of this legal framework?
5. How do these laws affect the working of your clinic?
6. How do the laws influence, help or obstruct the achievement of the goals the state wants to achieve (like reduce abortions, increase access to new technologies)?
7. What is your opinion about the law project that limits the use of ART?
8. Was it difficult to start the clinic? How did it evolve? Which problems encountered? (its history, the services offered, how these changed in time)
9. What cases you usually encounter during your medical practice?
10. Who are the people who generally come to the clinic? What is their approximate socio-economic status? What services do they use and what infertility problems they have? What is their age, sex, family situation?
11. How do you find surrogacy mothers? How do you choose between them?
12. When did various procedures like IVF, surrogacy, ICSI, etc. became available at your clinic? How did you get the necessary equipment?
13. How in main lines an IVF treatment looks like?
14. How many cycles the clinic does per year? How successful are they?
15. What is the role of the state in solving the problem of infertility?
16. How do you see the role of the state in regulation of ART? How do you see the relation between state and commercialization of ART?
17. What is the role of state program of ART treatment? How should it look like?
18. What do you think about professional community of medical practitioners in the field of ART in Ukraine? What obstacles do you see in collaboration with other reproductologists? What is the role of Ukrainian community of reproductologists in the development of ART in the post-Soviet area/world? What do you think about the development of professional knowledge about ART in Ukraine?
19. How relevant for Ukrainian society is the question of infertility? How relevant is the question of infertility treatment with the help of ART? Why do you think is that?
20. How the use of IVF appeared and spread, became popular in Ukraine?
21. How do you explain the success of the ART in Ukraine?
22. How in your opinion the development of ART influences Ukrainian society?
23. What is the role of Ukraine on the global map of reproductive medicine?

Appendix 6. Interviews with Medical Professionals: Coding

Respondents				Nodal Points	Chains of Equivalence
Doctor 1	Doctor 2	Doctor 3	Doctor 4		
✓	✓	✓	✓	state intervention	rigid bureaucratic system, ineffective management, the ART develops not “thanks to” state politics, but “despite of” them, low purchasing power of the population, complete lack of governmental support, misallocation of resources, corruption, cooperation is very difficult, a lot of obstacles, conflicts
✓	✓	✓	✓	commercialization of ART	advance of ART, good level of equipment, good level of knowledge, good level of medical service, good level of materials, good level of environments, growth, control of the quality, audit, training, self-control, education, professionals
✓		✓	✓	legal regulation	reputation, the clinics that respect themselves, the clinics that work adequately, the clinics that work in the legal field, civilized laws, to advance and support the ART, right image of Ukraine, expert knowledge.
✓		✓	✓	reproductive hooliganism	the bad image of Ukraine in the world, a country where you should go for surrogacy and donor eggcells, Mecca of surrogate motherhood, the problems with registration of children, worsens the reputation of the country, the transfer to the uterus of more than 2 embryos without medical evidence, the transfer to the uterus of more than 3 embryos, carrying out more than 5 cycles without any correction of prescriptions, conducting stimulation cycles in obviously hopeless cases, the use of donor sperm from a relative in the male line (non-anonymous sperm donation), two surrogate mothers, surrogate mother, which is both an egg donor, embryo transfer to the woman and the surrogate mother at the same time, embryo transfer to the women beyond certain age, the treatment of homosexual couples
Respondents				Subject Positions	Chains of Equivalence
✓	✓	✓		consumer	contractual relationship, free, informed, individual choice, efficacy, the quality of the treatment, evaluation upon the result, awareness of the patient about the treatment
✓		✓		patient	infertile body, demands assistance, genetically defective mothers, normal respondents, the mothers with poor response of ovaries, hostile environment for the fetus, premature birth, the mothers with ectopic pregnancy, abortion of defective fetuses, the prolific mothers who create problems for obstetrics

Appendix 7. Interviews with IVF patients: Demographics

Name	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5
Age	31	33	39	38	33
Home city	Kyiv	Kharkiv	Poltava	Kyiv	Boyarka
Employment	Unemployed	Lawer	Professor at the university	Unemployed	Unemployed
Marital status	Married	Married	Married	Married	Married
Date when the respondent started to do IVF/ Date of birth from IVF	2008/2010	2009/2009	2007/2007	2008/2011	2003/2010
Number of cycles /Number of successful cycles	3/1	1/1	2/1	4/1	3/1
Number of transferred embryos in successful cycle/number of implanted embryos	3/1	3/3	6/4	4/2	2/2
Number of children/ Number of children from IVF	1/1	3/3	2/2	2/2	2/2

Name	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
Age	32	39	33	38	33
Home city	Kyiv	Kyiv	Kyiv	Kyiv	Kyiv
Employment	Unemployed	Secretary	Unemployed	Professor at the university	Works at the international company
Marital status	Divorced	Married	Married	Married	Married
Date when the respondent started to do IVF/ Date of birth from IVF	2007/2008	2006/2012	2009/2009	2008/2008	2010/2010
Number of cycles /Number of successful cycles	1/1	11/1	1/1	1/1	2/1
Number of transferred embryos in successful cycle/number of implanted embryos	2/2	6/2	2/1	2/2	2/1
Number of children/ Number of children from IVF	2/2	2/2	3/1	3/2	1/1

Appendix 8. Interviews with IVF Patients: Questions

1. How have you decided to do IVF?
2. How were you treating infertility before IVF?
3. How long were you treating infertility?
4. When have you decided to undergo IVF? How old were you?
5. How many cycles you went through? How long did it take you?
6. In which clinic were you undergoing the treatment of infertility/ IVF procedure/ pregnancy monitoring?
7. How were you choosing the clinic/the doctor?
8. How much have you paid for the treatment of infertility/ IVF procedure/ pregnancy monitoring? What were your financial resources? How difficult/easy was it to afford IVF?
9. What were your expectations with regard to IVF?
10. How can you describe IVF procedure?
11. How can you describe your experience of undergoing IVF?
12. What was the most difficult/easy aspect of IVF?
13. When were you feeling yourself worst/best?
14. How your life changed after IVF?
15. Have you applied for the state program? How you evaluate it?
16. What was the attitude of your family/ friends/ coworkers towards IVF?
17. How you combined your work and infertility treatment/IVF procedure/pregnancy?
18. What was the role of your husband in the infertility treatment/IVF procedure/pregnancy?
19. What do you think about the doctors/clinics? How were they treating you during treatment of infertility/ IVF procedure/ pregnancy?
20. How were you following your treatment?
21. Where were you finding the information about the treatment?
22. How would you describe the women who undergo IVF?
23. What was the role of forum in your treatment/IVF procedure/pregnancy?

Appendix 9. Interviews with IVF Patients: Coding

Respondents										Nodal Points	Chains of Equivalence
Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10		
✓		✓		✓		✓	✓	✓	✓	infertility inferiority	worse than other women, handicap, derelict, put guilt on oneself, blaming oneself, self-hatred, unfulfilled femininity, not womanly enough, diminished as a woman, couldn't talk with anyone, depression, feeling abnormal, desire to be normal
✓		✓	✓	✓		✓		✓	✓	pressure condemnation	pressure of family/friends, condemnation of family/friends/society, being questioned about childlessness, losing friends, infertile women as dangerous, leading wrong way of life
✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	IVF pregnancy	less certain pregnancy, insecurity, prejudice of medical professionals, overprotection by medical professionals, too old for pregnancy, too many children, IVF pregnancy as abnormal, children as artificial, easy/complicated pregnancies, having trouble with supporting pregnancy, medical surveillance
✓		✓	✓	✓		✓		✓		prejudice towards IVF	keeping in secret, incomprehension, IVF children not normal, low quality of professional services, lack of professionals, lack of professional education with regard to ART, shame, negative attitude towards IVF, lack of information about the technology, professional community as exclusive
✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	motherhood	focused only on children and pregnancy, no other occupations, desire to become mother, struggle to have children, capability to be a mother, deserving motherhood, heterosexual marriage, stable employment, housing, financial ability to support a child, health and financial problems, caring, good mother, overprotection of children, motherhood as responsibility of women, responsible pregnancy management, genetic ties, children of a higher quality, pregnancy as a conscious choice, selected biological material, representing a couple

✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	body	difficult pregnancies, fear of losing a baby, lack of control, body's disobedience, precariousness, body acting against them, irresponsible body, disabled body, body incapable to do what is expected from it, anxiety because of the body's failure, miscarriage
✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	trust in medical institutions	helpless and powerless, doctor's mistakes, constant change of the doctors, learning to make choices between doctors, recommendations, uncertain Ukrainian market of medical services, the risk of wrong decision, material interest of doctors, low qualifications, prejudice of doctors, conveyor, negative attitude of doctors towards ivf pregnancy, indifference towards all patients, bad diagnosis, disappointment, amount of embryos, reduction, skepticism about state program, long lines, not enough money, bad treatment, discriminatory criteria of admission to the state program
✓	✓	✓	✓	✓		✓		✓		commercialization	absence of money as an obstacle, saving money for ivf, spending all money on ivf, austerity, not going for the holidays, private problem, necessity of financial support, free medications and treatment, rich people as more privileged, able to reproduce and use the bodies of others
✓	✓	✓	✓	✓		✓	✓	✓	✓	fear	constant fear of failure/miscarriage, necessity of psychological support in the clinic, the feeling that it is her last chance, that her life is going to end if she is not having a baby, necessity to control the body all the time, nothing gives joy, depression, distrust and fear with respect to the unknown medical treatment
✓	✓	✓	✓	✓	✓	✓	✓			ignorance	lack of knowledge about the body, lack of understanding of IVF procedure, they don't know what to expect from procedure, wrong expectations, expect it to be easy and guaranteed, certainty in the result, anxiety with regard to the unknown and unexplained reasons of failure, lack of control over the treatment
✓	✓	✓		✓		✓	✓	✓	✓	failure	dramatization of the negative outcome, want to get pregnant so desperately, transfer of numerous embryos, doing everything to bear a child, increase the doses of hormones, search for better doctors all the time, harm to the health, exhaustion, losing hope because of constant failure

✓		✓		✓	✓	✓	✓	✓	✓	biomedical knowledge control	self-treatment, self-education, experimental treatment, checking all prescriptions, overcoming challenges, medical literacy, control over medical treatment, control over pregnancy, trying different medications, self-prescribing medicine, becoming independent from doctors in treatment, increasing the doses of hormones, autonomisation and self-government, acquiring medical knowledge
✓		✓	✓	✓	✓	✓	✓	✓	✓	forum friendship	friendship on the forum, emotional support on the forum, IVF patients understanding each other, overcoming depression thanks to forum, forum as a source of information, sharing opinions about doctors, sharing experience of the procedure and body change, feeling not alone, identifying mistakes of doctors, seeing actual results of IVF, knowing what to expect

Appendix 10. Interviews with feminists

Olena Strelnyk	PhD in Sociology, the Head of the Department of Social Work at the Poltava University of Economy and Law “Ukraine” (Poltava, Ukraine)
Ludmila Males	PhD in Sociology, Professor at the Department of Theory and History of Sociology at Taras Shevchenko National University of Kyiv (Kyiv, Ukraine)
Galina Yarmanova	MA in Gender Studies, activist in the feminist initiative “Feminist Offensive” (Kyiv, Ukraine) - http://ofenzyva.wordpress.com
Lesya Pagulich	activist in the feminist initiative “Feminist Ofensyva” (Kyiv, Ukraine) - http://ofenzyva.wordpress.com
Tatsiana Schurko	PhD student in Sociology, activist in the feminist project “Gender Route” (Minsk, Belarus) - http://gender-route.org

Appendix 11. Interviews with feminists: Questions

1. What is your opinion about politics of reproduction in post-Soviet states?
2. What are the main problems that you identify in this field in post-Soviet societies?
3. What role assisted reproductive technology (ART) plays in politics of reproduction?
4. How and when infertility becomes constructed as a problem in post-Soviet societies?
5. What are the main discourses that articulate the question of reproduction, infertility and ART?
6. What role women and their bodies play in the discourse about reproduction and ART of medical professionals, politics, church?
7. Do you think that the question of reproductive politics and ART is raised by feminists in post-Soviet countries? In which way is it discussed by them, when raised?
8. In which way the discourse of infertility and ART relates to the ideology, which defines fulfillment of reproductive function as the main mission of woman and sees woman as responsible for the low birth rate/demographic crisis?
9. What is your opinion about the social consequences of the individualization of responsibility of women for their reproductive health?
10. Who has the right and possibility to use assisted reproductive technologies in post-Soviet states?
11. How the assisted reproduction in post-Soviet countries is stratified by gender, class, sexuality and race?
12. What is the role medical and state practices of ART implementation play in the normalization of motherhood and construction of the identities of women? What kind of identities are reproduced by it and which are excluded?
13. What is the role of class, race, sexuality in construction of the identity of good/bad mother in the discourse of ART?
14. Do you think infertility contributes to self/stigmatization of women?
15. Do you think that IVF patients are stigmatized? If yes, then in which way?
16. How the technological assistance to conception supports, adapts to or questions the conventional thinking about the family, sexuality and motherhood?
17. Do you think that discursive-material practices of ART in post-Soviet countries question the traditional ideology of "natural facts" about childbirth and kinship? What new kinship structures and identities emerge because of them?
18. How women's understanding of body and childbirth changes when reproduction becomes technologically assisted?
19. What kind of bodies are constructed in discourse of new reproductive technology?
20. What do you think about the emergence of the market of reproductive services in post-Soviet countries?
21. How commodification of reproduction transforms the reproductive model in post-Soviet societies? How this positions post-Soviet states on the global scale (reproductive travel)?