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Reproductive health as a gendered indicator of well-being: the case of 'infertility'[1]

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0. Introduction

Reproduction of human beings is also the reproduction of social relationships that constitutes a multidimensional process, in which biological but also emotional, cultural and economic aspects play a determinant role on the construction of the life cycle of the individuals. Therefore, the capacity of reproduction may be an essential ingredient of the experience and sense of well-being, mediated by gendered inequalities and sexual differences.

During the last decades, deep cultural, economical and political transformations have intensified the changing of the demographic scenarios. The generalization of the access to modern contraception has created a diverse range of possibilities of 'management' of the reproductive careers. Along with the growing delay of the decision of having the first child, especially from the part of the women that are integrated on the market of paid work, having at least one child became a central point of the life of the modern families. But what happens when couples face infertility?

Modern medicine is making impressive advances on what refers to assisted conception techniques, which in several countries have been the subject of intense public discussion and debate. Social sciences – and particularly the feminist studies

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– have been contributing to the debate by analysing the socio-cultural dilemmas that are being raised in the context of new reproductive techniques, in addition to difficult ethical, personal, moral and political questions.

Drawing on the making of qualitative interviews to couples who were unable to carry on the project of having a biological child (focusing on the woman's experiences and feelings) and who have, in almost all cases, undergone assisted conception procedures, this paper examines the concept of «reproductive health», perceived as something which evokes gender differences and that may be understood as an essential indicator of the perceptions and evaluations of well being and of 'living life' from the part of the individuals and of the families.

In the first part of this paper, we expose our main theoretical framework, invoking some different traditions coming from the feminist studies of science and technology on approaching assisted reproduction technologies. Then, we present some main considerations proceeding from our fieldwork, which consisted on the making of interviews to thirty infertile couples, in order to examine the sort of social relationships, cultural repertoires, narratives, interests and values that are reproduced and evoked in this particular context. Some considerations are made about the methodological difficulties of examining infertility both on national and international contexts. Finally, we develop some remarks about gendered differences on perceiving and constructing of what can be defined as sense of personal and family of «well-being».

1. Theorizing the concept of well-being: gender inequalities and reproductive technologies

Critical tradition in social sciences has theorized technology as a part of modern industrialization, and so has equated the social and personal effects of technology focusing on the means of production of industrial capitalism: for example, Karl Marx, by emphasising the class relations; or the point on the technological apparatus of bureaucracy can create the 'iron cage' of increased rationalization and control of social life, by Max Weber; or where increasing bureaucratization and surveillance is implicated in a loss of personhood, autonomy and agency, as Foucault as largely explored.

From this point of view, the relations that social actors create and maintain with technology are mainly perceived as being part of a process of objectification which is classified as alienating, with technology in imminent danger of usurping self-hood. However, different perspectives can be added and some fieldwork has shown that there are heterogeneous and diverse patterns and levels on what

concerns the interactions between patients, doctors and medical technology – on what concerns the question of personhood and objectification. The concept 'ontological choreography', proposed by Cussin to the context of infertility clinics, is developed "to describe the processes of forging functional trails of compatibility that create and maintain the referentiality between things of different kinds – like persons and reproductive technologies" (Cussin, 1996: 575). This onthological choreography challenges the traditional conceptualization of the inevitability of subjugation and alienation, in this case, from the part of the stereotyped infertile patient: middle or high class white women, in her thirties. This reconceptualization of the relations between personhood and science and technology can therefore be insightful for us, considering that our main aim in this paper is to focus on the narratives produced by infertile couples who have, in almost all cases, undergone assisted conception procedures without success, and then have experienced constructions and deconstructions of their subjectivities. And because women are primary patients and targets of reproductive technologies, we have focused on women.

This tradition is also exemplified in a considerable number of writings by feminist scholars that consider that reproductive technologies have an important role in the objectification of women and therefore are responsible for subjugating and disciplining effects on women's bodies and lives. However, feminist studies have been far from uniform (Cussins, 1996) and although it can be said that most of feminist studies that examine the mutual shaping of gender, science and reproductive technology emphasise the dangers of objectification, liberal feminist analysis points out that reproductive technology increased choice for women (Birke et al., 1990).

Feminist literature has been examining the mutual shaping of gender, science and technology (S&T), by focusing (i) how gender gets 'scripted' into the creation, design and use of new scientific knowledge and new technologies; and (ii) how the creation, design and use of science and technology may equally 'produce' gender relations and gender identities. It is specially this last dimension of analysis that interests us, as far as we are concerned with the production and reaffirmation of gender inequalities, pointing out how women and men encounter reproductive technologies and how and what this can tell us about how S&T can both shape and be shaped by gender relations and identities.

Crucial to us is the concept of reproductive health, defined as a state of complete physical, mental and social well-being, and may not be the synonymous of the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life and so it is not

merely about reproduction, as it is viewed by many authors as three interconnected domains that include universal rights, women's empowerment and health service provision. Therefore, for some people infertility can be perceived as a deviance, disease or infirmity and for others not.

Infertility is faced as a disease and a deviance to all the couples we have interviewed, simply because all of them have as a major pursuit in life to have a biological child. So, our main aim here is to analyse perceptions and practices that surround infertility, in the specific context that it is classified as a condition of 'non well being'.

2. How infertility remains invisible

Since the birth in 1978 of the world's first 'test-tube baby' that assisted reproductive technology has permeated the public imagination. In that process, the media play an important role, especially when it comes to face with extreme or scandalous situations (like insemination by using the doctor's sperm without the patients consent, old women being pregnant and so on). Many people have known or know actually someone who has had, a baby conceived with the help of these technologies, which helps to create the idea that infertility is increasing (which can be false, what we know for sure is that infertility treatments and mean of diagnosis are becoming more available).

Research in the area of infertility has been intensified and several new options for the treatment of infertility have been developed and are now routinely recommended to infertile couples.

Infertility is a condition which is estimated to affect 10-15 per cent of couples, although the prevalence may vary cross-nationally, as well as among sub-groups within a country, as it generally increases with age and tends to be higher among those of low socio-economic status, that are more exposed to environmental risks, mainly in their work. As Stickler puts it "infertility is to some extent determined by social factors such as sexually transmitted disease, general level of health and age patterns of child-bearing." (1992: 129).

However, we may say that infertility remains 'invisible'. The data we can achieve about infertility is the one that is reported by infertility clinics. And even so, it is difficult to achieve the real impacts of infertility condition, considering the fact that not all the countries have an effective and complete national coverage of information concerning the uses of assisted reproduction techniques. According to the "European IVF-monitoring programme", for the European Society of Human

Reproduction and Embriology (E.S.H.R.E.), on the last report on assisted reproductive technology in Europe (Andersen et al., 2005), for the year of 2001, only twelve out of twenty three European countries that produce annual reports presented a complete coverage in their reporting system: Belgium, Denmark, Finland, Hungary, Iceland, Latvia, Norway, Slovenia, Sweden, Switzerland, The Netherlands and UK. So, the available data is incomplete and besides that, it is generated through different methods using different definitions in different countries. Interpretation of the data must be done with some caution, specially, when it comes to make comparisons between countries.

Although the information about infertility and assisted reproductive technologies in Europe is incomplete and faces methodological problems, we can summarize the prevailing patterns of the uses of infertility medical treatments, in the following terms: (i) the availability of the services are higher in the Nordic countries and in The Netherlands; (ii) the proportion of children being born with assisted reproductive technologies may vary between 1 and 3 per cent to all children born; (iii) more than 50% of women treated with IVF or ICSI are between 35 and 39 years old.

In what concerns Portugal, we have incomplete data and we don´t know the real percentage of infertile couples, even if in 1990 the Regional Bureau for Europe of the World Health Organization (W.H.O.) concluded in Copenhagen Assembly that each country should evaluate the proportion of cases of infertility compared to the total of population, and also the male and female factors. Nevertheless, little have been done in Portugal to fulfil this request.

3. Adopted methodology and characterisation of the interviewed couples

Infertility has been mainly perceived as being a medical matter. However, it is our perception that it demands an analysis that focuses the involving social structures, mainly the cultural, social, geographical and economic dimensions that may be associated with infertility. We have carried out multidisciplinary a project, with a team composed by one sociologist, one geographer and three medical doctors, that had a duration of 17 months (2004-2005) and which was funded by the *Foundation for Science and Technology* (Portuguese Ministry of Science, Technology and Higher Education). The main objectives of the project were the following:

i) to quantify the rate of cases of infertile couples compared to the total population of Guimarães municipality (northwest of Portugal) by creating a database of infertile couples;
ii) to characterize the mainly socio-cultural and economical aspects related to infertile couples;
iii) to determine the factors that influence the infertile couples not attend the health services;
iv) to inform the infertile couples about the hospitals and private institutions that exist in the northwest of Portugal that have infertility consultations.

The study of infertility faces several obstacles that are created when researchers try to identify and contact the individuals and couples that are experiencing the infertile condition, which demand some ethical precautions in dealing with these intimate questions.

To accomplish the proposed objectives we developed a methodology focused, primarily, on the analysis of the marriage register and of the birth register in the Civil Registration Office in Guimarães municipality. This research was restricted to the period from 1995 to 1998 in the case of marriage and from 1995 until 2004 in the case of births, and it consisted of 21219 marriage registrations and 5553 birth registrations.

We identified 1129 couples without children after living together for at least 5 years and the database created permitted us to contact the women by letter inviting them to participate in our investigation and to do a geographical, socio-cultural, clinical and economic characterization.

Among the 1129 women contacted 122 stated that they had already children and 13 were not interested in the study as shown in Table 1.

Table 1-Type of answer to the invitation letter

Type of answer	Nº
She had already children	122
She was pregnant	5
Without children by option	5
She was not interested in participating in the study	13
She would like to participate in the study	31
Devolution of letters	265
Without answer	688

Total	1129

Source: Letter sent to 1129 women between February and June 2005.

The main problem was the devolution of 265 letters and we had no other mean to contact the women because of the lack of information about the address that we faced when consulting the marriage registration.

We had a total of 15.6% of answers to the letter of invitation to participate in this study and the number of interviews were 31 at the beginning but in the end we did 30 because one of the women was unreachable. In a methodology as the one we used, when an invitation is made and is focused on intimate subjects, a low response rate (below 20%) is expected.

As the number of couples that accepted to join the study was limited, we decided to carry out a semi-structured interview mainly with open questions and focused in the representations and the perceptions of the infertility condition by the inquired couples. After the making the analysis of the content of the interviews, we have reached 27 categories of analysis as shown in Table 2.

Table 2-Categories of analysis of the interviews

Subjects
1-Maternity project
2-Delay of maternity project
3-Absence of maternity project
4-Pregnancy project
5-Registration of pregnancies
6-Pregnancy insucess reasons
7-Type of health professional involved in consultations
8-Place of consultations
9-Type of medical help given
10-Information received about infertility assistance
11-Place of infertility consultations
12-Motives for the lack of infertility consultations
13-Feelings about the first consultation
14-Perceptions about medical exams
15-Reasons for the lack of medical exams
16-Medical diagnostic
17-Person who gave the diagnostic
18-Perception of family impacts
19-Type of treatment undertake
20-Reasons for absence of treatment
21-Factors that determined the stopping of the treatment
22-Treatment place

23-Feelings about treatments
24-Social evaluation
25-Evaluation of children absence
26-Support to infertile couples
27-Evaluation of the interview

Source: Interviews made to infertile couples in 2005.

This qualitative technique is accepted when the sample is not relevant and when the data reported to the phenomenon in study are incomplete and we need to do some deep understanding of the subject.

When analysing the jobs declared by the women and men we are confronted with a population with a large representation of factory workers mainly from textile, cloth or shoe industry (18 women and 7 men – Table 3).

Table 3-Jobs held by the sample couples

Jobs	Female Nº	Male Nº
Administration high-ranking staff	1	1
Intellect/Science related professionals	2	3
Middle -ranking staff	6	-
Services/Sales workers	1	3
Textile/Clothing industry workers	16	3
Shoes industry workers	2	4
Machinery setting/maintenance workers	1	1
Metallurgist	-	2
Carpenter	-	2
Jeweller	-	2
Graphic Arts worker	-	2
Mechanic	-	2
Driver	-	2
Construction workers	-	2
Housewife	1	-
Electrician	-	1
Total	30	30

Source: Interviews made to infertile couples in 2005.

The rest is divided into professional categories of medium low to medium social standard (9 women and 19 men) and 3 women and 4 men of high social standard. In fact, 12 of the 30 couples had less than 1000 Euros of family month income and only 4 benefited of 2000 Euros or more monthly. We must remember

that Guimarães is one of the great industrialized areas in the all country. This is an important aspect, has we know that some professions have more risk of infertility, especially for men, such as the ones that deal with some toxics, like glues, inks and solvents. The formation of spermatozoa is also compromised when the men are in contact with high temperatures.

The majority of the interviewed couples lived all their lives in urban areas of the Guimarães municipality (only 5 men and 2 women came from another municipality or country) and the majority of them had until six years of education – Table 4.

Table 4-Educational level of the sample couples

Educational level	Female Nº	Male Nº
Less than Six years of education	17	19
Nine years of education	4	7
Twelve years of education	6	1
University degree, Master or Doctorate	3	3
Total	30	30

Source: Interviews made to infertile couples in 2005.

These results are consistent with the data for the municipality as, in 2001 (last Census), 38.8% of the resident population had only four years of education, a little higher than the 35.1% at national level.

4. The changing perceptions of the body and subjectivities

We have interviewed thirty infertile couples who have undergone assisted conception procedures and only three of them did have success on having a baby, while eleven of couples have achieved a pregnancy that ended on a miscarriage and nineteen were never pregnant. Considering the period of time that these couples spent trying to get pregnant, we have people who have spent three years and others who spent ten years.

Although most of this couples have low degree of schooling education, we might say that some of them can be classified as being "expert patients" (Webster, 2002) in the sense that they reveal some medical knowledge regarding their own

clinical condition. In fact, they seem to be engaged with a process that might be called «socialization of clinical diagnosis» (Webster, *idem*), meaning that lay people are aware of most procedures, concepts, risks, in this case proceeding from high-tech medicine, such as assisted reproductive technology.

The following example of the things said about their infertility clinical diagnosis, is rather illustrative that process of becoming aware of the functioning of the reproductive body and namely of the things that can go wrong when trying to conceive:

"My gynaecologist taught me several things I could do in order to improve chances of getting pregnant (...) she told me to get my temperature (...) and to have sex during my fertile period (...). For some time we thought that something could be wrong with my fallopian tubes (...) or maybe it could be some problem with my husband, considering the fact that he had varicocele (...). But the sperm count is normal, and so she thinks there is nothing wrong with me, that it must be stress." (Factory worker, 36).

All this experiences with infertility medical treatments seems to push processes of redefinition of the body and subjectivities in the sense of changing understandings of themselves, both physically as well as emotionally. It can be said that these couples perceive themselves as being dualistic: there is the desire to be pregnant, and there is the body refusing to cooperate (Cussins, 1996). The infertile condition has make them aware of the different parts of the body that before were invisible, such as ovaries and ovulation or spermatozoons. It also has made them to monitorize their own bodies (with procedures such as taking one's temperature every morning or watching the body for signs of ovulation).

5. Psychological and social pressure

For some couples, infertility carries with it a feeling of loss of control over their bodies and their lives and there is a clear centrality of biological parenthood. The important aim is to have a child which carries their genes and adoption is the «last option» (Stickler, 1992).

There are some things that were said about adoption:

"I will keep trying to have a child of my own (...) When I feel that I have reached the limits of my strength, I will stop trying. But it is difficult to know when it is the time to give up. But when that time arrives, I will tell to myself 'Ok, that's it' and then I will have to decide if to have a child still is important, and if it is, I will think about adoption" (Tourist operator, 34).

"I completely reject the idea of adoption, because that child would never be really mine. If I can have a child of my own, I will have. Otherwise, I won't have any children. And I will be happy just the same way. If I find out that I will never be able to have a biological child, I will accept with resignation." (Secretary, 29).

"I don't want to adopt. I would not be able to deal with the idea that that child wasn't ours. I rather be alone." (Factory worker, 37).

In interviews several couples state that the inability to have a child is profoundly disturbing.

"To know that we had to make an infertility treatment has changed our lives (...). My husband doesn't accept and before we found out that that the cause of our infertility condition was derived from me but also from him, he used to tell me that I was a zero, not even good enough to be a mother." (House servant, 43).

"I'm lucky that I love my job and it makes me forget this problem. But sometimes I feel that I will be depressed. Then we go out, because at least we have friends." (Tourist operator, 34).

To have a biological child is presented as being a crucial factor of well-being in the sense of control and fulfilment in their lives. Some women talk about the most precious dream, others talk about the need to have a baby in order to reach femininity:

"To be a mother is my dream, that's the thing that I want most in life (...). I always liked children and if I just could have one of my own (...). I would love to be a mother. It would be the fulfilment of a life." (Factory worker, 26).

"I suppose that to have a child is the dream of any woman. I've married because I was in love, but mainly to have a child." (Social worker, 29).

Infertility is seen for most of them as a devastating experience that interferes with major aspects of their lives, such as relations with family and friends and careers. Some of them described senses of isolation, resentment and stigmatization, and thus avoid friends and relatives.

"Sometimes I feel discriminated. Once, a relative told me that he would prefer to dye if he could not have children." (Unemployed, 37).

"I always hate when people feel pity about us" (Manager, 34).

"Some people like to make jokes about our condition. And it hurts" (Secretary, 30).

Special occasions, such as Christmas or «mother's day» are perceived as painful occasions.

"I feel discriminated because I don't have any children. When we spend Christmas at my husband's family we usually give presents to our nephews, but of course that we don't receive any presents. What are we doing there? Watching them being happy?!" (Social worker, 29).

"My friends don't invite me to the birthday parties of their children and it really hurts when it comes the mother's day and Christmas." (Factory worker, 29).

6. Concluding remarks

Infertile couples have made a high personal investment (financially and emotionally) in what they are undergoing, with considerable impacts on what can be classified as personal and family well-being. So, infertility is generally acknowledged to be a 'major life crisis' (Stickler, 1992) and typically medical, psychological and sociological literature tend to present infertile couples as emotionally devastated and anxious. The interviewed couples had heterogeneous and ambiguous feelings about infertility treatments, that can be described, as Stickler refers, as "a love-hate relationship" (Strickler, 1992: 116), as they offer hope of becoming pregnant, but at the same time led to prolonged suffering, physically and emotionally.

The infertility condition can be examined as an essential indicator of the perceptions and evaluations of well being and of 'living life' from the part of the individuals and of the families, but also as a social phenomenon which evokes gender differences, as we could evaluate because we have made interviews to couples.

One of our main findings was the preference given to biological parenthood and the sense of having a biological child was the major dream of a woman. As feminist critics of reproductive technologies have maintained the desire for children is socially constructed and has been used to define the supposed essence of femininity as a way of keeping women under control and surveillance. Another aspect is that the emphasis on genetic ties rather than nurturance (as it was proved by the rejection of adoption) can be seen as defining parenthood in a male-centred way (Stickler, 1992). In fact, these narratives clearly show that women are mainly classified by their role at the private and domestic sphere, that reinforces or the social construction of deviance or stigmatization aimed at women who don't have children. Femininity is also a synonymous of motherhood.

Infertility reinforces the prevalence of gendered processes at two different but interrelated dimensions: at one hand, the medical intervention and the infertility treatments mainly focus women, even when the infertility cause if masculine, as the feminine body as been culturally perceived as being more vulnerable to medicalization (Augusto A., 2004). By the other hand, the social pressure to have children is mainly directed to women. This is reinforced by the medical power and actions, that consider that women (more than men) have a biological impulse or necessity of having children and when that doesn't happen there are high possibilities of developing diseases, as the notion of hysteria as clearly revealed, for centuries.

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