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**Author**

Takeshita, Chikako

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**Biopolitics of IUD: Strategies in the Global South**

Chikako Takeshita

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Women's desires regarding contraception and childbearing vary widely depending on social norms, cultural beliefs, and personal circumstances such as economic status, current family composition, and individual health condition. The ability of poor women in the global South to make their own reproductive decisions is generally very limited, due in part to the lack of access to contraceptive options and adequate health care, but more importantly owing to the intersecting oppression they endure as a lower-class female in a patriarchal society. Drawing on ethnographic studies of IUD (intrauterine device) users in China, Vietnam, Indonesia, Bangladesh, Tajikistan, Uzbekistan, and Nigeria, this article examines the variety of ways in which women have negotiated reproductive agency, sometimes with the help of, and at other times by refusing, the contraceptive device.<sup>1</sup> It demonstrates how women have mitigated anti-natal government policies, eluded husband's demands, and bargained with healthcare providers in order to protect their physical health and regulate reproduction in ways that suit them. While the IUD has at times had a negative reputation owing to coercive and non-consented insertions in marginalized women and health problems experienced by its users, the examples in this article show that the device can also become an ally of a woman's quest for reproductive self-determination. The long-acting, provider-controlled, and easily-reversible features of the IUD as well as its inconspicuousness have worked in favor of various women's reproductive strategies. Overall this article illustrates how the IUD functions as a *politically versatile device* in women's struggles to achieve personal reproductive goals.

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<sup>1</sup> The following seven ethnographic studies conducted during the 1980s and 1990s provided the qualitative data for my analysis of IUD users' reproductive strategies: 1) Chinese villagers' response to the one-child policy in the Shaanxi province (Greenhalgh 1994); 2) reproductive behaviors and beliefs of women in an Eteki Yoruba village in southwestern Nigeria (Renne 1997); 3) women's subversive strategies against male dominance in Tajikistan (Harris 2000); 4) interviews with midwives who monitor local women's reproductive activity and health in Uzbekistan (Krengel and Greifeld 2000); 5) attitudes toward contraception in two villages in Bangladesh (Stark 2000); 6) rural Vietnamese women's relationship with health, family planning, and daily challenges (Gammeltoft 1999); and 7) Balinese women's beliefs around reproduction in Indonesia (Jennaway 1996). Each of them offered unique and yet comparable cultural and political contexts within which women negotiated reproduction by using or rejecting the IUD.

I begin by introducing the political history of the IUD with an emphasis on the neo-Malthusian ideology that propelled the initial development of the device and its more recent transformation to a contraceptive "choice." The rest of the article draws on examples from the seven studies mentioned above to explore how women in the global South interacted with IUDs in their attempts to fulfill their reproductive goals amidst facing social and economic realities and health concerns. I briefly examine how women's desires are shaped and restricted by community norms around reproductive behavior. Then I offer insights on how women subverted government population policies, resisted patriarchal control, acted on behalf of their own health, and thwarted unwanted birth control by reinterpreting IUD use through an indigenous belief system.

### **A Brief Biopolitical History of the IUD**

Neo-Malthusianism or the idea that global population growth must be curbed in order to avert environmental catastrophes, food shortage crisis, and political uprising gained currency in the United States during the mid-twentieth century. The Population Council, a non-profit philanthropic organization in New York founded with a mission to address the world's population "problem," played major roles in convincing governments in the global South to adopt national policies that limit the fertility of their people and in providing technical support and resources necessary to launch family planning programs abroad. During the 1970s the United States Agency of International Development (USAID) disseminated millions of contraceptives overseas hoping that "inundating" them will compel poor people to use birth control (Connelly 2008). Under the influence of Western aid agencies, many developing nations instituted anti-natal population policies while subscribing to the idea that exponential growth in population will threaten the economic survival of their countries.

The modern IUD was developed, tested, and propagated starting in the early 1960s by neo-Malthusian philanthropists and physicians who made it their mission to invent a reliable contraceptive method that can dramatically decrease fertility rates in the global South. These Western elite men assumed that poor women in the global South were not educated or motivated enough to prevent pregnancy with the birth control pill, which required its users to adhere strictly to a daily ingestion schedule (Dugdale 2000). They turned to a simple piece of plastic device inserted inside the uterus as a solution to the “overpopulation problem” because it appeared to require only one intervention to achieve a long-lasting contraceptive effect and be easily applied to the masses. “Imposability,” or the ability of a non-user-dependent long-acting contraceptive method to force someone to stay on birth control, was an especially attractive feature of the IUD (Clarke 2000, p.50). As the former president of International Planned Parenthood Federation Alan Guttmacher put it, “no contraceptive could be cheaper, and also once the damn thing is in, the patient cannot change her mind” (quoted in Watkins, 1998, p.70). Another developer recalled in an interview: “... this was something that you could do to the people rather than something that people could do for themselves. So it made it very attractive to the *doers*” (emphasis mine, Christopher Tietze quoted in Reed, 1983, p.307)

The Population Council led IUD developers in their effort to find the ideal model with the best contraceptive efficacy. Devices of various sizes, shapes, and material were devised in search of a perfect configuration that minimized pregnancies, spontaneous expulsion from the uterus, and removal due to pain and bleeding. Inventors unaffiliated with the Council also designed, experimented, and patented devices, some of which were produced and sold. As I detail in *The Global Biopolitics of the IUD* (Takeshita 2012), developers imagined the uterus as a territory they were going to occupy and control in order to regulate women who “over-

reproduced.” There is a distinct parallel between IUD developers’ accounts of their effort to tame the uterus and the colonial narrative of conquering an unruly land. Fertile women’s uterine cavities and former colonial territories overlapped in the Western imagination as spaces to be targeted by scientific exploration and technological exploitation (Takeshita 2012). Zealous attempts to occupy the uterus materialized as dangerous devices such as the Maziling Spring and the Dalkon Shield, which became embedded into the uterine walls causing serious infections, sterility, and at least several deaths in users in the West. It is unknown how many women in the global South have been injured or died of complications from these devices. As feminist historian Tone (1999) articulated, some IUDs inflicted violence on women by design.

IUDs have caused havoc to women’s health during its early years. The original plastic devices were not as effective as the contemporary models, and thus resulted in more accidental pregnancies, sometimes with the IUD in place. Complicated insertion techniques resulted in many uterine perforations and improper sterility and lack of screening for reproductive tract infections led to numerous infections, some of them severe enough to render the woman infertile. Over the years more effective devices and safer insertion protocols have been developed. Today when used appropriately, copper-bearing and hormone-releasing IUDs are over 99% effective in preventing pregnancies. Given that trained healthcare provider handles the contraceptive method, it is consistently safe and reliable. Side effects such as pain and bleeding are generally tolerated by consumers in the West, although women who are sensitive to progesterone occasionally suffer from nausea, bloating, and depression.

Feminist scholars have been critical of the IUD, not only of its risk to health, but for its coercive and semi-coercive applications targeting poor women, women of color, and women in the global South. Mass insertions of the device started in the 1960s in Taiwan and South Korea

with the support and urging from the Population Council. Fertility rates declined exponentially as a result of strong government initiatives, making the two countries showcase examples of successful IUD distribution for the Council (Kim 2008). The organization also helped India orchestrate a Lippes Loop campaign. Quotas were set in each states, doctors were given incentives to perform sterilization and IUD insertions, and “Loop Squads” were dispatched to aggressively pursue targets going from village to village, where they gathered women to insert an IUD without providing them much information, let alone asking for consent (Connelly 2008). Hartmann (1995) reports that in Indonesia under Suharto’s military government during the 1980s, women were rounded up at gunpoint for IUD insertions. Under the one-child policy instituted in 1979, all married Han Chinese couples of reproductive couples with one or more children were required to adopt effective contraception, which often translated into the wife receiving an IUD after her first birth under a municipal regulation (Greenhalgh and Li 1995). In order to prevent women from tampering with the device, the Chinese government used steel-rings without a “tail” (Greenhalgh 1994). Extracting the ring devices from a woman required inserting a hook through the cervix and fishing around for the device inside the uterus and then pulling it out. This obviously made extractions much more difficult and dangerous than simply tugging on a string that protrudes into the vagina as is the case with most IUDs today.

By the mid-1960s IUD developers noticed that the contraceptive method did not perform as well in practice as it did in theory. The Lippes Loop campaign in India had ended in disappointment as Indian women refused to quietly and passively accept the device. Many women who were not informed of the possible side effects responded to bleeding and pain by promptly removing the devices themselves. Furthermore they told friends and relatives to reject IUDs, which hampered the mass insertion effort of the government (Dandekar 1976). In the end,

the Indian experience forced IUD supporters to acknowledge the fact that women can and do act as agents of their own health. The Population Council conceded that “educating” women was a necessary part of turning them into IUD “acceptors.” The organization gradually implemented women-centered approaches to reproductive healthcare under the guidance of one of its researchers (Bruce 1987).

Even after they gave up the idea that the IUD was a panacea of overpopulation, supporters continued to promote the device as a viable contraceptive method for all women. In the last five decades, they have improved the acceptability of IUDs significantly not only by enhancing the efficacy of the device, but also by tenaciously working around various obstacles along the way. The largest fallout was the Dalkon Shield crises, in which a widely marketed product caused serious infections that were especially devastating to young women whose injuries rendered them sterile before ever having a child (Mintz 1985). A class action lawsuit was filed against the Shield producer in the mid-1980s, which prompted IUD distributors to withdraw their products from the U.S. market and American doctors to stay away from offering the contraceptive device to their patients. The Population Council weathered out this backlash by reintroducing the copper-bearing IUD in the U.S. in order to bring credibility back to the device that was being distributed in the global South by American international aid agencies (Takeshita 2012).

IUD supporters also managed to form an alliance with pro-choice feminists by moving away from the language of population control that legitimated impossible long-acting contraceptives and instead adopting the rhetoric of women's empowerment. The United Nations International Conference on Population and Development in Cairo in 1994 brought former neo-Malthusians and women's health advocates together in their battle against the Vatican's attempt



to eliminate all references to abortion from the document produced through the collaboration of all interest groups involved. The Vatican's position against contraception made former population control advocates seem progressive in comparison, and aligned them with feminists in support of disseminating birth control. The Population Council renewed its commitment to developing new contraceptives arguing that increasing options would help meet women's needs and that birth control was the path to women's economic empowerment. By slightly changing their orientation and siding with feminist activists, IUD supporters converted the device from a technology that achieved national goals of fertility reduction to a contraceptive "choice" for individual women (Takeshita 2004).

Today there are 150 million IUD users globally. IUDs have been relatively common in some European countries for decades, whereas in the U.S. market for the device only recently recovered from the negative experiences of the Dalkon Shield past. The new generation of American doctors who are open to IUD insertions have replaced those who remember the malpractice law suits filed against the device's providers during the 1970s and 1980s. Sales in the U.S. have picked up since the late 2000s, particularly after a TV commercial introduced the hormone-releasing IUD called Mirena as a convenient birth control device for busy and active mothers. Today in the U.S., the IUD is provided by Planned Parenthood, campus health centers, and public and private practices as a viable contraceptive option, not only for older women in between childbearing or waiting for menopause, but also for younger women who have several years before they start a family. Meanwhile the "imposability" of the IUD never ceased to be an attractive feature to those who hope to reliably regulate the fertility of a certain population. Its unique history molded the IUD into a *politically versatile* device that embodies conflicting reproductive politics — population control and reproductive "choice," positive and negative

eugenics, control over women's bodies and women's reproductive self-determination. (Takeshita 2012). Its features including long-lasting efficacy, impossibility, reversibility, and invisibility have also contributed to the device's flexibility. The following section explores the political versatility of this contraceptive method by examining real women's reproductive strategies.

### **Women's Reproductive Strategies**

Examples of women's mobilization of IUDs are drawn from seven ethnographic works that I found through a review of literature. Combined these studies provide a rich variation in the socio-cultural and political contexts for analyses. Greenhalgh's study in China took place in 1988 in a rural village of the Shaanxi province, nine years after the one-child policy was instituted. At the time, seeing that the Chinese people were not adhering to the one-child per couple rule and worried that the national population fertility goal would not be met, the Chinese government had just tightened its enforcement (Greenhalgh and Li 1995). The Neo-Malthusian family planning programs also had a strong influence on rural women's lives during the mid-1990s in the Vietnamese villages where Gammeltoft studied their relationship to health, family planning, and daily challenges especially in relationship to the IUD (Gammeltoft 1999). Jennaway's study of Balinese women's beliefs around reproduction during the 1990s also followed a period of heavy-handed government intervention in fertility control (Jennaway 1996). Both Tajikistan and Uzbekistan during the 1990s, when Harris studied Tajik women's subversive strategies against male dominance and Krengel and Greifield interviewed Uzbek midwives who monitored local women's reproductive activity and health, were going under a transition from being parts of the Soviet Union into Islamic states. The politics of reproduction experienced a shift as governments changed, while the IUD, which was the only reversible contraceptive method available during

the Soviet era, remained an important device for fertility control. Similarly in the villages of Bangladesh where Stark (2000) conducted her study of contraceptive use and among the Etiki women of southwestern Nigeria studied by Renne (1997), government sponsored family programs were the main source of contraceptives. Women's attitudes toward fertility control varied significantly based on the local and personal contexts, while all were affected in one way or another by the patriarchal social structure as I describe in more detail below. The examples are not meant to be exhaustive, but they represent typical challenges that women in the global South still face surrounding reproduction and social status. The variety of circumstances have enabled me to illustrate how women in one cultural setting utilize different strategies for reproductive self-determination and how comparable means of taking control over ones bodies are observable in different contexts.

Regardless of geographical location, women who are marginalized in their societies must devise strategies if they were to actively pursue reproductive and social goals amid competing pressure from society, family, and the state. Some women find themselves simultaneously under the demand of their husbands and in-laws to continue to produce children and family planning workers' persistent effort to convince them to prevent pregnancy. In cultural settings where the husbands' cooperation is difficult to get, many women are compelled to take family planning into their own hands. They must leverage their limited mobility and decision-making power to act on behalf of their families' social and economic well-being and use their wits to protect their own health from the strains of multiple consecutive pregnancies. Meanwhile some women are compelled to stop using birth control methods due to intolerable side effects at the expense of heightened risks of repeated pregnancy. Other women may be forced to discontinue contraception under the orders of family members.

Women's reproductive desires are often shaped by community norms, which are products of a mix of influences from patriarchal social system, traditional belief systems, and relentless government propaganda for small families. For the past several decades, women in developing countries have been exposed to the notion that a smaller family is better because the parents are able to provide more resources to fewer children and that families with many children will remain poor. This idea is communicated directly to families by local health workers who are in charge of putting women on contraceptives as well as through government issued posters and billboards that show a picture of an unhappy, poor, and chaotic household with a large number of children next to an image of a happy, modernized, and orderly household with just a couple of children. In rural China, women's sense of an ideal family has downsized significantly from the traditional large household that consisted of many children who provided farm labor and secured the parents economic stability in old age. Chinese villagers interviewed by Greenhalgh (1994) on average wanted two children with at least one son, which, although exceeding the state-mandated one-child-per-family, suggests that women have adjusted their expectations accordingly to the state's pressure to limit the number of offspring. Similarly in Vietnam, most villagers have adopted the idea that a smaller family is economically better off (Gammeltoft 1999). In Uzbekistan, the ideal family size is two or three boys and two girls based on the idea that parents should have children of both sexes and that children should have siblings of the same sex.

In some societies, a woman's morality is judged based on her willingness to exercise her god-given ability to have children and nurture them. Because the social status of a female is based on motherhood, women fear infertility and are comforted when they have multiple children. In many cultures, women accept the task of producing sons; they celebrate when a boy is born, while they consider aborting if they know the fetus is a girl. Ironically, "cultural"

preferences such as these that presumably secure a woman's position in the community are often a reflection of a patriarchal society that retains itself by rewarding women for their domesticity. In other words, women's reproductive desires are often a product of internalized gender roles of their societies, in which a woman's value is measured based on her fecundity and ability to bear boys. There are real risks associated with deviating from these expectations, particularly in places where young women's status is extremely low and females are entirely dependent on men for economic survival. Some of the examples that follow show that a woman may be subjected to violence and social punishment if she pursues a reproductive goal that undermines male authority.

As Stark (2000) states: "Women initiate and discontinue use of contraceptives based upon self-interest derived from the need to maintain social and economic security balanced with productive and reproductive labor demands" (195). When women attempt to take an active role in controlling pregnancy, they are motivated by multiple factors including socio-political context, religious beliefs, cultural norms, and personal circumstances. In societies where women's agencies are severely limited and/or the state has a strong control over women's bodies, their strategies require diverse forms of negotiations and contraceptive manipulations. While their efforts do not fundamentally change their oppressed statuses, women act as reproductive agents making the best of the resources available to them and cleverly work around the restrictions. The subsequent sections illustrate how women subverted state anti-natal policies, defied patriarchal control, protected their own health, and dodged birth control by making references to local beliefs while initiating, discontinuing, or refusing IUD use.

### **Subverting the State**

Governments have a significant investment in women's bodies because sustaining the reproduction of citizens at a sustainable level is vital to a country's economic viability. Anti-natal state population policies implemented various measures including coercive birth control, incentives and penalties, and propaganda promoting small families. Around the globe, neo-Malthusian biopolitics justified imposing contraceptives on women in order to achieve a national agenda. Indonesia aggressively pursued anti-natal campaigns that limited each family to two children during the late 1970s and early 1980s during including in Bali where Jennaway (1996) conducted her study. The Nigerian government declared “Four-is-Enough” in 1988 and implemented the “Space Your Family” program. Around 1988 the Vietnamese government started to urge families to limit the number of their children to one or two with three to five years in between siblings. After becoming independent from the Soviet Union, which had promoted pro-natalism to increase the reproduction of laborers and soldiers, the Islamic governments of Tajikistan and Uzbekistan adopted measures to scale down the countries’ fertility rates to about four children per woman.

The burden of enforcing the national agenda was usually given to healthcare providers, who managed the birth rates of local communities by keeping records of pregnancies and births, persuading villagers to use contraceptive methods, making sure people were complying to the rules, and penalizing those who exceeded the birth quota. In Uzbekistan, midwives locally kept track of which woman is pregnant, which one has just had a child and therefore should refrain from getting pregnant, which one is free to get pregnant, and which one should stop having children because she is considered unhealthy after having had five pregnancies. Most notoriously, Chinese local health officials instituted drastic measures such as forced abortion and involuntary sterilization in response to the strict quotas imposed on them. When Greenhalgh

(1994) interviewed villagers in the province of Shaanxi, local birth planning cadres were inserting IUDs in women who had their first child. If the cadres found a woman pregnant with a second child, they would force her to have an abortion, and if a woman somehow managed to have two children, she would be sterilized. Like the rest of the country, villagers considered having a son vitally important for the parents' economic survival in old age and helped each other meet the two-child-with-at-least-one-son goal by hiding pregnant women from birth planning cadres. Greenhalgh also observed that villagers put pressure on the cadres to overlook some of the infringements. Cadres who succumbed to the villagers' pressure allowed women to carry out their pregnancies if they had not met the ideal family composition even though this violated the formal policy.

In her study Greenhalgh also found 18 women whose IUDs were purportedly spontaneously expelled. As I mentioned earlier, the Chinese population control program favored the tailless ring-shaped IUDs because they were more cumbersome to extract. As unauthorized IUD removals carried a heavy penalty, none of the women admitted to having illegally removed their devices, but instead told Greenhalgh that the rings simply "fell out." She speculates that women intentionally got rid of their IUDs to have more children since the majority of them got pregnant within three months. Greenhalgh concludes that unlawful discontinuation of IUDs, with or without the help of another person, was one of the strategies women used to resist the anti-natal population policy, which was made possible by the reversible contraceptive device that can be removed without being detected. Krennal and Greifeld (2000) also encountered a case of a "lost" IUD in an older woman who would have been considered not fit for pregnancy. In this case her midwives allowed her to continue her pregnancy reasoning that she was still healthy even though she had had enough children according to the state sponsored family planning

program. These examples from China and Uzbekistan demonstrate that where an anti-natal policy relies on the IUD to carry out its goal, there is also a potential for women to subvert the state via self-extraction.

### **Resisting Patriarchy**

Researchers often explain that female adherence to local social norms around reproduction reflects “cultural” differences, implying that the choices women make are normal, understandable, and acceptable. Such an explanation, however, overlooks the importance of patriarchy and its pervasiveness across cultures. Patriarchal societies maintain male dominance by depriving females of economic, political, and legal powers and by enforcing gender roles that continuously assign higher status to men over women. Men often assume control over female reproductive behaviors and capacities including how often the wife gets pregnant, how many children she has, and whether or not she practices birth control, has an abortion, or seeks medical care for health problems. Patriarchy and major world religions that encourage pro-natalism often converge in support of male-centered family ideals that mandate female subordination, domesticity, and maternity. This combination of religious and patriarchal ideologies also supports reproductive patterns that lead to more pregnancies for a woman. Men’s higher status in patriarchal societies means that sons are preferred over daughters, which preconditions women to having multiple successive pregnancies until one or more boys are born. In some cultures, female fecundity establishes the male partner’s masculine status as it is considered to be an evidence of the man’s virility and his ability to support a large family. A woman who gets pregnant frequently and cares for multiple young children are inevitably tied to the home with very little economic opportunity or social influence. She must depend on her husband for survival, which



secures his authority as the head of the household. Such reproductive practices unsurprisingly sustain gender hierarchy.

In a strongly patriarchal society, it is not uncommon for a husband to forbid his wife to use contraceptives and to demand for more children with an emphasis on boys. The wife meanwhile may want to stop having children for the economic survival of the family or because she feels the negative effects of repeated pregnancies on her physical health. She cannot, however, act freely to control her fertility in a society in which women's lives are undervalued and their submission to men are expected. A woman must take a significant personal risk when defying her husband and in-laws since disobedience may prompt punishment including physical violence and divorce. Tozgal, a Tajik woman interviewed by Harris (2000) met this fate. After having had six children in seven years, she secretly acquired an IUD. After a few years, her husband threatened to divorce her for sterility, upon which Tozgal told him that she had been on the IUD and therefore was not infertile. Her husband divorced her immediately, outraged by the "empty sex" he had been having. Another Tajik woman fortunately was able to convince her husband that she needed to be on birth control. When she was in labor with her fourth child, Zulfia held onto her husband and made him attend childbirth instead of letting him fetch a midwife. Prior to this incidence, Zulfia's husband was determined to have a son since his first three children were all girls. After a terrifying experience of witnessing the birth of his fourth daughter and understanding his wife's hardship, Zulfia's husband sent her to get an IUD, willing to give up having a boy (Harris 2000).

The discreteness of the IUD was an unintentional feature its developers did not associate with its intended use, population control. However, secrecy has now proven to be a characteristic of a contraceptive method that women sometimes value. In Uzbekistan when midwives saw

women who do not want to keep having children, they inserted IUDs to help women use birth control surreptitiously without their husbands' knowledge (Krengal and Greifeld 2000). In the Bangladeshi villages where Stark (2000) conducted her research, women were not permitted to go to a clinic without being accompanied by a husband or mother in-law. Local health workers filled the gap by visiting each woman in her home and giving a contraceptive shot every three months. The injection, Depo-Provera, was the preferred method since it left no evidence for the husband to discover. Local healthcare providers often played a role in enabling women to access contraceptives, particularly in places where women's mobility is severely limited and husbands are reluctant to permit their wives to use birth control. While local family planning programmers can become an adversary who enforces fertility control on women against their wishes, they are also an important point of negotiation for village women who want to deviate from the local norms of fertility control. Women's struggle for reproductive self-determination becomes complex when they are caught between anti-natal neo-Malthusian ideology and the pro-natal patriarchal norms. Occasionally though, women are able to play them against each other to fulfill their needs.

Women were exceptionally careful and strategic when thwarting patriarchal control and exercising reproductive self-determination. Stark (2000) tells the story of Komola, a Bangladeshi villager who convinced her husband to take their sick son to the hospital, and while she was there obtained an IUD without his knowledge. After a while Komola "confessed" about her birth control to her husband, who reluctantly admitted that the couple could not afford another child and consented to birth control. Stark explains that these men are reluctant to openly permit their wives to use contraception because they would be admitting their economic inability to support a large family. When a woman secretly obtains birth control and later "confesses" to her husband,

she satisfies his needs in two ways. First, it allows the husband to outwardly say that he never agreed to birth control and it was his wife's doing. Second, through the act of confessing, the wife acknowledges and restores the husband's authority. In this way the husband maintains social and religious standing and the woman escapes his anger. Stark reports that this is a common tactic Bangladeshi women in this community used to obtain an IUD or other forms of birth control. The surreptitiousness of Depo-provera and the IUD allowed women to deceive their husbands and the husbands to pretend not to notice their wives' contraceptive use. An inconspicuous, long-lasting contraceptive like an IUD therefore can in some cases help women who try to mitigate their lack of freedom in culturally appropriate ways. While this kind of reproductive strategy does little to reform the underlying gender hierarchy, the device has a potential to help some women resist patriarchy in a small but personally significant way.

### **Protecting Health**

Those who advocate for contraception in the global South often refer to the physical dangers of pregnancy, or maternal mortality and morbidity, as reasons to push for the dissemination of birth control methods. The nationalist population policy of Uzbekistan during the 1990s prioritized the reproduction of healthy Uzbeks. It focused on women's health in particular because many of them suffered from anemia caused by environmental toxins. Spacing children with contraceptives was not only meant to limit the size of Uzbek families, but also seen as a way to allow women to recover their health from their previous pregnancy before having another child. As abortion was illegalized by the new Islamic state, Uzbek midwives and women relied on the IUD to accomplish the national health agenda. Protecting reproductive health from the stress of multiple consecutive pregnancies, however, was also an important part of women's personal

reproductive goals in Uzbekistan and elsewhere. As we have seen in the case of Komola in Bangladesh, women who act proactively to obtain an IUD are often motivated by the desire to protect their own health. Paradoxically, contraceptives can also become the source of ill-health. IUDs can cause severe cramps and pain as well as irregular and heavy menstrual bleeding, which may worsen anemia in already malnourished women. Women in places such as Vietnam and Bali perceive undesirable side effects of the IUD to be detrimental to their health, and irregular menstruation in particular as something that made them excessively “dirty.” Stark contends that hormonal and intrauterine contraceptive methods’ side-effects significantly undermined the reproductive independence of Bangladeshi women as they were compelled to discontinue them, and inevitably got pregnant as a result.

The Vietnamese women interviewed by Gammeltoft (2000) endured pain and physical weakness brought on by the IUD because there was a dearth of contraceptive options. Despite the troubling side effects, many accepted IUDs and those who did considered themselves to be fortunate to be able to tolerate the device because the alternative would have been to risk falling into unwanted pregnancies and having to either have more children they cannot afford or seek an abortion. In order to conserve their physical strength, which they believed was compromised by the IUD, Vietnamese women occasionally used the device's side effects as an excuse to escape hard labor. Developing contraceptive strategies, then, is also about trying to optimize one’s health status amidst productive and reproductive demands on women’s lives.

### **Asserting Local Epistemologies**

Renne (1997) reports that Etiki Yoruba women in Nigeria, the older ones in particular, perceived the IUD as a “mythological object” associated with supernatural practices. Fecundity is

traditionally valued among the Etikis, who consider female fertility as a god's blessing. Those who believed that it was immoral to disregard the god's gift of fecundity had never been enthusiastic about intentionally controlling reproduction. They criticized young women who prioritized schooling or work as selfish individuals that abandoned maternal responsibility. Traditionalist or not, a typical Etiki woman worried about being or becoming sterile since having children provided women of social status; many welcomed repeated pregnancy because it was an assurance of fertility. In this context, because it prevented pregnancy for a long period, the IUD tended to invoke anxiety regarding infertility in Etiki women. Moreover, the device was inserted and extracted by a doctor or nurse, which reminded them of "turning the uterus," a witchcraft inflicted by an ill-intentioned person who takes control over the reproductive organ to make the woman sterile. In other words, IUD insertions to an Etiki women was reminiscent of having their fertility taken away, possibly irrevocably, by a powerful stranger with magic. This indigenous reading of the IUD made the device unacceptable to village women, who felt encouraged to reject the device in a cultural setting already tentative about birth control. By ascribing to local beliefs and turning down the contraceptive device, these women expressed reproductive agency and epistemological independence. Simultaneously, the villagers invalidated family planning programs imposed by the government, an entity that, according to Renne, they had already mistrusted.

Jennaway (1996) provides another example from Bali of women rejecting the IUD based on indigenous beliefs. During the 1970s and early 1980s, Indonesia executed an aggressive national population program that significantly decreased its fertility. The IUD was used almost exclusively as the "single-strike" technology, which was not only provided at no cost to women, but also inserted liberally by healthcare providers without checking for pre-existing reproductive

tract infections or giving any follow-up medical attention. In Bali, the local councils aggressively pursued fertile couples that resisted contraception until a high rate of compliance was achieved, and the Balinese birth rate declined dramatically. IUDs remained the most prevalent contraceptive method into the 1990s, in part because other methods were not readily available. Jennaway suggests that in this historical context, the device was associated with resentments toward coercive birth control. She explains, however, that Balinese women's dislike of the IUD was also cultural. First of all, the increased menstrual bleeding made them feel "dirty." They also believed that IUDs made them feel weak and made them thin. Interestingly, in places where Depo-provera was available, Balinese women preferred the injection method because it decreased menstrual blood flow and caused weight gain, which they appreciated since fuller female bodies were preferred in their culture (Jennaway 1996).

The Balinese culture also valued good "matches" whether it was in a social relationship or between a person and an object because the indigenous cosmology centered on the idea of harmony and order as the fundamental condition of the universe. When Balinese women wanted to reject the IUD for its side effects, they claimed that the device was not compatible with their bodies. Since a "bad match" was a legitimate reason in the local cultural context, women got out of the obligation to use birth control relatively easily. Jennaway notes that these Balinese women strategically deployed a counter-ideology to undercut state intervention in a passive way by saying that the contraceptive method was not suitable to local women. These Nigerian and Balinese examples show epistemological defiance or how women expressed their reproductive agency by asserting local beliefs about fertility and contraception. This involved assigning meanings to the IUD that dislodged it from its status as a scientific contraceptive device. Adopting a local worldview also enabled women to disrupt the family planning mandate and

undermine the epistemological violence that entails the imposition of Western values on indigenous people.

## **Conclusion**

Historical development of the IUD formulated a political versatile technology that can play in the hands of both feminist and anti-feminist reproductive agendas. Women's quest for reproductive autonomy has been complicated by the need to strike a delicate balance between their health and personal preferences with social acceptance, economic reality, and pressures from the state, local family planning programmers, and husbands. Negotiating reproductive agency required clever maneuvers by women in places where patriarchy dominates their lives and the state insistently intervene in personal lives. This article demonstrated several ways in which the IUD can be instrumental in the reproductive self-determination of women in the global South.

## **Works Cited**

- Bruce, Judith. 1987. "Users' Perspectives on Contraceptive Technology and Delivery Systems: Highlighting Some Feminist Issues." *Technology in Society* 9 (3-4): 359-383.
- Clarke, Adele E. 2000. "Maverick Reproductive Scientists and the Production of Contraceptives, 1915-2000+" in *Bodies of Technology: Women's Involvement with Reproductive Medicine*, edited by A. R. Saetnan, Nelly Oudshoorn, and M. Kirejczyk,. Columbus: Ohio State University Press.
- Connelly, Matthew, 2008. *Fatal Misconception: The Struggle to Control World Population*. Cambridge, MA: Harvard University Press.
- Dandekar, Kumudini, Vaijayanti Bhate, Jeroo Coyaji, and Surekha Nikam. 1976. "Place of IUD

- in the Contraception-Kit of India." *Artha Vijnana* 18 (3):189-286.
- Dugdale, Anni, 2000. "Intrauterine Contraceptive Devices, Situated Knowledges, and Making of Women's Bodies." *Australian Feminist Studies* 15 (32):165-176.
- Gammeltoft, Tine. 1999. *Women's Bodies, Women's Worries: Health and Family Planning in a Vietnamese Rural Community*. Surrey: Curzon Press.
- Greenhalgh, Susan. 1994. "Controlling Births and Bodies in Village China." *American Ethnologist* 21 (1):3-30.
- Greenhalgh, Susan and Jiali Li. 1995. "Engendering Reproductive Policy and Practice in Peasant China: For a Feminist Demography of Reproduction." *Signs: Journal of Women in Culture and Society* 20 (3): 601-641.
- Harris, Colette. 2000. *Control and Subversion: Gender, Islam, and Socialism in Tajikistan*. Dissertation, University of Amsterdam.
- Hartmann, Betsy. 1995. *Reproductive Rights and Wrongs: The Global Politics of Population Control*. Boston: South End Press.
- Jennaway, Megan. 1996. "Of Blood and Foetuses: Female Fertility and Women's Reproductive Health in a North Balinese Village" in Pranee Liamputtong Rice and Lenor Manderson (eds.) *Maternity and Reproductive Health in Asian Societies*. Amsterdam: Hartwood Academic Publishers.
- Kim, Sonja. 2008. "'Limiting Birth': Birth Control in Colonial Korea (1910-1945)." *EASTS: East Asian Science and Technology Studies: An International Journal* 2 (3):335-360.
- Krengel, Monika, and Katarian Greifeld. 2000. "Uzbekistan in Transition -- Changing Concepts in Family Planning and Reproductive Health." In *Contraception across Cultures:*



- Technologies, Choices, Constraints*, edited by A. Russell, E. J. Sobo and M. Thompson. Oxford: Berg.
- Mintz, Morton. 1985. *At Any Cost: Corporate Greed, Women, and the Dalkon Shield*. New York: Pantheon Books.
- Reed, James. 1983. *The Birth Control Movement and American Society: From Private Vice to Public Virtue*. Princeton: Princeton University Press.
- Renne, Elisha. 1997. "Local and Institutional Interpretations of IUDs in Southwestern Nigeria." *Social Science and Medicine* 44 (8): 1141-1148.
- Stark, Nancy. 2000. "My Body, My Problem: Contraceptive Decision-Making among Rural Bangladeshi Women." In *Contraception across Cultures: Technologies, Choices, Constraints.*, edited by A. Russell, E. J. Sobo and M. Thompson. Oxford: Berg.
- Takeshita, Chikako. 2004. "Contraceptive Technology and Reproductive Rights: The IUD at Historical and Geographical Junctures." *Advances in Gender Research* 8:251-284.
- Takeshita, Chikako. 2012. *The Global Biopolitics of the IUD: How Science Constructs Contraceptive Users and Women's Bodies*. Cambridge: MIT Press.
- Tone, Andrea, 1999. "Violence by Design: Contraceptive Technology and the Invasion of the Female Body." In *Lethal Imagination: Violence and Brutality in American History*, edited by Michael A. Bellesiles. New York: New York University Press.
- Watkins, Elizabeth. 1998. *On the Pill: A Social History of Oral Contraceptives, 1950-1970*. Baltimore.