

# Reproductive Technologies and the Remaking of Life and Death

Aalborg University, Copenhagen 2023



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## Program

### Thursday: 24th of August

08.30 – 09.00:	<i>Registration and coffee, A C Meyers Vænge 15</i>
09.00 – 09.45:	Welcome and introduction to the conference: Stine W. Adrian, Auditorium 1.008
09.45 – 11.15:	<b>Keynote 1.</b> Professor Kate Reed: 'It's just part of the job': exploring the role of care in perinatal post-mortem work, Auditorium 1.008:
11.15 – 11.45:	<i>Coffee break</i>
11.45 – 13.00:	Plenary debate: Abortion in turbulent times. Moderator: Janne R. Herrmann. Panelists: Laura L. Heinsen, Turid Hermansdottir, Turid Nolsøe, Auditorium 1.008
13.00 – 14.00:	<i>Lunch</i>
14.00 – 15.30:	Panels: A1- room 2.1.042, B1 room 2.1.043, C1 room 2.1.083, D1 room 2.1.121
15.30 – 16.00:	<i>Coffee break</i>
16.00 – 17.30:	<b>Keynote 2:</b> Professor Monica Casper: Birthing Death: What Infant and Maternal Mortality Reveal About Social Inequality, Auditorium 1.008
17.30 – 18.30:	Boat to the Copenhagen Admiral Hotel for the conference dinner

### Friday: 25th of August

08.30 – 09.00:	<i>Coffee, A C Meyers Vænge 15</i>
09.00 – 10.30:	<b>Keynote 3:</b> Professor Thomas Lemke: Beyond Potentiality and Latency: The Chronopolitics of Suspended Life, Auditorium 1.008
10.30 – 10.45:	<i>Coffee</i>
10.45 – 12.15:	Panels: A2 room 2.1.042, B2 room 2.1.043, D2 room 2.1.121
12.15 – 13.00:	<i>Lunch</i>
13.00 – 14.30:	<b>Keynote 4:</b> Professor Chia-Ling Wu: Anticipatory Regimes of Fetal Reduction, Auditorium 1.008
14.30 – 14.50:	<i>Coffee</i>
14.50 – 16.20:	Panels: A3- room 2.1.042, B3 room 2.1.043, C3 room 2.1.083, D3 room 2.1.121
16.30 – 17.00:	Plenary Wrap-Up, Moderator: Nina Lykke: Panelists: Ayo Wahlberg and Charlotte Kroløkke, Auditorium 1.008

All coffee breaks will be outside the Auditorium  
Lunch will be served in the cantina

## General information

### Venue

Aalborg University Copenhagen  
AC Meyers Vænge 15  
2450 Copenhagen SV

### Parking

If you arrive by car, please let me know if you need a parking permit, please write to [technodeathconference@ikl.aau.dk](mailto:technodeathconference@ikl.aau.dk)

## Panel format and information:

To each panel we have assigned a chair. Please provide them with your power point well in advance of your panel, in order not to spend time on setting up computers for power point presentations.

In the room there will be projectors and computers set up. The chair and panel should be present at least 10 minutes before their panel starts, to transfer the presentations to the computer on site, and to make sure the technology works.

In case you face technological problems please contact AAU IT services, there are information provided in the room.

All presenters have assigned 15 minutes to talk, this should also enable some time for discussion. To keep the time, please keep your presentation within the time limit.

The chair will provide help with the timing. There are signs for 5 minutes and 2 minutes in the rooms.

We are looking forward to your presentations, and a great dialogue and discussion!

## Panels

Panel 1 A room 2.1.042, Globegangen

### **Self management and abortion technologies**

Chair: Anna Sofie Bach

Carrie Purcell, Victoria Newton, Fiona Bloomer and Lesley Hoggart: Self-managed medication abortion supported via telemedicine: Experiences during Covid-19

Lynn Thomas: From North Carolina to Nairobi's Ward 6: An abortion technology for saving and enabling lives

Noga Friedman: "Abortion would be seven thousand times harder for me". Permanent contraception and reproductive citizenship

Panel 2 A room 2.1.042, Globegangen

### **Visualization technologies, law and abortion**

Chair: Laura Louise Heinsen

Pam Lowe, Rebecca Blaylock, Patricia Lohr, Lesley Hoggart: Seeing the Scan: Fetal Images in Abortion Care

Tracy Weitz, Hillary Gyuras, Danielle Besette and Michelle McGowan: Ultrasound and Abortion: Technological determinism and state control over the meaning of life/death

Alysaa Basmajian: Creating life by manufacturing a "heartbeat" with ultrasound technology

Panel 3 A room 2.1.042, Globegangen

### **Abortion, wombs and ethical and legal reflections**

Chair: Aimee Middlemiss

Dunja Begovic and Elizabeth Chloe Romanis: Language and Abortion: Addressing the rethoric of 'killing' in debate, practice and policy

Mio Tamakoshi: The Techno-legal Environment of Multifetal Pregnancy Reduction: A comparative case study of Italy and Japan

Ji-Young Lee: Artificial Amnion and placenta technology (AAPT) and abortion: Confronting the "Death of the Fetus"

Aimee Middlemiss: In relation to the state: the biomedical administration of the boundaries of legal personhood and kinship in England

Panel 1 B, room 2.1.043, Globegangen

### **Ambiguous reproduction**

Chair: Tine Ravn

Andie Thompson: "The fetus falls of a cliff": Oxidative stress relations at the nexus of the placenta

Bryan Lim and Mette Kragh-Furbo: Catalysing life: Exploring the tension surrounding folate as a reproductive technology

Mianna Meskus: Modulating death: Knowledge at the intersection of reproduction and ageing

Tine Ravn: The Social, Legal, and Ethical Implications of Research Concerning Embryoids in Relation to Human Embryos

Panel 2 B, room 2.1.043, Globegangen

### **Care and grief after pregnancy loss and induced abortion**

Chair: Li-wen Shih

Sofie Mørk, Dorthe Hvidtjørn, Søren Møller, Tine Brink Henriksen, Maja O'connor og George Bonanno: Grief trajectories after loss in pregnancy and during the neonatal period

Julia Böcker and Veronika Siegl: From hiding the foetus to seeing the baby. New norms and practices of "viewability" following pregnancy loss and induced abortion

Li-wen Shih: Rearticulation of "Hsiao-Chan" (miscarriage, lit.small birth): Taiwanese women's situated knowledges of pregnancy, life and loss

Paula Martone and Anna Molas: Negotiating 'viability' of preterm infants on the ground: the experiences of parents and healthcare workers in Spain

Panel 3 B room 2.1.043, Globegangen

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Dorthe Hvidtjørn, Natasia Hindsbak, Christina Prinds, Sofie Mørk and Joanne Cacciatore: Social and professional support after termination of pregnancy due to fetal anomaly

Dunja Begovic: The ethical challenges and implications of perinatal palliative care



Laura Louise Heinsen, Camilla Bruheim and Stine W. Adrian: Orchestrating Moral Bearability in the Clinical Management of Second-trimester Selective Abortion

Erica Millar: Second/third trimester abortions at the intersection of life and death

[Panel 1 C, room 2.1.083, Klimagangen](#)

### **Biopolitics and life and death**

Chair: Stine W Adrian

Karina Edouard: Suspending Death, Enabling Life: Situating Doula-care as a critical reproductive technology in black maternal health

M. Mena, Jallicia Jolly, Carolina Coimbra: Towards Black Reproductive Rights: Transnational Activisms and Strategies Among Black Birth Workers in Three Continents

Dr. Karla da Costa: "Obstetric Racism in Brazil: Knowing the Reality and Reflecting on the Consequences"

Bolette Blaagaard, Stine Adrian and Signe Nordsted: How Journalism Forgets: A case study of how practices of state issued and controlled IUDs to the Inuit population in Greenland were forgotten and then remembered in Danish Journalism

[Panel 3 C, room 2.1.083, Klimagangen](#)

### **Life/Death, viability and disaster**

Chair: Yael H Dolev

Tsipy Ivry: Ruptured obstetrical technologies, resilient birth: Women's stories of childbirth during the 11 March 2011 earthquake in Japan

Vladimir Ariza: Maling a "binomio". An exploration of "humanitarian objects" and their incidence in the relationship between mothers and child in the "1000 dias" program in Puerto Carreño, Colombia

Kateryna Moskalenko; Legal Regulation of Posthumous Reproduction in Ukraine

Yael H Dolev and Zwi Triger: Posthumous Reproduction in Israel: the alliance between familism, pronatalism, bereavement, militarism and patriarchy

[Panel 1 D, room 2.1.121, Klimagangen](#)

### **Reproductive technologies of life and death and Islam**

Chair: Mutlu Burcu

Tara Asgarilaleh: Assisted Reproductive Technologies in the Islamic Republic: Infertility, Inequality and Masculinities in Iran

Jess Marie Newman: Subjectivizing Therapeutic Abortion between law, islam, and prenatal diagnosis

Mutlu Burcu: The ethico-politics of uterine transplantation in cisgender women from deceased donors in Turkey

[Panel 2 D room 2.1.121, Klimagangen](#)

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Amarpreet Kaur: Reproductive technologies: The judge and jury of death before birth

Marie Hintnausová: Prospective and non-prospective pregnancies: ontological effects of PND in Czech Republic

Jung Chen: Gendering the beginning of life: Taiwanese gay fathers' decision-making on embryo sex-selection

Ayo Wahlberg: Selection and the normalization of "quality of life"

[Panel 3 D, room 2.1.121, Klimagangen](#)

### **Death during surrogacy and in the use of assisted reproductive technologies**

Chair: Malene Tanderup

Orit Chorowicz Bar-Am: "Death during surrogacy and in the use of assisted reproductive technologies"

Malene Tanderup: Impact of the war in Ukraine and the Covid 19 pandemic on transnational surrogacy- A qualitative study of Danish infertile couples experiences of being in "exile".

Catarina Delaunay and Luis Gouveia: Mourning and bereavement outside the clinic: dealing with embryo loss and grief within assisted reproductive technologies

Manon Lefevre: From the laboratory to the cemetery: Ontologies of embryo life and death collide

## Keynotes Abstracts

### Kate Reed

Professor of Sociology &  
Director of the Sheffield Methods Institute  
University of Sheffield, UK.

#### **'It's just part of the job': exploring the role of care in perinatal post-mortem work**

The concept of 'care' has been used by sociologists to explore a range of practices (including nurture, protection and work) in various settings - from children's homes to residential care for older people. Care is also often the central focus of sociological research on health, palliative or end of life 'care'. In contrast, existing studies on post-mortem have frequently focused on forensic pathology, and on the scientific rather than the emotional or care work that takes place during a post-mortem examination. Drawing on data from an ethnographic study on the development of Minimally Invasive Autopsy (MIA), this paper will explore the role of care in perinatal post-mortem work. It will uncover a range of latent care practises enacted by different health professionals (from pathologists to radiologists and midwives) which take place in the mortuary, maternity unit and radiology suite. As data shows, care practises, although hidden from the views of the public (and from some other clinical staff), are often crucial to parent and professional experience of the post-mortem process. By uncovering some of these hidden care practises the paper will contribute new knowledge to existing research on post-mortem practice, and, significantly expands sociological understandings of the concept of care.

### Monica J. Casper

Professor & Special Assistant  
to the President on Gender-Based Violence  
Department of Sociology  
San Diego State University, US

#### **Birthing Death: What Infant and Maternal Mortality Reveal About Social Inequality**

Drawing from her recent book, *Babylost: Racism, Survival, and the Quiet Politics of Infant Mortality, from A to Z*, as well as three decades of research on human reproduction, Dr. Casper will explore the relationship between premature death and social inequality. An axiom of medical sociology is that some people "get sicker and die quicker" than others, and this is poignantly true in reproductive health. Globally, infant and maternal mortality rates are shockingly high given what we know about how to save lives and the technologies available for doing so. In the twenty-first century, it is both tragic and sad that pregnant people and their babies die before, during, and after birth. Yet, it is deeply shameful that a vast number of these losses are *preventable*. Moving through history, sociology, economics, and politics, the talk will encompass structural questions of governance, quantification, and social investment alongside intimate concerns of grief and loss. At the heart of Dr. Casper's research program on reproductive health are enduring questions about who gets to live, whose deaths are accelerated, and why we should care.

## Thomas Lemke

Professor of Sociology  
Goethe University  
Frankfurt am Main, Germany

### **Beyond Potentiality and Latency: The Chronopolitics of Suspended Life**

The talk brings together two disparate and so far largely disconnected bodies of research: the critical analysis of cryopreservation technologies and the debate on modes of anticipation. It starts with a short review of the state of the debate on the concept of cryopolitics. In the next part I will suggest two revisions. I will problematize the concept of latent life and the focus on potentialities that have been central to the research on cryopolitics so far, proposing to shift the analytic frame to suspended life on the one hand and to modes of anticipation on the other. I argue that cryopreservation practices are part of contemporary technologies of anticipation. They are linked to a politics of suspension by mobilizing a liminal biological state in which frozen organisms or biological material are neither fully alive nor ultimately dead. This seeks to avert and/or enable distinctive futures by extending temporal horizons and keeping vital processes in limbo.

## Chia-Ling Wu

Professor of Sociology  
Department of Sociology, National Taiwan University  
Taiwan

### **Anticipatory Regimes of Fetal Reduction**

Fetal reduction is a clinical procedure utilized to reduce the number of fetuses in cases of multiple pregnancies, primarily stemming from assisted reproductive technologies (ARTs) since the 1980s. Its primary objective is to mitigate the reproductive risks associated with multiple pregnancies, yet it introduces new physical and moral complexities. This practice is perceived as a "technology of repair" by some and "risky medicine" by others, underscoring its multifaceted nature. The global implementation of fetal reduction varies significantly, with some countries integrating it into their ART protocols while others rarely employ it.

This presentation delves into the concept of "anticipatory regimes" surrounding fetal reduction, drawing mainly from extensive fieldwork and interviews conducted in Taiwan and Japan spanning from 2005 to 2021. The first part of the presentation elucidates the "anticipatory governance" of fetal reduction in both countries. It scrutinizes how key stakeholders, including pioneering scientists, medical professionals, government bodies, media, infertile couples, feminist groups, and civic organizations, emphasize distinct aspects of anticipation—maternal well-being, fetal survival, moral implications, success rates, and medical advancements—to shape the divergent pathways of fetal reduction regulation in these East Asian nations. While fetal reduction remains contentious and potentially violating abortion laws in Japan, it transitioned from being perceived as a medical breakthrough to an integral component of the ART network in Taiwan. This contrasting model in anticipatory governance is rooted in (1) power dynamics among science, the state, and society, and (2) distinct national sociotechnical visions of assisted conception, ranging from viewing IVF as a contentious innovation to embracing it as a source of national pride.

I then examine the "anticipatory labor" among Taiwanese women carrying multiples in the context of fetal reduction. Anticipatory labor refers to the thinking and actions taken by women during pregnancy to achieve perceived better futures.

The presentation discusses two dimensions of anticipatory labor. First, it highlights women's ability to conduct a technological assessment of fetal reduction. Some women view fetal reduction as an unreliable or problematic technology due to its potential to cause miscarriage or total pregnancy loss, its risk to the safety

of the remaining fetuses, and the uncertainty surrounding how doctors can accurately determine the fittest fetuses during the procedure. Ethical guidelines and medical communication should, therefore, consider women's critical evaluations of medical technology. The second aspect of anticipatory labor is information navigation. Those who consider fetal reduction as an option often need to navigate and clarify complex and conflicting opinions, advice, and support offered by doctors, family members, and religious traditions. I highlight the fetocentrism and marginalization of women's health risks and social needs in the navigating processes. What is most problematic is that health professionals in Taiwan do not have an official guideline, and individual doctors in different specialties and with different values offer opposing directions. I suggest that a detailed guideline based on global and local data and evidence should be available for women as one of their resources for enhancing their analytical and reasoning skills.

## Abstracts for presenters

### Panel A

#### Self management and abortion technologies, Panel 1 A

Carrie Purcell, Victoria Newton, Fiona Bloomer and Lesley Hoggart: Self-managed medication abortion supported via telemedicine: Experiences during Covid-19

Abortion continues to be a criminal offence in Scotland, England and Wales, except in strictly defined circumstances. Its availability across the United Kingdom (UK) is inequitable, including in Northern Ireland where it has been decriminalised, but where provision is yet to be effectively established.

There is extensive international evidence on the use of telemedicine to support safe abortion outside of a formal healthcare setting, as indicated in the Royal College of Obstetricians and Gynaecologists best practice guideline (2022). However, until recently, this mode of ending a pregnancy was not permitted in the UK. A change in policy due to the Covid-19 pandemic enabled telemedicine-supported self-management of medication abortion under 10 weeks of pregnancy to become a reality in parts of the UK from mid-2020 onwards. Evidence suggests this mode of abortion provision is safe, effective, and predominantly acceptable to those who have experienced it. It appears that the option for abortion to be self-managed outside of a clinical context will now continue.

The potential for self-managed medication abortion to challenge paternalistic models of care and foster reproductive autonomy has long been of interest to scholars of sexual and reproductive health. The changes this might facilitate were first mooted with the introduction of the 'abortion pill' in the 1990s, and much of the grassroots/activist discourse in this area cites the empowerment associated with putting control over abortion into the hands of the pregnant person. However, these questions of autonomy and control are far from settled, as are those around how people undergoing early medication abortion experience the process and might be best supported.

We designed a study to explore in-depth how early medication abortion outside of a clinical context - what we have termed supported self-management (SSM) - is experienced and understood. We present a thematic analysis of semi-structured telephone interviews with 17 women who had undergone SSM across the UK at the height of the Covid-19 pandemic.

Our analysis suggests that the concept of 'social connectedness' offers a lens through which to understand experiences of telemedicine-supported self-managed abortion. Key elements of connectedness in this context were feeling cared for (including a sense of trust and connection with health professionals); connectedness at home; and what can occur in the absence of connection (including isolation and fear of the unknown).

Our findings contribute to understanding to what extent and how the availability of self-managed medication abortion opens up options to those with a pregnancy which they cannot or do not want to continue, as a shift from clinic-based care to telemedicine-supported self-management becomes established practice. We explore the wider implications of our findings in the context of global abortion politics and reflect on the overall implications for the de-stigmatisation and normalisation – including potential decriminalisation – of abortion more broadly.

## Lynn Thomas: From North Carolina to Nairobi's Ward 6: An abortion technology for saving and enabling lives

When Kenya became politically independent in 1963, its male leaders retained a British colonial law that rendered most abortions illegal. Abortion was common but largely unsafe and illicit. By the 1970s, doctors and nurses in Ward 6 – the obstetrics and gynecology emergency ward at Kenyatta National Hospital in Nairobi – faced a dire situation. At certain times of year, upwards of twenty women arrived daily with incomplete and sometimes septic abortions, demanding that their suffering bodies be treated. Treatment entailed dilation and curettage (D&C), a surgical procedure that required general anesthesia and an operating room. Women could wait days and even die before care was available.

In 1987, a group of white second-wave feminists from North Carolina arrived in Nairobi with a technological alternative in their checked luggage: manual vacuum aspiration (MVA) kits. The feminists were employees of International Pregnancy Advisory Services (IPAS), a non-governmental organization founded by population control hawks in the early 1970s that, by the 1980s, had shifted its stated mission from reducing fertility rates to combatting the “pandemic of septic abortion.”

IPAS's MVA kit consisted of a flexible plastic tubing and a syringe. It evacuated the uterus through suction rather than a sharp instrument and did not require an operating room or even electricity. MVA was equally effective at completing abortions as inducing them. Dr. Khama Rogo, the medical director of Ward 6, quickly recognized MVA as a faster, cheaper, and safer way to manage his overwhelming caseload. Several months later, an American ob/gyn, temporarily working on Ward 6, marveled at the transformation. When he returned to the United States, he introduced MVA to his hospital in Baltimore.

In my current book project on the global history of abortion since the 1970s, I take the dissemination of MVA kits from North Carolina to Baltimore via Nairobi as a revealing episode. By tracking the movement of abortion technologies and politics, I aim to deprovincialize post-Roe discussions, by making them less American-centric and by demonstrating how current struggles emerged through international developments.

My conference presentation will focus on one aspect of this longer history: the introduction of IPAS's MVA kits to Nairobi's Ward 6 in the 1980s. I'll explain how this abortion technology was framed as a life-saving and life-enabling technology in two different ways. First, IPAS promoted MVA as safe and effective way to treat incomplete and life-threatening abortions that had turned septic. This framing sidestepped the issue of abortion's legality by focusing care on completing abortions started elsewhere. Second, IPAS promoted MVA as helping to prevent future infertility, one of the common complications resulting from septic abortion. MVA appealed to Rogo and other clinicians on Ward 6 because of its safety and efficiency. What was developed in the United States as a Cold War tool for staving off overpopulation and communist insurrection became, in Kenya and elsewhere, an instrument for managing women's health crises in public facilities increasingly strained by structural adjustment or neo-liberal policies. Like other birth control technologies through the twenty and twenty-first centuries, MVA kits spread through the turbulent confluence of top-down efforts to manage populations, and bottom-up struggles to survive and thrive.

## Noga Friedman: “Abortion would be seven thousand times harder for me”. Permanent contraception and reproductive citizenship

In Israel, permanent contraception is marginalized and socially criticized for its irreversibility. The pro-natalist ideology in Israel is prominent both socially and in terms of policy, which is reflected in unprecedented state funding of fertility treatments and virtually no subsidization of contraception. The proposed paper focuses on tubal ligation in Israel and its subjective meanings through the analytical framework of responsible reproductive citizenship developed by Caroll & Kroløkke. Though this term usually refers to the self-managing of future fertility, it is also a useful lens for examining the decision to end reproduction. Through 16 in-depth interviews with women who chose to have tubal ligation or salpingectomy, the paper

explores how women negotiate and make sense of the procedure, through the connections they draw between it and two other life-and-death reproductive technologies: IVF and pregnancy termination. Shaped by their past reproductive experiences, and against the backdrop of the Roe V Wade overruling, placing permanent contraception within this triangle of reproductive technologies enables participants to defy local temporal reproductive scripts and justify their contraceptive choice as enacting responsible reproductive citizenship.

## Visualization technologies, law and abortion, Panel 2 A

Pam Lowe, Rebecca Blaylock, Patricia Lohr, Lesley Hoggart: Seeing the Scan: Fetal Images in Abortion Care

Ultrasound scans in abortion care are a complex issue. From a clinical perspective, in the WHO guidelines they are recommended when needed for issues such as ruling out ectopic pregnancy or determine gestational age if this is not known. In some countries, such as the USA, ultrasound scans are mandated to enforce gestational age limits for abortion, and some anti-abortion statutes have mandated the viewing and/or audio description of scan images during abortion consultations. This enforced viewing of ultrasound images arises from twin anti-abortion beliefs that healthcare professionals mislead women about abortion, and that seeing the images will awaken 'maternal feelings' that have been suppressed through fear, coercion or the 'abortion culture'. This anti-abortion position is based on assumptions that there is a singular and universal reading and understanding of fetal images that arises from their understanding of abortion.

All encounters with fetal images, however, take place in the broader contemporary socio-cultural context in which the once hidden fetus has become a ubiquitous image and carries a range of symbolic meanings in terms of pregnancy, motherhood, and family life. Ultrasound technology, with its accompanying sharing of images, has contributed to fetal prioritisation, and this has consequences for those who do not wish to continue to be pregnant.

This paper arises from qualitative research on experiences of ultrasound scanning within abortion care in Britain during a time when clinical practice was shifting from universal scanning to ultrasounds only when clinically indicated for medical abortions up until 69 days' gestation. All twenty participants had undergone more than one abortion, one with and one without an ultrasound scan, and the interviews sought to draw out the practical and emotional comparison they made between the two experiences.

This paper will focus on two particular themes, first, ultrasound as an unwelcome intrusion in patients' abortion care, and second, ultrasound scanning as a symbolic reminder of normative, continuing pregnancy trajectories. Overall, the paper will argue that the inclusion of ultrasound scanning in abortion care can be considered as a technology 'out of place'. Its association with antenatal care and the development of future family members creates an uncomfortable liminal space for those seeking abortion. The entrenched social life of ultrasound scanning ascribes the misplaced role of 'mother' to the abortion patient, resulting in (internal) stigmatisation when they deviate from this norm. Whilst evidence from elsewhere shows that ultrasounds do not usually alter abortion decisions, our paper will show that being required to have an ultrasound scan is likely to have a negative emotional impact on abortion patients, regardless of whether they view the image or not.

Tracy Weitz, Hillary Gyuras, Danielle Besette and Michelle McGowan: Ultrasound and Abortion: Technological determinism and state control over the meaning of life/death



This paper is part of a larger project on the social history of ultrasound in the context of abortion. In it, I specifically examines the Ohio “heartbeat bill” which banned abortions after the detection of embryonic cardiac activity on ultrasound imaging. The law took effect in June 2022 as a result of the U.S. Supreme Court’s overturning of *Roe v. Wade* and was in effect for three months. By moving across macro, meso, and micro levels of analyses, I expose the role of technological determinism in the (re)production of reproductive governance (Morgan & Roberts, 2012), the medico-legal paradigm (Assis & Erdman, 2022), and stratified reproduction (Colen, 1995).

In this paper, I question how this legal regime developed and operated using numerous sociological theories to describe from whom and how compliance occurred without significant resistance. To explain the perspectives of those seeking abortions, I draw on a series of interviews with women who sought abortion care in Ohio when it was enforcing both its “heartbeat” bill and a 24-hour waiting requirement. Specifically, I share the experiences of women who had a negative ultrasound on visit day one and a positive result on day two resulting in a denial of an abortion. Several themes emerge including governmentality (Foucault et al., 1991), the belief in the necessity of legal abortion for a safe outcome, and divergence between technologically-defined fetal life and embodied pregnancy. Structural inequalities determine eventual abortion attainment and thus the perpetuation of stratified reproduction.

To explain, physician compliance I follow the historical transition of their discretion over pregnancy determinations from multiple assessments points to a single ultrasound reading. From there, I find that the rigid operationalization is taken up by abortion opponents who use ultrasound capability to move the gestational markers for meaningful fetal life and thus further abortion restrictions. I look to theories of necropower (Mbembe & Corcoran, 2019) to explain how anti-abortion terrorism became the mechanism for public surveillance required for strict physician compliance. Yet, I note, none of this possible without physicians’ belief in the “truth” present on ultrasound imagery.

The paper concludes by challenging the idea that societies can resolve conflicts over the meaning of life/death by deferring them to medicine, law, and technologies when those things themselves are structured by systems of oppression that create stratified reproduction.

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[Alysa Basmajian: Creating life by manufacturing a “heartbeat” with ultrasound technology.](#)

Technologies have a life of their own in how they are interpreted not only by medical staff, but also legislative bodies. After the United States Supreme Court released the *Dobbs v. Jackson Women’s Health Organization* (2022) decision overturning the right to an abortion, Ohio Senate Bill 23 was implemented, banning abortion after a “heartbeat” is detected or around 6 weeks of pregnancy when most people do not know they are pregnant. Three months later, abortion access was restored to 21 weeks and 6 days, but

these fluctuations in policy have severe consequences for patients and providers. “Heartbeat” bans, in particular, promote medical misinformation and shape the language that is used to describe different stages in pregnancy. Medical misinformation in state legislation shapes clinical care for abortion because medical staff must determine whether or not an ultrasound has detected a “heartbeat,” yet this is an arbitrary parameter. In fact, at about 6 weeks of pregnancy, the heart has not yet developed; the doppler sounds emitted from the ultrasound are embryonic electrical pulses, not a fully formed heart as state legislation suggests. During my conversations and interviews with healthcare workers, I have been careful to attune myself to the language that they use and have found that some healthcare staff use the terms “fetal heart tones” or “cardiac activity” to describe what legislative bodies determine to be the “heartbeat.” Through this paper, I question how legislation mandating the use of ultrasound technology to determine when a “heartbeat” is detected shapes both medical and colloquial discourse around abortion and personhood.

## Abortion, wombs and ethical and legal reflections, Panel 3 A

Dunja Begovic and Elizabeth Chloe Romanis: Language and Abortion: Addressing the rethoric of 'killing' in debate, practice and policy

In recent years, the medical ethics literature has seen a resurgence of debate on the “morality” of abortion. Some of this work considers the morality of abortion in any circumstances, and some in specific scenarios (such as reducing a twin pregnancy to a singleton by aborting one of the foetuses). Much of this literature has a distinct inclination against abortion, evident in the use of certain language: for example, describing abortion as ‘killing’ or ‘murdering’, and the entity killed as a ‘baby’ or ‘person’. A recent edited collection exemplifies this trend in a new wave of anti-abortion literature and the use of emotionally charged language in abortion ethics (Colgrove, Blackshaw, and Rodger 2022).

Against this backdrop, while the global norm is towards recognition of the importance of abortion, in some jurisdictions there remain considerable challenges to access to abortion, while in others such obstacles have recently been exacerbated. For example, in the United States, the repeal of the constitutional right to abortion (Dobbs v Jackson 2022) has seen access even further decimated. In Poland, the recent ban on abortion for fatal foetal abnormality (the last legal ground) has resulted in the death of several women (Schwartz 2022). In many of the jurisdictions where abortion is increasingly criminalised and vilified, rhetoric propagated by the state and by the media is often very similar to that which increasingly features in academic discussion.

In this atmosphere of abortion rights being both contested and fragile, in theory as well as practice, our paper asks the question: what might be the impact of academic scholarship about the morality of abortion, and the language it uses, on practical developments? We consider, from an ethico-legal perspective, what the obligations and responsibilities of authors and editors are in the way that abortion is presented and discussed in academic and public-facing forums.

We argue that the choice to use the language of ‘killing’ when discussing abortion, or to conceptualise the foetus as a ‘person’ or ‘baby’ without explanation or justification, is not value neutral but ‘an argumentative and rhetorical move’, especially where it is not acknowledged (Begović, Romanis and Verweij 2021). Equally, we problematise the assumption that “the ethical” operates in an entirely different sphere from “the political,” (Romanis and Horn 2020) and explore what the possible impact of this language in abortion discussion may be. Some have argued that academic literature often translates to political opinion and public discourse because it can be used by advocacy groups/politicians/journalists as authoritative support (Romanis and Horn 2020). The use of certain language can have ‘emotional undertones which may skew the discussion in a certain direction’ and can also have significant implications for the experiences of abortion-seekers (Begović, Romanis and Verweij 2021). We suggest an effort should be made, by authors and editors, to move away from certain types of abortion rhetoric in academic debate that are also employed by anti-abortion movements, due to the potential broader impacts of this on the experiences of abortion-seekers, and access to abortion in general.

Mio Tamakoshi: The Techno-legal Environment of Multifetal Pregnancy Reduction: A comparative case study of Italy and Japan

This study investigates multifetal pregnancy reduction (MFPR) as a case for the interaction between medical technology and legal development. MFPR is a first-trimester or early second-trimester procedure to reduce

one or more live fetuses in multiple pregnancies. Since the 1980s, MFPR has been utilized due to the increased number of multiple gestations following medically assisted reproduction (MAR). Whereas MFPR is regarded beneficial to reduce the higher risk of complications associated with multiple pregnancy both for the fetuses and the mother, it invokes legal and ethical issues conventionally associated with abortion and life selection. Although some technologies and practices have been developed to avoid multiple pregnancy following MAR from the first place, the availability of these circumventory measures is constrained by institutional settings, such as the legal status of embryos, the affordability of relevant MAR treatments and the accessibility of abortion. By looking comparatively at the cases of Italy and Japan, the study explores how technologies and practices surrounding MFPR have been developed in interaction with respective MAR and abortion regulations, shaping the stratified experiences of multiple pregnancy. The current policy landscapes surrounding MAR and abortion are similar in Italy and Japan: there have been governmental efforts to increase the access to fertility care in both countries, while the access to abortion has remained more restricted in practice than legally stipulated. Furthermore, neither of the countries has nation-wide regulations specific to MFPR. Despite such similarity, the medical and legal trajectories surrounding MFPR are significantly different between the two countries; whereas MFPR has been widely practiced in Italy, there are few clinics which openly deliver it in Japan today. Drawing on the tradition of comparative studies of policies in STS, the study conducts interpretive analysis on MFPR-related litigations, debates among the national gynecologist associations as well as government committees. The study shows how reproductive technologies and practices interacting with the (absence of) regulations shape the experiences of multiple gestation and MFPR in the two countries. The analysis is prospected to demonstrate that the highly regarded status of embryo in the Italian IVF law has paradoxically rendered MFPR more available to the extent that MFPR upon request is practiced, whereas the aversion of strict regulations on reproductive technologies in Japan has allowed the development of technologies and practices to prevent multiple gestation following MAR while leaving both the practitioner and the patient who resort to MFPR legally vulnerable.

#### Ji-Young Lee: Artificial Amnion and placenta technology (AAPT) and abortion: Confronting the “Death of the Fetus”

What is now commonly known as artificial “womb” technology is being developed in light of the aim to help the survival rates of pre-term infants. More precisely, artificial amnion and placenta technology (AAPT) is viewed as the most promising pathway to improve the health and life prospects of pre-term infants, given that neonatal care as it stands is associated with significant morbidity and long-term damage. The notion that a neonate might complete gestation in an artificial placenta is known as ‘partial ectogestation’. While AAPT is therefore proposed as a better alternative to neonatal intensive care units (NICU), the long-term hope is that AAPT will be able to sustain ‘neonates’ even earlier than our current standard of viability (>22~24 weeks) to replace the palliative care that is usually recommended for neonates below viability. This theoretical possibility has prompted some to suggest that ectogestation might resolve the issue of abortion, or at least provide an alternative to it. The thought here is that if it were possible to ‘extract’ the fetus early on from a pregnant body and integrate them in an artificial placenta instead, pregnant people can choose to effectively end a pregnancy without having to bring about the death of the fetus, unlike a traditional abortion. Thus, it appears on surface that both pro-choice and pro-life advocates might have their principles satisfied.

Yet, renegotiating what is implied for abortion rights due to the advent of AAPT promises to be a complex issue. Because most pro-choice arguments for abortion are premised on bodily choice and autonomy, questions about choosing whether the fetus should continue to develop independently of the human body at such early stages of development have not yet had to be invoked. Currently, abortion is legal in Denmark for pregnancies up to 12 weeks (except in special cases, where the pregnant person may apply for a late-term abortion) and abortion as we understand it, of course, necessarily implies the death of the fetus. Once

abortion can be disentangled from the death of the fetus, however, we will have to reckon with a fresh set of challenges to pregnant persons' reproductive autonomy. The possibility of continued 'life' for the fetus at any state of its development will, I argue, generate fresh justificatory schemes that might compete with the pro-choice model for the justification of abortion – thus, I anticipate that justificatory schemes in favour of abortion will have to evolve towards figuring out what reasons, if any, can be articulated to justify the death of the fetus during various stages of gestational development.

### Aimee Middlemiss: In relation to the state: the biomedical administration of the boundaries of legal personhood and kinship in England

The relationship between law and biomedicine in the context of reproduction is often understood as one in which biomedicine is the driver of change. In this model, the law reacts to biomedical advances, for example in the regulation of new reproductive technologies such as IVF, or research using human embryos, because new scientific developments require new forms of legal control and administration by the state. In this paper, I argue that rather than being the determining force behind legal change, reproductive biomedicine is in service to more foundational ideas about the state and its relations to its citizens in the English context. This is partly because the institution of the National Health Service (NHS) provides universal healthcare including pregnancy care, abortion care, and some assisted reproduction which is directly delivered by the state through general taxation. However, biomedicine in England also acts as an agent of the state in the regulation of the production or non-production of new legal persons and their kin, and the certification of dead persons and their kin. Biomedicine administers the life and death boundaries of personhood and kinship, and this produces effects in relation to legal citizenship and the allocation of non-medical resources. The entanglement of biomedical and legal technologies in the context of pregnancy and the production of new persons and kinships can be analysed through the case study of second trimester pre-viability pregnancy loss in England. Investigation of women's experiences of foetal death, extremely premature labour, and termination for foetal anomaly brings into focus legal technologies of foetal viability, live birth personhood, and civil registration. It also shows the extent to which biomedical reproductive technologies, of ultrasound, prenatal screening, abortion, feticide, and neonatal care, are enlisted in support of the legal technologies and their production of living persons, dead persons, or no person at all. These inclusions and exclusions of the beings produced in pregnancy have a further effect on the recognition of their kin and the claims those persons might have on the state, for example regarding entitlement to pregnancy or death related time off work, or financial support. Biomedicine is thus co-opted into the governance of citizenship and the welfare state. This co-option is biopolitical, in terms of the direct administration of life and death on an individual and population level. It is also biopolitical in terms of administering the means of ongoing life: the resources of time and money distributed by the welfare state and others on whom the state lays an obligation to its citizens. As a consequence, the example of second trimester pregnancy loss in England shows that biomedicine enacts and enables legal technologies and the operation of the state by administering the boundaries of life and death in the reproductive context.

## Panel B

### Ambiguous reproduction, Panel 1 B

Andie Thompson: “The fetus falls of a cliff”: Oxidative stress relations at the nexus of the placenta

“Pregnancy is an ultimate state of oxidative stress” stated a placentologist researching biomarkers for predicting pathologies that occur during fetal development. Oxidative stress is a chemical imbalance caused by an overabundance of a molecule called reactive oxygen species (ROS), a type of biological messenger that talks to tissues directing physiological actions— such as energy metabolism and programming controlled cell death—to make way for tissue regeneration. “Cells need to breathe!” explains the placentologist. “In a prolonged state of oxidative stress, pressure builds up like if you were holding your breath, and the DNA in healthy cells starts to erode.” The placentologist directs my attention to a slide on his computer screen showing an image of two cells, one labeled “normal” with an ovular shape and bright pink nucleus, and another labeled “oxidative stress” with a misshapen wiggly oval, with a sad beige nucleus, covered in flecks of black material. “What happens if there is too much oxidative stress in pregnancy?” I asked. “The fetus falls off the cliff.” the placentologist replied, directing my gaze to another slide where a graph titled, “Measuring mitochondrial respiration in placenta tissue”, showed an X/Y linear curve tracking the relationship between various biomarkers and time spent in a state of intense oxidative stress with a dramatic drop-off point for fetal survivability.

Oxidative stress acts as a molecular messaging system that is responsive to environments outside of the womb, actively shapes the tissues around it, and interferes with the capacity of the placenta to breathe and nourish. Yet the role oxidative stress plays in fetal survivability is not well understood. The locations of both the exposure site— where pathology materializes as tissue damage, and the site of exposure— why cellular respiration responded in way that caused an imbalance is not the same across specializations in reproductive science. Where difference occurs, spaces for feminist interference open, exposing the social and political struggles implicit in scientific knowledge production (Mol, 2015).

In this paper, I consider what oxidative stress is made to be by examining differences in exposure sites and sites of exposure as they are conceptualized in three reproductive health research labs in Portland, Oregon. Drawing on interviews and observations conducted as part of an ethnography of toxic stress between 2020-2022, this analysis includes a perinatology lab that takes obesity as the exposure that pathologizes the placenta, an Assistive Reproductive Technology (ART) lab mapping epigenetic changes in placenta formation from exposures during ovocyte preparation, and a lab researching the impact social and environmental exposures prior to pregnancy have on placenta formation.

Placentas are relational organs (Yates-Doerr, 2023), an organ shared between two— or more— beings, that serves as a “thresholding object” (Paxon, 2023) buffering what passes through the maternal/fetal nexus and mediating the molecular activity that balances fetal life and death. By challenging the model of human physiology where reproduction, metabolism, and genetics are imagined to be isolatable systems (Landecker, 2013), what can oxidative stress relations reveal about survivability in environments where the materials to thrive are not evenly distributed, for whom and how reproduction can happen is socio-politically volatile, and the pathological potential of exposures across the life-course often left unacknowledged?

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### Bryan Lim and Mette Kragh-Furbo: Catalysing life: Exploring the tension surrounding folate as a reproductive technology

Folate, one of eight distinct compounds within the group of B vitamins, plays a vital role in cell growth and development and has long been a key area of concern for developmental biology, nutrition research and public health. Folate (and its synthetic form, folic acid) acts as an essential co-enzyme catalysing biochemical reactions that are critical to the synthesis of DNA and amino acids, as well as DNA methylation. Stated simply, folate catalyses life. Folate's ability to assemble life is perhaps felt most keenly by those who are able to reproduce: after all, the link between folate deficiency in mothers and the development of (often fatal) Neural Tube Defects (NTDs) in their babies, have been known for decades. It is no surprise then, that states have employed folate-as-technology by way of national flour fortification programmes to help tackle what is seen as a public health problem of folate deficiency. Yet persistent questions related to the possible adverse health effects of high doses of folic acid and recent scientific research arguing for a link between one's folate status and the development disease (Goldstein et al. 2019) suggest however, that flour fortification programmes may have far-reaching effects that impact not just those with the ability to become pregnant. Thus, while flour fortification programmes may certainly help to secure life/prevent birth defects, what sort of ideas about the body – both on an individual and population level – and biopolitical norms related to health and disease are reproduced, when a mother reproduces? When is too little/much folate a problem and for whom is this so? Focusing on the recent decision by the UK government to introduce the mandatory fortification of flour with folic acid, this paper explores the ongoing folate controversy to develop an account of the manifold ways in which mandatory fortification may be experienced and relatedly, of how actors come to become differentially entangled with folate.

### Mianna Meskus: Modulating death: Knowledge at the intersection of reproduction and ageing

This paper explores the beginnings and ends of life as increasingly intertwined, biomedically constructed and affectively charged phenomena. While much of previous research has focused on the (cryo)preservation of reproduction, I wish to add to the discussion the concomitant attention on the preservation and regeneration of aging. In the paper I ask, how are reproduction and ageing co-constitutive of each other through parallel scientific interest on regeneration and degeneration. Focusing on bioscientific knowledge and emerging laboratory-based technologies, I discuss ethnographic case studies where reproduction and ageing intersect, from the biological to the political level. Drawing from my field work on aging research in laboratories, conferences, and venture capital meetings, the paper analyses how death is being modified and modulated through the preservation of vitality and regenerated bodily potentiality. The setting of the paper arises from the observation that reproduction and ageing have become two pertinent public concerns. They represent demographic trends (fertility decline and growing longevity) that require various forms of intervention as national futures are seen to depend on their successful management. Yet, it remains unclear as to what kinds of human futures are being pursued. Technological modification of either or both of the phenomena, reproduction and ageing, open up biopolitical and personal questions about the boundaries between "the natural" and "the artificial" in life.

## Tine Ravn: The Social, Legal, and Ethical Implications of Research Concerning Embryoids in Relation to Human Embryos

Human embryos and early human development can be studied through the means of in vitro fertilization. However, the internationally agreed-upon '14-day/primitive streak rule,' adopted by the Warnock Committee in 1982, limits the cultivation of embryos in vitro to 14 days post-fertilization. Research into human embryos is strictly regulated in most countries, as it entails major ethical concerns in relation to the value of human life, attribution of moral status, and 'the morality of creating human embryos or "early human life" in vitro' (de Jongh 2022, p. 15).

Emerging organoid technologies have allowed for the creation of embryoids—3D structures or models created through pluripotent stem cells that can mirror aspects of the early stages of human development in vitro to help improve our understanding of issues such as infertility, miscarriages, and birth defects. As these models advance, a number of concerns arise regarding whether they can be perceived as comparable to human embryos, and hence regarding their permitted days of maturation and attribution of moral status. The absence of clear governance structures and the lack of a clear cross-national definition of a human embryo complicate the distinction from its embryonic counterpart.

In this presentation, I explore the potential social, legal, and ethical implications of developing embryoids for research purposes and examine parallels and consequences for human embryo research. In this context, I discuss how this emerging technology shapes our conceptions and understanding of creating early human life in vitro, potentially altering reproductive technologies and cross-country practices and policies. Additionally, I consider how terminology such as 'synthetic embryos' might foster certain public moral imaginings and cause uncertainty and concern.



## Care and grief after pregnancy loss and induced abortion, Panel 2 B

Sofie Mørk, Dorthe Hvidtjørn, Søren Møller, Tine Brink Henriksen, Maja O'connor og George Bonanno: Grief trajectories after loss in pregnancy and during the neonatal period

Distinguishing patterns of grief over time in parents with a loss in pregnancy or during the neonatal period is important for identification of parents with severe grief symptoms, who may need additional support. Our aim was to describe grief in this population and to examine variations by type of loss in a large prospective cohort. We used questionnaire data from the Danish longitudinal cohort, Life After the Loss, which contains information on parents with a loss in pregnancy (from 14 weeks) or during the neonatal period. Parents completed the Prolonged Grief-13 scale at 1, 7, and 13 months after their loss. We applied Latent Growth Mixture Modelling to identify prolonged grief trajectories and used multinomial regression models to assess factors associated with class membership. Three distinct trajectories were identified in 676 parents: resilience (73.1%), recovery (16.9%), and chronic (10%). The distribution varied by type of loss, and the chronic group were overrepresented by parents with stillbirths (16.2%) and neonatal deaths (16.1%) in contrast to parents with spontaneous abortions (8.2%) and termination of pregnancy due to fetal anomalies (6.2%). Furthermore, not having a living child or identifying as a woman was associated with following the chronic trajectory. These results underline, that while most bereaved parents are resilient, 10% may benefit from early interventions. Information on type of loss, gender, and whether the parent has living children can be used to target these.

Julia Böcker and Veronika Siegl: From hiding the foetus to seeing the baby. New norms and practices of “viewability” following pregnancy loss and induced abortion

Following pregnancy loss, foetal bodies and remains were for a long time hidden from the formerly pregnant women and quietly disposed as medical waste. In countries such as Germany and Austria – where our research is situated – it was only in the 1990s that a gradual change set in, initiated by affected patients/couples as well as midwives, and influenced by the rise of notions of foetal personhood. Today, the former silence around pregnancy loss has been replaced by an understanding that frames patients/couples as mothers/parents and the foetus as baby. As a consequence, midwives and other clinic staff are more likely to encourage, and even expect, affected patients to look at and possibly hold their foetus/baby, to take on a parental role and to mourn the death of a baby rather than foetal loss. This applies to spontaneous pregnancy loss as well as to induced abortions of wanted pregnancies (e.g., in the context of a severe prenatal diagnosis), albeit with slight differences.

In our presentation, we are particularly interested in discourses and practices that establish and uphold this new norm by focusing on the notion of “viewability”. Viewability refers to characteristics of an acceptable body appearance. In a first step, we discuss the norms and discourses that establish the foetus/baby as “viewable”. In a second step, we elaborate on the material repertoires (protocols, objects, spaces, technologies of storage, etc.) that facilitate or hinder “viewability” in hospitals and spaces of farewell. We, thereby, focus on two crucial sites, where these norms are circulated and solidified: the clinic and the Internet.

Based on the analysis of qualitative data – such as interviews and video blogs – we reconstruct the perspectives of two “expert” groups: parents who have experienced pregnancy loss and midwives who witness and accompany these losses. These two groups, we argue, predominantly provide an unambiguous set of interpretations and tools to make sense of pregnancy loss. A crucial issue is the way “parents” are supposed to deal with the foetal body. While such clear guidance can be helpful and consoling for those affected, there are also some repercussions. Firstly, this tendency towards disambiguation slips into a

moralization about “proper” ways of understanding and dealing with pregnancy loss, for example, when patients/couples who reject the “parental” identification and do not want to view and hold the “baby” are evaluated as “too weak”. Secondly, establishing norms and practices based on a framing of death may strengthen ideas of “unborn life” and foetal motherhood.

Li-wen Shih: Rearticulation of “Hsiao-Chan” (miscarriage, lit. small birth): Taiwanese women’s situated knowledges of pregnancy, life and loss

This article explores how understandings of miscarriage and pregnancy loss are affected by technoscientific practice, with specific considerations regarding life and death. Miscarriage is situated in a provocative liminal space - not really a death and yet not quite a birth (Withycombe, 2018: 165). It has been described both as a bodily ‘natural process’ and also an ‘abnormal’ end to pregnancy. Moreover, the limits of technological advances are challenged by attempts to detect temporal limits of miscarriage. Despite the ambiguous and uncertain nature of pregnancy, much of the knowledge about pregnancy loss has historically been articulated through technoscientific practice, thus shaping our understanding of reproduction. The pregnant body and the foetal body become the object of knowledge. On the other side, the subject of the pregnancy, unborn-pregnant bodies, in miscarriage remains silent. Along with feminist endeavours to break this silence (Layne 1997), many complex ‘tensions and frictions’ have also been acknowledged and explored (Kuberska and Turner 2019). While miscarriage remains a social taboo, experiences of pregnancy loss from women have more recently been re-articulated through social media and other records. With the popularity of the accounts of these different ways of experiencing the pregnant body and the embryonic/foetal body, a subjective knowing and experiencing of pregnancy loss has been amplified. This article argues for women’s re-articulation of their embodied experience of miscarriage as a production of ‘situated knowledges’ in relation to pregnancy loss (Haraway 1988). To explore the multiplicity of ‘presence of absence’ (Kuberska and Turner 2019), we aim to identify the novel expressions of women’s understanding of miscarriage in social media and analyse these as self-narrations of life and death. What are the contexts in these expressions of unborn-pregnant embodiment, what are their experiences of unexpected ending in pregnancy, and how do these experiences reshape understanding of life and loss? Based on an ethnographic study in Taiwan, in which 256 posts from a major social media platform and 40 interviews with women were analysed, this paper explores Taiwanese women’s re-articulation of pregnancy loss to understand how women address the ontological enacting of, and their embodied connection to, their miscarried embryo/foetus. In particular, we compare the miscarriage experiences of two groups of women: 30 women from who became pregnant through natural conception and 10 women from who became pregnant through assisted conception. By exploring ontological enactments of miscarriage in these two groups, this paper extends the discussion on pregnancy loss and biopolitical life and death. This comparison of situated knowledges of pregnancy loss contributes to discussions of body, life, and loss in reproductive studies and science, technology, and society.

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## Paula Martone and Anna Molas: Negotiating 'viability' of preterm infants on the ground: the experiences of parents and healthcare workers in Spain

The implementation of the first incubators during the second half of the 19th century and their later improvements entailed a revolution in premature babies' survival. These technologies marked a milestone as to how sick babies were considered and who was supposed to take care of them: the responsibility passed from mothers to healthcare professionals, enabling the development of a whole new ground of expertise.

This research focuses on the impacts of the technologies used for treating premature infants on the experiences of parents and healthcare workers. Through an ethnographic fieldwork in a public hospital in Barcelona -which included observation in consultations, at the NICU, and semi-structured interviews- we analyze the relationships between technologies, knowledges, and parents and workers' experiences during all stages of babies' treatment.

We argue that premature babies find themselves in a liminal state, between the poles of life and death, underscoring the necessity of a detailed analysis about their status within the hospital and the decision-making process on the kinds and the aims of the interventions that might be carried out. We conclude that although the concept of viability is central in these decisions, parents and healthcare workers define it in different ways, through different knowledges, desires, and future perspectives

## Care and grief after pregnancy loss and induced abortion, Panel 3 B

Dorthe Hvidtjørn, Natasia Hindsbak, Christina Prinds, Sofie Mørk and Joanne Cacciatore: Social and professional support after termination of pregnancy due to fetal anomaly

The death of an infant in the perinatal period can be a devastating loss and may affect the life of the parents with intense grief and feelings of guilt. The impact of bereavement can be influenced by the individual's social environment and support, but parents with a perinatal loss may experience inadequate social support leading to disenfranchised grief; a mourning that is culturally denied and lacks recognition. Also, whether the loss was a spontaneous death late in pregnancy (as in stillbirth) or the result of a termination of pregnancy due to fetal anomaly may be associated with the level of support the parents' experience.

The objective of this study was to assess bereaved parents' experiences of support at 1, 7 and 13 months after the loss according to type of loss, and furthermore, how support was associated with post traumatic stress syndrome and grief measured by the Perinatal Grief Scale.

We used data from the longitudinal Danish population-based cohort Life after The Loss including 1.200 bereaved parents answering questionnaires at 1, 7 and 13 months after the loss.

Preliminary results show a decrease in support over time. The highest level of support was found in partners, but also midwives scored high; 90% of participants stated that the midwife had been supportive to a high or a very high degree. The support from midwives was equally high for parents regardless of type of loss, whereas the support experienced from family and friends was significantly lower when the loss occurred as a termination of pregnancy.

## Dunja Begovic: The ethical challenges and implications of perinatal palliative care

Advances in prenatal diagnostics and therapy in the last few decades have meant that, when an illness or anomaly is detected in the fetus during pregnancy, prospective parents are sometimes faced with proactive options other than termination. For a subset of conditions, different types of treatment for the fetus are

possible during pregnancy that can go some way towards improving outcomes and quality of life once the baby is born. In other cases, life-limiting conditions may be identified that cannot be treated. Nevertheless, their detection can still allow those parents unwilling or unable to end the pregnancy to opt for a palliative approach, which focuses on symptom control before and after birth. Perinatal palliative care comprises interventions aimed primarily at comfort, carried out in the period up to and after birth, where there is a life-limiting diagnosis of the fetus/newborn.

When it comes to prenatal therapy, ethical discussion has arisen over the issue of whether we should consider fetuses to be patients, with clinical interests independent of, or even sometimes opposed to, those of the person gestating them. The fact that fetuses literally depend on the body of an autonomous individual for their continued existence seems to go against their independence as patients, even if they are sometimes treated so in the public consciousness, or by medical professionals. Yet parents opting for prenatal therapy often stress that they do so in the interest of their fetus, or future child, benefiting from the treatment. One way of understanding this could be as ascribing some sense of 'patienthood' to the fetus. Another way is to see these prenatal interventions as aimed not at fetuses or pregnant people, but the broader family unit whose creation or development they enable.

The practices involved in perinatal palliative care lend support to this conceptualisation, as they often focus on allowing families to plan for the entire lifespan of their babies, and on making memories during this time. These plans may not only involve parents but also other family members. In that way, perinatal palliative care could be understood as a way of helping families conceptualise the future child and its life trajectory and prepare for the particular experiences this may involve. This is consistent with the general focus of palliative care on families and not only allowing individuals to experience better deaths, but also helping their loved ones deal with grief and witnessing the end of life.

A potentially positive conceptual implication of perinatal palliative care, then, is overcoming the conflict model of pregnancy and reframing prenatal care in general as preparation for family formation. Some worry that the existence of perinatal palliative care could be used as a way to delegitimise abortion in certain cases, effectively forcing pregnant people to bring unwanted children to term and subject themselves and their families to pain and trauma. A family-focused approach like the one outlined above, however, must depend on the decision that the child is wanted in the first place. To realise its ethical potential, perinatal palliative care should not be seen as a competing option with abortion but as a resource for those who are ready to form a family with the awareness they will have only limited time with the child.

### Laura Louise Heinsen, Camilla Bruheim and Stine W. Adrian: Orchestrating Moral Bearability in the Clinical Management of Second-trimester Selective Abortion

In present-day Denmark, second-trimester selective abortion has become a regular medical event, which has turned selective abortion care into a routinized task for health staff. In this article, we explore what forms of care practices abortion providers in Danish public hospitals engage in. Using in-depth interviews, medical documents and social media data, we show that at the center of selective abortion care provision is not only securing safe medical outcomes, but moral labor orientated towards achieving a morally manageable medical event, permeating institutionally developed clinical guidelines, relational face-to-face care, and ideologically driven encouragement of parental-fetal attachment through the use of material objects and visibility practices. We propose to view these entangled realms of practices as aiming towards generating what we term "moral bearability", meaning that selective abortion care is orchestrated in particular ways to make the abortion, and the implied making and handling of death, simultaneously bearable for couples and health staff.

## Erica Millar: Second/third trimester abortions at the intersection of life and death

Abortion providers work with the materiality of foetal death and foetal remains. Sighting embryonic/foetal tissue, viewing foetuses via ultrasound, and ethically disposing of foetal remains is part of their job. There is, however, no readily accessible language in which to speak about the materiality of foetal death in a way that unequivocally supports abortion access, abortion-seekers, and abortion providers.

This is because speaking of and about the foetus is generally the preserve of anti-abortionists, who use graphic descriptions of foetal death, foetal pain, and the disposal of foetal tissue to narrativize abortion as abhorrent and disgusting. Pro-choice discourse tends to focus on the life-giving potentiality of abortion for pregnant people and can 'silence the material, everyday experiences of abortion providers' (Martin et al. 2017: 81).

This silence likely contributes to the unwillingness of medical professionals to be involved in providing abortion care, particularly at later gestations. In countries with liberal legislative frameworks for abortion, the shortage of trained and willing providers is a major barrier to access. Targeting this shortage by providing a positive framework in which to speak about abortion work, in its complexity, is critical to the pro-choice aim of expanding abortion access; and, as some provider-scholars have argued, failing to acknowledge the material reality of providing abortion care may ultimately be doing a disservice to the movement (Ludlow, Harris).

This paper contributes to building this language through drawing on interviews with abortion providers to examine how they represent providing abortion care at later gestations. Some medical professionals experience aspects of their work as uncomfortable or distressing, while, for others, there is nothing inherently distressing about providing abortion care at later gestations. There is a hesitancy in speaking about the more graphic dimensions of their work because of a fear that this may reinforce foetocentric equations of abortion (solely) with foetal death. Providers frequently distinguish between people who have abortions for 'social' and 'medical' reasons, which dovetails into legal and health care systems that facilitate abortion provision in one instance, while obstructing it in the other. Medical professionals uniformly speak of the practical and material dimensions of their work alongside a commitment to pregnant peoples' autonomy and the ethos of delivering patient-centred care.

Narratives of life and death entwine in the way providers speak about performing second/third trimester abortion. This paper concludes by thinking about whether the pro-choice movement needs to think more about how to hold foetal death together with the life-giving potential of abortion, and how providers' narratives of providing care may be one way to hold these tensions together with the aim of increased access.

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## Panel C

### Biopolitics and life and death, Panel 1 C

Karina Edouard: *Suspending Death, Enabling Life: Situating Doula-care as a critical reproductive technology in black maternal health.*

Midwives and doulas have historically played an integral role throughout Black birthing peoples' pregnancies (Cooper-Owens, 2017; Washington, 2007). With the medicalization of childbirth and rise of the medical industrial complex, however, the role of the "granny midwife" has been systematically and methodically replaced by an emerging class of White male professional obstetricians and gynecologists (Bonaparte, 2007). Until recently, scholars, policymakers, and public health providers have begun to reexamine the critical role of midwifery and doula-care as key mechanisms for addressing Black maternal mortality.

This paper will explore the ways doula care—or the non-clinical physical, emotional, and informational support birthing doulas provide to expectant parents during pregnancy—functions as a type of reproductive technology. Drawing on ethnographic research I conducted in a three-day birthing doula training, I investigate the ways doula-care disrupts and shifts biopolitical fields of intervention, which necessitate "the right to make live or let die," towards the suspension of death and enabling of life (Foucault, 1976).

According to a recent U.S. Department of Health and Human Services report, Black mothers are twice as likely to receive late or no prenatal care compared to non-Hispanic White mothers (2021). In addition, Black mothers are three times as likely compared to non-Hispanic White mothers to die from pregnancy-related complications—most of which are preventable (Center for Disease Control, 2020; 2022). Importantly, the presence of a doula during pregnancy has been shown to radically alter and improve Black maternal, as well as neonatal, health outcomes. In a 2021 report, the New York City Department of Health and Mental Hygiene, found that doula-assisted births were associated with lower rates of Cesarean birth, preterm birth, low birthweight, and postpartum depression, as well as with increased rates of breastfeeding. The association between doula-assisted births and improved Black maternal health is evidenced across the public health and biomedicine literature irrespective of geographical location (Falconi et al., 2022; Knocke, 2022).

Despite evidence on Black birthing peoples' maternal mortality rates and the positive effects doulas have on health outcomes, little research has been conducted on the relationship between doula-care, Black maternal mortality, and biopolitics. Through an ethnographic study of a birthing doula training, I attempt to scaffold a new biopolitics—one that locates doula-care as an important framework and reproductive technology to understand the mediation of life and death during Black pregnancies. What does doula-care reveal about the ways biopower is manifested at the level of reproduction—over matters of the womb and of the Black female body? How might we understand doula-care as a type of reproductive technology that suspends death and enables life among Black birthing people? How does doula-care reposition Black female voices in the biomedical treatment decision-making process, particularly in instances that might otherwise result in their premature death?

M. Mena, Jallicia Jolly, Carolina Coimbra: *Towards Black Reproductive Rights: Transnational Activisms and Strategies Among Black Birth Workers in Three Continents*

SisterSong defines reproductive justice as as the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.[1]  
-SisterSong Women of Color Reproductive Justice Collective

In our tears and agony, we hold our children close and confront the truth: The future is dark.  
But my faith dares me to ask: What if this darkness is not the darkness of the tomb, but the darkness of the womb?

-Valerie Kaur [2]

The participants in this panel—which range from doulas and organizers to academics and practitioners from the Black Diasporas—will examine the mobilization efforts of Black activists laboring for the reproductive rights of Black communities, especially, in the contexts of Portugal, Jamaica, the U.S., and Brasil. The participants will provide insight into the current state of reproductive care, including reproductive technologies, vis-à-vis the reproductive justice movement in these distinct nations—sites where Black folks have long histories tied to colonialism and to nation building. Whether they are the majority (Jamaica and Brasil) or minoritized constituents (Portugal and the U.S.), Black life in and outside the womb is largely understood to be precarious and largely devalued. How are birth workers within these communities making sense of policies, institutional practices and social attitudes that negatively affect the people they serve? In the wake of the COVID-19 pandemic, which exposed the fissures and fracturing of public health systems across the globe, what can birth workers tell us about what they are witnessing on the ground? It is not a surprise that this health crisis further exacerbated existing reproductive inequalities. Thus, the panelists will shed light on what those social and intersectional inequalities look like in these distinct contexts among populations that often experience multiple forms of marginalization.. What would centering the experience of queer Black birthing people, for instance, and uplifting their reproductive rights do to enable the end of technologies and systems that drive premature deaths among Black populations and beyond? What solutions may there be in place to protect Black life and to remake Black futures centered on the well-being of the Black Diaspora? And lastly, the panelists offer insights into the interventions that Black Diasporic feminists offer to their communities that resonate and can be adopted in service of life in general. This panel will shed light on how the presence or absence of reproductive technologies shape the experience of birthing Black people. In addition to addressing the conference’s main inquiries, the issue of social death in the wake of obstetric violence will also be analyzed.

[1] <https://www.sistersong.net/reproductive-justice>

[2] Valerie Kaur “Excerpt from “A Sikh Prayer for America” 2016

### Dr. Karla da Costa: "Obstetric Racism in Brazil: Knowing the Reality and Reflecting on the Consequences"

In Brazil, as in other countries, Black women are constantly the target of obstetric racism - before, during or after childbirth. This type of racism is configured as obstetric violence as a result of race, which in most cases is also associated with class and gender identity. Obstetric violence is manifested against Black women based on stereotypes, such as: hypersexuality, medical superbodies, resistance to pain and infantilization. A nationwide population-based study demonstrated the following scenario: Black women had a higher risk of having inadequate prenatal care; lack of attachment to motherhood; absence of companion; less local anesthesia for episiotomies; and greater risk of having inadequate prenatal care. Knowing this reality is an essential condition to begin to address this issue. At the same time, it is also necessary to reflect on the medical, social and emotional consequences that these systemic forms of disrespect, abuses, mistreatment and violence cause in the lives of Black women. In this way, as a researcher in public health and co-founder of the Association for Black Mother's Health (SaMaNe), whose intersecting identities include: Black, Brazilian, being an immigrant I ask: What are the possible socio-historical explanations for the high prevalence of obstetric racism in a country where 56% of the population is black? What are the consequences of this type of racism on the lives of Black women?



Bolette Blaagaard, Stine Adrian and Signe Nordsted: How Journalism Forgets: A case study of how practices of state issued and controlled IUDs to the Inuit population in Greenland were forgotten and then remembered in Danish Journalism

To some, journalism is the first draft of history. To others, newspapers are for wrapping fish the following morning.

When the Danish broadcasting corporation, Danmarks Radio (DR), in the summer of 2022 released five episodes of the podcast series Spiralkampagnen (the coil campaign), it won prizes and enabled the Greenlandic and Danish parliaments to set up a committee to examine the postcolonial policies and practices of birth and population control in Greenland in the 1960s and 1970s. Outrage ensued, when the podcast reported that girls as young as 13 were offered and fitted with the coil – some, it turned out later, without their consent. Arguably, the journalistic podcast set in motion historical events of postcolonial reconciliation and reparation.

However, this was not the first time the coil campaign had been journalistically covered and discussed. A search in the journalistic archive, InfoMedia, reveals that the campaign had been the topic of political and public debate ever since the conception of the idea of fitting half the Greenlandic female population in the reproductive age with coils. Moreover, the potential implications for the women's reproductive health were well known and reported in Danish newspapers at the time. Arguably, this half a century worth of news and debate were keeping fishes wrapped.

Postcolonial critiques have argued that journalistic discourses and representation of postcolonial subjects are paramount to the production of national identity and feelings of belonging (Said 1978; 1997). Moreover, sexual differentiation underscores and upholds the hierarchical relationship between Western subjectivity and its Others (Yeegenoglu 1998). From a postcolonial perspective, the postcolonial historical and sexualized context is foundational to journalistic discourses, because of the continued impact of colonialism. At the same time, postcolonial critique seeks to deconstruct journalistic discourses by reading the Western narrative and national identity construction against the grain (Said 1978; Grossberg 2002).

In this paper, we identify and unfold the postcolonial discourses on the coil campaign found in Danish newspapers from 1965 to 1994 (N=44). We uncover how the news reported on “explosive population growth”, “irresponsible sexual habits”, and offered unwarranted assumptions about “Inuit male contraception preferences”, which all helped justify the campaign. When Inuit women were asked about the campaign in the 1970s, their answers reflect insightful and nuanced postcolonial and feminist critique – in stark contrast to the rest of the reporting. The articles draw a clear picture of a former colonial state's (Denmark) paternalistic attitude and racist infantilization of especially Inuit women. This was a relationship in which reproductive technologies were used to police and control Othered women's bodies and sexualities.

Based on the analysis, we argue that while journalism has the potential to remember historical transgressions and give voice to people who have been wronged, in this case journalism has also been part of forgetting historical and technological policies and practices, thereby silencing the victims of the postcolonial population control. While Danish politicians seemingly recognize the Danish culpability in Inuit women's distress due to the journalistic podcast and the critique it produced, previous journalistic coverage helped enable the very practices that now call on acts of responsibility and apology.

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## Life/Death, viability and disaster, Panel 3 C

Tsipy Ivry: Ruptured obstetrical technologies, Resilient birth: Women's stories of childbirth during the 11 March 2011 earthquake in Japan

What can childbirth experiences in the midst of calamities – with the latter's capacity to rupture technological infrastructures, and to cause mass death – teach us about the technological remaking of life and death?

On 11 March 2011, an earthquake of unprecedented magnitude hit the northeastern coast of Honshu, Japan, followed by a tsunami that wiped out whole communities and caused a nuclear accident at the Fukushima power plant. Pregnant women, babies and children were among the earthquake and tsunami victims, but 11 March 2011 is also the birthday of more than 110 children. I focus on the stories of their mothers who felt the violent movement of the earth while in labor and the stories of their birth attendants.

Social researchers of childbirth agree that worst-case scenarios of deliveries gone awry with catastrophic consequences for maternal and neonatal health and life underlie the techno-medical routines of institutionalized childbirth. My paper looks at childbirth events that ended safely despite serious ruptures in techno-medical monitoring and surveillance. I collected these childbirth stories as part of a broader project exploring pregnancy, prenatal care, and prenatal diagnosis (with a focus on the inculcation of NIPT) as well as birth and obstetrical care in the midst and the aftermath of earthquakes in Japan.

On 11 March 2011, women and care providers navigated between two different types of risks: risks associated with birth in the techno-medicalised model of care and risks associated with earthquakes. Significantly, the techno-medical surveillance of risk associated with childbirth proved to be secondary to the risk of the hospital building collapsing due to the earthquake. Thus, women were disconnected from fetal monitors, walked between contractions and gave birth outside of the hospital, low-tech necessities and professional care proved crucial for the management of safe births. Midwives often rendered the unborn baby as pleading with the mother, "to keep fighting", in spite of the dire conditions, to encourage the women, and sometimes to revive women's will to live in the shadow of destruction and mass death. The childbirth stories told by women and their care providers suggest that childbirth, especially when attended by skilled birth attendants, can take place relatively safely anywhere, even in the direst of conditions, thus adding evidence to midwifery literature on iatrogenic effects of technology on childbirth and the importance of staying upright and mobile. Nevertheless, the new mothers remained uninterested in what could be interpreted as the resilience of the childbirth process. Rather, some of my informants were more occupied with their urge to apologize to the baby for having given birth to it in the midst of a mass disaster, and many felt uneasy about announcing the birth in the context of the mass death caused by the disaster. Disasters urge us to pay attention to death and technological infrastructures on a broader scale when considering how reproductive technologies remake life and death at the beginning of life.

Vladimir Ariza: Maling a "binomio". An exploration of "humanitarian objects" and their incidence in the relationship between mothers and child in the "1000 dias" program in Puerto Carreño, Colombia

Since 2018, Puerto Carreño (Colombia) has been at the centre of a humanitarian crisis that affects mostly migrant populations and binational indigenous communities; as a result, food insecurity and rates of malnutrition have increased among them. In order to tackle this situation, the Colombian Government has

implemented a program for the recovery of children at risk of acute malnutrition and underweight pregnant women called “1.000 días para cambiar el mundo” (one thousand days to change the world). This program includes activities of assessment of nutritional status and the distribution of food supplements to families; those actions are made through “humanitarian technologies” (Scott-Smith, 2013; Street, 2015) at the beginnings of life in order to respond appropriately to two temporalities: first, the urgent temporality of the emergency and the risk to people's survival, and second, the idea to protect early childhood (including the first two years of life), which is seen as “a window of opportunity” that is decisive for the quality of life (vitality) of the future citizen (Wahlberg, 2016). Following Ian Hacking (2007), these measures can be seen as configuring not only the goal of improving the nutrition of the targeted people, but also as “making” them, in this case, through the stabilizing of new links between pregnant women and children whose health and life are seen as ‘at risk’. This presentation is based on five months of ethnographic work in Puerto Carreño with the technical team in charge of the “1000 días” program, as well as the participating pregnant women and mothers. It draws attention to the ways that discourses, measurements and technologies promoted by global health programs for children and pregnant women are applied by local organizations in the context of a humanitarian emergency. Furthermore, my aim is to reflect on how different technologies -such as humanitarian objects- that link dynamics of measurement and intervention are imbricated in the “making” of Mother-Child dyads.

### Kateryna Moskalenko: Is There Life After Death? Legal Regulation of Posthumous Reproduction in Ukraine

Posthumous reproduction (hereinafter - PhR) is the conception or birth of the child after death of one or both of the child's parents. PhR is mostly required in 2 cases: for cancer patients, who cryopreserved their gametes or embryos before chemotherapy treatment or for military servants, who have stored their gametes or embryos before serving their military duty. In Ukraine PhR is not regulated at all, however there is huge demand for this procedure, because of brutal aggression of Russian Federation against Ukraine. A substantial number of widows desperately look for the possibility to give birth to a child of their deceased husbands, while Ukrainian legal rules are a fertile ground for certain improvement.

There is no consensus on regulation of PhR in Europe. E.g. ESHRE ethical guidelines on Posthumous Assisted Reproduction require that the gametes or embryos can only be put at the disposal of the surviving partner; the partner can only use the gametes or embryos for his or her own reproduction; an obligatory minimum waiting period of a year should be established to undergo PhR; the child born after PhR should be the legal fruit of the deceased parent and should inherit. Different countries in Europe regulate PhR in their national legislation. Moreover, the European Court of Human Rights (hereinafter – ECtHR) starts to consider cases on assisted human reproduction. A decision in *Petithory Lanzmann v. France* states that the right to become grandparent is not guaranteed by the European Convention on Human Rights. The ECtHR is now considering 4 applications against France on PhR and it is very interesting to see the outcome of these decisions.

As stated above, Ukraine does not regulate the PhR and in practice the following documents are prepared to undergo PhR: 1) notarized consent of the person to use his gametes/embryo after the death; 2) contract, signed by the potential parents and the clinics, regulating the cryopreservation of gametes/embryos and their usage after the death of one of the parents. There are four law drafts that are currently considered by Ukrainian parliament, each of them containing rules on PhR. However, these legislative initiatives do not regulate the questions of succession, possibility to retrieve gametes after the death of person and the possibility to withdraw consent to PhR. In my opinion, the mentioned drafts should be brought in line with the recommendations of ESHRE.

### Yael H Dolev and Zwi Triger: Posthumous Reproduction in Israel: the alliance between familism, pronatalism, bereavement, militarism and patriarchy

This article asks what enabled the sociolegal consensus around posthumous reproduction (PR) in Israel and the establishment of a new family model in Israel, which we called "The Extended Family of Choice." This model was created either when a young man died without a surviving partner, or when the surviving partner did not want to become pregnant using his sperm. In the second scenario, the parents seek to have a grandchild with a woman who did not know their deceased son. Our argument is based on analysis of the official discourse around PR, including caselaw published between 1997-2022, the Attorney General's directive, recommendations of a public committee, 5 bills, and parliamentary protocols. Our exploration of the legal rules' evolution shows that while the early bills focused on soldiers' sperm, the latest bill (from September 2022) applies to all Israeli citizens, with a unique framework for soldiers embedded within the inclusive language of the bill. The article argues that the Israeli covenant between familism, pronatalism, bereavement, militarism and patriarchy opened a wide gate to the revolutionary family model, and to a certain extent has also made this model mandatory in the context of soldier's deaths.

## Panel D

### Reproductive technologies of life and death and Islam, Panel 1 D

#### Tara Asgarilaleh: Assisted Reproductive Technologies in the Islamic Republic: Infertility, Inequality and Masculinities in Iran

This research examines how (in)fertile couples, men in particular, can access and utilize assisted reproductive technologies (ARTs) in the socio-cultural, legal, religious and medical context of contemporary Iran. Iran is among few Muslim countries in which ARTs, including the use of donor gametes and embryos, have been partly regulated by the state through the recent Increasing Population Policies, and more significantly, have been widely legitimized by religious authorities. Although the state partly subsidizes ARTs, they are not equally accessible to all. In Iran, infertility—a stigmatized condition—is considered a ‘woman’s problem’; male infertility is hardly recognized or discussed in families, society, or the social sciences. This ethnographic study will yield insights into male infertility and the use of ARTs in Iran, and how this relates to dominant notions of masculinity, and reproductive precarity. It will build on the following core theoretical notions—‘reproductive navigation’, ‘stratified reproduction’, ‘affect’, and ‘emerging masculinities’—and take an intersectional perspective considering gender, class and religion. For the Reproductive technologies and the remaking of life and death Conference in Denmark, I will present a critical review of the literature on masculinities and Iranian ARTs, and preliminary findings about my empirical research to date, in particular on men and their emotions throughout their reproductive journeys. I will show how in conversation with the literature I designed my study, in particular, at the times of COVID-19. I began with my empirical research in the autumn 2020 which was built on months of initial contacts and my previous research on a similar topic in Iran. The research methods include observations of online platforms used and shared by (in)fertile couples; interviews with couples, and medical professionals.

#### Jess Marie Newman: Subjectivizing Therapeutic Abortion between law, islam, and prenatal diagnosis

In this paper, I unpack the interplay between fetal medicine and therapeutic abortions to understand why fetal outcomes, although not legal grounds for abortion in Morocco, became a sticking point in deliberations about patient care at an urban maternity hospital. The policy void surrounding therapeutic abortions—how to interpret the law, how to assess “health,” whether Maliki bioethical views on ensoulment contravene medical decision-making, whether and how to get permission to perform abortions—pushed doctors into zones of indistinction in everyday medical practice. Doctors practiced a hybrid, protective, poly-temporal mode of subjunctive ethics rooted in “what-if” scenarios and conditional “if-then” propositions.

Maternal and fetal medicine forms a subjunctive frontier in daily reproductive healthcare. The ethnography in this paper unspools daily bureaucratic and clinical practices surrounding not-abortions—selective reductions of high-parity pregnancies using IVF—to destabilize biomedical frameworks of harm reduction. Staff practiced subjunctive medicine that patched the gaps between the routinization of prenatal diagnosis, a legal structure that excludes fetal characteristics from grounds for abortion, and authoritative bioethical discourses that lay claim to the fetus, in particular the Maliki opinion that ensoulment takes place during a window from conception to 40 days of gestation.

One senior physician summarized the situation he and his colleagues faced, by covering his eyes with his hands. He said, “We are Maliki. We think that the soul is there from the moment of conception. We close our eyes. It [abortion] is against religion. But we harvest several embryos and implant them in the uterus.

And after, what do we do with the other embryos? We throw them away.” He swept his hand across his desk as though clearing it of debris. “No debate, no questions. Do you think that religion can understand that?”

I suspect that this murky reality—in which fetal deaths may be necessary for other lives or modes of survival—was part of what destabilized doctors’ convictions that therapeutic abortion was unequivocally harm reduction. Selective fetal reduction procedures allow the maternal-fetal dyad to remain a single bioethical and therapeutic unit, rather than ending a pregnancy, full stop. This allows doctors to balance two otherwise competing goals: therapeutic abortion and preservation of fetal life. The ambivalence surrounding prenatal diagnostic screenings and selective reductions exceeds their connection to abortion politics per se. Rather, terminating pregnancies on the basis of fetal anomaly represents a substantive challenge to principles of harm reduction. Prenatal diagnostic tests and selective reductions are the only routine practices “in all of medicine for which the only treatment is death” (Erikson 2007, 209; see also). Although selective reductions may reduce suffering as a whole, they are practices at the uneasy threshold of life and death. Medical students and junior residents alike had to learn to function at the subjunctive nexus of fetal medicine and abortion politics

### Mutlu Burcu: The ethico-politics of uterine transplantation in cisgender women from deceased donors in Turkey

This paper investigates the ethico-politics of experimental uterus transplants from deceased donors as an emerging assisted reproductive technology in Turkey. Experimental uterus transplantation, ethically choreographed (Thomson 2013) to offer a better alternative to surrogacy (which is forbidden in Turkey), gives the promise of becoming a biological mother to cisgender women who do not have a uterus at birth or who experience uterus-related reproductive problems in some way. Celebrated as a source of techno-national pride and success in the Turkish media and in the medical world, the world's first uterus transplant from a cadaver was performed in Turkey in 2011 and resulted in a live birth about ten years later. The same medical team recently announced the birth of a baby from the second uterus transplant. Turkey has thus joined in global competition for performing the world’s first uterine transplants, that relies on “the unevenly developed geographies of global fertility chains” (Vertommen, Pavone, and Nahman 2022). With the support of the Turkish state, the possibility of biotechnologically transferring wombs between dead and living bodies to achieve live births further opens women’s wombs to new operations of (bio)value extractions and exchange (Nahman 2008). However, in this process, while recipient women (and their babies) have to shoulder the risks and responsibilities involved, the lives of donors whose wombs are used are anonymized and turned into invisible clinical labor (Cooper and Waldby 2014).

Combining feminist science and technology studies with medical anthropology, this paper will discuss experimental uterine transplantation as a socio-technological site of making life and death, in which women's (dead or alive) bodies are instrumentalized for the ideological and biological reproduction of the sacred (heteronormative) family, while the boundaries of assisted reproduction in Turkey are being ethico-politically negotiated. The paper is based on a discursive analysis of media representations, scientific articles, legal regulations and official religious discourses. In doing so, it will reveal how this experimental practice derives its ideological legitimacy from motherhood (compulsory, biological and intensive) sanctified by the discourse of sacrifice. In other words, experimental uterine transplantation, as an example of bio-prosthetic restructuring of the body, provides a fertile ground for revealing new forms that the limits and potentials of women's reproductive capacities have taken at the boundaries of life and death in the 21st century. These new forms are also important in terms of showing the lengths the politicization, technologization and commercialization of reproduction can go to in millennium Turkey and beyond.

## Genetic selection and life and death, Panel 2 D

### Amarpreet Kaur: Reproductive technologies: The judge and jury of death before birth

Reproductive technologies have long been used to prevent the birth of people genetic disease. First, screening and genetic testing during pregnancy enabled women to terminate a pregnancy if their foetus was found to have a genetic condition (Franklin, 1997). Then, following the introduction of in vitro fertilisation (IVF) in the late 1970s, the technology has increasingly been used as a platform to enable many other reproductive technologies, such as preimplantation genetic testing (PGT) and mitochondrial transfer (MT) (Franklin and Roberts, 2006; Dimond, 2018). Such technologies enable people with genetic disease to avoid having a child that has inherited their condition. They also enable couples whose combined DNA may result in a child having a genetic disease, from having a child with a genetic disease (Kaur and Border, 2020). In these latter cases, embryos created via IVF can be tested before they are transferred to a uterus. Embryos that test positive for a genetic disease can be discarded. In this context, reproductive technologies can be framed as the judge and jury of death before birth; they enable the provisional parents and healthcare professionals to terminate life before it has been born based on genetic markers.

However, in most cases, genetic testing only reveals whether an embryo has a genetic disease. Such testing does not determine how and the extent to which the person which could result from the embryo may be affected by a given disease (Rapp, 2000). There are some conditions which will result in a still birth or near immediate death following birth if an embryo with such conditions were to be gestated. In such cases, reproductive technologies may be said to detect death rather than to induce it. But, for most conditions reproductive technologies, such as abortion and PGT, may induce the death of an embryo even when the person which could result from it may have a good quality of life despite having a genetic disease (Boardman, 2014, 2017). Potential reproductive technologies such as human germline genome editing (hGGE) could circumvent the death of embryos which may be affected by genetic disease. This is because the technology would edit the genetic disease from the embryo (Kaur, 2021; International Commission on the Clinical Use of Human Germline Genome Editing et al., 2020)

This paper therefore explores why reproductive technologies are used to induce death in the light of genetic disease, and how they could be used to facilitate life in cases where death may have otherwise been chosen. The paper draws upon data from research undertaken in March 2018 to October 2019. The research consisted of an online survey of a tailored sample of 521 members of the British Public, 13 semi-structured interviews with professionals and experts who could speak to the landscape of hGGE in the United Kingdom, and structured interviews with 21 people affected by monogenic diseases. The data reveals people's emotions and attitudes towards using reproductive technologies as the judge and jury of death before birth.

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### Marie Hintnausová: Prospectives and non-prospective pregnancies: ontological effects of PND in Czech Republic

Reproductive technologies have changed Western perception of and relating to the prenatal existence of humans. Fueled with the embryological view on fetal existence (Morgan, 2009) and biopolitical management of human reproduction, biomedical biochemical and imaging diagnostics and testing (PND) have become an integral part of pregnancy care in the Czech Republic. My ethnographic research in 2020/2021 among Czech middle-class women who experienced prenatal or perinatal loss reveals different modes of care for pregnant women and their unborn children derived from assessments of pregnancies made with PND. Such differences emerged from different ontologies of the unborn: whereas fetuses assessed as healthy, developing, and livable incorporate hope for a future member of the society, a not-yet-born citizen (Berlant, 1997; Morgan, 2009); misdeveloping or dying fetuses present a failure to the biomedical management of pregnancy (Löwy, 2018) — and as such are regarded by professionalized care providers mainly as a (t)issue or failure. As Luc Boltanski (2013) refers to “project fetus” vs. “tumoral fetus”, similarly my ethnographic research reveals distinction between “prospective” and “non-prospective” pregnancies, enforced by Czech post-socialist reproductive policies that promote extensive prenatal testing and interventional approach to pregnancy and childbirth, accentuating favorable birth outcomes and competitive national health statistics. Such distinction of pregnancies is embedded in caring practices and biomedical, political and legal institutions, but may be opposed by affected families and bottom-up initiatives that challenge differentiation of care practices and treatment of fetal bodies based on their prospectiveness.

In 2017, a major legal shift emerged in the Czech legal system when a new act on burial services allowed arranging funerals to dead human embryos, fetuses or stillborn babies of any gestational age and acknowledged humanness of such remains. This legal arrangement was a result of continuous grassroots efforts that - through the right to bury - promoted humanness and subjectivity of the unborn (and continue to do so). This shift in the notion of fetal subjectivity was justified with fetal humanness and legal personhood, concepts fueled with arguments of the embryological view (Morgan, 2009). In the present, similar NGO initiatives address the differentiation in quality and adequacy of antenatal and perinatal care which is derived from the effectiveness of the pregnancy and strive to establish novel forms of (perinatal palliative) care which acknowledges not only fetal life, but also fetal death as one that deserves to be cared for, biomedically prolonged and make sense of its own.

In this paper, I want to explore how PND applied in the Czech healthcare system created different fetal ontologies and affects the experience of and care for pregnancy and perinatal loss in the Czech Republic. Various bottom-up initiatives show that reproductive technologies play an unambiguous role as they serve them with arguments that challenge notions of “prospective” and “pointless” fetal existence. On the other hand, authoritative PND techniques also enforce the biopolitical management of pregnancies and facilitate, as well as trouble the early, prenatal stage of the parental project (Boltanski).



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#### Jung Chen: Gendering the beginning of life: Taiwanese gay fathers' decision-making on embryo sex-selection

In 2019, Taiwan became the first country in Asia to legalise same-sex marriage. Yet, the reproductive rights of LGBTQ+ people remain on hold. Neither joint adoption nor assisted reproductive technologies (ARTs) are accessible for non-heterosexual individuals. The only legal and feasible way for Taiwanese gay men to become parents is to attempt transnational ARTs, surrogacy services, and donated ovum. Since 2010, Taiwanese gay fathers have been travelling to various reproductive destinations, including the US, Thailand, Canada, and Russia. Except for Canada, sex selection via preimplantation genetic testing (PGT) is permitted in the aforementioned countries. Disproportionately, the majority of gay fathers decided to select male embryos, and some were so determined that they restarted the reproductive cycle once they realised the embryos were all female or after the embryo transfer of male ones failed. This article explores gay men's perceptions and decision-making on embryo sex selection in transnational settings where overseas PGT satisfies the local desires for male offspring, given the fact that their heterosexual counterparts cannot do so locally in Taiwan. This research also delves into gay fathers' feelings about deciding the sex of their future children to expect and aims to examine the intersecting nexuses of sex, sexuality, and gender in the use of PGT. Data came from 53 in-depth interviews with gay fathers and fathers-to-be, as well as participant observations with an LGBTQ+ family association. This research adopts a sociological qualitative method and employs the approach 'reproduction as a lens' to analyse the social implications of perceptions and actions related to using PGT to select sex. Firstly, the findings reveal that most gay men prefer sons for diverse reasons, including the pressure of family continuity, the gendered assumption of future childcare, and the self-projection onto their unborn sons. Secondly, gay men experienced emotional loss and financial burden while deciding to 'give up unborn daughters' via unselecting female embryos. Thirdly, a small number of gay men did not opt for sex selection due to legal restrictions in certain destinations or limited budgets for PGT. Since the application of PGT offers not only a guarantee of a healthy embryo but also the power to decide the beginning of life for a certain sex, gay men constructed the discourse of 'choosing the healthiest embryo' to justify utilising this technique to select particular embryos. Gay men consciously navigated their transnational reproductive trajectories in order to seek familial, social, and legal recognition, and the use of PGT allowed them to fulfil the obligation of conceiving healthy children as well as reproducing male offspring. However, they still encountered the inexplicit emotions of handling the beginning of life by determining or denying the potential existence of a son or a daughter. I conclude that sex selection is a two-edged sword that Taiwanese gay men used as a strategy to gain familial, social, and self-recognition as fathers to sons, but they also faced additional pressures and emotional disturbances as a result of the power to choose. This article also discusses the ambiguous position of Taiwanese gay men, who, on the one hand, faced reproductive inequalities and were forced to exile in order to become fathers, but, on the other hand, were privileged due to their socioeconomic background and were able to remake the meaning of expecting sons to come through PGT.

## Ayo Wahlberg: Selection and the normalization of “quality of life”

In this talk, I reflect on ever-changing practices of selection when it comes to technologically-aided gene editing, gamete donor recruitment, gamete fertilization, embryo implantation and pregnancy termination. What links these practices together are their instantiation of ideas about what kinds of lives should be brought into being and/or what kinds of lives should be brought to an end before they begin. Using my research on the routinization of reproductive technologies in China as a backdrop, I reflect on how practices of editing, fertilizing, implanting and terminating contribute to the normalization of imagined “quality of life” at the cost of different ways of being well in the world.

## Death during surrogacy and in the use of assisted reproductive technologies. Panel 3 D

Orit Chorowicz Bar-Am: “Death during surrogacy and in the use of assisted reproductive technologies”

Contrary to what commercial agencies and surrogacy clinics advertise, and despite its expanding popularity worldwide, surrogacy, much like any reproductive technology, is not a foolproof procedure in which successful outcomes are 100% guaranteed. What happens if the surrogate doesn't conceive after several treatment cycles, or if she eventually ends up experiencing a miscarriage, termination of the pregnancy for medical reasons or a still birth? The scholarship on surrogacy most often discusses successful surrogacy process and seldom consider the women who enter these agreements but never conceive or give birth to a live baby. Behind every surrogacy process that ends without the birth of a live and healthy baby, there is a surrogate who experienced physical and emotional loss. According to the Israeli Ministry of Health, it is estimated that 35% of the agreements signed between intended parents and surrogates end unsuccessfully. The phenomenon of surrogates' losses has received little attention in the empirical scholarship, rendering it transparent. The current paper addresses this gap in the scholarship and discusses how surrogates articulate their experiences of loss in their surrogacy narratives. Based on narrative interviews conducted with ten Israeli surrogates whose surrogacy journeys ended without a live birth, I discuss their unique form of loss. This is a loss made of physical loss, mixed with a unique form of grief which is distanced from the fetus itself, and centered on coping with the disappointment and the metaphoric death of the process they've been sacrificing for and fantasizing about. Thus, my talk will present how surrogacy, a controversial reproductive technology, creates a new sort of death experience at the beginning of life.

Malene Tanderup: Impact of the war in Ukraine and the Covid 19 pandemic on transnational surrogacy- A qualitative study of Danish infertile couples experiences of being in “exile”.

Family forms and fertility technology with development of in vitro fertilization (IVF) have changed the field of reproduction. Now 12 % of Danish children are conceived by assisted reproduction. However, as per Danish law, the permanently infertile couples<sup>1</sup> need to go abroad if they want a genetically-related child, as Danish health care professionals are not allowed to assist in the surrogacy process. Divergent legislation often creates a demography of permanently infertile couples moving around in the world depending on which country permits gestational surrogacy. Although surrogacy is frequently discussed in Denmark and much has been published on the topic worldwide, we know little about the Danish permanently involuntary childless: how do they cope with their childlessness and what are their use of surrogacy and other alternative reproductive methods. Especially in this presentation the focus will be on how the war in Ukraine and the Covid-19 pandemic have impacted on this.

The presentation is based on a qualitative in-depth semi-structured interview study which was performed between May and September 2022. Fourteen permanently infertile couples across Denmark participated and they were in different stages of using surrogacy. The interviews show that all except one couple decided to go abroad, mainly to Ukraine, to have an enforceable transparent contract, professionals to advise them and the possibility of using the eggs of the intended mother. They did not feel that this was a “choice” but rather the only option they had to have the longed-for child. According to the current Danish legislation, the intended mother could not obtain legal motherhood of the child, not even through stepchild adoption, and this increased the feeling of not being a “worthy mother”. This study expanded on the term

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<sup>1</sup> Permanently infertile defined as couples, who despite assisted reproductive technology (ART) do not obtain a child. In this context referring to couples who can have a physical or social cause of infertility. Further, it does not disguise between primary and secondary infertility.

“reproductive exile” by identifying four different forms of exile: the exiled Danish couple, the gestational carrier in exile, exile at home and, finally, the reproductive body in exile.

Understanding infertile couples’ experiences crossing borders is important for several reasons. It additionally may assist in developing sound Danish legal policy on surrogacy addressing the current issues of parental order and missing reproductive opportunities for permanently infertile couples.

### Catarina Delaunay and Luis Gouveia: Mourning and bereavement outside the clinic: dealing with embryo loss and grief within assisted reproductive technologies

Patients seeking Assisted Reproductive Technologies (ART), namely in vitro fertilisation (IVF), to achieve the desired pregnancy, face reproductive losses and mourning experiences (Earle et al., 2008; Lupton, 2013), which are encompassed by “emotional choreographies” (Adrian, 2015; Delaunay et al., 2023) and coping strategies to better deal with such complex situations. These emotionally loaded and impactful circumstances or decisions, which the beneficiaries face in the course of their therapeutic trajectories, cover different situations such as: the existence of non-viable embryos created, selected and discarded out of sight by others/third parties (embryologists) in a laboratory setting thus introducing a “necropolitics of reproduction” (de Wiel, 2018); embryo implantation failure mixing both the technical gesture and the biological body (embryos created in vitro, preserved in cryo and placed in utero); miscarriage or gestational loss referring to a burdened embodied experience by the pregnant woman (Frost et al., 2007); and also the decision to discard or donate supernumerary frozen embryos (either to research or other couples) and the associated ethical and moral dilemmas (Ellison & Karpin, 2011). According to the respondents in our study, all these unexpected, unexplained, and disturbing events, are most often experienced in a solitary way by the woman or couple. These include the diverse set of reproductive losses, inside and outside the “maternal” body, and without psychological support or understanding from health professionals. Standardised procedures and biomedical language thus prevail in the relationship between ART users and the medical staff, most of the time not accommodating the feelings, desires and demands of the former (Delaunay et al., 2023; Millbank, 2017). In this presentation, we discuss the emotional and moral experiences related to embryo loss by the prospective parents that bring to bear the liminality, hybridity and latency of the in vitro embryo (Casper, 1994; Squier, 2004), as well as the perceived hiddenness, imperviousness and technicality of ART procedures (de Lacey, 2017; Frost et al., 2007). These technoscientific bodies and landscapes complexify the forms of mourning and bereavement as coping strategies in dealing with grief. At the same time, they challenge traditional opposing categories including human/organism, viable/disposable, alive/latent, reproductive/researchable, science/nature and subject/object (DiCaglio, 2017; Franklin, 2006; Haraway, 1991; Mol, 2002). They thus call for a more patient-centred approach that respects patients’ needs, preferences and dilemmas (Raz et al., 2021). Furthermore, they encompass, for example, more personalised embryo disposal options (Fuscaldo et al., 2007, Riggan & Allyse, 2019), psychosocial counselling and follow-up throughout the therapeutic trajectory and even beyond (Delaunay et al., 2021; Nachtigall et al., 2010), and, overall, an ethics of care regarding patients dealing with loss, grief and bereavement. This is even more imperative since reproductive biotechnologies reshape life and death, parenting, and personhood as well as family and kinship. The analysis is based on data collected from 69 semi-structured in-depth interviews conducted with a convenience sample of ART users (both individuals and couples) between September 5th, 2019 and January 20th, 2021. This is part of a completed mixed-methods research project on the plurality of meanings and statuses ascribed by experts and lay people to human embryos created in vitro in Portugal (2018-2022).

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## Manon Lefevre: From the laboratory to the cemetery: Ontologies of embryo life and death collide

In the months following the 2022 Jackson vs. Dobbs ruling—which overturned fifty years of precedent guaranteeing the right to abortion in the United States—legislators in conservative states across the country passed a series of near- or total abortion bans (cite). Employing particular definitions of conception and personhood, these laws purport to protect unborn life at every stage, understood as beginning from the earliest stage of embryo development. In response, reproductive endocrinologists and IVF care providers

have expressed increasing concern for the future of infertility treatment in the U.S., especially concerning the possible criminalization of embryo disposal in the laboratory. Focusing on the IVF lab as its primary site of inquiry, my dissertation explores how embryos are differently ontologically 'enacted' (Mol 1999; 2003) in ever-shifting ways. Embryos can be reproductive cells, objects of moral work, living entities, and unborn children. In this current reproductive landscape, I argue that it is perhaps more critical than ever for feminist STS scholars of reproduction in the U.S. to examine the ontological and biopolitical configurations that govern embryo life and death (Franklin 1999; 2006; Franklin, Lury, and Stacey 2000; Maienschein 2014; Morgan 2009).

In this paper, I focus on the process of frozen embryo discard. I ask: How does the process of discarding embryos transform them—ontologically and materially? What affective and embodied relations reveal themselves in the process? What happens when competing conceptualizations of embryo death collide? To answer these questions, I focus on two ethnographic sites, places where competing ontologies of embryo life and death meet. The first is an IVF lab in the northeast U.S., where embryologists do the routine work of discarding frozen embryos when patients no longer want to keep them stored, and enter embodied and affective relation with the embryos they culture; the second is a Catholic cemetery in the Midwest, where frozen embryos are sent from IVF labs to be buried ceremonially. Together, these sites offer rich theoretical and empirical ground through which to consider competing ontologies of embryo death. Examining processes through which embryos are discarded (whether placed in a biohazard bin in a laboratory, or buried under the watchful eye of a Catholic priest), reifies particular understandings of embryo life. Finally, I argue that placing these multiple ontologies side by side gives new insight into the politics of life and death animating the politics of reproduction in the United States today.

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