

GENDER AND WELL-BEING
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**GENDER AND
WELL-BEING
IN EUROPE**

Historical and Contemporary
Perspectives

EDITED BY
Bernard Harris, Lina Galarraga
and Helena Machado

Gender and Well-Being

Series Editors: Cristina Borderias, Professor of Contemporary History,
University of Barcelona, Spain and Bernard Harris, Professor of the History
of Social Policy, University of Southampton, UK

The aim of this series is to enhance our understanding of the relationship between gender and well-being by addressing the following questions:

- How can we compare levels of well-being between women and men?
- Is it possible to develop new indicators which reflect a fuller understanding of the nature of well-being in the twenty-first century?
- How have women and men contributed to the improvement of individual well-being at different times and in different places?
- What role should institutions play in promoting and maintaining well-being?
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The volumes in this series are designed to provide rigorous social-scientific answers to these questions. The series emerges from a series of symposia, organized as part of COST Action 34 on 'Gender and Well-being: Work, Family and Public Policies'. Participants were drawn from disciplines including economics, demography, history, sociology, social policy and anthropology and they represent more than 20 European countries.

Gender and Well-Being in Europe

Historical and Contemporary Perspectives

Edited by

BERNARD HARRIS
University of Southampton, UK

LINA GÁLVEZ
University of Pablo Olivade, Seville, Spain

HELENA MACHADO
University of Minho, Portugal

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Chapter 12

Incomplete Women and Strong Men – Accounts of Infertility as a Gendered Construction of Well-Being

Helena Machado and Paula Remoaldo¹

Reproduction of human beings is also the reproduction of social relationships. It constitutes a multidimensional process, in which biological but also emotional, cultural and economic aspects play a determinant role in the construction of the experience and sense of well-being, mediated by gendered inequalities and sexual differences. Our aim in this chapter is to examine the ways in which infertility is a condition that can compromise both individuals' and families' sense of well-being and the extent to which this varies according to different gendered expectations. In medical terms, infertility is the diminished ability or the inability to conceive and have offspring. Infertility is also defined in specific terms as a delay in conception for a given period of time² (Boivin et al. 2007: 1057). It's important to take into consideration the fact that the negativistic words that are found in the medical

¹ Authors' note: this chapter is based on the outcomes of a project entitled 'Characterization of infertility in Guimarães Municipality (Northwest of Portugal)', POCTI DEM/44483/2002 (2004–2005), funded by the Foundation for Science and Technology (Portuguese Ministry of Science, Technology and Higher Education) (Remoaldo and Machado 2008). We would like to thank Susana Silva for the comments to a first draft of this chapter.

² According to the *European Society of Human Reproduction and Embryology* classification, which is consistent with standard practice and the WHO glossary, infertility is defined in medical terms as the diminished ability or the inability to conceive and have offspring and it is also defined in specific terms as the failure to conceive after at least one year of intercourse without contraception (Vayena et al. 2002: xx). Infertility is a condition which is typically cited 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 socioeconomic status, that are more exposed to environmental risks, mainly in their work (Strickler 1992). However, a recent study (Boivin et al. 2007) that reviewed existing population surveys on the prevalence of infertility and proportion of couples seeking medical help for fertility problems shows a different perspective. Based on data that came from 25 population surveys sampling 172,413 women, the authors indicate evidence of a 9 per cent prevalence of infertility (of 12 months). This estimate is lower than those typically cited and is remarkably similar between

definition of infertility, such as 'failure' and 'inability', project frameworks of understanding that convey a sense of inadequacy for those individuals – in particular women – that have problems conceiving and having children naturally.

The accounts on infertility or involuntary childlessness will be illustrated by the analysis of interviews with Portuguese women and men who wanted children but could not easily have them. We will explore the ways interviewees relate to their desire for children and the matter of infertility as a departure from well-being, as it is described in terms of failure, disillusion, incapacity, burden, incompleteness and social stigma. We will argue that understandings of infertility, as well as the way this condition is perceived as affecting well-being are related to the socio-cultural context in which women and men live and act. We intend to discuss, particularly, how infertility experiences reveal the weight of social, structural and gender relation factors, largely based on the ideological dominance of the nuclear and heterosexual family model, the symbolic importance of the biological dimension of kinship and the binding of the woman's identity and social role to maternity (Machado, 2007; 2008).

The most advanced western societies are nowadays facing a steep decline in birth rates, which is related, among other factors, to the growing insertion of women in the labour market, with the changes in conjugality and in the experiences of parenthood. However, society nowadays still shows some signs of pronatalism, in the sense that having children is widely assumed to be a natural and inevitable part of the lives of the married couple, in particular of being a woman (Ulrich and Weatherall 2000; Rowland 1992; Phoenix et al. 1991). This being the case, parenthood is still an element which provides status and identity to individuals.

In the first section of this work, we provide an analysis of interviews with women and men who wanted children but could not easily have them by focusing on the social construction of the desire to have children, as something which produces 'incomplete' women (which reveals the essentialisation of the natural impulse towards motherhood) and 'strong' men (which reveals the essentialisation of the natural impulse towards genetic perpetuation, combined with the supposedly masculine capacity to struggle against adversity).

In spite of the dominant idea that the experience of infertility constitutes an immense suffering for those who wish to have children, it becomes necessary to take into consideration the socio-historical conditions of the construction of the yearning for children, and in correlation, to approach the socially constructed character of the notion that children are a contribution to the couple's happiness and, therefore, their well-being. For all the couples we interviewed, to have a child was one of their major goals in life, which leads us to analyse the senses that the interviewees constructed in their pursuit for a child, and to equate the gender relations and models of affiliation and kinship involved in that search.

more and less developed countries, indicating that there may not be as much difference in prevalence of infertility according to development status, as has been commonly believed.

We will attend to two conditions that, in our point of view, and considering the socio-cultural context in which our interviewees are inserted, explain the essentialisation of the yearning for parenthood and of the couples with children and, simultaneously, the socially constructed perceptions which cause women to suffer the most when it comes to infertility. On one hand, we have the symbolical predominance of a conception of family and kinship grounded upon biological bonds, and in the sequence of marriage, sex, and pregnancy. This way, couples without children a while after marriage do not conform to socially created expectations. On the other hand, there is the continuance of gender inequalities which link motherhood to femininity (more than paternity to masculinity), seeing pregnancy and giving birth as an essentialised need for women, as well as a means of social integration and personal satisfaction and, consequently, a way of pursuing happiness and individual wholeness – of reaching satisfactory levels of well-being within a traditional family (Tamanini 2004: 79).

In the second and third sections of this paper we provide an overview of some feminist studies' approaches to infertility, in particular by discussing how the feminist analysis on assisted reproductive technologies (ARTs) has displayed the fact that the medical application of those technologies and its legal regulation reinforce gendered differences and inequalities. The assumption that individuals, above all women, need to have children in order to be healthy and happy, that is, to reach satisfactory levels of well-being (Ussher, 1989) may be seen and noted in several social contexts, which will justify the fact that women are the preferential targets of medical practices and, simultaneously, their bodies used as subjects of medical research (Barrett and Roberts 1978; Oakley 1987).

The feminist approach will be followed by a brief examination of the results of much of the available research supporting women's greater overt distress in response to infertility (Becker 2000; Saetnan et al. 2000; Strickler 1992; Ploeg 2001), which may well reflect differences in the ways in which men and women have been socialised to cope with negative effects. We intend to provide a framework for understanding the different gendered responses to infertility but also highlight the fact that assisted reproductive technologies act to the detriment of other proposals, like adopting a child or remaining childless. Hence, ARTs' emergence and applications come largely justified by assumptions related to the roles of women and men in society, such as the discourses and beliefs of motherhood as a biological destiny and an inevitable outcome of a woman's biology or, in the case of men, as a way of proving strength, virility, sense of responsibility (Webb and Daniluck 1999) and capacity to produce genetic continuity.³

3 Within western societies, kin relationships are deemed to be acquired by marriage and procreation, with generational ties being structured along bloodlines and the patrilinear kinship founded upon the ideological significance of genetic parenthood. One of the most widely debated influences on the nature of contemporary kinship across the social sciences has been the impacts created by the advancement of assisted reproductive technologies, in particular considering its potential to separate and fragment sexuality, reproduction and

This will inevitably generate new social, ethical and cultural problems for society to resolve and turns us to the point that technology and society are mutually constructed. In this case, we refer to technologies that may promise more than is deliverable. Hence, encounters with assisted reproductive technologies and fertility treatments can be described, as Strickler refers, as 'a love-hate relationship' (Strickler 1992: 116), as they offer the hope of becoming pregnant, but at the same time lead to prolonged suffering, physically and emotionally, with repercussions for the well-being of the individuals involved.

Feminist literature has been examining the mutual shaping of gender, science and technology (S&T), by focusing, on one hand, on how gender gets 'scripted' into the creation, design and use of new scientific knowledge and new technologies, and on the other hand, 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, insofar as we're concerned with the production and reaffirmation of gender inequalities, pointing out how women and men encounter fertility treatments by analysing their discourses about their desire for children and their infertility. This work follows the feminist legal studies agenda in the way Richardson (2005) proposes and illustrates in this quote: 'Instead of creating the identity of the woman-victim, feminism has questioned the meaning of what it is to be a woman. This has allowed feminism to challenge rather than create such a victim identity' (Richardson 2005: 291).

'Incomplete' Women and 'Strong' Men: The Construction of Conjugal Infertility

One of this study's objectives was to perceive in what way the experiences of infertility would conjugate with the dominant social and individual constructions of well-being, which in turn reveal themselves articulated with the social and cultural contexts of gender, conjugality and family roles.

Interviews took place in a region of northwestern Portugal that we consider to be rather illustrative of the socio-cultural characteristics that reproduce conformity with the notion of nuclear and biological family, although the scarcity of studies developed in Portugal about the subject of infertility would not allow the drawing of a comparative perspective or to present more consistent conclusions.⁴ According

parenthood. Some basic sources will be Stanworth (1987), Franklin and Ragoné (1998), Edwards et al. (1999).

4 Within the context of sociological investigation on the subject of infertility in Portugal, we must highlight the work of Amélia Augusto (2004) which focuses on the depictions of infertility produced by the media, by doctors and infertile couples. However, the author herself points out the study's lack of representativeness, for the reason that it only included 18 infertile couples. Another sociological study of interest for the Portuguese context is the analysis of processes of mutual conformity between law, science, technology

to recent official statistical data, this region has a birth rate (11.3 per cent) slightly above the national average (11.0 per cent)⁵ and the most common family model is the 'lawful' couple (heterosexual, bound by traditional matrimony) with children (60.1 per cent), which is well above the national average (42.3 per cent) (I.N.E. 2002).

In a total of thirty interviews,⁶ this study gathered the participation of 14 couples (woman and man) and 16 women. Participants selected for inclusion in this study had been medically diagnosed with infertility. Eleven of the interviewed women achieved a pregnancy that ended in a miscarriage and 19 were never pregnant. Considering that only two of the interviewed couples had not used assisted conception techniques but intended to seek medical help, most of these cases refer to situations in which the fertility treatments they had undergone proved unsuccessful.

The participants in this study were all Portuguese, heterosexual, married and white, but formed a heterogeneous group in social terms, showing diverse educational, professional and economical profiles, although there is a certain blue-collar prevalence (see Table 12.1).

All the interviewees were married at the time the study took place and the most common age group was the 30 to 34 years of age, with the lowest limit of the age range being a woman of 26 and the upper limit a man of 54.

When it comes to family income, 12 of the 30 couples had less than €1,000/month and only four made €2,000 or more a month.⁷ The low level of income of the majority of the people we interviewed appears along with unfavourable

and gender (Silva, 2008a), through the performing of interviews with women and men who had gone through personal experiences of medically assisted reproduction.

5 Some approaches of the procreative behaviour in Portugal reveal that the region in which the interviews took place showed, in the past, signs of strong social control, which would mean, namely, a high level of religiosity, mostly associated with the Catholic Church, that could partially explain the high levels of birth rate (Livi-Bacci 1971, Almeida et al. 1995). Up until the mid-80s of the twentieth century, this region showed one of the highest birth rates in Portugal. By force of changes in behaviour and mentalities and also through actual access to effective contraceptives, in the last three decades of the twentieth century in Portugal, the number of births has declined more than 30 per cent (Barreto 2000). In global terms, in the northern part of Portugal, the decline in the number of births started a bit later than the rest of the country, but today, we're seeing a nationwide convergence regarding a visible decline in the number of births, which is actually one of the lowest within the European Union.

6 Taken place in the homes of the interviewees during June and July 2005.

7 In Portugal, the costs of fertility treatments go about €1,250 in the public sector and €5,000 in the private sector, per treatment cycle. One could say that it's a rather expensive medical service in a country such as Portugal where the minimum wage in 2008 was €374.70. The difficulties in economical access to fertility treatments are immediately perceived. Although they aren't a subject of this chapter, they were consistently brought up by our interviewees.

Table 12.1 Interviewees' occupations

Profession	Women	Men
Public Administration's superior ranks	1	—
Intellectual and Scientific professions specialists	2	1
Intermediate professionals	7	3
Factory and manual workers	19	10
Unemployed	1	—
Total	30	14

educational levels, as three women and two men only had four years of education. The modal group regarding level of education was the individuals with six years of education, in women (n=14) as well as in men (n=12) and only three women and one man had a university degree.

The occupational profile of the people interviewed, combined with the fact that most of them didn't have more than six years of education, allows us to declare that this study came to widen the scope of knowledge around the experiences of infertility, insofar as most studies on this subject conducted in the field of social sciences have been mostly directed to middle and upper class female participants, thus reproducing the stereotyped infertile patient: middle or upper-middle class white women, in their 30s (Cussins 1996).

Reasons for Wanting Children

We began by asking our interviewees if they had already thought about having children and why. The responses reveal a wide diversity of reasons for wanting a child, from liking children, to a way to fight off loneliness or a 'natural' consequence of marriage or an individual's dream and yearning.

Within dream and yearning, the most frequently invoked reason for having a child is clearly expressed in the idea that this kind of yearning is mostly expected to come from a woman, within a cultural framework which, still nowadays, continues to bind woman and femininity to the reproductive sphere, turning childless women into 'incomplete' and socially disparaged individuals (Phoenix et al. 1991; Rich 1976).

The following account from one of our interviewees clearly illustrates the fact that motherhood is still, in society's eyes, one of the fundamental elements of femininity: 'I believe it's every woman's dream. And my greatest dream was to become a mother' (38 year-old woman, seamstress in a textile factory).

Another interviewee claimed that becoming a mother is a necessary condition to achieve 'full' femininity, revealing the sense that 'something' is missing, taken as essential to femininity's identity construction: 'For me to feel like a real woman all I lack really is just motherhood. I believe I have a good professional situation, sound family relations and I really miss that' (29 year-old woman, social educator).

The desire to have children also arises through the link between marriage and procreation that is, accordingly to the produced narratives, having a child is something which occurs 'naturally' in most couples after some time of marriage: 'It's part of it. When a person gets married she must get pregnant, right? If not, I don't think I would marry if I didn't want to raise a family' (30 year-old woman, textile worker).

Infertility as a Social Stigma

Whenever a marriage doesn't produce children after some time, the involved community, from close family, to friends and neighbours, begins to wonder about the reasons for the absence of children. The following account is illustrative of the evaluation processes that such couples are subjected to, which reproduces the idea of having children as a stage in the development of a relationship and as a social expectation: 'People always ask 'So, when is the baby coming? So many years you've been married!' (28 year-old woman, unemployed)

The perception of reproductive inability as a condition that doesn't accord with what society and especially with what closest relatives expect from an individual leads to diverse and complex feelings, which span from the sense of inferiority, to repulsion and social exclusion.

The next testimony from a woman portrays the sense of 'abnormality', of difference regarding the other women who can procreate, showing also a feeling of disgust, but of inferiority and impotence as well, for not being able to reach what one wants most: to have a child: 'That's what disgusts me the most, and I feel a little bit inferior to other women for [not having children]. Listening to my friends talk about [children] and knowing that is something that we want so bad, but we can't get it, it's very complicated' (35 year-old woman, factory worker).

Gendering Infertility

The binding of social stigma seems to appear mostly associated to the woman. According to testimonies collected from two male participants from couples, the popular voice (in this case, the family) ties the blame for the infertility to the woman, suggesting that she doesn't comply with the proper functions of feminine beings.

One of the interviewed men portrayed exactly the situation generated by factors related to tradition and culture which associate infertility predominantly with the feminine side. Furthermore, the 'blame' attribution for reproductive inability is projected by women in the family: 'We already felt the looks of my parents, my mother, my aunts and such. It's like: If you don't have children that's because there's something wrong with her. It's just the thing with the looks and thinking she's the one with the problem, even though it might be mine' (31 year-old man, jeweller).

One of the most recurrently used words by our interviewees was 'pressure', which assumes several forms, from discrete questions about the motives of the

non-existence of children, to subtle accusations of inability and selfishness, as if it were the couple's choice not to procreate.

Men and women feel themselves targeted by social pressure, which produces great emotional suffering, sometimes forcing them to pretend that having children is not a priority in their life. A socially accepted justification for not having children is presented: the need to get their life 'organised' that is, gathering financial resources and stability. What could otherwise be classified as a rational decision, based on the autonomy and freedom of decisions for their reproductive career, particularly by women, is reconfigured as a strategy which comes to broaden the female tendency to have children and take care of them. This happens because the postponing of the beginning of the reproductive career is only acceptable within many social groups as long as it is based on the concern to gather beforehand the necessary elements in order to afford comfort and well-being to future children: 'We kept saying that we had to take it easy; that we had to get our life sorted out... excuses!' (28 year-old woman, pharmaceutical technician)

The social pressure to have children and the suffering associated with the inability to have them often lead to feelings of exclusion, or 'being put aside'. The family's festive occasions which usually call for the presence of children, such as birthdays, Christmas, Mother's day or Father's day, are lived through like torture: 'I feel many times excluded and put aside for the fact that I don't have children. For example, during Christmas we trade gifts and we give them to all the children but the adults don't give us any. It's in these moments that we feel left out. But not just from the family, also from society' (29 year-old woman, social educator).

Although negativity is the dominant tone in the interviews, one of the interviewed men mentioned that he never felt like he had been discriminated against for not having children, stressing the positive aspects of such condition, namely, the absence of worries and the opportunity to enjoy more autonomy and rest. By pointing out the 'advantages' of not having children, this man is projecting an attitude of rationality and exercise of autonomy and personal freedom, socially valued in men, that appear as responses to what he considers to be the social pressure to have children: 'There are advantages and inconveniences. I might have a disadvantage such as "hey, it's Father's day and all", but in compensation I'm able to sleep all night. That is, I have some privileges for the fact that I don't have to put up with anyone' (45 year-old man, lawyer).

The seeming distance that this man shows concerning what is socially expected – to get married and have children – comes to consolidate the projection of associated behaviour to what we could designate as the 'dominant' masculine imagery which is ruled by the importance given to emotional control, autonomy and strength (Collier 1995). This narrative shows that there is a need to develop a positive reconstruction regarding the 'failure' of infertility. This 'deleting' of men's suffering is based on the dominant view of masculinity which perpetuates the idea that men can control their anxieties and emotional states by controlling the external environment (Silva and Machado 2008). The strategy of minimizing the impacts of infertility echoes the findings reached in a study of infertile men

(Webb and Daniluck 1999), that show the presence of positive reconstruction strategies of infertility situations, for example, through the redefinition of life priorities, allowing men to maintain identity processes socially attached to masculinity, namely those based on values such as competence and strength.

Another aspect which seems to differentiate women and men's responses to infertility, and which is related to the distinct socialisation processes that women and men go through, points towards the fact that there is a distortion of the suffering caused by infertility by focusing on the woman. This is because a strong man, even if he is suffering, conceals such feeling and transfers it to the female element. Contrary to what occurred with the women we interviewed, none of the men would make references to individual models of experiencing and living through infertility.

The strategies used to make men's suffering 'invisible' in situations of infertility disclose social processes of gender differentiation, which refer to the masculine as the side of reason and the feminine as the emotional side. Even if the infertility cause is the male's, the narratives surrounding infertility are centred on the woman – in her yearning to have children, in the suffering for not having them and the pain caused by the treatments, which concern the woman's body as their main subject: 'Knowing that she wants a child and can't have them ... having to go through the treatments and she suffers more than I do in the treatments... it is she that has to get all the injections ... it's a bit complicated. It's not easy' (31 year-old man, furniture dealer).

Our male interviewees often described the suffering caused by the absence of children in ways which tended to erase their own psychological suffering, either by placing more emphasis on the woman's suffering or by the use of descriptions which emphasised the suffering of both partners as members of a couple.

Valorisation of Biological Links

And what to do about infertility?

The dominant response was the will to carry on the 'fight' to fulfil the desire to have children, felt as fundamental by most interviewees. This meant that they continued to look for fertility treatments. The social construction of parenthood as a natural imperative, based on the argument of human instinct, above all feminine, for procreation is reinforced and consolidated by the importance of producing offspring naturally (Ulrich and Weatherall 2000: 327). The essentialisation of the natural desire for parenthood is conveyed by the interviewees when they mention their struggle to have a child of their own blood: 'I'll go all the way, for as long as I have the resources, as long as I have the possibilities to have a child of our own. When they tell me: It's over, you don't have any more egg-cells, you don't have ovaries, you don't have anything. Forget it, adopt ... or live your life without thinking you'll have your own child. As long as nobody tells me such things, if it depends on me, I'll go all the way' (30 year-old woman, textile worker).

But whereas the interviewed women refer to such struggle in the first person ('I will fight'), men refer to the couple's struggle. This comes to reinforce the idea that women are naturally more oriented towards procreation and that having

children is seen as an essential part for the construction of individual identity (the need to feel 'complete'): 'We're fighting till the end. Only when the doctor tells us it's over, that it isn't worth it to insist anymore... for we shall always fight' (38 year-old man, steel worker).

The privileging of biological parenthood is strongly rooted in what is considered to be the couple's, socially expected, 'normal trajectory'. With the development of ARTs which promise to fight the fate of procreational inability, the quest for genetic continuity – the biologisation of family – along with the entire symbolical load it carries, seems to be emphasised. In fact, social pressures towards biological parenthood are reinforced by reproductive technologies themselves, since the fundamentals of their use are precisely based on the possibilities to naturally engender a child (Stanworth 1987; Franklin and Ragoné 1998; Edwards et al. 1999). The privileging of genetic continuity is reflected by the rejection of adoption as a possibility of parenthood: 'To adopt, I think I wouldn't want to. Knowing it's not really ours ... I wouldn't want that. I'd rather stay alone' (37 year-old woman, factory worker); 'I don't want to [adopt a child], because I think it would never be my own. Either I have one or I don't' (29 year-old woman, office clerk).

Thus, once again, we see that procreation and parenthood, more than natural, are foremost the result of social constructions (Strathern 1992; 1995).

Impacts of ARTs in Family and Gender Relations: The Feminist Approaches

Assisted conception techniques, as well as other reproductive technologies, such as those designed to control infertility, to monitor and control labour and childbirth, to monitor the quality of the foetus and provide pre-natal and neo-natal care, have always been the subject of legal, political and moral debates (Stanworth 1987). Social sciences – and in particular feminist research – have been contributing to the debate by analysing the socio-cultural dilemmas that are being raised in the context of ARTs, in addition to difficult ethical, personal, moral and political questions. In the context of this chapter we are mainly interested in focusing on two of the fundamental aspects of the feminist approach on these technologies' impacts: on one hand, the way these technologies come to consolidate the patriarchal collection of ideas of family, based on the sequence of marriage, sex, procreation (based on biological bonds) and, on the other hand, the way in which the infertility experiences reproduce and amplify the gendered social relations.

Even the legal regulation of the ARTs itself, existent in the Council of Europe's recommendations on Artificial Human Reproduction (1989) and in most European legal frameworks (Ferreira 1999; Sheldon 2005a), privileges the traditional,⁸

⁸ The justification for the existence and development of ARTs depends, to a great extent, on the fact that most infertile couples show their preference for children resulting from their own genetic material, turning to gametal donation only as a last resort (Stanworth 1987; Franklin and Ragoné 1998; Edwards et al. 1999). An assisted reproductive technique

heterosexual, preferably married family and biological kinship. In Portugal, the present applications of ARTs⁹ reveal the power of the social and moral values which are dominant within Portuguese society in terms of sexuality, conjugality and family, by which conformity to the nuclear, heterosexual and biological family is essential (Augusto 2004; Nunes et al. 2004; Silva 2008b, Silva and Machado 2008; Remoaldo and Machado 2008). One of the most revealing aspects is the fact that, in Portugal, the ARTs are being faced as a subsidiary, rather than an alternative method for procreation, that is, as a therapeutic answer to fertility problems or to situations in which there is a risk of transmission of infectious or genetic diseases (in married heterosexual couples or in legal union considered to be 'stable'), which excludes its application in cases of single women or that are not in 'stable' relationships and non-heterosexual couples.

A considerable number of writings by feminist scholars 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.¹⁰ Many powerful critiques by feminist scholars call on reproductive technologies to backup their theories of objectification of women and emphasise the dangers of reproduction of a patriarchal logic which subjugates women, especially when allied to a market logic and power (mostly masculine) of medical practices.¹¹ Liberal feminist analysis decries the objectification of women (Cussins 1996) and points out that reproductive technology increases choice for women.¹²

In this study, almost all couples pointed out situations of discrimination, vulnerability and threats to the woman's physical integrity resulting from medical treatments (Douglas 1991), and the hindrance from fair access to this

which clearly describes the importance of genetic bonds between the parents and the children is the Intracytoplasmic Microinjection (technique which consists of injecting one spermatozoid into an egg-cell by micromanipulation), which avoids resorting to a sperm donor. The desire to achieve procreation through 'normal' means is also visible in the fact that many couples that resorted to Intrauterine Insemination with sperm from a donor would conceal the fact from the children (Golombok et al. 2005). In the same manner, the fact that the medical experts try to match the donor's physical characteristics (blood group, height, race, skin, hair and eye colour) of the child to the non-biological father's, comes to reveal exercises of kinship 'construction' which seek out to meet the social expectations of biological kinship (Thompson 2001).

⁹ In 1986 the first 'test-tube baby' was born in Portugal. But only 20 years later, in 2006 (Lei no. 32/2006), Portugal was given the first legislation on ARTs.

¹⁰ For a short and useful review of the main feminist approaches on Assisted Reproductive Technologies, see Cussins 1996.

¹¹ Feminist writings on the objectification effects of reproductive technologies on women's bodies and lives are extensive. Essential sources include Spallone and Steinberg (1987); Corea (1987); Kirkup and Keller (1992), Raymond (1993).

¹² For an illustrative liberal feminist critique of reproductive technologies see, for example, Birke et al. (1990).

sort of health care, mainly because of the lack of economical resources, access to information and conciliation between their professional activity and consulting hours. All of these processes interfere with the individuals' bodily, psychic and social conditions that may collide with the constructed notions of well-being, and represent impediments to a complete fulfilment of sexual and reproductive rights, leading to the questioning of the access and enjoyment of resources (Robeyns 2003), mainly when the socio-economical and cultural conditions under which women and men make their choices are not considered.

Western belief systems about motherhood and parenthood act in order to legitimate dominant socio-cultural beliefs and practices – namely, the patriarchal nuclear family, heterosexuality and genetic parenthood. In this context, infertility is constructed as impairment or as failure and much psychological and clinical theorising and research has presented infertility as a significant challenge to the psychological and emotional resourcefulness and well-being of couples, resulting for some in impaired sexual functioning and dissatisfaction, marital communication and adjustment problems, interpersonal relationship difficulties and emotional and psychological distress (Webb and Daniluck 1999).

More Stressed Women?

Findings of much research on the psychological and social consequences of infertility suggest that women, more than men, experience more negative effects of infertility, tending to reinforce dominant social beliefs about motherhood as necessary to womanhood by endorsing beliefs about women needing children in order to develop as healthy individuals and about mothers being crucial to a child's successful development (Ulrich and Weatherall 2000: 324; Phoenix et al. 1991). In this sense, psychology, as well as medicine and common sense assumptions have promoted motherhood as essential for women's well-being, for their psychological completeness and happiness.

The feminist research has been contributing to the critical deconstruction of these assumptions about the inevitability of the feminine yearning to become a mother and the direct association between reproductive capacity and happiness, health and well-being. In social contexts where femininity tends to be closely attached to reproductive capacity and the 'marriage-sex-procreation' triad prevails, there are cases of childless women that are recurrently seen as pathologies (Morell 1994) and childlessness and infertility are often conflated.¹³

¹³ We use the term childlessness as meaning 'no child after a given period of marriage' (Boivin et al. 2007: 1507). The term might be used for couples not wanting children but is commonly applied to couples who want children but experience a delay in conception. According to Boivin et al., in fertility surveys a distinction should be made between infertility (by posing a question such as 'Are you presently experiencing/have you ever experienced a delay in conception/difficulty in carrying a child?') from childlessness

Besides, it is also possible that in many cases the option to turn to ARTs is given as one of the few choices presented to women (if not the only one), because of the social stigma attached to infertility and non-motherhood (Crowe 1987). We must point out that one of the main achievements by feminist literature has been to set the need to argue for a broader definition of motherhood and a wider variety of culturally sanctioned roles for women (Ulrich and Weatherall 2000).

The incapacity to have a child is generally acknowledged to be a major life crisis and typically, medical, psychological and sociological literature tends to present infertile couples as emotionally devastated and anxious. Infertility is thought to be an experience that leads to prolonged suffering, physically and emotionally, also posing the question of the right to procreate and to fair justice on egalitarian access to health services, which in the case of ARTs, involves proceedings and arguments around the priorities for the Portuguese health care system.¹⁴

However, most studies about infertility experiences have focused essentially on women and it could be the case that the instruments used to collect information would be more sensitive to women's responses to infertility. The reasons why that would happen are diverse, beginning with the fact that women are the ones who must endure most of the medical investigations and treatments for the couple's impaired fertility, even if the cause of infertility is masculine. Another point is that the unsuccessful fertility treatments are given explanations based on the belief of the 'miraculous' character of scientific and technological progress, holding women as primarily responsible for the maximisation of the possibilities of success of the techniques or their failure. Women themselves tend to take full and individual responsibility for unsuccessful treatments (Silva 2008b, Silva and Machado, 2008). They see themselves as 'guilty' for not achieving pregnancy, even when the detected cause is found to be the male. Whether it's because they don't respond to hormonal stimulation, or because they fail to accept the embryo, or even because they don't conduct the most 'suitable' lifestyle after the transfer

('After being married for [specified number] years do you have a child?') (Boivin *idem. ibid.*). As Ulrich and Weatherall point out 'Not only has psychology promoted motherhood as essential for women's completeness and happiness, but childlessness or not wanting children has been viewed as unnatural and pathological.' (2000: 324).

¹⁴ Given that the economical income is one of the most widely used variables in order to uncover health care access inequalities, it becomes particularly striking in cases of infertility in Portugal once we notice the high costs associated with this kind of treatment which is offered in most cases by private clinics, predominantly orientated towards profit and cost-effectiveness and, thus, making their price range inaccessible for many Portuguese people. Most of the 28 (2007) clinics who offer fertility treatment are located in the larger urban centres (11 clinics in Lisbon and six in Oporto, respectively), which considerably raises the costs of access to fertility treatments for those who live far from the clinic's location. This comes to aggravate the inequalities in the access to ARTs for some population strata, which makes it difficult to accomplish the WHO goal of accessibility as a key millennium challenge for those involved in the delivery of fertility treatment and assisted reproduction (Boivin et al. 2007).

of embryos, they become vulnerable to certain psychological mechanisms or even to difficulties related to their age.

As Irma van der Ploeg puts it, in a book that focuses on the very invasive, dangerous and traumatic treatments for male infertility and foetal surgery solely through women's bodies, in a context of a medical approach to women's bodies that understands them as the 'natural' and 'given' subject of medical investigation and intervention, there is a paradox and a contradiction that has resulted from the 'combined achievements of medical reproductive technologies and feminism' (Ploeg 2001: 2). The paradox is that, at the same time women enjoy greater freedom over reproductive choices, in the case of reproductive technologies, they are often subjected to physical, invasive and risky procedures in a way that the struggles to emancipate women were attempting to move beyond (Stengel 2006).

In addition, it's also women who more frequently assume responsibility for initiating treatment efforts, a fact that may reflect women's long-standing involvement with medicine during the course of their lives, particularly when issues of reproductive health are concerned. Social context and expectation are also important. Since pregnancy and parenting are believed to be mainly women's issues, this means, in consequence, that failure to biologically reproduce may affect women more negatively to meet gender role expectations than men.

These techniques may also be used to overcome malfunctions of the male body, but in a process of medical intervention that is directed 'inside out', since the most widely used technique in a male infertility context is the intracytoplasmic injection (a technique which consists of injecting a sperm-cell inside an egg-cell through micromanipulation), that even permits the harvest of immature cells (spermatids – male germ cells derived from spermatocytes and developing into spermatozoa) allowing the male gamete to be prepared and capacitated for reinsertion in the conception process as fertile. From this perspective, the male body is perceived as 'naturally fertile' (which reinforces, through medical practices, the cultural conceptions that a man is always fertile). On the other hand, the female body is seen as more needy of medical help and intervention, and therefore, more vulnerable to screening processes. Hence, women are doubly integrated into the reproductive medicine techniques – on one hand, they are elected as fundamental actors in assisting medical production; on the other hand, they are seen as the preferential object of medical practices.

Conclusions

We have intended to understand the ways in which infertility experiences relate to social and individual constructions of well-being, which in turn disclose articulated relations with social and cultural contexts of gender roles, conjugality and family, based on processes of essentialisation of the yearning to procreate, and are mostly aimed at women. As Tamanini (2004) would say, based on the approach on the application of ARTs in Brazil, these promise to give the woman

back what she lost or what she didn't have in reproductive matters – and we are faced with the 'incomplete' woman imagery – at the same time men are offered the possibility to enhance what they already have – for men are naturally complete and therefore 'strong'. The applications of ARTs are developed in a social context which essentially invokes gendered social relations, despite the fact that fertility treatments appear legitimated by the couple's 'will' and 'yearning' and often mostly grounded on the woman's desire to have children. It's important to understand to what extent such desire is socially constructed and historically conditioned.

The desire to have children appears as something fundamental in the interviewed couples' lives, for several reasons, from the perception that procreation is something expected from those who are married, to the reports that mention the need to fulfil a dream and a desire. Generally, the aspect of desire and the perception of procreation as something which corresponds to individual as much as social expectations are articulated together and ARTs are themselves shaped with these social contingencies.

Women's social binding to procreation can cause incapacity to breed to be seen as a deviation from the expectations of the individual and those of others. Hence we suppose that the social pressure to have children and the condition of infertility mostly penalises the woman. There are, however, authors who mention that infertility can be as much or more penalising for men, insofar as male infertility appears culturally associated with the loss of virility, which may cause this condition to be experienced as a manifestation of impotence and a loss of manliness (Webb and Daniluck 1999; Wright et al. 1991).

Wanting children and not being able to have any engenders feelings of frustration, anxiety and disappointment. Suffering is kept silent and the condition of infertility is concealed. A heavy burden is carried by women, as well as men. The women feel incomplete and unable to fulfill what they understand to be their socially predestined function: to become a mother. The men feel threatened by the incapacity to procreate, which is culturally associated with a loss of their manliness. They assume an ambiguous role that comes with the 'protective element' function that reproduces the gendered social expectations: they are simultaneously cooperative and strong: cooperative, insofar as they share the women's suffering, manifesting discomfort towards the physical pain inflicted on their mates by fertility treatments and the risks they are subjected to, for it is on the women's body that most medical exams and medication are applied. But according to socialisation differences between men and women, this study identified in men the belief that they should be the couple's 'strong' element – the ones who share the pain and suffering but don't let themselves be shaken by the misfortune of infertility.

Previous studies about the way women and men deal with infertility and medical treatments point towards differences and similarities. Published literature on the theme, as well as our study, led to the fact that women, as much as men that are faced with the experience of infertility, feel that several dimensions of their personal and social life, the familial and social relationships, the conjugal relation and expectations regarding marriage and their senses of femininity or masculinity

are transformed. That is to say, infertility leads to the reconfiguration of life projects and identity processes, which in social contexts where healthy adult individuals – overall healthy women – yearn for children, contributes to the limitation of the possibilities of construction of well-being.

Differences in the ways of facing and handling infertility are also stressed and seem to indicate that the situation of being unable to bear children is apparently more penalising for women, who show higher levels of distress (Wright et al. 1991) among other reasons, because of differences that seem to reflect distinct socialisation processes regarding the manner in which it is socially expected for women and men to deal with negative events. According to the dominant models of sexual division of labour, the women are allowed to cry, whereas the men are not, which comes to essentialise the idea of the natural impulse towards parenthood – necessary for the 'wholeness' of the being, especially in women, and revealing of the male 'strength', through the naturalisation of the instinct for the genetic perpetuation of the species, evoking attributes culturally associated with men, such as vigour, energy and virility.

Paternity may be an attribute of manliness, but not in the same way that maternity is an attribute of femininity. The social construction of the desire for children appears, regarding women, as a yearning that has always existed, as something instinctive and natural, as if maternity was to be an experience of continuity, of repetition, of fulfilment of a plan always elaborated in the feminine past, necessary to make the woman 'complete' (Rich 1976; Oakley 1980; Phoenix et al. 1991). However, paternity reveals a fundamental design for a certain type of masculinity – that of the married man – since the single's masculinity may be grounded on the lack of responsibility and in sexual liberty, as a desire that is established during a certain moment of the life cycle, facing towards the future, for progeny, enabling changes or substitution of such project. But infertility brings the risk of femininity or masculinity being positioned in the lower strata of the 'more or less' feminine or masculine (Costa 2002).

One central assumption of this chapter is also that the ARTs, rather than revolutionising the conceptions and practices of gender relations, family and kinship, produce a reproduction or even an ideological amplification of the traditional definitions of these concepts (Sheldon 2005a; 2005b), grounded upon the nuclear and heterosexual family model, in the symbolical importance of the biological dimension of kinship and in the binding of the woman's identity and social role to motherhood. In fact, one of the basic assumptions of technological innovations and medical practices in the area of assisted reproduction is to contribute to the well-being of families.

We suggest that ARTs may be technologically innovative, but they are conceptually conservative in upholding existing cultural assumptions about parenthood, sex and marriage. From our perspective, the application of science and technology to the process of human reproduction should, above all, widen the possibility for a greater diversity to build familial and kinship relations with more fluidity than those of the barriers established by the ideological dominance of the

heterosexual, nuclear family with the ability to procreate. It is our assessment that a broader definition of motherhood and fatherhood is needed and, above all, a wider variety of culturally sanctioned roles for women (Ulrich and Weatherall, 2000). We argue for alternative representations of parenthood in a sense that enables individuals, women and men, to live a 'good' life, to reach more satisfactory levels of well-being and to compose their effective functionings, in the sense developed by authors like Amartya Sen (1985). Feminists see reproduction as a potential source of women's power but also as an historical justification for its limitation. Accepting this view, we consider that it is also imperative not to restrict women to the dominant normative representations of femininity within patriarchal societies and to allow real freedom or ability to develop positive states of being (Robeyns 2003). How can this potential contradiction be surpassed in a positive way? How can one call it a choice when it's seen by everyone else as a duty?

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Chapter 13

Time to Do and Time to Be? The Use of Residual Time as a Gendered Indicator of Well-Being

Claudine Sauvain-Dugerdil

The term 'indicators of well-being' implies an essential incoherence. By nature, an indicator is essentially factual and is supposed to reflect objectively the reality that it measures. It has therefore mainly an *etic* dimension, i.e. 'regarded as meaningful and appropriate by the community of scientific observers'. In contrast, well-being is rather *emic*, that is, regarded as 'meaningful and appropriate by the members of the culture under study'.¹ It is therefore highly variable, complex, difficult to define and even more difficult to measure.

As in the case of notions with similar meanings, e.g. the quality of life and human development, well-being has been the object of numerous studies and measures, though these have not really been satisfactory. It appears that, in practice, well-being is reduced to a few easily measurable dimensions. This is so inasmuch as well-being is generally considered in relation to actions (policies, programmes and projects) that need to be monitored. In other words, the usual approach refers to 'well-doing' rather than to well-being, to an exogenous, rigid scale rather than to an endogenous, flexible one centred on the individual's perceptions of his or her own needs. Introducing the *emic* dimension leads one to consider individual agency not only as expressed in practice, but also as a cultural agency. Beyond behaviour and the way a person lives her/his (everyday) life, one must then take into account her/his value system. The observable activities and decisions – the *etic* side – make sense through the meanings given by the individual themselves – the *emic* side. Yet, the meanings bestowed by each individual are the outcome of a complex negotiation among personal aspirations, social expectations and all types of constraints. The space of individual freedom and the capacity to conceive and realise a life project are thus diverse and depend on the human resources one possesses. Individual projects may only be conceived as 'grounded', i.e. in reference to one's status and position in the life course.²

¹ Notions introduced by Pike in 1954. See James Lett (1990) for a brief introduction on the topic. S.C. Hussey and K. Colich (1990) provide a more detailed bibliography.

² The notion of 'grounded project' (*projet situé*) has been introduced by Bassand and Kellerhals (1975) in reference to parenthood (see also Sauvain-Dugerdil 2005).