Social Stigma and the Medicalisation of Infertility

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Introduction
Woman's health has been located in her capability to reproduce for more than a hundred years. Her ability to menstruate and bear children is the main focus of her bodily health. If something was wrong with her body's ability to perform these activities she is seen as faulty, deviant or incomplete. The way that infertility is perceived and the social pressure for women (and men) to have children has changed over the years. Societies' need for couples (women) to bear children has gone through many ups and downs during the centuries. It is during the upward swing of this pressure that infertility and childlessness comes to the forefront. Indeed, the concept of infertility has gone through changes over the centuries; it has gone from being known as barrenness to being known by the medical term infertility. Women, as well, have gone through some changes; once considered to be the one at fault when they could not have children, presently, the couple goes in together to be tested. Even still the woman is the one to prompt medical treatment. Has the social situation around the inability to bear children improved? Are women still taking the brunt of the 'problem' on themselves? Has societal pressure to have children and social acceptance of being childless (voluntary or involuntary) changed? What has the advent of medical intervention done to societal pressure and/or acceptance of infertility? This essay will examine the history of infertility (barrenness) and the changes that have happened over the years to see if the situation of women's control and care of their health and bodies has improved, stayed the same or has worsened.

Women's Health
Women are essentialised as child bearers. Their reproductive health is seen by the medical community as the most important part of a women's well-being (Inhorn 2006). How many women see a doctor only for a yearly pap test/pelvic examine but otherwise do not see a doctor unless it was an emergency? In developing countries, the focus is on preventing maternal death, eliminating unsafe abortions, and preventing the transmission of HIV/AIDS. According to Inhorn (2006), reproductive health tends to be ignored by the global health initiative. Women's lives are increasingly being medicalised (Inhorn 2006), especially childlessness, which was once seen as a social problem and has now become part of the medical sphere. Infertility, though not a disease, is treated as such by the medical community (Becker 1994), and the words used to describe it increase its mediatisation. Infertility is described as a problem (Woollett & Boyle 2000) that needs to be treated (Ulrich & Weatherall 2000). The definition of infertility is very specific and medicalised. Women are considered infertile if they cannot conceive after a year of trying without contraception (Vissing 2002; Inhorn 2004) or cannot carry a child to term.
Infertility is further distinguished into primary fertility, which means that a couple has not conceived after a year of regular sexual relations without contraception and have not conceived before; and secondary infertility, which means a couple has failed to conceive after bearing at least one child or have failed to carry a baby to term (Miall 1986).

Other areas of women's reproductive cycle have been medicalised as well. For example, premenstrual syndrome and menopause have been named as conditions that need to be treated by the medical community. Women are not forced to take a doctor's diagnosis. Yet, in time, women are accepting of the biomedical power that doctors have over women's bodies. There are also local moralities that influence women's bodies; for example, the abortion debate and the decision whether or not to have an abortion (Inhorn 2006). Another example is the control rabbis have over the IVF treatment women received in Kahn's (2000) ethnography Reproducing Jews: A Cultural Account of Assisted Conception in Israel. The rabbis decided that with AID (Artificial Insemination by Donor) conception, the sperm donor should be a non-Jewish male because if it was a Jewish male it would be considered adultery.

**Barrenness/Infertility**
The inability to conceive a child (or carry a child), was historically called barrenness. The term barrenness is still used even though, more and more, infertility is replacing barrenness as the word of choice. Hysteria was one of the earliest reasons for barrenness. It was felt that women would develop hysteria, which at the time thought to a wandering uterus, because of being deprived of sexual relations (Rodin 1992; Micale 1995). The wandering uterus would cause many physical symptoms in a woman such as dizziness, motor paralyses and respiratory problems. The reason for hysteria in women changed over the years but the reproductive element did not; not until Charcot theorized that hysteria was a psychological problem did the focus moved away from the uterus and reproduction (Micale 1995).

For early Americans, having children was a means of survival (Tyler May 1997). Children were needed for economic reasons such as helping on the family farm. There was pressure on the early Americans to be fruitful and multiply as is stated in the Bible (Monach 1993; Tyler May 1997). Women who were unable to have children felt that it was God's will that made them childless; it was up to God to bless them with children like he did for Sarah and other barren women-in the Bible (Tyler May 1997).

Barrenness did not bear a heavy stigma in early America as it does today; it was met with a lot of pity but a woman could still be a good wife. Even though barrenness was not grounds for divorcing one's wife, impotence was considered an adequate reason to divorce one's husband in historic America (Tyler May 2006). While God was felt to be the main reason behind their barrenness, many childless couples turned to midwives for help with their circumstances. Physicians were gaining popularity in the eighteenth
century, but midwives were still sought out because their techniques were not as invasive and aggressive as physician's treatments. Some of the reasons given for barrenness in this time period were women hating their husbands, men masturbating and wasting their seed and women being frigid. Barrenness was felt to be more a woman's problem than a man's. It also was felt that women must eat well and live an active and virtuous life to prevent barrenness. The colonialists even gave their children names, such as Fruitful and Increase, to promote fertility later on in their lives (Tyler May 2006).

According to Tyler May (2006), by the nineteenth century people were turning to physicians in greater numbers. In return, physicians were becoming more aggressive in their search for ways to treat sterility. The treatments moved away from the balancing of bodily fluids within the body to the actual body parts themselves and surgery became the new solution. Surgery entailed making cuts in the cervix because it was felt that it was blocking the sperm but there was no evidence that this procedure was successful. Physicians also experimented with artificial insemination using a syringe filled with the woman's husband's semen but this as well was more likely to fail than to succeed (Tyler May 2006). Monach states that during the 1920s and 1930s, in America, childless women, or spinsters as they were called, were widely accepted and expected because of the lack of men to marry. The spinsters filled the roles of teachers, nurses, and social workers but as these roles started to be filled by married women and men, the spinster was looked upon more negatively (Monach 1993). The fervour for children began during World War II when the bearing of children was seen as a patriotic duty and it soon became an obsession. In the post-World War II era the push to have children was in full swing because the hope for the American future was seen in the nuclear family. During this time, childless couples were seen as socially maladjusted (Tyler May 2006).

In the 1970s, the social obligation to have children, that was part of the post-World War II era, was dying down because bearing children was redefined as an option not a duty (Koropeckyj-Cox & Pendell 2007a). But during the same time, the 1970s and 1980s, the United States had adopted a pronatalist policy. Pronatalism encouraged reproduction, birth, and parenthood for everyone. Pronatalism was seen everywhere from religion and education to media and medicine. Pronatalists believed that a couple who does not want to have children is not ‘normal’ but by bearing children a couple could be seen as ‘normal’ (Monach 1993). Pronatalists also believed children strengthen a marriage; children are necessary for mental and physical well being of men and especially women, and being a parent is an innate instinct (Monach 1993; Ulrich & Weatherall 2000). The 1980s were also a time where couples turned to medical treatment for their childlessness; this caused a shift from childlessness as being a social problem to being a medical problem (Becker 1994).
The social construction around the bearing of children has caused infertility to no longer be considered a social problem. The societal pressure to have children and the importance placed on children has forced the medicalisation of infertility. The society, in this case the United States, is controlling the woman’s body and the way it ‘should’ work. As stated above the woman has been essentialised by her ability to give birth, to the point that even the nation is focussed on that one idea. The cultural pressure, to have children to appear normal, has caused women to be set apart and medicalised much more than men. The blame cannot be fully placed on society, for the woman herself more often than not is a willing and active participant to seek and follow medical advice.

Beliefs and Misconceptions around Infertility/Barrenness

Throughout the world there are many beliefs and misconceptions about infertility and the inability to have children. The main one being, that it is women who are the ones at fault when it comes to infertility. This belief probably comes from the fact that a woman is the one who actually gives birth. So it would come to be seen, especially in a patriarchal society, that women would be responsible for fertility and pregnancy (Houghton & Houghton 1984). Even though in some places it is known that the man could have a problem, it is still the woman who seeks treatment before the man (Tyler May 2006).

Another misconception about infertile or childless people is they are childless because of their psychological makeup (Houghton & Houghton 1984; Vissing 2002). While dealing with infertility is a stressful time for a couple, women especially, (Houghton & Houghton 1984; Becker 1994; Lee, Sun & Chao 2001) only a small percentage of infertility is caused by psychological reasons (Houghton 1984). Indeed, Neo-Freudians have returned to Victorian notions of a woman’s place is in the home; they believe getting an education, having a career, and being sexually active would interfere with a woman’s reproductive potential (Tyler May 2006). Yet another misconception is that infertility is caused by a sexual disorder; while a disorder like erectile dysfunction or impotency would make intercourse impossible, the male still maybe fertile just not capable of functioning sexually (Houghton, 1984).

In different parts of the world there are many beliefs about how women are perceived to conceive and why women do not become pregnant. According to Feldman-Savelsberg (1999), in Cameroon, the Bangangté people feel that conception has a close relation to cooking. They use cooking terminology to describe the conception and birth of a child. The womb is the ‘hearth’ or ‘cooking pot’; the ova and sperm are the ‘ingredients’; sex is the ‘heat’ needed to cook; gestation is ‘cooking’ the baby; and birth is ‘serving the meal’. Yet, their beliefs about fertility are linked to the royal family. If they have a strong and prosperous king then the women of the kingdom will produce children; if the situation is the opposite then women will not produce...
many children (Feldman-Savelsberg 1999).

In China, where many of the Western treatments for infertility are available, Handwerker (1998) states that couples still turn to traditional Chinese medicine and beliefs for help with conception. The practitioners of Chinese medicine believe that a woman's fertility revolves around the woman's body "being full of the life force and unobstructed blood flow" (Handwerker 1998: 185). Infertility is believed to happen when the blood that flows in the uterus is not enough or is blocked. Handwerker (1998) states that traditional practitioners believe infertility can be caused by five different types of congenital anatomical abnormalities in the female genitalia. The practitioners also believe infertility can also be caused by different disharmony patterns that combine to form problems. These can include: phlegm dampness, cold uterus, and blood deficiency (Handwerker 1998). As well, the definition of infertility can vary from place to place. Some women in China believe they are infertile if they have not born a son (Handwerker 1997).

In Pemba, Tanzania, where Western medicine is available, Kielmann (1998) argues women sometimes turn to healers, midwives or in some cases the sheik for help with their inability to bear a child. Healers believe infertility can be caused by several things: a swollen uterus, a woman being too fat, the abdomen being unclean, organs being upside down, or the woman's blood being bad. Healers also believe that spirits have caused women to be infertile and need to be exorcised. In Pemba, where the majority of inhabitants are Muslim, if a woman fails to bear children she can be divorced (Kielmann 1997). As a result, fertility and being able to bear children is a major priority in their lives. As well, Muslim families feel they must be married in certain months and time of day can affect the fertility of a couple. They also believe the bride and groom should be related, cross cousins are preferred, and if they are not related this may also cause infertility (Kielmann 1997).

According to Katz and Katz (1987), despite high population growth in Kenya, the inability to have children is a common complaint among women. While women do go to the Kenyatta National Hospital for treatment, they often seek treatment from traditional healers called waganga, as well. The waganga have specific criteria about who they will treat. Some waganga will not treat a woman until she has had ten childless years of marriage or ten years have past since the birth of a child. Others will not treat a woman if she is over thirty years old. The waganga have many ideas about what causes infertility. These include: promiscuity, STDs which cause a 'wound' in the uterus or 'spoiled' ova in the ovaries, dirt (old blood) or germs in the uterus, tampons that interfered with the 'circulation' of the uterus, witchcraft, curses, or breaking of a cultural taboo (Katz & Katz 1987). Katz and Katz (1987) also mention that waganga believed that herbs and rituals to placate angry spirits or to please God were usual treatments for barrenness. While they had 'traditional' treatment for infertility, waganga also had medical knowledge
about menstrual cycles, suggested intercourse during periods of fertility and also suggested that husbands drink less alcohol (Katz & Katz 1987). Coreil, Barnes-Josiah et al (1996) discuss what they term ‘arrested pregnancy’ in Haiti. According to the authors, “...[i]t appears that arrested pregnancy is often associated with infertility and subfecundity. Women who have difficulty conceiving a child or who are unable to carry a fetus to term are diagnosed by family and friends as being in a special pregnancy state, one which the fetus has stopped growing but is still present within the mother” (425).

Pedisyon is the term used by Haitians to describe ‘arrested pregnancy’. Pedisyon is a folk condition: “a reproductive disorder attributed to the interruption of fetal growth during pregnancy” (Coreil, Barnes-Josiah et al 1996: 425). Coreil, Barnes-Josiah et al (1996) state Haitians believe that pedisyon begins as a normal pregnancy, but something happens that causes blood to be diverted away from the womb and is lost as menstrual blood. The fetus is left in a state of arrested development until a time that a cure can be found. Murray believed that pedisyon is “a culturally sanctioned face-saving mechanism for infertile and sub-fecund women...in a setting that places enormous social pressure on women to bear children” (Coreil, Barnes-Josiah et al 1996: 426).

It is felt that voodoo religion was not capable of treating infertility because only God can give you children but if a child was ‘present’ -traditional voodoo healers were then able to treat women (Coreil, Barnes-Josiah et al 1996).

Inhorn (2000) states poor infertile women, in Egypt, consult traditional healers to help cure their infertility because they cannot afford the expense of costly IVF treatments. There are many types of traditional healer that they can choose to consult: dāyāt or traditional midwife, attārīn or herbalist, sittāt kabīra or elderly lay woman healers and various other kinds of spiritual and divine healers. The lower class women have several beliefs about what cause them to be infertile. These include: a polluted person or substance enters the room of a new bride or new mother and this pollutant binds the woman’s reproductive capacity; exposure of genitals to cold water or cold drafts causing moisture in the woman’s reproductive organs; an ‘open’ back caused by the woman over exerting herself; and a shock or fright that can cause women, as well as men, to become infertile. These are all supposedly cured by the traditional healers (Inhorn 2000).

Many misconceptions and beliefs surrounding barrenness and infertility have repeated themselves over and over through time. While some cultures have different ideas about infertility and what causes it, they still have some basic ideas why it happens. Different parts of the globe have access to both biomedical and traditional explanations and can and will utilize one or both to help with their inability to have children (van Balen 2000; Katz & Katz 1987). Different areas of the world may or may not have access to all the Western treatments but they do what they can to solve their problems. But in the West, where science and medicine has
reined supreme, there are still some misconceptions existing about fertility. There is still the idea that it is God's will, women should not work because it takes away from their fertility, and men are still believed not to part of the problem. It seems that women are taking the stress and responsibility when it comes to infertility whether or not they themselves actually have the problem.

**Stress and Stigma**

There are many reasons why couples suffer from infertility. These include: endometriosis, ovulation problems, blocked fallopian tubes, or even low sperm in men. Before the present reproductive technologies were available, infertility was possibly seen as something that a woman or couple had to accept (Dykstra & Hagestad 2007). Now, with the technological progress that has been made in the field of infertility, there is a greater chance for a woman to become pregnant. But still, there is a great degree of stress in the process of treatment. During the time when women had to accept the fact they could not have children, there was embarrassment and possible stigma, but the couple could adopt or be a special aunt and uncle to their nieces and nephews (Whiteford & Gonzalez 1995) and that was acceptable. Now that so many treatments are available, there is the added stress when a couple cannot conceive or carry a child to term (Dykstra & Hagestad 2007) after receiving treatment. The loss of control over the fact that they are not conceiving can be a source of this stress (Greil 1997).

Most studies find that women are the ones to suffer the most distress when it comes to infertility. Infertility tends to affect women more than it does men (Lee, Sun & Chao 2001). This is probably due to the fact that infertility is a central part of these women's identities more so than men (Whiteford & Gonzalez 1995; Greil 1997). Also in Western culture, womanhood and motherhood are intensely linked (Malin, Hemminki et al 2001). There are studies that find that men, if they are the ones that have been diagnosed with an infertility problem, can suffer from stress related to low self esteem, isolation and feeling sexually inadequate (Lee, Sun & Chao 2001). This also can be seen in the belief that a man's fertility is linked to his virility (Houghton & Houghton 1984).

Infertility can cause stress in a marriage (Lee, Sun & Chao 2001; Greil 1997) and cause greater marital and sexual dissatisfaction within the marriage for women no matter if she or her husband is infertile (Lee, Sun & Chao 2001). Indeed, there are many other factors that can cause stress because of a diagnosis of infertility: feelings of being defective, lack of status (being a mother or parent), not being part of the 'fertile world', being totally immersed in the treatment for infertility, the actual treatment itself, not getting along with the clinic staff, and social stigma (Greil 1997).

The social stigma felt by childless couples, both voluntary and involuntary, is based on the fact that societies, especially Canada and the United States, are pronatalist (Miall 1986). These couples show no
outward sign of their infertility (Greil 1991; Whiteford & Gonzalez 1995) and sometimes might be perceived as a couple that has chosen not to have children (Greil 1991). The stigma the couples feel may be caused by internalising these social norms (Greil 1991): "(1) all married couples should reproduce and (2) all married couples should want to reproduce" (Miall 1986: 268). The perceived stigma and shame of being infertile have led many women to not seek treatment and others to become obsessive about receiving treatment because they want to remove the stigma that they feel infertility has left on their lives (Whiteford & Gonzalez 1995). The cultural norms see childlessness in a marriage, whether it is voluntary or involuntary, as deviant. Once this is internalized, then it can affect the couple's relationship and their own identities (Miall 1986). Women feel that infertility ruins their identity more so than men (Whiteford & Gonzalez 1995).

There seems to be a debate between whether the stigma that childless couples feel is actually coming from an outside source or is a feeling that couples perceived but not actually experienced from an external source. Greil (1991) believes that infertility is a secret stigma—because there are no outward physical signs that a couple is infertile. Infertility then would be seen as something 'felt' by the couple because they have internalized society's norms in regards to reproduction. Scambler (1984) states that 'enacted' stigma occurs when society tries to discriminate against someone for having a certain characteristic. He also feels that 'felt' stigma can cause greater stress on a person than 'enacted' stigma. But in a pronatalist society, if a person reveals his or her infertility there could be discrimination from the society. Miall (1986), in her study, states that infertile women felt like they were being stigmatized and rejected by society. Yet, the women Miall interviewed felt that infertile men have a greater stigma than infertile women. She found this to be true even though society still feels that infertility is more a female problem than a male one. Miall (1986) also found that women will cover up or hide their infertility problem so as not to be stigmatized. Women are resistant to talk to their husbands let alone tell their mother-in-laws and other family members, (Whiteford & Gonzalez 1995) because these women felt they have broken a cultural norm. They call women who are fertile 'normals' and classify themselves as 'other' (Whiteford & Gonzalez 1995).

In pronatalist societies, there are probirth policies put in place by the government that encourage parenthood and reproduction (Whiteford & Gonzalez 1995). There are tax deductions, childcare supplements and various other incentives for people to have children. This is added pressure on couples to reproduce and follow what society has prescribed as normal. Couples who have not reproduced feel that they have failed to live their lives the way society has prescribed as normal (Miall 1986; Whiteford & Gonzalez 1995). This sense of failure is an added stressor to an already distressing turn of events. Since infertility is perceived as something
deviant and against societal norms, this led to infertility becoming a medical problem (Becker & Nachtigall 1992).

**Medicalisation of Infertility**

Infertility at one time was considered a social problem (Becker & Nachtigall 1992). During the 1950s, infertility was considered more an emotional problem than a medical one (Whiteford & Gonzalez 1995). In the literature of the 1960s and 1970s involuntary childlessness was considered a social problem. As the problem grew to greater numbers (Becker & Nachtigall 1992) there were medical advances such as synthetic drugs to control ovulation and the invention of the laparoscope (Whiteford & Gonzalez 1995). Eventually, these advances in technology caused a shift from involuntary childlessness as a social problem to infertility as a medical problem (Becker & Nachtigall 1992; Whiteford & Gonzalez 1995). This can be evidenced by the changes in terminology: a condition once known as involuntary childlessness was now called infertility. In response to the social stigma attached to being infertile and not being a mother, the number of couples seeking medical help has increased, and because of this the number of physicians specialising in reproduction has increased (Becker & Nachtigall 1992; Ulrich & Weatherall 2000).

There were other factors that helped advance the medicalisation of infertility. First, there was a decrease in fertility rates in the United States between the 1950s and the 1970s. Second, during this time the number of doctors trained as obstetricians rose (Whiteford & Gonzalez) and the number of reproductive endocrinologists increased (Becker & Nachtigall 1992). Other factors that helped turn infertility into an industry include: the increase of women working and delaying having children; the increase in the occurrence of sexual diseases due to the sexual revolution; the decrease of caucasian babies available for adoption (Whiteford & Gonzalez 1995); and the increasing trend of women and men delaying marriage until they are older (Vissing 2002; Koropeckyj-Cox & Pendell 2007a, 2007b; Jones 2007). Indeed, all of these changes turned involuntary childlessness into medicalised infertility. Infertility, once a private and painful ordeal, was turned into stigma that was open to public scrutiny (Whiteford & Gonzalez 1995).

The medicalisation of infertility has changed it into a disease (Becker & Nachtigall 1992; Malin, Hemminki, Räikkönen, Sihvo & Perälä 2001) or a disability (Miall 1986; Whiteford & Gonzalez 1995) because it is felt that infertility “is a chronic condition that meets biopsychological, social role, and legal criteria for disability” (Miall 1986: 269). Medically, infertility, in most cases, is considered to be the result of a physical impairment (Miall 1986) such as blocked fallopian tubes or a genetic abnormality. Socially, couples are not meeting their reproductive or parental roles. Legally, infertile couples have to have medical proof that they cannot bear children before they can adopt an infant in Canada and the United States (Miall 1986).
Is the medicalisation of involuntary childlessness a good or a bad thing? While it has provided some women and men with more choices to solve their problem (Woollett & Boyle 2000), it has also added a burden of being ill (Becker & Nachtigall 1992). Becker and Nachtigall (1992) feel that, "[p]lacing social problems within a biomedical framework does not provide a satisfactory solution for conditions that deviate from cultural norms because the norms are replicated in biomedical ideologies about the nature and treatment of disease. While biomedicine appears to provide nature liberation from the moral burden of etiologies that implicate individuals for the cause of illness, medical discourse shifts the emphasis from a view of illness as the product of social and cultural conflict within the individuals' relations with society to one of conflict within the individual..." (467).

According to Woollett and Boyle (2000) there is the feminist argument that "see[s] the new reproductive technologies as empowering and increasing women's choices" (308) but in contrast there is also another feminist argument that new reproductive technologies "regulate still further women's lives, identities and embodied subjectivities" (Woollett & Boyle 2000: 308). Medicalisation of a social problem seems to aggravate the problem more than it solves it.

Pronatalist societies, like Canada and the United States, put pressure on women to submit to what is considered normal by society's standards. There is a stigma on couples, especially women, who remain childless whether involuntarily or by choice. Women and couples that remain childless by choice are made to feel deviant and selfish because they choose to not fulfill their roles as mothers and parents. Whereas, involuntary childless women and couples feel the pressure to fill the role of child bearer, mother and parent and feel incomplete and stigmatised when they cannot. The option to have infertility treatments can perpetuate the social norm of bearing and parenting children. Even the potential risks of having infertility treatments (Woollett & Boyle 2000) does not scare people away. They see it as their last chance (Modell 1989) and non-medical, less invasive treatments are rarely considered (Woollett & Boyle 2000). Because of the cultural and religious emphasis on biological kinship (Becker & Nachtigall 1992) it seems that adoption has lost priority as a solution to childlessness. The advent of in vitro fertilisation (IVF) treatment has caused women to choose this as a solution to their infertility problems (Ulrich & Weatherall 2000). Infertility treatments are expensive and only certain people can afford the expense of multiple treatments (Becker 1994). Women have lost their financial security, their husbands, and their self-esteem (Whiteford & Gonzalez 1995) because of the socially constructed need for children (Monach 1993). It is strange that women spend the majority of their reproductive lives trying to avoid pregnancy (Vising 2002) and many women who have chosen not to have children lead very productive and full lives (Whiteford & Gonzalez 1995).
without bearing and raising children. These women did not have to fulfill the social norm to feel like a whole person.

While not all countries around the world are pronatalist; there still is a stigma attached to being childless. There are many developing countries where an infertile woman may be isolated, neglected or even thought of as evil because she is unable to conceive (van Balen 1999). In areas such as Pemba, Tanzania, according to Kielmann (1998) being childless can lead to a divorce because the inhabitants of Pemba are mainly Muslim. Islam dictates that its followers should reproduce and if the wife does not bear children, the husband can take another wife, or she can be divorced and he can remarry. Kielmann states an infertile woman is also considered useless by her mother-in-law and sister-in-law because she has not gone through labour. For these women bearing children and having a successful marriage is an important way for her to achieve social status (Kielmann 1998).

According to Coreil, Barnes-Josiah et al (1996) there is great pressure put on Haitian women to bear children. In Haiti, a woman is not considered a social adult until she has borne children. There is also a lack of legal marriages between Haitian couples. For a woman to legitimise her relationship with a man she must bear him children. If a woman does not bear any children she will forfeit any support and other benefits of her conjugal relationship (Coreil, Barnes-Josiah et al 1996). It is no wonder women in Haiti suffer from pedisyon or arrested pregnancy (mentioned above), so as not to be left without support.

In Asian countries such as Japan, Singapore and South Korea there is so much pressure put upon couples, by their families, to have children as soon as they are married, that they avoid marriage as long as possible (Jones 2007). In China, with its one child policy, there is still pressure to have children. Handwerker (1998) states the Chinese believe that womanhood and motherhood go hand-in-hand. China has a pronatalist agenda, despite the one child rule. The one child rule is really a must have one child policy; because of this policy childless women are marginalised and thought of as deviant. The surveillance of women’s bodies and the control the government has over women’s reproduction has enforced the label of deviant for childless couples (Handwerker 1998). The stigma of childlessness is stronger in China because the Chinese government has enforced probirth policies; in other pronatalist countries, it is more social pressure than law. While some pronatalist countries have incentives, they are not invasive to the point of surveillance of women’s fertility as they are in China.

What the majority of these countries have in common is the social norm that womanhood equates motherhood. The pressure for women to live up to the social norm is strong in all of the countries discussed above. Whether based on religion, social belief or government policy the social construction of motherhood and
parenthood is strong and the social stigma attached to being childless is very damaging to women who are involuntarily childless. The stress it causes women, more so than men, pushes them to turn to infertility treatments. These treatments, whether done by traditional healers or medical professionals, can put a stress on a woman. The stress is greatest when the woman has great faith that the treatments are going to work but then fail. It seems like a vicious circle, where the people who take the brunt of the stigma and stress are women.

**Conclusion**

Throughout recorded history women have been equated with the role of mother. They have felt the social pressure of having to bear children so as to have a complete and normal life. The inability to have children has gone through many changes and forms over the centuries. It has been related to a wandering uterus, consorting with the devil, the practising of witchcraft, to the medical problem it is today. The terminology used to describe the inability to have children has changed as well. It was once called barrenness, involuntary childlessness, and when it became medicalised, infertility. Infertility is now considered an illness or a disease to be treated. As such, the infertile woman is now a patient with a disease.

The societal beliefs that a woman should have children and that she is not complete until she has her own biological children has forced women and couples to seek infertility treatments. The women who suffer the most are the ones who have internalised societal norms of child-bearing and child-rearing, and they are the ones who seek medical treatment. The medical industry has provided women more choices of how to deal with their problem because more women are seeking medical intervention. Women, acting under social pressure and stigma, and the medical industry play off one another. This has created a cycle from which some women cannot escape.

Has the medicalisation of infertility helped or hindered women and their control over their bodies? It depends upon what side it is viewed from. While the medical advances in reproductive technology have given women more choices when it comes deciding what to do about their childlessness, it has also taken away women's autonomy over their bodies (Purdy 2005). Women under social pressure to conceive their own children turn to new reproductive technologies to help them. The hope of conceiving and the social belief that women have a biological need to become children have made women forget they have other choices such as adoption. As Inhorn and van Balen (2002) argue, "...women are the ones who must 'embody' the new reproductive technologies, in the form of potent hormonal drugs, continuous monitoring of ovarian follicles and blood levels. Invasive egg retrievals and embryo transfers, and, in some cases, surrogate pregnancies, This body surveillance and invasion has led women (usually not men) to assume significant levels of medical risk" (14). Greil (2002) counteracts that infertile women understand that they are not in control but they use the situation to the best of their abilities. He wants us
to understand that the women are strategists in a system that they have very little power. The women learn as much as they can about infertility and use this to gain control over their bodies' inability to have children (Greil 2002).

The medicalisation of infertility can be problematic when women do not have the 'control' that Greil discusses above. While some women see themselves as having control, do they really? When people live in a society where the social norm is 'mother/parenthood will make you complete', it is hard to make the decision to not use new reproductive technologies. Media that produces advertising, magazines and television programs that glorified biomedical advancements and show women who had successful infertility treatments (Whiteford & Gonzalez 1995) does not alleviate the situation. The social from internalised social norms forces women towards medical invention without having an unhindered choice. When childless women are free from stigma and social pressure may-be then, new reproductive technologies can be seen in a different light.

References


