



# THE UNIVERSITY *of* EDINBURGH

This thesis has been submitted in fulfilment of the requirements for a postgraduate degree (e.g. PhD, MPhil, DClinPsychol) at the University of Edinburgh. Please note the following terms and conditions of use:

This work is protected by copyright and other intellectual property rights, which are retained by the thesis author, unless otherwise stated.

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge.

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author.

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.

Embodied Agency and Agentic Bodies:  
Negotiating Medicalization in Colombian  
Assisted Reproduction

Malissa Kay Shaw

Department of Sociology  
The University of Edinburgh

Submitted for PhD

2016



## Abstract

This thesis explores the processual nature of agency and constraints in the experience of medicalized conception in a not yet explored locale: Bogota, Colombia. In ten months of ethnographic research at two fertility centers in Bogota, and interview data from over 100 in-depth interviews with women and men undergoing ARTs and clinic staff, a complex ART industry driven by both doctors (qua entrepreneurs) and the couples seeking medicalized conception was explored. This thesis identifies how relationships in the clinic combined with understandings of “the fragmented body” (as a medicalized object under scrutiny) and “the self” (as a conscious agent), to produce intricate dynamics of agency and constraints that co-evolved in a processual manner.

Tracing the experiences of women in infertility treatment chronologically, the thesis explores how knowledge was established and renegotiated through productive power fields that relationally incorporated embodied, personal knowledge and authoritative medical expertise. Women adapted to constraints in both active and passive ways to create and assert their ever-transforming agentive capacities. In these processes, they were constantly reflecting on, and renegotiating their position in the treatment process, as well as in their social lives more broadly.

Drawing on, and seeking to contribute to, literature on agency in ARTs from across the world, particularly literature that considers agency as a process co-established by the constraints it confronts, this thesis makes two key arguments: First, that agency in Colombian ART clinics is defined *as* reflection and renegotiation, rather than as something which occurs *at a singular moment of* reflection and renegotiation. Second, that this negotiated process is *constrained*, but not *contained*. In other words, agency is a process that *looks both backwards and forwards*. Women and couples incorporated different

personal histories and embodied knowledge into negotiating the treatment process and constraints they encountered, and adapted their experiences of ART treatments to other aspects of their lives, negotiating constraints that reach beyond the clinical setting.

## Lay Summary

Through a qualitative study of women's and couples' experiences of assisted reproductive technologies in two medical centers in Bogota, Colombia, this thesis explores patients decision-making processes and barriers they faced during the treatment trajectory. Through this exploration it becomes clear that decision-making is a process that changes throughout the course of infertility treatment. Following women/couples through the treatment trajectory demonstrates how making decisions may involve patients being active and passive, and that decisions will depend on one's bodily experience of assisted conception as well as past experiences of fertility complications. Exploring power relations between medical staff and patients also demonstrates how patient-doctor interactions involve cooperation as they work together to achieve conception. These findings suggest that medical decision-making in Colombian infertility centers includes reflecting on one's personal history, treatment experiences, and future desires throughout the treatment process, and that women's experiences of assisted conception are incorporated into other aspects of their lives that surpass the clinical setting.

## Table of Contents

<b>Declaration of Original Authorship .....</b>	<b>9</b>
<b>Acknowledgements .....</b>	<b>11</b>
<b>Map of Colombia .....</b>	<b>13</b>
<b>Chapter 1 Introduction.....</b>	<b>15</b>
<b>Medicalization: The Broader Intellectual Context.....</b>	<b>20</b>
<b>Navigation and Negotiation: The Medicalization of Infertility in Colombia .....</b>	<b>25</b>
<b>Extending Agency &amp; Embodiment in Medicalized Conception: An Overview of the Thesis.....</b>	<b>28</b>
<b>Focus and Language of the Thesis .....</b>	<b>34</b>
<b>Chapter 2 Literature Review .....</b>	<b>37</b>
<b>Pertinent Feminist Issues in the Literature on Assisted Reproduction .....</b>	<b>38</b>
<b>Constraint and Agency in Reproductive Processes .....</b>	<b>40</b>
The “Compelling” Society .....	43
The “Compelling” Nature of Assisted Conception.....	55
<b>Conclusion .....</b>	<b>61</b>
<b>Chapter 3 Unraveling the Experience of Assisted Conception through an Ethnographic Approach .....</b>	<b>63</b>
<b>Clinical Ethnography.....</b>	<b>64</b>
<b>Entering the Field.....</b>	<b>65</b>
<b>Observations in the Clinical Setting: Becoming a Semi-Insider .....</b>	<b>68</b>
<b>Negotiating and Constructing Interviews .....</b>	<b>72</b>
Other Interviews .....	78
<b>Analysis .....</b>	<b>78</b>
<b>Chapter 4 Contextualizing Assisted Conception in Colombia .....</b>	<b>81</b>
<b>Impact of Conflict and Neoliberalization on the Research Context .....</b>	<b>81</b>
<b>Gender Norms &amp; Family Dynamics .....</b>	<b>84</b>
Importance of Parenthood and Children.....	87
<b>Colombian Healthcare System &amp; Assisted Reproduction.....</b>	<b>90</b>
Creating a Commercial ART Market in Colombia .....	92
Limited Regulations.....	94
<b>Chapter 5 Accessing Treatment: Agency and Coercion at the Outset.....</b>	<b>99</b>
<b><i>The Quest for Conception</i> .....</b>	<b>102</b>
Questioning the Body.....	106
<b><i>Learning How to Access ARTs</i> .....</b>	<b>109</b>
Limited Media Discourse.....	110
The Limitations of Public Healthcare.....	111
“Informational Gatekeepers” and Personal Recommendations.....	115
<b><i>Searching for Information and Accessing the Ideal Clinic</i> .....</b>	<b>119</b>
Becoming Informed .....	121
“Shopping Around”.....	124
Material Constraints .....	127
<b>Conclusion .....</b>	<b>134</b>

<b>Chapter 6 Negotiating Knowledge and Power: Multidimensional Agency</b>	<b>137</b>
<b>Establishing Authority in Assisted Conception</b>	<b>138</b>
<b>Negotiating the Doctor-Patient Relationship</b>	<b>145</b>
Control of Knowledge	151
Embracing the Authority of the Fertility Expert: "Desired Ignorance"	155
<b>Conclusion</b>	<b>159</b>
<b>Chapter 7 Medicalizing the Subjective Body</b>	<b>163</b>
<b>From the Whole Body to the Fragmented Body and Back Again</b>	<b>164</b>
<b>Embodying the Medical Realm</b>	<b>168</b>
Incongruence of Recognition and Focus: The Doctors' Perspective	169
Diagnosis	171
Ovarian Stimulation	176
Follicular Surveillance	182
Aspiration	183
Ambiguous Recovery	191
<b>Conclusion</b>	<b>194</b>
<b>Chapter 8 Recognizing Kin and Life Potential</b>	<b>197</b>
<b>Donor Materials: Negotiating Notions of Relatedness</b>	<b>199</b>
<b>Fertilization and Embryo Development</b>	<b>205</b>
Women's Perspectives of Fertilization and Embryo Development	206
Insignificant Processes Produce Significant Embryos	207
Embryos (and Eggs) as Potential Children and Living Entities	209
<b>Embryo Transfer</b>	<b>213</b>
Preparing for the Transfer	213
The Process of Potential Conception	214
Embodying the Sensations of the Embryo Transfer	217
<b>Rejecting Cryopreservation</b>	<b>220</b>
<b>Conclusion</b>	<b>224</b>
<b>Chapter 9 Transcending the Liminality of Pregnant/Not Pregnant</b>	<b>227</b>
<b>Returning Home</b>	<b>230</b>
Aiding Conception	231
Anxiously Reading the Signs of Pregnancy or Treatment Failure	237
<b>The Ambiguity of the Pregnancy Test</b>	<b>240</b>
<b>The Multiple Meanings of Sonography</b>	<b>243</b>
Seeing Life	244
Ambiguous Images	247
<b>Embracing Pregnancy Monitoring/Embracing Medicalization</b>	<b>249</b>
From Embryo to Child: Diagnostic to Imaging	250
Embodying Risk, Seeking Reassurance	254
<b>Conclusion</b>	<b>257</b>
<b>Chapter 10 Treatment Failure: Reflections and Renegotiations</b>	<b>259</b>
<b>Treatment Failure</b>	<b>263</b>
<b>Multiple Losses</b>	<b>264</b>
<b>The Ambiguity of Failure</b>	<b>267</b>
Losing Faith in the Body: Self-Blame	268
Losing Confidence in the Process	271
<b>Reflection and Renegotiation: Deciding to Try Again</b>	<b>276</b>
Regaining Faith in an Uncertain Process	277

Accepting the “Logical Progression” and “Routinization” of Treatment .....	279
Adopting a Medical Narrative.....	281
Time for Recovery and Renegotiation .....	282
Reflecting on Changed Circumstances.....	284
<b>Conclusion .....</b>	<b>287</b>
<b>Chapter 11 Conclusion .....</b>	<b>291</b>
Processual Agency .....	291
Implications for Treatment Delivery and Public Healthcare.....	300
Future Directions .....	302
<b>Appendix 1: List of Abbreviations .....</b>	<b>305</b>
<b>Appendix 2: Glossary of Medical Terminology .....</b>	<b>307</b>
<b>Appendix 3: Table of Informants .....</b>	<b>311</b>
<b>Appendix 4: Table of Medical Staff.....</b>	<b>319</b>
<b>Bibliography .....</b>	<b>321</b>





## Declaration of Original Authorship

I declare that the thesis has been composed by me and that the work is entirely my own. The work has not been submitted for any other degree or professional qualification.

A handwritten signature in black ink, reading "Malissa K Shaw", is written over a horizontal line. The signature is cursive and includes a small mark resembling a checkmark or a stylized flourish at the end.

Malissa K Shaw



## Acknowledgements

I am greatly indebted to the individuals who have contributed to this thesis.

Words cannot express the gratitude I have for the women and men whose often heartbreaking stories of childlessness and infertility fill the pages of this thesis. Without their willingness to share with me and allow me to accompany them through (part of) their fertility treatment journeys this thesis would not be written. I am also enormously grateful to the clinic administrators and fertility experts who acted as the gatekeepers to my fieldsites. Their willingness to allow me into their facility was also crucial to the development of this study. In particular I would like to thank Dr. Mabel who always made sure I was receiving the assistance I needed from the other medical staff and took time out of his busy day to explain to me medical procedures and aspects of the treatment process. The medical staff in general were invaluable to my research experience and the data collection process.

I am grateful to Jalime and Milagro, my initial hosts in Bogota who soon became my Colombian family. Even without knowing me they took me into their home, introduced me to life in Bogota, and helped facilitate my access to the clinics where this study was carried out. The friendships I made in Colombia were invaluable to my experiences there, allowing me not only to enjoy and better understand my field research but also the richness the country has to offer.

My supervisors, Patricia Jeffery and Gill Haddow, who took up my project at the beginning of my third year, have offered unwavering support. They instantly took the initiative to understand the context of my research and fieldsite, and have provided critical and thought provoking insights since. I am also grateful to Trudie Gerrits who sparked my interest in this topic and offered initial insights.

Support from my family has been invaluable. In particular, I would like to thank my parents who always encouraged me to pursue my endeavors to the fullest and have continuously taken an interest in my studies. I am also grateful for the support from my husband, Erich, who accompanied me first to

Edinburgh and later to Bogota, spent nights discussing my research findings with me, and helped me make sense of my thoughts and arguments as I put them on paper. Last, I thank my late grandfather, for whom this thesis is dedicated, for always encouraging me to travel and learn about different places and people.

## Map of Colombia



Source: <http://www.phpclasses.org/browse/country/co/>



## Chapter 1

### Introduction

Sitting in the white-walled, sterile-feeling office at the end of the hall, looking out the large window onto sprawling Bogota extending to the foothills north of the city, Juanita began to tell me how she arrived at Ferisuperior. “My husband, Daniel and I had been married two years when I finally went to see my gynecologist. I had discontinued my birth control when we married, but in two years I had not conceived.” She explained that her gynecologist took some blood samples for lab work, and recommended she take a medication to increase her hormone levels without further explanation. “For six months we continued trying. At this point my parents and parents-in-law had started asking when we would start a family.” She said that until then, they had been very patient; they knew she had wanted to finish her studies and they had intended to buy a home before starting a family. But with her studies complete, and a house purchased, they had grown impatient, as had their families, who did not know they had been trying since they married. “The pressure grew terrible. At first it was subtle but with time it become more direct.” Luckily for Juanita during a lunch with a dear friend, she was recommended to see Dr. Martino. The friend explained that her cousin had become pregnant after four years of trying because of a treatment Dr. Martino performed.

Juanita soon booked an appointment with Dr. Martino, whom she met the following week. “The first appointment was rather uncomfortable. The doctor asked a lot of questions about our sex life and my reproductive health. Then I had a transvaginal ultrasound examination to check my ovaries and uterus.<sup>1</sup> Dr. Martino said that my ovaries looked healthy and young, and my uterus was of the correct shape, which made me confused at first as I had anticipated he would find something abnormal since I had not conceived. But then he said I needed further examinations, including some blood work, which made me think this is more complicated than I had anticipated. The doctor also said Daniel would have to come in for a sperm analysis. I was initially worried that Daniel would reject but, seeing the pleading look on my face, he agreed.”

“Daniel’s sperm analysis came back normal. Dr. Martino said Daniel’s sperm were healthy and were unlikely to be the cause of our infertility, which left me. If the problem was not with Daniel than the problem had to be with me, even if Dr. Martino had said my ovaries and uterus were normal. He said he would schedule me for another

---

<sup>1</sup> Explanations for medical treatments, examinations, and conditions can be found in the Glossary of Medical Terminology in Appendix 2.



examination, a hysterosalpingography, to check my reproductive system more thoroughly. Knowing that the sperm analysis, blood tests, and consultations were already adding up, I asked Dr. Martino if this was an examination I could have done at a public clinic. At first Dr. Martino looked hesitant, saying the exam is quite technical and must be done with precision, but then he said if I would agree to use the services of a friend of his in the public clinic next door, he would agree. In the end the price of the examination was covered by my health insurance, but it came back normal, no information was gained from the results. Dr. Martino ordered a few more exams, but they too came back normal. He could not find a reason for my infertility, which made me question his expertise. At that time I could not understand how I could be childless if no medical complication were detected.”

When all the examinations came back normal, Dr. Martino recommended that Juanita and Daniel try in vitro fertilization (IVF), but her skepticism of his skills prevented her from agreeing to start the procedure. Instead she chose to “shop around” for another facility. “I did not know where to start, so I asked my friend who had originally told me about Dr. Martino. She told me about another clinic. I went there but I did not like the doctor. He did not clearly explain the possible causes of my infertility or the treatments that I could try. Fortunately, a woman in the waiting area mentioned that she was thinking of consulting the doctor at Fertisuperior, a clinic that her sister-in-law had just recommended to her. I called to book an appointment and met Dr. Mabel two days later.”

“Dr. Mabel went over my previous exam results, but in the end he insisted I have the exams performed again either within his clinic or at a public clinic he recommended. I ended up doing a combination of both to bring down the costs of the examinations as much as I could, but the results were the same: normal. Dr. Mabel said there was no explanation. Our options were to continue trying on our own, which *could* eventually result in pregnancy, or to undergo a procedure at his clinic that *would* give us a better chance of having a child. Daniel and I discussed it for nearly two months. We were concerned about the costs and our chances of conceiving. I was also slightly scared of the procedure.” Juanita looked out the window for a moment, and when she turned back to me, she had tears in her eyes. In between short snuffles she said, “in the end we agreed to give it a try, and we were left with nothing.”

Juanita took a moment to compose herself, and continued: “We agreed to use our savings to pay for the treatment. Dr. Mabel said we should do ICSI (intra-cytoplasmic sperm injection) as that is the procedure the clinic specializes in. We did not know if another option was better, so we agreed. I was told to come into the clinic the day that I started my next menstrual cycle to begin the hormone injections. The injections were terrible! Nurse Luz showed me how to inject myself in the buttock, which was quite painful but also caused me anxiety, as I worried I would do it wrong and put the whole cycle at jeopardy. Luckily

I reacted to the hormones quickly, which Dr. Mabel confirmed through the ultrasounds I underwent every other day for 10 days.”

“Before I even felt prepared, Dr. Mabel scheduled the aspiration saying that the follicles had reached the intended size. I was very nervous about the aspiration mainly because it was scheduled quicker than I intended, but also because I was worried about the number of eggs they would retrieve. In the end they removed nine, a number Dr. Mabel said would be sufficient. During the days when the eggs were in the laboratory I was in a bit of pain from the aspiration, but my main concerns were about the embryos that were developing in the laboratory and the embryo transfer (ET) still to come. Dr. Catalina, the embryologist, said five of the embryos were “beautiful” and she would wait until the fifth day to decide which embryos to transfer. On that day they transferred two embryos. The ET was an odd experience: there were so many people in the surgical room, the embryologists, nurse, and Dr. Mabel, watching as the embryos were injected into my uterus. I never anticipated conception could happen that way! I mean, with so many people in a sterile room. But then I saw them... the two embryos floating inside my uterus on the ultrasound screen. It was magical.” Juanita appeared to drift away in thought for a minute, reflecting on what she had said.

Her voice was sad when she began talking again. “And then I went home to wait. I had to wait 10 days before I would know if the treatment had been successful. Those 10 days were terrible. I could not do anything. I stayed in bed partly because I thought it might help the embryos implant, but also because I could not think about anything except whether or not I was pregnant. Then, on day 10 the blood test came back negative. I was not pregnant. We had given so much – the time, the money, the emotions – and we were left with nothing. And now here I am, three months later, back in the clinic wondering if I should try again. After the treatment failed I said I would not try again, I did not think I could. But now, I still want to be a mother, Daniel still wants to be a father, and the doctor says our only chance is to try again.”

This collage of experiences depicts much of the turmoil women in Bogotano fertility clinics expressed while undergoing the processes of medicalized conception. This story exemplifies many aspects of these experiences, and provides a glimpse into how women negotiate access to the private medical realm where assisted reproductive technologies (ARTs) are located, as well as the uncertainties that surround deciding to engage in these treatments. It also highlights the various embodied sensations of these medicalized processes, the losses that accompany treatment failure, and the necessary reevaluation that accompanies deciding to try again. It is these multiple and different subjective,

embodied experiences of ARTs, and the processes of agentic maneuvering that they entail, that I will explore in this thesis, specifically looking at the context of Colombia.

Since the birth of the first “test tube” baby in 1978 in the UK, social scientists have been exploring the experiences of ARTs, and the socio-cultural, political, and legal implications that have accompanied their use across the globe. Initially, such studies (and the practice of ARTs) were limited to the “Global North” (e.g. Becker 2000; Edwards 2000; Gerrits forthcoming; Greil 1991b; Franklin 1997; Konrad 2005; Sandelowski 1993; Thompson 2005; Throsby 2002). As observed by van Balen and Inhorn (2002:16-17), however, the rapid globalization of these cultural artifacts has been accompanied by expanding ethnographic studies of their use. Inhorn’s (e.g. 2003, 2012) research in the Middle East has been crucial in the general social science analysis of the context-specific practices and use of ARTs, while work by Bharadwaj (forthcoming) in India, Gürtin (2012a,b) in Turkey, Hörbst (2012a,b) in Mali, Pashigian (2002, 2009) in Vietnam, Tremayne (2009, 2012) in Iran, and Whittaker (2015) in Thailand have also demonstrated how these technologies shape and are shaped by local socio-cultural constructs.<sup>2</sup>

Since the early 2000s, there has been increasing qualitative research from Latin America, including Roberts’ (e.g. 2012) work in Ecuador, Raspberry’s (2007) in Argentina, and Braff’s (2010) and González-Santos’ (2010) in Mexico. To date, however, there has been no research published on ARTs in Colombia (other than from a legal perspective, all in Spanish). In this thesis, then, I aim to contribute to the growing body of literature that explores the global “localization” of ARTs (Inhorn 2003b) in the Global South, and Latin America in particular. Through an analysis of the diverse (but specific) practices, attitudes, and embodied experiences of this medicalized process in two Colombian ART clinics, the goal is to shed light on the complexity of assisted conception, to explore the diverse constraints couples encountered and the unique, agentic

---

<sup>2</sup> This is not an exhaustive list but indicative of the richness and variety of qualitative studies conducted on ARTs.

practices they adopted during their fertility treatment journeys, contributing to the expanding literature on the subject.

In particular, Inhorn's (2003b) seminal work on couples' experiences of assisted conception in Egypt (and the material, socio-cultural, ideological and other constraints that they faced as they attempted to access these technologies) informs the analysis that unfolds here. Despite the magnitude and diversity of constraints faced by her informants, Inhorn does not discount the agency, however limited, that they enacted. This thesis likewise explores the agentic abilities of women (and couples) as they came to seek and engage with medical assistance for their childlessness, vis-à-vis the various constraints they encountered throughout the process. Through exploring women's/couples' agentic maneuvering during their fertility treatment journeys, and the way in which their agency transforms to counter diverse constraints, we come to recognize that agency is more than just "choice alone," but is a diachronic process (Franklin 1997:196), a process that combines past and present knowledge and experiences, and that inevitably extends beyond the realm of fertility treatment. Mulling's (1995:133) concept "transformative work" is particularly useful for unpacking how this functions. She presents a means for understanding human agency "that does not require categorizing cultural practices as either dominant or alternative," but rather "helps us recognize the emergence of new social and cultural possibilities in the activities of daily life," and argues this may be useful in recognizing that human agency (and its constraints) is visible in the smallest of activities (in Ginsburg and Rapp 1995:11).

Seeking to understand couples' *lived* experiences of medicalized conception (and thus understand the diachronic processes of combining/negotiating choice and constraints that create and define agency as emergent and transformative), this thesis follows couples chronologically through their treatment journeys. The themes that emerge during their journeys are explored throughout the empirical chapters along with the relevant literature, which is presented comprehensively in the following chapter. Based on this literature, I draw on a number of different

conceptualizations of agency (i.e. forms it can take and the ways in which it can be constrained by various material and social factors), emphasizing the diversity of the phenomenon and its empirically different nature in different contexts. Agency is not an all-or-nothing phenomenon, meaning we must explore its differences and peculiarities across contexts.

Ultimately, this thesis does not claim to make an entirely new statement about agency. Rather, it seeks to amplify existing understandings of agency and constraint (and the relationship between the two) in assisted conception. Many authors have explored this topic in great depth in other locales. However, as mentioned, Colombia remains an unexplored context. Therefore, it is my goal to explore the Colombian case in its own light, but also in relation to the explorations of agency in assisted (medicalized) conception that have been made in other locales, seeking to make subtle contributions to the overall field. I particularly draw on, or attempt to contribute to, ideas of agency as processual, co-constituted/defined by constraints, and intimately defined as transformative in how it relates to small, everyday activities (as opposed to singular events). More broadly, however, it is a study pertaining to the concept of “medicalization,” which (as discussed below) is a concept traditionally defined by control and constraint, and thus constitutes the wider field of debate around agency in which this thesis is placed.

### Medicalization: The Broader Intellectual Context

Since the development of modern medicine, some scholars have argued that various “nonmedical” problems (such as hyperactivity, alcoholism, and menopause) have come to be classified as medical concerns, expanding the scope of medical professionals’ authority. The creation of new “medical categories” (Conrad 2005:3) reinforces the theory that “illness,” “health,” and what is deemed “medical knowledge” can be socially constructed. Since the inception of the study of medicalization in the social sciences, there has been an interest in exploring the drivers of this phenomenon. Broadly speaking, the

processes that have led to increasing medicalization have occurred on three distinct levels: the conceptual (recognizing and defining a problem as a medical problem), the institutional (in which an institution adopts a medical approach to counter a problem) and the interactional (when treatment is sought and a problem is diagnosed as medical during patient-doctor interactions) (Conrad and Schneider 1992[1980]; Conrad 1992).

Embedded in a Marxist framework and “the liberal humanism” that fueled social movements in the 1960s and 70s, processes of medicalization have been highly criticized by medical sociologists (Lupton 1997b:95). From the 1950s onwards, the medical domain was seen as adopting a role of social control that had previously been performed by religion and law (Freidson 1970; Parsons 1951b; Zola 1972). Zola (1972:487), the proclaimed father of medicalization discourse (e.g. Bransen 1992:98; Clarke et al. 2003:164), attributed the “medicalising of society” to the “increasingly complex technological and bureaucratic system” which has expanded our reliance on experts. He argued that increasing the medical profession’s power and scope has augmented its role as “an agent of social control,” as it no longer presides only over bodily symptoms but also over the daily practices and habits that are deemed appropriate to maintain health and prevent illness (493). Similarly, Illich (1976:61) characterized medicalization as a by-product of “over-industrialized society,” and argued that it was attributable to the professionalization and bureaucratization of “the institutional shape health care has taken” (39). Illich (1976:39-124), however, was more critical than Zola, arguing that modern medicine has adversely affected people’s health due to *iatrogenesis*, the negative consequences caused by medicalization itself, specifically the masking of why and how people become sick through “the medicalization of life.” This, as Conrad (2007:7) states, is where the processes of medicalization change “aspects of everyday life into pathologies, narrowing the range of what is considered acceptable.”

Illich (1976) and Zola (1972) both recognized how the spread of medicalization resulted in regarding sick individuals, rather than social issues, as responsible and culpable for health problems, ultimately diminishing

individuals' capacity to manage their own health, which now must be assessed and treated by a trained medical professional. When considering individual patients' responsibility to manage their health, Parsons (1975:268-269) also recognized the micro-processes that insert medicalization (as a means of social control) into the patient-doctor interaction, as doctors try to control patients' supposedly deviant behavior and reinforce their "motivation to minimize illness and its disabilities." Here patients must work in conjunction with the doctor to return to health (Parsons 1951a:456, 1975:267), enhancing the doctor's power over the patient.

A large wave of criticism of the medicalization of society has also come from feminist sociologists since the 1980s. These scholars have explored the increasing medicalization of women's bodies, arguing that processes once deemed "natural" have become problematized, and occasionally denounced, by the medical profession (e.g. Plechner 2000). Some feminist theorists argue that the medicalization of pregnancy, childbirth, menopause, menstruation, and now conception essentially reproduce gender hierarchies, putting female bodily processes further under the control of a largely *male-dominated* medical profession. Davis-Floyd (2004[1992]:152) interprets the medicalization of childbirth as the "cultural control of natural [and unpredictable] processes" of the female body by "superior" and male-developed science and technology. Radical feminists, such as Arditti et al., (1984), Corea (1985, 1987), Rowland (1987) amongst others, have argued that the conquering of nature by culture, and female by male, has reinforced existing power relations and the authority of men, while re-situating the subordination of women. As these critiques suggest, analyses of medicalization have generally been presented in sociology "in a pejorative manner: to be 'medicalised' is never a desirable state of being," and medicalization has essentially been "positioned as something which should [sic] resisted, in favour of some degree of 'de-medicalisation'" (Lupton 1997b:96).

Since the 1980s, however, sociologists such as Conrad and Schneider (1992[1980]) have identified other driving-forces of medicalization and the benefits of contemporary medicine. Lupton (1997b:97) claims that a major weakness of the "orthodox medicalization critique,"

[I]s its rather black-and-white portrayal of Western medicine as largely detracting from rather than improving people's health status, of doctors as intent on increasing their power over their patients rather than seeking to help them, and as patients as largely helpless, passive and disempowered, their agency crushed beneath the might of the medical profession.

From a Foucauldian perspective, the power utilized both in institutionalized and more individual forms of medicalization is multi-directional and "productive" as it works to acknowledge diverse forms of suffering and move towards its alleviation. Conrad (1992, 2005, 2007) claims that the "engines of medicalization" are expanding to surpass the once "dominant" position of the doctor and medical domain. Now advocacy groups and patient organizations push for new conditions to be recognized and treated through medical practice and the rise of consumer medicine permits individuals to become more active in their pursuit of medical interventions. The biotechnology and pharmaceutical industries and managed-care organizations also decrease the power of the medical profession as they manipulate the market. The multiplicity of these "engines" (e.g. advocacy groups, patient organizations, the pharmaceutical industry, etc.) has created a complex array of actors pressing for further medicalization, and ultimately demands new, or adapted perspectives of analysis to match.

Clarke and Shim (2011), for example, claim that medicalization is evolving into a new phenomenon – biomedicalization. They emphasize the transformation of medical practices by "technoscientific means" (173), and argue that part of what is missing in the medicalization critique is the "escalating complexity, multisitedness, and multidirectionality that are enabled by these twenty-first century conditions" (186). In particular, the influences of capitalist markets, the changing "nature of biomedical interventions (as increasingly 'inside out' and aimed at transformation), the interpenetration of science and technology, and the increasing simultaneity of research-development-application" have contributed to this (186). Rose also acknowledges this increasingly complex context and argues for moving beyond



the concept of medicalization because the doctor's "monopoly of the diagnostic gaze and of the therapeutic calculation" (2007b:11) has been replaced by evidence-based medicine, the demands of (public and private) insurance companies, and notions of ownership (intellectual property) and capitalization. Rose (2007a:700) claims that "clinical medicine is only one component among many ways in which individual and group life have been problematized from the point of view of health," which makes it insufficient to concentrate on oversimplified forces of medicalization. Further, we should also remember that medicalization can be reversed, although this is rare, and that some previously medicalized conditions have become de-medicalized (e.g. Fox 1977) in recent decades, most noticeably homosexuality, the de-medicalization of which was not propelled by traditional drivers (i.e. medical professionals and institutions).

Despite these critiques, however, the concept is still useful for exploring medicine's increasing influence over issues that were previously seen as social problems, and establishes the broader intellectual context in which this study is placed. Recognizing the authority of the medical profession and its actors (i.e. doctors, nurses, etc.) provides tools for analyzing the multiple power dynamics one encounters in the medical setting, and thus the agency of patients. As noted by Conrad (2005:8), it is no longer only the medical profession pushing for the medicalization of human ailments and therefore we must consider the actions, power, and experiences of those seeking treatments. Moreover, following Rose (2007a:700), it is essential to recognize that "medical knowledge, medical experts, and medical practices play very different parts in different locales and practices." This acknowledges that medical practices are also influenced by socio-cultural, religious, political, and legal features, which affect how they are perceived, accessed, and utilized (Inhorn 2003a,b; Lock and Kaufert 1998; Rapp 1999). In other words, exploring the dynamic relationship(s) between medical knowledge and local socio-cultural knowledge is key to understanding local forms and understandings of health. This is precisely why exploring the processes of medicalization requires a context-specific lens to understand the characteristics of this phenomenon, as I propose here through the example of the medicalization of infertility in Colombia.

## Navigation and Negotiation: The Medicalization of Infertility in Colombia

Throughout history, couples have sought solutions to childlessness through a diversity of socially accepted practices: “folk” medicines, adoption, fostering, divorce and remarriage, etc. With the development of ARTs, childlessness has been transformed into a medical condition (infertility) that often requires diagnosis and treatment by trained medical professionals. Becker and Nachtigall (1992) explain that as increasing rates of infertility (primarily due to delayed childbearing) were recognized in the US in the 1980s, medical intervention was increasingly sought. This happened in conjunction with the institution of medicine’s rising emphasis on infertility, “including increasing numbers of physicians who specialise in reproductive endocrinology, an escalation of research on infertility, and the development of reproductive technologies” (457). In the social science literature, the medicalization of infertility is marked through the replacement of the term involuntary childlessness with infertility, which reflects, “a discourse increasingly dominated by biomedicine” (457). This change in terminology was also prevalent among my informants who had not characterized themselves as “infertile” or to “have a fertility problem” until after a medical professional diagnosed them with a fertility complication. Before this, they were in a state of “still trying to conceive.”

The medicalization of infertility is a continuation of a long history of medical intervention into women’s bodies, bodily processes, and childbirth practices, which medical discourse has increasingly viewed as problematic or as risky bodily processes that need to be monitored by trained professionals. The medicalization of infertility has furthered this problematic notion, because the inability to conceive without medical intervention has become recognized by the medical profession and society alike as a bodily abnormality that deviates from social norms (this is discussed further in the following chapter). Instead of de-stigmatizing childlessness and/or making adoption more socially acceptable, however, medicalizing infertility focuses on the individual and *her* responsibility to seek out the expertise of a doctor (it is usually the woman who initiates treatment).

However, while ARTs may appear quite negative when viewed through a lens that critiques medicalization, these technologies have also allowed infertile couples to have a biologically-related child – a scenario previously not possible. Thus, reframing the medicalization debate to incorporate the diverse forces pressing for the inclusion of further social and life-style complications into the medical realm should also include the exploration of the drivers of infertility medicalization as these technologies spread to new locales, particularly in the “Global South.” In order for a technology, such as ARTs, to become socially acceptable, it must fit into the established socio-cultural context and knowledge system in which it will be used (Birenbaum-Carmeli and Inhorn 2009:10). In this sense, the acceptance of ARTs is not a neutral, apolitical process, but is intimately linked to social norms and power relations. In 2003 Inhorn stated that ARTs “are rapidly globalizing to pronatalist developing societies, where children are highly desired, parenthood is culturally mandatory, and childlessness socially unacceptable” (2003a:1837). These societal characteristics occur in Colombia, a developing, pronatalist country where processes of incorporating ARTs are highly complex. They entail multiple agents and structures that both promote and constrain infertility treatment, and medical practices that reach only a minute segment of the population, while producing a portfolio of treatment options that lacks standardization and regulation.

ARTs have been available in Colombia since the 1980s, but they have not been incorporated into the national healthcare system, due to limited healthcare resources. Lack of government and private healthcare insurance coverage for ARTs greatly limits who can access these treatments. Furthermore, lack of knowledge about the availability of these technologies among the general population and general practitioners (GPs) and gynecologists, prevents some women who could benefit from (and afford) ARTs from accessing them.

The lack of government support for ARTs has been compensated for by the emergence of private initiatives, where medical professions/entrepreneurs are the active agents driving this neoliberal market-based system of medicalization (Conrad 2007:6). Limited government regulation of ARTs and

competition between clinics has created a medical environment where medical practices vary across (and even within) clinics and collaboration amongst clinics is non-existent. Unlike in healthcare systems where the government decides which treatments should be available to patients, doctors in Colombia determine which ART treatments they are willing to offer, decisions which are based within doctors' moral and cultural understandings of "normal" family structures.<sup>3</sup> This doctor-determined model of providing medical services creates a context that is more complex than in many in the global north.

Enhancing this complexity, couples who can access ARTs become, essentially, active agents in this medicalization process, as they willingly engage in and even promote the medicalization of infertility (Friese et al. 2006:1557). Women actively seek out the information and treatments that correspond with their reproductive desires. The non-existence of practice regulations and lack of practice standardization provides some couples with the ability to maneuver between clinics and the portfolio of treatment options in their search for a child. In this way, couples who *can* access these technologies may face fewer regulatory constraints, and be seen as actually having more options than in contexts where ARTs are promoted, supported, and monitored by a dominant healthcare institution. As I will demonstrate, however, even though the treatment portfolio may not be constrained by regulatory/standardizing mechanisms, the entire portfolio is not necessarily liberating for all couples, as their experiences and perceptions may actually self-constrain the options they are willing to utilize in their search for a child, particularly when considering the use of donor materials and the cryopreservation of extra embryos (chapter 8). Thus, a multi-dimensional process of the medicalization of infertility in Colombia is driven by doctors/entrepreneurs and by couples/quasi-medical consumers in a market-based private medical system that lacks formal regulation and standardization, but which functions under personal/private mechanisms of culturally-based and material constraints (i.e. taboos, orthodoxies, power dynamics, finances, etc.), which change around the

---

<sup>3</sup> See Holm (2009:34) for a discussion of how medical practices are influenced by doctors' moral understandings.

incorporation of new technologies and practices, creating a complex context in which to explore couples' and medical professionals' perceptions of and experiences with ARTs.

### Extending Agency & Embodiment in Medicalized Conception: An Overview of the Thesis

As illustrated in the introduction to the medicalization of infertility in Colombia, couples seeking assistance for childlessness face numerous constraints that they must overcome (or transform) in order to access and engage with these technologies. In what follows, I will briefly explore the diverse forms of agency women and couples may draw upon during their fertility treatment journeys, followed by an overview of this thesis.

According to Madhok and colleagues (2013:3) “the privileged location of agency and progress” has often been limited to the Global North, while the Global South has been seen as “a space characterized by coercion, violence, oppression, and subjugation.” This reductive dichotomy affectively limits (or ignores) the agency of actors in the Global South, who’s agency may be more constrained than in locations in the Global North, but nevertheless still utilize various forms of agency. As will become evident in this thesis, agency is far more than the ability to act freely – a definition that is simultaneously too broad and too narrow for an in-depth analysis of the diverse ways in which agency can manifest. As Madhok (2013) claims, reducing agency to one’s ability to act or openly resist one’s oppressor, denies agency that manifests as passive or inactive. Thus, analyses of agency should be shifted to explore “critical reflections, motivations, desires, and aspects of our ethical activity,” which, as Madhok claims, may appear “in our speech practices” (106), but also in our interactions or lack of interactions with others.

Essentially, Madhok and colleagues problematize a definition of agency as being one’s *ability to make choices*, as choices may be constrained, such as by the maternal mandate ingrained in Colombia society that is (verbally) pushed

on childless women (chapter 5). This thesis agrees that agency cannot be reduced to one's ability to choose, but acknowledges that agency can be present in one's choices, as people reflect on and determine the decisions they are willing to make, particularly in contexts of limited choices. Mullings (1995:133) explains that even in contexts where options are extremely limited women still have the ability to make choices. Van Hollen's (2003) research on birthing practices in Tamil Nadu reflects this as she explains that decisions are not made in a "power vacuum by totally 'free' individuals" (208). Even women whose choices are constrained utilize multiple forms of agency as they determine where and under what circumstances they will give birth.

As Rapp (1999, 2011) expresses, making decisions within local social understandings (specifically in contexts or on subjects that raise new ethical conundrums, such as her research on amniocentesis and that on engaging with reproductive technologies more generally), demonstrates "a form of *constrained but real agency*" (2011:703, my emphasis). Even though one's choices may be constrained she is not devoid of agency. Unlike Madhok and colleagues (2013:7-8), who argue that recognizing agency through one's ability to choose detracts from exploring the constraints (or coercion) women face, I do not see these (choices and constraints) as mutually exclusive. The ability to choose does not imply a situation free of constraints. I recognize that agency is always accompanied by constraining factors, or that the two (agency and constraints) are interdependent. In other words, we must go beyond agency and constraint being "understood in a binary relationship of presence/absence, where the one is present only by virtue of the other's absence" (Madhok et al. 2013:2). Rather, we should accept that "agency is always exercised within constraints," constraints that "relate to social, not just personal, power relations" (7). Given the diversity of constraints that exist (across a range of social and personal power relations), Madhok and colleagues (2013:7) suggest the use of "coercion" in place of "constraint" (in certain circumstances) to refocus attention on "the wider power regimens within which we operate," instead of "the more exclusive focus on individual capacities and vulnerabilities." An emphasis on coercion allows us to demonstrate the embeddedness and subtlety of certain constraints

and power dynamics within society. This means accepting, as Inhorn's (2003b) research demonstrates, that constraints are context-specific, take various forms (e.g. material, socio-cultural, institutional, ideological, etc.), and affect individuals in heterogeneous ways.

The *diversity* of constraints and coercion that women (and couples) encounter on their fertility treatment journeys, and the equally diverse and complimentary modes of agency (passive, active, reflexive, embodied) that they enact, are what will be explored throughout this thesis. The coexistence, or even codependence, of agentive practices and their constraints must be explored through a contextually specific analysis, as certain circumstances are more empowering than others (Madhok et al. 2013:3), and individual actions and decisions are embedded within wider socio-cultural understandings. To explore agency and constraints as codependent and context-specific, in other words, is to deepen our understanding of both the socio-cultural context in which certain processes of agency/constraint exist (such as assisted reproduction processes), and of the nature of those processes themselves. Thus, the goal is to contribute to the literature on agency as well as that of the lived experience of assisted reproduction in a specific context, exploring women's/couples' experiences in a new locale (Colombia) to add breadth and depth to our understanding of diverse constraints and agency in the field of medicalized assisted reproduction.

I first and foremost, then, seek to show (supporting Madhok and colleagues) that agency and coercion/constraint are not mutually exclusive, but rather coexist and are intertwined in complex relationships (2013:3). For instance in chapters 5, I discuss how women's engagement with ARTs was constrained by material factors and issues pertaining to knowledge, particularly gaps in knowledge derived from a public healthcare system that lacks the necessary resources (technological and pedagogical) to comprehensively explain, much less accurately diagnosis and treat, infertility. This often inhibited women's access to ARTs, and thus their potential forms of agency. Yet women seeking medical assistance for childlessness gained information through other avenues such as through the experiential and embodied knowledge provided by "informational gatekeepers" (i.e. former ART users) and through shopping

around for what they perceive to be the ideal clinic to access treatment (chapter 5). In chapter 5 I also discuss constraints posed by financial, temporal, and locational factors that constrained agency. Through unique means (e.g. using services at both private and insurance covered facilities, accessing a clinic close to one's work or home, arrange treatment around holidays/weekends, etc.), however, some women acquired the material resources necessary to access treatment.

As discussed in chapter 6, power dynamics between fertility experts and women seeking assistance also constrained some women's abilities to fully engage in the treatment process. By recognizing the productive, rather than repressive, potential of power (Foucault 1982, 1984), however, I explore how women strategically collaborated with the authority of the fertility specialist to cultivate the potential for assisted conception. In this setting, while the doctor had authoritative power, the women also enacted unique forms of agency (such as gaining more knowledge through observing interactions between the medical staff, and seeking informational and emotional support from nurses) to navigate the treatment process. Other women adopted a more passive form of engaging with the doctor and treatment. These women saw distancing themselves from the process (through obtaining limited information and allowing the doctor to make decisions) as a way to reduce the anxiety that accompanies treatment. This demonstrates that inactively or passively can manifest as a form of strategic agency, in this case as a means to reduce treatment related anxiety and allow the fertility expert to make the necessary choices for a positive treatment outcome.

However, agency is not only evident through our interactions/inactions and decisions but also through the lived experience of our bodies (embodiment). Shilling (1991:664) states, "bodies may be surrounded by and perceived through discourse, but they are *irreducible* to discourse. The body needs to be grasped as an actual material phenomenon which is both affected by and *affects* knowledge and society." In chapter 7, I explore how women's embodied experiences of infertility diagnosis and ovarian hormone stimulation refutes the Cartesian dualism of mind/body separation that dominates medical



discourse (e.g. Sharp 2000; Sullivan 1986). The women's lived experiences suggest the integration of the mind and body (or the "body-we-are" as suggested by Mol and Law 2004), producing a woman in her entirety, who was then recognized (at least partially) by the medical professionals who engaged not only with the woman's body-object but also her body-subject. These reductive dualisms – mind/body, whole/partial, subject/object, active/passive – are challenged throughout this thesis, as the women's lived experiences and perceptions of ARTs depict a more complex analysis than that offered by these socially constructed categories (Haraway 1991). This demonstrates the idiosyncratic and multiple experiences of assisted conception.

Good (1994:53) explains that individuals' embodiment of medical interventions is multiple and produces diverse meanings that are grounded in socio-cultural beliefs and practices. In chapter 8, I consider the meaning-making quality of embodiment when exploring how women's embodied experience of the ET transformed some of the embryos produced in the laboratory into potential future children, while the embryos that remained in the laboratory were insignificant to most couples and therefore could be disregarded. This chapter also explores the significance of donor materials and couples' abilities to embrace or deny the potential for relatedness with a donor conceived child, based on local notions of the familial and the familiar.

Roberts (2002) explains that the biological body cannot be separated from our experiences: it is not ahistorical and should not be construed solely within biomedical parameters. Rather the body is situated within contextual, embodied experiences that influence our health-making decisions. Subjective, embodied experiences caused women to embrace medicalized conception to various degrees, while affecting how they experienced their current treatment cycle and the ensuing treatment success or failure (chapters 9 and 10 respectively). I consider this when analyzing how women embraced the "knowing" capacities of pregnancy tests and ultrasound images following the embryo transfer and a successful treatment outcome (chapter 9), and women's (un)willingness to undergo another cycle when treatment failed (chapter 10).

Embodied experiences are also means of knowledge (Lippman 1999), which influence the meanings attributed to future bodily sensations. I explore this in chapter 9, where I analyze how women's embodied experiences of past pregnancy complications and treatment failures produced a heightened awareness of bodily sensations that influenced the significance women placed on early-term pregnancy monitoring and their liminal position of "possibly pregnant."

Through my analysis of embodiment, we can see the individual as an agent that is situated within past experiences. As an active agent in the medicalization of infertility, then, women are not "docile bodies" (Foucault 1973, 1977) controlled by the authority of the medical profession. Rather they enact diverse strategies or means of agency to arrive at a positive treatment outcome. Here we can see how viewing agency as only active rather than also passive restricts our conceptualization of the diverse agentic movements of individuals. In chapter 10, I draw on this when I consider how women reflected on, renegotiated, and reevaluated the "multiple losses" that accompany treatment failure – a lost attempt at pregnancy, financial, emotional, psychological, and physical losses, and a loss of confidence in the self, the treatment process, and those involved in the process. This is an agentic process because the experiential and embodied knowledge of treatment increased women's abilities to evaluate the quality of care they felt they received, renegotiate the treatments they were willing to use, and renegotiate if and where they would undergo another cycle to fulfill their child-wish. As I discuss in the conclusion, it is this process of reflection and renegotiation, not only at the moment of treatment failure, but continuously throughout treatment practice and beyond infertility treatment, that allows us to conceive of agency as a processual phenomenon.

## Focus and Language of the Thesis

Before I begin to unravel these complex journeys of infertility medicalization in Colombia, I must first provide three explanations: the focus on women, the use of the word “fertility” versus “infertility,” and the use of the Spanish word *paciente* (patient). First, as I explain in chapter 3, I interviewed both women and men inquiring about or undergoing ARTs. Despite the *physical* presence of men in over half of these interviews, however, women contributed most to the dialogue and offered the most vivid descriptions of their experiences with infertility and ARTs. Further, as I explain in chapter 4, Colombian women have historically held the responsibility for childrearing and reproductive practices. This notion is reproduced by ARTs which “focus almost exclusively on the female body” (Throsby 2010:234) and reinforce the notion that women are responsible for reproductive problems.

Furthermore, as Tjørnhøj-Thomsen (2005:74) has noted, reproductive medicine’s fixation on the female body “seems to have excluded men from the ‘clinical gaze,’” a practice that was reflected by the medical staff in the clinics where I conducted my research. Doctors noted the integral role women play in the reproduction process, whether medicalized or “natural,” while they rarely acknowledged the role of men, except in cases of severe male infertility. Given this context, husbands were often absent from the clinic. Women were more often physically present in the clinic and more present in my research, and they rather than their husbands were experiencing the medicalization processes on and within their bodies. I present men’s narratives throughout this thesis, but those of the women are most evident and vocal.

Second, most studies on ARTs have used the vocabulary “infertility” when referring to medical treatments that intend to overcome undesired childlessness. In Colombia, however, couples seeking treatment and medical staff referred to “fertility treatment” and “fertility clinics” instead of “infertility treatment” and “infertility clinics.” The Spanish vocabulary uses the same Latin root as English, “*fertilidad*” and “*infertilidad*,” which diminishes the likelihood for a discrepancy in translation. I am not going to speculate as to why there is

this variation in vocabulary, but throughout this thesis I have adopted the terminology used by my informants.

Finally, I have also chosen to use the Spanish word *paciente* in reference to the way medical staff referred to women undergoing treatment. Medical staff clearly referred to the women in their practice as *pacientes* (patients), while the male partner was generally referred to as either her “partner” or “husband.” This reinforces the primary position of women in assisted conception, while disregarding the role of the male partner and the position of the couple (as a united entity) as the patient (e.g. Thorsby 2003:62; van der Ploeg 2004). The women, however, did not refer to themselves or other women in the clinic as “patients.” The term patient implies a passive and compliant individual who aims to overcome an illness (Parsons 1951a). The women in my study were not passive. Rather they utilized diverse forms of agency throughout their fertility treatment journeys. Their agency combined with the absence of this term in the women’s narratives, restricts my use of *paciente* except in reference to the doctors’ narratives or perspectives.



## Chapter 2

### Literature Review

As Throsby (2002:30) notes, “there is an extensive body of feminist literature on the NRTs (new reproductive technologies) — a body of work which is marked by strong ideological divides, and yet which shares a concern to *centralise women* in those debates” (my emphasis).<sup>4</sup> A debate about the *centrality* of women is one that inherently acknowledges that women do not exist independent of other things, but in relation to them. “Centrality” suggests a field of diverse relations rather than linear, binary ones, or relations defined vis-à-vis another singular thing (like men). Looking at how multilateral relational fields coalesce around women in ART processes is useful to understanding broader processes of relational social structures, as the particular relational processes involved in ARTs overlap with other multilateral fields, and can, through this connectivity, alternatively challenge and/or reproduce structures that exist in these other fields. This process of structural formation, and resistance to it, can be seen as processual, real but constrained agency (Rapp 2011:703).

In this chapter, following this idea of the centrality of women (in both the literature and reproductive processes), and drawing primarily on ethnographic literature about the lived experience of reproductive technologies, I will explore the constraints on women’s choices that have been highlighted by these scholars, and the ways in which women (and couples) actively and/or passively overcome these, thus developing forms of agency. I draw heavily on the works of sociologists and anthropologists studying the experiences of ARTs in the Global South, following the spread of ARTs to new locales and emphasizing the importance of contextualizing ARTs in order to understand their specificities and the influences of the broader socio-cultural context within which ARTs

---

<sup>4</sup> In this literature review and the thesis more generally I primarily concentrate on ARTs, not the broader category of NRTs, but engage with research on amniocentesis, contraceptives, ultrasound, etc. where relevant.

operate. As with other scholars using Kleinman's (1995) concept of "indigenization," this concept shows how these technologies obtain context-specific meanings and applications in specific locales (see Bharadwaj 2006; Inhorn 2003b; Pashigian 2009; Roberts 2008).

### Pertinent Feminist Issues in the Literature on Assisted Reproduction

Since the birth of the first test-tube baby, Louise Brown, in England in 1978, feminist scholars have debated the increasing medicalization of reproduction. While some liberal Western feminists appeared to support the development of new biomedical techniques, viewing them as liberating and increasing reproductive choice (Thompson 2005:57), radical feminist critiques emerged in the early 1980s depicted these technologies as patriarchal tools to further control, oppress, and objectify women and their bodies (e.g. Arditti et al. 1984; Corea 1985; Klein and Rowland 1988, 1989; Raymond 1993; Rowland 1987, 1992; Spallone 1989). The argument was that women's bodies are controlled by male dominated medical technologies. Men were seen as taking control of procreation, a bodily process that had historically been controlled by women. Concern was raised that women's bodies were being used as experimental sites (Klein and Rowland 1988, 1989), while others, as Sandelowski (1993:38) notes, called women's desire for children to be no more than the reproduction of "pronatalist imperatives of patriarchal culture," effectively challenging the authenticity of the desire to be a mother (e.g. Raymond 1984; Rothman 1984).

Thompson (2005) identifies two broad phases of feminist writings on reproductive technologies. She defines phase one (approximately 1984-1991) as consisting of arguments based on structural stratification (central to broader feminist discussions at that time), an issue which many feared would be exasperated by ARTs (2005:60-66). According to Sandelowski (1993:38), the infertile woman's choice to engage with assisted conception was "paradoxically portrayed as choosing against other women," as her privileged position was "satisfied by denying the necessities to the underprivileged." Women were

pushed not to engage with ARTs, and instead to give up their individual desires for the general “goals of feminism” (Thompson 2005:60) and the good of women as a collective (Throsby 2002:60). These concerns did not recognize the suffering experienced by infertile women, but instead saw the women as controlled by social ideologies, particularly maternal desire (Crowe 1985). Focusing on the dominant discourses that govern reproduction, these critiques denied women agency as they engaged with these technologies, rendering them, rather, “as the delusional dupes of patriarchy” (Throsby 2002:61).

Thompson (2005:56-57) explains that phase two (about 1992-2001) feminist writings on reproductive technologies, drawing on poststructuralist feminist concerns, generally valorized womanhood and women’s experiences, and called for the return of agency. They commonly argued that whether maternal instincts were “socially conditioned or innate was irrelevant; infertile women’s desire to have children was more important and more substantial than simply a patriarchal mandate to reproduce” (Sandelowski 1990, 1993 in Thompson 2005:67). Phase two literature moved away from outright rejection or acceptance of assisted conception, focusing instead on the “ambivalent and contradictory nature” of engaging with these technologies (Throsby 2002:30). These ideas were perhaps first introduced by Rapp (1988) and Rothman (1993[1986]), whose studies on prenatal testing have shown the “multiplicities of women’s experience of reproductive technologies” (Thompson 2005:69), and the ways in which social factors (such as class, race, and education level) impact the meanings that surround these technologies, further highlighting the importance of situating studies of medical technologies in particular contexts.

Phase two consisted mainly of empirical studies focusing on the “lived worlds of infertility and reproductive medicine” (Thompson 2005:69), which tended to reveal as much about social ideologies in specific contexts as about the experience of infertility and reproductive technologies. Initially these studies primarily explored Euro-American contexts (e.g. Becker 2000; Edwards 2000; Gerrits forthcoming; Greil 1991b; Franklin 1997; Konrad 2005; Sandelowski 1993; Thompson 2005; Throsby 2004), but more recently research sites have included Asian, South American, and African locales (e.g. Bharadwaj



forthcoming; E. Roberts 2012; Grtin 2012a,b; Hrbst 2012a,b; Inhorn 2003b, 2012; Pashigian 2002; Raspberry 2007; Tremayne 2009, 2012; Whittaker 2015). These studies have primarily explored women’s experiences of engaging with high-tech reproductive technologies in particular contexts. They analyze the medical encounter, patient-doctor interactions, decision-making surrounding the use of ARTs and donor materials, and consider theoretical concepts such as social ideologies, power dynamics, gender relations, medical discourse, etc.

Perhaps most important to this thesis, they explore structural factors that both impede and press for the use of these technologies, as well as where agency can be located within these structures. Sandelowski (1993:3) argues that through exploring women and men’s experiences of infertility and their pursuit of parenthood, and by demonstrating the existence of both resistance and agency within individuals’ experiences of infertility and their engagement with assisted conception, the struggles of the individual against society can be seen, as well as how these struggles can transform dominant structures. Thus, an emphasis on the structural/material and social ideological constraints that both inhibit and enable the use of these technologies and the ways women (and men) maneuver between these constraints has remained central to “phase two” studies of ARTs.

### Constraint and Agency in Reproductive Processes

In Petchesky’s seminal work she states,

Women make their own reproductive choices, but they do not make them just as they please; they do not make them under conditions they create but under conditions and constraints they, as mere individuals, are powerless to change. That individuals do not determine the social framework in which they act does not nullify their choices nor their moral capacity to make them. It only suggests that we have to focus less on “choice” and more on how to transform the social conditions of choosing, working, and reproducing. (1990[1984]:11)

Petchesky (1990[1984]:11) makes it clear that “it is the social and material conditions under which choices are made,” that should concern feminist inquiry, not just the content of the choices themselves. From this perspective, reproduction and reproductive decisions are both individual and social, suggesting that agency is less defined by individual reproductive choices and more by transforming broader social structures that dictate the context, and ultimately practice, of choosing.

Rothman (1993[1986]), echoing the work of Petchesky, emphasizes the influential nature of society on women’s decisions. Through the analysis of women’s decisions to engage with amniocentesis testing and whether to undergo a subsequent abortion in the case of positive results, Rothman (1993[1986]:49-85) shows that decisions are made within a personal context, influenced by social networks, medical professionals, one’s understanding of the world, and one’s value system. However, she claims, “society, in its ultimate meaning, may be nothing more and nothing less than the structuring of [or constraints on] choices” (Rothman 1993[1986]:14). Rothman thus argues that new reproductive technologies provide the *illusion of choice*, while simultaneously *eliminating old choices*. In other words, women can only choose within the limits of what is socially acceptable and what is affordable (Rothman 1993[1986]:12-13). Though Rothman acknowledges the potential for reproductive technologies to offer us new opportunities and new control over reproduction, she also recognizes that they may “simply be incorporated into the social order and bring no social change” (1993[1986]:3). Thus the social constraints that women may be able to push against, as acknowledged by Petchesky, may simply be reproduced in new ways by engaging with these technologies, a perspective that ultimately limits the abilities individuals have to alter social constraints.

In contrast, other scholars have taken a more concentrated approach, considering agency from the perspective of subtle actions and forms of resistance rather than from the perspective of societal structures that control these. Inhorn’s (2003b) influential research on infertility and ARTs in Egypt reveals a multitude of constraints on women’s agency, but rather than denying

them agency, she highlights the nuanced forms of resistance and agency within women's actions. The constraints identified by Inhorn can be grouped into structural and systemic constraints (such as economics and the function of the technologies and the medical system), and ideological constraints (such as religion, gender norms, knowledge, embodiment, and local notions of IVF). Combined, they include economic and class based constraints; knowledge and scientific literacy problems among the Egyptian population; the often limited social and technical capabilities of Egyptian IVF providers; problems of efficacy, specifically the limited success rate of IVF/ICSI (a general problem with IVF/ICSI that is inflated in this context); religious constraints, chiefly the prohibition of third-party donation; local perceptions of ART risk and the physical embodiment of these technologies; gender norms and effects of ARTs; and stigma of IVF and infertility, "which has led to a socially invisible, 'underground' world of test-tube baby making" (268).

Despite this long list of constraints, however, she also identifies a wide range of agentic responses. She sees this in, for instance, the ways couples search for and access scarce hormonal medications, or through "doctor shopping" in order to protect themselves from disrespectful and cruel doctors, or by seeking further information about ARTs, or through conjugal love and emotional intimacy. These, she argues, are all subtle forms of agency that women (and couples) utilize in their quest for a child. Inhorn, then, ultimately warns us not to overlook the "constraints and suffering that accompanies trying to access and use these technologies," but also suggests that women should not be portrayed as dopes, desperately seeking biomedical solutions to their infertility (268-269).

These debates between "illusion of choice" and forms of resistance ultimately demonstrate the need for analyses that can better deconstruct structures/constraints, and uncover the nuanced processes of structural alteration that constitute unique forms of agency in assisted reproduction. Sandelowski (1991, 1993:46-51) moves towards this with the categorization of two general compelling forces that impact women's agency in ART processes: the "push" of society and the "pull" of technologies. Somewhere between this

“pull” and “push” lies women’s agency (constrained though it may be), or the underlying processes of re-structuring.

At the center of this, however, as Throsby (2002) reminds us, is the woman, which, it must be remembered, is not just a gendered identity, but also a biological body. In what follows, I will explore what this means in two subdivided sections. First, I explore the social factors that can “push” women to engage with ARTs, specifically considering kinship ideologies and gender norms. Within this discussion I locate the body, both as it is seen through historically produced medical discourse and notions of embodiment. Then I consider how technology can compel (or “pull”) women to try IVF, specifically exploring the hope that it generates, its comparison to “natural” conception, and the medical setting in which it is employed.

### *The “Compelling” Society*

Webster (2002 in Birenbaum-Carmeli and Inhorn 2009:10) claims that in order for a society to accept a technology, it must be seen to fit into local “social relations and knowledge systems.” The adoption of ARTs into various contexts demonstrates how these technologies coincide with particular social norms such as gender dynamics and maternal expectations, while other social constructs have become transformed or recreated with the use of these technology. As Becker (2000:238) explains, “cultural [or social] ideologies not only shape action [or lack of action]; they also become a locus around which people marshal their resistance.” In other words, social ideologies may constrain women’s choices but at the same time these dominant constructs may also be (re)created through resistance and agency. Some of the key social ideologies/constructs involved in ART processes are discussed individually below. These include traditional family relations, gender roles, and understandings of the female body.

## Transforming Family Relations

Rapp (1999) argues that couples choosing to engage with reproductive technologies base their decisions within local social constructs. As they traverse new ethical conundrums that the use of these often uncontrolled reproductive technologies raise in order to create what they find to be a socially (and personally) acceptable family formation, they become, in a sense, “moral pioneers.” As Rapp (2011:703) explains, this means “using comfortable resources to decipher uncomfortable situations, a form of constrained but real agency.”

The various ways in which individuals “pioneer” new socio-cultural territories in “constrained but real” ways is a theme commonly explored in the literature on ARTs through the lens of creating, or locating, kinship. Robert’s (2009) research on familial egg donation in Ecuador clearly portrays this. She demonstrates how women’s preferred use of sisters or other family members as egg donors further solidifies a bond between these women, commonly reiterating an existing reciprocal relationship. This not only “maintains pathways of inheritance and property transfer” (115), but also challenges the traditionally male-dominated practice of trading, as women make transactions, sometimes due to debts between their husbands or themselves, and take control of the negotiating position. Women, therefore, challenge socioeconomic gender norms while finding unique ways to create relatedness with a donor conceived child through already established social constructs that reinforce economic and familial bonds.

Thompson’s (2005:145-178) research from the US likewise explores what she calls “strategic naturalization,” or the processes of couples seeking to construct their own narratives about kin and family. She demonstrates how her informants used a variety of everyday practices and ideas to “naturalize” relationships with children conceived with donor materials. While clearly innovative, these strategies are also replicative: reproducing “deeply rooted and familiar ways of forming” kinship (Thompson 2005:177). Thus, couples both

follow socially accepted paths to kinship, and create new ways of forming families.

Edwards' (2009:140) research in England, and Bharadwaj's (2003) research in India come to similar conclusions, as does Pashigian's (2009) work in Vietnam and the work of Inhorn (2011) in the Middle East. Pashigian's (2009) research in Vietnam demonstrates how the cultural notion *tình cảm*, the sentimental bond between mother and child, has been extended to the gestational stage, allowing women to create *tình cảm* with a donor conceived child in utero and "shifting what constitutes biological relatedness from being rooted in genetics to being located in the shared experience of mother-fetus gestation" (46). Bharadwaj (2003) alternatively shows how some Indian infertile couples prefer to silently accept donor sperm from a male family member allowing society to recognize the resulting child as their own through the observation of gestation and birth, rather than pursue adoption, a socially stigmatized practice due to fear of "alien genetic input" into a family line (1877). This reflects findings in Edwards' (2009) research, who reports the practice of using the semen from a male relative means "you would also know (recognize) the child - who would be familiar" (140). In other words, the characteristics of the child would be predictable to some degree, and not "alien." Using a familial sperm donor, therefore, allows the couple to strategically create a family that maintains the patriarchal line with a child that will be genetically *known* to the parents, while demonstrating one's fertility to society. This highlights how couples can modify certain circumstances to enact kinship in a way that is both socially and personally acceptable.

Religion also affects social understandings of family, but is strategically navigated by ART patients. Inhorn (2011) shows that despite *fatwa* prohibiting third party contribution to reproduction (i.e. prohibition of gamete/embryo donation and surrogacy) in Sunni Muslim-majority countries, some clinics in Shia Muslim-majority Lebanon and Iran have begun to permit the use of donor conception under the teachings of Ayatollah Khamene'I, Iran's Supreme Leader. This has caused some elite Egyptians and Syrians to secretly seek donor conception in Lebanon in hopes of "saving their marriage" regardless of their

faith's prohibition of the practice (97). Even though these individuals maintain the secrecy of their conception (indicating their desire to avoid stigma and appear to comply with social norms) they still find strategic ways to embrace a different kinship model in the attempt to have a child.

In sum, Rothman (1993[1986]) rightly claims that we can only make choices within the options available to us, which may be limited by material resources (e.g. money, available technologies, etc.) and/or social constructs (e.g. kinship structures, gender norms, etc.). However, she also correctly notes how the development of new reproductive technologies has clearly provided the opportunity for us to alter our interpretations of acceptable social constructs, and adapt these to fit new possibilities, which in turn increase our options, even if only slightly (Rothman 1993[1986]:235-237). The women/couples in the examples cited above demonstrate how social understandings of family can be flexible and molded to strategically fit new family formations. A range of experiences entails a range of adaptive practices. Observing how women either maintain dominant kinship structures, or how they completely remake them, we can see what Rapp (2011:703) calls a variety of real, if not constrained, forms of agency.

### Gender Dynamics and the Female Body

Gender norms also demonstrate the extent to which social ideologies can both constrain and enable individuals' decisions to engage in assisted conception. As reproduction and childrearing are often *socially* defined as being the woman's realm of responsibility, pertaining to commonly recognized characteristics that define femininity and womanhood, women are often blamed and stigmatized for involuntary childlessness, even if the *physiological* complication lies with the man. These social norms, which have been incorporated into medical practice and biotechnologies, push women to engage with ARTs as they seek a solution to their childlessness. They are, however, as with kinship norms, both a form of social coercion as well as agency, as women embrace and/or resist dominant gender dynamics.

Whittaker (2014) takes a particularly critical approach to the constraint gender dynamics place on women's choices in the context of ARTs in Thailand. She concludes:

...the unequal status of women in most Thai heterosexual relationships, the moral imperative that women should be mothers, the emphasis upon "bloodlines" and biological inheritance, an ideology of male sexual privilege, differing expectations of fidelity in marriage, and the belief that children make a relationship and individual 'complete' (Whittaker 2014:25)

leave women with little choice but to undertake IVF. This reinforces the patriarchal control of women, while creating new forms of submission as the technology reinforces women's imperative to become pregnant (Whittaker 2014:12). Despite considering women's engagement with ARTs as a strategy to maintain their status or prevent conflict in their relationship, and as a means to fulfill maternal desires, Whittaker stresses that gender dynamics still limit, and even control, the choices women can make, ultimately coercing (at least some) them to undergo assisted conception.

Inhorn's research from Egypt, a male-dominant society, also depicts the pivotal position in which women may find themselves when faced with a childless marriage, and the threat of divorce even in the case of their husband's infertility. Despite the hardships couples face, Inhorn (2003b:226-231) claims conjugal love and emotional intimacy propel infertile couples to sustain their marriage regardless of childlessness, and are what lead fertile wives to willingly hide their husband's infertility to protect his masculinity. This allows women to support their infertile husbands and undergo treatment in hopes of overcoming his infertility, a "willingness" that other scholars, alternatively, have characterized as patriarchal coercion or "patriarchal bargaining" (see Lorber 1989; Whittaker 2014).

Bharadwaj (2001:282), reporting similar constraints surrounding ARTs in India as Inhorn describes in Egypt, suggests that the persistence of conjugal love is a means for couples to push against the patriarchal norm for "men to abandon 'barren' wives." This norm reemphasizes the gender asymmetry that



exists in contemporary Indian society, but husbands' willingness to persist in treatment with their "barren" wives contradicts the influential nature of this norm, or suggests its gradual transformation. Alternatively, in the case of male infertility, Bharadwaj (2001:284) cites "women's growing resistance at being made accountable [blamed] for their husband's infertility." Thus while he acknowledges that this requires further research, he suggests this growing resistance among women demonstrates a form of female empowerment *despite* pressure from traditional gender norms.

Paxson (2002), analyzing the importation of family planning programs from the UK and the US into Greece, interprets gender as a form of constraint to the uptake of "modern" contraceptives, such as the pill, even though campaigns promote them as empowering the modern woman. Greek women, according to Paxson, resist their use and risk unintended pregnancy because of gender norms that define men as responsible for contraceptives. Hence condoms and the withdrawal method are the most common forms of birth control, defined around notions of love and women's submission to emotion. Paxson analyzed Greek women's refusal of modern contraceptives and their apparent submission to their male partner to be a unique form of women's agency, as it may allow women to "test out" the responsibility, and thus love, of their male partner (2002:321-322). Instead of constraining women, gender norms in this context provide women with a reason not to engage with modern contraceptives, while they seek out a responsible, trustworthy partner.

Within her analysis Paxson also brings to question the gendered nature of contraceptive technologies, claiming that "modern" contraceptives are gendered *feminine* (Luker in Paxson 2002:318) in that the "burden of *personalized* contraceptive responsibility" lies with the woman (Paxson 2002:318, original emphasis). This factor has continually been emphasized in the study of assisted conception, where it is the female body that is medicalized. Regardless if infertility lies with the man, woman, or both, the woman is always a/the patient in assisted conception treatments. It is the woman's body that is medicated, probed, and manipulated, while the man's responsibility has been "reduced to an ejaculatory role" (Thompson 2005:121).

Even where the oversimplification of the male's role is challenged, as by Inhorn (2007b), who considers the advancement of testicular sperm extraction (TESE) and percutaneous epididymal sperm aspiration (PESA), women remain the central focus of ARTs. Thus, despite the invasive and painful character of these procedures to overcome male infertility, the *female body* remains the primary site of medical treatment, suggesting an "example of male bias in the practices of modern Western biomedicine" more broadly (van Balen and Inhorn 2002:15). Ultimately, then, focusing on the female body reiterates the social understanding that women are responsible for pregnancy and childrearing, which is reinforced through the functioning of reproductive technologies, while highlighting "the extent to which ideology determines which treatments and technologies are developed" and hence which treatments become available to and are used by patients (Throsby 2002:44). This also reproduces women's position as the source of blame for infertility, as they are the ones who fail to become pregnant (Greil 2002:101), suggesting a flaw in the body (even in the case of male infertility).

This conceptualized inadequacy of the female body is rooted in power relations that have influenced interpretations of medical practice since the time of ancient Greece. Until the 18<sup>th</sup> century men and women's bodies were conceptualized as containing the same genitals, but with those of women being located inside the body due to their inferiority and lack of perfection (Laqueur 1990:4). Recognizing the male body as the prototype made any deviation from this standard grounds for interpreting the female body as abnormal, defective, and unsustainable as a natural entity, and thus requiring manipulation by man, i.e. culture (Merchant 1980). Here we see the congruent dualisms of man/woman and culture/nature, where the superior man representing culture, dominates the inferior woman *and* nature, dualisms that have come to shape "the structure of western thought" (Price and Shildrick 1999:218), including medical practice.

However, another prominent dualism plays a significant role here, as well. Cartesian dualism – rooted in Descartes' famous line "I think therefore I am" –has separated the mind from the body, the rational, thinking self (or

mind), from the emotional, material body. This is central to contemporary biomedical practice, allowing for the “depersonalization – and, thus, dehumanization – of persons-as-bodies” (Sharp 2000:290). Modern biomedical practice that allows for the “clinical detachment” required for anatomical dissection and surgical processes was achieved through “a progressive denial of [the] symbolic and humanistic meaning of human anatomy” (Richardson 1988:31), a persistent recognition of the mind/body dualism. It is this reduction of the body to a material “body-object,” detached from the subjective self that allows the body to be poked, prodded, bled, cut open, etc., and it is this “object” which normally comes under scrutiny in the medical encounter.

Foucault, considering this objectification of the body through medical practice and discourse, introduces the notion of the “clinical gaze” – the importance of being able to see the body in the rise of modern medicine and the creation of medical knowledge (1973:xiii). Through the “clinical gaze,” the “surveillance” of the “docile” body, the medical professional observes the patient arriving at a necessary treatment for her condition. Mol and Law (2004:46) explain that medical diagnoses of disease or deficiency are “object-definitions in line with the tradition of pathology portraying a body-we-have.” Seeing the body as a possession of the self again separates the body from the subject-self – it is “the body patients have” that is represented and manipulated under the “medical gaze” (Lyon and Barbalet 1994:53).

As Foucault explains, it was, and still is, the female body that often came under the scrutiny of the “clinical gaze” (in Turner 1987:88). The womanly body, fraught with weakening menstrual cycles, debilitating pregnancy, and near death-causing menopause, has been medically described as fragile and likely to malfunction, requiring the surveillance and intervention of medical expertise (Davis-Floyd 1994:1126; Ehrenreich and English 2005[1978]). The “irregularities” of the functioning of the female body that contradict notions of the “healthy,” “normal,” male body, make women natural patients who must be regulated “in the interest of social order” (Turner 1992:88; see also Lock and Kaufert 1998).

Particular focus has been placed on regulating women's role in the preservation of society through pregnancy and childbirth. The development of observational technologies and pain-reducing pharmaceuticals, such as ultrasound and epidurals, has increased the objectification of the female body during pregnancy and childbirth. The woman's experience of pregnancy is now "mitigated" through the doctor's observations of ultrasound images, while the body is cut off from the experience of birth through pain medications. The technological hegemony of reproduction has, in essence, removed women's agency from pregnancy and childbirth (Sharp 2000:300), while disembodiment the experience, creating a sense of alienation (Burkitt 1999:103).

The objectifying and regulatory character of medical practices and technologies has also been accused of fracturing the body into faulty and replaceable parts (Gupta and Richters 2008). The "body-as-machine" metaphor, based in Descartes' Cartesian dualism, interprets the body as "interdependent parts, any of which can malfunction" and be treated by "eliminating, fixing, or bypassing the malfunctioning part" (Greil 2002:102). Thus, Gupta and Richters (2008:240) claim, "There is an increasing tendency to view women as wombs and childbearing machines instead of whole persons." Similarly, Davis-Floyd (1994:1127) argues that the medical system, at least in the US, has successfully convinced women of the "defectiveness and dangers" of their deviating bodies and their faulty parts, as evidenced by high rates of hysterectomies, mastectomy, and hospital birth.

However, it must be remembered that it is *acceptance* of this dominant medical discourse (not only within the medical community, but also by women themselves) that ultimately renders women subject to the "medical gaze." This is why, as mentioned before, radical feminists have interpreted the increasing medicalization of reproduction and the growth of reproductive technologies as a process by which a patriarchal medical system expands control over women's bodies and reproductive processes, while reducing women to passive objects of medical surveillance and management (Sawicki 1991:76-77). This perspective, however, not only emphasizes the power of medicine to take over docile women and their bodies, it also justifies this control given the "faultiness" of the female

body. However, just as other gender and family norms have been proven to be both constraining and empowering, many scholars have shown how women have used gendered medical discourses to their advantage.

Sawicki (1991:68), for one, following Foucault's (1978:139-140) concept of biopower, argues that reproductive technologies do not work through *control*, but as disciplinary techniques that create "desires, attaching individuals to specific identities, and establishing norms against which individuals and their behaviours and bodies are judged and against which they police themselves." By going to the clinic and engaging with reproductive technologies, in other words, women's bodies become the focus of medical surveillance and bodily "discipline," which comes to match women's own policing of their bodies as they themselves adopt a "clinical gaze" (Sawicki 1991:85). From this perspective, engaging with disciplining biomedical technologies and practices can be viewed as empowering. Rather than reducing women to passive dupes devoid of agency, these women are actively involved in treatments to overcome their infertility and obtain a child.

Other scholars have also demonstrated ways in which women actively engage with assisted conception. Greil (2002), considering women's reactions to metaphors such as the body as machine, and the body as property, also demonstrates how women become strategic and active when confronted with the medical model. Even though women described infertility treatment as a failure of their bodies and selves (reiterating dominant medical discourse), some also embraced the metaphor of body as property "as a way of claiming autonomy to make their own decisions" in overcoming infertility (108). Through women's narratives and actions, Greil demonstrates how some women use their knowledge of the medical system, treatment protocols, and their bodies to maximize the limited control they had during treatment, and push it in the direction they wanted it to go (113).

Becker's (2000) research also explores how infertility made women feel as though their bodies had failed them, or that their bodies did not correspond with their gender role/identity, but that treatments still had empowering potential. She argues that while seeking medical intervention for infertility often

left women “dismayed by the invasiveness of the treatment,” *over time* “they came to discover and wield their own power and to resist, in various ways, specific aspects of the medical approach” (51). Thus, through experiencing and reflecting on this invasive treatment process, patients became more engaged with treatment and in some cases even took an “assertive, and even aggressive” role in their infertility treatment (50).

Thompson (2005:179-204) likewise demonstrates how women become active agents in medical treatment through embracing objectification in pursuit of a successful treatment. She argues that objectification through medical practice is not always a reductive state that opposes the goals of the subject, and denies her agency. Rather, patients’ narratives alluded to the compatibility of objectification and agency while being objectified did not reduce them to a position of helplessness and victimhood (185). In the infertility clinics, Thompson states, “patients willingly accept the role of being the object of the “medical gaze” and in fact *actively* participate in it,” complying with the physician in the objectification of their bodies in hopes of conception (191, my emphasis).

Taking a slightly different approach, some scholars have argued that the fractured and objectified “dividual” (Gupta and Richters 2008:248) can become whole again through “an analytic focus on ‘lived experience’” (Howson and Inglis 2001:302), which intertwines experiences of the body, self, and personhood. Exploring the embodiment of lived experience “entails a repositioning of the body as a site of knowledge/experience and of intention/action, shaped (never determined) by social structures” (Howson and Inglis 2001:302). An analysis of lived experience displays how the body is not a docile and weak object, but rather a pragmatic and agentic subject that both constructs and is “constructed by the lifeworld” (Nettleton and Watson 1998:11). In other words, as Price and Shildrick (1999:218) explain, exploring the “relationship between embodiment, power, and knowledge,” reveals a female body that (may) move “against the grain of custom and expectation.” The lived body is, therefore, an agentic, malleable body, a body able to resist social constructs that try to bind it.

Young (1990), recognizing bodily experience as a unified experience, or as experienced by the body in its entirety (or wholeness), refutes the mind/body split as the subjective-self and the subject-body are interconnected – they are one in the same. Similarly, in Tjørnhøj-Thomsen’s (2005:85) research on Danish couples’ experiences of IVF, she reports how men and women “express a strong need to be ‘whole’ and unify their fragmented experiences,” referring to the division of their bodies, emotions, and the separation of their gametes from their bodies. Greil (2002:109-110) likewise claims that women in his study in the US “viewed their bodies as integral to their selves.” Thus, because infertility is seen as “a failure both of body and of self,” infertile women have to work with a medical profession that does not treat them as whole beings in order to “restore their selves to a sense of wholeness” (Greil 2002:110). Rothman (1993[1986]:108) explains that in her study on the use or rejection of amniocentesis in the US, women who refused amniocentesis were reassured about the health of their developing child through their experience of their own bodies, and their developing relationship with their babies. Unlike women who used amniocentesis and were reassured through the authority of medical science, those who refused used a form of embodied knowledge (see chapter 5), to recognize the health of their child, demonstrating the connection between bodily sensations and ways of knowing.

As these examples explored in this section have demonstrated, embracing the “medical gaze,” or exercising dominant medical (and gender) discourse, does not *necessarily* reduce women to passive victims of reproductive technologies. Rather, women should be seen as actively participating in treatment processes in ways that empower them as both patients and women. By exploring the nuances within women’s strategies we can recognize the coexistence of structure and agency in the biomedical setting. Heeding the advice of Inhorn (2003b:269), however, we need to be cautious of romanticizing individuals’ struggles with infertility and infertility treatment, as real, inhibiting constraints beyond dominant social and medical discourses exist and impede women’s choices. In the next section I will explore how the functioning of the technology (its efficacy, or lack there of), and meanings ascribed to it, can

likewise be viewed as both inhibiting as well as motivating – both constraint on, and opportunity for, agency.

### *The “Compelling” Nature of Assisted Conception*

Dumit and Davis-Floyd, in defining the “technocratic imperative” (or the drive to overcome natural or bodily deficiencies through technological fixes), suggest that “*if it can be done, it must be tried... if it can be tried, then I must try it*” (1998:7, original emphasis). Following this rationale, it would appear totally logical for infertile women to turn to any new technology in the hope of achieving conception. In other words, the availability of a potential medical solution can be said to compel (some) women to try ARTs (Sandelowski 1991). Some scholars, however, are critical of this. Franklin (1997:132), for one, reminds us to be cautious of overemphasizing the draw of these technologies, noting that only women who find infertility to disrupt their lives will seek relief through having a child, and thus “produce the ‘obviousness’ of the choice to opt for IVF.” In short, not all women will feel a need to try ARTs.

Yet there are (as discussed above) certain social pressures that dictate the extent to which a “technological imperative” exists in ART contexts. Throsby (2002:58), for example, when considering social interpretations of normalcy, explains that “where the desire to have a child is constructed as ‘normal’ and essential to feminine identity, then the refusal to engage with IVF... leaves women vulnerable to the suggestion that she was unwilling and perhaps too selfish, to make the necessary sacrifice to be a mother.” Becker (2000:33) echoes this, noting her informants’ desire to fit in, to fulfill society’s expectations – expectations that *could* be fulfilled through the use of assisted conception.

Despite the highly sophisticated and complex nature of ARTs, Franklin (1997:200) explains that the scientific knowledge surrounding conception is incomplete: fertility specialists can explain the “facts of life” when conception is achieved and pregnancy takes place, but when conception is unsuccessful, a scientific explanation is missing – “the technical term is ‘unexplained infertility’”



(see also Franklin 1997:146-151; Tjørnhøj-Thomsen 2005:80-81). Similarly, Inhorn (2003b:158-162) recognizes the inefficacy of ARTs (only approximately 25-30 percent of IVF cycles end in conception) as an impediment to individuals' choices. Yet all this does not necessarily limit the attractiveness of the technology. Despite the lack of scientific evidence or information surrounding infertility and ART failure, and their limited success rate, some individuals still feel propelled to try their hand at conception through their use.

Sandelowski (1991) argues that the "compelling" trait of ARTs derives from the way the technologies function, not necessarily from patriarchal or pronatalist agendas. She notes that with IVF the process of conception becomes fragmented into segments of biological processes, "transforming it from an inchoate event into consciously lived states of achievements and failures" (Sandelowski 1991:39, 1993:122-123). This fragmentation of conception, Sandelowski argues, is an aspect that renders IVF "compelling" as women can see themselves moving closer to pregnancy with each successful treatment stage. When treatment fails women are thus "compelled" to try again as they had never been that close to pregnancy before (also see Becker 2000:119; Franklin 1997:152).

Similarly, ARTs also serve as forms of further diagnosis – another potentially compelling factor. With each treatment cycle, something new may be learned about the infertility complication, pointing to a new treatment option (Franklin 1997:154; Tjørnhøj-Thomsen 2005:80). The repetitive and persistent character of ARTs also influences couples to continue trying, even in the face of failure (Sandelowski 1991:36, 1993:49). These technologies, similar to unassisted conception, are not intended to succeed immediately. Repetition is required for success. Thus repetition, Sandelowski (1991) reports, something that is required in both unassisted and assisted reproduction, allowed assisted conception to ultimately be interpreted as natural by most of her informants. It is important to note, though, that this is very specific to a North American context. Studies of ARTs in the US have connected this necessary repetition and required aptitude of persistence to an American cultural norm that with enough effort any goal can be reached (e.g. Becker 2000; Greil 1991b; Sandelowski

1991, 1993; Thompson 2005). In other parts of the world (or even given other circumstances), conception is sometimes understood to come easily, and is seen as a biological process that must to be controlled (i.e. contraceptives) rather than augmented.

In general, many infertility patients have found ways to relate these technologies to natural conception processes. As Sandelowski (1991:38) reports, even if IVF was seen by women as “extraordinary” or “unusual,” it was still natural “because nature allowed it to succeed... because the pregnancy and birth were themselves natural processes.” In this way IVF can be seen as “giving nature a helping hand” (Sandelowski 1991:38, 1993:52).<sup>5</sup> The importance of this, as Sandelowski (1991:40, 1993:49) notes, is that interpreting assisted conception as natural may enable the acceptance of limited success rates, as the probability of natural conception is also very limited.

Another aspect of technologies’ potential influence is that due to the constant development of reproductive technologies that offer potentially new possibility for conception, it is difficult for individuals to completely forego treatment when they become aware of the existence of a new treatment method (Gerrits forthcoming). Inhorn (2003b), for example, demonstrates that with the introduction of ICSI into Egyptian clinics, infertile men were given “new hope” of fathering a child, particularly salient in the Egyptian context where donor conception and any forms of adoption or fostering are highly prohibited. This technology, however, is “reliant on the viability of the woman’s ova.” If she does not respond to hormone stimulation or her eggs fail to fertilize through microinjection, “then ICSI cannot succeed” (Inhorn 2003b:232). The potential for fatherhood that ICSI has created has thus pushed some men to divorce their older wives in hopes of conceiving with a younger woman.

Hope is, perhaps, the most powerful aspect of the “compelling” force ARTs possess, and is something instilled in more conventional ARTs, such as IVF, as well as new technologies/practices. Franklin (1997:192) labeled IVF a

---

<sup>5</sup> The notion of assisted conception giving “nature a helping hand” has become a dominant topic of analysis in the study of ARTs, see for example Edwards (2004), Franklin (1995, 1997, 2013), Thompson (2005), Throsby (2002).

“hope technology” – a technology that offers a chance, and thus hope, for pregnancy. It is this hope that IVF gives a woman that makes it a desirable option (177). Couples thus feel “compelled” to maintain a positive attitude towards treatment and its possibility for success (Becker 2000:117). Becker (2000:120) contends that women stayed in treatment, despite the emotional fatigue they experienced, “because it continued to symbolize hope. Each new treatment or physician brought renewed hope.” This hope has, therefore, been interpreted as a mechanism to sustain often numerous treatment attempts despite limited probabilities of success. Although this may portray ARTs and the individuals that utilize them negatively (i.e. presenting women as “desperate” and willing to try anything), Franklin (1997:165) notes that “despite its costs and pains,” the women in her study endorsed IVF and even felt it had “‘made something of them’ as women.” These women “made sense” of the emotional, physical, and financial demands of IVF by interpreting it as a form of “enablement through technological assistance,” which sustained their hope for success against the odds of failure.

Inhorn, on the other hand, paints a more critical interpretation of “hope” and ARTs in Egypt, where she notes that the hope that revolves around ARTs is (at least) partly created by the medical environment, where doctors “sell hope” as well as “false hope” to their patients (2003b:159). Similarly, the notion of hope has become a marketing tool for assisted conception as hope is seen as a cornerstone of American individualism and responsibility for one’s health (Becker 2000:117). Unlike the knowledge couples often have of the limited probability of ART success in the global north, however, both Bharadwaj (2001) and Inhorn (2003b) note that couples in their studies in India and Egypt respectively were not informed of the limited likelihood of treatment success. It was not directly discussed between doctors and couples. This not only represents the barriers posed by the technology’s lack of efficacy, but also the medical setting in which fertility treatment is carried out.

Inhorn (2003b:159) explains that the poor odds of treatment success are augmented in Egypt by the privatization of clinics and untoward competition between doctors. Doctors engage in a “deceptive ‘game of inflation’” where

success rates are manipulated to increase their appeal to willing clientele (163), ultimately creating false hope for success. Regardless of the “false hope” sold by doctors, infertile couples did not recognize inflated success rates as a major concern, which Inhorn (2003b:168) attributes to Egypt’s “position on the regional and global stage” as the oldest and most impressive biomedical health system in the Middle East, and the local discourse of hope, patience, and faith. Religious doctrine in particular stresses the importance of these attributes and the quest to resolve “human problems in an agentic fashion,” which includes infertility (170). Thus it is not necessarily false hope that pushes couples to try assisted conception, but hope that is tied to God (i.e. religious faith), as well as belief in medical technology.

Bharadwaj similarly notes the role of religion when doctors and patients are confronted with undesirable outcomes and uncertainty in the IVF clinic. These instances, when the doctor can do or explain no more, are explained through understandings of the capacity of destiny and God, “rather than by empirical and ‘objective’ clinical facts” (Bharadwaj 2001:265, also see Bharadwaj 2006). Here religion does not necessarily promote hope and persistence, but it may provide clarity or explanation when science is unable to do so, offering a reason to engage with these uncertain technologies (again).

Inhorn (2003b:170) notes that faith and hope in technology embraced through religion is similar to non-religious types of hope and faith discussed by Franklin (1997) and Becker (2000) regarding progress in the UK and the power of technology in the US respectively. Robert’s (2006:511) research in Ecuador also highlights the significance of IVF as a symbol of modernity and progress, which is connected to notions about socio-economic status, race, and the body. Modernity has made the middle-class Ecuadorian woman’s body be perceived to be faulty and likely to experience some form of reproductive complication, which must be overcome through financial sacrifice and access to modern reproductive medicine, such as IVF or cesarean section. Roberts (2008:93) explains that social status is established through these biomedical interventions that separate the urban Ecuadorian elites from the “functioning bodies of poor, rural, black or Indian women.” Utilizing IVF, then, is not only a means to bypass

a malfunctioning body and have a child, but also a way to solidify one's social status. High-tech reproductive technologies also serve as powerful signifiers of Chinese modernity, where Handwerker (2002) has noted how reproductive technology use has created a "new" eugenics aimed at creating modern, superior, and often male children. Thus, the notion of modernity and progress – rooted in wider political, economic, and innovation frameworks – is another factor that may propel couples to seek the assistance of ARTs.

Despite the push hope may provide to repeatedly engaging with these uncertain technologies, Bharadwaj (2001:285) explains that couples in his study "critically focused on the finer processes of their past and present treatments," as a way of "making sense" (Franklin 1997:165) of the treatment. This critique, focused on the "medical (mis)management" of infertility and the doctor's lack of sensitivity, often sent couples elsewhere to seek treatment. This perpetuated a cycle of searching for the best IVF provider and a solution to infertility (thus, propelling women/couples to use the technologies), even while becoming "a powerful critique of the 'incompleteness' of the science of conception" (Bharadwaj 2001:285). Further, negative experiences presented opportunities for agency, both in couples' criticisms of treatments, and in decisions of where and with whom they will undergo treatment.

Ultimately, these examples highlight how engaging with assisted conception is both empowering and constraining, as it is entangled in "material circumstances and cultural location of 'experience' that informs how the infertile... understand medical management of infertility" (Bharadwaj 2001:216). They show that the "pull of technology" (Sandelowski 1991:34, 1993:49-51) is a key factor that propels couples to engage with ARTs, but that this pull is situated, or embedded, in other aspects of society (such as gender norms, medical discourse/practice, religious hope, faith in medical technologies and progress, notions of modernity, and, clearly, the desire for a child). The significance of this embeddedness is discussed in the following conclusion.

## Conclusion

In sum, what the literature on agency in ARTs shows is that it is not possible (nor perhaps desirable) to define a universal theory on women's agency in seeking and undergoing assisted reproduction treatments. A vast array of constraints are encountered by women in different contexts that make agency in ART processes highly specific to different societies, and perhaps even to different clinical settings. While we can see that across cultures/societies, technologies themselves (which are, admittedly, embedded in hegemonic discourses and structures of progress and modernity) do seem to have a sort of universal draw, or "pull." However, specific cultural, social, political, and economic forces determine the exact nature of this coercive force. Thus, we must explore in greater detail how the combined "pull" and "push" of technology and society actually function in different contexts to create specific, nuanced forms of agency.

Likewise, it can be said that women's agency is universally constrained in ART processes. This is because agency in general is a constrained phenomenon, as discussed in the previous chapter. However, the different nuanced forms of agency that are evident in women's engagement with assisted reproductive technologies in different settings demonstrate the culturally embedded nature of agency. Importantly, this embeddedness (as well as processes of structural alteration) is, as Becker (2000) suggests, something that develops *overtime*. Agency is, in other words, a process. Thus, not only must we look at agency in specific treatment *contexts*, but we must explore how it exists in specific *moments* in treatment processes – before, during, and after (hence why this thesis is linearly structured to follow women's fertility treatment journeys).

As suggested in the literature review above, this entails looking at processes of reunifying the gendered 'dividual'. If women are central to debates on agency in assisted reproduction, the woman's body and embodiment are of key importance. Thus, these are themes explored throughout this thesis, both in terms of women's bodily experiences of fertility treatment, and forms of knowledge, or ways of knowing the body and bodily practices, and how these

emerge through lived experiences. Exploring the lived, embodied experience of fertility treatment may allow agency to be viewed through, or as part of, the body, as women embrace or refute the fragmentation of their bodies, experiences, and selves, and look to their bodily knowledge to understand and “make sense” (Franklin 1997:165) of fertility treatment. In the empirical chapters that follow, I explore the diverse forms of agency that women engaged in during the various phases of the fertility process, demonstrating how agency does not only manifests as a single act or even a stream of multiple acts, but as a processual phenomenon that unfolds before, during, and after fertility treatment.

## Chapter 3

### Unraveling the Experience of Assisted Conception through an Ethnographic Approach

Understandings of our social world(s) are malleable. They are created through everyday personal experiences and interactions with people around us, and change across locales and time. According to Schutz (1962:59), social reality “has a specific meaning and relevance structure for the being living, acting, and thinking within it.” In other words, from an interpretive phenomenological perspective, the meanings encompassed in human actions can be observed through the ways people live and act, and the verbalization of their thoughts, allowing social scientists to interpret the subjective meanings people give to their social realities. To capture these meanings and be able to extrapolate from these actions and interactions, the researcher has to become embedded in the social realities of the particular context she is exploring. This characteristic of social phenomenological research makes ethnography a valuable investigative tool.

Ethnography entails the researcher’s immersion into the socio-cultural activities of the fieldsite. Ethnographic practice aims to produce an emic interpretation, or what Geertz (2003) called “thick description,” of lived experiences. Through immersion in the social context (i.e. using observation, informal conversations, interviews), the ethnographer aims to grasp the social realities of her informants to allow their subjective understanding of the world to emerge. Through thick description, a fuller picture of a social context and the significance of social actions and interactions can be built (Blaikie 2000:240), such as those that shape the meanings attributed to the dominant discourses present in individuals’ interpretation and experiences of assisted conception.

Ethnography, and qualitative methodology in general, allows for a flexible research strategy, which does not impose stringent conceptual categories but permits the transformation of research questions to fit the



emerging context better. As I discussed in the introduction, the literature on ARTs in the Global South has greatly increased in the past 15 years, but still remains scarce in Latin America, and non-existent in Colombia. Before entering the field I had limited insight into the context I would encounter. The flexibility of ethnographic research allowed me to reformulate my research objectives as the context became more comprehensible. Starting with a broad observational scope and general questions, I focused my queries as I became immersed in the context and important themes began to emerge. The descriptive accounts on which the themes of this thesis are based have allowed me to explore the meanings and complexities of infertility and ARTs from the subjective experiences of couples and medical staff, which are embedded in this particular context.

### Clinical Ethnography

As I explained in the introduction, medical technologies are not innate entities. Rather, the meanings we attribute to them are socially constructed and reflect the norms and values of particular contexts. Not only are these technologies context-specific, but also the biomedical settings in which they are employed. Medical institutions may appear as “monolithic enterprises” (van der Geest and Finkler 2004:1995), but they vary across cultures, and even within them. Diverse diagnostic practices, therapeutic traditions, resource allocations, legal regulations, and medical training influence the environment of these establishments, and create variation within them. Van der Geest and Finkler (2004:1996) explain that medical establishments “both reflect and reinforce dominant social and cultural processes,” but these dominant processes differ from place to place. Exploring these institutions, then, provides a lens into the values, norms, and ideas of “wider society” in context-specific ways.

In order to unpack the meanings and interpretations of technologies, the experiences and conceptualizations of assisted conception, and the environment in which these treatments are employed, I conducted a clinical ethnography

combined with in-depth interviews. For ten months, from October 2012 to August 2013, I spent countless hours observing the inner workings of two private medical facilities offering ARTs in Bogota, Colombia. Through these hours of observation, I could explore people's subjective experiences of these technologies and follow the transforming narratives of women as they progressed through treatment.

Long and colleagues (2008:76) note that conducting a clinical ethnography allows for "greater depth of understanding than, for example, interviews with patients and their families outside of the hospital." My ability to follow women through their treatment trajectory in the clinics allowed me to explore their changing narratives and embodied experiences of ARTs. Through daily observations, I witnessed the interactions and dialogues that developed between individuals seeking fertility assistance and the medical staff providing the services, between people seeking treatment and their accompanying family members, and relationships between medical personnel. These interactions illustrated the dynamic environment of the fertility clinic and the complexities that surround infertility and its treatments. Furthermore, exploring these relationships, which are embedded in wider social-cultural meanings (Good 1994), provided a window into the core beliefs and values surrounding family and childbearing, and illuminated evolving societal discourses that both permit and reject the utilization of these high-tech treatments. Investigating these subjective experiences has also exposed the local, situated knowledge, knowledge that addresses "the critical and interpretive core of all knowledge" (Haraway 1988:584).

### Entering the Field

Twelve clinics offer ARTs in Bogota, six of which are listed on the Latin American Registry of Assisted Reproduction (Redlara), the database I used to

contact clinics before arriving in Bogota.<sup>6</sup> I was initially selective about the doctors I contacted through the Redlara database, choosing doctors with professional connections to Europe or North America, as I thought they might be more willing to allow a foreign researcher to conduct a study in their clinic. An embryologist at the only public clinic offering ARTs in Colombia returned my email and agreed to meet me on my arrival to Bogota.

Dr. Parra<sup>7</sup> was interested in working with me, but, given that the fertility unit in which he works is part of a public clinic, he was not authorized to grant me access to the facility or the couples with whom he works. I was instructed to contact the clinic's ethical board to seek approval for my study. Unfortunately, the ethics board was not equipped to evaluate qualitative research: the application form was intended for biomedical or scientific research, not a qualitative study on experiences and understandings. Furthermore, upon submitting the incomplete and incongruent application I was informed that the committee would not meet for another month, which would have delayed my intended start date even if my application were accepted. The ethics committee did not respond to my application, nor were my email inquiries answered. Fortunately, Dr. Parra put me in touch with a fertility specialist at another clinic, Medivida.

With Dr. Parra's referral, Dr. Herrera invited me for a meeting. Our conversation quickly turned into my first interview for which I was unprepared. After consulting with the other fertility expert at the clinic, Dr. Álvarez, and the other clinic staff, I was invited back to Medivida to start my research. Despite Dr. Herrera's initial willingness to allow me to conduct my research with her staff and patients, she continuously postponed introducing me to couples, one of her stipulations of my presence in her clinic. Thus I became concerned that my access to couples might be limited. Moreover, Dr. Álvarez repeatedly canceled interviews with me due to his hectic schedule, an obstacle I had anticipated

---

<sup>6</sup> Redlara is a regional network of clinics and practitioners offering ARTs in Latin America. The organization hosts a self-reporting system to monitor the various techniques being performed by these centers and their outcomes. Numerous sub-regional meetings are held yearly, and there is a full conference biannually (<http://redlara.com/>).

<sup>7</sup> All names of individuals and institutions have been changed.

(Olarde Sierra 2010:38), but one that nevertheless augmented my concern about access.

Recognizing that I would probably not be able to collect the amount, type, and quality of data that I required only at Medivida, I was eager to make the acquaintance of another fertility expert when the opportunity presented itself. A friend introduced me to a pharmaceutical representative who was a longtime acquaintance of the fertility expert at Fertisuperior. Again I was invited for a meeting with the lead specialist, Dr. Mabel. Taking an interest in my study, he invited me to conduct my research at his clinic, but I was asked not to start until the New Year, just a few weeks hence. Feeling anxious that the situation at Fertisuperior would be similar to that at Medivida, I chose to continue observing in the waiting area of Medivida and building rapport with the medical staff.

Despite my apprehension, when I returned to Fertisuperior in mid-January 2013 I was welcomed with enthusiasm. Dr. Mabel, the primary fertility specialist, granted me access to the entire facility, and he began introducing me to *pacientes* even before I was prepared to begin interviews. Fertisuperior soon became my primary fieldsite, but I also continued visiting Medivida, primarily to observe in the waiting area, albeit less frequently. From January until August 2013 I spent four to six days a week observing in the waiting area, consultation offices, laboratory, and OR (operating room) at Fertisuperior, and interviewing medical staff and women and men undergoing or inquiring about assisted reproduction.

My ethnography also went beyond the walls of these two clinics, extending into the many cafés, restaurants, homes, *busetas* (small busses), etc., that I visited across Bogota and Colombia more broadly. Everywhere I went people would inquire about my presence, why a *monita* (blond, fair skinned woman) was in their country. Many people I encountered knew someone – a sister, an aunt, or a mere acquaintance – who had experienced difficulties conceiving, and were willing (sometimes even eager) to share their accounts with me. While many of these stories are not present in this thesis, they did (and

do) contribute to my overall understanding of infertility and assisted conception in Colombia.

### Observations in the Clinical Setting: Becoming a Semi-Insider

Rapp (1999:2) explains, “the basic benefit of participant observation is its open-endedness: I set out with one set of research questions, and was forced to enlarge and transform them as people educated me on the complexity of the issues as they perceived them.” Like Rapp, after a year of working on my research proposal, I went into the field with particular questions to address, but, still having minimal knowledge of my fieldsite, I was prepared for these questions to transform as I learned from my observations and informants. Observation – one of the key tools of ethnography – allows for researchers to become situated in particular social realities where they can record and analyze the interactions that directly create and recreate a particular context (Timmerman and Tavory 2007:498). These two essential aspects of observational research (i.e. being situated in a particular context and the ability to record and analyze interactions that (re)create that context) formed the backbone of my study.

In particular, direct observation of everyday occurrences in two fertility centers served (at least initially) as my primary data collection technique. I intended to gain an understanding of this social environment first to allow for my research questions to transform before I began interviewing women and men seeking fertility assistance. This entailed countless mornings sitting in the waiting areas of Fertisuperior and Medivida. At first I sat quietly, scribing in my notebook, eager to be (and look) engaged in my work. At Medivida, this is how my observations remained (more or less) during most of my research. I did develop relationships with the nurses in the waiting area, with whom I would engage in small talk, and ask questions about the events of that day. My position in this clinic though was primarily that of the quiet researcher in the corner observing everything and everyone from the waiting area. I was permitted to

observe in the laboratory and OR one morning, and during two consultations, but that was all. This was partly because Dr. Herrera did not appear to have time to arrange for my presence elsewhere in the clinic, and I was not allowed to make arrangements on my own. Dr. Herrera's limited understanding of ethnography and social research more generally also prevented me from accessing other parts of the clinic. She had understood I wanted to observe various clinical activities, but she could not grasp why I would need to do so on multiple occasions. My qualitative study did not compute in the clinical, "scientific" environment in which I found myself. The power of Dr. Herrera's role as the gatekeeper to the rest of the clinic certainly played a role in the shaping and development of my research. She influenced what areas of the clinic were open to my observation and when, and with whom I was to speak. Within Dr. Herrera's clinic, I was not free to study what I pleased but was constrained by her willingness to open the "gate," which she did only slightly.<sup>8</sup>

Many scholars have problematized the extent to which an ethnographer can participate in the medical realm. Some have argued that the possible roles are limited to that of the patient, practitioner/nurse, or visitor (e.g. Wind 2008, van der Geest and Finkler 2004). Wind (2008:82), reflecting on her research in hospitals, argues that the inability "to participate more fully... in an immersive capacity is intrinsic to most if not all ethnography." I did not participate in the clinic by fulfilling one of these roles, but neither was I a mere observer, withdrawn from the everyday occurrences of the clinic. At Fertisuperior I participated in clinic "life" in the sense that I translated medical information from English to Spanish and vice-versa, fetched patient records during appointments, and invited women into their appointments when asked to do so. Once I even assisted in the laboratory when one of the embryologists was absent. My position in the clinic was not that of "outsider"/researcher, nor was it that of an "insider." Mullings (1999:340) explains that this binary of being an "insider" or "outsider" assumes a fixed role, rather than an unstable and dynamic position that changes at different times and in different places. My

---

<sup>8</sup> See Inhorn (2004) for a further discussion of the power-dynamics between medical professionals and ethnographers specifically in private medical settings in the Middle East.

position in the clinic was not fixed: I occupied a place somewhere in between a complete “insider” and a complete “outsider.” This dynamic position allowed me to explore aspects of the clinic not open to an outsider, but also to retain enough distance to remain critical of the social realities I was observing (Lewis 2003:64).

This blurred, semi-insider/semi-outsider role also allowed me to build relationships with the clinic staff, a rapport that facilitated my entrance into consultations, examinations, medical procedures, and the laboratory. Some of this, though, depended on the character of the clinical staff. In contrast to Dr. Herrera, Dr. Mabel took an immediate interest in my research and encouraged other staff to do likewise. His perception was that my research would provide him with valuable feedback about the patients’ perspectives of the clinic’s services – feedback I provided upon the conclusion of my fieldwork – while his general interest in academic work (he is also a lecturer on bioethics at a local university and a member of numerous medical research communities) made him particularly interested in the study. Within a few weeks, I could observe not only the interactions between nurses and couples/women in the waiting area and those between the doctors and the nurses (as I could at Medivida), but also interactions between doctors and couples during consultations, women and technologies during ultrasounds, aspirations, and embryo transfers, relationships between doctors and other medical staff, and those between the embryologists and the bodily substances being manipulated in the laboratory. These various interactions provided insight into the multidimensional context of fertility treatment, while allowing me to analyze the complexities of the diverse cases I encountered.

Ethically speaking, my role as observer during these activities had to be negotiated with both medical staff and couples. Inhorn (2004:2096) has called for more transparency in research methodology particularly when researching sensitive topics. She was referring to transparency between academics, but this also applied to transparency between the researcher and informants/those being observed. With medical staff I achieved this by meeting with them before starting my research to explain my project and solicit their assistance in gaining

access to different areas of the clinic to support the observational portion of the study. This demonstrates the ways in which the medical staff shaped the research and data collection opportunities (Goodwin et al. 2003:576). The staff were more than willing to assist me in these matters, as well as with gaining access to and seeking consent from couples. Before entering a consultation or examination room, the medical staff would explain my research and ask permission from the woman/couple for me to observe, which I also followed-up by personally soliciting their consent and offering a further explanation of the research if it was desired.

Offering transparency and negotiating consent in the waiting area was more difficult, as not all informants recognized I was a researcher, nor was it possible for me to introduce myself and my position to everyone who walked through the doors of the clinics. I did, however, try to make my note taking openly visible to individuals as suggested by Dewalt and colleagues (1998:274), which led numerous women to inquire about my behavior and presence in the clinic. Still, some individuals remained unaware of my role in the clinic. Thus, within the first month of observation, following Punch's (1994:95) advice, I made the conscious decision of what to include in my fieldnotes as data, and what not to include. I included observations that were clearly visible to anyone sitting in the waiting area and was conscious to only note conversations between individuals that already knew I was a researcher and the nature of my study. Furthermore, clearly visible observations were recorded in a generic and anonymous manner, to avoid causing any potential harm to the observed and to respect their rights as individuals, the ultimate goals of conducting ethical research. The same ethical considerations arose regarding conversations I overheard between medical staff about couples, and stories I was told directly by them about women and men undergoing treatment. Most of this information was verified by the couples who permitted me to use this data, while a small portion of these stories, similar to some observations, have been reproduced here without the individual's consent, as I did not meet them, but again is presented in a general and anonymous manner.



Unlike my ability to establish a semi-insider role among the medical staff, I could not gain even a partial insider perspective of the women and men undergoing assisted conception. Browner (1999:137), discussing the difficulty of studying a medical condition without experiencing it first hand states, “our contact with ‘the field’ is intermittent and we cannot internalize the illness experience.” Even though my observation of the women undergoing medical procedures and my experiences of these instances are central to my analysis (Browner 1999:138), my observations cannot reveal firsthand the embodied experiences of assisted conception. Rather, I needed the insights of in-depth interviews in order for the women to reveal their interpretations of the bodily experiences of ARTs and what they were feeling and imagining as they underwent fertility treatment.

### Negotiating and Constructing Interviews

Before going to the field, I determined that couples and staff in a fertility clinic would be my primary informants. The lack of a database of infertile couples, couples undergoing treatment, or a support group, made it unlikely I would contact infertile couples through other means. Initially I intended to place fliers at the clinic reception soliciting participants. The fertility specialists, however, did not regard this as appropriate and they preferred to explain my research to couples and then ask if they were willing to speak to me. Upon an affirmative response, the doctor introduced the couples to me.<sup>9</sup> Inhorn (2003b:24) and Thompson (2005:83) have also reported accessing patient informants through the mediation of doctors in their studies on ARTs in Egypt and the US respectively.

Despite other scholars having accessed patients through this method, I initially found this procedure problematic for two reasons. First, I worried that the women (who represented the majority of my informants) would feel obligated to speak to me because the doctor had asked them to do so, or that

---

<sup>9</sup> As explained above I was unable to conduct interviews at Medivida, but initially Dr. Herrera insisted this would be how I met my informants.

they would do so out of courtesy to me, ultimately voiding the voluntary means by which informants should agree to be interviewed (Green and Thorogood 2004:57). Second, given the sensitivity of the topic and my subjects' potential vulnerability, I feared that being implicitly coerced into an interview might cause informants further distress.

With these concerns in mind, I went into my first interview intending to introduce my research to the couple and inquire if they would be willing to schedule an interview with me. To my surprise, they appeared delighted to speak with me and were confused when I wanted to postpone our conversation. Instead, they preferred to discuss their experiences of infertility and their attempts at conceiving through ARTs right then. Feeling unprepared, as I had not yet finished my topic list, I listened to their stories taking notes, and asking for verification when I did not understand or needed further explanation. Keeping our conversation short, I asked if we could speak again soon, a proposal to which they willingly agreed.

Despite my earlier concerns, it became apparent from my initial interviews that the women/couples enjoyed speaking with me. They appeared comfortable sharing their stories, and would often seek me out to continue our conversations later. There were a few exceptions, though. Some women were unable to converse with me because of time constraints, and would normally request that we could speak at a later time – a commitment most of them fulfilled. Only two women told me they were not interested in speaking with me, which I accepted. Women's ability to refuse or postpone an interview indicates that they had not felt coerced by the doctor, while the limited number of women who refused an interview and the others who approached me at later times suggests a general willingness to share their experiences with me.

In total, I interviewed 48 couples together, and 39 women and 4 men separately – 61 of these stories are presented in this thesis.<sup>10</sup> These women/couples came from all corners of Colombia, the majority were part of the middle-upper or upper class, and were well educated professionals. They

---

<sup>10</sup> See appendix 3 for a table providing details about these 61 women/couples.

were at various stages of their treatment journeys: some were “shopping around” for a clinic, others were initiating their first cycle, while others were on their second or third cycle and had experienced one or more treatment failures. The majority of the couples were undergoing IVF/ICSI, but a few were doing AI. Most were using their own gametes, but some were using donated (either known or anonymous) eggs and/or sperm.

The number of interviews conducted far exceeded my expectations and was largely due to Dr. Mabel’s insistence. Browner (1999:138) reports that ethnographers may end up working with large sample sizes to appease biomedical colleagues while conducting research on medical conditions. Although I was not working with Dr. Mabel in the conventional sense, he was concerned that I would not obtain enough data for my research to be significant, in a quantitative sense, and therefore he was persistent about introducing me to couples I had not yet interviewed. Dr. Mabel’s desire for my research success, combined with *his* understanding of a relevant research sample, resulted in this large sample size.

Most of my interviews took place in a clinic consultation room or an administrative office, which provided a private and quiet environment. On occasion I interviewed couples in the waiting room when it was vacant, once in a nearby café upon the couple’s request, and once during a family lunch in Cartagena, though this was more of an informal conversation with the entire family. Initial interviews lasted between 30 and 90 minutes, depending on the amount of time the informant(s) had and their willingness/ability to elaborate on the questions I asked. I did not record the interviews. During some early interviews that I conducted with the recorder on, the informants appeared more anxious and less conversational than in those interviews I conducted without the recorder. Even though the informants had agreed to be recorded, turning the recorder off produced a more fluid dialogue. Recognizing this, I began taking written notes during interviews and audio-recording my recollections of the interviews when the informant(s) left the room. I translated, typed up, and digitally recorded these detailed accounts on a nightly or bi-nightly basis.

I obtained verbal consent instead of the written consent I had originally intended, also because of the experiences I had. After my first meetings with the fertility specialists at both clinics, I presented a draft consent form and asked for any suggested alterations. In both instances, however, the consent form was dismissed as unimportant and potentially even inappropriate in this setting. Some scholars have labeled Euro-American ethical research codes as social constructs (Miller and Boulton 2007). Through reflecting on their various studies in Bangladesh, Zaman and Nahar (2011) demonstrate that such “ethical” practices, like informed consent, are not applicable, and are even viewed as absurd in the locations where they have conducted research, reflections that parallel my own experiences. Further conversations with Colombians outside the clinical environment revealed that years of conflict and corruption have made many Colombians anxious when asked to sign formal documents. Given these insights, I decided to explain the parameters of my study verbally, making my research intentions and the future intentions of any collected data known and clear to the informants. I emphasized that all names (including institutions) would be changed and that agreeing or refusing to participate in the study would not affect the medical treatment received. Discussing my research verbally and then asking for consent not only allowed me to avoid the culturally insensitive request for a signature, but also provided space for my informants to inquire about the study, as a line of verbal communication had already begun, a practice that I found to be more ethical than merely signing a piece of paper.

Recognizing the complexity of fertility treatment and the topic’s potential sensitivity, I chose to employ what Douglas (1985) labeled “creative interviewing” to encourage a free flow of dialogue and expression between the participant and myself, as we co-constructed a two-way flow of information (Atkinson & Silverman 1997; Holstein and Gubrium 2004). Douglas has been criticized for depicting a passive interviewee who is a mere “repository of opinion and reason,” rather than a participant in a “meaning-making project” with the researcher (Holstein and Gubrium 2004:150). Combining these two ideas – the flexible, free-flowing interview and the co-construction of meaning – enabled me to see how interviewees can take an active role in the interview

process where they have a level of “control over the direction” of this meaning construction (Poulin 2010:242).

To arrive at a constructive, meaning-making dialogue requires an establishment of trust and mutual disclosure. Knowing the sensitivity of the topics, I anticipated that I would need to meet and interview women/couples on several occasions to build rapport and trust before they would share their experiences. One way in which to establish trust was allowing (and even encouraging) couples to ask me questions, particularly at the beginning about the study and then providing space for them to ask me personal questions. Some initial interviews actually involved the participants’ asking me more questions (about why I was interested in ARTs, why I came to Colombia, what my favorite thing about their country is, am I married, do I want children, etc.) than them responding to my questions. By providing details about my life, I too was being asked to delve into my intimate life (Legard et al. 2003:160; Oakley 1981; Poulin 2010:263-265), creating a more “level playing field” and demonstrating respect from my participants (Dickson-Swift et al. 2006:857). Furthermore, permitting the interviewee to take charge of the conversation allowed them to disclose the experiences/sentiments that they felt comfortable discussing, a factor that is particularly important when conducting interviews on sensitive topics. Through these exchanges I developed relationships with my informants, some which lasted only a few weeks, and others which lasted for months.

Given the ad hoc means by which I was introduced to women and the ever-changing schedules of fertility treatment, it was difficult to arrange follow-up interviews with many women, a methodological limitation also discussed by Bharadwaj (2001:276-277) and Inhorn (2003b:27). Unlike Bharadwaj who claims some of his informants were not interested in follow-up interviews (while others were unavailable), in my research after an initial interview many women sought me out when attending their appointments to tell me about their treatment progression, and voice any concerns they had about the next treatment stage. These follow-up interviews and informal conversations were generally very insightful and often lasted until the woman was called into her

appointment or was urged to leave the clinic by her partner. As with Inhorn's (2003b:24, 2004:2098) experience in Egypt, the women appreciated the ability to share their experiences and concerns about a normally undiscussed topic. My interactions with them provided an outlet to share their worries, intimate stories, and sometimes losses with an empathetic listener, and someone other than the doctor or a close family member or friend. Furthermore, being "outside" the women's social networks alleviated their concerns that I would divulge their intimate stories to others. Seeing me as a professional, well-educated individual, some women also came to me for clarification about medical procedures. Following Inhorn (2003b:27), when I could answer a question accurately, I did so. But more often than not, I suggested the women consult the fertility experts or nurses for further biomedical information. I also recommended women, who demonstrated exceeding distress about their engagement with assisted conception, whatever the nature, to speak to the clinic psychologist, a service provided by the clinics, but one I rarely heard women discuss using or doctors recommending.

Reflecting upon the confidence the women had in me and their willingness to share their hardships, I had to be conscious of my position in the clinic: was I crossing the boundary between researcher and friend (or even therapist) (Dickson et al. 2006)? Aware that I may have been overstepping these boundaries, I continuously reminded the women about the investigative quality of my presence and asked them to confirm their willingness to continue participating in the study. Providing consent is not a singular phenomenon, but a continuous process that must be negotiated and renegotiated throughout the course of a study (Miller and Bouton 2007:2209), particularly when the boundaries of the study or the reasons for the researcher's presence become blurred. None of the women I interviewed asked to withdraw from the study (apart from the two who did so during our first meeting) when we revisited the reasons for our conversations, and this facilitated a continuous dialogue between these women and myself. Reflecting on my role as the researcher kept the relationships with the women, with whom I inevitably became entwined, professional as opposed to personal, a process that was tiresome and difficult

(Dickson-Swift et al. 2006:866), but one which helped me to maintain a critical distance (Watson et al. 1991:509-510).

### *Other Interviews*

To obtain a more holistic interpretation of the meanings surrounding fertility treatment, I also interviewed all the medical staff and most of the administrative staff at the two clinics. This included interviews with four fertility specialists, one urologist (who worked with both clinics), three embryologists, four nurses, four administrators, as well as informal conversations with two other embryologists, a cleaner, one of Fertisuperior's financial investors, and an anesthesiologist.<sup>11</sup> Formal interviews with medical staff were audio recorded in Spanish (except on three occasions when the medical staff wanted to practice their English), transcribed, and later I translated them into English. Two medical staff refused to be audio recorded. The interviews with medical staff were semi-structured and partly specific to the informant's specialization.

Towards the end of my research, I also interviewed a family practice lawyer who had experience working with fertility clinics and an adoption agent, because they could provide insightful information and perspectives about infertility and ARTs that had not yet been provided. Furthermore, I took the opportunity to interview three egg donors and a former surrogate mother when the opportunities presented themselves.

### Analysis

Given the qualitative and particularly descriptive nature of my research, I employed an inductive framework for data analysis. I had done an extensive literature review prior to fieldwork but I did not want to be bound by the theories and concepts in the literature (e.g. Charmaz 2006). Rather, I followed Glaser and Strauss' (1967) notion of "constant comparison:" data analysis

---

<sup>11</sup> See appendix 4 for a table detaining the medical staff whose narratives appear in this thesis.

coinciding with data collection to identify key themes emerging during the study. During fieldwork this interactive process consisted of typing up my field and interview notes on a daily or bi-daily occasion, serving both as a review of the data as well as a security measure, as there was always the threat of my bag (with notebook in side) being stolen on my way to or from the clinics. In this way, I remained familiar with the data, identified the key themes that were emerging, and was able to follow-up particular narratives or treatment aspects that remained unclear. The co-practice of data collection and analysis also allowed me to recognize when new themes were no longer transpiring.

When the research came to a close, the identified themes were incorporated into the coding process when the data – including interview transcripts/notes, fieldnotes, and fieldwork diary – were imported into NVIVO, a qualitative data analysis software package. The compiled data was coded, line-by-line, using the key themes that emerged during the research, terms from the literature, and language used by my informants (32 codes were identified), as I sought to identify the substantive meaning of the data. Due to the bulk of data I collected, once the data was coded, I had to decide which themes to select in order to generate a coherent plan for my thesis. The initial coding and selection process enabled my lengthy notes to be broken up “and laid the foundations for a more iterative analytical process by which the relationships between those coding categories became more apparent” (Thrsoby 2002:92). The links across the various codes were identified through time-consuming re-reading, computer highlighting, and jotted notes, but eventually the data was pieced back together in a new configuration. The chapters that follow are based on the exploration of the links created across the coded data, and the “local” conceptual patterns that have emerged (Turner 1994:196).





## Chapter 4

### Contextualizing Assisted Conception in Colombia

Upon starting my research, I realized two things very quickly. First, even though my ethnography focused on medical practices that create life, I could not escape the violence, death, and inequality that have shaped Colombia's history and the stories from Colombians who have lived this history. Second, even though I was doing an ethnography in Bogotano clinics that did not mean I was conducting an ethnography about Bogotanos' perceptions of ARTs: being the capital, Bogota is a heterogeneous environment composed of individuals, ideas, cultures, and languages that once scattered the country but in recent years have come together in this metropolis.

In this chapter I explore the wider contextual features – historical, political, socio-cultural, economic, and legal – that shape how ARTs are provided, accessed, and perceived by the couples who seek their assistance (Inhorn 2003b; Rapp 1999). First, I briefly address the two points laid out above, and the drafting of the 1991 Constitution that emphasizes government decentralization and individual autonomy. Next, I explore the transformation of gender roles and family dynamics, and the importance of parenthood. Finally, I discuss the 1993 Colombian healthcare reform and the marketization of health services, which provide an introduction to the emergence of the Colombian ART industry and the legal framework that surrounds these practices.

#### Impact of Conflict and Neoliberalization on the Research Context

Colombia has a long history of conflict. It has undergone several civil wars, bloody conflicts related to political and religious tensions between Catholic conservatives and more secular liberals (most recently *La Violencia* 1948-1958), as well as the more than 50 years of multilateral internal armed conflict (1960s-present) between various leftist guerilla groups such as the

Revolutionary Armed Forces of Colombia (FARC, Spanish acronym), corrupt paramilitary groups supported by the government (especially the United Self-Defense Force of Colombia), and the Colombian military and national police.<sup>12</sup>

Paradoxically, despite constant conflict, Colombia's economy has continued to grow, and is one of the most stable in the region. Further, it is the longest continuous democracy in the region. Yet only a minority of the population has access to this wealth. Colombia has a Gini coefficient of 58.6, which reflects one of the highest levels of economic inequality in the world (United Nations Development Program in Yamin and Parra-Vera 2009:0147). An influential factor in this inequality is the vast urban migration resulting from violence in rural areas. According to the *Registro Único de Población Desplazado* (National Registry of Displaced People), in 2009 Colombia had approximately three million *desplazados*, accounting for the second largest internally displaced population in the world following Sudan (Carrillo 2009:529). Urbanization has also been fueled by "urban industrial development and agricultural modernization," which has reduced the need for rural labor (Rueda-Garcia 2003:1).

The result has been a massive demographic and social shift in the country. Today approximately 80 percent of the Colombian population lives in urban areas (Rodriguez 2012:13). Bogota is by far the largest of these, having grown from just over 100,000 inhabitants to over 9 million since 1900. It is home to Colombians of all regional and ethnic backgrounds. The clinics where I conducted my ethnography reflect the diversity of Bogota's population. The medical staff come from various regions of the country (as well as from abroad). Similarly, some of the couples had moved to Bogota from elsewhere. Others traveled to the capital only for ARTs, among them Colombian expatriates who returned from abroad to undergo an ART cycle. Given the diversity of the individuals who participated in my research, I interpret my research to not only be a study of Bogotano fertility centers, but an ethnography of Colombian experiences of ARTs. I am not implying that my research findings are

---

<sup>12</sup> For a more comprehensive account of Colombia's history see Bergquist et al. (eds) (1992, 2001), Safford and Palacios (2002).

generalizable to the entirety of Colombia, but reflect more than the perspectives and experiences of people from and living in Bogota. Thus, Colombia's history of conflict is essential to understanding the context of this research in that it has brought a great diversity of Colombians to the city where my researcher was conducted, making it perhaps a better site for conducting an exploratory study of assisted conception in Colombia.

Another important contextual factor has been a 25-year process of neoliberalization in Colombia. On July 4, 1991, Colombia adopted a new constitution that made dramatic changes to the country's governance. The new charter diminished the powers of the president, which had been protected throughout Colombia's centrist political history, and gave more power to the judiciary and legislative governmental branches. It also pushed for the decentralization of power and more autonomy for Colombia's 32 departments and its many municipalities.

Guillermo Perry (2011), chief economist of the Latin American and Caribbean Region at the World Bank and a Colombian, explained that this has made Colombia one of the most decentralized countries in the world. However, while he argues that this has allowed public services to improve in some states, he notes that they have deteriorated in others. Changes to fiscal legislation have also proven to be ambiguous. In particular, changes to economic and social rights have affected the financial viability of health insurance and housing-loans, and led to new inequalities, instead of reducing inequalities and poverty, as many intended the Charter to accomplish.

Nevertheless, the Bill of Rights adopted a human rights discourse and specifically acknowledged the rights of women (addressed in more detail below), children, indigenous, disabled individuals, and minority groups. Citizens have also benefited from improved standards of public services, which can be provided by private or public enterprises alike but remain under the State's supervision to guarantee efficient service delivery (Perry 2011). The Constitutional Court, accessible to government officials and citizens alike, has permitted legislation pertaining to human rights, the judiciary, political parties, and the opposition, and provided more secure mechanisms of political

participation (Fox et al. 2010:478). Thus, despite an ambiguous record, the 1991 Constitution has attempted to combat some of the inequalities that were perpetuated throughout years of conflict. Although these broader implications are at least tangentially relevant, however, the subsequent processes of privatizing medical care in the country is the most pertinent to this thesis.

### Gender Norms & Family Dynamics

A national study completed in the early 2000s in five major Colombian cities (Bogota, Bucaramanga, Cali, Cartagena, and Medellin) reported only minor differences in family structures and the roles of mothers and fathers across these metropolitan areas (Puyana et al. 2003). Puyana and colleagues (2003:7, Spanish original) explain that factors such as urbanization, marriage across regions, and the increasing availability of the media, education, and other cultural trends, “have influenced changes in the social representations of paternity and maternity once demarcated by regional boundaries.” Thus, while Colombia has a long history of mixing Spanish family ideals with those of indigenous groups and later with those of African slaves, resulting in slightly different familial models in the various regions, the nuclear heterosexual family was (and still is) the primary household structure, while extended family networks have remained strong and proven useful in times of economic struggle (Puyana et al. 2003; Gómez et al. 2001).

As in most of Latin America, gender roles in Colombia are highly segregated, and men and women have distinct realms and responsibilities. Colombian gender relations have been extremely hierarchical (Carrillo et al. 2011:76) and reflect the hierarchical character of the Catholic Church whose historical structural patterns and ideologies have been maintained in the Colombian diocese more than in other Latin American countries (Levine 1985, 1992). Most academic literature characterizes the role of the dominant male in patriarchal societies as a masculine figure who overpowers the subordinate woman (Nolasco 1993 in Viveros 2001:239).

Colombian men have traditionally held the authoritative position within the family and have been responsible for providing for their wife and children. Men have not normally engaged in domestic activities, such as raising and educating children, cooking, and cleaning (Puyana 2003:76), but have been responsible for representing the family in the public realm, a domain that has often excluded women (Henaó 1997). This masculine figure was often distant from his children (and sometimes wife), and did not display affection or make physical contact for fear of losing his authoritative position.

Marriage has been characterized as monogamous, between a man and a woman, and everlasting, although free unions and children out of wedlock have been common, especially among the lower classes. Despite being common, they have historically been socially marginalized (Puyana 2003:6). Bastos (2007), referring to research in Guatemala, discusses the “double-system” of masculinity that requires men both to be their household’s economic provider to cement their social position in the family, and to present themselves as without social ties, particularly ties to women. This “double-system” may account for the lack of male responsibility for their children in certain parts of Colombia.

Browner (2000), reporting on research in Cali in the 1970s, explains that unmarried men were rarely held responsible for the women they impregnated or any subsequent children. They were not stigmatized for their actions, and could enter the next woman’s home without reprimand. By contrast, the Colombian woman was bound to her children and the domestic realm. She was subordinate to her husband (and men in general), and excluded from wider society. She was a housewife and mother, affectionately caring for her husband, children, and extended family and making use of the monetary resources made available to the family by her breadwinner husband, although she was responsible for managing household funds (Puyana 2003). The woman was responsible for both educating and disciplining her children.

Despite movements for women’s equality and women’s presence in the public sphere, traditional gender norms persist in Colombian society. Puyana’s overview of the data in her study with colleagues (2003) outlines three

categories of Colombian households: the traditional family, the transitional family, and the ruptured family (*la familia ruptura*). The *traditional* family is like the Colombian family of the 1960s in displaying many of the characteristics of men and women described above, with the exception of poorer households where the mother is required to seek paid employment, thus leaving her children alone or supervised by a family member. In the *transitional* family, children are allowed more freedom, the wife may be employed outside the home, but the man participates only minimally in domestic chores. Such families often experience periods of conflict, with one partner displaying more “contemporary” characteristics than the other or with conflicting childrearing ideals. *La familia ruptura* has adopted a “modern,” democratic family system where father, mother, and children can participate equally. Commonly the wife is well educated and is employed outside the home in a professional career, which allows husband and wife alike to contribute to the family income. Furthermore, children are treated with respect and are embraced by their parents both verbally and physically.

According to Puyana most families in the study were either traditional or transitional. She explains that “only men who have made significant breaks with the father-provider and woman-housewife model” participate in household work and responsibly care for other family members, fulfilling the characteristics of the *familia ruptura* (Puyana 2003:77, Spanish original). Most, however, are in transition. De Suremain and Acevedo (1999 in Viveros 2001:243) show that in Medellin (Colombia’s second largest city) the new social pressure put on fathers to fulfill a paternal role has been confronted with obstacles such as unemployment or unstable employment and displacement caused by civil conflict, making it difficult for men to fulfill this newly established ideal father role. This has led to further strife in family networks. Echeverri (1998:55) claims that as women gain more liberties, men hold onto their patriarchal norms “supported by religion and cultural tradition,” causing conflict among families in this transitional position.

Puyana (2003) concludes that Colombian family dynamics are transforming more slowly than the population believes, due to factors such as a

family's social economic class, family formation, and the subjectivities of the individuals involved. Puyana attributes these transformations in family structures to women obtaining gainful employment outside the home, pressures of modernization, and increasing secularization (72). However, as displayed through Valdés and Olavarria (1998) analysis of the influences of 17 years of military dictatorship (1973-1990) on male identities in Chile, it is plausible that the 50+ years of civil war have reinforced notions of masculinity, power, and authority. These conflicting factors, one pushing for transformations and the other reinforcing traditional gender stereotypes, are evident in new legislation and reinforced through media, as I explore briefly in relation to the significance of parenthood.

#### *Importance of Parenthood and Children*

Siting at Fertisuperior one morning early on in my fieldwork, Dr. Mabel introduced me to an American woman, Nelsy, who had been living in Bogota for some years. Even though she did not meet my sampling criteria, as she is not Colombian, I thought her story might be insightful since she is also a Colombian "outsider." Thus, we made our way to a vacant consultation room in the back of the clinic. Nelsy explained her husband is a foreign diplomat posted here for a five-year term. After telling me about her reproductive history and her renewed interest in having a child, she started to tell me about the difficulties of being childless in Colombia. She explained that random people she has come across – waitresses, taxi drivers, doormen – have asked her why she does not have children. Finding it too personal to explain that she is infertile and recognizing she is in a Catholic country, she finally told a man it was not God's will that she have children. Hearing this response, the man forcefully told her God would never wish for a woman to be childless. On the contrary, God wants everyone to have children. Taken aback by the man's directness, she apologized and changed the subject. After reiterating this story to me she explained, "I now tell people I prefer to have dogs." (Fieldnotes 18 Jan. 2013)

Motherhood, fatherhood, and procreation have held significant meaning in Colombia since ancient times. Pre-Columbian artifacts, structures, and sacred



sites throughout Colombia pay tribute to fertility and the importance of conception. The importance of motherhood (more so than fatherhood) and the creation of life were reiterated with the arrival of the Spanish and their Catholic values. Browner and Lewin (1982) explain how the Virgin Mary portrays the most important role model for women in Colombian society. Speaking of Latin American women more generally, they claim that the self-sacrificing and pure mother “emerges as the ideology of *Marianismo*” which positions women as spiritually superior to men, while requiring them to live for their children and husbands instead of themselves (Browner and Lewin 1982:62). This image of the selfless mother has been incorporated into Colombian society, and is continuously reproduced in government legislation and societal norms.

Government policies, including those arising from the 1991 Constitution, identify women as the principal care-provider of children. Article 43 of the 1991 Constitution states, “During pregnancy and after birth [women] will enjoy special assistance and protection from the State, and will receive support benefits from it if they then become unemployed or abandoned” (in Morgan and Buitrago 1992). In the same article, the State guarantees additional financial support for woman-headed households. The article intends to provide women with further financial support, but at the same time it reinforces the potential vulnerability of women, while disregarding the father. This may be due to the rise in female single-parent households (Gómez et al. 2001) and that the labor market still pays women a reduced income, placing women in a more precarious economic position (Puyana 2003:74). Social policies intended to improve the living conditions and development of children specify that *mothers* will “ensure that children and adolescents receive both health and educational services” (Carrillo et al. 2011:82). The government’s program for achieving the Millennium Development Goals focuses only on empowering and providing autonomy for women and mothers within the context of the family (Conpes 2005). These policies reproduce the maternal ideology embedded in Colombian gender norms.

Browner (1985:107) explains that Colombian society sees “maternal roles as the only legitimate one for women.” Puyana (2003:69-70, Spanish

original) found that “ideas that privilege motherhood are still preserved in all the [studied] cities under the belief that the mother – rather than the father – is essential for breeding and the growth of child.” Newspaper articles addressing children and childcare services often mention only women and mothers. For instance, an *El Tiempo* news article about the opening of a new government subsidized daycare facility in a poor Bogotano neighborhood addresses the help it will offer *mothers* instead of families (El Tiempo 2013a).<sup>13</sup> Another news article discusses a program aiming to reduce teenage pregnancy by educating *girls* (but not boys), through the use of robotic babies, about the responsibilities of raising children (El Tiempo 2013b). Florence Thomas, an opinion columnist for *El Tiempo*, published an article entitled “¿La maternidad a cualquier precio? (Maternity at any price?), in which she states,

[In Colombia], women steal babies, they kill to steal newborns, and want to be mothers from the age of 12. Here the fate of women continues to be that of the mother at all costs. Speaking of the real challenges of motherhood is still taboo... [Speaking of women who choose not to have children] but that is still almost impossible, as the enormous weight of materialistic culture, which sanctifies motherhood, still lives in the vast majority of teenagers and Colombian women. Changing this will take decades and will only be achieved if there is *real political will* that pervades all public policy aimed at women. (Thomas 2013, my emphasis, Spanish original)

Despite Thomas’ heated tone, the article depicts not only the social importance of maternity, but also that which women themselves place on motherhood. Thomas indicates that motherhood is ingrained in most Colombian women and girls and she depicts the lengths they will go to obtain a child.<sup>14</sup>

Drawing on research in Cali in the 1970s, Browner (in Browner and Lewin 1982:65) reported that Caleña women saw voluntary spinsterhood to be unimaginable, not because they would lack a husband, but children. From her fieldwork in the early 1980s, Browner (1983:500) still found that Caleña women “derive their primary identity from the traditional wife-mother role,”

---

<sup>13</sup> *El Tiempo* is one of the primary Bogotano newspapers.

<sup>14</sup> While in Colombia I heard (and read) about numerous stories that involved women stealing newborns from clinics.

although they regarded marriage primarily as a means to obtain the more sought after goal of motherhood. Although Browner's research derives from only one part of the country, she clearly depicts the central role that maternity plays in these women's narratives. In the next chapter, I discuss this maternal ideology expressed in my informants' narratives.

Despite the social emphasis on the importance of motherhood and women's primary role in parenting, fatherhood is a valued status in Colombian society. Less scholarly attention has been paid to fatherhood and the male role in childrearing, but the available literature emphasizes fatherhood as the ultimate form of masculine responsibility in Latin America (Viveros 2001:245), as a symbol of adulthood, and marker of important manly experiences. Fatherhood is a public demonstration of the fertile, reliable, and complete man (Fuller 1997), who has fulfilled the transition from childhood to manhood.

The inability to have a child within a society that highly values parenthood raises questions about those who cannot conceive. Many studies have explored the stigmatization and hardships that accompany childlessness (e.g. Inhorn and van Balen 2002; Whiteford and Gonzales 1995; van Balen and Gerrits 2001), topics this thesis will not specifically address. Assisted reproductive techniques, however, can counteract the misfortune experienced by some infertile men and women, and since they correspond well with dominant ideologies, there is space for these technologies to be adopted and accepted.

### Colombian Healthcare System & Assisted Reproduction

In the 1990s, the International Monetary Fund (IMF) and World Bank pressed many Latin American countries to adopt neoliberal structural adjustment programs that required the dismantling of social welfare programs (Abadía-Barrero 2012:1; Restrepo and Valencia 2002:742). In Colombia, this resulted in the adoption of *Ley 100* (Law 100) that structured the 1993 healthcare reform and replaced the National Healthcare System – a supply-based healthcare model

supported by government-funded public hospitals – with the market/insurance-based General Health Social Security System (Abadía and Oviedo 2009:1153). The new system has two variants: the contributory system (*Plan Obligatorio de Salud*, POS) and the subsidiary system (*Plan Obligatorio de Salud Subsidiado*, POSS).

The POS includes people in the formal work force and is financed by employer and employee contributions. Those included in the POS must choose a medical insurance provider or health-promoting entity (EPS – Spanish acronym) regulated by the government to cover their healthcare costs. The contributory plan provides access to three levels of medical treatment: I Basic, II Intermediate, and III Complex. Some individuals also choose to purchase private medical insurance (i.e. *prepagada*) that offers further healthcare options. The POSS is sustained by a percentage of the resources from the contributory system combined with resources from the Ministry of Health. The subsidiary system covers the economically disadvantaged who cannot pay for insurance (Abadía and Oviedo 2009; Plaza et al. 2001). The subsidized plan allows access only to level I care, and some aspects of levels II and III. All individuals are required to pay a fixed price for services, including consultations, examinations, and prescriptions (Abadía and Oviedo 2009:1154).

The reform intended to increase access to healthcare while reducing State expenditures. Statistics indicate the number of people insured rose from 28 percent in 1992 (Plaza et al. 2001:46-47) to approximately 90 percent in 2003 (Calderón et al. 2011:289). Yet the quality of services provided has decreased and the price of treatment and other barriers to care have actually increased, and some commentators declare there is a healthcare crisis in Colombia (Abadía-Barrero 2012:1; Abadía and Oviedo 2009:1154). Subsidized insurance packages primarily offer preventative and primary care, and cover only a minimal list of more complicated procedures (Plaza et al. 2001:46). Since the healthcare reform, the mortality rate and the incidence of preventable diseases have increased, and vaccination coverage has declined. Public health programs in general have diminished, as have the number of regional hospitals.

Additionally, physicians face new restrictions on treatments and prescriptions because of cost controls (Abadía-Barrero 2012:2).

The declining availability and quality of services has led to a steady increase in *tutela* suits (a form of legal action established in the 1991 Constitution to protect citizen's fundamental rights) since the late 1990s as people claim the costs of treatments no longer provided under the new system (Abadía-Barrero 2012:2; Abadía and Oviedo 2009:1154). Yamin and Parra-Vera (2009:0148) claim that healthcare providers and insurance companies have not adopted principles established by the Court into their policies "due to a failure of oversight and regulations." This has led to a financial deficit in the government healthcare sector as people claim their right to health, which was guaranteed by the 1991 Constitution (Calderón et al. 2011) and reinforced by the Court in 2008. Moreover, the government's and individuals' over-reliance on *tutelas* to guarantee citizens' rights is furthering a system in which individuals have to take responsibility for their personal wellbeing, which align with the new Constitution's goals more broadly. This includes couples seeking ARTs, which are not covered by either the POS or POSS, but are still indirectly included in the right-to-health framework adopted in the Constitution. The Ministry of Health has generally covered the costs of ARTs and/or of the accompanying medications for those individuals who have invoked this right through *tutelas*. Few cases have been brought to the attention of the Courts, however (interview with Dr. Herrera 23 Nov. 2012).

#### *Creating a Commercial ART Market in Colombia*

Colombia was one of the pioneers of high-tech fertility treatment in Latin America. Private clinics have offered services since the mid-1980s, and facilitated the treatment that led to the first IVF baby in the region, Diana Carolina Mendez, born on January 10, 1985. Currently the country hosts 11 clinics registered with Redlara: six in Bogota and five in other major metropolitan areas. According to Redlara's records presented at their biannual

meeting in Panama City in May 2013, the 11 Colombian clinics registered with their network account for 4.5 percent of ART procedures performed in Latin America (following Brazil, Argentina, Mexico, and Chile), and between 1990-2011 these clinics contributed to the births of 5,191 ART babies. However, according to my research, these 11 clinics represent less than a quarter of the clinics offering ARTs in Colombia. The pharmaceutical company Merck supplies most of the hormonal drugs used in assisted conception procedures in Colombia (and Latin American in general). In August 2014, a Merck representative reported to me that they supply 45 clinics, and he estimated there are three other clinics with whom they do not work. However, there is no publically accessible registry of ART centers in Colombia with which to confirm this information.

Medical practitioners themselves are largely responsible for the introduction of ARTs in Colombia. According to Dr. Mabel, a training workshop in Barranquilla in 1982 was the starting point: “Everyone who was interested in ARTs was there.” Shortly after this workshop, the first clinic offering these treatments, *Centro Colombiano de Fertilidad y Esterilidad* (CECOLFES) was founded in Bogota by four “pioneering” ART specialists, whose procedures resulted in the first clinical IVF pregnancies in Colombia, followed by the birth of the first Colombian IVF baby. Around the same time as CECOLFES opened, another team of doctors opened the clinic *Genes* in Medellin (interview 30 July, 2013).

Even now, however, despite the enterprising work of doctors interested in ARTs in Colombia, no medical training for assisted conception techniques are available in Colombia. Thus, aspiring doctors receive training and accreditation in other Latin American countries, such as Mexico and Argentina, at European institutions, or in the U.S. Like the technologies themselves, then, ART training has also been brought to Colombia from abroad, especially from North America.

Even though this industry has expanded throughout the country, access to ARTs is constrained. They are not covered by public healthcare or private medical insurance (discussed further below) and are restricted to the private medical sector. ART clinics require substantial financial investment by medical

practitioners and others to procure the clinical space, necessary technologies and equipment, and trained personnel all of which are very expensive. Lacking necessary start-up funds, many Bogotano clinics initially used the resources of major hospitals (clinical space, microscopes, incubators, diagnostic tools, etc.), and were affiliated with, but not run or financed by, these large institutions. As clinics' have gained the necessary financial capital through consistent treatment demand many have become autonomous enterprises.

The doctors' entrepreneurial character, combined with their high financial investments, fuels competition and restricts cooperation between doctors and clinics. Dr. Herrera explained that she does not collaborate with other clinics because it is private medicine: "We are all jealous of the other. There is collaboration at conferences and other academic events, but that is the extent of it" (interview 23 Nov. 2013). Hörbst (2012b:48) has reported a similar situation in Malian ART clinics, where she notes how doctors take risks because they invest heavily in "businesses" that may fail. Dr. Mabel echoed this sentiment in his commonly-voiced complaints about needing more *pacientes* to cover overhead costs. The development of these clinics beyond the coverage of medical insurance or public healthcare allows their services to be delivered directly to potential patients. This creates a market similar to that of any other product, and the commercialization of medical services (Conrad and Leiter 2004; Conrad 2007).

### *Limited Regulations*

According to Decree No. 806 of April 30, 1998, Article 10 "the *Plan Obligatorio de Salud* [Mandatory Health Plan] is not obliged to contribute to the diagnosis, treatment, or rehabilitation of *sicknesses* that are considered cosmetic, esthetic, or sumptuary, or that are a complication resulting from these treatments or processes" (my emphasis, Spanish original). By placing ARTs in the same category as cosmetic surgery, the government has classified these treatments as unnecessary and extravagant expenditures that the government cannot afford.

Ecopetrol, Colombia's largest petroleum company, is the only enterprise in the country that covers these procedures for its employees. Otherwise, ARTs are not covered by private medical insurance either. The relatively high cost of these treatments, ranging between US\$1,000 for AI and US\$7,600 for ICSI with donor eggs,<sup>15</sup> are unaffordable for most Colombians who earn an average legal wage of US\$8,304, and a legal minimum wage of US\$3,936 annually (Peters 2012). This does not include individuals working in the informal sector, which was estimated at 48 percent of the population between December 2014 and February 2015 (DANE 2015).

Although these technologies are available to only a small minority of Colombians, between 2003 and 2004 there was an extensive debate in the Congress about how to regulate ART procedures "better." Laws implemented in 1998 pertain to the registration and maintenance of biomedical facilities offering ARTs and their laboratories, the accreditation of fertility experts, the diagnostic examinations necessary for ARTs to be considered viable treatments, and the regulation and registration of donors and their biogenetic materials. These laws were viewed as minimal by two groups of Senators, influenced by prolife Catholic lobbyists, who put forth new bills to further restrict the permitted techniques, who can access these procedures (i.e. heterosexual married couples, single women, etc.), and the specifications for left-over biogenetic materials. The fertility specialists with whom I worked were relieved that none of the bills passed into law, because they feared they would be restricted in the procedures they are permitted to perform.

Current legislation does not regulate who is permitted to access ARTs. In practice, access is limited to those who can pay. The only regulation restricting treatment options pertains to the manipulation of embryos and effectively outlaws the practice of "designer babies." As mentioned above, most legal regulations for ARTs concern the use of donor gametes: all donors must be at least 18-years-old, be screened for infectious diseases, and undergo physical, genetic, and psychological examinations. All gamete banks should be

---

<sup>15</sup> The US\$-Colombian Peso exchange rate during 2013-2014 was approximately US\$1 to 1,800 Pesos. This is the exchange rate used throughout this thesis.



anonymous, but all donors must be registered with an identification number, and donation should be voluntary and altruistic. My findings, however, reveal that practice in these private facilities does not always correspond with regulation (see Roberts' findings in Ecuador, 2006:521). Ova donors receive approximately US\$400 per donation, a payment that on paper claims to cover lost wages and trips to and from the clinic, but is actually seen by medical staff and donors alike as a payment for the "donation." Furthermore, donors often are not screened for psychological conditions. Additionally, some doctors permit the use of known donors,<sup>16</sup> which is not regulated by the government, and creates variation in the practices across (and even within) clinics.

Surrogacy also evades regulation. The practice is not technically illegal in Colombia, but it requires the falsification of legal documents, because Colombian law recognizes the birth mother as the legal mother. This stipulation, however, has not prevented some clinics from allowing surrogacy. Following legal proceedings in countries with similar regulations, such as the UK, some doctors recommended that upon birth the commissioning parents could adopt a child born through surrogacy, but the *Instituto Colombiano de Bienestar Familiar* (Colombian Institute of Family Welfare) claims this process would not be legal under current adoption regulations. Therefore clinics practicing surrogacy require all prenatal appointments and the child's birth to happen in private facilities to evade documentation, and a lawyer must be present upon birth to falsify the birth certificate. These practices may allow couples to obtain a biological child when other options have been exhausted, but they provide no legal protection or recourse for the surrogate.

Unlike in contexts where the government regulates the types of treatments available, Colombian doctors are the primary regulators of the treatment options they are willing to offer, based on their moral consciousness and interpretation of the ideal family structure.<sup>17</sup> Thus, different clinics and even different doctors within the same clinic offer diverse treatments. The

---

<sup>16</sup> This practice is not in violation of the anonymity of gametes stored in banks as known donor gametes do not enter these banks.

<sup>17</sup> See Holm (2009:34) for a bioethical discussion of the influences of doctors' moral understanding of medical practice.

clinics' economic resources affect the technologies and services they can offer and adds further diversity. This doctor/market co-determined model of ART provision creates a system that is more complex than in many contexts in the Global North.

As I will discuss throughout this thesis, the variation in treatments offered by clinics and the commercialized ART market creates a system in which couples who can pay can also choose among an array of clinics, doctors, and procedures. Couples “shop around” for a doctor who will provide the treatment they are seeking, and a clinic that meets their quality standards and financial budget. Here the fusion of “medicalization and commercialized medicine ... can be conceptualized as the business of medicalization” (Conrad 2007:154), where couples seeking treatment are turned into quasi-consumers who also contribute to this medicalization process. But, as will be explored in the empirical chapters that follow, the agency that women have to “shop around” and “control” the treatments they receive is constrained by structural forces (such as lack of information and financial limitations), power dynamics between couples and doctors, couples' own willingness to undergo particular procedures (such as using donor materials), and the uncertainty of the outcomes of ARTs which may leave them with nothing. This context, then, represents a complex milieu in which to explore the medicalization of infertility in a neoliberal market system, and the diverse forms of agency that women (and couples) can adopt as they maneuver around (and within) the constraints inherent in this.



## Chapter 5

### Accessing Treatment: Agency and Coercion at the Outset

In the literature review, I explored how constraints couples encounter as they engage with ARTs in diverse contexts differ, as do the nuanced forms of agency they employ. I then delineated the qualitative methods I employed to explore the complex nature of assisted conception, and provided a contextual framework of the Colombian medical system, and the privatized environment of ARTs. In this, I also discussed the importance of parenthood and the transformation of gender roles, which are ingrained in society and are reproduced through the media and legislation. The significance of family and parenthood has provided space for the development of the private fertility sector, facilitated by both medical professionals and the market demand for a solution to childlessness. Moreover, I discussed the limited regulations governing ART practices and the lack of standardization across clinics. Thus in these chapters, the stage has been set to analyze the specific, subjective experience of ARTs in the Colombian context. I will now, however, move away from the broader contextual framework to consider the earliest stages of women's fertility treatment journeys – when they start to search for a solution to their childlessness.

Embedded in a society that values motherhood highly, it was the women themselves, often pushed by social norms to conceive, who initiated the search for fertility treatment, utilizing the limited resources available to them and *willingly* accepting the medical expertise of the fertility specialist. It was their demand for a solution for their childlessness that ultimately drove these women to commence the medicalization process, fueling the commercial nature of ARTs. This is not to say, however, that they did not meet constraints upon initiating their search.

One of the key constraints experienced by women from the outset was contained in their interaction with various, sometimes contradictory,

knowledge systems. Here, “knowledge systems” are understood as diverse frameworks of knowing which are produced by various social organizations, such as knowledge produced through religious belief, scientific “facts,” or personal experience. In *Birth in Four Cultures* Jordan explains:

For any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both. In many situations, equally legitimate parallel knowledge systems exist and people move easily between them... (1993[1978]:152)

The specific knowledge systems in question here include: social understandings of reproduction and the body, biomedical knowledge that holds different levels of legitimacy given the resources available, and experiential or embodied knowledge. These different forms of knowledge complimented each other at times, and produced conflicting and incongruence meanings at others, serving to both constrain and enable women’s choices as they sought to overcome their childlessness.

On another level, lack of *efficacious* knowledge formed a particular barrier once women decided to consult a medical professional. Here, knowledge is not only a “knowledge system,” but is also a resource to be employed. The availability and potential (even if limited) of ARTs is not common knowledge among the general public, or in primary medical care facilities in Colombia. Instead knowledge about ARTs is primarily restricted to *trained* fertility experts and former *users* of reproductive interventions. Given this scenario, I explore how this information, or efficacious knowledge, was incorporated into different knowledge systems, how women obtained or were denied knowledge as a resource, and how different knowledge systems became legitimate in the eyes of women embarking on fertility treatment journeys. “Informational gatekeepers” – women who have previously undergone ART treatment or another medical intervention at a fertility center – often were the preeminent knowledge resource for women seeking fertility assistance. Here, I discuss the

role these gatekeepers, possessing experiential and embodied knowledge of highly technical medical interventions, played in the treatment seeking process as they provided women seeking fertility assistance with a particularly valuable form of knowledge. The knowledge offered by informational gatekeepers led most women to directly access a fertility expert. Others chose to take a more “consumer” based approach through either searching the web for further information or “shopping around” for what they perceived to be the ideal treatment and facility for their situation.

Despite the differences in constraints women faced as they initiated their infertility treatment journeys (some, for instance, faced serious material constraints, which I will discuss below), all the women in this study ultimately engaged with these different knowledge systems to varying degrees (depending on resources available to them), and arrived at a fertility center. By following how these women arrived at a fertility center we can see how the agency enacted by women receiving fertility treatment often consists of a stream of creative acts, which are influenced or limited by external factors. Focusing on medical decision-making, Sherwin (1998:32), calls for researchers to look at the full context in which decisions are embedded. Failing to do so neglects the “complex set of relations and policies” that may constrain or promote an individual’s agency. In this chapter, then, and throughout the thesis, I am not only concerned with *who* had the ability to act upon their agency and who did not, but also *when* during the fertility treatment process these actors had agency, and *what* having agency meant for their treatment experiences.

By focusing on the significance of individuals’ employment of agency I am answering the call of Madhok and colleagues (2013:4) who urge us to transform and extend our conception of agency to explore *what having agency does*. Sewell (1992:20) explains that all human beings have the aptitude for agency, but the extent of their ability to exercise agency depends on their knowledge of “culture schemas” and the “resources available in a person’s particular social milieu.” Women entering the precarious realm of assisted conception employed the ability to actively utilize the knowledge systems available to them to navigate the various systems that simultaneously enabled

and constrained their pursuit to conceive a child. At the initial stage of their fertility treatment journey it was particularly the women's agentic capacity to maneuver knowledge systems and utilize their (limited) resources that brought them to the medical encounter.

### The Quest for Conception<sup>18</sup>

Despite the fact that medical intervention has become basically standard throughout the pregnancy process and during delivery, particularly for middle and upper class Colombians, conception is still seen as a natural process that should come easily. Lock (1993:135) describes how the understandings of homologous relationships create and reproduce dominant social and moral orders, which generally go unquestioned and thus appear as "natural." This includes the inscription of "social categories" onto and into the body, such as reproductive potential. The perception of the ease of conception is ingrained in Colombian society, supported by historically high fertility rates, the abundance of teenage pregnancy, and traditional knowledge of natural abortifacients (Browner 1980, 1985) and current high rates of (illegal) induced abortion.

Historically, pregnancy has been viewed as the logical step following marriage and a necessary passage to legitimize a union (Olarde Sierra 2010), an understanding that resonated in the narratives of my informants. When asked how long they had been trying to conceive, the majority of my informants reproduced this cultural norm for pregnancy to directly follow marriage referring to the number of years they had been married. During our first interview Laura said she and her husband celebrated their 20<sup>th</sup> wedding anniversary this year, marking 20 years of trying to conceive (interview 7 March, 2013). Other women specified that they wanted a year or two to enjoy their union before having child, but measures were not taken to prevent pregnancy during this time. Luna, for example, explained she and her husband

---

<sup>18</sup> *Quest for conception: Gender, infertility, and Egyptian Medical Traditions* is the title of Marcia Inhorn's book published in 1994.

had been trying to conceive for five years. They did not “try very hard” during their first year of marriage, but neither did they try to prevent pregnancy. When Luna did not conceive after being married for a year, they *truly* began trying (interview 5 March, 2013).

Only a limited number of the women that I interviewed initially choose to prevent pregnancy, either because other obligations (such as work or university) took precedence over starting a family, or because they had not yet decided if they wanted to be a mother. However, when arriving at the opportune moment to start a family, these women still anticipated that pregnancy would happen quickly. Before meeting her husband, Jimena was convinced she did not want children. However, once she married, she finally gave in to his “pleas for a child.” When Jimena did not conceive within a few months, she sought medical assistance sooner than many others as she worried her “advanced” reproductive age may be inhibiting her body from doing “what it should do naturally” (interview 22 June, 2013). Despite the diverse time frames in which these women began their quest for conception, they understood pregnancy to be a natural process that should come easily, or, at the most, require a bit of “trying,” a perception reflected in remarks from friends and family.

Given the importance of childbearing and the cultural significance it holds when joining two people, pregnancy and birth are common discussion topics among family and friends, even if they are not yet the priority of the woman. The majority of women mentioned nagging remarks from parents or siblings and the pressure from friends to start a family. Adriana, for example, explained, “My parents are getting older and have recently started incessantly asking when they will have grandchildren” (interview 28, Feb. 2013). Valentina had a similar experience. She commented that her ten-year-old niece had started pleading with her for a cousin saying, “*Por favor tía* (Please aunt), I want a cousin” (interview 3 June, 2013). Neither Adriana nor Valentina regarded the comments from their family as intended to be malicious or hurtful (though at times they were), but rather expressions of the family’s desire for them to start a family.



Pressure to have children was also prevalent among couples who already had a child. When describing the large Paisa family her husband comes from, Sara, who was diagnosed with secondary infertility, explained that both her in-laws and her husband want to carry on this large family tradition. Sara's nine-year-old daughter had also started asking for a sibling. Her daughter has friends with siblings and recently gained a cousin, which instilled in her the desire for someone to care for and play with at home (interview 27 Feb, 2013). Sara's narrative not only portrays the pressure she received to have another child in an effort to increase the family, but that *she* also reproduced this motherhood ideal by saying her daughter wants someone to "care for." Vanesa, also diagnosed with secondary infertility, expressed a similar narrative regarding her son, who had started asking for a *hermanito* (little brother), information she originally received from his teacher (interview 20 May, 2013).

Dominant ideologies constructed through meanings and symbolic processes are cemented in society where they are not only internalized by people, shaping their expectations and beliefs, but are also reproduced by these individuals. The remarks from childless women's friends, family (even children), and mere acquaintances, reproduced the meaning of, and social mandate behind, motherhood and the importance of family in Colombian society. This social pressure to conceive can be interpreted as a means of social coercion, a constraint to decision-making, or a means to encourage, and even force, women to adhere to the expectation of being mothers.

This is not to suggest women do not possess subjective motherhood desires (Sandelowski 1993:19-20, 37-38), but that these desires are interwoven into a complex stream of power relations and social mandates, and are reflected in women's appetency for a child. However, women are (at least somewhat) consciously aware of the social pressure to have children. Ortner (2006:111), building on work by Giddens, claims, "actors are always at least partially 'knowing subjects,'" who "have some degree of reflexivity about themselves and their desires." Adriana, Valentina, Sara, and Vanesa were all mindful of the pressure they were receiving to have children, and, even though this pressure was at times overwhelming and unintentionally hurtful, it was incorporated

into these women's *own* narratives about their desire to be mothers and have a family.

Embodying this social pressure to conceive, while recognizing the maternal success of others, caused some women to question their position in their family, their role as women, and their bodies as they deviated from their understanding of social norms. Laura explained that she comes from a family of nine children, five of whom are girls. Each of her sisters has a family, but she has never been pregnant (interview 7 March, 2013). Laura felt inadequate compared to her sisters, who had fulfilled their maternal responsibility, as their mother had before them. She was concerned about being the only woman in her obviously fertile family who has difficulty conceiving.

Women who had younger siblings with children especially questioned their position in their family. Gabriela had a sister seven years her junior who already had a child, which resulted in her mother asking, "When are you going to have a child? You are the older one," despite her mother knowing she suffers from endometriosis (interview 21 June, 2013). Her mother's insensitive comments brought strife to their relationship, while causing Gabriela to question why she could not conceive, as well as her position as the elder sister.

Both Gabriela and Laura understood their childlessness as a deviation from their intended role in their family, and more broadly as women. Becker (2000:33) and Throsby (2002:238) note that a dominant narrative among their infertile informants was the desire to locate the self within local understandings of normalcy, in other words, to comply with social norms. Burkitt (1999:17), drawing on the concept of bio-history, explains that bodies are malleable and can be shaped to adopt "many aspects of the practices, beliefs and values contained in social relations," but they "cannot respond to every social demand." A body "may not be able to control some of" its functions in a manner that complies with social norms. Gabriela and Laura, being childless, were in a position where their bodies were transgressing familial and womanly expectations, as is reflected in their feelings of inadequacy. They were in a position where they could not fulfill the social expectations placed on them, a realization that many women were unable to cope with. Viewing their bodies

and social roles as deviating from their understandings of the norm caused some women to enter a state of disbelief, particularly when they viewed their bodies, as a whole, to be healthy.

### *Questioning the Body*

The women in this study represent the highest strata of Colombian society (see chapter 3). Most are well educated and many hold professional careers. Their understandings of bodily functions were drawn from a wealth of professional and lay discourses, including but not limited to biomedical discourses, holistic understandings of the body, and popular interpretations of the ideal body, all of which portrayed, to some degree, the healthy body as a functioning body. Browner (1985), studying reproductive beliefs in Cali, Colombia found that women equate the appropriate functioning of the reproductive system with the maintenance of good health in general, a correlation also expressed by some of my informants. Adriana explained it is hard for her to imagine having a fertility problem, as her physical health is impeccable and she has always had regular menstrual periods (interview 28 Feb. 2013). Laura, continuing her narrative from above, expressed her inability to comprehend her childlessness, claiming she had never used contraceptives, never had a major health problem, nor a gynecological problem, but she still had not become pregnant (interview 7 March, 2013). Both Adriana and Laura considered their bodies to be healthy, an image that was reinforced through a clean bill of health legitimized by medical professionals. From their perspective, their healthy body should have also reflected a healthy reproductive system. This image of the healthy body made Adriana's and Laura's inability to conceive unbelievable for them, as it contradicted their knowledge of the functioning, healthy body.

Most women I spoke with went through some stage of disbelief during their fertility journeys. However, the depth of this disbelief (sometimes manifesting itself as denial), and exactly when it was experienced, was contingent on the women and how they were able to cope with their

childlessness.<sup>19</sup> Not being able to accept the possibility of having a fertility complication (referring to the time period before infertility is diagnosed by a medical professional) caused some women to delay seeking medical assistance, as they required time to comprehend and cope with potentially having a faulty body (see chapter 10 for more on faulty bodies). Being confronted with delayed conception drove other women to question their body's potential, as Laura and Gabriela did, and seek a medical explanation.

As mentioned above, most of the women framed their bodily understanding in a biomedical framework. Thus when conception, a socially understood "natural" and "easy" process, did not occur they started to fear something was physically wrong with their body. Liliana explained that during the two years she and her husband were trying to conceive she began to worry her body may be the culprit, a fear that made her realize they may need medical assistance and that finally pushed her to seek medical advice (interview 23 April, 2013). Marisol added to Liliana's experience expressing that the whole process had been stressful and emotional, starting with trying for "natural" conception but not being successful, to realizing that there must be a problem, and finally recognizing the need to seek help (interview 29 January, 2013). Nichter (1998:327) explains, "the medicalization of a disorder may be self-initiated or engaged prior to medical confirmation." Marisol and Liliana interpreted a prolonged period of childlessness to be a sign of bodily malfunction, an interpretation that was grounded in *their* "biomedical" understanding of the body, one that had not yet been diagnosed by an expert. This interpretation of the malfunctioning body possessing a physiological problem validated the women's motivation to seek medical assistance.

As discussed in the literature review, medical and societal discourses emphasize the role women's bodies play in reproductive processes, specifically over that of men's. This is reflected in the narratives of women that I collected in which they problematize *their* body and, hence, *their* need to seek medical

---

<sup>19</sup> According to Menning (1980) women generally pass through stages of shock, denial, anger, guilt, and grief following a diagnostic exam that labels them or their husband as infertile. In my sample the stage of denial was commonly followed by a second medical opinion and eventual acceptance leading to medical intervention.

advice. Echoing Liliana and Marisol's narratives Linda also assumed her body must be at fault when she did not conceive. She explained that after months of trying unsuccessfully she presumed her body was the culprit and the fertility complication was a result of a problem with her reproductive system. Thus, she sought medical assistance from her gynecologist. When no physiological complications were diagnosed, her gynecologist recommended Linda's partner also undergo diagnostic examinations, which revealed that her husband had varicocele (interview 26 July, 2013). Clearly, medical and social emphasis on the woman's central position in childbearing and the reproduction process caused these women to focus on their bodies, at least initially, and disregard the contribution of men in the conception process, a characteristic echoed by studies of infertility around the globe (e.g. Inhorn and van Balen 2002). This focus on the women's bodily role in reproduction leads to delays in accessing fertility treatment (e.g. Gerrits and Shaw 2010; Jenkins 2002), while perpetuating childless women's internalization of the malfunctioning and, hence, nonproductive image of their own bodies.

The key point here is that women's perceptions of their faulty body, which deviates from the social demand for motherhood (and other roles) and is reinforced by a biomedical understanding of bodily malfunction, *pushed* women to seek medical advice. Here, however, local understandings of conception and the body, and the role of this maternal expectation, were both enabling and constraining. We can interpret these knowledge systems surrounding a maternal ideology as a constraint that portrays childless women as failing to meet their social expectations, but at the same time, it propels women to actively seek a solution to their childlessness, in this case ARTs. Arriving at the moment to actively seek medical assistance is a process that may take various paths (Hutchings 2013). There was not an exact moment or action that caused women to navigate their way through the constraints and latitudes of this social context. Rather it was a process of reflecting upon one's desire for a child, whether or not this was socially constructed, and determining how to obtain a child when it did not happen "naturally." Below I explore the various paths the women experienced between recognizing a need for medical assistance and

arriving at a fertility specialist, paths which involved turning to female kin or friends for advice, exploring the limited resources in the primary healthcare domain, searching media platforms for explanations for childlessness, or a combination of the three.

### Learning *How* to Access ARTs

Even though private clinics in Colombia have been using ART techniques since the 1980s, public information about the availability of these technologies has been limited, effectively reducing access to them. Women were thus required to use idiosyncratic strategies, generally calling upon personal networks to obtain relevant information and gain access to these services. Discussing entering the medical system in the US, specifically without adequate health insurance, Nichter (1998:329) explains that one has to be knowledgeable about the functioning of the system, as well as of the necessary language to explain one's ailment, in order to access care. The women in my study often found themselves in a similar predicament: first they had to acquire knowledge about the availability of these treatments, and then they needed to learn where to access these services, in addition to leveraging the monetary means to do so.

In this section I will first discuss the lack of ART information available to the general public and the limited knowledge GPs and gynecologists have about these techniques. This deficiency in knowledge eliminates two primary routes women could have utilized to access ARTs. Second, I will explore the crucial knowledge system that was available to women: the experiential knowledge of "informational gatekeepers." Informational gatekeepers provided the women with the necessary tools to maneuver through (or around) the public healthcare setting and gain access to the expert knowledge of a fertility specialist.

### *Limited Media Discourse*

This study did not include a systematic investigation into the available, or rather lack of available, information on assisted conception in Colombia. However, regular attention to mainstream media and web searches for clinic websites and articles in popular magazines, combined with conversations with individuals seeking assisted conception technologies, medical staff, and the general public, all suggest that there is limited public knowledge and access to information about these high-tech procedures. This finding is significant in that it varies greatly from findings reported in other parts of the Global South, where knowledge about ARTs appears to be abundant (e.g. Bharadwaj 2001; Inhorn 2003b; E. Roberts 2012).

Only occasionally, popular magazines directed at women – *Fucsia*, *Aló Colombia*, *Cromos*, and other magazines claiming to cover health, fashion, beauty, and lifestyle for “today’s women” – print articles addressing infertility and possible medical interventions. Even less frequently do such articles discuss treatment experiences of Colombian women or contain an interview with a fertility specialist operating in Colombia, which would make the information more relevant and useful for Colombian women specifically.

Rarely, mainstream news media, such as *Semana* or *El Tiempo*, publish articles relating to ART usage in Colombia. However, past articles have been concerned with legal aspects of ART usage and/or the implications of creating embryos outside of their “natural” environment. These have been highly political, often criticizing the use of ARTs particularly from a religiously conservative position, ultimately framing the use of the technologies negatively. Furthermore, the language in which they are written is often very complex due to their political nature and legal focus. The limited coverage of ARTs by major newspapers is not surprising given their controversial social and political position, the small population that can utilize these technologies due to their high costs, and the focus on more pressing issues, such as the internal conflict and poverty.

Recently, fertility clinics have begun to advertise their resources on the radio, in magazines, on the web, and even through Groupon promotions. Further, Bogotano clinics offering ARTs tend to have websites displaying their services, although some prove to be more user-friendly and informative than others. Yet only two of the women I spoke to reported arriving at a fertility clinic through these channels. One had seen an interview with a fertility specialist on a medically orientated TV talk show, while the other reported searching the web for a clinic that appealed to her.

Conrad and Leiter (2004, see also Conrad 2005) claim self-help and patient organizations, which have surfaced around the globe as an informational, support mechanism that empowers individuals with particular medical ailments, are changing the medicalization process in some societies. Yet no such groups for infertility exist in Bogota. The absence of such a network, combined with minimal media coverage of the topic, presents one less resource Colombian women could utilize in their search for pregnancy.

#### *The Limitations of Public Healthcare*

In Colombia, the primary source of medical knowledge is still that of the medical system (a factor that may contribute to the limited media information on ARTs and other advances in medicine more broadly). Being familiar with the Colombian medical system and often already having an established relationship with a GP or gynecologist, most of the women's initial contact with a medical professional about their childlessness was at a public clinic covered by private insurance or the EPS. Marisol recounts her experience with her gynecologist:

The appointments were brief, and nothing was explained. Even when I had an exam, nothing was explained to me about the reason for the exam or how it would be done. Then, when I received the results, again nothing was explained, at least not in a way I could understand. (Interview, 29 Jan. 2013)



Marisol was particularly frustrated with the level of care she received from her gynecologist, and disappointed that she could not understand what was happening to her body or why she was having difficulty conceiving. The doctors were unable (or as Marisol interpreted, unwilling) to explain in non-medical terminology why she was having complications. She felt the doctors were deliberately withholding information from her, either because they thought she would not be able to understand or because they did not have a medical explanation to provide her. Fortunately, having known a fertility specialist for some time, Marisol was able to use other avenues to access ARTs.

Laura, however, spent 15 years trying to conceive before seeking treatment at Fertisuperior, primarily due to the lack of knowledge and action of her gynecologist.

Laura had seen the same gynecologist at the Fundación Santa Fe de Bogotá for years. He always assured her she would get pregnant, saying, "You will get pregnant this year." She would endure numerous exams and no fertility problem would be detected, but another year would pass without a pregnancy, causing the doctor to exclaim that she would get pregnant the following year. After 15 years at the Santa Fe a friend suggested she seek the advice of a specialist. (Fieldnotes 7 March 2013)

Laura was patient and compliant with the orders (or lack of orders) from her Santa Fe doctor. To Laura her doctor held a position of power and authority, which was granted to him because of his medical expertise, knowledge she did not possess (this will be explored further in chapter 6). Furthermore, Laura was consulting a doctor at one of the best hospitals in Colombia, which she saw as an indicator of his prestige.

Laura was firmly under the influence of a dominant institution, which not only caused her years of waiting for a pregnancy along with heightened stress and suffering, but also caused her body to move from a stage ideal for conception and pregnancy, to a matured state where pregnancy is less likely and more dangerous. Discussing the implications of seeking treatment in the public healthcare sector, Dr. Diaz explained:

General practitioners do not have the resources to help with fertility issues, nor do they have the necessary knowledge. Gynecologists, on the other hand, know more about fertility complications, and may be able to help with minor fertility problems, but their abilities are still limited. Thus patients who first seek advice from GPs or gynecologists may spend a lot of time and financial resources with these practitioners before turning to fertility specialists. (Informal conversation 7 July, 2013)

Dr. Diaz's narrative suggests that the medical advice of non-specialists may not only delay the intervention of experts, who he saw as possessing the legitimate knowledge to address infertility, but actually cause harm to a woman's reproductive system, further reducing her fertility potential. According to Dr. Diaz, non-specialized knowledge (i.e. that of GPs, and to a lesser extent gynecologists) is not only less technical and advanced, but it may also be an "inaccurate," "destructive" form of knowledge. Laura was not physically harmed by the passive nature of her Santa Fe doctor, but due to her *and* his inaction, her body progressed to the perimenopausal stage, requiring her to use an egg donor when she finally accessed a fertility specialist at age 48.

Advances in medical knowledge, the development of new medical technologies and diagnostic techniques, and the discovery of new bodily ailments have increased the importance of specializations within healthcare, creating a hierarchy among medical professionals in specific fields, some having more specialized training than others. Infertility falls into this realm of specialized knowledge, particularly when considering the use of highly sophisticated ARTs. Dr. Diaz's narrative alludes to the existence of this hierarchy between medical specialists and non-specialists whose knowledge is perceived as inferior to that of Dr. Diaz and other fertility experts, and, therefore, not legitimate.

Davis-Floyd and Sargent (1996:115) claim there is a link between the control of technologies and the creation of a hierarchal relationship between medical specialists and patients. In the Colombian case, the development of this knowledge hierarchy is perpetuated by a lack of resources in public clinics, including limited educational and training resources for practitioners, time constraints on consultations and examinations, and the lack of technologies. The

lack of available diagnostic and treatment options for infertility in public clinics reduces women's access to these services. Inhorn (2003b:141-142) and Bharadwaj (2001:77-89) have noted a similar constraining character of the public healthcare systems in Egypt and India respectively, where effective treatment options are minimal and referral to specialists is limited. This ultimately traps some couples in a system that cannot provide a solution to their infertility and may actually augment it.

All the women in the study who initially sought advice from their GP or gynecologist experienced a delay in their search for a medical solution to their infertility, but some were eventually recommended to see a specialist. These recommendations usually followed the diagnosis of a physiological complication, such as in the case of Tania, who experienced two ectopic pregnancies that resulted in her losing both of her fallopian tubes. This physiological complication was easily visible through an ultrasound, and was one which would prevent her from conceiving without medical intervention (interview 22 May, 2013), making it an obvious case to refer to a fertility specialist. Cases such as Tania's or those in which a reproductive system abnormality (again generally physiological) was revealed through common diagnostic tests, often resulted in GPs' referring women to specialists due to the doctor's inability (both technological and educational) to treat the woman. Women suffering from unexplained infertility (approximately 15-20 percent of infertile couples) or a fertility complication that could not be easily detected through basic diagnostic techniques available in non-specialized clinics (such as in Laura's story above), often found themselves trapped in a medical system that could not provide further assistance.

Two women in this predicament were fortunate enough to be assisted by a female doctor who herself had undergone fertility treatment and therefore could provide a personal recommendation that consisted of not only a specific clinic, but also doctor to consult. One woman, however, was actually discouraged from seeking further medical assistance. During Barbara's first visit to Fertisuperior, she expressed frustration with the gynecologist from whom she had sought advice. She explained that the doctor told her there are

treatment options but taking that course would be very difficult. Instead she recommended they consider adoption. Despite her doctor's discouragement, Barbara was interested in the available medical options, and chose to seek out a fertility specialist on her own (interview 24 June, 2013). Barbara's case is the only instance among my informants of a doctor disapproving of ART intervention that caused her to withhold further information, but given the contested nature of ARTs within political and religious circles (see chapter 4) it is unlikely that Barbara is the only woman to be dissuaded by a medical professional from using high-tech fertility treatment.

In only 10 cases did the knowledge provided by the public health system directly result in a woman being referred to a fertility clinic. Those without a referral had to navigate their way through primary care facilities, acting as their own advocates to access the necessary resources to arrive at a private clinic. Other women bypassed the primary medical system altogether, a task that, from an outside perspective, would appear challenging due to the limited public awareness of fertility treatment. In both scenarios, the experiential knowledge of a personal contact proved to be the most efficacious knowledge system for accessing fertility assistance.

#### *"Informational Gatekeepers" and Personal Recommendations*

Most women utilized their personal network of family and friends to gain information about infertility and ARTs, at times without even intending to do so. Browner (1985), discussing research she conducted on reproductive knowledge in Cali, explains that Caleña women often openly converse about their menstrual and conception concerns (primarily regarding preventing conception instead of supporting it) with other woman (both lifelong and new acquaintances), as these natural processes are common knowledge and ones that affect all women. Browner's research alludes to a relatively open space for women to discuss their reproductive experiences and concerns, a characteristic of female relationships that is congruent with the open concern for and

pressure expressed towards childless women. Infertility, however, contrary to menstrual and everyday reproductive concerns, is not a bodily condition that affects all women. It is an ailment most women would prefer to conceal; yet it is a predicament that is nearly impossible to hide. Thus, even without soliciting advice, women received information, particularly through the form of *chisme* (gossip/casual conversation) about available treatments and fertility centers other women had utilized.

Lupe, a 43 year old woman who conceived naturally after going through two failed IVF cycles, explained that, given the social dynamics of a small community in Los Llanos (the state southeast of Bogota), there is no space for secrets; effectively everyone knows everyone else's business. Thus when a woman has a successful fertility treatment, the news of her experience spreads, providing others with useful information and a recommendation of where they can access such services (interview 25 April, 2013). Many women expressed concern about Colombian's love for *chisme* and the unsolicited advice people would offer on how to overcome their infertility, a factor that caused some women to go to great lengths to conceal their desire for children and their search for pregnancy. Julia, for instance, went as far as lying to her family, claiming she and her husband did not want children, to stop her family's nagging and worried remarks, and resist the social pressure to be parents (interview 14 May, 2013). However, deceiving her family restricted the information she could receive by eliminating potential information avenues, delaying her access to treatment, while also preventing the development of a support system for Julia and her husband.

In addition to receiving information through *chisme*, other women reported receiving personal advice from female kin or friends, information that was often offered in private. Female relatives, friends, friends of friends, and even chance acquaintances, provided childless women with the name of a magnificent doctor, or a fantastic clinic to consult. These "informational gatekeepers," as I will call them, often had undergone successful fertility treatment performed by the doctor they were promoting. For instance, Vanesa, having received references from three friends (one a doctor herself) who

fulfilled their motherhood desires through treatment with Dr. Mabel, decided to inquire about treatment at Fertisuperior (interview 20 May, 2013).

Receiving a personal recommendation for a specific service, in this instance a medical service, is common in Colombia. Taussig (2012), studying the use of plastic surgery in Colombia, notes the lengths to which people will go to access the services of a well-known and highly recommended plastic surgeon. These recommendations were even more valuable when they came from a close friend or relative who had utilized the services of this particular doctor and whose results could be seen firsthand. Here the value of this informational resource is enhanced, as it comes from within a woman's personal network, while being provided directly by someone who has experienced the treatment, creating a resource that is both socially and experientially valuable. However, compared with plastic surgery (which has become common in Colombia), the situation is more intimate when discussing the recommendation for a fertility specialist, given the secretive nature of infertility and the use of ARTs as well as the negative connotation that being infertile holds. Furthermore, the infertility rate in Colombia is approximately 10-12 percent (similar to that in the rest of the world). Considering the limited number of people affected by infertility and the high costs of treatment in a country where 46 percent of the population lives below the poverty line, there are relatively few women who have accessed these services and could provide a personal recommendation. The sheer fact that these recommendations, and thus this knowledge, are limited gave them added value to the women seeking advice.

Additionally, ARTs are invasive procedures that involve the most intimate parts of a woman's (and man's) body. They involve the intervention of third parties (embryologists, nurses, anesthesiologists, administrators, and other specialists) in the conception process, a process traditionally reserved for private interactions between a woman and a man. The experiences of these invasive procedures that were provided by an informational gatekeeper gave this particular kind of knowledge legitimacy in the eyes of women seeking fertility assistance. Abel and Browner (1998) note the importance women place on the experiential and embodied knowledge of female kin to understand bodily

processes and medical explanations. Borkman (1976:446) defines experiential knowledge as “truth learned from personal experience with a phenomenon.” Embodied knowledge, alternatively, is a combination of knowledge drawn from biomedical information, a woman’s understanding of her own body through experience, her feelings and beliefs, and experiences of others she interprets as her own (Lippman 1999). These combine to create a personal and inclusive form of knowledge. The knowledge provided by informational gatekeepers can, therefore, be interpreted as a highly legitimate form of knowledge to women seeking fertility assistance.

Unlike Abel and Browner’s claim that women use experiential and embodied knowledge provided by other women to maintain a “critical distance from biomedical authority” (1998:314), at this stage of treatment seeking, my informants embraced the knowledge provided by informational gatekeepers in order to access the medical services they were looking to encounter. It was the valuable knowledge provided by past treatment users that often propelled other women to seek further information from a fertility specialist, and seek out treatments at particular clinics.

Such positive recollections of treatments performed by specific fertility specialists caused some women to travel long distances to access the services of a particular doctor. Angelica explained she chose to travel from Cartagena because her cousin now has “beautiful twins” thanks to a procedure performed by Dr. Mabel (interview 29 Jan. 2013). Daniela decided to travel all the way from Miami, where she lived, to access treatment at Fertisuperior due to the recommendations from a chance encounter with a Colombian she met who had used the clinic’s services (interview 22 July, 2013). Angelica and Daniela willingly traveled long distances to access services at particular facilities because they held the embodied knowledge of informational gatekeepers at such high esteem. Even endorsements from former fertility patients who did not complete a successful treatment cycle, but who appreciated the level of care and commitment from the medical staff who performed the procedure(s), were valued by women seeking treatment. This also applied to the recommendations from women who underwent different treatments (removal of uterine cysts,

post miscarriage complications, hysterectomies, etc.) performed by doctors who specialize in ART therapies.

Ultimately, the value women place on experiential knowledge is evidenced by their willingness to embrace, and use this knowledge. It is a combination of the experiential and the embodied knowledge of these informational gatekeepers, their personal stories, that made their experience valuable and relevant to women seeking treatment for such a sensitive ailment. Based on the women's reported use of informational gatekeepers, then, the most valuable knowledge system these women had access to in their search for a fertility specialist was the word of mouth from former ART users. That this is true is supported by the fact that the large number of women arriving at clinics due to these gatekeepers came as no surprise to the doctors who manage these clinics. In our first meeting, Dr. Herrera explained that most of their *pacientes* arrive at the clinic through the recommendation of former *pacientes*. The clinic puts some resources into advertising, but their biggest promoters are satisfied *pacientes*. Medical staff at Fertisuperior expressed the same understanding of the importance of former *pacientes'* recommendations, which they use to their advantage by posting gracious thank you cards on their website and Facebook page. The way the clinics use the praise and positive images provided by former *pacientes* reflects the commercial nature of fertility treatment in Colombia. This consumerism aspect, however, is not only supported by the clinics but also by some service users, the discussion which I turn to now.

### Searching for Information and Accessing the Ideal Clinic

As mentioned in the previous chapter, neoliberal economic reform pushed by the IMF/World Bank, and incorporated into the 1991 Constitution, led to the 1993 healthcare reform in Colombia, which has reduced the availability of public sector medical services accessible to the whole population. This has been accompanied by a decrease in the quality of services provided. The competitive nature of the (relatively) new insurance-based healthcare system has



consumerized healthcare seeking behavior, creating more space for the growth of private healthcare services. Further coinciding with neoliberal reform, the new Constitution has emphasized the autonomy of the individual and personal responsibility (Eslava 2009), while idealizing characteristics that encompass perceptions of individual health.

Jeffery and Jeffery (2008) note that in the case of India the consumer-driven nature of neoliberal healthcare policies intends to create informed and responsible medical service consumers who are empowered through the ability to make choices, choices that regulate the healthcare market. Unfortunately, reality does not always meet these optimistic ideals. The ideal of the informed medical consumer who is “better able to assess the risks and benefits of different treatments for themselves” (Henwood et al. 2003:590), a process that grants a patient greater agency, has yet to emerge in the Colombian context. However, the building blocks are being laid for the emergence of such a consumer prototype in the realm of ARTs.

As women gained knowledge about the availability of medical interventions that may allow them to overcome their childlessness, some women actively sought out further information before agreeing to treatment. Women wanted to be knowledgeable about the different services – treatment options and treatment providers – available to them. Their desire for increased knowledge about the fertility treatment domain pushed them to seek information on the Internet, from informational gatekeepers, through “shopping around,” or a combination of the three.

Women utilized these diverse knowledge resources not only to gain knowledge about available technologies and the treatment process, but also to determine the specialist with whom they should undergo treatment. Similar to the significance placed on recommendations from informational gatekeepers, a woman’s first impression of a fertility clinic and the specialist influenced her decision of where to seek treatment. The consumerist aspect of ARTs, augmented by the high costs, placed couples in a position where they not only aspired to, but also purposefully sought what *they* determined was the “best” treatment option for their situation. Despite a woman’s desire to obtain the best

quality services available, she still had to access treatment within her means. Financial, locational, and temporal constraints limited the extent to which a woman could choose where she would seek treatment, while other women were constrained by the informational resources available to them.

### *Becoming Informed*

Before arriving at a clinic, having received some information about specific fertility interventions from informational gatekeepers, some women chose to search the Internet and relevant literature for further information. Lorena was one of these women eager to learn about ARTs. Speaking to me after her first consultation she explained, "I prepared myself," referring to how she used the Internet to educate herself about IVF before coming for her first consultation. She felt a need to be "prepared" for the consultation, to be aware of the options available to her (interview 1 June, 2013). Lorena's desire to be informed about the medical procedure she was eager to undergo before she arrived at the domain of the medical professional borders on the concept of the "informed consumer."

Lupton (1997a:374) explains that the patient qua consumer represents a rational decision-maker, who is a knowledgeable and calculating subject utilizing the resources available to her. Lorena did utilize resources available to her (the Internet) to gain information about IVF before entering the medical setting, an action she interpreted as motivated by her astrological sign, which labels her as an inquisitive person who yearns for knowledge. However, despite Lorena's reason for seeking information, and her treatment-seeking behavior that was intertwined in the dominant motherhood ideology discussed above, I would not call her a rational consumer, necessarily able to assess the risks and benefits of undergoing treatment (Henwood et al. 2003). Furthermore, her choices were limited to the conception techniques available from a limited number of specialists in Colombia. Lorena was consciously taking an active role in educating herself about the medical assistance available to her, but her

choices were still constrained by her social situation and the portfolio of available healthcare options.

Other couples sought further information to subdue their anxiety about the treatment process, not necessarily in order to make rational decisions. During our first interview, Laura said that before deciding to seek specialized fertility treatment, her husband Felipe spent many nights on the Internet researching IVF until one o'clock in the morning, while she had sleepless nights thinking about all the implications of going through treatment (interview 7 March, 2013). Laura admitted that before learning more about IVF she envisioned some type of futuristic, almost supernatural, technology that mysteriously impregnates women. Her husband's late-night research eased Laura's anxiety and permitted her to understand the treatment process better. Felipe's endeavor was geared toward providing his wife with solace, but at the same time he gained valuable knowledge about the opportunities available to them and the various treatment options, without necessarily intending to become informed and/or make rational treatment decisions.

Approximately half of the women (and men) who sought fertility or ART related information on the Internet before arriving at a fertility clinic were either medical professionals or already knew they had a specific infertility condition. For instance, Eduardo and his wife, Luisa, are both doctors. Before they started fertility treatment at Fertisuperior, he was diagnosed with low sperm count and he started to research means to improve the quantity of his sperm (Interview 27 June, 2013). Neither Eduardo nor his wife were actively seeking information about fertility treatment. He was seeking information about his medical condition and taking an active role in his health improvement before engaging with the medical domain, thus demonstrating his ability to be a responsible "consumer," a desirable attribute of a neoliberal healthcare system.

Mariela, on the other hand, was actively seeking information about the treatments available to her and her husband, who has azoospermia. Mariela is a biologist and her husband, Adrian, is a pediatric cardiologist. While inquiring to her gynecologist about her inability to conceive, it was suggested that her husband have a sperm analysis, which diagnosed him with azoospermia. Before

they accessed a fertility specialist, Mariela explained she read everything: all the medical information she could access on the Internet about IVF, ICSI, AI, basically any treatment available to counter azoospermia. “My head was filled with all this information, which overwhelmed me” (interview 25 May, 2013). It is important to note that when Mariela started searching for fertility treatment options, she was already aware of the physiological impairment she and her husband would have to overcome. Furthermore, her background as a biologist provided her with the knowhow to maneuver the informational resources available on the Internet. She (as well as Eduardo) is familiar with the medical environment, including the language and presentation of scientific data. Their medical knowledge, combined with already having received a diagnosis, may have made it easier for them than for other individuals without this prior knowledge to search the Internet for further information. Their social position and medical education put them in a better position than others to utilize their agency to navigate the biomedical knowledge system. Despite the information-seeking abilities these couples employed and their backgrounds in the medical sciences, they still highly regarded the knowledge and the expertise fertility specialists could provide them, rather than presenting a critical attitude towards expert knowledge as is characteristic of informed consumers (Conrad and Leiter 2004; Gunson 2010; Lupton 1997a; Sulik and Eich-Krohnm 2008).

The number of women and men choosing to pursue Internet searches before consulting a specialist was limited; rather, seeking further information or clarity from other sources was usually a process that accompanied fertility treatment, not one that started before seeing a specialist and then concluded. Furthermore, most people who took the initiative to seek ART information on the web wanted this information confirmed by a specialist.

### *“Shopping Around”*

Instead of searching for general information on the web, some women preferred to “shop around” to gain the information they desired through speaking with multiple specialists to find the clinic that best fit their needs.

When Dr. Mabel first introduced me to Tatiana and Hernan he told me, “They like to travel.” Seeing my confusion, he continued, “They like to travel around fertility clinics.” We all laughed at Dr. Mabel’s joke, while the three of us made our way to the consultation room where we would have the interview. Tatiana soon told me they have visited multiple fertility centers, but still have not made the decision to undergo treatment. Hernan interjected here explaining there are two main factors: first, concerns their initial impression of the clinic – how they are received, what the doctor says, how he presents the information and takes their medical histories – the second is the cost since the treatments are very expensive. (Fieldnotes 7 July, 2013)

When Tatiana and Hernan visited Fertisuperior (along with the other clinics), they were still unsure if they would go through a treatment cycle, despite knowing it was their only option to have a biologically related child. They were shopping around to obtain as much information as possible, while searching for the facility and doctor where they felt most comfortable. In a consumerist market of medical services, would-be-patients often actively seek out what they interpret to be the best services for their situation. They employ consumerist strategies to encounter the services that will provide them with the most satisfaction, and proceed to the next clinic if the services are determined to be substandard. Lupton (1997a:373) claims, “patients qua consumers are urged... to actively evaluate doctors’ services and go elsewhere should the ‘commodity’ be found unsatisfactory.” This is seen as a means to control the quality of care in the private sector. However, what Tatiana and Hernan could assess from their initial contact with a fertility expert was the quality of the social care they would receive, not that of the medical care. Even though some couples shopped around for the care they believe would be of a high standard, they could not actually judge the quality of the medical care, and therefore, did not regulate the quality of the medical care that patients receive. Inhorn (2003b:143) has reported

similar findings from Egypt where patients would veto the poor quality of care they received “‘with their feet’ by walking out,” but they did not confront doctors about their practice and therefore did not directly impact the doctor’s demeanor.

Four other women/couples chose to consult a second, and even third, clinic because they were unsatisfied with the level of attention and social care they had received at the initial clinic(s). Liliana explained:

She did not receive the level of attention she had expected at the first clinic. At the second clinic she had been recommended the urologist, but they were not sold on the clinic. So they continued looking until they came across Dr. Mabel’s C.V. which caught their attention, particularly his experience outside the country. (Fieldnotes 25 April, 2013)

Apart from being unsatisfied with the other two clinics, Liliana and her husband also appeared to be very skeptical about medical care in Colombia more generally. Meeting a doctor with connections in the U.S. and Europe helped convince them that they had found the right clinic.

Doctors’ reputations and credentials, along with their demeanor, were factors that weighed heavily on couples’ impressions of their skills and the quality of the clinic. As mentioned above the knowledge provided by informational gatekeepers is highly valued due to its experiential quality. The significance of experiential knowledge is also evident in the women’s own encounters, particularly first impressions, with fertility experts. Women greatly emphasized the comportment of the fertility specialists in their evaluation of the clinic’s services. Dissatisfaction with the initial impression of the doctor was related to minimal time spent with the woman, overemphasis on treatment costs, rushing through treatment explanations, not providing information about alternative options, etc. This caused some couples to move on to the next clinic. How doctors sell themselves and the services provided by the clinic was reflected in the woman’s willingness to undergo treatment under their care. As women’s knowledge about ARTs and their availability increased, so did the realization that they had some ability to choose where to pursue treatment.

Even if they could not evaluate the quality of treatment they would receive, they could select a doctor based on his bedside manner.

Most couples chose to shop around after having experienced a failed treatment cycle, a phenomenon that other scholars have noted (e.g. Bhardwaj 2001; Dhont et al. 2010; Dyer et al. 2002; Koster-Oyekan 1999; Sundby 1997). Experiencing a treatment failure made some couples lose faith in the clinic's abilities and the services provided, propelling them to seek treatment elsewhere (this will be discussed further in chapter 10). Many "experienced users" decided to move from one clinic to the next within the same geographical area, but Leandra and Rodrigo traveled all over the country. Rodrigo explained they first went to a clinic in Santa Marta where they live, then to Barranquilla, next Bogota, later Bucaramanga, and finally back to Bogota (interview 27 June, 2013).

Taking the approach of shopping around, particularly after having started treatment, often delays treatment success. When women who have undergone fertility treatment at a different center arrive at Fertisuperior, despite having the woman's treatment recorder from the previous clinic, the doctor starts at the beginning, often being wary of the skills of the proceeding physician. Diagnostic tests are redone and a new hormone regimen prescribed. This can lead to conflicting treatments and diagnoses, and even over-medicalization (Holloos et al. 2009; Sundby and Jacobus 2001), let alone increased expenses and time.

Despite the potential negative consequences of deciding to shop around, this process demonstrates couples' tenacity in the search for the "right" clinic for their situation, their desire to be more informed, and their unwillingness to settle for "just" any service, particularly considering the costs of treatment. Becker (2000:128-132) explains that women and men in her study in the US found it to be their social responsibility to be "smart" and active consumers of reproductive technologies, as they would be with the consumption of any other commodity. The responsibility of the user to be self-informed and critical of the medical treatment/professionals has, however, not yet emerged in the Colombian ART context. Nevertheless, I interpret the process of shopping

around for the best service and seeking information on the Internet to represent the initial stages of developing an informed consumer community. This process will be augmented with an increase in ART clinics, more readily available information (through experienced ART users and print sources), and a rise in prices. As couples gain more knowledge about the services and number of clinics available to them they will become more pragmatic in their search for the facility they utilize.

### *Material Constraints*

Regardless of some women's desire to shop around for the "ideal" clinic, they may be constrained from implementing this desire.

After having gone through three failed treatments Reanna told me she wanted to look for another clinic. She had been recommended one in *El Barrio Chico*, but she could not remember the name of the doctor. Furthermore, she was currently working in *El Centro* and did not have time to set up a consultation with another clinic in the north of the city. She barely had time to consult Dr. Mabel about her options. Her monetary resources were also dwindling, requiring her to maintain regular working hours. (Informal conversation on 27 April, 2013)

Like Reanna, many women discussed the various factors that constrained, or at least limited, their ability to access ARTs or shop for a new clinic. As mentioned by numerous other studies on ARTs, both in the Global South and Global North,<sup>20</sup> the primary constraint couples faced was monetary but temporal and locational constraints were also common.

---

<sup>20</sup> The financial barriers to ARTs have been discussed in great detail in the literature, particular in contexts where public healthcare programs do not cover treatment. For an overview of the financial burden of ARTs in low resource countries see Gerrits (2012:3-4). For specific examples see Bharadwaj (2001:227-232), Inhorn (2003b:37), Thompson (2005:27), and Whittaker (2014:16).



## Economic Constraints

As I have already discussed, ARTs are not covered by public or private insurance plans in Colombia, making these technologies unaffordable for the majority of the population. During our second interview, Dr. Herrera explained that a couple with two fixed incomes could access ARTs even if their salaries are not very high. However, the clinic cannot accept people who are not working and cannot pay for treatment costs: “in a sense this functions as a type of selection process,” even though the clinic does not have explicit patient selection criteria (interview 23 Nov. 2012).

Luz, the primary nurse at Fertisuperior, explained that money is the most influential factor in the treatment process. It affects which treatments *pacientes* are willing to undergo and if/when they will choose to forego treatment after a (or multiple) failed cycle(s). As most of the contact Luz has with couples comes after they have decided to undergo treatment, her narrative excludes the negotiations couples go through before agreeing to undergo treatment. This negotiation required potential *pacientes* to seek out information about treatment costs. This, in addition to being an often ambiguous process (as costs vary across centers, and “package deals” offered by some clinics make it difficult to determine the actual costs involved in a single cycle), was limited by the general lack of informed consumerism (shopping around) and Internet use, as discussed above.

Both Fertisuperior and Medivida offer a type of package deal that includes some of the costs incurred during treatment. For instance, the package deal for IVF at Fertisuperior covers the initial consultation, diagnostic ultrasound, sperm analysis, ultrasounds and consultations during ovarian stimulation, aspiration, second sperm analysis, in-vitro or ICSI fertilization, and finally the embryo transfer. Medications such as hormones needed for ovarian stimulation, initial blood work, other necessary medical interventions such as reproductive surgeries, and additional techniques including cryopreservation of extra embryos or pre-implantation genetic diagnosis (PGD), are not included in the package deal and can be very expensive. Women were provided with an

estimate of the additional costs they were likely to incur upon agreeing to undergo treatment, however, the costs often seemed overwhelming once the cycle began.

Women who had gone through treatment cycles at other clinics told me about other package deals or the absence of such packages. Francesca explained:

Another Bogotano clinic offers a package that includes up to three IVF cycles as the price of freezing extra embryos is included in the package and then these embryos are used in a second and possibly third cycle if the initial package price will cover these subsequent cycles. Due to unforeseen complications in Francesca's cycles, the package deal only covered two cycles before the initial funds had been spent. She was very frustrated with the clinic, as she had not understood that the three cycles were contingent on the costs of the first and subsequent cycle. Furthermore, the treatment process and the costs incurred in each step had not been explained, making it impossible for her to understand where the money had gone. (Fieldnotes 25 June, 2013)

This experience made Francesca very cautious when she decided to undergo treatment at Fertisuperior. She wanted to confirm that she would not have the same experience again. Thus, she sought out further information about the cost breakdown before beginning treatment. In contrast, a clinic Jimena visited in Los Llanos did not offer any form of package deals; every expense had to be paid for outright. Jimena exclaimed, "I had to pay to walk in the door" (interview 22 June, 2013). In this case, Jimena knew exactly what she was paying for but the expenses became overwhelming.

Some women mentioned feeling skeptical about the care they would receive based on how the clinic dealt with their finances. Reanna expressed concern about a clinic she visited in Medellin that she felt was very expensive, but then the doctor would give her discounts on exams and free medications (interview March, 2013). The doctor's lack of transparency made Reanna question his ethics and the efficacy of the clinic.

The transparency of treatment costs is also compromised by doctors' desires to withhold this information until a diagnosis is made and a treatment

regimen recommended. There is a vast difference in price between low-tech ARTs (i.e. AI) and high-tech ARTs (i.e. IVF), as well as between treatments using the couple's gametes and donated gametes. Thus, from the doctor's perspective, as Dr. Mabel explained, it is reasonable to discuss treatment costs only after a diagnosis is made and a treatment regimen determined. Even if a couple cannot afford IVF, they may only need AI with donor sperm, for example, but if they choose not to go through diagnostic procedures, this determination cannot be made. Some couples were very receptive of his concern and agreed to wait to discuss the costs of treatment, but others became frustrated at Dr. Mabel's approach to finances, particularly when the couple had limited financial resources.

Regardless of the lack of transparency of treatment costs and the various factors that contribute to this, the ultimate question was always whether or not a couple could afford to pay for these expensive medical interventions. Those who are on the margins went to great lengths to afford their only option to have a biological child. Dr. Diaz explained that *pacientes* pay for treatments however they can; they borrow from friends or family, sell possessions, and even pay for treatment by credit card. He continued by relaying a story another doctor told him about a couple who sold mobile phone credit on street corners for over a month just so that they could afford the initial consultation and diagnostic examinations. He claimed they are now saving again in order to move forward with the treatment process (informal conversation 28 Feb. 2013).

Many couples explained they had to save money and forego luxuries in order to pay for treatment. Filipe, Laura's husband, said, "We do not drink or travel so that we can afford the treatment" (interview 12 June, 2013). Other couples who did not see themselves in a position to afford treatment on their own received help from family. Samara told me her husband is just a laborer. He is not an executive or business owner, so they cannot afford treatment on their own. Their economic predicament resulted in her husband's family lending them money to pay for treatment (interview 11 March, 2013). Women whose families were unable to lend them money choose to pay by credit card. While sitting in the waiting room one morning, Reanna explained that her credit cards

have reached their limit. She has spent all her savings and used all her credit trying to conceive through assisted conception, and now cannot afford another cycle (informal conversation 27 April, 2013). Roberts (2009:122) has noted similar desperate acts women endure to afford ARTs in Ecuador, including their willingness to go into debt.

Some couples employed unique strategies to reduce costs. One such strategy involved maneuvering between the public and private healthcare systems, and utilizing their insurance coverage as much as possible. Some diagnostic examinations can be performed at public clinics where they are cheaper and may even be covered by insurance. The medical staff at both Fertisuperior and Medivida recommended that *pacientes* attend other facilities to undergo hormonal exams and disease screenings<sup>21</sup> and for particular ultrasound examinations. The examinations that clinics are willing to outsource are generally non-technical, indicating a minimal likelihood for misdiagnosis. For example:

Being made aware of Martha and Edger's financial situation, Dr. Mabel instructed them to go across the street to a public clinic to have their blood work done. He explained, "If you have any problems, tell the receptionist you are trying to become pregnant and want to be screened before potentially infecting a child. If you have further problems, request to speak to nurse María." (Consultation observation 20 June, 2013)

Those for whom the treatment costs did not pose a problem, however, generally preferred to have the examinations done in the fertility clinic, because it is more convenient and the waiting-time for results is shorter. However, some couples, such as Martha and Edger, needed to save as much money as possible to afford treatment and therefore willingly utilized the cheaper services at public clinics whenever possible. Some couples attempted to employ this strategy of moving between the public and private sector as frequently as possible, but fertility experts' skepticism about the abilities of other facilities prevented them from doing so in some instances.

---

<sup>21</sup> Potential fertility patients are screened for contagious diseases such as HIV and STDs to protect the medical staff and a potential future child.

Despite the financial predicament in which couples found themselves, they eventually accepted these costs. It was a price they were willing to pay in an attempt to have a child. Filipe told me all the sacrifices,<sup>22</sup> including missed vacations, would be worth it if the treatment resulted in a child. On July 8, 2013, Dr. Mabel told me Laura was pregnant with twins, making all the financial struggles she and Filipe endured worth every penny.

#### Locational and Temporal Constraints: Being Available and Being Together

In addition to the limitations posed by high treatment costs, women also have to consider the constraints of location and time when searching for a fertility center. As Reanna's narrative above demonstrates, the location of fertility clinics within the metropolitan area of Bogota may require women to take time off work and spend hours in traffic jams to reach the clinic. For some women, particularly those employed outside the home, the location of their home and their job may constrain where they can seek treatment. Liliana choose to undergo ARTs at Fertisuperior because it is close to her home. She explained that the first time she came to the clinic she did not know it had a good reputation, she just came because it was convenient (interview 23 April, 2013). Other women, such as Laila, choose the clinic closest to their work (interview 27 April, 2013). These women chose a clinic based on convenience, minimizing the time they would have to spend traveling to and from the clinic.

The location of the clinic also affects how easily women and men can make themselves available for appointments. Bogota is a large, congested city. Choosing a clinic because of its convenient location means women do not have to take time off work for appointments, as they can attend the clinic over their lunch break or early in the morning. Dr. Herrera explained that women with flexible work schedules, or those who are not employed, can more easily access treatment, which is a time-consuming process that follows a strict schedule (interview 30 Nov. 2012). However, women without this luxury must make

---

<sup>22</sup> For a further discussion of sacrifice in assisted reproduction see Fleischer (1990), Franklin (2006), Throsby (2002).

sacrifices to follow the treatment schedule. Francesca, who lived in a small village outside of Bogota, resigned from her job when she started treatment, because of the numerous hours she spent traveling between her home and the clinic several times a week (interview 27 June, 2013). This permitted her to attend appointments more easily, but being unemployed also constrained her household finances, making it more difficult to afford treatment. By relinquishing her job to access treatments, Francesca created another constraint to overcome.

Other couples gave up their weekends or holidays to come to the clinic. Larissa and Nicholas, who lived in Los Llanos, came to Fertisuperior every weekend that fit their treatment schedule so that Nicholas could accompany his wife, as he felt he should be present. But when Larissa had appointments during the week, she would come with a relative, a less than ideal option in Nicholas' opinion, or Nicholas had to take time off work, further restricting their finances (interview 25 May, 2013). Nicholas' desire to accompany Larissa meant he had to forego some of his income: thus their desire to attend appointments together placed further constraints on their ability to access treatment. For many couples, this predicament resulted in the women attending the clinic on their own, while their husbands became (or remained) detached from the treatment process.

As these examples portray, many couples must work within limitations – money, time, location, and the desire for co-presence – to access fertility treatment, a process that may require them to make sacrifices to overcome these limitations. Moreover, eliminating one constraint may increase the impact of another, further limiting a woman's ability to choose where she wants to access treatment. Despite the intentions of free market, neoliberal healthcare reform, which aims to provide people with increased healthcare options and the ability to become active, informed consumers, this has not yet become the reality in the Colombian ART market. Instead, women are still constrained by numerous structures that dictate where and how a woman can access treatment. As the next chapter will show, certain constraints, such as limited knowledge of the treatment process, pose barriers to women's active

participation in this process, requiring them to take a backstage role while the doctor takes the lead.

## Conclusion

In this chapter I have discussed the numerous knowledge systems and knowledge resources, some constraining and others enabling, women had to maneuver to access fertility treatments. This journey begins with Colombia's dominant motherhood ideology, which instills in most women a necessity to be mothers. As women navigated their way through the maternal mandate pushed on them by family and friends, and inevitably reproduced in their own interpretation of their bodily malfunction, they reached a point at which they actively started seeking a solution to their childlessness through medical intervention. We cannot then interpret this motherhood ideology as only a coercive factor that binds women to a maternal role. It is also an enabling element that pushes them to the next stage of child seeking, a force that drives women to initiate the medicalization process.

As women began seeking information about medical interventions, the availability of different knowledge systems possessing varying level of legitimacy became pertinent to the women's ability to access assistance. Dr. Diaz's narrative demonstrates the lack of efficacious ART knowledge GPs and gynecologists possess, reflecting a lack of economic and educational resources in the public healthcare system. This environment of depleted resources posed consequences for some women seeking fertility assistance in the public sector. Laura's story in particular raises questions about the number of women who access a primary care facility for their childlessness, but are never recommended to a specialist. A lack of awareness about the availability and use of ARTs in Colombia among primary physicians was inhibitive to the women in my study who were seeking a solution to their infertility. Similarly, the lack of collaborative networks between GPs/gynecologists and fertility specialists also

limits awareness, potentially adding to the costs incurred when diagnostic exams and consultations are repeated in multiple healthcare settings.

Many women who accessed a fertility expert did so through their social network, i.e. an informational gatekeeper, who provided them with the essential knowledge to access a fertility specialist. The experiential knowledge of these former medical technology users gave their testimony value in the eyes of women seeking fertility assistance, as these testimonies provided recommendations for fertility specialists and stories about their experiences. For some women, this knowledge provided direct access to a specialist. Others choose to adopt a semi-consumerist role and gain more knowledge about the fertility domain before consulting a specialist, knowledge that not only allowed them to determine where they wanted to seek treatment better, but also allowed them to maintain an active role during the fertility treatment process. In the next chapters I will show that women's limited knowledge of the treatment process may prevent them from actively participating in the procedures, a factor that some women embraced, while others despised the constraints the medical domain places on their active agency.

Access to knowledge was a continuous process during the fertility treatment journey – one that required women to adopt strategic and persistent measures as they navigated the diverse knowledge systems available to them. It was through the women's consistent agentic engagement with these different knowledge systems – and their use of (often limited) available resources – that women arrived at the private fertility realm. In other words, the agentic use of knowledge and resources is what allowed these women to access fertility treatment, demonstrating what agency in this context can do (Madhok et al. 2013:4). As the discussion of accessing information on the Internet and through shopping around reveals, however, not all women had access to the same resources due to further constraints, such as limited time and finances, constraints that reduced a woman's ability to choose freely where and with whom to undergo treatment. Entering the domain of the fertility expert provided women with access to further sources of knowledge, that of the fertility specialist, the nurses, and other staff members, and for some, other



women utilizing ARTs. This additional knowledge does not necessarily mean women were further empowered in their search for a child, however. Rather, upon entering the medical domain women faced additional constraints that reduced the active part they could play in their fertility treatment journeys.

## Chapter 6

### Negotiating Knowledge and Power: Multidimensional Agency

In this chapter I explore the distribution of power and knowledge amongst fertility clinic staff, and between fertility experts and couples. Using Foucault's (1984:61) notion of power as productive, rather than merely repressive, and borrowing Bourdieu's concept of "fields," I first demonstrate how power, while not equally distributed, is still *distributed*, forming a collective, productive force in the fertility center.

Despite the overarching authority of the doctor, which I briefly situate within the historical development of Colombia's medical profession, the complexity of fertility treatment processes require role specialization in the clinic, meaning the fertility expert(s) must acknowledge the knowledge and contributions of other actors. This legitimizes the roles of other staff members (i.e. other doctors, embryologists, and nurses), while demonstrating that visualizing power in a linear or hierarchical fashion over-simplifies power dynamics in the clinic. Rather, power in the clinic is multiple, discerned through diverse resources and knowledge, and serves different functions depending on the individuals involved and the context. Thus, instead of (always) being repressive, power can be seen as a relational and productive force that requires each individual to "act, think, and expect certain responses from themselves and others" (Foucault 1984 in Mayes 2009:484).

This fact also extends to women (and men) using fertility treatments. Women (and men) leveraged the knowledge provided by various expert actors (and other sources of knowledge, as discussed in the previous chapter) in strategic ways to gain more information, and at times influence the way in which they wanted treatment to go. This often involved strategically maneuvering between moments of active and passive agency to engage with the doctor and his medical expertise, and to achieve conception.

Constraints, however, do exist in the fertility center, and prevented women from fully participating in treatment decision-making. These constraints stemmed from the complexity and stress of assisted conception, the functioning of the clinic, access to limited information, and understandings of the prestige of the doctor. Restricted by these constraints some women were denied information about treatment options and protocols, limiting their ability to interact with the doctor and medical procedures during certain stages, while raising questions about the extent to which women/couples are informed. As Sewell (1992) explains, however, the exercise of agency requires the ability to work within structures (or constraints) to transform them, a practice that was embraced by some women as they negotiated their position within the treatment process and took a more active position. Others, however, chose to take an inactive position during treatment, preferring to trust the authority and knowledge of the doctor, as it is his expertise that may result in treatment success.

In short, this chapter, which explores the initial or early-stage of treatment consultations, asserts two key claims. First, it disrupts the notion of “expert” that assumes centralized power in the doctor, showing how power is collectively distributed in the clinics. Second, and relatedly, it asserts that the dichotomy of active agent (e.g. doctor) and passive victim (e.g. patient) restricts our understanding of the concept of agency and how it can be utilized (Madhok et al. 2013). Exploring the subtle ways in which women intercalated their agency into the treatment process, while permitting ample space for various experts in the clinic to utilize their expertise, illustrates the multifaceted nature of agency in assisted reproduction.

### Establishing Authority in Assisted Conception

Proponents of the orthodox medicalization critique (e.g. Freidman 1970; Parsons 1951b; Zola 1972) contend that medicine, through processes of medicalization, has become a source of social control such as that previously

performed by religion and law. Obregón's (2002, 2003a,b) historical analysis of the legislative and medical initiatives to control the spread of leprosy in Colombia illustrates the processes by which medical doctors obtained an authoritative position within Colombian politics and society, a role that was previously held by the Catholic Church. She (2002) explains that despite the founding of medical faculties in the 1860s, and that of professional medical societies in the 1870s and 1880s, the Catholic Church presided over social and educational affairs, and was the authoritative head of health matters. Increased concern about the apparent rise in (or increased awareness of) leprosy cases, however, provided an opportunity for the Colombian medical community to legitimize its position in the international medical scene, and establish its authority within Colombian society.

To summarize briefly, plans to develop completely isolated lazarettos and reduce the rights of those suffering from leprosy were devised but repeatedly abandoned due to political conflict from 1899-1902. With the presidency of Rafael Reyes (1904-1909), who sought to modernize the country partly through establishing "economic and culture links with Europe and the United States" (Obregón 2003b:134), concern was raised that the high incidence of leprosy in Colombia would prevent international investment and trade. This led the government to seek the advice of leprosy experts in both Colombia and abroad. With the assistance of expert physicians, the Colombian government established new legislation to manage the existing lazarettos, which included diminishing the role of charity organizations, the Church, and leprosy patients themselves, while placing doctors in an authoritative position to medicalize the disease (Obregón 2003a). The role of religious organizations was discredited as they were largely blamed for previously exaggerated leprosy incidence estimates, while the medical community was praised for controlling the spread of the disease as indicated by a 1909 census (Obregón 2003b:146).

Furthermore, the rising concern about the spread of leprosy made it a subject of medical debate, pushing for further exploration into the pathology of the disease. Colombian doctors embraced this challenge for academic prestige, "expressing a stance of strong scientific nationalism" that aimed to address

Colombian health problems instead of adopting international programs (Obregón 2002:105). This effort legitimized the efficacy of Colombian doctors, and established the authority of the medical profession in Colombian society. Obregón (2002, 2003a,b) explains the biomedical profession gained authority at the expense of the prestige and power of other (medical) systems (e.g. indigenous medicine, the Church) and patients themselves, discrediting their medical knowledge while legitimizing that of (bio)medical discourse.

Obregón's historical analysis reiterates Foucault's (1982) concept of governmentality, through which he explains the emergence of state-created forms of societal and individual control, which exert an individualizing and totalizing form of power, one that Foucault equates to that of the Church and its responsibility to lead communities and individuals alike. This pastoral power increased and was incorporated into state apparatuses and public institutions, including that of medicine and the public institution of the hospital (Foucault 1982:784), reiterating the role the State plays, as Obregón depicts, in legitimizing the authority of the medical community.

The authority or power of the medical profession and its position as an instrument of social control, not only stems from the State's legitimization of this community, but also through local understandings of the position of doctors within this community and their control (or at least management) of knowledge systems. Doctors' authority is in part due to the position of power the State has granted them, but it also comes from their high levels of education and knowledge. Biomedical knowledge is obtained and accredited through a university education and advanced training that eventually leads to a certification that entrusts doctors with the responsibility for healthcare (Parsons 1975:266). Access to such university education has historically been limited in Colombia, where only individuals from the higher socio-economic strata have had the resources to attend university. In 1996 only about 15 percent of university-aged individuals enrolled in higher education, with the vast majority (over 80 percent) coming from high-income families (Cerdán-Infantes and Blom 2007:1). Medical school in Colombia is generally even more expensive, as the program is six to seven years long, and subsequent residency

programs are unpaid. This greatly limits who can apply to medical school, while reproducing the local perspective that doctors are commonly from wealthy backgrounds. Moreover, as Freidson (1970:xx) explains, the medical profession has developed a unique status where it can “control the content if not the terms of its own work.” In other words “the medical profession has managed to monopolize medical knowledge and access to training” (Mol and Berg 1998:4); it not only produces medical knowledge but controls who can access and utilize the knowledge, effectively increasing the authoritative status that they possess.

Knowledge and power, according to Foucault (1977), constitute a symbiotic relationship: as more knowledge is obtained an increase in power will follow, and every expansion of power will be accompanied by an increase in knowledge; the two are interconnected and reflexive of one another. Thus, the high levels of education and specialized, limited/controlled knowledge, combined with a generally wealthy, and even elite, background, as well as the support from the State, all contribute to the privileged and authoritative status of Colombian medical doctors.

In the realm of medical practice, however, the authoritative position of doctors becomes more complex. As I discussed in the last chapter, different domains of the medical system possess different levels of prestige and knowledge (e.g. GPs/gynecologists versus fertility specialists). Thus, simply being characterized as possessing authority and knowledge does not guarantee possession of the necessary resources to use that knowledge/power legitimately. Furthermore, given the complexity of infertility treatment (discussed in more detail in the next chapter), different medical staff perform specialized tasks based on their education and role in the clinic. This creates an environment of collaboration, where fertility specialists, embryologists, nurses, and couples combine their knowledge in order for assisted conception to be successful. Here then, instead of power being repressive, it is productive as it works towards a common goal (Foucault 1984:61).

Bourdieu’s concept of “fields” can provide a framework to consider the multiple actors participating and using their knowledge in the fertility center to

achieve a pregnancy.<sup>23</sup> A “field” is a network or configuration, or in this instance a clinic, that is defined at any given moment by the “state of relations” or positions of the agents (e.g. doctors, nurses, patients, etc.) in that “field.” The different actors in the “field” possess various distributions of power and knowledge, and may constantly struggle to obtain the power and knowledge of others. Thus “fields” are in constant flux (Bourdieu and Wacquant 1992:96-103).

The distribution of knowledge/power in a “field” could create a power hierarchy based on the recognized value or prestige of one’s knowledge/power. In the medical profession, agents have different levels of expertise based on their training and experience and their intended position in the “field.” Thompson (2005:102) explains, “Infertility medicine is like other arenas of expert technical culture in that marking and differentiating skills and expertise (and the social, hierarchical roles that go with those notions) are an intrinsic part of the culture.” A common example is the level of expertise (or knowledge) and authority possessed by a doctor compared to a nurse. However, doctors themselves possess different levels of training and knowledge, and hence, expertise. As I explained in chapter 4, Colombian ART experts often train at foreign institutions. Obtaining access to such an education not only excludes certain segments of society, including other medical professionals, from this knowledge and its use, but also “creates the basis for prestige and social distance” between experts and non-experts (Turner 1987:135). During an interview Claudia explained she chose to undergo ICSI at Fertisuperior because Dr. Mabel’s C.V., which she obtained online, states he is a member of international medical organizations and he has studied at foreign institutions (interview 25 April, 2013). Dr. Mabel’s foreign ties and education provided him with a level of authority in Claudia’s eyes, authority that doctors (including other fertility experts) without international connections may not be granted.

The understanding of this hierarchy becomes more complicated when we consider that the participation and knowledge of all of the “field’s” actors is

---

<sup>23</sup> Franklin (1997:144) explains that in the model of assisted reproduction conception is no longer “a taken for granted event but has to be achieved.”

required for the clinic to reach its goals, or in Bourdieu's words invest in the "collective enterprise" of the "field" (Bourdieu 1990:68). In the case of the fertility center the "collective enterprise" is the conception of a child. Thus, even though the head doctor may possess the most authority and knowledge in the clinic, placing him in a dominant position, the "field" cannot function solely on the basis of his expertise. For conception to occur, the fertility specialist must recognize, and rely on, the knowledge and skills of the other actors in the clinic, for instance relying on the highly specialized skills of the embryologist for fertilization and the potential subsequent conception to be possible.

The pivotal role the embryologist plays is expressed through daily interactions between the fertility specialists and embryologists, such as Dr. Mabel consulting Dr. Catalina about the development of the embryos in the laboratory incubator. He would ask her when the embryos should be transferred – on day three or day five following fertilization – and the number of embryos to be transferred, which depends on the particular fertility complication and the woman's treatment history. Before witnessing these interactions I had assumed Dr. Catalina would provide Dr. Mabel with "objective" observations of the embryos' development, allowing him to make the subjective decisions of when and how many embryos to transfer. However, Dr. Catalina's expertise in embryology gives her authority in these matters, and reiterates her pivotal position in the conception process.

Women undergoing treatment also recognized the integral role the embryologist plays in their fertility treatment journey. Not all women met the embryologists while undergoing treatment, but those who did often expressed their gratitude for their contribution to the process if they conceived.

Not wanting to receive the information over the phone, Anita chose to come into the clinic to receive the results from her pregnancy test. A smile was spread across her face as she approached Dr. Catalina after leaving the consultation. Anita embraced Dr. Catalina, repeatedly saying, "Thank you! Thank you!" as she did so. (Observation 7 March, 2013)



Anita's recognition of the role Dr. Catalina played in her conception gives Dr. Catalina's position value and authority, ultimately recognizing her contribution to the "collective enterprise" of the "field."

Nursing staff, the other primary medical actors in the fertility clinic, also contribute to the clinic's "collective enterprise," although the other medical staff may not fully acknowledge their knowledge and contributions. Despite the fertility specialists and other doctors having more training and formal expertise than nurses (and thus more authority), the nursing staff were an integral part of the functioning of the clinic, and generally the most accessible means of information and support for the women undergoing treatment. Johansson and colleagues (2002:337) explain that patients expect to receive high quality technical or medical care, and thus "place high value on the interpersonal care provided by" nurses, care which they anticipate will play a central role in their treatment and be of a personal nature. Nurse Luz's narrative reflects this level of responsibility and care that the women undergoing treatment expected (and appreciated):

"I *always* [both during and after working hours] have to make myself available to take the women's phone calls." They call her about injecting the hormones, to inquire about their appointments, and to express their concerns and fears about the treatment. She explained, "This is very stressful, but I am always here for the women to share their stress, pain, and happiness throughout the treatment process." (Interview 9 July, 2013, her emphasis)

During stressful moments the nurses are available to console and inform the women. They have the ability and the time to relate to the women on a personal and emotional level, developing a different type of relationship from that which the women developed with the doctor. Their ability to connect with the women on a personal level while providing them with more easily accessible/understandable information provides the nurses with particular forms of authority/knowledge in the clinic. This is similar to the authority/knowledge of informational gatekeepers discussed in the last chapter, a combination of an emotional-social and experiential/non-institutionalized

form of knowledge derived not from experiencing the treatments themselves, but from their participation in numerous treatment cycles.

In essence, the diversity of knowledge and skills held by the different medical staff in the “field” of the fertility center gave women a range of “authoritative” individuals from whom they could seek information. As I will show in the next section, some women made use of the knowledge possessed by these different actors individually and that contained collectively in the power struggles between them in strategic ways to further enhance their own knowledge and authority in making treatment related decisions. The knowledge that (some) women gained allowed them to (sometimes) push treatment in the direction they wanted it to go (Greil 2002), even if only slightly.

### Negotiating the Doctor-Patient Relationship

As I discussed in the last chapter, the doctor’s expertise in assisted conception is sought by women in their efforts to overcome childlessness. The fertility expert’s control of technologies, and his recognized ability to make life, give him his authoritative position in the clinic. However, it is not necessarily only his position of authority that compels women to comply with his demands (which are a reflection of the demands, or constraints, of the technology as I discuss in the next chapter), but also women’s pursuit to conceive a child. This appears to reflect Morgan’s (1998:96) concept of “medicalized agency,” which she describes as the process by which

[i]ndividual members of the culture internalize, use, actively support, and demand the use of medicalizing concepts, discourse, and practices and when they not only comply with but seek out active involvement in medical technologies claiming medical discourse and vocabularies as their own.

As I will show, the participants in my study used various strategies to engage with the fertility treatment process, some proving to be more active, and others more passive, depending on the women’s desired level of involvement, and their

ability to maneuver between the constraints of the treatment process and the authority of the fertility experts.

The women's ability to engage with the fertility expert in the patient-doctor relationship illustrates how the fertility expert may possess an authoritative position that does not diminish the agency of the women. Lupton (1997b:99) explains, "From a Foucauldian perspective, power as it operates in the medical encounter is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies." The power that the doctor embodies is meant to guide or lead the actions of the patient to make them comply with medical practice. Dr. Diaz (fertility doctor in-training) reiterated this understanding of the doctor's role as he described the ideal patient:

A patient is someone who has patience; they are patient with their disease while searching for a cure with the help of the doctor. [A patient] is someone who has to seek the advice and help of a doctor and then follow the doctor's advice to get better. A patient is someone with whom you can build a relationship and trust. (Informal conversation 8 July, 2013)

Without directly saying so, Dr. Diaz was suggesting that the ideal patient should comply not only with the power of the doctor, but also the power of medicine, to treat her ailment and be able to endure the treatment process. Dr. Diaz was reproducing a Parsonian image of the "sick role" adopted by the patient who works with the doctor to overcome her sickness (Parsons 1951a:456, 1975:267). Dr. Diaz's ideal patient, however, does not lack agency, a factor incorporated into Parsons' later work (e.g. 1975). His narrative leaves space for the patient to have an active role in the treatment process when the patient is "searching for a cure with the help of the doctor." Furthermore, the act of building a relationship requires collaboration between both parties in an effort to reach a common goal. In other words, *both* the patient and the doctor have to take an active role in creating this relationship in order to facilitate successful treatment. Thus the ideal patient may obey the authority of the doctor and medical discourse, but that does not mean she is an inactive and passive figure.

Maia and Matias' consultation with the fertility experts further demonstrates these dynamics. Their consultation with Dr. Mabel and Dr. Diaz shows how doctors sought to maintain authority through subtle attempts to control the medical encounter. Yet we also see in Maia's unwillingness to comply with the doctors' agenda her ability to interject agency into the treatment process:

After Matias returned to the waiting area from providing a sperm sample for analysis, he and Maia were called back by Dr. Diaz to Dr. Mabel's office. Dr. Diaz made his way to the large office chair. Matias and Maia sat down across the desk from him. The desk was cluttered with papers, models and diagrams of the female reproductive system, a calendar, with a computer monitor and keyboard off to the side. I sat on a small stool next to Dr. Diaz.

Once I explained who I was and Matias and Maia agreed I could observe the consultation, Dr. Diaz began. He already knew that Maia wanted to start the hormone injections immediately, the initial stage of the treatment process, and thus asked her to confirm when her last period started.

Maia consulted the calendar sitting in front of her. She said her last period started July 20<sup>th</sup>, but then contradicted herself saying the 19<sup>th</sup>. A moment later she said the 20<sup>th</sup> again. Dr. Diaz appeared a bit frustrated and exclaimed, "It was just last weekend. Do you not remember?" Maia ignored his comment, and once again stated her last menstrual period started on the 19<sup>th</sup>.

Hearing this commotion, Dr. Mabel entered the room. Dr. Diaz explained Maia could not remember when her last menstrual cycle began and therefore he could not determine if she could start the treatment this month or if she would need to wait until the following month (the treatment cycle strictly follows the women's menstrual cycle). This was news to Maia, who had not realized the significance this single day could make in her treatment schedule. She intended to start the treatment cycle that day and once again changed the date of her last period to July 20<sup>th</sup>. Dr. Mabel asked if she was sure, and upon her verification, nodded to Dr. Diaz to begin filling out the patient-log that contains the couple's details, the prescribed hormone drug(s) and dosages, and the treatment schedule.

As Dr. Diaz filled out the form he explained the aspiration would take place around July 31<sup>st</sup> and the embryo transfer would be sometime during the first weekend of August or that following Monday, all depending on how Maia reacted to the hormone injections. Hearing this, Maia interrupted Dr. Diaz saying they could not come that weekend as they already had plans to attend a wedding in Santa Marta. Dr. Diaz, appearing concerned, began to explain the schedule is not flexible, but

Dr. Mabel interjected, stating they would just plan to transfer blastocysts (five-day-old embryos) on the Monday or Tuesday instead of three-day embryos on the Saturday or Sunday. At this Dr. Mabel suggested Maia go change for the exam to check her ovaries. Maia was not ready for the examination, however, and told the doctors they had some questions they wanted answered first. Hearing this Dr. Mabel left the room to permit Dr. Diaz to answer their questions.

First Maia asked how many embryos they will transfer. The doctor explained they usually transfer two and at the most three, clarifying that it depends on the particular fertility complication and the preference of the couple. Maia was satisfied with this answer and moved on to ask about the treatment process, and how her menstrual cycle is controlled. Dr. Diaz asked if they had seen the fertilization video, referring to a video filmed in the laboratory that captures the egg being fertilized through the ICSI process. Maia stated they had, so Dr. Diaz moved onto her next question. He stated, “*I control your mensuration with the medications. I provide the medications allowing the follicles to grow, and then so they stop growing and remain in the ovaries until I want to remove them*” [emphasis added]. At this point it became evident that Maia asked this question because she was concerned that if the treatment schedule was not exact than it would be unsuccessful since she would be away during part of the treatment process. Dr. Diaz assured her he would control the timing of the treatment cycle so that it did not interfere with her travel plans. Maia appeared satisfied with this and moved on to her next question: What happens to extra embryos? Dr. Diaz explained that extra embryos are frozen to be used in a later treatment cycle. Maia winced at this information and then stated, “But you see I am Catholic and I do not think embryos should be frozen. I do not want my embryos to be frozen.” Dr. Diaz appeared a bit taken aback by this, possibly shocked by her forcefulness. A moment later he responded, “We can discuss this later. Any extra embryos do not have to be frozen if you do not want them to be.” (He was clearly avoiding the conversation.)

At this moment, Dr. Mabel walked into the office to see if Maia was ready for the ultrasound, but instead she took the opportunity to ask him about extra embryos. He practically repeated what Dr. Diaz had said, “Extra embryos are frozen so they can be used in a later cycle, which is advantageous for you.” She again specified that she did not want to freeze extra embryos and asked if any additional eggs could be frozen instead. Dr. Mabel told her it is possible but they would have to see how the treatment progressed, and then asked her to go for the ultrasound. (Fieldnotes 23 July, 2013)

The power dynamics in this excerpt are multiple. Dr. Diaz was clearly in control of the consultation when he was alone with Maia and Matias. This control derives from his knowledge of the treatment process and his ability, as he

stated, to control Maia's body through his control of the medications, and by regulating her menstrual cycle to coincide with the treatment schedule. Dr. Diaz also demonstrated his authority by disregarding some of Maia's questions and concerns, and thus controlling access to his specialized knowledge. Morgan (1998:84) claims the authoritative position of the doctor is part of the larger medicalization process that devalues and silences women's concerns and their knowledge, and simultaneously reestablishes the doctor's authoritative knowledge. When Maia asked about the treatment process, Dr. Diaz merely asked if they had seen the fertilization video and moved on; he did not provide her with further details. He also disregarded her question about extra embryos by saying what she wants to hear (extra embryos do not have to be frozen). But rather than actually granting Maia the power to decide, he reinstated his position of power by saying they will address the issue later. From his "knowledgeable" position, it would be medically beneficial for Maia to cryopreserve extra embryos, even if she objects to the process – Dr. Diaz was devaluing her concern, silently asserting his medical perspective as more legitimate than her personal beliefs and opinions.

Although Dr. Diaz's authority placed him in a position of power to act upon the agency of Maia and Matias (Foucault 1982:789), he was still subordinate to the senior position of Dr. Mabel. When Dr. Mabel was present, he was in the position of authority, demonstrated through him interrupting the conversation, and by stating they would transfer blastocysts if necessary in order not to conflict with the couple's schedule. As the head of a private fertility clinic, Dr. Mabel is concerned with promoting a positive image of his facility, which includes not only producing positive results (i.e. pregnancy), but doing so in a manner that is compatible with the lives of the patients-cum-clients (i.e. producing positivity). The multidimensional objectives of the two doctors and the power struggle between them made space for Maia to interact in this process. For instance, although the result was nearly the same, she used the opportunity of Dr. Mabel entering the consultation to ask once again about extra embryos; Maia used this moment to gain further information and confirm Dr. Diaz's explanation. She also utilized the information Dr. Diaz provided Dr. Mabel

about the timing of her menstrual cycle and its effects on the treatment schedule, to help her “determine” when her last cycle started.

Some scholars have identified resistance as a form of action against the doctor’s power (e.g. Mitchinson 1998; Morgan 1998; Pappas 1990). Pappas (1990:200) explains that no matter the severity of the power imbalance, the patient can always resist the doctor’s authority. However, I do not interpret Maia’s actions as a form of resistance; she did not want to resist the expertise the doctors offered, since abiding by their orders was her sole opportunity to obtain a biological child. Instead, Maia’s actions, her desire to understand the fertility treatment journey better, reflects her desire to actively participate in the treatment process, not to merely stand on the sidelines while the doctors took control. She did this by inserting her voice – utilizing her agency – where she found space to do so. Even though Maia claimed she would not do the examinations until her questions were answered, she eventually moved forward with the consultation despite not having received clear answers to these questions. Maia’s claim to stop the medical encounter – or counter the doctors’ authority – was actually a mechanism for her to create space to ask questions.

Maia’s ability to insert agency into the medical encounter demonstrates her ability to strategically act within the realm dominated by the doctor in order to maximize the limited amount of control she had (Greil 2002:113). Foucault (1982, 2010[1984]) suggests that we consider how power is utilized, the techniques and forms power takes, and how it is enacted in relationships, instead of critiquing the exercise of power by particular elites or institutions. Considering this, we can see Maia’s actions not as a defiance of the doctor’s authority, but rather her ability to co-create his authority, while still utilizing his expertise in her attempt at conception. This, then, constitutes a form of constrained but strategic agency.

However, despite the fact that Maia strategically participated in the consultation and gained further information, the doctors unwillingness to address all of Maia’s concerns left her in a position where she only had partial, though slightly more, knowledge. As discussed in the last chapter, having limited access to information left many women embarking on their fertility

treatment journeys for the first time in a state of partial knowledge, where they did not know what would happen next. This made it difficult for them to actively engage with the treatment process and be psychologically prepared. Their access to knowledge was constrained by the doctors' authority and by the limited resources available to the public.

### *Control of Knowledge*

When I first started observing in the waiting area of Medivida, I was surprised by the amount of time the nurses dedicated to explaining the treatment process to the women, not only women in the initial stages of the treatment journey but also those nearing the end of a treatment cycle. I was aware that IVF/ICSI is a high-tech procedure and the treatment process is quite technical and complicated. However, I had anticipated the doctors would be keen to help their *pacientes* understand what the treatment entails. When I started conducting interviews with women at Fertisuperior it became apparent that the women lacked specific information about IVF/ICSI, details about the various stages, and choices the women may need to make. When I asked women who were just initiating treatment if they had any concerns about the process or if they were worried about a particular phase of the cycle, my questions were often met with a blank stare and silence, or questions about the treatment cycle. It became evident that many women lacked a clear understanding of the treatment process and they did not know what to anticipate. When I began observing consultations, I half expected the doctors to neglect to explain the procedure but this was not the case. Instead, I encountered several factors that affected a woman's ability to understand the treatment process, including how information is relayed, when information is provided, the doctor's attitude, the woman's psychological state, her ability to ask questions, and her desire to be informed.

During initial consultations with new *pacientes*, doctors explained the treatment process, generally using visuals such as models of reproductive



organs and diagrams of the various treatment stages. However, the explanations accompanying these visual props were commonly quite vague, rushed, interrupted, or contained technical/inaccessible language. For example, in a follow-up consultation with Martha and Edger, Dr. Mabel was finding it difficult to explain the treatment course to the couple in a way they could understand. So he picked up another woman's patient-log containing her treatment schedule. Pointing to various parts of the log, he explained,

The log shows her menstrual cycle, when she started the first medication and that now she has started taking a new medicine. She will have the aspiration on Saturday [he points to a red circle on the chart]. The ova will be removed and then [the embryologists] will perform ICSI, and three days later the embryo transfer [he puts down the log]. You have seen the video right [referring to the fertilization video, which he then turned on]. (Consultation observation 20 June, 2013)

Using the patient-log Dr. Mabel pointed out the different stages of the cycle, while providing a visual timeline for the couple to follow. However, the explanation was limited and many details were omitted. Furthermore, instead of explaining what ICSI fertilization entails, he showed a video, which served as a visual aid, but also as a barrier between himself and the couple. He did not have to engage with them, which limited the couple's ability to ask questions. When he did engage them, he used technical language (such as aspiration, ICSI, embryo transfer, etc.) instead of clearly explaining what each phase of the treatment process entails. Finally, he was visibly frustrated by the couple not understanding the treatment process, an attitude that was likely another factor that limited their ability to ask questions. Luz said to me one afternoon that the doctors' lack of patience when explaining the treatment process causes many women to consult her about the treatment details instead of asking the doctor for verification (informal conversation 15 June, 2013). Luz's narrative demonstrates Dr. Mabel's limited ability to explain the treatment process in a clear and efficient manner, while reiterating the integral role she plays in the treatment process.

In addition to information being provided in this type of short and limited fashion, it was also generally provided piecemeal throughout the treatment process, instead of comprehensively. The doctors know IVF is a complicated procedure that may be difficult for the women to comprehend. To minimize confusion, as the doctors at Fertisuperior explained various times, they prefer to provide the information little by little to avoid overwhelming the *pacientes*. However, this prevents women from being fully informed before agreeing to undergo treatment, while potentially hindering their ability to be psychologically prepared for particular treatment stages. Gabriela, who had a laparoscopy to check her uterine lining before starting ICSI, explained that she did not know until she arrived for the procedure that she would be put under anesthesia: she hates anesthesia, and would have requested a different procedure if she had known beforehand (interview 21 June, 2013). Susi expressed a similar concern when she discovered only a couple days before the aspiration that the procedure requires anesthesia (interview 29 Jan. 2013). Learning late in the treatment processes that anesthesia was required, both Gabriela and Susi said they might have changed their treatment choice had they been aware of it sooner. Similar to findings reported by Benjamin and Ha'elyon's (2002) research from Israel, being provided with incomplete procedure information required women to learn firsthand.

Other women expressed concerns to me but were unwilling to ask the doctor for clarification or further information. Fatima had been Dr. Mabel's *paciente* for some time when I met her. She had been through numerous failed treatments, but was still intent on continuing her fertility treatment journey. While performing a transvaginal ultrasound in preparation for Fatima to start the next ICSI cycle, Dr. Mabel discovered a polyp in Fatima's uterus that he claimed needed to be removed. He instructed Fatima to schedule a surgical appointment with Luz before leaving. During an interview following the examination, Fatima expressed confusion about why she was just being informed the polyp needed to be removed. Why had she not been informed of this earlier? She asked if I could explain the situation to her. Indicating I could not, I suggested she consult Dr. Mabel. However, she responded that this was

unnecessary, and asked that we continue the interview. She left afterwards without speaking to anyone else (interview 25 May, 2013).

Even though Fatima wanted further information from Dr. Mabel, she was unwilling to question why he wanted to remove the polyp at this very moment. According to Morgan (1998:92), complying with the doctor's orders is integral to the power dynamics of the doctor-patient relationship, and resistance or defiance "can quickly be labeled 'lack of compliance.'" This shows how the doctor's powerful position, and that of the intuition of medical more generally, can create a barrier that prevents some women from seeking further information.

Women's emotional state during fertility treatment may also contribute to a lack of knowledge about the treatment process. Morgan (1998:92) explains how we often seek medical assistance in states of "pain, uncertainty, dread, and terror, suffering from the loss of integrity." Parry (2006:2357) similarly recognizes how the stress and vulnerability of patients may cause misunderstandings among couples seeking egg donation, compromising an important decision-making juncture. Thus, during consultations, women's worries about examination results, the potential for treatment success, or the pain that accompanies treatment may distract them from focusing on the information being provided. They may forget to ask specific questions during appointments simply because they are overwhelmed. This, in addition to the doctor not providing space to ask questions, means many consultations conclude without an opportunity for the woman to think about concerns, let alone voice them. However, neither the doctors nor the women were unaware of this process. Dr. Herrera explained to me:

Day by day we [i.e. doctors] have to improve the way we communicate. You think you are being very clear, but sometimes a patient, who you have talked to before and who you think understands, comes to you again and they clearly did not understand. It is difficult to explain these processes. (Interview 11 Nov. 2012)

Regardless of being immediately evident or not, this process of doctors relaying incomprehensible information, combined with limits to women's abilities to obtain further knowledge, becomes a vicious cycle. The authority of doctors (and the medical profession more generally) derives from the *recognition* of their expert knowledge and, therefore the ability not only to create, but also control what counts as knowledge in the medical encounter. This, combined with the emotional stresses of treatment, not only inhibits the effective relay of information to women (and men), but it also prevents some individuals from inquiring about further information. This allows the doctor to remain in control of this knowledge, and, at times, also the fertility treatment.

*Embracing the Authority of the Fertility Expert: "Desired Ignorance"*

A small number of the women and men preferred to embrace the fertility expert's authoritative knowledge and their own lack of understanding, relying on the doctor's authority to make them conceive rather than challenging this authority to increase their own knowledge and power.

Upon walking through the large glass door into the reception of Fertisuperior one Saturday morning I encountered a full waiting area. This was not unusual; the clinic was generally very busy on Saturday mornings. As I looked through the waiting area to see if I recognized anyone, I spotted Larissa and Nicholas sitting on the far sofa. They smiled at me while I made my way over to greet them. After exchanging a bit of small talk, I asked Larissa why they were at the clinic. She looked at me blankly and responded, "I don't know, the doctor told me to come today." I was surprised by her answer, particularly because they drove nearly three hours to Bogota from their home in Los Llanos for this appointment. (Fieldnotes 1 June, 2013)

Larissa was one of many women who came to the clinic, regardless of distance, simply because the doctor had told her to. But this was not a passive response to the doctor, or a display of ignorance. The women actively choose to place their faith in the doctor's hands – in his knowledgeable and authoritative hands – to make them conceive. Women undergoing fertility treatment know from

experience that they cannot conceive on their own, and thus some women choose to embrace medical domination instead of engaging with it.

Lupton (1997b:98) claims there are various feelings and opinions that people have about medical practice, and ways in which “patients willingly participate in medical dominance.” In other words, people do not always struggle against authority. They may actually embrace and reproduce its domination. For instance, during an interview with José and his wife, José reported being reluctant to ask the doctor for further information when I suggested they consult him about their treatment concerns. José explained,

“We do not need to understand all of the details of the treatment process. We are just curious.” It is more important for them to have the examinations the doctor orders and then for the doctor to recommend the best treatment option. They do not need to have a say in what is best, because they do not know (interview 21 Feb. 2013).

This demonstrates the confidence José and his wife had in the doctor’s knowledge and his ability to determine the correct treatment option to result in conception.

Roberts (2008:84-85) has reported similar findings in Ecuador where she claims couples desired paternalistic doctors who they could trust and who would make treatment decisions for them, which would relinquish couples from having to take charge of their own care. This case also reflects Inhorn’s (2003b:73) informant who desired further information (José was “curious”) but stated she believes what the doctor says “because he’s a doctor and he knows everything.” Inhorn’s informant was clearly embracing the dominant position of the doctor and his valuable knowledge, while desiring to take a more informed position. In both cases, however, patients/couples *chose* to relinquish their responsibility to the doctor because they wanted him to make the decisions, a *conscious* in-action that reinforced the doctor’s authoritative position in the medical setting by reducing the information the couples received. Yet this did not diminish the *choice* they made in hopes of a positive treatment outcome.

As discussed, Foucault (1984:61) explains how power can be positive and productive, not only repressive and confining. In the realm of fertility treatment, the doctor does not only control knowledge and the medical encounter in order to maintain his authority. Instead, he uses his knowledge and his dominant position in conjuncture with the couple's wish for a child. Fertility experts can be seen as facilitators of knowledge as they guide women through the necessary stages to reach conception. This guidance is facilitated through their authoritative knowledge and their ability to build rapport with their *pacientes*.

Anita and her husband are both from La Costa (Caribbean Coast) but they met in Bogota some years ago while at university. In 2009 she was diagnosed with endometriosis after having a laparoscopy done to remove a uterine cyst. She was placed on hormone therapy for six months to treat her condition; however, afterwards she was unable to conceive. In the fall of 2011 her mother recommended she make an appointment with Dr. Mabel. After another laparoscopy the doctor informed her she would not conceive without the use of ARTs.

Despite the doctor telling her she had only a ten percent chance of conceiving with AI she wanted to do "something more natural" than IVF to begin with. She went through two failed AIs, and then Dr. Mabel told her she would have to do IVF if she wanted a chance at pregnancy.

It took her almost a year to agree to undergo IVF; she was very hesitant, she did not want to do anything too technical. However, Dr. Mabel finally called her and asked why she was so doubtful, why had she not decided to go through treatment. Their conversation convinced her it was time and she agreed to undergo IVF in February of 2013 (the first time we met she was a few days shy of the aspiration).

Anita said that since deciding to go through treatment, Dr. Mabel has been very vague with her about the treatment process, because he does not want her to be anxious. She prefers that he simply tells her to come to the clinic on this or that day and does not explain what the appointment is for, if she will have a procedure or only an exam. She claimed her lack of knowledge about the treatment process prevents her from worrying and stressing about the next stage of the treatment trajectory. (Interview 21 Feb. 2013)

Anita's story demonstrates the doctor's ability to convince a woman to undergo high-tech fertility treatment despite her initial hesitation. First his expert knowledge facilitated Anita's acceptance of AI. Then through the development

of a relationship and the cultivation of trust, Dr. Mabel facilitated Anita's understanding that IVF was the only option if she wanted a biological child. With time Anita willingly agreed to undergo IVF and allowed Dr. Mabel to take charge of the treatment process. This scenario could be interpreted as Dr. Mabel pushing Anita to undergo assisted conception against her will. Anita, however, willingly succumbed to Dr. Mabel's pressure, and made a conscious effort (through avoiding treatment details) to remove herself from a decision-making position. She made a choice to be as far removed from the treatment as possible, actually being resentful of receiving more information than she needed, which prevented her from being *consciously* separated from the procedure (physical presence is an obvious requirement).

During the same interview, Anita said that during the consultation Dr. Diaz had explained to her how the fertilization process could lead to extra embryos, meaning she would have to decide whether to cryopreserve the embryos or discard them. Anita was upset that Dr. Diaz had provided her with this information, and explained she hopes only the embryos that are needed for the transfer will survive so that she will not have to make the decision later. (Interview 21 Feb. 2013)

Anita's desire not only to lack information, but actually be deprived of information, represents what I will call "desired ignorance." Desired ignorance entails wishing to be uninformed to prevent both anxiety and the need to make difficult decisions that may inhibit treatment success. At times it may entail maintaining an unrealistic expectation of treatment success, as in Tania's case:

Tania's situation was unique; her husband took an active role in the treatment process, while she preferred to remain in the dark. When I interviewed her a couple of days before the egg retrieval, she appeared to be very unknowledgeable about the treatment process, and took the opportunity to ask me about the potential for treatment success. Two days later, while I was talking to Tania in the recovery room after she had undergone the egg retrieval, she said she had been very anxious since she discovered treatment was only 25% likely to succeed. On saying this, she held her index finger to her lips and said, "Shh... do not say anything else," indicating that she did not want any further information. (Fieldnotes 15 June, 2013)

Tania regretted having obtained more knowledge and she was suffering from heightened anxiety because of it. She would have preferred to continue having unrealistic expectations of treatment success than confront the reality of a possible negative outcome.

José, Anita, and Tania consciously *made the decision* to be removed from the treatment process, preferring to permit the doctor to control the medical encounter (even if they were only partially successful); they *chose* not to participate actively. Their lack of participation, or action, does not mean they were unable to utilize agency in the medical encounter. Rather their agency took an inactive form, while still consisting of an intentional decision-making process. In other words, their agency did not manifest in an active, overt form of control, but rather in the *choice* to be inactive and, especially in the case of Anita, as uninvolved, and as removed from authority as possible. Perceiving agency as only the ability to act in a directly empowering way disregards individuals' ability to *choose* non-action, and hence disregards José, Anita, and Tania's chosen forms of agency in the fertility process. Allowing the doctor to control the fertility process represents a hidden form of agency that embraced the doctor's expertise, and reduced these patients'/couples' anxieties.

## Conclusion

In this chapter, I have focused on untangling the intricate workings of power dynamics in initial, or early-stage treatment consultations. In analyzing these interactions, I have suggested that power relations represent a negotiation of various forms of authority produced through the diverse and multiple forms of knowledge and expertise that exist in the fertility center. Despite the fertility expert's dominant position, other staff members play an integral role in the functioning and success of the clinic, such that power does not exist solely in its recognition, but as a productive distribution of positions and actors that contribute to the "collective enterprise" of the clinic. This distributed, collective power is ultimately productive (in the Foucauldian sense) in that it does not



oppress, but works towards something literally productive: the conception of a child.

In this, women/couples undergoing fertility treatment alternatively draw on their ability to act either against, or in congruence with, this collective (but still highly centralized) authority. Women's agency may take an active form that enables them to increase their participation in the treatment process, or their agency may be subtler as they adopt an inactive position that allows them to embrace the doctor's authority and remove themselves from a decision-making role. However, neither instance manifests as pure resistance against the dominant discourse and the expertise of the doctor/medical staff, knowing that this expertise is the key to a positive pregnancy result. Here, then, agency transcends the passive victim/active agent dichotomy, and rather becomes multidimensional, utilized by the women (and men) based on their desired involvement in the fertility treatment journey, and their confidence in the doctor's/medical staff's abilities. Women's agency may, however, also be *constrained* by the power of this expert knowledge, particularly through the emotional stresses it entails. Thus, in this setting the power of the fertility expert is both constraining and enabling.

However, this still means women/couples lack certain information about the treatment process when they initiate fertility treatment, and raises the question of how informed couples are when they agree to treatment, a question that has been asked by other scholars, particularly studying the use of ARTs in the Global South (e.g. Bharadwaj 2001:217-238; Inhorn 2003b:63). As discussed in the last chapter, women in early-stage consultations did not present themselves as informed consumers, though some tried to gain further knowledge. Whether women strive to know more but suffer from the vicious cycle that misunderstanding creates (women/couples find it emotionally draining, and inevitably acquiesce to the fertility expert's knowledge), or they choose to distance themselves from treatment-related knowledge, the lack of information in general media/print form discussed in the last chapter as a barrier to accessing treatments is compounded in early treatment stages.

Despite this limited information, however, as Thompson (2005:191) has emphasized, and is reflected here, it is not so much that women comply with the doctor's control of this knowledge and the treatment process because he is a doctor, but they comply with the doctor to let him use his knowledge and expertise (in congruence with the range of resources couples and other actors introduce) in hopes of *producing* treatment success. This then is a *willing* compliance with the authority of the doctor with the intention to achieve conception; it is a (controlled) means to a desired end (Thompson 2005:178), or another example of constrained agency.



## Chapter 7

### Medicalizing the Subjective Body

Many social scientists have discussed how the medicalized process of assisted conception objectifies the body through the surveillance of the reproductive system, a process that is said to reduce the woman to fragmented parts as her body is controlled and manipulated by the fertility expert (e.g. Gupta and Richters 2008; Perrotta 2008; Sharp 2000). When taking a more neutral approach towards assisted conception and the bodily interventions it entails, however, we can see how agency is also present within these processes of fragmentation and manipulation.

Thompson (2005:178) claims that “infertility clinics are... instructive places to look for the possible coexistence of objectification, agency, and subjectivity.” Here, she describes agency as a woman’s ability to “change” or alter her conception of self to *actively* participate in the objectification of her body during certain moments, and reject it during others (2005:181; Cussins 1998:168-169). In saying this, Thompson argues that objectification is not always reductive and “in opposition to the presence or goals of the subject” [i.e. a take-home-baby], but that “patients can manifest agency (and so enact their subjectivity) through their objectification” (2005:179).

In this chapter, I seek to extend Thompson’s analysis of objectification and fragmentation processes in fertility treatments by exploring women’s subjective experiences of fertility diagnosis, hormone stimulation, follicular monitoring, and egg retrieval, and the various forms of constraints and agency entailed in these. Women can only actively participate in certain stages of these processes. Thus, it may be better to think of their agentic participation as *willing* rather than *active* during these stages of inactivity, (again) refuting the dichotomy of active agent/passive victim. I argue that women’s willingness to participate in these processes did not reduce their ability to oppose the objectification and fragmentation of their bodies by the “medical gaze,” a gaze

that varied greatly throughout the treatment process. Although at times, medical practice can fragment our bodies through bodily imaging, probing, and chemistry, reducing us to infinite parts (Gupta and Richters 2008:240) while removing our subjectivity and dividing us into body-objects and body-subjects (Mol and Law 2004), not all people allow their bodies to be reduced to body-objects, at least not in their subjective experience of medical processes.

In this chapter, then, I demonstrate that the medicalization of conception *may* fragment the body into both functional and dysfunctional parts, but generally does so only from the medical perspective, which is imbued with the Cartesian duality of mind/body – a duality, which I demonstrate oversimplifies the doctor’s engagement with women. Not only did women consciously reject this medicalized fragmentation and mind/body separation, instead adopting a holistic, subjective perception of self that reflects a type of embodied agency, but doctors, too, *engaged with* the body-subject (as opposed to strictly “gazing” at the body-object).

### From the Whole Body to the Fragmented Body and Back Again

As discussed in chapter 2, Cartesian dualism (a central principle in modern biomedical practice) separates the rational, thinking self (mind), from the emotional, material body. Grosz (1994:7) contends that the “unbridgeable gulf between mind and matter” created by this, entails reductionism:

To reduce either the mind to the body or the body to the mind is to leave their interaction unexplained, explained away, impossible. Reductionism denies any interaction between mind and body, for it focuses on the actions of either one of the binary terms at the expense of the other.

It is from this reductive separation that other dualities emerge: rational/irrational, nature/culture, object/subject, male/female, and so forth. Through these further separations, a hierarchical system has developed, producing a systematic logic and practice of domination (Haraway 1991:177), such as with male authority over women, and the domination of objective

reasoning over subjective knowing. These two dichotomies have been reproduced or utilized particularly by the biomedical system.

The objectification of the body, through the “clinical gaze” (Foucault 1973) has transformed the physical body into a “body-we-have” (Mol and Law 2004:46), turning the body into a possession of the self, again separating it from the subject-self. It is this “body-we-have” that is surveyed and manipulated by the “medical gaze” (Lyon and Barbalet 1994:53). Through the objectification and regulation of medical practice, this body has been further divided into faulty and replaceable parts, like a machine whose malfunctioning parts can be easily eliminated, fixed, or bypassed (Greil 2002:102). The individual is thus not only split into the mind and the body (which separates *experience* from the body), but is fractured into functional parts, which ultimately enhances the separation of the mind and body, creating multiple bodies/body parts.<sup>24</sup>

This abstractionism, however, can be overcome through reconstituting the body as an experiencing and sensational being (Csordas 1994b). Through a phenomenological exploration of perceptions and practice, Merleau-Ponty (1962) and Csordas (1994b:282) contend that embodiment precedes objectification and is our situated being-in-the-world, and that in this recognition, the conventional distinction between subject and object is collapsed. In other words, through an embodied interpretation of lived experience, we can acknowledge the interwoven experience of the body, self, and personhood, or place “bodily sensations back into the body” (Low 1994:140).

This phenomenological perspective understands the body as our “fundamental corporeal anchor in the world” (Waskul and Vannini 2006:9). We experience ourselves and practically engage with the world through *interpretations of meanings*, which we live through our bodies. The phenomenological tradition is grounded in the works of Merleau-Ponty for whom our being and consciousness (indeed all human perception) is situated in

---

<sup>24</sup> See pages 44-47 in the literature review for a more detailed discussion of the objectification and fragmentation of the body.

the body: “we cannot perceive anything and our senses cannot function independently of our bodies” (Nettleton and Watson 1998:9).

Unlike Merleau-Ponty’s view that we are always conscious of our body, other phenomenologists, such as Leder (1990), have argued that the body has become absent in the modern world, only manifesting during times of strife and/or pain. I take up the middle-ground between these two positions, adopting a phenomenological position where the body may not always be present, as Merleau-Ponty argues, but is also present other than times of pain. In any case, it is clear that recognizing embodied representations of the world as grounded in “meaning and human understanding,” requires exploring accounts of *lived experience* as they are constructed through socio-cultural beliefs and practices (Good 1994:53). This, in turn, requires repositioning “the body as a site of knowledge/experience and of intention/action,” *shaped* by, but not *determined* by, social structures (Howson and Inglis 2001:302). Analyzing lived experience demonstrates how the body is not docile and weak, but rather pragmatic and agentic (Nettleton and Watson 1998:11). Through exploring the relationships between embodiment, power, and knowledge, as emphasized by Price and Shildrick (1999:218), we reveal a female body that (may) move “against the grain of custom and expectation.” The lived body is, therefore, an agentic, malleable body, a body able to resist social constructs that try to bind it. As Minh-ha (1999:258) proposes, “we don’t have bodies but rather we are bodies;” the body is not something separate from us, but is us, emphasizing a whole, not separate self.

As Jenkins (2014) notes, the completeness or fragmentedness of the body relates directly to the notion or action of *reflexivity*, something which has been central to debates surrounding the “dramaturgical,” or “performative” body. This is grounded in Goffman’s analysis of the presentation of self. Goffman based his analysis of the body in an “understanding of sentient and embodied social praxes” (Crossley 1995:134). Here, the body is embedded in social practice, where it, and its experiences, are *produced* both individually and socially through *interactional* contexts. In the dramaturgical tradition, people are not interpreted as “having” bodies, rather people “do” their bodies through

action, or what has been labeled “performativity.” As Waskul and Vaninni (2006:7) explain, “if the body is something that people do then it is in the doings of people – not their flesh – that the body is embodied; an active process by which the body is literally real(ized) and made meaningful.”

Building on this performative tradition, Mol and Law (2004) propose we have three interconnected bodies: the bodies we *have*, the bodies we *are*, and the bodies we *do*. The “body-we-have” is the “body-object” that is poked, prodded, and explored for illness during a medical examination. The “body-we-are” is our lived body, the “body-subject” that we experience day in and day out. The “body-we-do” is our enacted body, our practicing body. The “body-we-do” is neither whole nor fragmented; it is both and neither at the same time. While there are boundaries around this “body-we-do,” it is also semi-permeable. It is, ultimately, a “complex configuration” (57).

I find Mol and Law’s conceptualization of these three bodies particularly useful to my analysis of embodied experiences of fertility treatment. More specifically, I propose placing a stronger emphasis on the phenomenological “body-we-are,” and how this is constituted through the “body-we-do,” and at times the “body-we-have,” in order to better understand the lived experience of fertility treatment. The women in this study were often unable to physically act during most treatment processes. Thus we cannot consider only what the body does, but also what it feels, how it reflexively embodies these sensations.

As these various perspectives make explicit, our embodied experiences are heterogeneous. Treatment stages were not experienced in a singular manner; rather, the experience was multiple. As I explained in the last chapter, the fertility treatment process is complex and involves numerous stages that construct different understandings of one’s body at different moments, depending on what the body is experiencing. The multiplicity of these embodied processes and meanings need to be analyzed through multiple lenses, which I attempt to do with the cases that follow. These, I argue, challenge the mind/body separation, as women consciously experience treatment as subjective body-selves.



## Embodying the Medical Realm

The ART procedures performed at Fertisuperior and Medivida can be separated into three different realms: medical, laboratory, and home. This chapter is concerned with the first three stages of treatment in the medical realm. This realm is where most of the treatment takes place – diagnosis, ovarian stimulation, and aspiration. The last two stages of the medical realm, the embryo transfer and pregnancy test, will be discussed in chapters 8 and 9 respectively. The second realm, the laboratory, involves the fertilization process that takes place between the aspiration and embryo transfer (see chapter 8). The final realm, the home, entails the woman's returning home for a 10 to 14 day period before the first pregnancy test (see chapter 9).

Various technologies incorporated into the treatment stages in the medical realm are controlled by the doctor, and allow for the surveillance and manipulation of the woman's body. As will become evident in the following examples, the fertility expert, with the use of these technologies, is the active participant during most of the processes in the medical realm; he is the one performing (or "doing") the ultrasound, aspiration, and ET on the body. Hormone stimulation is the exception. Here, the women themselves (or the nurse) administer the injections. The doctor's active role did not prevent the women from willingly participating in the process. The presence of their bodies, and their lived experiences of the treatment stages, made the *women*, even when inactive, part of the treatment practice. Fertility treatment is a highly physical and emotional experience; this augmented the women's consciousness of their bodies and bodily sensations.

The different treatment stages account for diverse types and levels of severity of bodily objectification by the doctor and the technologies involved. During transvaginal ultrasound examinations the doctor is active primarily through the "clinical gaze" facilitated by ultrasound (Mol and Law 2004:51). His gaze (through the technology) is what objectifies and fragments the body. While performing the aspiration and the embryo transfer, however, the doctor is both active through his gaze (again facilitated by ultrasound) and bodily movement

as his physical manipulation and fragmentation of the body augment the intensity of objectification. Furthermore, using anesthesia during the aspiration enables the doctor to forego acknowledging and interacting with the body-subject. Despite the objectification and fragmentation of the body through these medical processes, the women's lived experiences of treatment were embodied as integrated body-objects and body-subjects. They experienced not only pain and discomfort, but also anxiety and fear, sensations that affected the women, their selves, in their entirety.

### *Incongruence of Recognition and Focus: The Doctors' Perspective*

Before analyzing the various embodied experiences of the women in the medical realm, I want to explore briefly the doctors' "focus." Following the biomedical tradition, the fertility experts I observed and interviewed were most concerned with the functioning of the female body. I specify female body because, as these doctors told me, the functioning of the female reproductive system is more complex than that of the male reproductive system in regards to fertility. They were very conscious of the psychological and social effects that undergoing fertility treatment can have on an individual; but they were less conscious or concerned with the physical side-effects of treatment, and psychological and social factors that could manifest as bodily sensations. Thus, these doctors reproduced the Cartesian dualism so engrained in medical practice.

While discussing fertility treatment, Dr. Herrera explained, "The treatment process is not physically as invasive as an operation, for instance, but emotionally and socially it is more invasive" (interview 23 Nov. 2012). In this narrative, Dr. Herrera alludes to the mind/body dualism, as she separates *her* perspective of the physically non-invasive quality of ARTs, from the technologies' emotionally and socially invasive character. In this instance the physical body is not an experiencing body, as it does not experience the psychological stress of treatment, (it is a "body-we-have," not a "body-we-are").

Continuing her narrative Dr. Herrera also acknowledged each couple's doubts, concerns, questions, and emotions about infertility and treatment, and that the couple's role in the processes are unique. She stated, "The possibilities are endless." Dr. Herrera recognized the multiplicity of treatment experiences, not in an embodied sense, but psychologically or emotionally. Despite her focus on women's bodily processes, Dr. Herrera was more conscious of the psychological implications of treatment.

Luz's narrative also depicts her recognition of the taxing character of the treatment process. She explained, "For the *pacientes* the process is expensive, it is psychologically tiring, it is stressful, it is the only thing they can think about" (interview 9 July, 2013). Luz acknowledged how overwhelming the fertility treatment journey is, but this is a psychological, emotional, and even financial overwhelming sensation(s), not necessarily an overwhelming *bodily* sensation. Like Dr. Herrera, Luz elaborated on the psychologically and socially distressing aspects of treatment, not on the body.

As these narratives suggest, medical staff recognized the significance and multiplicity of treatment experiences in regards to emotional and psychological anguish. Yet the bodily sensations of ARTs often went unmentioned, and thus overlooked. When considering physical implications, the emphasis was on potential pain, which is seen as minimal (complications notwithstanding). For the staff, the bodily experience of ARTs is not multiple; there is little room for variation. Moreover, how the doctor objectifies and manipulates the body is not multiple. Rather, practice is standardized, creating a singular bodily experience of ARTs, one which is less significant to the medical staff than that of the emotional/psychological sensations of treatment. As I discuss further below, the medical staff appeared to characterize the women's bodies as both split and whole during the treatment process – acknowledging their bodily and cognitive presence as they interacted in the processes, but at the same time overlooking the bodily sensations of treatment.

## *Diagnosis*

Ultrasound, specifically the transvaginal ultrasound, is integral to fertility treatment. It is the technology that the women first confronted when they started the fertility treatment journey, and the last one they utilized when leaving (or foregoing) fertility treatment. Ultrasound technology is used during every stage of the medical realm, permitting the fertility expert to gaze inside the woman's body during diagnosis and surveillance of ovarian follicle development. It is used to locate these follicles during extraction, to guide the embryos to their ideal location during the transfer, and finally (hopefully) to detect a developing embryo weeks later. Gupta and Richters (2008:240) explain how the "medical gaze" penetrates the body in three ways – through x-ray and ultrasound, steel instruments, and chemistry – reducing the body to parts that "can be tested and fixed" (Thompson 2005:197). The transvaginal ultrasound entails two forms of penetration, as it involves the penetration of an object through the woman's vaginal canal as well as the generation of images of the inside of her body. As I show below the fragmentation and objectification of the woman's body, however, did not reduce her subjective wholeness, which remained intact through the doctor's engagement with her and her embodied experience of the procedure.

### Fragmented but Whole Bodies

Even if the women had already been diagnosed with a particular fertility complication before arriving at Medivida or Fertisuperior, further diagnostic examinations were carried out. The first examinations included a transvaginal ultrasound and hormone level tests. As Dr. Romero explained, "First they usually observe the uterus and ovaries [using the transvaginal ultrasound] to check for any malformations or mechanical problems affecting conception" (information conversation 25 Jan. 2013).<sup>25</sup> Dr. Romero's narrative depicts the

---

<sup>25</sup> Dr. Romero is an anesthesiologist who occasionally participates in surgical procedures at Fertisuperior, and a financial investor in the clinic.

technologies ability to allow the doctor to gaze inside the woman's body-object and diagnose whether or not she has an anatomical complication. The following observation of a diagnostic transvaginal ultrasound demonstrates how Dr. Mabel used the technology to objectify particular parts of Martha's reproductive system:

Dr. Mabel told Martha to change in the bathroom, motioning in the direction of the examination room. He followed her and sat down at the ultrasound machine computer. He created a file using her *cedula* (national ID number) where he could save the examination results. A moment later Martha returned and sat in a reclining position on the examination chair, sliding into the crevasse of the chair where she appeared comfortable. Dr. Mabel instructed her to slide her buttocks to the end of the chair and place her feet in the stirrups. She did as he instructed while he prepared the ultrasound wand. First he applied gel to the long phallic shaped object. Then he covered it with a condom and applied more gel to the outside of the condom.

Seeing that Martha was sitting as he instructed, he easily slid the wand into her vagina placing the end near her cervix. A 3D image of her uterus appeared on the monitor in front of him and the flat screen television on the wall in front of Martha. Dr. Mabel took a moment to gaze at the uterus. Using various applications on the machine, he measured her uterus and saved the images for later analysis. Not finding any blatant abnormalities, he moved the wand slightly to observe her ovaries.

The right one showed three black dots [follicles which likely contain eggs]. He explained to Martha and her husband who entered the room a moment earlier, "If we do not see the black dots in the ovaries, then it shows that the ovaries are too old and have stopped producing eggs." The husband commented, "Then this is a good sign." Dr. Mabel nodded in response.

Dr. Mabel moved the wand to the left ovary, which depicted only one large black dot covering the whole space of the ovary. Martha asked if it means the follicle has left the ovary. Looking more intensely at the screen, Dr. Mabel said he believes so.

He then removed the wand and told Martha to change. While she was in the bathroom, Dr. Mabel revised the images he had saved and looked at the information the computer had generated from the photos. He said, not really speaking to anyone, "Everything is good." (Observation 20 June, 2013)

By using ultrasound, Dr. Mabel could isolate images of Martha's uterus and ovaries on the screen, where he then analyzed the quality of these parts of her

reproductive system. The images he took of her uterus and ovaries were separated from Martha as a whole, as they appeared as isolated entities. The way he spoke about these body parts further separated them from her, and gave them qualities of their own. He referred to her ovaries as not being “too old” as they were still producing eggs, without reference to Martha or her biological age, again detaching these organs from her.

Despite these processes of reduction/fragmentation, however, Dr. Mabel still interacted with Martha during the procedure. He recognized Martha’s presence by discussing his observations with her (and her husband), and engaged with her knowledge of the images being studied. This interaction prevented Martha from being fully reduced to fragmented objects that merely needed to be observed through an ultrasound image. Dr. Mabel was not only exploring and probing Martha’s body-object (“body-we-have”), he was also acknowledging her subjective-knowing-being (“body-we-are”), making Martha both fragmented and whole at the same time.

The doctors often use the ultrasound’s sophistication to foster further engagement with the women during transvaginal examinations:

During an examination of Fatima’s uterus, Dr. Diaz discovered an abnormality. He zoomed in and then used the computer mouse to draw a circle around a white looking object, allowing the object to become clearly visible to the untrained eyes of Fatima and myself. Turning to Fatima, he explained, “The object is a myoma, which needs to be removed before you can start ovarian stimulation.” The screen on the wall in front of the examination chair allowed Fatima to see the highlighted image clearly. At a click of the mouse, the myoma was displayed from another angle. Dr. Diaz explained that he was assessing the size of the myoma and determining how difficult it would be to remove. (Observation 25 May, 2013)

The ultrasound allowed Dr. Diaz to explain the abnormality he discovered in Fatima’s uterus more effectively, as she could also view the myoma on the screen in front of her. Dr. Diaz highlighted the myoma not for his own benefit, as he was aware of the appearance of a myoma, but for Fatima and myself so that we could more easily observe the growth inside Fatima’s uterus, a uterus that

*appeared* far away and detached from Fatima on the screen in front of us. Despite the detached appearance of Fatima's organs, Dr. Diaz was engaging with her, trying to make her understand through a visual representation what needed to be removed. Dr. Diaz was engaging with Fatima's body-object through the ultrasound, while simultaneously striving to engage with her body-subject, through the use of the same technology.

Foucault (1973) explains how the living object-body was produced through the use of medical technologies that allowed doctors to see inside their living patients' bodies (whereas previously this was possible only with corpses). In the case of ARTs, the ultrasound is the doctor's guide to women's internal bodies, creating the "public body object" that is viewed (from the inside) by both the doctor and the woman (Mol and Law 2004:43). As these observations demonstrate, however, from the doctor's perspective the women were not always merely bodies, separated from the woman as a whole. At times these women were still whole, even when attention was focused on the "body-object" instead of the body in its entirety. The doctors did not merely objectify or concentrate on specific parts of the body – reproductive organs. Rather, they acknowledged the reproductive system's connection to the rest of the body, and the woman's "life" in general (i.e. smoking habits, stress levels, body weight, etc.). Thus, for the doctor, the women were both body-objects and body-subjects during these examinations. The doctors may have viewed the women as "bodies" separate from their "selves" at particular moments, reinforcing the body/self dualism, but they were not reducing the women to only their bodies.

### Refusing Fragmentation through Embodiment

The women, who also saw their bodies from the inside through the ultrasound image, were not separated or divided from the body-subject (the "body-we-are" and the "body-we-do") through this embodied experience. Most of the women that I interviewed discussed the transvaginal ultrasound as a strange, new experience. Adriana elaborating on the strangeness of the examination stated:

The experience of the ultrasound was very odd and a bit disturbing. It was strange having something inside me, while someone [referring to the doctor] described to me the health of my body parts – my uterus, fallopian tubes, ovaries – while pointing them out on the screen. (Interview 28 Feb. 2013)

The way Adriana described the experience as “disturbing” might express her difficulty viewing these organs as detached from her. Adriana’s narrative does not depict a body that appears fragmented through the ultrasound experience; rather, she appeared to resist the fragmentation of her body, labeling it as “strange” for the doctor to speak of her organs in this independent, fragmenting manner.

Selina’s experience of the examination was very different from that of Adriana. She found the examination very informative, with the wand inside of her and the doctor explaining the anatomy of her reproductive organs and the physiological complications she has. She was intrigued by the depiction of her organs on the screen in front of her, and mentioned being curious about the “functioning of her body” (interview 17 April, 2013). This may suggest that she embraced the ability of the ultrasound to fragment her body into various organs, which were then displayed on the screen and examined individually by the doctor. However, she mentioned being interested in the “functioning of her body,” not the functioning of these individual organs. Even though Selina was fascinated by the experience of seeing her body as fragmented, she still interpreted her body as a *whole* entity. Furthermore, she connected the sensation of having the wand inside her body with learning about her body, viewing the technology as connecting her cognitive and physical sensations.

Many women found it difficult to find the words to explain the ultrasound experience beyond being odd or strange, a difficulty scholars have acknowledged in studies of embodiment (e.g. Csordas 1994a:11; Benjamin and Ha’elyon 2002:670). My observation of women’s behavior during these examinations is, however, suggestive. Women’s facial expressions were often contorted or scrunched, a possible sign of confusion or curiosity about what was depicted on the screen, or an expression of pain (see below). Potential confusion



is consistent with the women's narratives that explain the examination being an odd experience that allowed them to see their bodies from an angle they had not experienced before, which contributed to some women's curiosity. Some women asked the doctor questions during the examination, engaging with him to understand what they were seeing and experiencing better. As Waskul and Vannini (2006:7) explain, "in communicative action the body comes to be." Through the women's engagement with the doctors they made themselves present and active in the process. However, as Selina's narrative demonstrates, being curious about one's individual organs does not preclude embodying the sensation in one's entirety.

Only one woman said the transvaginal ultrasound was painful or uncomfortable, a sensation that was visible on her face during the examination. Unlike wellness, which Leder (1990) claims allows our bodily awareness to disappear and intensifies the absence of the body, pain brings a heightened awareness of the body, further reducing the significance of the mind/body dualism. Following a transvaginal ultrasound exam, Adriana complained about the pain she experienced from the wand, and how it made her feel uncomfortable when it was inside of her, a discomfort she was still experiencing during our conversation even though the procedure had finished approximately thirty minutes before (informal conversation 29 June, 2013). Adriana's narrative suggests that an embodied experience does not dissipate at the end of a physical experience, but may be internalized and continue its affects on the person's life. This continuous sensation, or embodiment, is even more significant in the women's experiences of hormone injections.

### *Ovarian Stimulation*

After a fertility problem(s) had been diagnosed (or had not, in the case of unexplained infertility) and a treatment regimen established, women began ovarian stimulation through hormone injections. The hormones stimulate the ovaries to produce multiple ova, instead of the usual single egg per month. The

eggs are later removed from the woman's body through a surgical procedure and then fertilized in the laboratory. There are various drug regimens for ovarian stimulation depending on the woman's natural hormone levels, her age, fertility complication, and previous treatment cycles. The hormones have to be injected in various amounts throughout the treatment cycle, at a particular time of day, and hormones are added and/or discontinued as the treatment progresses, making for a very complex drug regimen that women generally administered themselves.

As mentioned above, unlike other treatment stages in the medical realm, the doctor did not directly control the administration of hormones. Once the doctor wrote the prescription (or informed the nurses through sticky notes, as the hormones were distributed by the clinics), ovarian stimulation became an interaction between the woman and the nurse(s), and the woman and her body. Following Mol and Law (2004), hormone injections were "done" to the body by the woman (and sometimes a nurse). The doctor re-entered the scene to monitor the development of follicles through further use of the transvaginal ultrasound. The women's embodied experiences of administering and being a body "saturated" with hormones, to use Samara's description (interview 11 March, 2013), varied, but generally included fear, pain, and discomfort.

## Fear

Hormone injections are designed to be self-administered, thus, the women took control and managed, or "did," this part of their treatment journey on their own. In other words, they became, at least partly, "bodied-we-do." Most women undergoing their first cycle, however, lacked medical knowledge and experience in administering such medications, and tended to worry about injecting themselves, fearing that doing so incorrectly could jeopardize the treatment cycle and eliminate the cycle's potential to produce a child. Thus, similar to Leder's (1990) view that pain reiterates the mind/body connection, *fear* can be seen as an embodied state that often makes us hyperaware of our bodies.

Women's expressions often showed signs of concern while receiving instructions from the nurses about how to inject the hormones, a clinical practice that followed the prescription of a new injection:

A woman walked out of a consultation with Dr. Herrera, sat at the reception desk, and handed Nurse Paulina a prescription form. Paulina read it quickly and then explained to the woman that she could take home the Lupron<sup>®</sup> [hormone] but she should inform the clinic when she starts injecting it after she has started her menstrual cycle. Paulina then went to fetch the medication from the back room. Upon returning she explained how to administer the injection. She demonstrated how to read the syringe and verify the dosage, and showed the woman where on the abdomen to apply the syringe and how to clean the area. Paulina noticed the woman was displaying signs of anxiety, so she explained a second time, this time referring to the instruction guide and its photos. The woman laughed nervously as she took the medication and syringes and said she is scared. Paulina told her not to worry and to call with any questions. (Observation 31 May, 2013)

This woman both verbally expressed her concern, and did so through her facial features, but she was still encouraged to administer the injections on her own, reiterating the necessary responsibility the women must take during this stage of the treatment journey. The pressure of this responsibility was often embodied as further concern or anxiety, as women feared the consequences of administering the injections incorrectly.<sup>26</sup> The lived experience of hormone injections was embodied as heightened anxiety and fear of treatment failure.

The anxiety and fear caused some women to try to arrange a daily clinic visit to receive the injections from a nurse. During a conversation in the waiting room at Fertisuperior, Reanna explained she would be at the clinic every morning at 10am for the next ten days or so to receive the injections. "I have to be *muy juiciosa* [very diligent], because, God willing, the treatment will work this time" (informal conversation 7 March, 2013). Reanna was not necessarily choosing to come to the clinic for the injections because she was scared of administering them herself, but because she worried that doing so incorrectly

---

<sup>26</sup> See Inhorn (2003b:200) for a discussion of self-blame regarding poor ovarian response following hormone injections.

would result in another failed treatment.<sup>27</sup> After numerous surgeries, two failed AIs and one failed IVF cycle (previous procedures in which she injected the hormones on her own), she intended to do everything possible for that cycle to be successful. Reanna had embodied a sense of security by allowing someone else, a trained nurse, to administer the injections for her. She willingly traded her active “body-we-do” status for a passive “body-we-have” one in order to appease her “body-we-are” (i.e. the subjective, experiencing, *whole* body).

Most women could not attend the clinic daily to receive injections, but this did not prevent them from embodying the fear and anxiety that accompanied hormone stimulation. The anxiety attached to incorrectly administering injections caused women to telephone the nurses to verify the dosage, where and when to apply the injection, and for how many days. Other women visited pharmacies to have the injections administered “properly.” Although women could manage this part of the treatment process on their own, their lack of experience in and confidence about administering injections, and their fear that doing so incorrectly would decrease the likelihood of treatment success, caused some to reject this position of control. In these moments of worry and fear, some women embraced the medicalization of their bodies through embracing the expertise of a trained medical professional. By allowing nurses to “do” hormone stimulation women evaded (at least partly) the anxiety and fear that would have accompanied their active participation in the treatment process. Embracing the medical professional’s expertise, however, did not reduce the women’s consciousness of their embodied state. Rather their state of emotional embodiment was transformed from fear and anxiety to relief. Here, avoiding, or reducing, these negative embodied sensations did not diminish the consciousness of the body, as Leder (1990) suggests. Instead, consciousness was transformed into another embodied experience.

---

<sup>27</sup> Failing to inject the accurate hormone dosage or doing so at the wrong time may interfere with the development of the egg containing follicles, reducing the likelihood of treatment success; it may also result in ovarian hyperstimulation syndrome (see appendix 2).

## Pain

When I asked women about their experience with the hormone injections, their first reaction was generally a facial expression of disgust or rolling their eyes. Nearly all the women complained about the injections and mentioned the physical pain the injections caused them. Larissa, recalling all the injections she had experienced, explained she had 18 injections in her abdomen and countless more in her buttocks. Larissa's painful embodied experience of the injections must have been expressed verbally to her husband, as he snickered at her remark, and then commented, she complained a lot about the injections, but they did appear to hurt (interview 25 May, 2013). Julia foresaw the pain she would experience when Alexa (the administrator at Fertisuperior) confirmed she would have to administer ten hormone injections in the buttocks over the next few days. Julia commented, "I will be without buttocks," (i.e. she would be unable to sit down due to the pain) (informal conversation 14 May, 2013). Larissa and Julia's narratives concerning hormone injections depict more than localized physical pain; rather, they show that this pain was embodied as complaints and irritation, or an inability to perform a common task such as sitting. The physical pain emanated from a particular part of their bodies to affect other aspects of their lives.

This physical pain also manifested as heightened awareness of one's body. Women came to differentiate between different severities of pain depending on the specific hormone being used and where on the body it had to be injected, in the buttocks or the abdomen. Iris specifically mentioned the severe pain of the ones in her buttocks and the difficulty she was having sitting, while the ones in her abdomen were painful but did not affect other parts of her life (interview 22 Jan. 2013). Nicola differentiated between the hormone type and the applicator. During our interview, Luz entered to administer two injections in Nicola's abdomen. Afterwards, Nicola commented that these ones hurt, the ones that have a lot of liquid and have to be administered slowly, while the ones that click and are quickly injected are not as painful (interview 12 April, 2013).

Benjamin and Ha'elyon (2002) claim pain becomes a part of IVF, part of what a woman is willing to endure for the possibility of having a child. Iris' narrative reflects this embodied notion of endurance:

"I was not able to sit for two days because of the injections, but I did it with love." She added, particularly because "we see a child in our future, concentrating on our end goal, the end success, helps us get through this." (Interview 22 Jan. 2013)

The discomfort Iris had experienced with the injections was transformed into perseverance fueled by her (and her husband's) desire for a child. This suggests hormone injections are not only embodied as anxiety, concern, and pain, but also motivation to *endure* these and persist with treatment.

### Discomforts

In addition to pain, women discussed physical and mental discomfort, as well as lifestyle disruptions. Physical discomfort differs from pain because it is related to the hormones' effects on the body rather than to the actual injection. Women described their bodies as "full" or "saturated" with hormones. The women equated this to prolonged or augmented premenstrual syndromes, or what women called *colico*. *Colico* manifests as body aches, abdominal cramping, and the inability to eat or sleep. I often saw women sitting in the waiting area, rubbing their stomachs, not in a caressing fashion as for instance, pregnant women do, but rather out of discomfort. The nurses' greetings to arriving *pacientes* often included asking how the woman was handling *colico* that day. In addition to these physical symptoms, women often experienced added anxiety, depression, or augmented emotional sensations overall.

Adriana, for instance, claimed her body being full of hormones was causing her to "go crazy." She wanted to cry about everything and fight with everyone. She gave the example of being at a funeral for a friend's mother and crying as though it was her own mother's death she was mourning (informal conversation 27 June, 2013). Adriana was connecting her body's physical

saturation with hormones with her inability to control her emotions. Her embodied experience manifested as emotional distress connecting her physical and mental being.

Other types of discomfort entailed lifestyle disruptions, as the women struggled to administer the numerous injections on a strict daily schedule. Most of the hormones require refrigeration, which limited where the women could physically be when injections had to be administered. Furthermore, hormones must be administered in accordance with regular, or natural, bodily functions. If the woman's menstrual cycle started a day earlier or later than anticipated, she had to alter when injections were started, which made it difficult for women to manage their schedules and plan for treatment initiation. The physical and mental discomforts also contributed to life's disruptions, as the women had to manage these discomforts in tandem with their daily lives.

#### *Follicular Surveillance*

Hormone injections can be administered anywhere. Surveillance of follicular development, however, cannot. Particularly during an initial cycle, a woman's body must be regularly monitored to determine her reaction to the hormones and the progress of follicular development. Surveillance is performed through the transvaginal ultrasound, similar to that performed during diagnosis but with increased attention to the ovaries. The rate of follicular development determines the number of ultrasounds necessary; some women require only a couple, while others may be subjected to monitoring every or every other day, increasing the disruption the women experience to their lives.

The number of ultrasounds required during high-tech fertility treatment diminished women's perception of the procedure as intriguing or mysterious, as it may have appeared during the initial diagnosis. The process became normalized. Women became accustomed to the ultrasound, and with time often appeared to go routinely through the process of undressing, donning the robe, placing their feet in the stirrups, permitting the doctor to objectify their

individual reproductive organs, and finally re-dressing and leaving. Even when the procedure became routine for some women, however, their bodily experiences were still connected, if only vaguely, to notions of treatment success or failure that accompany follicular monitoring, retaining the conscious experience of the body. The women still attached meaning to the transvaginal ultrasound examinations, as they mark the barrier between hormone stimulation and moving onto the next stage, the aspiration. Furthermore, for women questioning the quality of their eggs, the ultrasound was entwined with their ability to use their own gametes, or their need for donor materials. Given the significance of the ultrasound, and the bodily meanings and projections of possible treatment outcomes in which it is enmeshed, women remained conscious of their bodies as they underwent repeated surveillance.

The surveillance of follicular development reveals the number of follicles being produced by the hormones and when they are mature enough to be removed for fertilization. Following a surveillance ultrasound, the women would be instructed to continue with hormone injections or change to a new hormone, depending on the development of the follicles. Either scenario entailed more injections – further fear, pain, discomfort, and possibly motivation – and potentially the anticipation (and often anxiety) that accompanied scheduling the aspiration.

### *Aspiration*

If women actively participated in the ovarian stimulation stage, the doctor completely controlled the aspiration, as women were anesthetized for the duration of the procedure.<sup>28</sup> However, the woman still participated both in the moments immediately preceding the administration of anesthesia (moments that were usually filled with anxiety and doubt), and directly following the aspiration, when discomfort and occasionally post-operative pain overwhelmed

---

<sup>28</sup> Unlike findings from other parts of the world where a local anesthetic may be used for the egg retrieval (e.g. Franklin 1997:117-118; Tjørnhøj-Thomsen 2005:86; Throsby 2002:37), the use of general anesthesia is common practice for egg retrievals in Bogota.



her body. Still, aspiration is the treatment stage where the body was most severely objectified by the medical staff. During the procedure the medical staff did not recognize the woman's subjective being; she was only an object to be moved, probed, manipulated – essentially objectified – by the fertility expert.

### Pivotal Procedures: Embodying Anxiety

When the follicles had grown to the desired size, the doctor scheduled the aspiration along with the appointment to collect the husband's sperm sample.<sup>29</sup>  
<sup>30</sup> The scheduling surprised some women, particularly women undergoing their first treatment, as they were unaware of the rate at which the follicles were developing, or because their bodies reacted more rapidly to the hormones towards the end of the stimulation process. This sometimes caused psychological distress.

During our first interview, Anita explained that the aspiration had been moved to the coming Saturday, despite Dr. Mabel originally telling her it would be on the Sunday or Monday, because the follicles developed quicker than he (or Anita) had expected. She claimed she was not psychologically prepared for the procedure even though Dr. Mabel insisted that her body was ready for the follicles to be removed (interview 21 Feb. 2013). Even though the doctor may have claimed her body was prepared for the aspiration, Anita did not feel psychologically prepared, which increased her anxiety and, according to her, made her body unprepared.

Anita's embodied experience of anxiety was expressed as unpreparedness. She believed that her anxiety during two previous AIs she had undergone prevented her from becoming pregnant. She believed her mental state (being anxious) had a physical consequence on her body (not becoming pregnant). Anita was equating anxiety not only with her mental state but also with her physical body, refuting the mind/body separation. As I discuss in the

---

<sup>29</sup> If a frozen sperm sample or sperm donor is being used than the sample is removed from the liquid nitrogen tank the morning of the aspiration.

<sup>30</sup> Men's experiences of providing the sperm sample are beyond the scope of this thesis. See Inhorn et al. (2009) for a review of this literature.

following chapters, anxiety experienced during other parts of the treatment journey, particularly during and following the ET, was also equated to the body's inability to conceive, a connection that increased women's anxiety.

Women also reported anxiety due to the realization of how the procedure is performed and its significance. As I discussed in chapter 6, the fertility experts generally explained the treatment process in further detail as the treatment progressed. Therefore, the scheduling of the aspiration often entailed a more detailed explanation of how the procedure would be performed and the significance of the procedure in the overall treatment process. Women became informed that the aspiration required anesthesia, alluding to the surgical (even though minor) nature of the procedure. They also came to realize that the follicles removed during the aspiration contained the eggs that would be fertilized, and recognized the "importance" of the *number* of eggs removed during the procedure.

A number of the women voiced concerns about the anesthesia, most having undergone a procedure that required anesthesia in the past. Mariana explained that, due to the numerous past surgeries she had undergone to remove uterine cysts, she feared being anaesthetized again. Of the whole procedure, she was most concerned about the aspiration and the pain she feared would follow it (interview 7 Feb. 2013). Gabriela was also concerned about the anesthesia, saying she would not have agreed to the treatment if she had known earlier that part of the process would include anesthesia. She explained that anesthesia not only makes her feel uncomfortable physically, but it makes her *desconcertado* (discombobulated) when she wakes up, a feeling she did not want to experience again (interview 21 June, 2013). Mariana and Gabriela had internalized, or embodied, their past (negative) experiences with anesthesia, which were relived as heightened anxiety about the aspiration.

Women were also anxious about the outcome of the aspiration. As the aspiration loomed closer women became increasingly concerned about the number of eggs they would produce. Although many women did not realize how complicated the fertilization process is (see chapter 8), they equated the number of eggs they produced with the number of embryos that would develop,

and therefore their likelihood of treatment success. For example, Lila explained that she was very nervous the night before the aspiration, worried that the doctor would be unable to remove enough follicles for a successful cycle (informal conversation 28 June, 2013). She related the number of eggs removed with the likelihood of treatment success.

During the ultrasound prior to the aspiration, women would ask the doctor about the number of follicles he saw, generally talking in terms of eggs and not follicles. As women had no established reference point, they often inquired about the average number of eggs women produce:

During Dr. Mabel's explanation of the aspiration and fertilization process, Maia interrupted asking how many eggs would be removed. Dr. Mabel explained the number varies but ten eggs is about normal for her age. However, sometimes there are more and sometimes less depending on how the woman reacts to the hormones. (Observation 23 July, 2013)

Not recognizing the complex nature of follicular stimulation and the variables involved, women undergoing their first treatment cycle anticipated that this question would generate a clear answer. Furthermore, even though follicles become visible as ovarian stimulation progresses, the number of follicles is not directly related to the number of eggs produced. Rather, as Dr. Mabel explained, the number of follicles visible through the ultrasound serves as "a rough guide" for the number of eggs that will be recovered (informal conversation 6 June, 2013).

Despite the uncertainty surrounding the number of eggs that will be produced and then removed for fertilization, women often placed great significance on the figures the doctors provided (no matter how ambiguous). They directly associated the merit of their bodies' egg production, and their chance of conception, with these numbers.

During a short conversation with Tania as she was lying in the recovery room after the aspiration, I asked if she knew how many eggs were removed. She responded by asking how many are normally removed. I explained, "It depends on the individual." She looked at me with sad eyes saying, "They removed very few, only six." She paused appearing to

be very disappointed with this number, and then commented that she was worried about conceiving with so few eggs. (Informal conversation 15 June, 2013)

Unlike Tania who was dissatisfied with the number of eggs she produced, and anxious about her chances of conception, Carmena was delighted with the large number of eggs she produced, despite the *colico* it caused her:

After the aspiration Carmena explained, “They removed 11 *ovocitos*” (little ova), which she felt was a lot, and an achievement, since she has only one ovary. She continued by saying she experienced a lot of *colico* before the procedure, which she now equated to the large number of eggs that were growing inside her. She explained that the *colico* was now subsiding as the eggs had been removed. (Informal conversation 23 April, 2013)

After the egg retrieval, the pain Carmena had experienced was transformed into part of the success of developing so many eggs, a bodily success that gave her further hope for a positive treatment outcome.

Unlike Carmena, many women experienced continued *colico* and other post-operative pain following the aspiration. The women often associated the pain with the procedure and the anesthesia that prevented them from participating in the egg retrieval, a process, as I describe below, that transferred the attention from the women to the ova she has produced.

### Objectifying the Unconscious Body

Aspirations take place in the operating rooms located at the back of the clinics. These rooms are separated from the rest of the clinic by large doors and are only accessible to medical personnel and the person undergoing the surgery who have donned the appropriate sterile medical scrubs or gown.<sup>31</sup> Women are informed to arrive at the clinic without makeup, creams, or perfumes on the day of the aspiration (and embryo transfer) to avoid contaminating the OR.

---

<sup>31</sup> Other gynecological outpatient procedures are performed in the ORs of both Fertisuperior and Medivida. Fertisuperior also performs male-fertility procedures such as testicular biopsies.

Removing the woman from the areas of the clinic she usually encounters, requiring her to don clothing other than her own, and prohibiting the use of daily cosmetic products mark the initiation of a process that alters the woman's subjectivity. Even before the surgical procedure begins, the clinic focuses on the woman's body-object, what she is wearing and applying to the body, rather than the woman as a whole.

Aspirations are performed under light general anesthesia administered through an IV drip inserted in the back of the woman's hand. As Dr. Mabel explained, anesthesia is used to prevent the *paciente* from moving during the procedure, reducing the chance of the doctor inserting the aspiration needle into the wrong place (informal conversation 6 June, 2013). Essentially anesthesia is used to prevent the woman from interfering with the procedure.

Once the woman is unconscious, monitoring devices are placed on her finger and chest by the anesthesiologist to observe her vital signs. Her body is positioned in the lithotomy position: her legs are placed in holders to the sides of the operating table and secured with Velcro straps; the bottom half of the table folds down to provide direct access to the woman's vaginal canal. Some women's bodies have to be repositioned forcefully, as she is under anesthesia, to obtain the "correct" position. The insentient body is moved like a heavy ragdoll, pulled and pushed from side to side until it is in the desired position. With the maneuvering of her body and the attachment of monitoring devices to her chest, the woman's entire body becomes exposed, but the exposure of the body as a whole is not important, only that of her reproductive organs.

Once the body is in place, the doctor, the primary actor in this procedure, sits on a stool between the woman's spread legs. He adjusts the stool and/or bed height to his liking. To his left, he finds a small stainless steel cart equipped with the necessary tools to perform the aspiration. First he cleans the vaginal canal inside and out using iodine, turning the woman's skin a dark yellow-brown color. As with the pushing and pulling of the woman's body, the doctor's thorough cleaning of the vagina would probably cause the woman pain if she was awake, but this was not a factor the doctors discussed when explaining why they used general anesthesia. Once the vagina has been cleaned to the doctor's

satisfaction, the iodine is rinsed with sterile water, washing away the yellow-brown stains that have settled on the woman's skin.

The doctor checks the follicles, which appear on the screen as large black circles surrounded by white or grey space, in the left and then the right ovaries. He then turns to the cart again to obtain the ultrasound wand with the aspiration needle attached to its top, which he inserts into the woman's vaginal canal. His focus is on the follicles and their removal from the body that contains them. As he does this, the surgical nurse prepares the tubes connected to the aspiration needle and the vials used to collect the aspirated liquid containing the eggs. The doctor ensures that the nurse is ready to collect the liquid and then, guided by the ultrasound image, jabs the needle through the upper uterine wall and into the left ovary. As Dr. Mabel explained during an aspiration I observed, the insertion of the needle into the ovary (which must be done with some force) has to be precise to avoid piercing the femoral artery on the other side. He further stated different techniques are performed at different clinics, but he prefers to puncture each ovary only once to prevent further damage and excess bleeding (informal conversation 6 June, 2013).

Once the needle is in place, light suction is applied. One by one the black circles (follicles) on the ultrasound machine are drawn into the needle and soon pinkish liquid starts to collect in the vial held by the nurse. As the vial begins to fill to the top, the nurse tells the doctor to slow and then stop. She removes the vial from the tube, caps it, and attaches another vial to the tube, taking great care not to miss a drop of potential egg containing liquid. Depending on the number of staff present, the vial is either rushed to the laboratory down the hall, or placed in the nurse's bra to keep the liquid warm until it can be taken to the laboratory.

Once in the laboratory, the vials are placed in the fume hood which has already been prepared to receive the eggs: the lights turned off (eggs and embryos are sensitive to light), microscope and hot plates turned on, petri dishes labeled and placed in the hood, the warm culture medium (the liquid solution in which eggs and embryos are placed to help them grow) placed in the hood, and the plates used to clean the eggs put in place. One by one the vials of

bodily fluid are placed in a petri dish, which has been heated to body temperature (37°C), and are examined under the microscope. Eggs, visible both through the microscope and with the naked eye, are pushed to one side of the petri dish in a scooping motion and then transferred by a pipet controlled through suction applied by the embryologist's mouth onto the plate that is used to clean the eggs.

As the embryologist works meticulously to separate and clean the eggs, the nurse brings in more vials of egg containing liquid. With each trip to the laboratory, the nurse asks for an updated number of eggs that have been retrieved. This information is then relayed to the eagerly awaiting doctor, who has by now removed the aspiration needle from the left ovary and transferred it to the right ovary where the process is repeated. The doctor is still working on removing the eggs from the insentient body lying in front of him, but his attention has shifted to the eggs, specifically the number of eggs that have been retrieved. These eggs will take precedence over the woman in the coming hours.

When all the follicles have been removed, the aspiration needle and the attached tubes are flushed with culture medium that are collected in the final vial to ensure any final eggs are collected. The doctor then inspects the vaginal canal and ovaries a final time before putting away the ultrasound wand. He then inserts a speculum into the woman's vagina to survey and clean the vaginal canal another time. Using needle-nose forceps and sterile cloth, he cleans the small amount of blood that is present. The anesthesiologist standing by the woman's head is told to turn off the anesthesia, while the nurse injects a pain medication into the IV. A moment later the woman begins to come too, at which moment the doctor says he is done and gets up to leave.

After the anesthesiologist removes the monitoring devices, the nurse covers the woman's body with the gown she had been wearing. The woman is then moved to a recovery bed and wheeled from the OR into the recovery room. She is wrapped in a blanket to keep warm and told to sleep awhile longer. Before returning to her slumber, however, she turns to the nurse and asks how many eggs were removed. Like the doctor, the woman's attention is on the eggs

recovered from her body, rather than, for instance, on any complications the minor surgery may have posed.

All three aspirations I observed at Fertisuperior happened in this manner without complication, and lasted approximately 10-15 minutes. Dr. Mabel explained that the above is an average procedure, and denied ever encountering a major complication in the more than 4,000 aspirations he has performed during his career (informal conversation 6 June, 2013). I was not allowed to observe aspirations at Medivida, but the process Dr. Herrera described paralleled that which I observed at Fertisuperior. Given Dr. Mabel's claim that techniques vary across clinics, I assume the procedure is performed at Medivida in slightly different ways, but the overall process is very much the same: through the procedure the woman's body becomes an object that must be invaded (through a natural orifice) to remove the precious eggs required for the next stage of the fertility treatment journey.

#### *Ambiguous Recovery*

From a medical perspective, the recovery process after aspiration is very quick. It is an outpatient procedure and women can go home usually an hour or two afterwards. The doctors encouraged women to continue with life as normal. For the time being, the doctor's concerns were with the eggs, their ability to be fertilized, and become "beautiful" embryos, and not with the women, who should have been able to recover from the aspiration on their own. For the women, however, their post-operative experience often entailed discomfort or pain, from the procedure and the numerous hormones they still needed to inject, and from anxiety about the quality and fertilizability of their eggs.

#### *Colico and Pain*

A man knocked on the glass door of the waiting area. When I opened it, Nurse Yvonne told him to sit down and wait a moment, gesturing to a chair; his wife would be out in a moment. A few minutes later his wife



emerged from the back of the clinic. Her face appeared drained of life. She wore a bandage on her hand where the IV drip had been inserted. She sat down by her husband to have tea and a packet of crackers he brought her. She shivered, and exclaimed, "I am cold." She rested her head on his shoulder as he wrapped his arms around her and her eyes closed. (Observation 14 April, 2013)

Following the aspiration, once the women have left the recovery room, they have to wait to speak to the doctor. Women were often shivering and holding their abdomen as they waited, frequently in the arms of their partner or an accompanying female relative (e.g. mother, sister, friend, etc.). In passing, the nurse commonly asked, "Are you still feeling cold? Has the *colico* improved?" Most of the women responded, "It has subsided." Given how women discussed the hours or days following the aspiration, however, these responses appear to have been mere niceties that did not represent their actual embodied experience.

Verbally paralleling the observation mentioned in the previous paragraph, while waiting to speak to the doctor, Anabel explained, "I feel ok, but I have pain in my abdomen," and she rubbed her belly as she said this (informal conversation 14 May, 2013). Pain was generally reported in the abdomen, instead of in the vaginal/uterine area where the procedure was performed. Most women referred to this pain as *colico*, appearing to adopt the nurses' vocabulary or connect it to menstrual pains they had previously experienced (either before or during the fertility treatment). The women related *colico* following the aspiration to what they were experiencing in their bodies more generally (as depicted in Carmena's narrative above about the large number of eggs growing inside her body), and not necessarily to the procedure that had just removed eggs from their ovaries. A procedure localized in the vaginal and lower abdominal area manifested as pain and discomfort in the body more broadly.

The women commonly referred to pain or discomfort related to the procedure as nausea, fatigue, or feelings of cold caused by the anesthesia – common post-operative symptoms. Chatting in the waiting room after the aspiration, Reanna exclaimed, "Thank God it all went well, but I am nauseous

from the anesthesia, so I am going to take it easy” (informal conversation 7 March, 2013). Tania explained she would take a cab the four blocks to her hotel (she had travelled from Barranquilla for the treatment) instead of walking because of the fatigue and nausea she was experiencing after the aspiration (informal conversation 15 June, 2013). Like many women, the fatigue and nausea Reanna and Tania experienced was embodied as a need to relax and allow themselves to recover after the procedure.

For some women, though, the side-effects from the aspiration were more severe and further disrupted their lives. For instance, Larissa explained she had a lot of pain the day after the egg retrieval, which prevented her from going to a lunch she had scheduled. Instead, she stayed in bed and did not want to move. The medications she was provided did not reduce the pain either. Her husband nodded his head verifying Larissa’s statement (informal conversation 25 May, 2013). As with the hormone injections, the post-operative pain Larissa experienced disrupted not only her physical body, but also other parts of her life – i.e. her social life.

### Focusing on the Eggs

Despite the discomfort and pain some women experienced following the aspiration, they needed to recover quickly to be ready for the embryos that would be transferred three or five days following the egg retrieval. As illustrated in the observation above, some women overlooked their own discomfort/pain (or possibly overcame it), by transferring their focus to the eggs that were removed from their bodies.

Following the aspiration, Elsa was being wheeled into the recovery area when she started to come to. I asked her how she was feeling. Appearing confused and still partly sedated she responded, “Fine,” and then instantly asked about the number of eggs that were collected. Dr. Mabel explained he had removed seven eggs. Her face fell at this, as she appeared disappointed with what she interpreted as a limited quantity with limited potential. Dr. Mabel tried to reassure Elsa by telling her it was a sufficient number. Before she could respond, the scrub nurse told

Elsa she should relax and sleep awhile longer, a request Elsa seemed pleased to accept as she shut her eyes and snuggled into the blanket. (Observation 6 June, 2013)

Even while Elsa was still drowsy and confused from the anesthesia, her attention was on the eggs that had been removed from her body and her concern that the seven eggs would not be sufficient to result in conception. Despite Elsa's concentration on the eggs, she was still conscious of her bodily state, revealed through her concern about the potential of the embryos to result in conception, a process involving her body as well as the embryos developed in the laboratory.

The egg retrieval marks a milestone in the fertility treatment journey. Some couples became (even more) hopeful that the treatment would be successful, as they then knew egg and sperm were available and would be fertilized into embryos – potential future children – in the laboratory. While couples waited to speak to the doctor after the aspiration, I often heard them talking about their future child(ren), calling them by names, one for a girl and one for a boy. This procedure, then, and the knowledge and technology that go into it, mark the point when couples really began to recognize what was happening as the (potential) creation of a child. Women's (or couples') concerns about the collected eggs were quickly transformed into concerns about the success of the fertilization process as a whole, the number of embryos produced, and the likelihood that these embryos would develop to a high enough quality to be transferred in three to five days' time and result in conception.

## Conclusion

In this chapter I have explored the highly medicalized processes of fertility diagnosis, hormone stimulation, follicular monitoring, and egg retrieval – processes in which doctors engaged in various degrees of bodily objectification as they gazed at the body-object, and in which women enacted their “bodies-we-

are” and “bodies-we-do” to varying degrees. Contrary to the findings of other ART studies and reproductive medicine more broadly (e.g. Benjamin and Ha’elyon 2002; Gupta and Richters 2008; Perrotta 2008; Sharp 2000), the cases presented here suggest that the complexity of fertility treatment prevented the doctor and technology from completely reducing the woman to merely a body-object (the “body-we-have”). Rather, depending on the treatment stage, the doctor had to engage with the woman’s whole body-subject (the “body-we-are”) while he objectified and fragmented her reproductive system. This allowed women to be both fragmented and whole from the doctor’s perspective. The interpretation of the dominant position of Cartesian dualism in medical practice is, therefore, over-simplistic, as medical staff must consider both the body-object and the body-subject during medical procedures, and in fact must grant women the power to adopt a “body-we-do” role for certain at-home treatments. Doctors have to consider the social, psychological, and lifestyle factors, amongst others, that affect, and are affected by, the physical body and the possibility of conception.

Exploring narratives of women’s lived experiences of the surveillance and manipulation of themselves (their bodies) reveals the wholeness of the body-self (“body-we-are”). Through the women’s experiences of the transvaginal ultrasound, they rejected the fragmentation of their bodies as they viewed their organs depicted on the screen to be part of themselves, rather than separate entities. The multiple embodied sensations of anxiety, even fears that anxiety would/could cause a non-pregnancy, also demonstrate the mind/body connection. These sensations, which could be viewed as merely psychological, manifested as bodily sensations of discomfort and unpreparedness. Similarly, diverse complaints of bodily pain (for instance those accompanying the administration of hormone injections), were lived as experiences of fear as women worried about “doing” injections wrong, lifestyle discomforts/disruptions, and chances of treatment success and failure as they embodied the side-effects and significance of the treatment processes.

The ways in which these women embodied these medicalized processes suggests a form of embodied agency that moves beyond the docile and non-

agentic body, and refutes the separation of mind and body that have historically been presented in medical practice. Moreover, the highly invasive nature of fertility treatment made women immensely aware of these embodied sensations, refuting Leder's (1990) claim that we are only conscious of our bodies during times of pain and discomfort. As I show in the coming chapters, some women aimed to *consciously* detach themselves from the extremely medicalized ET in order to embody the moment of potential conception in a more intimate setting. Directly following this potential conception, however, women strived to be highly aware of bodily processes and sensations, as they negotiated the multifaceted liminality of being possibly pregnant.

## Chapter 8

### Recognizing Kin and Life Potential

The Catholic Church, the dominant religious institution in Colombia, characterizes embryos as human life, sacred entities that possess the status of living beings. For the Catholic Church it is not birth that marks the beginning of life, but the creation of an embryo. The status of the embryo, and the substances that contribute to its creation, are more ambiguous in Bogotano fertility centers, where embryos are not endowed with life merely because they are living human cells. Strathern (1992b:174) explains, development is continuous not catastrophic, making it difficult to determine at which state an embryo becomes personified as (potential) life. In the fertility center the significance of embryos was multiple, evolving at diverse rates depending on the perception of the individual.

Taussig and colleagues (2013:S4) contend that exploring potentiality is complex: “to imagine or talk about potential is to imagine or talk about that which does not (yet and may never) exist.” The recognized potential of the embryo was based within diverse perspectives adopted by couples that ascribed embryos with various levels of potentiality at various stages during the treatment process. The potential of the embryo was contingent upon the moment at which it was personified as a potential life, an idiosyncratic moment depending (in part) on the positionality of the individual. For couples this was based on perceptions of kinship relations, imagined ideal images of a future child, and notions of natural conception. For most couples the status of the embryo became significant after the aspiration or during the ET when embryos were either being created in the laboratory or had been transferred to the woman’s body. For a few, however, it became significant when they were confronted with the need to use donor materials. These couples, then, based the significance of potentiality on their understanding of the gametes that would create the embryo, and (potentially) the ensuing child. The idea of a non-

genetically related child was either embraced through notions of familiarity and family, or rejected, as the potential future child would not correspond with local understandings of relatedness.

For couples using their own gametes, some embryos became personified as future children when they were created in the laboratory, due to their genetic and familial relationships to the couple, while others were denied personhood as they did not comply with a couple's ideal image of a child. Exploring interests in cryopreserving extra embryos, however, reveals that for most women it was only the embryos that were selected to be transferred to the ideal (natural) environment for implantation that possessed the *potential* to become living, future children. Thus, we see a variation between personifying embryos as future children, and acknowledging that the embryos may *actually* become (i.e. they have the potential to become) future children.

At Fertilisuperior fertilization most commonly involved ICSI, the process by which the sperm is directly injected into the egg. From the couples' perspective, using ICSI instead of IVF was insignificant, as the fertilization process did not directly affect them; this medically-augmented fertilization process was just another unseen procedure that took place in the laboratory. The embryos produced through this process – their materiality – and the ET that transfers these embryos to the woman's womb, were what concerned the couples. Even though the couples may not have been concerned with the fertilization process consisting of ICSI rather than IVF, this may have *indirectly* affected couples' decision-making processes, particularly by creating extra embryos. ICSI increases the likelihood of fertilization, but research has not shown it to affect the clinical pregnancy rate (implantation observed by ultrasound).<sup>32</sup> This increases the probability of there being extra embryos after the ET that need to be cryopreserved, donated (the ideal choices from the

---

<sup>32</sup>IVF/ICSI pregnancy rates are broken down into various rates depending on the stage of conception/pregnancy: chemical pregnancy rate (hCG hormone level increase), clinical pregnancy rate (implantation observed by ultrasound), ongoing pregnancy rate (fetal heart beat observed by ultrasound), and take-home baby rate (delivery of a live baby). Given these various success rates, IVF/ICSI can be interpreted to be "successful" at any of these points from a medical perspective, but it is not until the delivery of a healthy baby that most couples perceive treatment to have been successful.

medical perspective), or discarded (the common decision couples made). As I show, many couples did not have the financial resources to cryopreserve extra embryos, or did not want to imagine that the current cycle would fail, meaning numerous embryos were discarded. The use of ICSI, therefore, further medicalized the fertilization process – utilizing more resources and advanced technology – while concluding in the same result (or pregnancy rate). The abandonment of numerous extra embryos suggests, however, that the embryos, either frozen in liquid nitrogen tanks or left in the incubator to perish, were not perceived by couples to articulate life potential. Rather, it was the *embryos that were selected and transferred to the women's womb* that articulated the potential for life. As I will show, through negotiating embryos' potential for life and that of their familial connection, couples traversed new moral parameters utilizing their understandings of the social world to grapple with such discussions, again demonstrating, as Rapp (2011:703) explains, a form of real, but constrained, agency.

#### Donor Materials: Negotiating Notions of Relatedness

Some couples were initially confronted with the question of potential kinship or recognizing the familial potential of an embryo/child during the diagnostic stage of the fertility treatment journey, when the doctor recommended the use of donor materials. Making the choice to use donor materials – whether sperm or eggs, or anonymous or known donors – is a difficult decision requiring couples to choose whether to forego treatment or create a family with a child that is not genetically related to both parents, a question that involves interpretations of parenthood, inheritance, and relatedness.

Relatedness, according to my informants, is generally understood in terms of the inheritance of particular *traits* and the sharing of *substance* (e.g. blood, physical traits) between family members. Women did not specifically discuss genetics, but gametes, understood as biological substances, were seen to contain inheritable traits (physical/biological and cultural/behavioral), that are



passed from “genetic” parent to child. Non-fertility patients (family members or friends of couples in the fertility clinic) expressed a general lack of understanding of, and even disdain for, the prospect of donor conception, as well as resistance towards adoption (expressed by both non-patients and couples seeking fertility treatment), a resistance that was based on the fear of *negative* traits from the “genetic” parent being passed on to the child. This understanding of relatedness, based on inheritance and shared substance, presents an often strong social barrier to accepting donor materials.

In the case of sperm donation, in particular, women would say their husbands were against donation because they wanted a biologically related child, not a child of someone else. While explaining why she is going through treatment, Pamela said,

[Her husband] comes from a family of boys – four of them. They are a religious family and having children is very important to them. He truly wants a child of *his own*. Thus using a sperm donor is not an option. (Interview 7 Feb. 2013, her emphasis)

Pamela already has a daughter from a previous relationship whom her husband had raised; however, biologically he did not consider this child to be his own, and felt he had not yet fulfilled his fatherly role, which involved contributing to the progeny of his family. Using a sperm donor would result in the same predicament: the child would not be his offspring. Luckily for Pamela and her husband, he was able to produce enough sperm for Pamela’s eggs to be fertilized through ICSI.<sup>33</sup> Marisa’s husband also refused sperm donation for the same reason, not recognizing a child conceived without his sperm as *his* child. Unfortunately, he only produced three viable sperm, which did not fertilize the eggs aspirated from Marisa, and resulted in treatment failure (interview 11 Feb. 2013).

---

<sup>33</sup> ICSI was the most common ART procedure reported by Redlara in 2009, accounting for 84 percent of all procedures (Zegers-Hochschild et al. 2009). The high usage of ICSI in Latin America in general, suggests sperm donation does not reproduce accepted notions of relatedness, and therefore is not seen as a legitimate option.

Becker (2000:155) explains that using a sperm donor does not allow the man to “naturalize” the parent-child bond as women can with ova donation, as they still conceive and gestate the child. Dr. Diaz made a similar point that when using a sperm donor, it is difficult for the man to make paternity claims when he knows his genetic material has not been used, whereas for women, gestation allows the child to be seen as part of them (informal conversation 28 Feb. 2013). My research supports Becker’s claims concerning men and sperm donation, showing how their ability to accept sperm donation is constrained by locally prescribed gender and family structures, as well as socially constructed understandings of their genetic role in reproduction. My results concerning women, however, differ slightly. None of my informants using donated eggs mentioned gestation-based kinship as a reason for choosing to use an egg donor – unlike the findings of Konrad (2005) in the UK, Pashigian (2009) in Vietnam, and Roberts (2008) in Ecuador. It could be, however, that this went unsaid because it is simply understood, as Colombian law stipulates that the mother is the woman who gives birth to the child. However, some women did reject egg donation as the potential for relatedness did not correspond with local understandings of familiarity and familial inheritance. Thus women’s understandings of the inheritance of genetic traits, like those expressed by men, also posed barriers in some instances.

Luz offers a concise explanation for why some women reject using donor materials that reflects many of the women’s narratives:

“This is very difficult... Do you remember Adriana? She told me she is completely against using anonymous donor materials. She will not do it. She is worried about the health of the donor, and possible physical diseases or psychological problems the donor may have [and pass on to the child]. A lot of women have this same concern.” I interjected here saying, “But the donors are screened, yes?” Luz continued, “Yes they are, but that does not mean women take this information to mean there is not a possibility for the donor to still pass something onto the child. The reaction is not necessarily logical.” (Interview 9 July, 2013)

In addition to an apparent lack of understanding of, or trust in, screening processes, many women expressed fears over unscreened *behavioral* traits.

Many were worried that behavioral traits, such as being a *ladron* (robber), *paramilitar* (member of the right-wing paramilitary group), *guerrilla* (leftist guerilla fighter), *narcotraficante* (narcotrafficker), etc., could be passed from the donor to the child – a concern that was also expressed regarding adoption. Bharadwaj (2003) has reported similar findings from India, where couples rejected the use of anonymous gamete donation based on the fear of “alien genetic input,” to use Bharadwaj’s terminology, or the potential contamination of their family with unknown (and potentially tainted) genetic material. This understanding of inheritance, particularly the inheritance of potentially negative behavioral traits that could be passed from donor to child, manifested as a constraint that prevented some women from recognizing the *potential* of a donor conceived child, and hence the acceptance of anonymous egg donation.

To bypass this, some women sought eggs from a familial donor. When I asked Adriana if she had considered using a donor because of her age – she was 44 when she started treatment – she explained:

“I want to keep it in the family, in my family’s blood.” Discussing her options she continued, “I am the youngest of six children, so I do not have a sister I can ask [to donate eggs]. I have a niece who is very bright. I get along well with her mother [Adriana’s sister] and the father is intelligent... so we are thinking to ask her. I have another niece with whom I am closer, but I do not get along with her mother.” (Interview 28 Feb. 2013)

Adriana’s narrative reflects concerns about genetic contributions from an unknown source, as well as the inheritability of behavioral traits (in this case “intelligence”). These factors led Adriana to consider using a known, familial donor, and influenced which of her nieces she would ask. However, her poor personal relationship with one niece’s mother (“not getting along”) also influenced this decision. This suggests a further constraint that women face when trying to get around anonymous donation by using known donors, particularly familial donors: their own personal relationships. Adriana’s concerns about anonymous donation eliminated her ability to access an unknown donor, while her options for a known donor were limited due to her

family composition and relationships; however, she ultimately found a solution that reduced the potential for unknown, and potentially unwanted, traits contributing to her potential child – including known behavioral traits that manifested in “not getting along.” In this instance, Adriana’s concerns about using an anonymous donor and her understandings of inheritability actually produced an ideal solution.<sup>34</sup>

Other women choose to use a known egg donor not only because the inheritable traits would be known (i.e. familiar), but also because it allowed family traits to be passed through the egg to the child (i.e. familial). Ariana, for instance, choose to use the eggs of her elder sister because: “I wanted the baby to have something from both my husband’s and *my* family. I wanted it to have my grandmother’s eyes” (interview 7 Feb. 2013, her emphasis). For Ariana, intrafamilial egg donation allowed the donor material to be both familiar and familial, while permitting relatedness to be maintained between Ariana and a donor conceived child. Sara also used the eggs of her sister, as she put it, because, “it is best to keep the blood in the family” (interview 27 Feb. 2013), a reference she made both to the familiarity of familial blood and the passing on of the familial line.

Five women who did not have the option of using a familial donor found other ways to accept egg donation and imagine relatedness with a non-genetically related child. The main reason for accepting egg donation mentioned by these women was having confidence in the donor selection process and the doctor. As already mentioned, a common fear was undesirable traits being passed from the donor to the child, a concern that was also voiced in regards to adoption. Unlike adoption, with donor egg conception the woman’s partner provides half the inheritable material, and the donor is screened for physical, genetic, and psychological disorders. This includes two levels of familiarity: a more complete familiarity with the embryos derived from the husband’s genetic input being known, and a more partial familiarity with the donor, most often a

---

<sup>34</sup> Adriana chose to do an initial cycle with her own gametes, despite the doctor’s recommended use of egg donation. Unfortunately, all the eggs she produced were of too poor of quality to be fertilized. She had not agreed to do another cycle by the time I finished fieldwork.

university student, who has been screened by the clinic, and thus become *known* by the clinic staff – a process that couples trust confirms the donor is not a *ladron, paramilitar, guerrilla, or narcotraficante*. As Sandra clearly explained:

[Accepting egg donation] was a very difficult decision. I wanted a baby of my own, but if this was my only option and the path God put me on, than I had to accept it. I felt reassured by knowing that the clinic's donor selection process is very thorough, that donors are checked for genetic and physical characteristics as well as mental and psychological problems. Knowing this helped me relax. (Interview 27 April, 2013)

Those couples that used anonymous egg donation on the grounds of familiarity found a strategic way to accept a child that may not reproduce their understandings of relatedness, and eliminate fears they had about unknown or unfamiliar inheritance. As Thompson (2005:148-149) claims,

[H]igh-tech interventions in reproduction are not necessarily dehumanizing or antithetical to the production of kinship and identity, as some critics of the procedures... have maintained. Indeed, in the clinical setting, gestational surrogacy and donor egg IVF are a means, albeit a fallible means, through which patients exercise agency and claim or disown bonds of ancestry and descent, blood and genes, nation and ethnicity.

Following Thompson's (2005:145-178) work, we can see how women in Colombian fertility clinics "strategically naturalized" donor conception, allowing them to recognize a non-biological child as *their* child, although this recognition may have deviated from the local understandings of relatedness. The acceptance of donor materials more broadly, whether known or unknown, demonstrates how understandings of kinship are malleable, i.e. their ability to be altered to fit new family formations (Bharadwaj 2003; Roberts 2008). As demonstrated through the examples of Pamela and Marisa, however, dominant kinship notions still exist and do, in some cases, pose real constraints to choosing ARTs with donor materials. Ultimately, it was the couple's desire for a child, and their ability to recognize relatedness through altered forms of the

dominant kinship structure, that determined whether or not a couple could acknowledge the potential for a donor conceived child to be both familial and familiar (and thus continue with treatment). Accepting gamete donation, therefore, demonstrates a certain kind of agency – one stemming from a strong desire, and which allows for the emergence of new possibilities (i.e. kinship structures) through the negotiation and reshaping of social constraints (Mullings 1995:133).

### Fertilization and Embryo Development

After the aspiration, the collected eggs (either those of the woman undergoing treatment or those from the donor) are cleaned and stripped, and the sperm sample (either collected or removed from the liquid nitrogen tank that morning) is washed in preparation for fertilization, which takes place only hours after the egg retrieval.<sup>35</sup> Once the gametes have been prepared, fertilization is performed (most commonly through ICSI). ICSI involves first selecting a sperm with ideal morphology and mobility, which is then injected into an egg that has been evaluated as viable for fertilization through the use of the micromanipulator. According to the embryologists and fertility specialists these gametes are objectively selected based on biological characteristics that make them the most likely gametes to result in fertilization.

Once injected, the eggs are placed in the incubator to be monitored for three to five days. During this time, the embryologists observe and grade the embryos throughout their development to determine which embryos to transfer.<sup>36</sup> The ones that are selected are labeled as “*embriones bonitos*” (beautiful embryos), a practice reported by other scholars exploring embryonic development (e.g. Bharadwaj 2006:458; Thompson 2005:114; Roberts 2006:515, 2007:189). This perceived beauty is derived from the embryos’ ideal,

---

<sup>35</sup> For a description of these laboratory procedures see appendix 2.

<sup>36</sup> The process of selecting embryos has raised ethical concerns, particularly in regards to eugenics and the use of PGD, a discussion that is beyond the scope of this thesis. See Inhorn and Birenbaum-Caremeli (2008:185-186) for a review of the literature.

or beautiful, morphology – shape, color, symmetry of cellular division, etc. – characteristics that the embryologists claim are objectively observed, but, which, nevertheless endow the embryos with a perceived potential to create life once they are transferred. Two to three of these embryos that have been recognized as having (life) potential will be selected for transfer to the woman’s uterus.

### *Women’s Perspectives of Fertilization and Embryo Development*

Before starting this research, I assumed the fertilization process would be of great concern to most couples undergoing IVF/ICSI in Colombia. Looking back, this preconceived notion probably derived from Colombia’s Catholic tradition, and the Catholic Church’s condemnation of ARTs that rests partly on the development of embryos outside of their “natural” environment, a topic that was also present in recent Colombian political debates. I quickly learned, however, that women’s concerns about the fertilization process focused on the quality and quantity of the embryos’ development – vocabularies they probably adopted from the medical staff – not with the actual process of fertilizing the eggs.

The fertilization process takes place behind closed doors in a part of the clinic the women never visited. Yet what happens in the laboratory was not a mystery to the women, as they were informed about the process (as mentioned in chapter 6, they see a video illustrating ICSI fertilization), as well as the progress of their embryos’ development and the quantity of *embriones bonitos*. In what follows, I discuss women’s (and men’s) general lack of interest in the fertilization process achieved in the laboratory. Their main concern was the final product: the embryos (more specifically, the embryos that were transferred, as discussed in the section on cryopreservation). The *materiality* of these embryos, not the process of their development, allowed them to be personified as future children. Attributing personhood was a multifaceted process. Recognizing the viability of the embryos through their development

and the kin relationship women attributed to them, these entities commenced the process of developing personhood, as their significance was attached to women's ideal images of a child.

### *Insignificant Processes Produce Significant Embryos*

For most couples, the fertilization process, and the materials being manipulated in this, was a rather insignificant part of their fertility treatment journey. This is because neither women nor men had any physical, or embodied, connection to this part of the processes, and because at this stage, "materials" lost significance as potential life was perceived as forming (in the embryos that were being created). For instance, during an interview with Chela, who was considering undergoing her first treatment, she explained, "Dr. Mabel has recommended ICSI over IVF, but I am not sure why he has made this recommendation, nor do I understand the difference between the two procedures." When she asked me to explain, I said the difference has to do with the way the eggs are fertilized, Chela jumped in saying she already knows the embryologist will inject the sperm directly into the ovum. Then she asked if there was nothing else that differentiates ICSI from IVF (interview 15 April, 2013). Chela did not see the difference between ICSI and IVF fertilization to be meaningful. She assumed there would be a more apparent difference between the two procedures, a difference she might visibly notice, or one that her body would experience. The only differences Chela may have noticed, however, would have been the increase in the treatment cost and the potential increase in the number of eggs that fertilized, differences she was aware of but did not find significant. Essentially, as this was a stage of the fertility treatment journey that did not directly affect her body, it was considered one she would not experience, and was granted little significance.

Leandra's husband, Rodrigo, also appeared uninterested in the details of the fertilization process. While his wife was recovering from the aspiration, Rodrigo asked Dr. Mabel what the next step would entail. Dr. Mabel explained



that each egg would be fertilized with “one normal sperm.” Dr. Mabel then started the ICSI fertilization video to demonstrate the process. Rodrigo watched the procedure for a moment and then turned to Dr. Mabel to ask about the fertilized embryos (observation 27 June, 2013). Rodrigo was more interested in the end result of the fertilization process, the embryos, than the details of the procedure. Rodrigo would not have the same bodily experience of the fertility treatment journey as his wife; therefore, it was not his inability to experience the fertilization process that diminished its importance, as in the case of Chela. Rather, it was Rodrigo’s concern for the embryos’ potential to become his future child(ren), the end result of the procedure, that diminished the significance of the technical process for him.

Both Rodrigo’s and Chela’s narratives reflect a similar detachment from these materials than that found in women’s narratives following the aspiration. Here, women focused on the embryos that would develop from the recently extracted eggs, not the eggs themselves or the process that would convert them into embryos. When Adriana was talking about the six eggs that were aspirated, she moved from recognizing my comment about the collected eggs, to asking when she would know about the embryos that she hoped would make her conceive (informal conversation 29 June, 2013). Adriana’s lack of concern about fertilization reflects Mariela’s explanation that conceiving through the use of ARTs is only one part of a larger pregnancy process (interview 25 May, 2013), a sentiment that was shared by most couples undergoing treatment at Fertisuperior. Their main concern was the end product of the fertility procedure – *their* embryos – that they hoped would result in pregnancy once they were transferred to the woman’s womb.

The only women that appeared to be expressly concerned with the fertilization process were the two women who cited religious objections to fecundation manipulation. Anita claimed she had religious reasons for not wanting to conceive through a highly technical or medical process. This is why she chose to do two AIs despite Dr. Mabel saying her chances of conceiving would be minimal. After the second failed AI, it took her over a year to agree to ICSI. During this time she “asked God to walk with” her throughout her fertility

treatment journey. Anita further explained that her husband was also initially against ICSI, as he did not want science interfering with conception (interview 21 Feb. 2013). Anita's first ICSI procedure resulted in pregnancy.

Samara was more specific about her reasons for initially rejecting ICSI:

After a failed AI, Dr. Mabel suggested she do ICSI, a process she was against. The recommendation made her disinclined to return to the clinic. She "loathed" the idea of the embryos' being created through micromanipulation. Nevertheless, she agreed to return to Fertilisuperior to have the treatment explained in further detail. At the time of our interview, Samara was undergoing her second ICSI procedure; in the end, she explained, her desire for a child overcame her aversion to the medical treatment. (Interview 11 March, 2013)

Both Anita and Samara were concerned about the fertilization process, specifically because of the technical manipulation of the gametes involved in the creation of embryos. The religious basis of these concerns indicates that they revolved around the creation of life. However, as it was not just the creation of any life, but of their own potential children, their religious concerns were put aside, and they did what they could to increase their potential for creating life. Thus, even when women/couples placed significance on the fertilization process (which they rarely did, principally due to their physical detachment from it), they did so with less conviction than they had for producing a child. In the next section I consider the significance women placed on the embryos that resulted from fertilization.

#### *Embryos (and Eggs) as Potential Children and Living Entities*

One afternoon, while I was leaving the clinic with Dr. Mabel, he asked about my research. I explained I was surprised at women's reluctance to speak about embryos, half hoping he would offer some insight. He stated, "I do not think people want to consider the significance of the beginning of life, what embryos mean, whether or not embryos are living beings, simply because what they want is a child, and thinking about these questions complicates their desire, and their willingness to agree to

obtain a child through the use of ARTs.” (Informal conversation 28 Feb. 2013)

Women did not seem able to answer direct questions about the significance of the embryos developing in the laboratory. Yet through subtle remarks it became apparent that the embryos had already been constructed, in some women’s minds, as an entity with the potential to possess life and, in some cases, an entity that resembled their future child(ren). This became more evident during and directly following the embryo transfer, as I show below, but certain narratives contained earlier oblique references to embryos’ possessing (relational) personhood and life potential. These narratives were not connected to religious sentiments, but rather to these entities having come from their bodies and representing (or not corresponding with) their ideals for a child.

Ariana was one of the few women I met who used a known egg donor. She was experiencing early onset menopause at the age of 37, and had decided to use her sister’s eggs. As mentioned above, Ariana did not want something (an embryo) that came from an unknown source placed in her body, but an egg from her sister was an entity from her family (interview 22 Jan. 2013). Embryos created from her sister’s eggs and her husband’s sperm represented a potential child that would have characteristics from her husband as well as from her family. For Ariana, embryos created from her sister’s eggs represented something familiar and familial, instead of foreign and unknown, characteristics she desired in a potential future child.

Ariana’s ideal child possessed characteristics from her family, a slightly altered ideal compared with most of the women because she could not conceive using her own eggs. Roberts (2007:193), following the work of Strathern (1992a), claims, “an embryo is not an autonomous individual in the bourgeois sense but one formed by its role and positionality in a family.” For Ariana, the embryo’s position within her family allowed her to envision it as a potential future family member and, hence, a person. The embryos’ potential “embodied relationship” (Strathern 1992a:65) with Ariana produced their potential personhood.

For others, the image of an ideal child entailed a chosen sex for a potential future child. Dr. Mabel told me about a couple who used sex selection in hopes of having a boy. They already had two daughters and wanted the experience of raising a son. All ten of the biopsied embryos, however, were female, which did not fit the couple's ideal child image. Although Dr. Mabel suggested that the embryos be cryopreserved in case the couple changed their mind or agreed to donate them, they requested that all the embryos be discarded (informal conversation 12 April, 2013). The embryos that developed in the laboratory did not correspond with the couple's image of a potential child, and therefore were not significant, which denied the embryos potential personhood. Yet, despite the embryos' lack of significance for the couple, they refused to donate *their* embryos to another couple.

Dr. Ortero believes couples are unwilling to donate extra embryos, either to science or to another couple, because they regard these embryos as their children, created from their genetic material (informal conversation 22 May, 2013). A prospective egg donor incorporated this notion of ownership into her narrative about genetic material when she said it would be "*feo*" (unpleasant, awful) to have children later and then tell them she had previously donated eggs and that her genetic material is "floating around" somewhere in the world (interview 6 June, 2013). She thought of her potential donated eggs in terms of *her* inheritable genes, characteristics a donor-conceived child would share with her own children. Roberts' research (2007) also indicates that Quiteño couples' concerns about the whereabouts of their genetic material were connected to their refusal to donate extra embryos – their potential children – to another family. This aversion to embryo donation was also present among my informants. I did not hear of a single couple at either clinic that was willing to donate their embryos (see below). Even if the couple could not visualize the embryo as a potential person, its embodied connection with them prevented it from being attributed potential personhood by another couple.

These narratives demonstrate how attaching an ideal relational or future child characteristic to embryos can create the potential for future kin. By

contrast, Maia attributed life to the mere idea of future embryos because they *would be* embryos, entities that for her represented human life.

During a consultation with Dr. Diaz, Maia asked about the possibility of doing sex selection. Dr. Diaz said it is possible to select the sex of the embryos that will be transferred, but the clinic has to work with another laboratory to do so, the procedure poses additional risks, and additional costs. He continued explaining it is another procedure altogether that requires the embryos to be biopsied and then the chromosomal sequence has to be determined to establish the sex of the embryos. Maia appeared shocked by this information, and asked how the biopsy is performed. The doctor responded, a needle is used to remove one of the embryonic cells, which is then analyzed. Maia repeated, "They remove one of the cells?" Dr. Diaz confirmed. Now understanding the procedure and appearing disgusted she stated, "That must be painful, I am not interested in doing it." (Observation 23 July, 2013)

Pain is a sensation attributed to living entities, a feeling Maia was attributing to the act of biopsying an embryo. In her interpretation of pain, Maia attributed life to the embryos she hoped would develop in the laboratory, embryos that had not been created yet. Furthermore, similar to Ariana and the couple who did sex selection, Maia's initial interest in sex selection alludes to her already envisioning a particular child that would develop from the embryos created in the laboratory.

Although these narratives are not specifically about the significance of embryos, they illustrate the importance of these entities to women undergoing treatment, their characteristics as potential future children and their potential for life. These factors all became more evident once the embryos were transferred to the woman's womb. In the following section I show that most women were more interested in the embryos once they were injected into their bodies and could be seen on the ultrasound monitor "floating" in their wombs, an embodied experience that further emphasized the embryos' life potential for the women.

## Embryo Transfer

Three to five days after the aspiration, the women returned to the clinic to have the embryos fertilized in the laboratory transferred to their uteri. From a biomedical perspective, the procedure is very simple, generally lasts less than five minutes, and should not require much, if any, recovery. Nonetheless, neither the women nor the medical staff found this procedure insignificant. Rather, much like the aspiration, the embryo transfer marks a pivotal moment in the fertility treatment journey, when “beautiful” embryos are placed in a womb that has been conditioned for their implantation and further development. The ET marks the first processual stage of potential conception.

### *Preparing for the Transfer*

While I was sitting in the waiting area one morning, Tania and Mauricio (who I had interviewed a few days before) arrived. Tania came over to speak to me. She greeted me, and started explaining that she would have the embryo transfer that morning. She made a face indicating she was nervous. Breathing deeply I told her to relax. She smiled and took a deep breath. At that moment Dr. Catalina brought over a pitcher of water and a glass, which she put on the table. She motioned for Tania to sit down, and instructed her to drink the water slowly until she felt the need to urinate, at which point she would be ready for the transfer. Dr. Catalina left in the direction of the laboratory, and Tania and Mauricio took a seat next to the pitcher of water. Mauricio took out his phone, while Tania sat quietly, drinking the water, and occasionally picking at her fingernails. (Informal conversation 18 June, 2013)

The moments leading up to the ET were filled with anxiety and discomfort, as the woman, often accompanied by her husband or a female friend/relative, eagerly waited to be called back to the OR/laboratory area for the procedure that *may* result in pregnancy. Anxiety associated with the significance of the embryo transfer appeared to build as the treatment journey progressed, peaking during the embryo transfer, and being sustained through the days of waiting that followed when conception was intended to take place.

Here, as with the hormone injections, anxiety was exacerbated by a physical discomfort that accompanies the treatment process. This one was meant to prepare their body to receive the embryos in the OR. The water Dr. Catalina instructed Tania to drink was intended to increase the size of her bladder to allow better visibility of the uterus and catheter on the ultrasound monitor during the procedure, as well as tilt the uterus into the ideal position to receive the embryos. Before Tania even entered the OR, her body was being prepared, in an uncomfortable way, for the “clinical gaze” of the doctor that would guide his manipulation of her body in hopes of conception.

Despite the anxiety and discomfort the women experienced while waiting for and undergoing the ET, they were instructed (here by Dr. Mabel) “to arrive as calm as possible... for the embryo transfer” (observation 27 June, 2013), as tension in the body may obstruct the catheter from entering the uterus smoothly. In his comment, Dr. Mabel acknowledged the stress the ET may cause the woman. The procedure, however, also caused the medical staff heightened tension, which reiterates the pivotal nature of this medically simplistic but very symbolic procedure that marks the moment that *may* lead to conception.

### *The Process of Potential Conception*

Once the woman’s bladder is sufficiently full and the doctors are ready to conduct the embryo transfer, the woman is called to the back of the clinic. She is led to a changing room and given a gown, booties, and a head cap. Having donned them, she enters the OR where she lies on a surgical bed. The embryologist pulls up her gown, puts a blanket across her waist and legs, and instructs her to place her feet in the stirrups and to slide to the end of the table.

While the woman is getting in position, one of the embryologists prepares the transfer tools for the doctor. On a small metal cart there is a pair of needle-nose forceps, a two-piece catheter still half in its package (the interior catheter has been removed by the embryologist to be filled with the embryos in

the laboratory), a metal speculum, a syringe loaded with sterile water, and sterile gauze. A stool is placed between the woman's legs and a lamp is positioned to shine on the woman's vagina. As one embryologist prepares the area for the doctor, another embryologist or nurse turns on the ultrasound machine, squirts gel on the woman's abdomen, and with the ultrasound transducer, rubs gel across the woman's abdomen.

Once the woman and the transfer tools are prepared, the doctor, the key actor during the procedure, is called into the room. He sits on the stool between the woman's legs. First, he inserts the speculum into the woman's vagina and observes the cervix for blood or irritation. With sterile water the doctor cleans the vaginal canal of blood and vaginal mucus. Using the needle-nose forceps and gauze, any liquid is removed from the area. As the doctor performs these tasks, he explains his actions to the woman to avoid surprising her and increasing her anxiety. Recognizing if she is tense or not breathing regularly, Dr. Mabel commonly repeated, "*tranquila*" (calm), "*relaje*" (relax), "*respira*" (breathe), touching her leg gently as he made these requests.

While the doctor prepares the woman's body to receive the embryos, the embryologist prepares the embryos in the laboratory. Under the fume hood, one by one, the embryos are carefully sucked into the transfer catheter. Dr. Catalina explained, "I place a tiny bit of air and media in between each embryo to help protect them, but I must be precise. If I suck up too much air the embryos could be launched into the fallopian tube, which could result in an ectopic pregnancy" (informal conversation 7 June, 2013). The embryologist must handle the embryos carefully as she gently sucks them into the transfer catheter, to avoid causing future complications, acknowledging both their fragility and their importance.

When the vaginal canal has been sufficiently cleaned, the doctor picks up the package containing the catheter. Dr. Mabel bends the catheter slightly between his glove-covered fingers so that it curves slightly upwards. He explained that this allows the catheter to slide more easily into the uterus (informal conversation 24 June, 2013). The catheter is then inserted through the woman's cervix and into her uterus. The doctor watches the ultrasound



monitor to determine how far to insert the catheter. Although two indicating marks on the catheter also guide the doctor, not every woman's uterus is the same depth, so the markers serve only as an estimate. Sometimes the catheter enters smoothly and quickly, but sometimes the doctor must make several attempts to insert the catheter, causing the woman further discomfort and even pain.

Once the catheter is in place, the filler catheter inside the slightly wider catheter is removed, the transfer catheter holding the embryos will soon take its place. The doctor calls to the laboratory for the embryologist. With the doctor's call the embryologist screams "*voy!*" informing everyone she is coming, and then walks swiftly but cautiously into the room and hands the catheter to the doctor who steadies his hand and carefully inserts the transfer catheter into the catheter already placed in the woman's uterus to prevent contaminating the embryos. Dr. Mabel often breathed a sigh of relief when the transfer catheter was finally in place, indicating the stress of this particular moment and the precision with which it has to be actualized. When the catheter is in place, the doctor pushes on the end of the catheter, which acts like a syringe injecting the embryos one after the other into the woman's uterus.

Time appears to stand still once the embryos are injected as the medical staff and the woman watch them apparently floating inside the womb, on the ultrasound monitor. An embryologist or nurse will point out the embryos on the monitor, as the woman is not always familiar with the "visual language of the embryo" (Roberts 2007:184). During one transfer Dr. Mabel expressed, "*Que bonito*" (how beautiful), referring to the embryos he had just released into the woman's uterus (observation 22 May, 2013). In the laboratory, embryos are labeled "beautiful" when they display ideal morphology, characteristics that contribute to their viability. Dr. Mabel's reference to embryos in the womb as "beautiful" may also be suggestive of their life potential, now being articulated as the embryos enter the ideal environment for implantation and further development.

Once the embryos have been injected the catheters are removed and brought to the lab to confirm that the dots on the screen were indeed the

embryos. I did not hear of any instances where the embryos had not been properly injected, but this stage reassured the doctors and the woman alike that the embryos were inside her uterus. Upon confirmation from the laboratory, the doctor checks the cervix once again and the speculum is then removed, the stirrups are put away, a small table is pulled out from inside the bed, and the woman is instructed to lie comfortably, covered with a blanket.

The actual procedure takes approximately five minutes, but the woman is required to remain lying down for roughly an hour following the transfer, which can be unbearably uncomfortable with a full bladder that has been agitated by the insertion of the catheter. Yet she remains lying down, willing to endure the pain, in the hope of increasing her chances of pregnancy. The stilled image of the embryos remains on the ultrasound screen for the woman to observe as she waits patiently. This prolonged expose to the image implants the significance of the process of transferring viable embryos to a medically-conditioned womb, a process that augments the significance of the embryos fertilized in the laboratory, embryos that were unsustainable in the petri dish and incubator but which now have the potential to become human life. At Medivida women receive photos and an animated DVD of the embryos floating in their wombs as keepsakes. These photos are essentially a potential future life's first photos, which some women presented to their husbands and family members upon returning to the waiting area after the ET. Women undergoing treatment at Fertisuperior were not given such mementos, but would continue observing the stilled image of their potential future children as they recovered from the transfer.

### *Embodying the Sensations of the Embryo Transfer*

From the perspective of the medical staff the embryo transfer consists of three crucial moments: the insertion of the catheter, the injection of the embryos, and verifying that the embryos actually injected. For the women, each of these stages contained additional sensations and significances: pain, conscious

detachment from the medical environment, seeing the embryos, and the discomforts of recovery upon entering the stage of possible pregnancy.

When I asked women about the ET, most first recalled the simplicity of the procedure, but then remembered the discomfort of having the catheter inserted. Larissa said that this was the worst part of the entire treatment because it caused her immense pain (interview 25 May, 2013). Of the processes entailed in the embryo transfer, inserting the catheter through the cervix appeared to cause the women significant pain, but no medication is used to numb or relax the cervix as this may interfere with the embryos' implanting. As the catheter was inserted, the women I observed scrunched their faces, gritted their teeth, and/or squeezed their eyes shut from the agony, even though the doctor had told them to relax. The women undergoing IVF in Benjamin and Ha'elyon's (2002) study in Israel claimed to detach themselves from their bodies during moments of pain, a finding that challenges Leder's (1990) claim that pain makes us more conscious of our bodies. My informants did not replicate the narratives presented by Benjamin and Ha'elyon, however. Rather, they appeared to simply deal with the pain, often declaring, after the procedure was over, that they were fine.

During the second crucial moment, the injection of the embryos, the women either closed their eyes or stared intently at the ultrasound monitor. I relate the act of closing one's eyes to the lack of intimacy some women/couple's reported in regards to the ET. Iris and Fernando explained, talking more to one another than to me, "We do not want to think of conception as a scientific process, when it should be a loving, pleasurable, and enjoyable process, not one that happens in a clinic. But this is what we have to do if we want a child" (interview 22 Jan. 2013). The thought of conception as a medicalized process instead of an intimate moment was disturbing to Iris and Fernando, suggesting their desire to detach themselves (as they could not be removed) from the clinical, sterile quality of the ET. The act of closing one's eyes during the moment the embryos were injected may have allowed women to imagine conception as taking place in a setting more intimate than a surgical room filled with a minimum of four sterile medical personnel. This, however, should not be

characterized as an unconscious separation of the mind and body, but rather a conscious desire to embody a sensation of conception that does not include an ultrasound, catheter, and trained medical personnel. For the women who closed their eyes, the medical staff's mention of the embryos on the ultrasound screen often brought the woman back into her wholeness, as her attention, like that of the women who did not close their eyes, became focused on the image of the embryos inside her womb.

As the catheter was removed and brought into the laboratory to verify that the embryos had truly been transferred, marking the final crucial moment, the women, continuing to stare at the two or three small dots floating in their wombs, appeared to relax. Knowing they needed to remain lying down for approximately an hour many tried to get comfortable, but this period often involved additional discomfort due to the insertion of the catheter and their full bladders. I chatted with Jimena for the hour of recovery following the procedure, during which she repeatedly scrunched her face in pain while holding her breath and touching her abdomen. When I asked if she felt all right, each time she took a deep breath and said, "I am fine" (observation 22 June, 2013). Jimena was clearly in pain but she endured it without complaint. Jimena's unwillingness to acknowledge the pain verbally may be interpreted as her desire to detach the pain from her embodied experience of the first stage of potential conception. Yet, as with the discomfort caused by the hormone injections, I interpret this lack of verbal recognition as acceptance of the pain that women have to endure if they intend to obtain a child. Angelica, recalling the pain after the ET, said, "It was horrible." The insertion of the catheter caused her pain even after its removal, and then she could not urinate following the ET, which augmented her pain (interview 11 Feb. 2013). The pain women such as Angelica and Jimena experienced following the ET often subsided within hours or a few days, replaced by anxiety about their entering the stage of being possibly pregnant, which I discuss in the next chapter.

## Rejecting Cryopreservation

Couples undergoing their first treatment cycle were generally unaware of the possibility of cryopreserving extra *embriones bonitos*. Doctors usually did not address cryopreservation until they knew whether or not there would be extra embryos to freeze. Dr. Mabel explained that informing *pacientes* about cryopreservation creates further stress and anxiety, as they start to worry about producing more viable embryos than are needed for the transfer (informal conversation 23 July, 2013). Despite the doctor's positive intentions, denying couples this information, however, meant this decision had to be made within hours of the ET.

If viable embryos remained after the ET, the medical staff would try to persuade couples to cryopreserve them. From the doctors' position, cryopreservation is the logical decision:

While discussing cryopreservation with Dr. Ortero I mentioned that many couples do not appear interested in this option. He nodded in agreement and added, "But this is illogical. If we say treatment is only successful in 50 percent of cases, then there is a 50 percent chance a couple could use frozen embryos during the next cycle..." (Informal conversation 7 March, 2013)

As Dr. Ortero's narrative indicates cryopreserved embryos can be used in a subsequent cycle if treatment fails or, additionally, to fulfill the desire for another child. Doctors persistently highlighted the benefits to the women of eliminating the need for an additional and costly cycle of hormonal stimulation and egg retrieval, which would also allow the thawed embryos to be transferred to a body that has not been (over) medicalized with hormones. Even though this carried the potential for lost revenues, doctors made recommendations they believed would (and often did) accompany a positive outcome. Although the medical staff presented just one rational option, couples considered other factors when choosing to freeze extra embryos, such as ideas about kin and life ethics, "practical" considerations, and faith in the current cycle.

Roberts (2007) differentiates between kin and life ethics in regards to couples' decisions to cryopreserve extra embryos in Ecuador. From a kin ethics perspective, embryos are family members, which causes couples to reject cryopreservation for fear that cryopreserved embryos may be donated to another couple and their genetic material would become part of another family (189-190). None of the couples I interviewed voiced concern about *their* embryos being donated without their consent or knowledge to another couple. Yet donation was not accepted by any of my informants because embryos are embodied within a familial network (see above).

Life ethics, on the contrary, supports the freezing of extra embryos, as they are perceived to be living entities with the potential for personhood, and promotes embryo donation (187-189). Only two women adopted the life ethics perspective suggested by Roberts. Maia stated she did not want extra embryos cryopreserved because she is Catholic. However, she did not only reject cryopreservation but also the creation of embryos that would not be transferred to her womb (informal conversation 23 July, 2013). Maia was not rejecting cryopreservation per se; she was rejecting the creation of embryos that would not be transferred during the current cycle, a choice she framed within the Catholic discourse of embryos as human life. She objected to making the decision either to cryopreserve or discard extra embryos because they would be human life. Anita expressed a similar life ethics narrative when she stated, "Throwing [extra embryos] away is very difficult to think about. I hope only the ones that are transferred survive so I do not have to make the decision" (interview 21 Feb. 2013). I do not know what choice Anita or Maia made when they were confronted with the decision about cryopreservation, a choice I can only assume they had to make.

The liquid nitrogen tanks at Fertisuperior are nearly full of cryopreserved embryos, many of which have been abandoned – unclaimed and unpaid for.<sup>37</sup> This indicates that other couples have either supported a life ethics

---

<sup>37</sup> This scenario is problematic for the clinic as their storage tanks are filling up and many couples eventually stop paying for the storage costs. The medical staff, however, are apprehensive about discarding these unaccounted/unpaid for embryos, as they fear potential

perspective (one that did not lead to donation) or heeded the advice of the doctors, but then either became pregnant or chose not to undergo another cycle. For couples who adopted life ethics, their embryos still possessed the potential to become children; while embryos that were merely abandoned (or forgotten), were not recognized as possessing the potential for life. I will return to this second notion below.

Despite the large number of embryos stored at Fertisuperior, most of my informants chose not to freeze extra embryos. Given the abrupt information couples receive about cryopreservation, and the haste with which the decision is needed, couples generally had very limited time to consider the implications of freezing extra embryos. When we discussed their concerns, they generally mentioned “practical” considerations – additional costs, where frozen embryos are stored, the timeframe for storage, the quality of frozen/thawed embryos, etc. – and having faith in the current cycle. The costs of freezing and thawing embryos posed a particular problem for many couples who had already spent a large sum of money on the current cycle. Recalling why they did not cryopreserve extra embryos from the cycle that resulted in her son five years before, Vanesa explained, “The deciding factor was money. We had already spent enough money and we were not going to spend any more” (interview 20 May, 2013). Cryopreserving, storing for one year, and thawing extra embryos costs approximately US\$2000. This is a considerable expense for many couples, although significantly less than paying for another cycle. This suggests that many couples, like Vanesa, did not anticipate undergoing further treatment, either because they assumed the current cycle would be successful or they already knew another cycle was unaffordable.

Given the monetary commitment of undergoing another cycle and the limited success rate of these therapies, from the medical perspective the decision to forego cryopreservation may appear to be shortsighted and naively optimistic. For the couples, however, choosing to decline cryopreservation was not shortsightedness or naivety but a means of embracing and having faith in

---

legal repercussions should a couple return to claim their embryos. Currently no laws address this predicament.

the current cycle. Nicola explained, "I have not really thought about it, I may freeze extra embryos, but I am not thinking about a second cycle. I can only think of this cycle being successful" (interview 12 April, 2013). For Nicola, not thinking about the need to undergo a subsequent cycle was her way of focusing on, and coping with, the highly stressful process she was undergoing. Franklin (1997:185) reports that women utilizing IVF have to remain hopeful that treatment will result in pregnancy, otherwise there is nothing propelling them to continue. Dividing emotions and efforts between the current cycle and a potentially necessary subsequent cycle implies losing faith/confidence in the current cycle, and this creates a psychological barrier to cryopreservation.

Embryos that are not cryopreserved or donated are simply left in the incubator, unattended, to dry up and perish. Once the cells have "died," the petri dish is tossed into the biohazard bin. Apart from Anita and Maia, no other couples expressed concern or anxiety about their extra embryos being left to perish. Couples' lack of interest in cryopreservation or concern about abandoning extra or frozen embryos may suggest that extra and frozen embryos do not possess the potential to become children – while frozen in a liquid nitrogen tank or sitting in the incubator waiting to perish – these embryos may not embody the potential for personhood. In a sense, extra embryos (whether frozen or waiting to be discarded) may be out of place, not in a place of potential, unlike those that are transferred to a womb. This further indicates it is the act of transferring acknowledged viable embryos to a womb that has been medically conditioned to receive the embryos that allows the couple to perceive these embryos as a potential future child. Yet from the doctor's perspective, discarding extra embryos is a waste as these embryos could have life potential if they were transferred to a womb in the future. These viable embryos are recognized as *possibly* possessing the potential for life according to the doctors, and that is why they *should* be cryopreserved for later use or donated. The contrary perspectives of the couples and doctors suggest the latter unconsciously invoke a life ethics perspective, while for the majority of couples, embryos left in the incubator or frozen in a liquid nitrogen tank possess neither life nor kin potential.



## Conclusion

This chapter has demonstrated the complexity of the embryo's potentiality and the diverse imaginaries – as life, as kin, as a future child – in which it is entwined. As embryos developed in the laboratory, some women recognized their potential as future kin or imagined children. This potential was based on notions of relatedness and the couple's ideal image of a child, a potential that had already been acknowledged or denied by couples requiring the use of donor materials. Couples who accepted the use of donor materials placed these substances that carry inheritable traits within an understanding of familial relations and/or familiarity. Particularly for those couples using anonymous gametes, this process involved them placing more significance on the familiar aspect of relatedness in place of that of the familial to overcome concerns about the inheritance of unfamiliar and potential tainted behavioral traits. This demonstrates how notions of relatedness can be slightly *reshaped* to allow for new family formations that still embrace dominant kinship notions.

For women who did not recognize the kin or life potential at an earlier stage, the act of transferring the embryos to a viable womb via the ET transformed them into potential life. It is in the womb that these embryos could grow and develop into the future children already imagined by the couples. As demonstrated through practices of cryopreservation and the understanding of kin and life ethics (Roberts 2007), most couples only perceived embryos that were transferred as potential future children, while those that remained to perish in the laboratory or frozen in liquid nitrogen tanks were devoid of this potential. This suggests the strategic maneuvering of couples as they acknowledged the financial and psychological constraints of cryopreserving extra embryos, and therefore chose to abandon those embryos through embracing their non-potential.

Ultimately, the ways in which women (couples) grapple with the decision to cryopreserve extra embryos, and whether or not to use donor materials, demonstrate how they must confront new ethical, as well as practical, conundrums. Their strategic maneuvering/decision-making, which is based in

already familiar social understandings and their personal financial and psychological state, emphasizes what Rapp (2011:703) has called, a real, but constrained, form of agency. As “moral pioneers,” again to use Rapp’s (1999) terminology, these women/couples create new possibilities through the negotiation of established social constraints. Through grappling with these ethically- and socially-bound decisions, couples demonstrate the difficulties of making choices when their options are exceedingly constrained. This challenges Madhok and colleagues (2013:7-8) claim that exploring agency through one’s choices detracts from acknowledging the constraints they face. Rather, in these cases, the constraints couples faced directly inhibited or influenced the choices they were able/willing to make.

The act of transferring viable embryos not only provides the potential for life, but it also moves the woman into a liminal stage of pregnant/not pregnant. The next chapter explores the significance of this liminality and the means by which the women tried to remove themselves from this phase.



## Chapter 9

### Transcending the Liminality of Pregnant/Not Pregnant

“Pregnancy is, by definition, a liminal state” (Rapp 1999:105), as women undergo physical, emotional, and life-style transformations in their journeys to become a mother. Within this extended period of transition, however, there are shorter, and possibly more pivotal, liminal stages that women pass through on their quest for motherhood. The first stage (possibly the most significant in the context of infertility) is that of conception, a *process* that is recognized and strived for by couples trying to conceive spontaneously, but one that becomes more evident when conceiving through a medical intervention that breaks down the conception stages (Sandelowski 1991:39; 1993:122). Unlike spontaneous conception, medicalized conception involves the physical placing of viable embryos that have the *potential* to implant and develop into a fetus into a womb that has been medically conditioned to receive and nurture them. This chapter is concerned with the liminal period between ET and confirmed (or denied) pregnancy, the phase in which the woman is possibly pregnant.

Victor Turner (1991[1969]) explains liminality as a transitional state of being “betwixt and between,” two relatively stable conditions. Based on this definition of liminality, several scholars have analyzed the state between choosing to have a child and achieving pregnancy as a liminal state, identifying a variety of different liminalities related to childlessness (Becker 2000; Franklin 1997; Greil 1991a; Sandelowski 1993, 1995; Tjørnhøj-Thomsen 2005; Throsby 2002). Tjørnhøj-Thomsen (2005:77), for one, claims that the process of becoming a parent “is a rite of passage, which marks an important change in social status, relatedness and identity.” As Greil (1991a:25) states, however, the (involuntarily) childless individual is neither a child nor a full adult. Infertility disrupts the culturally accepted path to adulthood, creating chaos and bringing personal identity and life course events into question. Alternatively, Becker (2000:44) has called infertility an “assault on gender identity” as women and

men experience a sense of incompleteness or feel unwomanly/unmanly. Infertility may cause women to experience a loss of identity and a sense of personal failure, as they feel cut off from or denied access to “normality” (Greil 1991a:26, see also Throsby 2002).

As these authors suggest, fertility treatment is commonly sought in order to overcome some form of liminality related to childlessness. Yet the medicalization of infertility may actually produce *further* uncertainty relating both to diagnosis and treatment (Becker 2000; Greil 1991a; Franklin 1997; Sandelowski 1993). Franklin (1997:154) discusses this in terms of a dual liminality, defined on the one hand by lives being in limbo because of infertility, and on the other by “treatment in limbo” “because of [the] lack of diagnosis.” Fertility treatment, in other words, creates a second liminal phase to overcome a prior liminal state (i.e. infertility) – where women persistently wait for conception as they progress through various treatments that (re)create the very uncertainty that women seek to resolve (Franklin 1997). In this chapter, I explore the liminal, uncertain stage of waiting for or anticipating conception immediately after ET. As Bharadwaj (2006:458) notes, this is a phase filled with uncertainty: women know viable embryos have been transferred to their wombs, but they are in the liminal phase of possibly pregnant.<sup>38</sup>

As the women transition from the scientifically controlled environment of the clinic to their home environment, “nature” is meant to take its course (according to the doctors), and allow or deny the implantation of the embryos. Knowledge of their liminal position caused some women to intervene in the intended “natural” conception process and to assist the establishment of pregnancy by changing their behavior – taking to bed-rest or “taking care.” Others reported “taking care” because they worried a medically conceived pregnancy could pose more risk than spontaneous pregnancy (McMahon et al. 1997; McMahon et al. 1999). This (intended) return to “nature” was brief, however, as the women returned to the clinic 10 days later for the first

---

<sup>38</sup> Sandelowski (1993:123) refers to women being “potentially pregnant,” but this refers to the potential of pregnancy occurring anytime from the onset of hormonal stimulation to the ET, as long as the woman was not “canceled” than she was “potentially pregnant.”

pregnancy test, an examination that itself may produce ambiguous results (and thus, a new state of liminal uncertainty). Nonetheless, many women in my study embraced the uncertain indicator, whether denying or confirming pregnancy, simply to remove themselves from their current liminality.<sup>39</sup> Pending a positive result, the women were returned to the “rollercoaster” of medicalization as they awaited another pregnancy test, followed by an early term ultrasound – examinations that frequently revealed more equivocal outcomes.<sup>40</sup>

As I show, personal histories and embodied experiences of past pregnancy complications and miscarriages influenced the extent to which women embraced these ambiguous exam results and unclear images produced by early term pregnancy detection techniques. Some women with particularly devastating reproductive histories prolonged the liminal phase by denying “positive” results and delaying the recognition of a pregnancy they feared would only result in miscarriage. Others eagerly accepted the authority they gave to the technology and its ability to remove them from the liminality of being possibly pregnant.

During this phase, women also explored embodied interpretations of pregnancy and perceived pregnancy risk as a means of reassurance and “self-monitoring.” Foucault’s (1977:195-228) idea of “self-surveillance” that arose from the concept of “Panopticon” (in which individuals come to behave in particular ways through understandings of discipline) suggests that through the medicalization process, women learn to observe and examine their bodies in accordance with the ideals of the fertility experts (Lupton 1997b). Here, surveillance is shifted from *medical* surveillance done *to* the body, to internalized *self*-surveillance, or what Sawicki (1991:68) has called the “policing” of one’s self, a practice which may further discipline the objectified body as women adopt a “clinical gaze.”

---

<sup>39</sup> Franklin (1997:153) describes that some of her informants wished to be “rescued from limbo, even if by the ‘worse’ news” to end “the stress of uncertainty.” Franklin was, however, discussing unexplained treatment failure, and the question of how long to endure treatment, not the particular liminal phase of waiting to determine treatment success or failure.

<sup>40</sup> The “rollercoaster-like” effect of assisted reproduction has become a common metaphor used by patients to describe the experience of ARTs and is used throughout the literature (e.g. Becker 2000; Franklin 1997; Sandelowski 1993).

As previously stated, however, adopting a clinical perspective does not necessarily reduce women to passive dupes. Rather, in my study, they actively sought out and engaged in these medicalized processes. Howson (1998:224-225) urges us to look at the *lived-experiences* of self-surveillance instead of at the *practices* of surveillance, the latter of which often masks the multiplicity of resistance to the institutionalized disciplining of the body. In this chapter, then, I am not suggesting that the women in my study resisted surveillance. Rather, the extent of a woman's engagement with medical surveillance depended on her personal history and embodied experiences. Embracing "self-monitoring" through embodiment does not reinforce the notion of the "disciplined" and "docile" body, which is coerced (or transformed) by the conditioning of medical practice as suggested by Foucault's earlier works (such as *The Birth of the Clinic* (1973) and *Discipline and Punishment* (1977)). Rather, as I argue, the women's desires to surpass liminality and bring a pregnancy to term combines to create an active, agentic, and embodied form of "self-monitoring" that entails taking measures to facilitate conception (bed-rest and "taking care"), recognizing bodily sensations of conception and/or risk, and seeking reassurance through medical monitoring.

### Returning Home

After the embryo transfer, the primary medical processes of the fertility treatment journey come to a close. The woman leaves the clinical realm for ten days. At this stage, the process of conception transforms from being medicalized and controlled by the doctor, to "natural" as the women and "natural reproductive processes" become responsible for conception (Perrotta 2008:180). The fertility specialist and embryologists have done all they can to enable pregnancy, as was acknowledged by many women in this sample, such as, Alvina, who understood there was nothing else the doctors could do; she just had to wait and have faith that pregnancy would ensue (interview 4 March, 2013). It thus became the women's responsibility to allow the embryos to

implant and continue development in their medically conditioned wombs, a responsibility women embraced by doing what they interpreted as necessary to facilitate treatment success.

Medically speaking conception corresponds with the moment the embryo *implants* in the uterine lining. Colloquially, however, the term is used synonymously with fertilization, creating room for discrepancies. I never heard the doctors discuss with women how long it could take the embryo(s) to implant following the ET. This left space for women to wonder, “Am I already pregnant, is the embryo currently floating around in my uterus as it appeared to be when injected, or has the moment of possible implantation passed and treatment has failed.” IVF research is inconclusive on the exact moment of embryo implantation. It is said to vary between one and five days following ET, depending on factors such as the stage of embryonic development, the quality of the embryo(s), and the woman’s age. This creates a liminal phase when the woman may or may not be pregnant, and when the embryo could still implant if it has not already done so. From the moment the women in my study knew embryos had been transferred until the results of the first pregnancy test, they were in limbo: possibly or possibly not pregnant. This liminal stage caused many women to take precautions either to help facilitate pregnancy or maintain it, depending on when conception was perceived to have taken place.

### *Aiding Conception*

The women returned home after the ET with instructions to continue with life “like normal.” Yet most women defied the doctor’s orders in the hope of either helping facilitate pregnancy or maintaining it, depending on their perception of when conception took place. Their knowledge of their liminal state of possibly pregnant, combined with embodied knowledge of previous fertility, conception, and pregnancy complications led most women to ignore the doctor’s expert advice (Lupton 1997a) and change their behavior with the intention to aid the embryos’ implantation and development. Many believed pregnancy may be



aided by minimizing physical activities, taking leave from work, or taking to bed-rest.<sup>41</sup>

Jamie, who was five months pregnant at the time of our interview, recalled, “I stayed in bed for the first three months following the ET. For two weeks after the transfer, I did not leave the bed at all.” She continued by explaining that she wanted to be extra cautious to allow the embryos to implant (interview 21 Feb. 2013). Jamie believed she needed to take bed-rest to facilitate conception; it was her way of taking responsibility for the conception process. Carina did not take to bed-rest as long as Jamie, but she also believed she needed to recover following the procedure. A couple days after the ET, she told me, “I need to take it easy and relax in bed.” This was partly because she had developed hyperstimulation syndrome due to the over stimulation of her ovaries, but more because she recognized her current condition as possibly pregnant (informal conversation 10 April, 2013). Both Jamie and Carina chose to monitor their behavior, minimizing activity and taking bed-rest – adopting a pseudo “sick role” (Parsons 1951a, 1954, 1975). Yet they did so for different reasons. Jamie’s two-week bed-rest was intended to assist the embryo(s) to implant in her uterine lining and continue to develop. By contrast, when Carina took to bed-rest, she already envisioned that conception had taken place (if it was going to happen), and she intended her precautionary behavior to further the development of the pregnancy. Here we see how the “elusiveness” of the embryo (Becker 2000), whose status is difficult to define, resulted in Jamie and Carina’s divergent interpretations of “not yet pregnant” (Greil 1991b) and possibly pregnant. Both women embodied a liminal state of not knowing if the elusive entity that was placed inside their body would develop into a future child, and this uncertainty caused them to change their behavior in hope of entering a stage of confirmed pregnancy (i.e. certainty).

Martha also stayed in bed after the ET. When she left the OR following the procedure she said that she would spend the rest of that day and the

---

<sup>41</sup> Other scholars studying ARTs have reported similar findings such as Inhorn (2003b) in Egypt, Svendsen (2011) and Tjørnhøj-Thomsen (2005) in Denmark, Throsby (2002) in the UK, and Whittaker (2014) in Thailand.

subsequent few days in bed to allow her body to recuperate from the medical procedures she had undergone (informal conversation 15 June, 2013). Martha's narrative was not directly related to facilitating conception or sustaining pregnancy, but to maintaining a healthy body, which the clinic staff indicated was a way to facilitate a healthy pregnancy.

Having left the medicalized environment of the clinic, then, Jamie, Carina, and Martha engaged in activities they believed were necessary to facilitate pregnancy. These actions – rest and recuperation – reflect the general behavior of the “responsible” patient following medical intervention (Parsons 1975). Lack of congruence between the doctors' insistence on continuing life as normal and images of “responsible,” recuperating patients created space for women to maneuver between the biomedical discourse they wanted to embrace and their own embodied knowledge of pregnancy potential and past pregnancy/conception experiences, to produce their own interpretation of the behavior necessary to encourage pregnancy (Lippman 1999).

Not all women had the luxury of staying in bed following the ET, however. Many women who had traveled from other parts of Colombia (or further) could not take time to recover, as they needed to return home and/or were unable to take further leave from work. Mira, an ophthalmologist with a demanding practice where she worked “26 hours a day” in the eastern part of Colombia, explained she would stay in Bogota for two additional days and then would *have* to return to work (interview 7 Feb. 2013, her emphasis). Gabriela who is from San Andres said, “I do not have vacation time and will have to return to San Andres whenever I do not need to be at the clinic,” a predicament she was aware of before starting treatment (interview 21 June, 2013). Anticipating their inability to take time off work, a few women asked the doctor to provide a medical excuse to allow for recovery time, requests the doctors granted begrudgingly, as they did not recognize the need to adopt this “sick role.”

When women were unable to take to bed-rest following the ET, they changed (or anticipated changing) their behavior in other ways. Most mentioned foregoing physical activities, ranging from horseback riding to daily

running. Even before the ET was scheduled, Anita mentioned she could not plan her normal *Semana Santa* (Holy Week) camping and hiking activities with her husband, because the week would fall soon after the ET and she *could* be pregnant during the holiday (interview 21 Feb. 2013, emphasis added). Anita felt strenuous activity could prevent or interrupt pregnancy, but she also worried that a pregnancy conceived through ARTs would be a risky one, therefore she anticipated avoiding activities that could put such a pregnancy at further risk.

Scientific evidence is unclear about the risk of ART-pregnancies. The most cited complications are those of multiple gestations, which is mentioned widely in the literature, and was discussed in the clinics. Despite the lack of scientific evidence about the risk of conceiving through ARTs, however, some couples did see their pregnancies as more risky. During an interview with Sara and Pedro, Sara mentioned how their friend who underwent IVF was particularly careful following the ET, and had continued to worry throughout the course of her subsequent pregnancy. Sara had not previously expressed any concerns about having a medically conceived child, and Pedro appeared startled. He asked, “Why, are you worried?” and then began asking if conceiving through ARTs results in risky pregnancies or a higher likelihood of giving birth to a child with health complications (interview 27 Feb. 2013).

The fear of risky ART-pregnancies caused some husbands to pressure their wives to “take care,” to change their behavior and become more cautious. Two days following the ET, David said he would have to take over some of the household chores his wife usually did, such as cleaning and washing dishes, particularly because they require the use of chemicals (informal conversation 10 April, 2013). Larissa also mentioned that her husband, Nicholas, wanted her to “take care” following the ET. She explained, “He wants me to be careful, not to stress, and to forego any strenuous activity.” According to her, Nicholas was always protective, but his protectiveness was augmented by her possible pregnancy and it did not diminish once her pregnancy was confirmed. Instead, Nicholas insisted that Larissa continue her cautious behavior until their child’s birth, and he was skeptical when Larissa was told she could continue with her

normal activities (interview 25 May, 2013). This is similar to Whittaker's (2014), discussion of the particular case of Nut and Mani, a Thai couple who became pregnant through ICSI. Whittaker explains that Mani took a controlling, even overbearing, position once Nut became pregnant, making her stay in her room, while he took over the household responsibilities. According to Whittaker, Mani's behavior intended to protect Nut and their pregnancy, but in reality it reinforced patriarchal control while making Nut responsible for pregnancy success (24). Contrary to Whittaker's analysis, however, I do not interpret the protective character David and Nicholas adopted to have intended to control and place the responsibility for pregnancy success solely on their wives. Rather, their desire for their wives' to "take care," and the behavior changes they themselves made, demonstrates their desire to participate in this responsibility while indicating their recognition of their wives' liminal state of possibly pregnant and the possibility of a risky-ART pregnancy.

An emphasis on taking care and being cautious was often grounded in previous experiences of conception complications or early term miscarriages.

Angelica, for instance, was nervous about the pregnancy outcome because during an earlier (non-ART) pregnancy, the amniotic sac formed but no embryo developed inside it.<sup>42</sup> Thus, for months she had falsely thought she was pregnant: "My body displayed the signs of pregnancy, but there was no embryo." The failed conception caused Angelica's anxiety to persist until it was confirmed by ultrasound that an embryo was indeed growing inside the amniotic sac. (Informal conversation 25 Feb. 2013)

Women who had experienced previous failed ART cycles were particularly cautious following the embryo transfer. Pamela, who is from a city 200 miles from Bogota, had experienced a miscarriage four weeks after her first ICSI cycle. Following her second ET, she forewent most of her normal activities, which included her remaining in Bogota for a longer period of time in hope that a healthier pregnancy would develop (informal conversation 7 Feb. 2013). These

---

<sup>42</sup> The early term pregnancy complication Angelica had experienced was probably a blighted ovum or anembryonic pregnancy. Blighted ovum pregnancies account for approximately 50% of first trimester miscarriages.

women's knowledge that pregnancy was possible combined with their embodied knowledge of previous pregnancy complications propelled them to take additional precautions (i.e. minimizing their activities and avoiding traveling) to aid their chances of pregnancy success.

It should be noted that some women neither took precautions nor changed their daily activities in the hope of augmenting the chances of pregnancy. Instead, a few women heeded the advice of the fertility experts and continued their normal activities. Emma, for example, was castigated by another woman undergoing treatment for her lack of precautionous behavior:

Emma, a Colombian woman living in Miami, traveled to Bogota to undergo ICSI at Fertisuperior. After her first ET she returned to Miami the following day. Another woman who was undergoing treatment at Fertisuperior, Jamie, spoke to Emma about her treatment process, and was astonished that Emma would travel so soon after the ET. A few weeks later Jamie inquired of Dr. Diaz about Emma's treatment outcome. He sadly responded that her treatment was unsuccessful, the result Jamie had anticipated given Emma's lack of precautionous behavior. (Interview with Jamie 21 Feb. 2013)

When Jamie relayed this story to me, she thought that Emma had acted irresponsibly by not recognizing the significance of the ET. "She acted like nothing had happened... like it was any normal day. She did not take any time to rest, but rather was right back on the plane to the US" (interview 21 Feb. 2013). Jamie blamed treatment failure on Emma's lack of precaution and not taking time to recover. Emma, however, did not blame herself for treatment failure (interview 29 Jan. 2013). Following her second ET, Emma connected her first treatment failure with the limited probability of IVF success, a rational explanation that many women choose to embrace once having decided to undergo a subsequent treatment cycle (see chapter 10).

### *Anxiously Reading the Signs of Pregnancy or Treatment Failure*

Despite women's attempts to relax, whether physically or mentally, during the ten days following the ET, they were anxious about what their body would experience during that period and about the coming pregnancy test result, and found it nearly impossible to continue with life as normal. Women feared the embodied sensations that would indicate their menstrual period was coming. Some yearned to feel the oddities and discomforts of early pregnancy which, if experienced, were interpreted as confirmation of treatment success or failure before pregnancy could be scientifically proven. Monitoring the "signs" of pregnancy was a strategy to combat the anxiety produced by this liminal phase.

Similar to findings reported by Inhorn (2003b:210), women in my study characterized the ten days following the ET as the worst stage of the whole treatment process. Laura explained that waiting after the ET was filled with anxiety, constantly wondering whether or not the treatment was successful, and the inability to stop thinking about it. At this Laura trailed off, appearing to be thinking about the likelihood of treatment success at that very moment (interview 12 June, 2013). Alvina also mentioned how difficult it was to think of anything other than the treatment outcome: "Waiting is so difficult. I do not want to think about it, but I keep having dreams [related to the treatment outcome]. For instance last night I dreamed about giving birth" (interview 4 March, 2013). These examples show that despite women's desires to avoid dwelling on the treatment outcome during the waiting period, the liminality of this state overwhelmed them, and made it impossible to relax or detach themselves from constantly worrying about whether or not they were pregnant.

Women experienced both psychological and physical anguish in this waiting period. Angelica explained that she felt physically and psychologically unable to contain herself while she waited for the day when she would receive the results of the first pregnancy test (informal conversation 11 Feb. 2013). Some women blamed this anxiety and subsequent physical distress for treatment failure. In one such case, two sisters underwent fertility treatment simultaneously (Magdalena utilizing AI and Marisa undergoing ICSI), and felt

their anxieties fed off one another's, to the extent that Magdalena claimed, "This may have prevented both of us from conceiving" (interview 11 Feb. 2013).

Anxieties related to uncertainty and waiting were augmented by embodied experiences of *colico* and the fear of seeing blood, both of which signified different pregnancy outcomes for different women. During those ten days women appeared very aware of their bodies, particularly looking for signs that would indicate treatment failure. Some women mentioned feeling abdominal discomfort, or *colico*, directly following the ET. As mentioned in chapter 7, *colico*, is commonly used to refer to menstrual pains. Thus, some women related the *colico* to menstruation and, therefore, treatment failure, while others related it to the ET and catheter being inserted through their cervix. Francia recalled, "At times I had what felt like *colico*, like menstrual pains, and I would run to the bathroom afraid I would see blood, but there was nothing," saying the last phrase with such relief (informal conversation 12 June, 2013).<sup>43</sup> Francia's embodied knowledge of menstrual pain had led her to believe her menstrual period had started and treatment had failed. Fortunately, she had not been experiencing *colico* connected to her menstrual period, but a different sort of abdominal discomfort, for her pregnancy had already been confirmed by the time of this conversation.

Angelica, alternatively, read *colico* not as a sign of treatment failure, but as a sign of treatment success. The day before her first pregnancy test, she interpreted the abdominal discomfort as morning sickness, an indication that treatment had been successful (informal conversation 11 Feb. 2013). I do not know whether Angelica had a different sensation of abdominal discomfort, or merely expressed wishful thinking (or a combination of the two), but to her the sensation she embodied indicated a positive outcome, which the hormone test confirmed the following day.

Blood was another sign many women associated with treatment failure. Mariela told Dr. Mabel and myself, "I started bleeding a bit yesterday, it was brown in color, but then this morning it [her menstruation] really started and I

---

<sup>43</sup> Gerrits (forthcoming) and Inhorn (2003b:210) have reported similar narratives from women undergoing IVF treatments in the Netherlands and Egypt respectively.

had *colico*" (informal conversation 25 June, 2013). Mariela's mention of the brownish color of the blood the day before her consultation provided room for her to wonder if treatment had failed or if she was just spotting (women are taught in the clinic it is the dark red blood that indicates menstruation has started). However, the following day when her menstruation "really started" dissolved any room for hope; the blood definitively indicated treatment failure.

For other women, however, the significance of blood was more ambiguous. Anita explained that spotting after the ET was not uncommon, and it was not necessarily an indicator of treatment failure or pregnancy. She reiterated, "It does not mean anything." Despite Anita's assurance that small amounts of blood following ET were meaningless, she was convinced she would not see anything during the ten days leading up to her first pregnancy test (interview 21 Feb. 2013). For, Anita who had not yet experienced the stage following the ET, the presence of blood was meaningless, while for Mariela it was a clear sign of treatment failure.

Despite the women's desire to be in-tune with their bodies following the ET, the ambiguous signs of treatment success or failure (and the various meanings they held for the women) often made it difficult for them to determine for themselves if treatment had been successful. This finding corresponds with Sandelowski's (1993:125) research, where she claims an information overload (due to the knowledge of potential conception and recognition of bodily signs that would often go unnoticed during spontaneous conception) often caused women to be uncertain about their pregnancy status. Similar to Sandelowski, then, I largely attribute these ambiguities to women's attempts to recognize pregnancy at an early stage. As I will discuss below, women's awareness of their possible pregnancy combined with anxieties that accompanied the waiting-period (and the desire to escape this liminal stage of pregnant/not pregnant), ultimately reinforced the importance of medicalized pregnancy confirmation.



## The Ambiguity of the Pregnancy Test

Ten days following the ET, the women returned to the medical realm to have their blood drawn for the first pregnancy test. As the women re-entered the clinic they became exposed once again to the authority of the doctors and their medical probing. As a result of this probing, women were either drawn into a period of intensive pregnancy monitoring, or were advised to begin a subsequent cycle.

Most women recognized the pregnancy test as the first means of medically verifying their embodied sensations of pregnancy or treatment failure. Many women embraced the medical authority of the test, as it could remove them from their present pregnancy limbo. Georges (1996) discusses the authority attributed to the ultrasound due to its ability to verify pregnancy, as well as bring the entities displayed by the technology to life. In my research, however, most women regarded the pregnancy test as authoritative, as it medically determines pregnancy, while the ultrasound, as Georges describes it and as I discuss below, served more as a technology that creates pleasure. This took place through the images it created, images that allowed pregnancy to be *reconfirmed* while also permitting the women to connect visually with the embryo(s).

The significance the women placed on the pregnancy test's ability to determine if they would be mothers was reiterated when medical staff also acknowledged the significance of the results. The medical staff sympathized with the women's eagerness to know whether or not they were pregnant. Dr. Mabel often reassured his *pacientes* that pregnancy results would be available soon, reminding them the laboratory would process the tests in 12 to 24 hours. Attempting to reduce women's anxiety, Nurse Luz would willingly call the laboratory when women asked if results had been processed but not released to them. The medical staff's recognition of the women's anxiety, and their subsequent desire to relay results quickly, reinforced the significance of the results and the *need* to confirm treatment outcomes through further medical

examinations, while also discrediting the women's embodied signs of treatment success or failure.

Despite the authority attributed to the technology (by the women and the medical staff alike), and women's eagerness to receive the first pregnancy test results, the results are often ambiguous. The test does not definitively indicate pregnancy, particularly at this early stage. The blood test measures the level of human chorionic gonadotropin (hCG) hormone in the woman's body. HCG begins to be produced as soon as the embryo attaches to the uterine wall and placental cells develop. The hormone can first be detected in the blood approximately ten days following implantation, or after 12-14 days through a urine sample. The range of hCG levels in the blood at first detection varies greatly, from 5 to 50 mIU/ml. A value below 5 mIU/ml indicates not pregnant, but a measure between 5 and 25 mIU/ml provides an ambiguous result. Medically speaking, a single blood test is insufficient to determine pregnancy and, consequently, women are scheduled for another blood test, generally two days after the initial test.

Even with two positive hCG exams, however, pregnancy is still not conclusive. In spontaneous and assisted conception alike, an increased hCG level can indicate a chemical pregnancy (when only the placental cells grow). However, the likelihood of chemical pregnancy may appear higher with assisted conception because hCG levels are measured only ten days following the embryo transfer. This augments the likelihood for the hCG level to initially increase, as indicated by the blood test results, only later to diminish and return to normal indicating a chemical pregnancy. Performing the hCG test only a few days later – as is common with spontaneous pregnancy when the woman waits for a missed menstrual period to suggest she could be pregnant<sup>44</sup> – may reveal a normal hCG level, and, thus, treatment failure.

The woman's awareness of the exact moment when embryos were transferred, and the timeframe within which she could become pregnant,

---

<sup>44</sup> The development of new early detection pregnancy tests that can determine pregnancy up to a week before a missed period is changing the moment when women conceiving spontaneously recognize pregnancy, which also may appear to increase the probability of chemical pregnancy.

encourage her to look for pregnancy at a particular moment, while increasing the likelihood of false positives (chemical pregnancy). Approximately 50 to 60 percent of first time pregnancies do not progress past chemical pregnancy. Notwithstanding the high probability of chemical pregnancy, however, none of the women in this study discussed experiencing *chemical* pregnancy, because they interpreted an increased hCG level as a *confirmed* pregnancy. If the subsequent ultrasound did not reveal the embryo(s), women inferred that they had miscarried – not had a chemical pregnancy.<sup>45</sup>

Regardless of the ambiguity of the hCG blood test, for many women (particularly those who had not experienced pregnancy complications in the past), the blood test confirmed that pregnancy had occurred. Angelica, for example, told her whole family the first pregnancy test came back positive:<sup>46</sup>

Angelica is from a city in La Costa that I visited the weekend following her first pregnancy test. When Angelica heard I would be in “her city” she invited me to lunch with her family on Sunday, six days following the pregnancy test. Upon arriving at the restaurant that Sunday afternoon I was greeted by Angelica’s aunt and uncle who were overjoyed that their niece was finally pregnant. Within the first hour of my visit with this ecstatic family (lunch in Colombia can last hours) they were discussing who would go to Europe (Angelica and her husband were moving to Europe) to help Angelica with the twins she would have in nine months time. (Informal conversation 17 Feb. 2013)

For Angelica’s family, the positive pregnancy test ten days after the ET was proof of pregnancy. Moreover, they assumed she would have twins, as two embryos had been transferred to her uterus. This presented a common misunderstanding of informants, who believed that if one embryo implants, then all the embryos transferred would implant.

Larissa and Nicholas also inferred a positive outcome from the results of their first pregnancy test. I met them for the first time within an hour of their

---

<sup>45</sup> Inhorn (2003b) reported similar findings in Egypt.

<sup>46</sup> Generally speaking Colombian women are not accustomed to keeping their pregnancies a secret until the end of the first trimester, as is common in the US and the UK. Rather, as one husband explained, as soon as a woman knows she is pregnant “the whole world knows,” there is no waiting to determine if the pregnancy will last. He was speaking in regards to pregnancy in general, not only ART pregnancies (interview 22 Jan. 2013).

receiving the news that Larissa's blood test was positive. They were both ecstatic, grinning from ear to ear, but also astonished that the first cycle had resulted in pregnancy. Nicholas said they had already notified their families about Larissa's pregnancy, and by the end of our conversation, Larissa was complaining about her husband's protectiveness, which she assumed would be augmented by her current status (interview 25 May, 2013). Angelica's family, Larissa, and Nicholas' faith in the first pregnancy test, demonstrates a strong desire to embrace the confirmation of pregnancy as soon as possible. I interpret this as an extension of their desire to end the liminal phase of pregnant/not pregnant, as well as the liminality of infertility. Additionally, it reflects their faith in the efficacy of the pregnancy test, and their lack of awareness of chemical pregnancy and the chance of miscarriage.

### The Multiple Meanings of Sonography

When both pregnancy tests were positive, a transvaginal ultrasound was scheduled for approximately three weeks after the embryo transfer (approximately five weeks gestational age). For the women who interpreted a positive blood test as confirmation of their pregnancy, the ultrasound was their first chance to see their future child (e.g. Mitchell 2001; Georges 1996:161; Mitchell and Georges 1997:378), an experience that reconfirmed pregnancy while producing sentiments of excitement and joy. The first ultrasound was also a means to identify if a woman was carrying twins or a singleton (or possibly triplets), and to assess the health of the developing embryo(s). For the women who were less willing to accept the first or even second positive pregnancy test as confirmation of a positive treatment outcome, generally due to their embodied knowledge of past pregnancy complications, the first ultrasound may have provided confirmation that they were pregnant, and removed them from their liminal state. However, it could lead to further uncertainties.

## *Seeing Life*

I interviewed Nora two weeks after her first ET. That morning, she told me confidently that her pregnancy had been confirmed a week earlier through the increase in her hCG hormone level. In four days, she would have the first sonography “to see if there are one or two babies growing inside me” (interview 25 Feb. 2013). Nora was anxious about the first ultrasound, not because she worried that she might not be pregnant or that her “future child” might present complications, as reported by the women in Gammeltoft’s (2007) study in Vietnam, but because she wanted to know if she would be having twins, as she desired, or a singleton. Nora’s attention was focused on the technology’s basic detection abilities to *show* her how many embryos she was carrying. She was unconcerned, and possibly unaware (she did not mention any concerns when prompted by my questions), that the technology might detect complications for her pregnancy or her embryo(s). She was still astonished and overjoyed that the first treatment cycle had resulted in pregnancy, and thrilled by the prospect of having a child.

Angelica, alternatively, was anxious about the initial ultrasound, an anxiety that stemmed from a combination of curiosity about the number of embryos and previous early stage pregnancy complications.

The morning Angelica arrived for her first ultrasound, she told me she was very anxious to have the ultrasound done, and thus called out Dr. Diaz’s name as he walked through the waiting area to inform him she was waiting.

A few minutes later she was setting her bag down in Dr. Mabel’s office and heading to the small bathroom in the examination room to change. When she emerged in the pink robe she instantly went to sit in the large recliner, put her feet in the stirrups, and looked at Dr. Diaz with anticipation. He asked if she wanted to see a singleton or twins as he prepared the ultrasound wand. She commented she only wanted to see one amniotic sac and one embryo. I then asked if she was nervous. Looking at Dr. Diaz and not me she said, “A bit,” and then explained she had been pregnant before but only the gestational sac formed, not an embryo, so she was worried about seeing an empty gestational sac again. Without responding, Dr. Diaz continued preparing the ultrasound equipment.

A moment later the ultrasound image of Angelica's uterus was projected onto the television screen in front of us. The image revealed only one blurred amniotic sac, but Angelica wanted confirmation of this and asked Dr. Diaz if there was any possibility of there being a second one, which he denied. Dr. Diaz then enlarged the image and started explaining the different objects we were looking at on the screen. Pointing to different images he explained, "Inside the amniotic sac is the yoke sac, which nourishes the embryo, and this here is the embryo," he pointed to a small, white blob. Angelica asked once again if he was sure there was not a second embryo. Upon receiving confirmation a second time, she began to stare in awe at the white mass depicted on the screen. Her mouth fell open a little bit as she continued looking at the image. At one point I heard her mumble two names, "Juan Manuel or María Cristina." I asked if she has already picked names, she responded, "I chose names for my future children when I got married." Dr. Diaz finished the ultrasound, removed the wand, and printed off three photos of the sonogram to give to Angelica before she left. At this, she removed her feet from the stirrups and went into the bathroom to change. (Observation 25 Feb. 2013)

Angelica regarded the first pregnancy test as confirmation that she was indeed pregnant, but given her past experience with early term pregnancy complications, she still doubted the viability of the pregnancy the ultrasound would reveal. Dr. Diaz interpreted the ultrasound as a clear image of an embryo and Angelica's concerns transformed within seconds from detecting a viable pregnancy to detecting a specific number of embryos. Once Dr. Diaz confirmed that she was indeed pregnant with only a singleton, she was relieved and could enjoy the image of what she saw as her future child.

For Angelica, seeing this blob-like entity developing inside her womb (re)confirmed that she was actually pregnant. Seeing, in the sociological tradition, has commonly been associated with the mind, with the means of knowing, which is detached from the sensual experiences of the body (Shilling and Mellor 1996:5). Social scientists have noted the reality-producing effect of seeing the fetal image for the first time through an ultrasound that can confirm a woman's pregnancy (e.g. Georges 1996:163-164; Mitchell and Georges 1997:388; Nash 2007). Yet the act of seeing this entity in her body did not reduce Angelica's embodied sensations of pregnancy, such as the *colico* she mentioned experiencing that morning, as many studies of later stage pregnancy

ultrasounds have suggested (e.g. Georges 1996:164; Mitchell and Georges 1997:378-379; Mitchell and Georges 1998:110; Sandelowski 1994:241-242).<sup>47</sup> Instead, the uncertain embodied experiences of what Angelica believed were sensations of pregnancy became *real* sensations that she could then confidently attach to her pregnancy.

The reaffirmation of pregnancy and seeing the entities inside their wombs also gave the women (and their accompanying husbands) intense happiness as they gazed upon their future child, a finding also reported by Georges (1996) in Greece and Gammeltoft (2007) in Vietnam.

As I walked into the examination room I found Nicholas standing in front of the television screen that was displaying an image of his wife's uterus with a white blob in the middle. He was staring from the screen to his phone, on which he appeared to be sending a text message. Noticing me standing in the doorway, I asked Nicholas about the image, referring to the screen, and added, "Congratulations!" He thanked me, and continued typing on his phone. When he looked up again he said, "I already took a photo [referring to his phone] and sent it to my sister. With technology the whole family will know [about the ultrasound outcome] before we return [home]." At this moment Larissa emerged from the bathroom. She was grinning from ear to ear and her skin seemed to be gleaming. She appeared as though she could hardly contain her emotions/excitement. Smiling at me, she turned to the screen, joining her husband as they marveled at the tiny white blob. Still looking at the screen Nicholas touched his wife's belly and gave it a little rub his gaze moving from the screen to Larissa's belly as he did so. (Observation 1 June, 2013)<sup>48</sup>

The pleasure expressed on Larissa and Nicholas' beaming faces was derived from the visible proof that the ultrasound image had provided, and that they could now share this image of pregnancy confirmation with others. Even though the image Larissa and Nicholas received was only a small white blob without

---

<sup>47</sup> This difference may be due to the early stage at which the ultrasound was performed, revealing only a small blob-like entity, instead of a life-like fetus, moving about or sucking its thumb as later stage sonograms may reveal. Thus Angelica may not have become as "captivated" by the ultrasound image, preventing the entity from being detached from Angelica as Mitchell and Georges have suggested (1998:110).

<sup>48</sup> Larissa and Nicholas told me during a later interview that Dr. Diaz had actually pointed out two embryos during the first ultrasound, but one was much smaller than the other. The doctor explained to them that the smaller one may continue to grow, or it may be absorbed back into the uterine lining or aborted resulting in a singleton. The latter was the eventual outcome (interview 22 June, 2013).

human characteristics that needed to be interpreted by the doctor, the image became evidence that Larissa was carrying their future child. Her pregnancy was no longer merely an increased hormone level reading; it had become an observable entity. The power of the image as proof of pregnancy was clearly evident in Larissa and Nicholas's joyous reaction and their desire to share this proof with their families.

The ultrasound also produced happiness through its ability (combined with the doctor's interpretation) to reveal the viability of the developing entity. As I discuss in further detail below, an ultrasound three weeks after the ET offers minimal detail. Viewing the white mass identified as the embryo by the doctor could reconfirm a viable pregnancy. At this early developmental stage, however, the women relied heavily on the doctor's ability to decipher the grainy image. The fertility expert's lack of concern reassured the couple of the health of their future child, dispelling anxiety and anguish in the process.

### *Ambiguous Images*

Despite the reassurance that the ultrasound image gave most women, it also had the potential to produce ambiguous results at this early stage of pregnancy. Three weeks after the ET, a transvaginal ultrasound should reveal the gestation sac, the yoke sac, and possibly the fetal pole – or what the fertility specialists considered the embryo.<sup>49</sup> Yet embryos do not develop at the same pace. Sometimes, the rate of development may not cause concern, and the doctor may simply ask the woman to return for an additional ultrasound five to seven days later. In other cases, however, the ultrasound may suggest that the entity has stopped developing, as in the case of Felicia, the only devastating case of an ambiguous three-week ultrasound I observed.

Felicia, lying on the examination recliner, her feet in stirrups, eagerly awaited her chance to see her future child for the first time. Dr. Mabel

---

<sup>49</sup> A transvaginal ultrasound can detect fetal development in the uterus approximately a week before a transabdominal ultrasound.



gently moved the transvaginal ultrasound wand around in Felicia's vaginal canal as he attempted to locate the entity. Upon finding the white mass Dr. Mabel stared in silence as he switched the angle at which we could see the blob on the computer. He appeared uncertain about the images he was analyzing on the screen in front of us. Still looking at the screen, he told Felicia and me that what we were observing inside the embryonic sac, which was clearly visible, was not the embryo [the image I had assumed was the embryo]. Rather, the image we were all staring at was the yoke sac. He then contradicted himself saying we could be looking at the embryo from a side angle [therefore, it could be the embryo], but if this object was the embryo then it was not developing at the rate it should be. Felicia, expressing evident concern, asked the doctor what this meant. He told her not to worry, took another moment to look at the uterus, and then removed the wand and told her she could change. (Observation 26 July, 2013)

Dr. Mabel's apparent uncertainty may have reflected his reluctance to tell Felicia that treatment had failed once again (Felicia had already undergone eight ART cycles of various intensities). The ambiguity of this entity was reinforced when Dr. Mabel told Felicia to return the next day for another ultrasound to see if he could decipher a clearer image, and then suggested that she also have blood drawn to check her hCG level again. Felicia left the consultation office that day back in limbo – unsure if she was pregnant or if the child that had been growing inside her had perished. The blood test results revealed that Felicia's hCG level had decreased, indicating she was not pregnant, and eliminating the need to perform another ultrasound. From Felicia's conversation with Dr. Mabel and myself, Felicia had clearly regarded herself as pregnant between the positive pregnancy test and the first ultrasound, but when the ultrasound showed no clear image of an embryo, Felicia (temporarily) returned to a liminal state of possibly pregnant.

Like Felicia, Pamela's first pregnancy test also conferred that she was pregnant. At the first ultrasound, she was thus expecting clarification about whether she was carrying twins or a singleton, but received ambiguity results. During an interview approximately three months later, Pamela explained that two embryos had appeared on the screen during her first scan but another ultrasound, eight days later, only depicted one embryo. According to Dr. Mabel's explanation, one had been reabsorbed into the uterine lining. Pamela did not

appear devastated that one of the embryos had stopped developing, but her image of an ideal pregnancy had been reshaped by the possibility of having twins, or the knowledge that she was at one point pregnant with twins. She began talking about the benefits of having twins, how they could grow up together, and her parents-in-law's desire for more grandchildren, indicating that having twins would please them (interview 18 June, 2013). During many other conversations, Pamela had never mentioned wishing to have twins or even to have two more children (she had already raised a daughter from a previous relationship). She wanted one child, to give her husband the chance to raise a child of *his* own. The two entities growing inside her womb had slightly altered Pamela's perception of treatment success, which *might* not have happened but for the early stage ultrasound image that she had seen, and *would* not have happened if the ultrasound had been just one week later. Pamela's story demonstrates how the technology and early term ART-pregnancy monitoring can alter a woman's perception of the ideal outcome.

#### Embracing Pregnancy Monitoring/Embracing Medicalization

In Colombia, ultrasounds are widely used as a means to monitor pregnancy in both public and private medical facilities alike. If no fetal abnormalities are suspected or diagnosed, the ministry of health advises only a single ultrasound (Ministerio de la Protección Social 2007), which limits how many ultrasounds a woman can access if she cannot afford private care. There is, however, a demand for "social" ultrasounds, intended "solely for the purpose of allowing pregnant women and their partners and other family members to view images of the unborn as a social event" (Lupton 2013:35). Similar to Gammeltoft's (2007) report from Vietnam, the demand for this technology has created a consumer market around sonography that is reflected in the numerous Groupon advertisements that appeared in Bogota throughout my fieldwork.<sup>50</sup> In

---

<sup>50</sup> I did not specifically monitor the availability of ultrasound Groupon advertisements, so other promotions that may have been available did not come to my attention.

approximately six months, four Groupon advertisements from three different clinics became available, offering a 3D or 4D ultrasound, take home DVD of the moving fetus, and digital and print photos for 75,000 to 125,000 pesos (approximately US\$41-69), depending on the clinic. The advertisements also specified that medical information would be provided, but this was placed at the bottom of the advertisement, as high-resolution images and take-home mementos were the enticing aspects of the offer. This shows how the diagnostic and monitoring purposes of sonography performed by medical experts have been replaced by the novelty of seeing a life-like image of one's future child. Further, the consumerist demand for ultrasound imaging has normalized the use of the technology for people who can afford it. Early term ART-pregnancy monitoring acquired a similar normative sentiment for women who had acknowledged/embraced their pregnancy and for whom no developmental abnormalities were detected. The diagnostic capacities of ultrasound also diminished in the doctors' eyes as pregnancies came to be interpreted as healthy and viable.

*From Embryo to Child: Diagnostic to Imaging*

The three-week ultrasound marks the beginning of prolonged pregnancy monitoring. Fertisuperior recommends and provides its *pacientes* with pregnancy monitoring until the end of the first trimester (although women diagnosed with high risk pregnancies or multiple gestation pregnancies may continue monitoring at Fertisuperior beyond the first trimester). The women's continued clinic visits during this period allowed me to accompany them through what I have termed "intensive" pregnancy monitoring. This entailed an ultrasound every eight days for the first month after the initial ultrasound (until approximately eight weeks gestational age), with monitoring reduced to every 14 days thereafter. Women living in or close to Bogota utilized the continued monitoring offered at Fertisuperior at an additional cost. Women living far from Bogota commonly continued ultrasound observations at a local (private)

facility. Medivida does not have the resources (space, time) to offer further pregnancy monitoring and women are advised to continue prenatal care with their gynecologist or obstetrician.

Women's narratives reflected a diversity of reasons for embracing continued monitoring: wanting to monitor embryonic development, needing reassurance of the health of their pregnancy, or, if they were confident about the pregnancy outcome, simply wanting to see their child-to-be again. Women's reactions to continued monitoring reflected their embodied knowledge of pregnancy complications and pregnancy loss and their embodied sensations of the current pregnancy. Women who had not experienced pregnancy complications previously (or those of a close friend/family member), emphasized the ultrasound's ability to show their developing child, a sensation that lost its novelty with each passing ultrasound. Women with embodied experiences of pregnancy difficulties, by contrast, saw the ultrasound as a tool to reassure them that their pregnancy was viable and would progress until birth.

During intensive pregnancy monitoring, all the women discussed the significance of viewing their future child's development, a comment that was often related to the increasingly visible details the sonogram depicted as development progressed:

I noticed Francia sitting on the metal sofa as I walked into the waiting area. She said hi to me, and I went over to greet her. I told her, "Congratulations, I heard there are two [embryos]!" She responded in a cheerful voice, "Yes, we are back today to see them better!" (Informal conversation 12 June, 2013)

Sitting on the examination table, waiting for her second post-ET ultrasound, Talia expressed how excited she was to have another look at the baby growing inside her. Dr. Mabel entered the room and prepared the transvaginal ultrasound wand while making small talk with Talia. He began the examination explaining the details of the entity that appeared on the screen. Looking at Talia he said, "Yes, everything looks normal for this stage." Talia giggled a bit with joy and smiled back at Dr. Mabel ... After the ultrasound, Talia emerged from the changing room and while staring at the stilled image of the embryos exclaimed, "Tan bonito! Si?" [How beautiful! Yes?]. (Observation 26 July, 2013)

Both Francia's and Talia's narratives highlight the eagerness and pleasure associated with viewing a clearer, more developed "child." As pregnancy progressed, the ultrasound images became more detailed and more humanlike with every passing week, aspects of the ultrasound that the women embraced.<sup>51</sup> The images also gave the doctor further information about the developing embryo(s), which they then relayed to the women. When women received no diagnostic information, or a definitive response like that which Dr. Mabel provided to Talia, they were reassured that the child(ren)-to-be was developing properly. This provided further pleasure for the women, even if they had not been worried or inquired about further information. As embryonic development progressed, women relied less on the doctor to interpret the sonographic images and instead merely enjoyed the increasingly humanlike entity developing inside them.

Women were disappointed when monitoring was on a 2D ultrasound machine (which offers a grainier, less life-like image) rather than a 4D machine. After Pamela left the examination room, I asked if she saw a clear image of the fetus and she responded, "Not on the ultrasound machine they used." She explained that that machine does not produce a detailed image like the one in Dr. Mabel's office [the 4D ultrasound]: "I would rather see the clear image from the other machine" (informal conversation 18 June, 2013). As indicated from this narrative, Pamela, like Francia and Talia, regarded routine ultrasounds as a means for her to see her developing child.

The reduced biomedical significance of pregnancy monitoring was also reflected at times by the doctors, as they, too, started to see the ultrasound merely as a means for the couple to "see the baby," a phrase expressed by Dr. Mabel proceeding a routine ultrasound. The non-diagnostic way in which the ultrasound came to be used in cases of "healthy pregnancy" corresponded with the doctor's adopting a new vocabulary for the embryo as it was transformed into a "baby." The doctors were commonly cautious to refer to the entity

---

<sup>51</sup> See Gammeltoft (2007:144) for a similar discussion from her research in Hanoi.

developing inside the woman as either an embryo or fetus (depending on developmental stage) partly to create distance between the woman and what she considered her child. For instance,

While discussing the significance and viability of gestating embryos with three pre-medical interns visiting the clinic, Dr. Mabel explained, "It is very important that we [referring to the medical staff] use clear terminology in the clinic, calling an embryo an embryo, and a fetus a fetus, not a baby or child." He went on to describe an incident where at 20 weeks of pregnancy the gestating *fetus* was found to be missing the frontal lobe of the brain and the skull. He had to inform the couple that they could either abort the *fetus* or carry it to term for it only to live for a maximum of two hours, the former being Dr. Mabel's preference. (Informal conversation 30 July, 2013, my emphasis)

Despite this intended differentiation between fetus and child, however, as pregnancy progressed, the doctors also started referring to these entities as "babies" during the ultrasound, a practice that has been noted by other scholars exploring the use of "social" ultrasound (e.g. Lupton 2013:36; Palmer 2009:183; J. Roberts 2012). I did not detect a definite moment when this transition occurred, but it clearly related to seeing the pregnancy as viable and likely to proceed to birth.

With the diminishing biomedical significance of the ultrasounds and the waning novelty of seeing the developing entity, some women found routine pregnancy monitoring problematic, particularly if they had to endure long travel times to reach the clinic.

While I was talking to Larissa as she waited for her fourth ultrasound, she asked me, appearing annoyed, "How many more times will we have to make the trip to Bogota for the [ultrasounds]?" Nicholas, also appearing frustrated with the journeys, added, "Every other Saturday we leave our home at 5am to drive over three hours to the clinic." (Informal conversation 22 June, 2013)

Larissa and Nicholas' former eagerness to see their developing child had begun to wane, lessening their desire for medical intervention. The continued "normal" ultrasound results had alleviated any concerns about their future child's health,

while the image of the slowly developing embryo no longer enticed their enthusiasm.

### *Embodying Risk, Seeking Reassurance*

It is one thing to get pregnant, but it is another to keep the baby and carry it to term. (Interview 11 March, 2013).

The above quote is from Samara, who had experienced two miscarriages before trying to conceive through assisted conception, which, thus far, included two failed AIs and a failed ICSI cycle. Samara's practical (or realistic) approach to pregnancy parallels the perpetual anxiety embodied by other women who had experienced miscarriages, pregnancy complications, and treatment failures. Their previous experiences of loss prolonged the liminal phase they endured following the ET, and propelled them to embrace intensive pregnancy monitoring as a means of repeatedly reconfirming the pregnancy's viability. The following narratives reflect women's concerns about their child-to-be's health as they relived past pregnancy complications and embodied the perturbing sensations of the present one.

Sandra was 44-years-old and single. Seeing ARTs as her only means to have a child, she decided to undergo an initial IVF cycle with donated sperm. The first cycle resulted in pregnancy, but she miscarried two weeks after the pregnancy was detected. Her subsequent cycle, which utilized both donor eggs and sperm, also resulted in pregnancy. Speaking to me four weeks after the embryo transfer, Sandra explained, "I come every eight days for an ultrasound. I will remain very *juiciosa* [diligent] to make sure the baby stays healthy." Having heard the heart beat during the second ultrasound, she felt more confident about the pregnancy and said she would start telling people she was pregnant. (Interview 27 April, 2013)

Sandra's embodied experience of early miscarriage manifested as concern about the viability of her current pregnancy. She saw ultrasound monitoring as a means to prove that her current pregnancy was developing healthily, a notion that may have been linked to the reassurance provided by viewing a "healthy"

embryo through the ultrasound (and the doctor's interpretation). Sandra's narrative reflects those reported by Gammeltoft (2007) in Hanoi, where women continuously utilized sonograms to relieve anxieties concerning the development of the fetus. Gammeltoft explains how the fetus is perceived as an ambiguous being, unstable and contingent, in many Asian cultures, and how women repeatedly gained reassurance regarding this unstable entity through "normal" ultrasound diagnoses (145). Unlike Gammeltoft's findings, however, the women in my study worried about the viability of the developing embryo/fetus (depending on the stage of the pregnancy) because of their own embodied knowledge of pregnancy complications and loss and embodied sensations of the current pregnancy, not because of the contingent nature of an ambiguous entity.<sup>52</sup> Furthermore, Sandra's experience of past pregnancy complications made her wait to inform others until she was convinced that the pregnancy was viable. For Sandra, the liminality was prolonged until she could hear the heartbeat.

As I entered the waiting area, I saw Paula sitting on the small sofa staring off into space. When I said "good morning" she looked up, obviously surprised to see me, she had not noticed me walk over. She apologized and explained she was worried about the twins because she had been bleeding. She continued, "I know sometimes it is normal and does not mean anything, but I want to make sure everything is ok." (Informal conversation 15 June, 2013)

Paula's previous pregnancy difficulties had led her to perceive any *potential* abnormal manifestation as inherently negative. Despite Paula's recognition that vaginal bleeding during pregnancy may *not* be abnormal, she interpreted blood as a sign of pregnancy risk and she sought an ultrasound to (re)confirm her twins were healthy. In the end "the twins [were] fine," but Paula was diagnosed with a uterine infection that required her to take antibiotics and stay in bed for 12 days.

---

<sup>52</sup> Gammeltoft also relates women's concerns to "awareness of risk generated through experience." This experience, however, is mainly attributed to the experience of "intimate others" instead of the women's own experiences of pregnancy complications (2007:146-147).



Bella, who, like Paula, had a long history of miscarriage and treatment failure, also returned to the clinic because of fears of miscarriage.

Bella had come to the clinic one morning for an ultrasound because she had been experiencing *colico* the past mornings and now was bleeding. She was worried about the “two babies growing inside” her. Lying on the recliner in the examination room, Dr. Mabel, Bella, and I soon saw the two fetuses moving about inside Bella’s womb.

Bella: “Everything scares me and I prefer to come [to the clinic].”

Dr. Mabel: “I get scared too. It is better that you come.”

While Dr. Mabel finished the ultrasound, Bella watched the two fetuses move about. (Observation 2 Aug. 2013)

Like Paula, Bella embraced the information the ultrasound provided and the technology’s ability to alleviate the uncertainties her body was experiencing, while Dr. Mabel applauded Bella for choosing to seek out medical surveillance.

Lupton (1997b:99) explains how medical staff urge patients to “understand, regulate and experience their bodies” through a medicalized lens, a process that simultaneously reinforces the authority of the “medical gaze” and diminishes the patient’s embodied experiences. During the fertility treatment journey, doctor-patient interactions reinforce the importance of medicalization, conditioning the women to embrace the “knowing” ability of the technology (Morgan 1998). This conditioning may also propel women to engage in self-surveillance, which Howson (1998:223) characterizes as a means to reinforce “their recruitment to the [medical] management of their own bodies.”

Even though Paula and Bella embraced the ultrasound machine’s diagnostic abilities, this did not necessarily eliminate the “women’s multifaceted embodiment and consciousness” of their pregnancy and the entity growing inside them (Rapp 1997:39), in contrast to what numerous ethnographic studies of ultrasound monitoring have suggested (cf. Georges 1996, Mitchell and Georges 1997, Nash 2007). Rather, Paula and Bella’s awareness of their bodies and embodied sensations that something was wrong led them to worry about

the health of their future children and seek the reassurance of the ultrasound.<sup>53</sup> Paula's awareness of her body and her embodiment of pregnancy risk allowed the uterine infection to be detected and treated. The ultrasound diagnosed the infection, but her agency led to the diagnosis. In both of these cases, Paula and Bella were drawn back into the medical realm through a combination of their own awareness of their bodies (that had been heightened through embodied knowledge of pregnancy risk) and of their desire to embrace the reassuring diagnostic abilities of the ultrasound.

### Conclusion

In this chapter I have explored how the liminal phase of pregnant/not pregnant, created through the transfer of viable embryos to the womb, propelled women to take various actions to facilitate or maintain pregnancy. Following the ET, the women adopted "self-monitoring" (first through changing their behavior and "taking care"), and later through selectively interpreting the significance of early term pregnancy detection techniques. Women embraced medical surveillance – the knowledge produced by the technologies and examinations – to remove themselves from their liminality. The extent to which these women recognized the efficacy of these often ambiguous results depended on their personal histories, as they negotiated when and to what extent these techniques produce legitimate knowledge. Women who embraced the "knowing power" of these technologies early on quickly transcended the liminal phase, allowing subsequent ultrasounds to become imaging experiences instead of diagnostic examinations. On the other hand, those who denied the veracity of positive results remained in limbo longer, until they could be certain the pregnancy would come to term.

In brief, these case studies show how embracing medicalized surveillance and adopting "self-monitoring" did not mean that women were

---

<sup>53</sup> This is similar to Mol and Law's (2004) study of diabetics' ability to decipher that their blood sugar is low through awareness of their bodies, which alleviates their reliance on medical devices.

transformed by the medical profession into “disciplined” and “docile” beings, devoid of knowing the body through bodily experiences. Rather, the women’s combined desires to deny or confirm the embodied sensations of pregnancy and remove themselves from liminality pushed them to embrace medicalization. It was through a heightened awareness of bodily experiences, developed through embodied knowledge of infertility, pregnancy complications, and miscarriages, that women returned to the medical scene when confronted with potential risk, risk that they feared would return them to a state of liminality. Combined, the women’s desires to surpass liminality, and the desire to bring a pregnancy to term, create an *active, agentic, and embodied* form of “self-monitoring,” a practice that may not change the treatment outcome, but one that allows women to take control (at least partly) of the early stages of possible pregnancy. Unlike the liminality produced during rites-of-passage referred to in Turner’s writing (1991[1969]), however, the liminal phase between pregnant/not pregnant does not always culminate in “passage.” Nearly three-fourths of treatments end in failure, accompanied by a multitude of losses, including the losses of bodily- and self-confidence, which will be explored in the next chapter.

## Chapter 10

### Treatment Failure: Reflections and Renegotiations

It was February 7th; I had only been conducting interviews at Fertisuperior for a couple of weeks, but imagining I would find the opportunity to interview someone who had just experienced treatment failure interesting, Luz instructed me to go to Dr. Mabel's office. As I walked through the door I was surprised to see Ariana sitting across from Dr. Mabel. Ariana lives in Italy with her husband, but had come to Colombia, her home, to undergo an IVF cycle. When we met previously she was preparing for the embryo transfer. Now she was red in the face, her eyes bloodshot from crying. Unsure how to comfort her I said, "I am so sorry," as I went to sit in the seat Dr. Mabel had just left. Dr. Mabel motioned for Ariana's mother who had accompanied her to exit the room, leaving Ariana and me in the office alone. After clarifying that Ariana did want to talk to me and that her story could still be used for my research, her experience of treatment failure came rushing out.

Ariana began explaining that the embryos developed from her sister's ova and her husband's sperm did not implant. She reiterated her desire to use a known donor, someone who possesses traits from her family, allowing a subsequent child to be a part of her husband and herself. She discussed the strong bond she had with her sister, and her sister's ability to detach herself from her genetic material given her biomedical background – her sister saw her ova as "just tissue." Furthermore, she could not use the ova of another family member because she was not as close with anyone else, nor would she want her entire family involved if there was a disagreement about a subsequent child. Ariana appeared to be reiterating this information which we had previously discussed as a way of reflecting on why she chose to use the ova of a reproductively mature woman (her sister was 38 at the time of the interview, the clinic recommends that egg donors be younger than 33-years-old) while recognizing she did not have another option for a known donor.

Ariana explained, "I am in a dark place where everything is negative." She recognized she needed to wait for this moment of darkness to pass, but she did not know how to deal with the situation right then and there. She began to recap all of the negative things that had happened during the previous year: the death of her grandmother, being diagnosed with premature menopause, and the economic crisis in Italy. "I told myself 2013 would be better, but now I am starting the year with an unsuccessful IVF treatment."

Referring to her current state she said, "I had imagined before the treatment that everything would be fine and if the treatment failed I

would be calm and ready to think about what the next step would be.” She explained she had been calmer when she received the news yesterday, sad, but more collected. She spoke to her husband, who was also very distraught, on the phone (he was in Italy); his absence made the situation more difficult for both of them. She exclaimed, “Today I am much worse,” adding, that is why she came to the clinic.

She wanted to discuss other possible avenues to obtain a child – adoption, anonymous ova donation – but, at the same time, she had doubts about these various other options, doubts that she did not think she could overcome. From my perspective her doubts appeared irrational at times, for instance when she started to worry that her husband may also have a fertility complication, despite no diagnosis having been made. She knew she could not start another cycle right then as she was going back to Italy, nor did she appear sure she wanted to, but she was not ready to accept being childless either.

After nearly 90 minutes of an emotional-rollercoaster of a conversation, Ariana appeared to be a bit calmer. She had agreed to speak to a psychologist about her treatment failure (I gave her the information for a psychologist in Bogota) and she mentioned she would search for an infertility support group upon returning to Italy. As we said our goodbyes Ariana thanked me for listening to her, hugged me, and breathed a sigh of relief before walking into the waiting area to find her mother. (Interview 7 Feb. 2013)

The above narrative reveals the despair and hopelessness women often experienced upon recognizing treatment failure. Ariana’s story was, of course, not necessarily typical of treatment failure, as women’s experiences were multiple. However this interview does remind us of how women continuously experience moments of reflection, renegotiation, and doubt, during the treatment process. Franklin (1997:131) argues that exploring “women’s perceptions of their needs, desires and expectations of the technique” is important to understanding how they make sense not only of “the experience of IVF” as a procedure, “but as a process over time which involves continual re-evaluation.” The experiences of women in this study were a rollercoaster of ups and downs, particularly following treatment failure, where they experienced moments filled with doubts and uncertainty, accompanied by the (sometimes hesitant) desire to try again.

This chapter explores the multiple forms of loss women experienced when a treatment cycle did not result in pregnancy. I show that treatment

failure not only included a lost attempt at pregnancy, but also financial, emotional, psychological, and physical losses. Women also found *themselves* to be “at a loss” as they struggled to understand why treatment had failed. The causes of treatment failure are often unknown, demonstrating the incompleteness of medical knowledge (Franklin 1997:146-151, 200; Tjørnhøj-Thomsen 2005:80-81). For women, this incomplete knowledge led to moments of doubt and uncertainty in one’s body, the efficacy of the technology, the motivations of the doctors, and the decision to participate in such an uncertain undertaking, ultimately producing a loss of confidence in the self, the treatment process, and those involved in the process (i.e. medical staff).

Following treatment failure, there are limited options available to women who still have an unfulfilled child wish. They are confronted with the decision of whether or not to undergo another cycle. Uncertainty may be augmented by the initial failure, although insofar as it may also reveal additional diagnostic information, it may provide increased likelihood of subsequent success (Franklin 1997:154; Tjørnhøj-Thomsen 2005:80). In Colombia, the commercialized form of private ART clinics creates a medical environment with a huge variety of doctors to consult and (ever new) techniques for couples to try. “The open-ended nature of infertility is... a mixed blessing” (Greil 1991a:24). It produces a sense of gamble, a common metaphor that has been reported among users of ARTs around the globe (see Becker 2000:125-128; Franklin 1997:176-177; Inhorn 2003b:176; Modell 1989:129-130), as trying again holds the possibility that pregnancy *may* be achieved, while not engaging in another cycle does not.

Franklin (1997:192) describes IVF as a “hope technology,” a technology that provides a chance, and thus hope, for pregnancy. The possibility that a subsequent cycle may result in pregnancy propels women to try IVF again. The women in my study, however, primarily discussed having “*fe*” (faith) in the process rather than “*esperanza*” (hope), a faith that diminished with treatment failure, and which needed revival for the fertility treatment journey to continue. “Hope” is related to a desire for an outcome and the possibility of obtaining it; faith, however, expresses *confidence* in an outcome or, here, recognition that a

desire *can* be achieved. Ultimately, the women I interviewed expressed both hope and faith when reflecting on failed treatment cycles, and their willingness to undergo another cycle, but applied the two to different things: a woman's *hope* for a child allowed her to sustain her *faith* in the process and, therefore, her willingness to continue.

For most women, choosing to undergo another cycle was not an impromptu decision; rather it involved an intense reevaluation of the quality of the medical care and the specific treatment regime they experienced, and reflecting upon their willingness to experience this process again. With changing life circumstances, some women reevaluated the boundaries they were willing to cross to obtain a child. Following Madhok and colleagues (2013), I consider that such reflection and renegotiation constitute a form of agency. Throughout this thesis I have demonstrated how agency, in various and unique forms, is constrained by material and social constructs – access to information and financial resources, power/knowledge, social networks, socially embedded understandings of kinship and personhood, etc. – and the options available for individuals to overcome these. When treatment fails, options may be further restricted for some women, but for the majority of the women in my study, reflecting upon their treatment experience and desire for a child, and renegotiating the available options, permitted women to maneuver around certain constraints. The experiential knowledge of the process, and embodied effects obtained through undergoing a cycle, increased women's abilities to evaluate the quality of care they felt they had received, and thus renegotiate the treatments they were willing to use, and renegotiate if and where they wanted to undergo another cycle. Deciding to continue with fertility treatment was entwined in a *mélange* of child-desire, treatment potential, reflection and renegotiation, and agency, which, as I show, produced a renewed faith in this complex process.

## Treatment Failure

According to the European Society of Human Reproduction and Embryology (ESHRE), world data from 2009 estimates 25 percent of initiated treatment cycles result in a delivery (2014). This rate is comparable to data reported by the Latin American Registry of Assisted Reproduction at the 11<sup>th</sup> General Meeting of the Latin American Network of Assisted Reproduction held in Panama City in 2013. Of the 61 women represented in this study, retrospectively 29 reported experiencing a failed treatment cycle, of whom 19 had multiple failed cycles, while 10 experienced a failed cycle during the course of my research.<sup>54</sup>

The medical community globally considers three IVF cycles to be the ideal number of treatment attempts, as statistically that produces the highest probability of pregnancy (Olivius et al. 2002). Three cycles mark the limit of publicly funded or insurance-covered treatment attempts in countries such as the Netherlands, where IVF is funded by national healthcare systems or insurance policies. In the absence of public funding or insurance coverage for IVF in Colombia, combined with the commercial nature of IVF, women are not prevented from exceeding three cycles, and they themselves (and their financial situation) – not a doctor, a healthcare policy, or medical board – decide when to forego treatment, and decide, as Sandelowski puts it, “enough is enough” (1993:50). This decision requires women to accept their inability to conceive via ARTs and, for many, to accept a life without children, as adoption is not commonly perceived as a viable solution.

Treatment failure can happen at any stage of the IVF process: hormone levels may not increase, follicles may not form, the aspiration may extract overly mature or immature eggs, fertilization may not occur in the laboratory, embryos may not develop “beautifully,” the embryo may not implant following the ET. Yet with advances in hormone regimens, meticulous monitoring of follicle

---

<sup>54</sup> This number is not representative of the statistics as I did not follow all the women in my study through the entirety of their treatment journeys, while others did not return to the clinic after learning treatment had failed and therefore did not tell me about the failure, though in most cases I was informed about treatment failure by the medical staff.



development with sophisticated ultrasound technology, and the use of ICSI instead of IVF, more and more women are proceeding to the final stage of the cycle. Only two of the women I interviewed experienced treatment failure before the ET.<sup>55</sup> The rest learned of treatment failure following the ET, either through a call from the clinic informing them that the pregnancy test was negative or through the onset of menstrual bleeding. Although a majority of cases progressing further appears positive, Franklin (1997:169) explains that reaching the end of the fertility cycle only to fail is “even worse than never coming close to success,” as the woman’s faith “has come even closer to becoming a reality, and the resulting loss is that much more devastating.” As I explain below, this destruction of faith entails women recognizing multiple losses, including a loss of self-confidence.

### Multiple Losses

Franklin (1997:179-180) describes IVF failure as a “double loss” that leaves the woman still childless, and also entails loss of time and financial investments in treatment, which may have also required the woman to put other life events on hold. When IVF, a treatment that incurs many “costs” and is supposed to alleviate childlessness fails women are left to cope with their unfulfilled child-wish plus the losses that accompany treatment failure, actually compounding a woman’s sense of loss (Franklin 1997:180). Many informants in my study experienced compounded losses, when they recognized they had “gained” nothing from the treatment, but had sacrificed a great deal in going through the process.

While sitting in the waiting area one afternoon three women I was becoming acquainted with, Pamela, Angelica, and Anita, started chatting. The conversation, which was initiated by Angelica, began gradually, but

---

<sup>55</sup> The doctors spoke about other women besides the two mentioned here who experienced treatment failure at earlier stages, but mention of these cases were still minimal compared to the number of women undergoing treatment. It was obvious that treatment failure was associated with the final stage of IVF when the embryos did not implant.

with time the women began exchanging experiences and complaining about the treatment process. At this point Pamela had experienced a miscarriage after her first treatment, Angelica had been through various failed AIs, and Anita was just beginning her first ICSI cycle after two failed AIs over a year ago. The women spent an extended amount of time discussing the physical pain of treatment, especially complaining about the hormone injections. This developed into a conversation about the astronomical price of the hormones, and the money they had spent over the numerous treatments they have endured. Both Pamela and Angelica traveled to Bogota from other Colombian cities for treatment. Hotel stays and travel expenses were worked into their large treatment bills, only to have treatment fail. Pamela also mentioned the countless hours she had spent traveling to Bogota and sitting in the waiting area, another sacrifice Angelica and Anita could relate to, as they recalled the activities they had given up to undergo treatments that resulted in nothing. Pamela also recalled the anguish she experienced following her miscarriage, the emotional pain it caused her and her husband, and the time she needed to recover. (Fieldnotes 29 Jan. 2013)

These women's narratives suggest an exacerbated (or intensified) sense of *losses* (in the plural) following treatment failure. More than the sense that they had been left childless, their attention focused on the various, individual investments they had made – the physical pain, the monetary price, the time, and the life activities they had foregone – and their grief about treatment failure. In this research, women specifically cited the *multiplicity* of their lost “investments” and the emotional pain they suffered (possibly because none of these women saw this treatment failure to be the end of their pursuit of a biological child, which I will discuss further below). Reanna's case serves as a good example, as she explained,

“I do not know what else I can do. When I was recommended Dr. Mabel, I thought treatment would work. He told me ICSI was the only option and, now, it did not work. It was not successful. I had been told just to spend the 10 million pesos (approximately US\$5,550) and have the treatment, but it did not work ... I have put all my energy, emotion, and money into these treatments for so long, and now what can I do? I was so excited about the treatment but it resulted in nothing.” Noticing how distressed Reanna was, and knowing she was living in Bogota alone (her husband was on military assignment in another part of the country), I asked if she could stay with her sister, who lives in another city, for a while. She responded, “No, I do not want to. I had thought about going for *Semana*

*Santa*, but [after finding out treatment had failed again] I will not. I do not want anyone to know what has happened.” (Interview 22 March, 2013)

During a previous interview, Reanna told me her family had not approved of her going through another treatment cycle because it was so expensive and she had already experienced two failed AIs and a failed IVF cycle. Now that she had put her “energy, emotion, and money” into treatment once again, only for it to end in failure, she was embarrassed. Her embarrassment stemmed from a *loss* of confidence in her decision to undergo another ART cycle and prevented her from seeking the emotional support she needed at a time of immense pain and vulnerability. Furthermore, treatment failure made her doubt the abilities of the doctor who had been highly recommended to her and his advice that the treatment was her only option. Reanna’s sense of loss included lost investments and a chance of conceiving, but also the loss of faith in the process she had endured and the possibility of ever conceiving. Seeing ICSI as the only option, Reanna began to doubt whether she would ever have a biological child.<sup>56</sup>

The women’s losses represented here are multiple, consisting of monetary, temporal, physical, and emotional losses, a lost treatment attempt, as well as a loss of, or doubt in, the self (and the medical professionals). Reanna’s narrative in particular highlights the emergence of self-doubt, as she doubted her ability to conceive, the decisions she made, and the knowledge upon which the decisions were based, which included the choice to engage with the process of medicalized conception and belief in the medical system more generally. When treatment failed the faith women once had was replaced (even temporarily) with doubt. As I discuss below, treatment failure caused women to ask *why*, a question that was answered with an ambiguity that fueled their uncertainty and doubt.

---

<sup>56</sup> With time Reanna’s doubts about ever conceiving were projected onto Dr. Mabel and the fertility center, as she lost confidence in his abilities and those of the clinic more generally. During a later interview, she told me she was considering trying again at a different clinic, but she first needed to raise the funds for another cycle.

## The Ambiguity of Failure

Following a failed treatment cycle, women returned to the medical realm to seek an explanation. They embraced “medicalized subjectivity” (Morgan 1998:96) by internalizing and demanding that a medical explanation give meaning to failed treatment:

Recalling her first ICSI cycle at Fertisuperior, Nadia explained the treatment had failed and the doctors could not provide a conclusive reason why. She said she had experienced the symptoms of a urinary track infection (UTI) after the embryo transfer, an infection she was later treated for. Dr. Mabel told her, the irritation from the UTI could have prevented the embryos from implanting, but there is no definitive way to know if it was the cause of treatment failure. (Interview 9 July, 2013)

Nadia recognized that the UTI *could* have prevented her from becoming pregnant. Dr. Mabel, however, rejected Nadia’s medical perception of treatment failure, by stating there was no way of knowing what actually caused her treatment failure. He was undermining a potential means of coming to terms with treatment failure, replacing Nadia’s attempt at understanding with ambiguity and uncertainty.

Biomedical knowledge is not a univocal, unambiguous discourse (Good and Good 1993). Rather, it is an uncertain and incomplete form of knowledge (Tjørnhøj-Thomsen 2005:80-81). Franklin (1997:146-147) argues that there is a “gap between information and knowledge” in the biosciences, particularly in relation to reproduction, where knowledge is actually “incomplete.” The variables affecting treatment outcomes are multiple: quality of the embryos, condition of the uterus, the woman’s age, and the expertise of the doctor to name but a few. Thus a definitive answer is unattainable, and available results provide only partial information at best (Franklin 1997:148). Bharadwaj (2006) argues that the “incompleteness” of “Western technoscience” creates space for uncertainty in the IVF process, particularly following the ET. This uncertainty leaves women, such as Nadia, to question what went wrong, to question the ability of their bodies, the technology, and/or the doctor.

Such questioning generated another form of loss mentioned above, as women also started to doubt their ability to conceive, which in the instance of ARTs is also dependent on the capacities of the technologies and medical experts. Below I explore how this loss of confidence in one's ability to conceive often manifested in a loss of confidence in the body. Lacking complete knowledge about what caused treatment failure women began to recognize their bodies as the potential place for uncertainty within this highly medically controlled process.

It was not only the body, however, that presented uncertainty, the woman's knowledge – her trust and decisions – also came under scrutiny, as she doubted the faith she had placed on the technology and the doctor to make her conceive. Becker (2000:173) describes the loss of hope people experienced in treatment failure as amounting to a loss of faith, going so far as to say people respond "in ways similar to loss of faith in religion." The loss of faith the women experienced here, however, came to represent a loss of *self*-confidence, or faith in the simultaneously physical and knowing self, rather than in a specific cosmology.

#### *Losing Faith in the Body: Self-Blame*

Despite the numerous factors that may affect IVF outcomes, this medicalized process also controls for (or, at least, appears to) fertilization. It takes place in a laboratory under sterile conditions. Eggs and sperm are selected based on visible characteristics. Embryos are selected based on potential viability and the selected embryos are transferred to a womb that has been medically conditioned for their implantation. This perception of IVF is presented to the women, when responsibility is transferred from the fertility expert to the woman following the ET (see chapter 9). Given this breakdown and monitoring of the fertilization and conception processes (Sandelowski 1991:39; 1993:122), treatment failure resulted in the woman herself, her body, becoming the

variable to question, whether or not she was the one with the diagnosed fertility problem (Greil 2002:101).

Mariela and Adrian had come to the clinic to discuss with the doctor why treatment had failed. With tears coming down her cheeks she started asking if treatment failure could have something to do with the egg? “Was something wrong with it? Was it possible something happened to me all that time working as a biologist in a laboratory? Something that might have affected the quality of my eggs?” Dr. Mabel interrupted Mariela’s hypothesizing and said, “It is unlikely anything is wrong [referring to her body and eggs], but there is no way to know for sure. All we know are the numbers [referring to the probability of treatment success].” (Observation 25 June, 2013)

Having used a sperm donor, Mariela did not think the sperm could have been the problematic factor. This left her body, her eggs, to be the culprit of treatment failure,<sup>57</sup> an assumption Dr. Mabel could not refute other than by reference to the probability of treatment success. Without another factor to blame for treatment failure, Mariela attributed failure to her *self*, diminishing her confidence in her body’s ability to conceive. Synnott (1992) claims the body is emblematic of the self. We are responsible for our bodies, for their deficiencies and capacities, which are reflections of the self. The inability of Mariela’s body to conceive, even when all the “mechanisms” (gametes, uterus, etc.) were medically accounted for, meant she could blame only herself for treatment failure.

Techniques designed to overcome male infertility complications, such as ICSI and testicular sperm extraction, still require the embryo created from this sperm to implant in the uterine lining for treatment to be successful. Thompson (2005) describes the female body as the one that is manipulated and becomes pregnant. Regardless if infertility lies with the man or the women, the woman’s body must accept the embryos for pregnancy to occur (94).

---

<sup>57</sup> Mariela is a biologist, so she had a better understanding of the chances of conceiving when using abnormal gametes than most women in the study. As they had used a sperm donor, she assumed her eggs were genetically deficient and were thus problematic.

Nadia was very disillusioned that she had not become pregnant, particularly because she had not been diagnosed with a fertility problem. Her husband had low sperm mobility and vitality so they had used ICSI, but she still had not become pregnant. She explained she had been pregnant once before, while in secondary school, and now worries that something went wrong during the abortion that is preventing her from becoming pregnant. (Interview 9 July, 2013)

The doctors said she had no lasting indication of abortion complications, yet without a definitive infertility diagnosis or an explanation for treatment failure, and with proof that embryos could develop from her own eggs and her husband's sperm, Nadia blamed her body and her past decision (the abortion) for her inability to conceive. Reanna similarly attributed her unexplained infertility and continuous treatment failures to past events: abortions and an ectopic pregnancy she had suffered three years before. However, neither Nadia nor Reanna hinted at a moral connection between their past abortions and their present inability to conceive: infertility was not a "punishment" for past transgressions (cf. Braverman 1997:223; Davis 1995:15; Sandelowski 1990). Rather, previous reproductive choices had made their bodies faulty, and therefore unable to accept a formed, viable embryo. Without a medical explanation for treatment failure, Reanna and Nadia had space to pathologize their bodies (Benjamin and Ha'elyon 2002) and lose faith in them, to blame themselves and past choices for their inability to conceive, even with medical assistance. Their bodies' ability became uncertain, despite having no diagnosis of specific fertility complications or bodily abnormalities. Doubt translated into a loss of bodily/self-confidence.

Other women blamed their lack of precautionous behavior during the fertility cycle for treatment failure:

While discussing their first treatment failure, I asked Marcela, "What went wrong?" She responded, "We have not been given any reason. But we think maybe we went out too much, had too much fun, and did not take the treatment seriously enough." (Interview 26 March, 2013)

As with Nadia and Reanna, an unclear medical explanation caused Marcela to adopt a narrative of self-blame to understand and give meaning to treatment failure.

Medical staff discouraged women from blaming their bodies and actions for treatment failure. During a consultation, Dr. Mabel explained to a *paciente*,

You cannot blame yourself, you cannot blame your activity for the embryos' not implanting. I once performed an embryo transfer on an afternoon when the power went out. That woman had to walk down all nine flights of stairs [the elevator was not working]. Even after all that movement, right after the ET, the embryos implanted. (Observation 23 July, 2013)

Dr. Mabel's narrative reinforces the medically-based belief that rest and recuperation are not necessary following the ET, but, more importantly, it emphasizes women's lack of control over the treatment outcome. Even though these women's bodies had been conditioned to accept the transferred embryo(s), the women cannot be held responsible for the embryo's inability to implant and continue development. Without necessarily intending to do so, Dr. Mabel had restated the lack of control the woman and the fertility expert have over the treatment outcome, as well as the lack of the technology's perfection (as discussed below). His narrative did not necessarily neutralize women's self-blame as he had not provided "evidence" to dissuade them from doubting their bodies' abilities, but he had created space to doubt the technologies and the expertise the doctors have in using them.

#### *Losing Confidence in the Process*

Agreeing to undergo fertility treatment involves placing one's faith and trust in medical science, including the technologies involved and the abilities of the specialists (Franklin 2006:549). When treatment failed in my study, faith and trust began to diminish, and most women started to doubt, even briefly, the potential of IVF, the doctor's and/or the clinic's skills and prestige. Losing



confidence in the technology, in addition to the professionals in whom the women had placed trust, is another aspect of loss.

Wondering how many treatment cycles will be necessary to become pregnant, a question without an unequivocal answer, is a major source of doubt. Reanna had experienced two failed AIs and a failed IVF cycle at different clinics before her first ICSI failure at Fertisuperior. About six weeks later, she expressed her diminishing confidence in the technology.

Reanna explained, Dr. Mabel had told her to come to the clinic on Saturday to discuss starting another cycle. She said, "I do not have much faith in another treatment, but I will see. It is hard, particularly since I do not know how many cycles I will need to have a child. Five? Six?" Reanna looked at me with a questioning expression, as though she wanted me to give her an answer. (Informal conversation 27 April, 2013)

Reanna's reflection on the potential need to undergo multiple cycles before she would become pregnant, made her realize that with each failed cycle her confidence in the technology would decrease, and suggested she might completely lose faith in the process before she would achieve treatment success. Here Reanna voiced uncertainty about when to stop treatment, reflecting the "maybe-next-time" character inherently held by ARTs (Throsby 2002:16). Reanna's diminishing "faith" in the technology corresponds with what Franklin (1997:185) describes as a diminishing "'will' to continue," a "will" that, with time, no longer paralleled the "hope" women had in the process and its success. However, Reanna's diminishing faith in the process, or will to continue, did not necessarily outweigh her "hope" for success; rather she began to lose faith in the ability of the technology (a phenomenon that was not present among Franklin's informants) and thus, hope for a successful outcome. Reanna doubted whether she would be able to sustain her faith in the process until it would be successful.

In other conversations, women often recalled being informed that *multiple* treatment cycles may be necessary, but they questioned why this is so, particularly because "multiple" is unspecific. Statistically, a woman's chance of treatment success increases with consecutive cycles. Olivius and colleagues (2002) found the cumulative probability of success of three IVF cycles to be

approximately 60 percent, compared to 30 percent when only completing a single cycle. However, the limited transparency in the way the potential (and likely) need for multiple treatments was presented to women during initial consultations (in chapter 6 I discussed how information was gradually provided as women initiated the treatment process) made this information disreputable, especially when it was introduced after a cycle had already failed. This “unreliable” information, combined with increasing doubts from an already failed treatment cycle and the perpetual uncertainty as to whether treatment will eventually end in pregnancy, produced a sense of skepticism among some women as they considered undergoing another cycle. Nadia explained,

I have heard doctors explain the probability of success is higher with the second cycle and that the first cycle has the lowest probability of success. But I have also read blogs about and heard other patients say this is a financial ploy to get you to spend more money at the clinic. (Interview 9 July, 2013)

Interpreting this “medical” information as a commercial or financial strategy of the clinic, reflected doubts some women in this study had about the motivations of the clinic and the “altruistic” character of the doctor. These doubts correspond with those expressed by some of Becker’s (2000:128-129) informants who questioned if the doctors were pursuing financial gains at their expense, as they came to recognize the business-like character of IVF in the US.

As women started to lose confidence in the doctors, and questioned their intentions, they also started to question their own confidence and willingness to engage in this commercialized healthcare process. Their skepticism may have been rooted in wider social cynicism of healthcare services. As I discussed in chapter 4, in 1993 the Colombian government implemented new healthcare policies, eliminating the national public healthcare service and implementing a two tiered, insurance-based system. Since the healthcare reform, the private medical realm has flourished on a supply and demand basis, increasing competition across private clinics. Acknowledging the commercial nature of IVF is not only a criticism of the system, but also a self-criticism by the women

themselves of their own decision to engage with and perpetuate this process by “shopping around,” seeking recommendations, paying for multiple cycles, etc.

As the women started to question the doctor’s abilities and motivation, some also started to doubt why they chose to undergo treatment.

Nadia appeared very disillusioned when she told me about her first failed ICSI cycle at Fertisuperior. She explained the clinic had been highly recommended to them, which caused them not to anticipate treatment would fail. But since it had, she was not so confident about the reputation of the clinic, and was considering going to another clinic that also had been recommended to her, if nothing else just to have a consultation to see what the doctors there had to say. (Interview 9 July, 2013)

The recommendation Nadia received from an “informational gatekeeper” (see chapter 5) created an exaggerated expectation for treatment success for her and a high level of trust in the doctors and their techniques. She never had anticipated that treatment would not result in pregnancy. After treatment failure, she lost confidence in the clinic staff and her ability to become pregnant through their services.

Bharadwaj (2001:232-236) explains that treatment failure often caused his informants in India to lose trust and faith in the ability of the doctor to produce results, particularly because expectations had been augmented by some fertility specialists themselves and by the media who sensationalized success stories. On the contrary, Nadia (and Reanna, who’s story is presented above) had increased expectations of success due to the recommendations they received from a former treatment-user. Regardless of the production of this augmented perception of success, faith in the medical staff’s abilities still decreased. Additionally, Nadia questioned her ability to judge the quality of the clinic, and her engagement with the medical staff, as she wondered why she and her husband trusted the recommendation from her informational gatekeeper. Despite deciding to do another ICSI cycle at Fertisuperior, her faith in the clinic was altered after her first failed treatment, and she continued to question whether she should seek the services of another doctor.

Many couples similarly reported being unsatisfied with the services received, and moved from clinic to clinic, particularly after treatment failed. Greil (2002:111), following the work of McGuire (1988), describes women utilizing IVF in the US as “infertility contractors” referring to patients’ active engagement with the medical system, and how they decided whether or not to follow the doctor’s advice. As women in my study became more familiar with the process, many also adopted a more active role in seeking out what they anticipated would be good quality treatment, becoming more critical and willing to make use of the options available to them.

This often included changing clinics, which was perceived by couples as a way to take control of the treatment process. Leandra and Rodrigo reported having undergone treatment at five different centers in four different Colombian cities because they had been unsatisfied with the treatments at each (interview 27 June, 2013). However, as couples move from one clinic to another their fertility treatment journeys are not continuous; the new clinic – often skeptical of the efficacy and prestige of the former fertility center(s), as discussed in chapter 5 – requires “new” couples to repeat diagnostic examinations and start new (possibly different) hormone regimes. This not only reduces the probability of treatment success, as the accumulative treatment course is interrupted and started anew, but it also creates an environment of over-medicalization, as examinations are repeated and treatments are duplicated without necessarily considering altering former regimens. Given this context it is the woman/couple who must decide to discontinue treatment by accepting a life without (biogenetic) children, and thus, end the perpetuation of the only process that *could* result in pregnancy.

The fertility experts were aware of this predicament, as Dr. Herrera indicated in an interview about treatment failure and patient-doctor relations:

It is very common around the world that a couple will visit a different clinic if they have a negative outcome. But if you have a good relationship, it is possible they will stay with you, or if you cannot do more, then they will feel they tried but were unsuccessful and that is all they can do. But many times [the latter] is not the case, as for many, the

information [referring to treatment outcomes] is unclear, and it will remain unclear when they go to another clinic. This obviously is not positive. (Interview 23 Nov. 2012)

Dr. Herrera believed doctors' inability to provide *clear* information to couples and dissatisfaction with clinic services is what caused couples to change clinics when treatment was unsuccessful. More importantly, she emphasized how information will likely remain unclear when provided by the next fertility specialist, only perpetuating this course, while augmenting the losses the women experience. Following Inhorn (2003b), we can see that this medical context of consumerism and insufficient information may pose as a constraint to accessing effective treatment and/or the ability to choose to forego treatment, creating a "vicious cycle" of continually searching for the "right" doctor and treatment regimen (Bharadwaj 2001:255).

#### Reflection and Renegotiation: Deciding to Try Again

The multiple losses these women experienced created an environment where women lost *self*-confidence (in their bodies, in their knowledge, in their capacity to evaluate others and their advice, and in their ability to conceive), but still desired a biological child. At this point, reflecting on the whole treatment process, and on how their desires were not met through it, opened up a space for women to renegotiate their position. This process of reflection and renegotiation "pushed" and "pulled" (Sandelowski 1991) women as they grappled with whether to try again, either at the same facility or a new one, or to discontinue treatment and accept childlessness. As Luna explained:

This process is very hard... particularly after the embryo transfer when my period came and I lost all hope... But I have to endure this if I want a child. I have to remain faithful that this next cycle will work or there is no point in doing it. (Informal conversation 6 June, 2013)

Overcoming lost hope, as Luna described it, is a complex process entwined in the larger treatment course, one that women are willing to endure to fulfill their

desire for a child. Throsby (2002:16) explains the IVF experience as one of “being on a treadmill from which there is no easily apparent exit point, and the cyclical nature of IVF presents a persistent maybe-next-time promise” (see also Franklin 1997:157). This continuing “ability” to try is perpetuated by the *potential* for success, the *chance* of pregnancy, and the “*what if*” that encompass ARTs. The possibility of success allows faith and the hope for a child to survive and drives women to continue with treatment. However, as Luna’s narrative indicates, hope is not always there: it is lost once treatment fails, and must be found again if women are to sustain their faith that they can become pregnant using ARTs.

### *Regaining Faith in an Uncertain Process*

Most fertility treatment journeys are lengthy and my fieldwork was time-bound. Consequently, I could not follow all (or even many of) the women I interviewed through the entirety of their fertility treatment journeys. I met some women at the beginning of their treatment journeys, while they were “shopping around,” learning about their (or their partner’s) fertility problem. I followed those women (24 of 61) who chose to undergo an initial cycle at Fertisuperior through at least one cycle. More than half the women I interviewed, however, were in the middle of their treatment journey when we met, having returned to the clinic (or come to a new one) to inquire about undergoing another cycle. Thus, I cannot know how many treatment cycles women plagued with “serial failures” (Franklin 1997:157) endured before discontinuing treatment. I met only three women who explicitly said they would not go through another cycle, one of whom conceived spontaneously a few years later, but I do not know if the other two ultimately stayed true to their intention.<sup>58</sup>

During my interviews in the clinic, I met women who said they had never intended to go through another cycle after their first failure because the first

---

<sup>58</sup> Thompson (2005:94) reported meeting only one woman in her study in the US who chose to give up treatment on her own accord.

cycle was too stressful, painful, and expensive to endure a second time, and still possibly be left with nothing. Yet there they were, inquiring about another cycle. Other women expressed desire to undergo treatment again, but did not have the money to do so at that time. Others needed time to recover and/or wanted to try to conceive spontaneously once again before starting another cycle. Thus, in many cases it was not necessarily a matter of whether the woman would or could withstand another cycle, but *when* she would initiate the next cycle, and *how* she would arrive at her decision to continue.

Women overcame their lost hope or faith at various rates and through idiosyncratic means. This section explores four of the routes women took to arrive back at a fertility center for another cycle. The first route, “logical progression” and “routinization” of treatment, portrays the pressure doctors exerted on women to continue with treatment, and the women’s internalization of this. Unlike the other routes, this return to treatment represents the coercive character that ART practitioners can adopt when women feel compelled to keep on trying at all costs. The other three routes – “adopting the medical model,” “recuperation and renegotiation,” and “reflecting on changed circumstances” – represent how women came to regain faith in this uncertain treatment regimen and its ability to make them conceive, a process that required reflection and (re)evaluation. Reflecting upon their embodied experiences of treatment, the quality of care they received, their desires for a child, and renegotiating the choices available indicates an agency these women enacted as they maneuvered within a realm of limited options (Madhok et al. 2013). Madhok (2013:106) argues against interpreting agency solely as a means of action and “‘open’ resistance” towards an oppressor (in this case, action limited by material and social constructs and the institution of medicine); rather, our theoretical gaze should focus on analyzing “critical reflections, motivations, desires, and aspects of our ethical activity.” Thus, following, Madhok, I interpret these processes of reflecting upon and (re)evaluating one’s experiences, desires, motivations, choices, and justifications as an agentic and engaged process that allowed women to regain faith in fertility treatment and try again.

### *Accepting the “Logical Progression” and “Routinization” of Treatment*

Some doctors were often eager for women who had experienced one or two treatment failures to start another cycle.<sup>59</sup> This was a logical approach from their perspective as the woman had not obtained the desired outcome, and waiting would merely reduce her chances of conceiving as she grew older. Dr. Mabel recommended that some women take a hormonal medication to return their menstruation to its “natural” cycle so that another treatment could be initiated immediately. This recommendation was not presented as an option, per se, but as the next logical step in the fertility treatment journey, consistent with the medical perspective that three cycles produce the highest probability of a successful outcome. Presenting continuing treatment as the “logical” next step pushed a minority of women in this study to endure another cycle even if they had not initially intended to do so.

Before the consultation with Dr. Mabel to discuss why treatment failed (see above), Mariela told me she was unsure if she wanted to undergo another cycle, that she needed time to think about her options before making a decision. However, when Mariela and Dr. Mabel’s conversation drew to a close and Dr. Mabel recommended she come that Friday to begin the next cycle, Mariela wavered only slightly, saying her husband was not available that day, but then agreed to come anyway. (Observation 25 June, 2013)

Monarch (1993:181) claims that choosing to continue or forego treatment is “one of the only elements that the couple has a sense of control over.” Yet when the doctor presents another cycle as the “logical” next step, as opposed to one of many options, undergoing another cycle may appear to be the routine practice, and thus reduce the woman’s choice to discontinue treatment.

Koenig (1988), discussing the “routinization” of new biomedical technologies, explains how the meanings of technologies change and lose their

---

<sup>59</sup> After three failed treatment cycles at a particular clinic doctors did not encourage women to continue treatment, as they did after an initial or second failed cycle; however, they did not appear to dissuade women from continuing either. This reiterates the active role women must take to forego subsequent cycles. Thompson (2005:95) discusses a similar practice in the US clinics where she conducted her research.



luster through a process of socialization. As “participants become habituated” to their use, previous struggles become “routinized” in everyday practice (469-470). This same logic can be applied to a woman using ARTs who becomes accustomed to the technology, and to the struggles, pains, and losses that accompany its use. The “routinization” of fertility treatment normalizes the process as Thompson explains (2005:81), perpetuating the treadmill-like quality of fertility treatment as it propels women on to the next treatment without time to reflect on the recent failed cycle.

The routinization of treatment may partly account for the situations of Felicia and Fatima, two of the five women in my study who appeared particularly determined to obtain a child through ARTs. Their stories verged on desperation as they depicted their desire to try everything before discontinuing treatment. Just before Felicia discovered that her latest treatment cycle had resulted in a blighted ovum pregnancy, she explained that she and her husband had been considering looking for a surrogate before she realized she was pregnant (interview 26 July, 2013). At this time, Felicia had been through eight failed cycles. Her interest in finding a surrogate even before knowing her present treatment had failed suggests she had lost faith in the process, and was just going through the necessary motions to reach the next stage. From Felicia’s perspective, ICSI would not make her conceive, but using a surrogate may provide a child. The once novel technology with its potential to bring about pregnancy had become “routinized” and like any other medical procedure on the path to conception.

Fatima still displayed faith in the conception process and a “need” to try everything before accepting she could not conceive through ARTs.<sup>60</sup> Fatima explained, “We are not against adoption, but we want to exhaust all treatment options before considering it” (interview 25 May, 2013). Fatima had been through numerous AIs with donor sperm, ICSI with donor sperm, and then ICSI with both donor sperm and ova. Her treatment journey had involved a steady progression from one treatment regimen to the next, reflecting her desire to

---

<sup>60</sup> See discussion of the technocratic imperative on page 49 of the literature review.

“exhaust all options” before considering adoption. Unlike Felicia’s loss of faith, the routinization of treatment progression led Fatima to anticipate that there would always be another technique to try, perpetuating her engagement with this uncertain medicalized process.

Despite the determination and even desperation that Felicia and Fatima portrayed, these women were a minority in the study. This is similar to Inhorn’s (2003b) finding that the “never enough” approach to ARTs “demonstrated by many Western women and their physicians was much less clear in Egypt,” where only seven of the 40 women she interviewed said they were “prepared to repeat ‘as many times as necessary’ to achieve their reproductive goals” (172-173). Though other women in this study were persuaded by the doctor’s pressure and the routinization of treatment to undergo (an)other cycle(s), the majority of women did so through a conscious, decision-making process, that did not reiterate the apparent desperation and willingness to go to all lengths portrayed by Felicia and Fatima.

#### *Adopting a Medical Narrative*

The women who apparently overcame the “losses” of treatment failure most readily adopted an understanding of treatment outcomes that nearly mirrored that provided by fertility experts and the medical literature. About two weeks after learning that treatment had failed, Carmena explained:

It was difficult but I realized the chances were minimal. I think we are always disillusioned when we go through a procedure like this. We always think our chances are higher than they really are. (Interview 12 April, 2013)

Like Nadia (see above), Carmena mentioned being disillusioned when she realized treatment had failed and alluded to her “unrealistic” expectations. Nevertheless, Carmena quickly adapted her expectations of treatment success to reflect a medically rational explanation (“minimal chances”) for why she had not become pregnant. Carmena, then, renegotiated not only her perception of

likely treatment outcomes, but also how she saw herself potentially completing another cycle, again without pregnancy.

Emma's explanation for treatment failure also reflects a vague medical explanation for failure. Emma was nearing the end of her second IVF cycle when she explained, "[my first cycle] ended in failure, but this is normal with IVF, and now I have more hope for my second cycle" (interview 29 Jan. 2013). Emma's narrative reflects the cumulative probability of treatment success mentioned above.

However unclear or vague the medical explanations Carmena and Emma adopted to rationalize their failed cycle, these nevertheless helped them accept the limited probability of treatment success. By recognizing the gamble the women were ultimately embracing the uncertainties and even limited possibility of pregnancy that another cycle offers. Rather than making Carmena and Emma lose faith, however, this rejuvenated their faith in the process. Another cycle offered only a limited probability of success, yet it was nevertheless greater than their probability of pregnancy when foregoing treatment, and, as Emma mentioned, the probability of pregnancy was greater with their second attempt. Thus, for Carmena and Emma undergoing another cycle was a rational decision in their pursuit for conception.

#### *Time for Recovery and Renegotiation*

Taking time to recover was one way to resist the doctor's pressure to proceed to the next cycle swiftly and provided space for women (and often their husbands) to reflect on the "costs" and losses of undergoing treatment. This was time to not only recuperate emotionally and physically, but to also regain one's confidence in the process. Reflecting on a failed treatment cycle seven months before, Victoria explained,

We needed a break. We needed time to rethink what we wanted to do, whether we wanted to continue, and to recuperate. I think emotional and

psychological [recuperation were what we needed], not physical.  
(Interview 23, July 2013)

Victoria and her husband's experience of multiple losses required them to reconsider why they chose to undergo treatment and whether they were willing to "pay the costs" again, perhaps only to be left with nothing. For this, Victoria required a psychologist's assistance to overcome her emotional distress, which included feelings of animosity towards female kin and friends with babies, negative projections that may have stemmed from a negative self-image. Through counseling, Victoria began to overcome these hostile feelings and focus again on undergoing another cycle, a process in which Victoria claimed not to have lost faith, but rather appeared to have lost part of herself when treatment failed. Seven months after the initial cycle, having regained faith in herself, Victoria returned to the clinic ready for another attempt.

Nadia's fertility treatment journey included multiple moments of renegotiation and recuperation as she moved between clinics and multiple treatment attempts involving AI and ICSI, all of which resulted in failure:

After the failed AI, we said we would not do any more treatments, but then we ended up at Fertisuperior [because of a recommendation], and decided to try ICSI, which also failed. Then, after the failed ICSI, we wanted to take a break to see if we could get pregnant on our own. I thought maybe, somehow, the hormones would have improved our chances [of pregnancy]. I also wanted to let my body rest after taking all the medications. But now, after more than seven months, we are back for another cycle. (Interview 9 July, 2013)

Nadia's progression from AI to ICSI, from a low-tech procedure to a high-tech one, was common; diagnosis (if any) and the couple's ability to pay generally were the deciding factors. Following the ICSI failure, however, she needed a break. Nadia was disillusioned about her initial treatment failure at Fertisuperior and skeptical about continuing treatment there. Her diminishing confidence in her ability to become pregnant through this process may have encouraged her to *hope* she could conceive naturally. She was unwilling to relinquish all hope for conception and her hope was (briefly) transferred from

the technologies to spontaneous conception. For Nadia, not only the need to recuperate caused her to postpone another cycle, but also the loss of confidence in the treatment process that had to be recuperated before she could resume treatment. When Nadia's efforts to conceive naturally were unfruitful, she returned to Fertisuperior to try again. Like Carmena and Emma, Nadia considered her chances of conception to be greater with ARTs than without them.

### *Reflecting on Changed Circumstances*

Deciding to undergo another cycle required some women to reflect upon and change their priorities, a process that often coincided with changes in life circumstances. For Ariana, choosing to undergo another cycle included accepting the need to use an anonymous egg donor in addition to dealing with her initial treatment failure and regaining the necessary faith in the process. Ariana's initial treatment cycle (see narrative above) failed at the beginning of February 2013; six months later she returned to Fertisuperior to initiate another cycle.

During an impromptu conversation, Ariana explained that she had accepted the need to use an anonymous egg donor, realizing her chances of conceiving with her sister's eggs was minimal. "As you go through the process you become more accepting, more open to the process and the options that are available to you." She continued, "I am also considering adoption if treatment fails again (during initial interviews in January and February she refused to consider adoption). I am not quite there yet, but if treatment fails again, I will consider it." Ariana discussed a friend who had also undergone a number of ART cycles, all of which failed. With time this woman began to accept adoption as the solution to her childlessness, a process Ariana imagined she could also go through. (Informal conversation 1 Aug. 2013)

Ariana's narrative depicts the negotiation processes women endure when coming to terms with treatment failure and, with time, accepting other options for obtaining a child. Initially, Ariana was adamant about using a known donor,

but when treatment failed, she came to accept the doctor's recommendation to use an anonymous donor (instead of the eggs of her reproductively mature 38-year-old sister). She explains that going through the treatment process made her more willing to accept other options that she would not have considered before. This willingness to accept other fertility solutions emphasizes her ability to renegotiate her priorities.

Ariana was the only woman among my informants who agreed to use an anonymous donor after using a known donor.<sup>61</sup> A handful of couples agreed to use either a sperm or ova donor after a failed cycle with their own gametes, a concession they had initially been unwilling to accept. Experiencing failure not only opened new doors for Ariana concerning unknown donors, but also in regards to the possibility of adoption. Ultimately, Ariana wanted a child. The difficulty lay in determining what she was willing to do in pursuit of that desire. If she could not have her *own* child, using an egg donor would at least give her a chance to have a child.

For Bella accepting another treatment path involved changes both in her perception of the treatment and her life circumstances:

In 2010, Bella endured an IVF cycle that ended in a miscarriage after one month. She explained, "The experience was so emotionally stressing and difficult, not only the miscarriage, but the whole treatment experience, that I decided not to do another cycle." But during the time between Bella's first attempt and our meeting, she and her husband had separated. She reported that he works in shipping, and was spending most of his time in China, where he has since moved. The change in her marital status rejuvenated Bella's desire for a child. She went back to Fertilisuperior to undergo another cycle, with the request to use her ex-husband's frozen sperm that had been collected three years before. With her ex-husband's consent, the clinic allowed Bella to use the sperm sample. Since she was then 43-years-old, Dr. Mabel recommended the use of an ova donor, a treatment option she would not have accepted before. Seeing this as her only option, she accepted and since has undergone two cycles with embryos created from donor ova and her ex-husband's sperm. The first cycle (in this series) failed, but when we met she was four months pregnant with twins; the second attempt performed

---

<sup>61</sup> This is likely because other women who elected to use known donors picked reproductively more ideal donors with the probability of producing more viable eggs.

with extra embryos from the first attempt had been successful. (Interview 2 Aug. 2013)

Bella's story demonstrates a woman's desire for a child does not necessarily disappear. In her study of couples' decisions to forego further treatment, Thorsby (2002:19) highlights the long, complex process, not a singular transitional moment, in which the "hope of future restitution" may never completely subside and may resurface after many years. Even when a woman seemed to have come to terms with her childlessness, and vowed she would not undergo another cycle because of the hardships of the process, changes in life circumstances can return that woman to fertility treatment. If Bella had not endured two cycles in the second series, we could infer that she had forgotten in the interim about the "emotional stress" and "difficulty" she experienced (or at least that her memory of the disheartening aspects of treatment had diminished). Yet Bella withstood two cycles in the second series. Her desire for a child propelled her to endure these additional two cycles. Furthermore, her changed circumstances – increased age and single marital status – required her to reconsider using an ova donor. Like Ariana, Bella's ultimate desire for a child caused her to take another path in pursuit of it.

Additionally, treatment failure may reveal further diagnostic information that can modify subsequent cycles, and/or may provide the woman with the necessary "evidence" to accept another treatment path, such as in Ariana's case. Despite the potentially reassuring or influential quality of more medical information, the continuously unfolding characteristic of ART processes reiterates the uncertainties surrounding treatment and the incompleteness of biomedical knowledge that make it difficult for women to know when to discontinue treatment since enduring one more cycle may lead to the awaited outcome. In my ten months in these two clinics, I never heard a doctor tell a woman she would not conceive through the use of ARTs. Furthermore, with advances in reproductive technologies, numerous clinics to attend, and the commercialization of IVF in Colombia, women (who can pay) can access

numerous ART treatments in their pursuit of conception, making it difficult for them to know when to stop.

Despite the treadmill-like nature of ARTs, it is important to highlight that except for five women (including Felicia's and Fatima's stories mentioned above), the women whose narratives are presented here had only undergone one or two failed cycles when they were interviewed about their intentions to try again. Thus, it is not known how many cycles women were willing to endure before arriving at the point when the last cycle was enough. As Ariana's mention of her newfound consideration to adopt demonstrates, for some women there is a point at which treatment comes to an end, when other paths have to be considered to actualize their child-wish, or when their desire must be fulfilled through other means (see Becker 2000:172-186).

As mentioned above, only three women with whom I spoke arrived at the point where they had endured enough treatments and chose to forego further medical intervention.<sup>62</sup> Instead, through a complex process of reflection and reevaluation, the majority regained their faith in the treatment process and in their ability to conceive. Interpreting the struggle to make the decision to undergo another cycle as a form of agency challenges the notion that women are simply coerced into treatment, either by the "push" of society or the "pull" of technology (Sandelowski 1991:34, 1993:49-51). Rather, it is a conscious decision in pursuit of a child. For most of these women, at this particular stage in their fertility treatment journeys, the possibility of trying again and ending with nothing did not outweigh the possibility of realizing one's child-desire with a subsequent cycle.

## Conclusion

In this chapter, I have explored the multiple losses and ambiguities associated with treatment failure. The complexity and multiplicity of losses – monetary,

---

<sup>62</sup> Given that women were recruited to participate in this study through the clinics and that some women who experience treatment failure did not return to the clinic, it is likely that more women chose to forego treatment, but this was not brought to my attention.



temporal, physical, emotional, and a lost attempt at pregnancy – creates an immense sensation of doubt and loss of faith in medicalized conception and the medical system, and ultimately a loss of the self, as women doubt their bodies and their decisions. The uncertainty of treatment failure and the incompleteness of biomedical knowledge caused many women to doubt that their bodies could conceive, even when using technologies. Others questioned their decision to engage with the process of medicalized conception, and their choice of where to seek medical assistance. Irrespective of the uncertainty, doubt, and losses associated with treatment failure, women faced a scenario in which their child-wish was still unmet and fertility treatment offered the only potential option to obtain a biological child. As repeatedly noted in the ART literature, the possibility that IVF could end in conception outweighed the immense losses that would accompany another failure.<sup>63</sup>

In a realm of limited options following treatment failure, the complex processes of reflecting upon one's desires and reevaluating the lengths one is willing to go to obtain them helped women reestablish their faith in treatment. This was an agentic process as the experiential and embodied knowledge of treatment increased women's abilities to evaluate the quality of care they felt they had received, renegotiate the treatments they were willing to use, and reevaluate if and where they would undergo another cycle to fulfill their child-wish. This act of agency returned many women to a clinic to undergo another cycle.

Some scholars may interpret the reflections and renegotiations these women underwent as a reflection of the coercive character of ARTs and their "never-enough quality" (Sandelowski 1991). These women's decisions were, however, based on conscious understandings and negotiations of the positive and negative potentials of engaging in this uncertain process again. Even if these technologies can be analyzed as ultimately coercive, the women in my study did not blindly engage with them, especially the second or third time. Yet in this process of returning to the medical realm, particularly multiple times, the

---

<sup>63</sup> This has often been referred to as the "gamble" or "chance" of IVF discussed in the introduction to this chapter.

plurality of losses was augmented by the lack of collaboration between fertility clinics, and the limited legal restrictions that permit women to move between clinics/doctors and seek new treatment regimens in their pursuit for a child. I witnessed such a scenario only on a few occasions, but this environment increases the likelihood for the exploitation of at least *some* couples' financial resources, *some* women's bodies and their emotional distress, and for the over-medicalization of infertility, as examinations and treatments are repeated time and again without necessarily improving the treatment regimen.

This medical environment, therefore, is both enabling and disabling: it provides couples, at least couples with the necessary resources (financial and knowhow), the necessary medical services to facilitate assisted conception and the opportunity to choose the service they perceive to be the best option to achieve their child-wish. Simultaneously, however, it does so within a context of limited success, uncertainty, incomplete knowledge, and limited options as ARTs are the sole option to obtain a child of one's own. Echoing Inhorn (2003b:268), we can see that ARTs are not the save all technology for infertility that the medical community has portrays them to be. Rather they are a means for *some* (limited) couples to have a child, within a context of numerous constraints. However, as I have emphasized throughout this thesis, these constraints are met with correspondingly, various forms of agency. This is what I turn to in the final chapter.



## Chapter 11

### Conclusion

As evidenced throughout this thesis, and suggested by Becker (2000), agency develops *overtime*, or is a process. This is, as Inhorn's (2003b) work demonstrates, a process defined by the co-relations of constraints and agency, or is processual because of the constantly changing relationship between constraints and agentic responses. In this way agency is, as Rapp (2011:703) notes, constrained but real. The aim of this thesis has been to contribute to this conceptualization of agency more broadly by exploring how a specific group of actors (women and couples) experience a specific process (assisted reproduction) in a specific context (Bogota, Colombia).

Through exploring assisted conception in a processual manner, delving into specific moments of the treatment trajectory and looking at how these moments relate to one another, we have seen how women's agency was transformed as they moved through the treatment process and were confronted with various constraints. In this conclusion I will first retrace the agentic movements of women and discuss the significance of this continuous agentic process as it transcends the borders of fertility treatment. This will be followed by a brief discussion of implications for treatment practices in both the public and private sector, and future research directions.

### Processual Agency

Looking at the various paths women took to arrive at a fertility center, my thesis began with an exploration of how agency consists of *streams* of agentic acts that are influenced or limited by external factors. Limited access to knowledge proved to be one of the primary barriers women faced when seeking a solution to their childlessness. Unlike in other locales where assisted conception has been explored in the Global South, information on the availability or even the

existence of these technologies is very limited in Colombia. As discussed in chapter 5, information is not readily available through public media, or in healthcare settings (even among reproductive experts, such as gynecologists). As reflected in Laura's narrative, some women were greatly constrained by this limited or inefficacious knowledge, which ultimately trapped them (at least temporarily) in the public healthcare sector where fertility treatment is not available. The lack of resources in the public sector, and non-existent collaboration between public and private facilities, greatly limited the ability of women to access high-tech fertility treatment.

Thus, rather than accessing fertility care through conventional means (i.e. through one's GP), women resorted to their social networks to arrive at a clinic. Specifically, "informational gatekeepers" – previous ART-users – provided women seeking fertility assistance with a particularly valuable and rare form of experiential/embodied knowledge, and thus the necessary information to access a private fertility center. Through the example of these gatekeepers, we can see how experiences gained through the body can produce a particular kind of knowledge that is turned into a resource not only for oneself, but for others seeking fertility assistance. This is an example of how agency can extend beyond an individual case of infertility, becoming a collective effort of knowledge sharing.

Gaining this knowledge, however, did not alleviate all barriers women faced as they attempted to access treatment. Rather many were faced with further constraints – monetary, temporal, and locational – that further limited their ability to access ARTs. The women in this study used strategic means to overcome these material constraints, but we cannot overlook the debilitating barrier treatment costs pose to the majority of couples seeking fertility assistance in Colombia.

Considering these knowledge and material constraints, women's agency manifested as a very active form of agency as they sought to enter the medical encounter. Upon entering the clinical realm, however, this highly active (and nascent) form of agency was transformed as women gained access to authoritative knowledge/information, which they had to approach in different

strategic ways. As demonstrated in chapter 6, the authority (or power) and knowledge in the fertility center is not necessarily hierarchical, but rather dispersed across the medical staff (and women/couples) as they play different roles in achieving the “collective enterprise” (i.e. successful treatment outcome) of the clinic. Using a Foucauldian understanding of power, I demonstrated how power can be productive (rather than merely repressive) as medical staff and women/couples work together to achieve conception.

The dispersal of authority and knowledge across the clinic gave women access to different forms of knowledge and support with which they could engage, and from which they could learn, expanding their knowledge and further enabling their engagement in the clinic’s productive power field. As I demonstrated through the example of Maia, some women actively sought out more information about treatment processes and options through strategic means such as observing the interactions/conversations between medical staff or directly refusing to continue with treatment until further information was provided. Though the authority of the fertility experts sometimes limited women’s abilities to gain knowledge, they nevertheless became more informed than they had been previously, which increased their ability to push treatment in the direction they wanted it to go (Greil 2002:113).

Other women/couples adopted a more passive role in treatment decision-making, preferring to let the doctor determine the ideal treatment path in the hope of improving the likelihood for a positive treatment outcome. In other words, these couples desired a paternalistic doctor who would take responsibility for treatment decision-making (Roberts 2008:84-85). As demonstrated through the notion of “desired ignorance,” some women *purposefully* avoided knowledge as a means to reduce anxiety and enable the doctor to do what was necessary to achieve conception. This passive engagement with their doctor and treatment shows that agency does not have to be active for women to push treatment in the direction they want it to go. Rather, it was through the women’s willing compliance with the doctor’s authority/knowledge that they intended to achieve conception; it was a means to a desired outcome (Thompson 2005:178). In brief, early consultations

showed how women both actively and passively participated in creating fields of power-knowledge that functioned as a “collective enterprise” – reflecting the idea of “productive power.”

Moving further into the treatment process, I explored how, during processes of physical diagnosis and treatment, women used their bodies to enact agency. In chapter 7, women’s narratives refuted the fragmentation of their bodies as the doctor’s explored their body-objects (or “bodies-we-have”) through the “medical gaze.” Though doctors engaged with the women’s body-object and body-subject to various degrees throughout treatment processes, women, themselves, embodied these processes as integrated whole bodies (“bodies-we-are”), meaning that their selves were not divided into mind and body (or mind and multiple body parts).

This represents a subtle form of agency through which women maintained the ability to create and sustain holistic images of the self, and to incorporate bodily sensations into this, sustaining the “body-we-are” through differently engaging, or using, the “body-we-have” and/or the “body-we-do.” Women experienced treatment processes as whole beings (not as divided minds and bodies), as they connected embodied sensations (e.g. hormone injections) with their overall physical and emotional experiences, which often extended beyond the treatment cycle (e.g. affecting their social lives). This is not to say that women rejected the objectification of their bodies by the doctor, as it was through these objectifying processes of ARTs that they intended to conceive (Thompson 2005:191). Rather, in women’s subjective experiences of treatment, objectification did not reduce them to “docile” objects.

Following the most objectifying procedure of fertility treatment (the aspiration), attention was transferred from the women to the embryos that would be produced in the laboratory. As discussed in chapter 8, it was during the moments leading up to the embryo transfer, or during the procedure, that couples began to consider the significance of these entities – recognizing their potential as kin and/or life more generally. Through the example of couples negotiating the use of donor materials, however, I demonstrated how some couples had to grapple with this consideration at an earlier stage, as they

considered whether non-genetically-related substances could create potential kin. Here, following Rapp's (1999) concept of moral pioneers, I explored how couples used notions of kinship (i.e. the familiar and the familial) to either embrace or deny kinship potential with a donor conceived child. Particularly for those who used anonymous gametes, the significance of the familial was transformed or molded into notions of the familiar. This reflects the importance of being familiar (or at least comfortable) with both the potential genetic and behavioral traits of a future child and the ways through which this cultural understanding of inheritance can be reshaped by those using donated gametes to produce an ideal (or acceptable) future child (Bharadwaj 2003; Roberts 2008; Thompson 2005:145-178).

For the majority of couples, however, the life potential of their embryos produced in the laboratory was not acknowledged until the embryo transfer. As evidenced in decisions about the cryopreservation of extra embryos, it was specifically the embryos that were transferred into the body that were perceived to have the potential to become future children. For the majority of couples, the embryos that remained in the laboratory were denied this potential due to "practical" considerations (e.g. financial constraints), but also the barrier cryopreserving extra embryos posed to sustaining the hope that the current cycle would result in pregnancy. Acknowledging this need to remain positive about the current cycle corresponded with extra embryos being denied life/kin potential, and being disregarded. This demonstrates the strategic maneuvering of couples as they sought to "make sense" (Franklin 1997:165) of the difficult decisions that accompany the treatment process. Furthermore, exploring the difficult ethically- and socially-bound decisions these couples grappled with, we can clearly acknowledge the constraints they faced. As highlighted in chapter 8, this challenges Madhok and colleagues (2013:7-8) claim that by exploring agency through one's choices, the constraints they encounter become masked. Rather, through these couples' choices the constraints they faced were made evident.

With the embryo transfer, agency once again became focused in the women's bodies and their actions (as opposed to making decisions about the



embryo's potential). In chapter 9, I discussed how the women adopted a form of "self-monitoring" upon entering the liminal stage of pregnant/not pregnant following the embryo transfer. Sawicki (1991:85) claims that through medical intervention, women adopt a practice of self-policing based on their experiences of/with the "clinical gaze," demonstrating how disciplining medical technologies and practices can actually be empowering rather than repressive. Contrary to this, the self-monitoring women in my study adopted following the ET actually defied the doctors' orders in some instances (i.e. taking to bed-rest) as women placed more emphasis on their embodied experiences and embodied knowledge. It was through self-monitoring and embodiment that women chose to either embrace or deny the knowing capacity of pregnancy detection technologies, influencing when they acknowledged they were pregnant (e.g. after a positive pregnancy test, after confirmation of the existence of an embryo through a transvaginal ultrasound, or later, for instance after hearing the heartbeat). For some women, then, it was not the knowing capacity of the technology that confirmed pregnancy, but time and their embodied sensations, and it was through women's self-monitoring and heightened awareness of their bodies that these became (to the women, at least) authoritative knowing capacities. In this treatment stage, then, it was again through the body that women enacted agency, using embodied sensations to embrace or deny pregnancy, to sustain said pregnancy in both instances, and particularly to protect oneself from disappointment and pain in the latter.

For the women who experienced treatment failure, agency became a process of reflection and (re)negotiation. As discussed in chapter 10, treatment failure forced women to confront multiple losses, losses that became constraints that women had to overcome in their decision to try again or forego further treatment. This process involved: (a) reflecting upon bodily knowledge and the "self," which had been brought into question when treatment failed, as women doubted the capabilities of their bodies and their decision to engage with these uncertain technologies; and (b) renegotiating their position vis-à-vis the productive power field of assisted reproduction they had been integrated into –

were they willing to undergo another cycle at the same clinic? To try the same technology again?

To some scholars, choosing to continue with treatment (in the same clinic, or a new one) represents the “never-enough quality” of ARTs (Sandelowski 1991), but if we consider reflection and renegotiation to be a form of agency, as Madhok (2013:106) claims, continuing can be seen as an engaged, decision-making *process*. Women enacted agency throughout the different, unique moments involved in treatment (particularly agency involving embodied knowledge), a constant process of renegotiating (in light of various constraints) their desires and their position. It can be said, then, that the renegotiation and reflection that took place at the end of the treatment cycle is less a distinct moment (indeed, this can maybe be said for all “moments” in the processes of assisted conception), and more a clear representation of agency’s broader processual nature. In other words, agency is defined *as* reflection and renegotiation, not as a phenomenon *at the moment of* reflection and renegotiation.

This emphasizes, first and foremost, that agency and constraints are co-constitutive. Agency does not exist without constraining forces or structures, and these are not constraining unless there is something (i.e. agency) to constrain. In the real world (specifically, in this case, in Colombian fertility clinics), this manifests in the ways that agency and constraints are intertwined in complex *processual* relationships, as has been depicted numerous times throughout this thesis.

Where desire for a child existed, but information was not readily available from conventional sources (i.e. knowledge was constrained), agency became the sharing of embodied knowledge across social networks. Where authoritative knowledge became active, and this personal knowledge became constrained, agency became both passive and active (i.e. negotiating constraints involves not only resisting them, but also selectively accepting or complying with them). Agency was transformed yet again by constraints as it became more directly involved with the body. As women rejected the fragmentation of their selves, embodying treatment as unified body-objects and body-subjects, they

adapted bodily constraints to create a subtle form of embodied agency. When the body was removed from direct treatment focus (during fertilization), women “pioneered” (Rapp 1999) ways to “make sense” (Franklin 1997) of life and kinship constraints. Then, when the body was reintroduced into the equation (during/after ET), women adapted their previous experiences of the treatment process (and the various forms of embodied and/or negotiated knowledge) to confront constraints surrounding the moment of acknowledged pregnancy. Finally, when treatment failed women adapted all the embodied knowledge they had gained to reflexively renegotiate the productive power field of the clinic, which they had helped build, in order to chose a new, or continued, path forward. In summary, given the co-existence of constraints and agency, the diverse constraints women faced during their fertility treatment journeys, had to be countered by equally diverse means of agency (active, passive, embodied, strategic, reflexive, negotiated), reflecting the multiplicity and variability of agentive practices.

Second, these examples of agency functioning as a process of reflexive renegotiation, co-defined by the constraints it confronts, emphasize that agency is a process (or agency and constraints are co-constituted as a process) that is *constrained*, but not *contained*. In other words, reflection and renegotiation demonstrate how agency is a process that *looks both backwards and forwards*. Women brought different personal histories and embodied knowledge into the treatment process, which suggests they will likely adapt their embodied experiences in the clinic to other aspects of their lives. What this means specifically to women undergoing ARTs is explicitly demonstrated by the case of Ariana: through reflection and renegotiation she was able to accept an anonymous donor conceived child as *her* potential child, a treatment option she initially rejected as the child would not correspond to her (or the dominant) kinship understanding; furthermore, through this process she also came to accept that adoption *may* be a reasonable option for obtaining a child, again a option she initially rejected.

In Rothman’s (1993[1986]:235-237) seminal work on women’s engagement with amniocentesis in the US, she notes how new reproductive

technologies have clearly provided the opportunity for interpretations of acceptable social constructs to be altered to fit new possibilities. These in turn may increase our options, even if only slightly. Ariana's use (and failure) of assisted conception, combined with the process of reflection and renegotiation that she underwent, demonstrates how she began to alter *her* understanding of relatedness and the possibility of raising a non-genetic (and non-biogenetic in the case of adoption) child. With treatment failure, therefore, instead of Ariana's options being reduced, they may have actually been increased as she began to imagine a future child as an adopted child. This indicates that new technologies may not only provide "new" options, but also overtime unintentionally reintroduce "old" options, or even introduce what were previously non-options.

Here defining agency as a process means looking not only at its development on a temporal continuum but also on an experiential continuum. Whether or not they pursue further means to obtain a child, these women will continue carrying the knowledge, experience, and agency they gained/used during fertility treatment with them into other aspects of their lives (just as they brought other aspects of their lives into fertility treatments), which may push against social constructs (as with Ariana), opening new realms of possibility. Combining this understanding of the processual nature of agency and the possibility to transform social constructs (i.e. constraints) emphasizes, once again, that both agency and constraints are processes in co-development. They are not static or bound, but rather transform relationally overtime; thus as one transforms, so will the other, and vice versa.

As I emphasized in the introduction, rather than claiming to make groundbreaking new theory, this thesis has intended to *contribute to* the discussion on forms of agency and constraints, exploring agency using the theories of other authors to see how it can be understood in the context of assisted reproduction in Colombia. Through the analysis in this conclusion, I have demonstrated that agency is not a single act, or even a stream of multiple acts, but rather a phenomenon that develops processually, augmented by past and current experiences. Thus agency, as a continuously developing process that combines past, present, and future knowledge and desires, both from

within and outside the specific field of power struggles in which it is being applied and developed (i.e. the fertility clinic), will inevitably stretch far beyond fertility treatment. Thus, understanding the subtleties of these processes is key to developing a better understanding of what treatment means to women's/couples' lives in a broader social context, and how changes in one setting can be transformative in another.

This better understanding is relevant not only to the social sciences, but also to the applied fields of health sciences that are being scrutinized by social research. Social research on medical phenomena should, or at least can, be beneficial to both the development of social theory, and to the development of better social practices in "real world" health settings. Thus I now briefly explore some recommendations for altering infertility treatment practices in both the private and public realm in Colombia.

#### Implications for Treatment Delivery and Public Healthcare

The two greatest barriers faced by couples as they tried to seek medical assistance for their infertility were limited (or inefficient information) and financial constraints. As mentioned various times throughout this thesis information about the availability of ARTs is greatly limited among the general public as well as in the public healthcare setting. First, this means that individuals with the other necessary resources to access treatment (i.e. finances) may be barred from treatment merely because of lack of information. Second, it raises questions about inefficient and even iatrogenic infertility treatments taking place in the public healthcare sector due to lack of training/knowledge and resources. Even if couples do not have the monetary resources to access high-tech ARTs, they *should* have access to effective diagnostic and low-tech interventions in the public sector, particularly given the right-to-health framework emphasized in the Colombian Constitution.

Furthermore, collaboration between the public and private medical sectors is greatly needed. As discussed in chapter 5, very few women accessed a

private facility through a referral from their GP or gynecologist. Collaboration between these sectors could also raise awareness about the extent of the availability and possibilities of ARTs as well as potentially increase general infertility and diagnostic knowledge among doctors in the public sector.

This brings us to the second primary barrier: finances. ARTs are exceedingly expensive in Colombia, where they are not covered by public healthcare nor private insurance. It is unlikely that the costs of these treatments will decrease, especially since equipment and training have to be obtained from abroad. However, increasing the efficacy of infertility diagnosis and the treatment of minor complications may reduce the number of individuals who need to seek treatment in the private sector. Furthermore, raising awareness about the causes of infertility (e.g. septic abortion, STDs) may also reduce the number of people who need to seek assistance for infertility complications.

Collaboration across private infertility centers may also reduce the costs for those seeking assistance, reducing the practice of repeating diagnostic exams, as well as potentially reducing the number of couples who decide to seek treatment elsewhere after a failed cycle. Collaboration may also reduce the likelihood of over-medicalization, or repeating examinations and treatment protocols when moving to a new clinic, as this stems from mistrust between fertility experts. Alternatively, collaboration, combined with the development of further medical regulations, could standardize treatment protocols and options across clinics in such a way that couples would be less likely to move between clinics.

In fertility centers there is a great need to deliver information to couples in a more effective way. As discussed in chapter 6, information is commonly provided piecemeal and in technical (often inaccessible) language during treatment processes. Lack of effective communication and lack of understanding was often a source of anxiety among the women in my study as they were, for instance, uninformed about the details of treatment processes, unsure and scared about injecting hormones, and unaware of the likelihood for treatment success. The latter caused some women to question the competence of the doctor and efficacy of the technologies when treatment failed and they were

urged to undergo a subsequent cycle. Providing information through more effective means – such as using various communication techniques (e.g. video, pamphlets, group informational sessions, etc.), using everyday language instead of medical terminology, and repeating key information during every consultation – may reduce women’s anxiety, better prepare them for treatment failure, reduce skepticism about doctors’ motivations, and possibly prevent women/couples from moving from one clinic to the next and feeling a need to try everything (i.e. treatment options and doctors) before foregoing treatment. Furthermore, it is necessary that fertility experts promote the psychological services available within their clinics and outside. Psychological therapy is not common practice in Colombia, which poses a barrier to women/couples utilizing these services, but their promotion from within the clinic may increase women’s use of the services better preparing them for the emotional and physical hardships of treatment and coping with treatment failure.

### Future Directions

In this conclusion I have retraced the constraints that women/couples faced during their fertility treatment journeys in Colombia and the agency they enacted to overcome these constraints. I have also provided recommendations to decrease or eliminate some of the constraints the women in my study encountered, while highlighting how some of the current practices may negatively affect how couples experience the use of these treatments.

This thesis has focused on the micro-experiential level of the medicalization of infertility in Colombia. To explore further the experience of assisted conception, the constraints couples face, and the structuring of these constraints requires further analysis of the macro-level processes at work in this context. I have proposed some systemic changes to the ART industry such as increasing the information about infertility and ARTs in the public healthcare sector, promoting collaboration across clinics, and increasing knowledge/training among GPs/gynecologists. To create the space required for

such changes to take place, we need more insight into the functioning of these institutions and programs and how they are interconnected. In ending, I am proposing further exploration into the government policies on ARTs and healthcare provisions in general, those under deliberation in the Congress and Courts (including current *tutela* suits), and the influence Catholic officials, who still hold a dominant position in Colombian politics and society, have over these policies/deliberations. Further research must investigate the power of international actors, such as the pharmaceutical and biotechnology industries, the Latin American Network of Assisted Reproduction (Redlara) and other medical professional entities, and “medical tourism” brokers which are becoming more prevalent in Colombia. All of these shape the ways in which those seeking and undergoing treatment experience assisted reproduction, and influence the future of this industry.





## Appendix 1: List of Abbreviations

AI	Artificial Insemination
ART	Assisted Reproductive Technology
CECOLFES	Centro Colombiano de Fertilidad y Esterilidad
EPS	Empresas Promotoras de Salud (Health Promoting Entity or health insurance company)
ET	Embryo Transfer
hCG	Human Chorionic Gonadotropin
ICSI	Intracytoplasmic sperm injection
IMF	International Monetary Fund
IVF	In Vitro Fertilization
NRT	New Reproductive Technology
OR	Operating Room
PESA	Percutaneous Epididymal Sperm Aspiration
PGD	Preimplantation Genetic Diagnosis
POS	Plan Obligatorio de Salud (Mandatory Health Plan)
POSS	Plan Obligatorio de Salud Subsidiado (Subsidized Mandatory Health Plan)
Redlara	Red Latinoamericana de Reproducción Asistida (Latin American Network of Assisted Reproduction)
SAP	Structural Adjustment Program
TESE	Testicular Sperm Extraction

UTI

Urinary Track Infection

## Appendix 2: Glossary of Medical Terminology

Abortifacient – a substance that is generally consumed to induce an abortion.

Artificial insemination (AI) – an infertility treatment that involves injecting a, generally, concentrated volume of semen into a woman’s uterus. This may be done using the semen of the woman’s partner or that of an anonymous or known donor.

Blighted ovum pregnancy – when a fertilized egg attaches to the uterine lining but an embryo does not develop inside the gestational sac. HCG (human chorionic gonadotropin or pregnancy hormone) levels often increase indicating implantation has occurred, but an embryo will not be detected during an ultrasound. It is the most common cause of early pregnancy failure or miscarriage. This is also known as an anembryonic pregnancy.

Cryopreservation of extra embryos (and eggs/sperm) – the process of freezing, generally, 3 to 5-day-old embryos, at sub-zero temperatures. When used in conjunction with ARTs embryos are commonly being preserved for a later treatment attempt, or frozen for donation. Collected eggs and sperm can also be frozen to be used in later pregnancy attempts or to preserve fertility.

Egg stripping – a process that involves removing the cumulus cells from the outer surrounding of the egg to access the quality and maturity of the egg and to better visualize the egg during fertilization. The process is done using an enzyme – hyaluronidase (see explanation below) – and small needles.

Endometriosis – a common condition in which endometrium or uterine lining grows outside of the uterus, most commonly on the ovaries, the pelvis, or the top of the uterus, but may also be found in other areas. The condition can cause painful and/or heavy periods, pain in the lower abdomen, pelvis, and back, and may be a cause of infertility. Some women may not experience any symptoms.

Fume hood – a local ventilation device used to limit exposure to toxic vapors, fumes, and other contaminants. In an ART laboratory a fume hood is commonly used to reduce the risk of bacterial contamination of eggs and embryos.

Hyaluronidases – a family of enzymes. The enzyme is found in the head of the sperm. During spontaneous conception this enzyme breaks down the outer membrane of the egg allowing the sperm to fertilize the egg. In the fertility laboratory this enzyme is manually applied to the egg to facilitate fertilization.

Hysterosalpingography – a medical procedure that entails injecting a radiopaque material (a substance that will appear on an x-ray) into the cervical canal to investigate the shape of the uterus and fallopian tubes. The resulting x-rays can be used to detect conditions such as uterine malformations, pelvic inflammatory disease, and fallopian tube obstruction.

Intra-cytoplasmic sperm injection (ICSI) – an assisted reproductive fertilization procedure that entails the use of a micromanipulation machine and a high-powered microscope to inject a single spermatozoid into an ovum to achieve conception. Resulting embryos are transferred to a woman's uterus.

In vitro fertilization (IVF) – an assisted reproductive fertilization procedure that entails manually combining ova and a concentrated sample of semen in a petri dish in a laboratory to achieve fertilization. Resulting embryos are transferred to a woman's uterus.

Myoma – a benign growth of muscle tissue that grows inside the uterus, ranging in size from a melon to a small coin. They may grow in clusters or as a single mass. The growth may interfere with conception. Also known as a fibroid, leiomyoma, fibromyoma.

Ovarian hyperstimulation syndrome (OHSS) – a medical condition that may result from taking hormone stimulation drugs to increase egg growth. Cases range from mild to severe and may include minor abdominal pain, nausea, and diarrhea, to severe thrombosis, distension, and respiratory distress.

Percutaneous epididymal sperm aspiration (PESA) – a procedure in which sperm are aspirated using a needle from either the testis or the vas deferens. The procedure is primarily used when no sperm is present in the ejaculate.

Preimplantation genetic diagnosis (PGD) – a technique used to screen embryos created through IVF/ICSI for genetic diseases before transferring them to a woman’s uterus. The technique involves biopsying a single cell from an embryo.

Sperm analysis – a standard examination of male semen to evaluate certain characteristics such as sperm quality and quantity. The exam involves the male collecting the ejaculate in a sterile cup and delivering it to the laboratory where it is analyzed. The exam may be done numerous times throughout a fertility cycle.

Sperm washing – a process that removes the individual sperm from the semen, and washes away chemicals that may adversely affect the uterus. This process is used for both AI and IVF/ICSI.

Testicular sperm extraction (TESE) – a surgical procedure that removes a small portion of tissue from the testis in order to access any viable sperm to be used in ICSI fertilization. The procedure is primarily used when no sperm is present in the ejaculate.

Transvaginal ultrasound – a standard examination of the female reproductive organs, specifically uterine cavity and ovaries to determine the shape of the organs and if the ovaries are producing follicles. The exam involves the use of a phallic shaped ultrasound wand that is placed inside the woman’s vaginal canal. The exam is performed for diagnostic means, to observe follicular development during ovarian stimulation, and to detect/monitory pregnancy.

Varicocele – a medical condition in which the pampiniform venous plexus (the veins that drain the testicles) in the scrotum is enlarged. It is one of the main causes of male infertility and can be treated by both surgical and non-surgical therapy.



### Appendix 3: Table of Informants

Pseudonym*	Age**	Occupation	Treatment & Treatment History	Outcome & Intended Next Step(s)
Adriana & Adam	44 & 40	Adriana is an actress Adam is a producer	1 <sup>st</sup> ICSI cycle	Treatment failed, the eggs produced were not of high enough quality for fertilization, Adriana had discussed using donor eggs from a niece if treatment failed, but after failure she said she would not do another cycle
Alvina	32	Voluntarily unemployed She lives in Dubai with her Emirati husband	1 <sup>st</sup> ICSI cycle	Treatment was successful,**** informed by medical staff
Anabel	34	English teacher	1 <sup>st</sup> ICSI cycle	Treatment failed, informed by medical staff
Angelica	35	Voluntarily unemployed Husband is admiral in Colombian navy	1 <sup>st</sup> ICSI cycle, had 3 failed AIs at another clinic***	Treatment was successful
Anita	33	English teacher	1 <sup>st</sup> ICSI cycle, had 2 failed AIs before	Treatment failed, informed by medical staff
Ariana	38	Voluntarily unemployed Lives in Italy with German husband	1 <sup>st</sup> ICSI cycle with known donor eggs (sister)	Treatment failed, initiated 2 <sup>nd</sup> cycle 6 months later
Barbara & Andrés	28	Barbara is a teacher Andrés works in construction	Recommended ICSI but had not initiated treatment	
Bella (single)	43	Marketing analysis	2 <sup>nd</sup> ICSI with donated eggs and frozen sperm from ex-husband, embryos left over	Treatment was successful, pregnant with twins



			from initial unsuccessful cycle. Did IVF 6 years before (at time still with ex-husband), treatment was successful but ended in miscarriage	
Carina & David	33 & 34	Carina is a marketing specialist David works in sales	1 <sup>st</sup> ICSI cycle	Treatment was successful
Carmena	34	Journalist	1 <sup>st</sup> AI which failed, then tried ICSI	Treatment failed, informed by medical staff
Chela	37	Architect	Considering undergoing 1 <sup>st</sup> ICSI cycle	She did not undergo treatment at Fertisuperior
Claudia	42	Data analyst	1 <sup>st</sup> ICSI cycle	Treatment was successful, pregnant with twins
Daniela	40 & 58	Works in sales for a multinational company	Recommended ICSI	Traveled from Miami for treatment, had intended to do AI, but doctor recommended ICSI
Elsa & José	32 & 32	Elsa is a graphic designer José is a store manager	1 <sup>st</sup> ICSI cycle	Treatment was successful, informed by medical staff
Emma	28	Voluntarily unemployed Lives in Miami with her husband who is a medical doctor	2 <sup>nd</sup> ICSI cycle, initial cycle ended in failure	Treatment was successful, pregnant with twins
Fatima	42	Corporate lawyer	1 <sup>st</sup> ICSI cycle with donor egg and sperm, had 2 failed AIs with donor sperm and 2 failed ICSI with donor sperm before	She had not completed the ICSI cycle with donor egg and sperm when research ended as she had to have a uterine polyp removed before initiating the cycle
Felicia	41	Voluntarily	4 <sup>th</sup> ICSI cycle, had	Treatment was

		unemployed Husband owes numerous businesses	3 failed AIs and 3 failed ICSI cycles before, experienced 2 miscarriages before starting treatment	successful in that Felicia became pregnant but an embryo was not detected in the amniotic sac during the 6 week ultrasound
Francesca	36	Unemployed Resign from job during initial IVF cycles	Recommended ICSI, had not initiated treatment, had 3 failed IVF cycles at another clinic	Had not completed cycle by end of research
Francia & Franco	30 & 34	Francia is a secretary Franco works for an oil company	1 <sup>st</sup> ICSI cycle	Treatment was successful, pregnant with twins
Gabriela & Gurvir	35 & 51	Gabriela is an accounts manager Gurvir works in the tourist industry	1 <sup>st</sup> ICSI cycle, husband froze sperm during first appointment so he would not have to return to the clinic	They had not finished their first cycle by the time research ended, Gabriela needed a laparoscopy to remove tissue build up from severe endometriosis, which delayed treatment
Iris & Fernando	32 & 34	Both work in finance in international companies	1 <sup>st</sup> ICSI cycle, had 2 failed AIs at another clinic, second one resulted in the loss of a fallopian tube due to ectopic pregnancy	Treatment failed, were initiating 2 <sup>nd</sup> ICSI cycle at end of treatment
Jamie & Juan	36 & 38	Jamie is voluntarily unemployed Juan is an engineer	5 <sup>th</sup> ICSI cycle, had 4 failed cycles at another clinic	5 <sup>th</sup> cycle was successful
Jimena	42	Pediatric dentist and professor	3 <sup>rd</sup> ICSI with donor ova, embryos were left over from 2 <sup>nd</sup> failed ICSI cycle, had 2 failed AIs and 2 failed ICSI before	Treatment failed, informed by medical staff
Julia	36	Pharmaceuti cal sales	3 <sup>rd</sup> AI with donor sperm, had 2 failed AIs at	Treatment failed, informed by medical staff

			another clinic. male factor infertility (Klinefelter Syndrome)	
Laila	33	Paralegal	2 <sup>nd</sup> ICSI cycle, did initial failed cycle 3 years before. Lost both fallopian tubes due to 2 ectopic pregnancies	Treatment failed, informed by medical staff
Larissa & Nicholas	26 & 27	Larissa is a veterinarian technician Nicholas is a mechanic	1 <sup>st</sup> ICSI	Treatment was successful
Laura & Filipe	44 & 44	Laura is voluntarily unemployed Filipe is an accounts manager	1 <sup>st</sup> ICSI cycle, had 4 failed AIs before	Treatment was successful, pregnant with twins
Leandra & Rodrigo (interview with husband)	39 & 43	Leandra is voluntarily unemployed Rodrigo is a business owner	5 <sup>th</sup> ICSI cycle, had 4 failed cycles each at different clinics.	Treatment failed, informed by medical staff
Lila & Sebastián	31 & 35	Lila is a veterinarian Sebastián is a financial lawyer	1 <sup>st</sup> ICSI cycle	Treatment was successful, informed by medical staff
Liliana & Juan David	32 & 32	Liliana works in human resources Juan David is an assistant bank manager	Shopping around for clinic. Had not started a cycle at Fertisuperior. male factor infertility	
Linda & Paco	31 & 32	Linda is a high school teacher Paco works in marketing	2 <sup>nd</sup> ICSI cycle, initial cycle was successful but she miscarried at 6.5 months after having an amniocentesis, decided to try	Had not finished cycle by end of research

			again a year later	
Lorena	32	Administrative executive	3 <sup>rd</sup> ICSI cycle, initial cycle resulted in hyperstimulation, 2 <sup>nd</sup> cycle resulted in the miscarriage of twins at 10 weeks	Treatment was successful, informed by medical staff
Luisa & Eduardo (interview with husband)	34 & 36	Luisa is an epidemiologist Eduardo is a doctor	Recommended ICSI, husband was taking hormones to improve the quality of his sperm	Had not initiated cycle by end of research
Luna & Pablo	33 & 44	Luna is a marketing executive Pablo works in the oil industry	2 <sup>nd</sup> ICSI cycle, first cycle ended in failure	Treatment failed, informed by medical staff
Lupe	41	Event planner	2 failed cycles of ICSI with sex selection, wanted a baby girl, already had two sons conceived spontaneously	Decided to forego treatment, conceived a girl spontaneously soon after foregoing treatment.
Magdalena (sister of Marisa)	37	Works in media production	1 failed AI	She was considering doing ICSI but did not currently have the funds to do so
Maia & Matias	34 & 34	Event planner	1 <sup>st</sup> ICSI cycle	Had not finished cycle by end of research
Marcela & Santiago	25 & 28	Marcela is an editor Santiago works in shipping	2 <sup>nd</sup> ICSI cycle, first cycle ended in failure before research started	Treatment failed, informed by medical staff
Mariana	32	Bank employee, Husband is training to be a doctor	1 <sup>st</sup> ICSI cycle	Treatment failed, informed by medical staff
Mariela & Martín	34 & 36	Mariela is a biologist Martín is a pediatric cardiologist	1 <sup>st</sup> ICSI with donor sperm	Treatment failed, started 2 <sup>nd</sup> cycle soon after first failed, had not finished 2 <sup>nd</sup> cycle by end of research
Marisa (sister of	35	Voluntarily unemployed	2 <sup>nd</sup> ICSI cycle, initial cycle failed	Treatment failed, the three sperm her

Magdalena)				husband produced did not fertilize her eggs, he refused sperm donation. At time of last interview they had not agreed to undergo another cycle.
Marisol	39	Voluntarily unemployed Husband is a financial manager	1 <sup>st</sup> AI, had attempted ICSI before but did not produce high enough quality eggs	Treatment failed, informed by medical staff
Martha & Edger	32 & 31	Martha is in grade school teacher Edger is a financial advisor	1 <sup>st</sup> ICSI cycle, they had delayed treatment before because she had a thyroid complication that needed to be resolved first. Using services available through the EPS to reduce treatment costs	They had not finished their first cycle by the time research ended
Mira (single)	28	Dentist	1 <sup>st</sup> AI with donor sperm	Treatment was successful, informed by medical staff
Nadia & Alexander	32 & 35	They own a cattle ranch	2 <sup>nd</sup> ICSI cycle with frozen embryos from first cycle, initial cycle failed, first tried hormone stimulation and AI at a different clinic both of which failed	Treatment failed, informed by medical staff
Nicola (single)	40	Business executive	1 <sup>st</sup> ICSI with donor sperm, had 2 failed AIs with donor sperm before	Treatment failed, informed by medical staff
Nora	31	Administrative assistant	1 <sup>st</sup> ICSI cycle	Treatment was successful
Pamela & Patrick	38 & 49	Pamela is voluntarily unemployed Patrick is a business executive	2 <sup>nd</sup> ICSI cycle with frozen embryos left over from previous cycle which resulted in miscarriage	Treatment was successful
Paula &	42	Paula is	1 <sup>st</sup> ICSI cycle using	Treatment was

Mario		voluntarily unemployed Mario is a doctor	embryos that were frozen after aspiration because Paula suffered from severe hyperstimulation	successful, pregnant with twins
Reanna	34	Administrative assistant	1 <sup>st</sup> ICSI cycle, 2 failed AIs and 1 failed IVF cycle before	Treatment failed, at time of last interview she was considering undergoing another cycle at a different clinic but did not have the funds to do so
Samara	33	Samara is an administrative assistant, Husband is a policeman	2 <sup>nd</sup> ICSI cycle using frozen embryos from initial cycle that failed. Also had failed AI.	Treatment failed, informed by medical staff
Sandra (single)	44	Engineer	2 <sup>nd</sup> ICSI with donor egg and sperm, initial cycle with her own eggs resulted in miscarriage	Treatment was successful, 2 months pregnant at time of interview
Sara & Pedro	30 & 32	Sara is a psychologist Pedro is an accountant	1 <sup>st</sup> ICSI cycle with known donor eggs (sister)	Treatment was successful
Selina & Ramón	27 & 30	Selina is an assistant professor Ramón is a project manager	1 <sup>st</sup> ICSI	Treatment failed, her husband who already has two children was not interested in undergoing another cycle, she was undecided
Susi	36	Voluntarily unemployed Husband is project manager of an international company	1 <sup>st</sup> ICSI cycle	Treatment was not completed because Susi's husband did not come from Cartagena to provide the sperm sample, her eggs were frozen for a later cycle, but I did not meet her again
Talia	30	Chemist	1 <sup>st</sup> ICSI cycle	Treatment was successful, interviewed after 2 <sup>nd</sup> ultrasound
Tania & Mauricio	32 & 44	Tania is a bank cashier Mauricio is a	1 <sup>st</sup> ICSI cycle	Treatment failed, informed by medical staff

		business executive		
Tatiana & Hernan	42 & 41	Tatiana is a sales specialist Hernan is a family counselor	Shopping around, recommended ICSI, had 3 miscarriage 2 of which were blighted ovum pregnancies before started looking for treatment	Considering going through treatment at Fertisuperior but first needed to find the financial means to do so
Valentina	41	Marketing researcher	Shopping around for clinic. Had not started a cycle at Fertisuperior, first needed to have large uterine fibroid removed	
Vanesa & Camilo	40 & 41	Vanesa is a secretary Camilo is a photographer	2 <sup>nd</sup> ICSI cycle, initial cycle resulted in the birth of a son 5 years before, did 2 failed AIs at another clinic before initial ICSI cycle	Treatment failed, they did not know if they would undergo another cycle
Victoria & Mateo	34 & 37	Victoria is a history professor Mateo is a chemical engineer	1 <sup>st</sup> ICSI cycle, had 3 failed AIs before, waited 7 months before agreeing to try ICSI	Had not finished cycle by end of research

This table presents the state of the women/couples as of the last time that I heard from them or was informed about their treatment status by the medical staff.

\* All women were married unless stated otherwise.

\*\* When both partners were present during the interviews the woman's age is first, followed by the man's.

\*\*\* When table states "failed treatment before/at another clinic" this implies that these cycles failed before I met the woman/couple.

\*\*\*\* Unless otherwise stated, treatment success in this instance refers to an embryo(s) being detected during the first ultrasound.

#### Appendix 4: Table of Medical Staff

<b>Medivida</b>		<b>Fertisuperior</b>	
Dr. Herrera	Fertility Expert (Partner)	Dr. Mabel	Senior Fertility Expert, Director of Medicine
Dr. Álvarez	Fertility Expert (Partner)	Dr. Ortero	Fertility Expert
Dr. Pamela	Senior Embryologist	Dr. Diaz	Fertility Expert (in training)
Dr. Cecilia	Embryologist	Dr. Catalina	Senior Embryologist
Daniela	Senior Nurse	Dr. Samuel	Embryologist
Paulina	Nurse	Dr. Lanka	Embryologist
Yvonne	Nurse	Luz	Senior Nurse
Carla	Administrator	Alexa	Administrator

This table only includes pseudonyms for the medical staff whose narratives appear in this thesis.





## Bibliography

- Abadía, Cesar Ernesto, and Diana G Oviedo. 2009. "Bureaucratic Itineraries in Colombia. A Theoretical and Methodological Tool to Assess Managed-Care Health Care Systems." *Social Science & Medicine* 68 (6) (March): 1153–60.
- Abadía-Barrero, César. 2012. "The Colombian Health Care Reform: A 'Living Laboratory' of Global Capitalism?" *Medanthro.net*.
- Abel, Emily K., and C. H. Browner. 1998. "Selective Compliance with Biometrical Authority and the Uses of Experiential Knowledge." In *Pragmatic Women and Body Politics*, edited by Margaret Lock and Patricia A. Kaufert, 310–326. Cambridge: Cambridge University Press.
- Arditti, Rita, Renate D. Klein, and Shelley Minden. 1984. *Test-Tube Women: What Future for Motherhood*. London: Pandora Press.
- Atkinson, Paul, and David Silverman. 1997. "Kundera's Immortality: The Interview Society and the Invention of the Self." *Qualitative Inquiry* 3 (3): 304–325.
- Bastos, Santiago Amigo. 2007. "Familia, Género Y Cultura: Algunas Propuestas Para La Comprensión de La Dinámica de Poder En Los Hogares Populares [Family, Gender and Culture: Some Proposals for the Compensation for Power Dynamics En Popular Homes]." In *Familia Y Diversidad En América Latina: Estudios de Casos [Family and Diversity in Latin America: Case Studies]*, 103–132. Buenos Aires: Consejo Latinoamericano de Ciencias Sociales.
- Becker, Gay. 2000. *The Elusive Embryo: How Women and Men Approach New Reproductive Technologies*. Berkeley: University of California Press.
- Becker, Gay, and Robert D. Nachtigall. 1992. "Eager for Medicalisation: The Social Production of Infertility as a Disease." *Sociology of Health and Illness* 14 (4): 456–471.
- Benjamin, Orly, and Hila Ha'elyon. 2002. "Rewriting Fertilization: Trust, Pain, and Exit Points." *Women's Studies International Forum* 25 (6): 667–678.
- Bergquist, Charles, Ricardo Peñaranda, and Gonzalo G. Sánchez. 1992. *Violence in Colombia: The Contemporary Crisis in Historical Perspective*. Wilmington, DE: SR Books.
- . 2001. *Violence in Colombia, 1990-2000: Waging War*. Wilmington, DE: Scholarly Resources Books.

- Bharadwaj, Aditya. 2001. "Conception: An Exploration of Infertility and Assisted Conception in India." PhD Dissertation. Department of Sociology. University of Bristol.
- . 2003. "Why Adoption Is Not an Option in India: The Visibility of Infertility, the Secrecy of Donor Insemination, and Other Cultural Complexities." *Social Science and Medicine* 56: 1867–1880.
- . 2006. "Sacred Conceptions: Clinical Theodicies, Uncertain Science, and Technologies of Procreation in India." *Culture, Medicine and Psychiatry* 30 (4): 451–65.
- . Forthcoming. *Conceptions: Infertility and Procreative Technologies in India*. New York: Berghahn.
- Birenbaum-Carmeli, Daphna, and Marcia C. Inhorn. 2009. "Introduction." In *Assisting Reproduction, Testing Genes: Global Encounters with New Biotechnologies*, edited by Daphna Birenbaum-Carmeli and Marcia C. Inhorn, 1–26. New York: Berghahn Books.
- Blaikie, Norman. 2000. *Designing Social Research*. Cambridge: Polity Press.
- Borkman, Thomasina. 1976. "Experiential Knowledge: A New Concept for the Analysis of Self-Help Groups." *Social Service Review* 50 (3): 445–456.
- Bourdieu, Pierre. 1990. *The Logic of Practice*. Stanford, CA: Stanford University Press.
- Bourdieu, Pierre, and Loïc J.D. Wacquant. 1992. "The Logic of Fields." In *An Invitation to Reflexive Sociology*, 94–115. Chicago: University of Chicago Press.
- Braff, Lara R. 2010. "Reconceiving Personhood: The Localization of Assisted Reproductive Technologies in Mexico City." PhD Dissertation. Center for Latin American Studies. University of Chicago.
- Bransen, Els. 1992. "Has Menstruation Been Medicalised? Or Will It Never Happen..." *Sociology of Health & Illness* 14 (1): 98–110.
- Braverman, Andrea M. 1997. "When Is Enough, Enough? Abandoning Medical Treatment for Infertility." In *Infertility: Psychological Issues and Counselling Strategies*, edited by Sandra R. Leiblum, 209–229. New York: John Wiley & Sons.
- Browner, Carole H. 1980. "The Management of Early Pregnancy: Colombian Folk Concepts of Fertility Control." *Social Science & Medicine* 14B: 25–32.

- . 1983. "Male Pregnancy Symptoms in Urban Colombia." *American Ethnologist* 10 (3): 494–510.
- . 1985. "Traditional Techniques for Diagnosis, Treatment, and Control of Pregnancy in Cali, Colombia." In *Women's Medicine. A Cross-Cultural Study of Indigenous Fertility Regulation*, edited by Lucile F. Newman, 99–123. New Brunswick, NJ: Rutgers University Press.
- . 1999. "On the Medicalization of Medical Anthropology." *Medical Anthropology Quarterly* 13 (2): 135–140.
- . 2000. "Activities Situating Women's Reproductive." *American Anthropologist* 102 (4): 773–788.
- Browner, Carole, and Ellen Lewin. 1982. "Female Altruism Reconsidered: The Virgin Mary as Economic Woman." *American Ethnologist* 9 (1): 61–75.  
<http://onlinelibrary.wiley.com/doi/10.1525/ae.1982.9.1.02a00040/abstract>.
- Burkitt, Ian. 1999. *Bodies of Thought: Embodiment, Identity and Modernity*. London: Sage Publications.
- Calderón, Carlos Alberto, Jaime Cardona Botero, Jesús Ortega Bolaños, and Rocio Robledo Martínez. 2011. "Sistema de Salud En Colombia: 20 Años de Logros Y Problemas [The Colombian Healthcare System: 20 Years of Achievements and Problems." *Ciencia & Saúde Coletiva* 16 (6): 2817–2828.
- Carrillo, Angela Consuelo. 2009. "Internal Displacement in Colombia: Humanitarian, Economic and Social Consequences in Urban Settings and Current Challenges." *International Review of the Red Cross* 91 (875): 527–546.
- Carrillo, Sonia, Karen Ripoll-Núñez, and Paul L. Schvaneveldt. 2011. "Family Policy Initiatives in Latin America: The Case of Colombia and Ecuador." *Journal of Child and Family Studies* 21 (October 4): 75–87.
- Cerdán-infantes, Pedro, and Andreas Blom. 2007. "Colombia: Assisting Talented Students from Low-Income Families Attend Tertiary Education." *En Breve, World Bank* (100): 1–4.
- Charmaz, Kathy. 2006. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: Sage Publications.
- Clarke, Adele E., and Janet Shim. 2011. "Medicalization and Biomedicalization Revisited: Technoscience and Transformations of Health, Illness and American Medicine." In *Handbook of the Sociology of Health, Illness, and*

- Healing: Blueprint for the 21st Century*, edited by B.A. Pescosolido, 173–199. New York: Springer.
- Clarke, Adele E., Laura Mamo, Jennifer R. Fishman, Janet K. Shim, and Jennifer R. Fosket. 2003. "Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine." *American Sociological Review* 68 (2): 161-194.
- Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18: 209–232.
- . 2005. "The Shifting Engines of Medicalization." *Journal of Health and Social Behavior* 46 (1) (March 1): 3–14.
- . 2007. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: Johns Hopkins University Press.
- Conrad, Peter, and Valerie Leiter. 2004. "Medicalization, Markets and Consumers." *Journal of Health and Social Behavior* 45 Suppl (2004) (January): 158–76.
- Conrad, Peter, and Joseph W Schneider. 1992[1980]. *Deviance and Medicalization: From Badness To Sickness*. Philadelphia: Temple University Press.
- Consejo Nacional de Política Económica y Social (Conpes). 2005. "Metas Y Estrategias de Colombia Para El Logro de Los Objetivos de Desarrollo Del Milenio – 2015 [Colombian Goals and Strategies to Achieve the Millennium Development Goals – 2015]." Bogota, D.C.
- Corea, Gena. 1985. *The Mother Machine: Reproductive Technology from Artificial Insemination to Artificial Wombs*. New York: Harper and Row.
- Crossley, Nick. 1995. "Body Techniques, Agency, and Intercorporeality: On Goffman's Relations in Public." *Sociology* 29 (1): 133–149.
- Crowe, C. 1985. "'Women Want It': In-Vitro Fertilization and Women's Motivation for Participation." *Women's Studies International Forum* 8 (6): 547–552.
- Csordas, Thomas J. 1994a. "Introduction: The Body as Representation and Being-in-the-World." In *Embodiment and Experience: The Existential Ground of Culture and Self*, edited by Thomas J. Csordas, 1–24. Cambridge: Cambridge University Press.

- . 1994b. *The Sacred Self: A Cultural Phenomenology of Charismatic Healing*. Berkeley: University of California Press.
- Cussins, Charis M. 1998. "Ontological Choreography: Agency for Women Patients in an Infertility Clinic." In *Differences in Medicine: Unraveling Practices, Techniques, and Bodies*, edited by Marc Berg and Annemarie Mol, 166–201. London: Duke University Press.
- DANE (Departamento Administrativo Nacional de Estadística). 2015. "Medición Del Empleo Informal Y Seguridad Social." *Dane*. Bogota. [https://www.dane.gov.co/files/investigaciones/boletines/ech/ech\\_informalidad/re\\_ech\\_informalidad\\_dic\\_feb2014.pdf](https://www.dane.gov.co/files/investigaciones/boletines/ech/ech_informalidad/re_ech_informalidad_dic_feb2014.pdf).
- Davis, Kathy. 1995. *Reshaping the Female Body: The Dilemma of Cosmetic Surgery*. New York: Routledge.
- Davis-Floyd, Robbie E. 1994. "The Technocratic Body: American Childbirth as Cultural Expression." *Social Science & Medicine* 38 (8): 1125–1140.
- . 2004[1992]. *Birth as an American Rite of Passage*. 2nd ed. Berkeley: University of California Press.
- Davis-Floyd, Robbie, and Carolyn Sargent. 1996. "Introduction." *Medical Anthropology Quarterly* 10 (2): 111–120.
- Dewalt, Kathleen M., Billie R. Dewalt, and Coral B. Wayland. 1998. "Participant Observation." In *Handbook of Methods in Cultural Anthropology*, edited by H. Russel Bernard, 259–299. Walnut Creek, CA: AltaMira.
- Dhont, N., S. Luchters, W. Ombelet, J. Vyankandondera, a. Gasarabwe, J. Van De Wijgert, and M. Temmerman. 2010. "Gender Differences and Factors Associated with Treatment-Seeking Behaviour for Infertility in Rwanda." *Human Reproduction* 25 (8): 2024–2030.
- Dickson-Swift, Virginia, Erica L James, Sandra Kippen, and Pranee Liamputtong. 2006. "Blurring Boundaries in Qualitative Health Research on Sensitive Topics." *Qualitative Health Research* 16 (6): 853–871.
- Douglas, Jack D. 1985. *Creative Interviewing*. London: Sage Publications.
- Dumit, Joseph, and Robbie Davis-Floyd. 1998. "Cyborg Babies: Children of the Third Millenium." In *Cyborg Babies: From Techno-Sex to Techno-Tots*, edited by Robbie Davis-Floyd and Joseph Dumit, 1–20. New York: Routledge.
- Dyer, S. J., N. Abrahams, M. Hoffman, and Z. M. van der Spuy. 2002. "Infertility in South Africa: Women's Reproductive Health Knowledge and Treatment-

- Seeking Behaviour for Involuntary Childlessness." *Human Reproduction* 17 (6): 1657–1662.
- Echeverri, Ligia. 1998. "Transformaciones Recientes En La Familia Colombiana." *Revista de Trabajo Social* 1: 51–60.
- Edwards, Jeanette. 2000. *Born and Bred: Idioms of Kinship and New Reproductive Technologies in England*. Oxford: Oxford University Press.
- . 2004. "Incorporating Incest: Gamete, Body and Relation in Assisted Conception." *Journal of the Royal Anthropological Institute* 10 (4): 755–774.
- . 2009. "Skipping a Generation and Assisting Conception." In *Kinship and beyond: The Genealogical Model Reconsidered*, edited by Sandra Bamford and James Leach, 138–158. New York: Berghahn Books.
- Ehrenreich, Barbara, and Deirdre English. 2005[1978]. *For Her Own Good: Two Centuries of the Experts' Advice to Women*. New York: Anchor Books.
- El Tiempo. 2013a. "Los Niños Del Bronx, Con Nuevo Jardín [Children from the Bronx, with New Daycare]." *El Tiempo*, page 7, March 20.
- . 2013b. "Video: Con Bebés Robot Buscan Prevenir Embarazos Adolescentes [Video: With baby robot to prevent adolescent pregnancies]." *El Tiempo*, May 22. [http://www.eltiempo.com/colombia/bogota/bebes-robots-en-colegios-de-fontibon\\_12815607-4](http://www.eltiempo.com/colombia/bogota/bebes-robots-en-colegios-de-fontibon_12815607-4).
- Eslava, Luis. 2009. "Constitutionalization of Rights in Colombia: Establishing a Ground for Meaningful Comparisons." *Revista Derecho Del Estado* 22 (2003): 183–229.
- European Society of Human Reproduction and Embryology. 2014. "ART Fact Sheet (June 2014)." Accessed November 2, 2014. <http://www.eshre.eu/Guidelines-and-Legal/ART-fact-sheet.aspx>.
- Fleischer, Eva. 1990. "Ready for Any Sacrifice? Women in IVF Programmes." *Reproductive and Genetic Engineering* 3 (1): 1–11.
- Foucault, Michel. 1973. *The Birth of The Clinic: An Archaeology of Medical Perception*. Translated by Alan M. Sheridan. London: Tavistock Publications.
- . 1977. *Discipline and Punish: The Birth of the Prison*. Translated by Alan M. Sheridan. New York: Vintage Books.
- . 1982. "The Subject and Power." *Critical Inquiry* 8 (4): 777–795.

- . 1984. "Truth and Power." In *The Foucault Reader*, edited by Paul Rabinow, 51–75. New York: Pantheon Books.
- . 1978. *The History of Sexuality Volume 1: An Introduction*. Translated by Robert Hurley. New York: Pantheon Books.
- . 1988. *Technologies of the Self: A Seminar with Michel Foucault*. Edited by Luther H. Martin, Huck Gutman, and Patrick H. Hutton. Amherst, MA: University of Massachusetts.
- . 1991. "Governmentality." In *The Foucault Effect: Studies in Governmentality*, edited by Graham Burchell, Colin Gordon, and Peter Miller, 87–104. Chicago: University of Chicago Press.
- . 2010[1984]. *The Foucault Reader*. Edited by Paul Rabinow. New York: Vintage Books.
- Fox, Donald T, Gustavo Gallón-Giraldo, and Anne Stetson. 2010. "Lessons of the Colombian Constitutional Reform of 1991: Toward the Securing of Peace and Reconciliation." In *Framing the State in Times of Transition: Case Studies in Constitution Making*, edited by Laurel E. Miller, 467–482. Washington, D.C.: United States Institution of Peace.
- Fox, Renée C. 1977. "The Medicalization and Demedicalization of American Society." *Daedalus* 106 (1): 9–22.
- Franklin, Sarah. 1995. "Postmodern Procreation: A Cultural Account of Assisted Reproduction." In *Conceiving the New World Order: The Global Politics of Reproduction*, edited by Faye Ginsburg and Rayna Rapp, 323–345. Berkeley: University of California Press.
- . 1997. *Embodied Progress: A Cultural Account of Assisted Conception*. London: Routledge.
- . 2006. "Origin Stories Revisited: IVF as an Anthropological Project." *Culture, Medicine and Psychiatry* 30 (4): 547–55.
- . 2013. *Biological Relatives: IVF, Stem Cells, and the Future of Kinship*. London: Duke University Press.
- Freidson, Eliot. 1970. *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. New York: Dodd, Mead & Company.
- Friese, Carrie, Gay Becker, and Robert D Nachtigall. 2006. "Rethinking the Biological Clock: Eleventh-Hour Moms, Miracle Moms and Meanings of Age-Related Infertility." *Social Science & Medicine* 63 (6): 1550–60.



- Fuller, Norma. 1997. *Identidades Masculinas: Varones de Clase Media En El Perú*. [Masculine identities: Middle class men in Peru]. Lima, Perú: Fondo editorial de la Pontificia Universidad Católica del Perú.
- Gammeltoft, Tine. 2007. "Sonography and Sociality: Obstetrical Ultrasound Imaging in Urban Vietnam." *Medical Anthropology Quarterly* 21 (2): 133–153.
- Geertz, Clifford. 2003. "Thick Description: Toward an Interpretive Theory of Culture." In *Culture: Critical Concepts in Sociology*, edited by Chris Jenks, 1:173–206. London: Routledge.
- Georges, Eugenia. 1996. "Fetal Ultrasound Imaging and the Production of Authoritative Knowledge in Greece." *Medical Anthropology Quarterly* 10 (2) (June): 157–75.
- Gerrits, Trudie. 2012. "Biomedical Infertility Care in Low Resource Countries: Barriers and Access." *Facts, Views and Visions in ObGyn* Monograph: 1–6.
- . Forthcoming. *The Patient-Centred Clinic: Dutch IVF and Bioethics*. New York: Berghahn.
- Gerrits, Trudie, and Malissa Shaw. 2010. "Biomedical Infertility Care in Sub-Saharan Africa: A Social Science Review of Current Practices, Experiences and Viewpoints." *Facts, Views and Visions in ObGyn* 2 (3): 194–207.
- Giddens, Anthony. 1979. *Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis*. *Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis*. London: Macmillan Press LTD.
- Glaser, Barney G., and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing Company.
- Gómez, Clara Ramírez, Oscar Fresneda, Geovana Acosta, Natalia Ariza, and Jario Baquero. 2001. "La Familia Colombiana: Crisis O Renovación? [The Colombian family: Crisis or renovation?]" *Boletín* 10: 1–15.
- González-Santos, Sandra P. 2010. "The Sociocultural Aspects of Assisted Reproduction in Mexico." PhD Dissertation. Department of Sociology. University of Sussex.
- Good, Byron. 1994. *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.

- Good, Byron J, and Mary-Jo Del Vecchio Good. 1993. "Learning Medicine': The Construction of Medical Knowledge at Harvard Medical School." In *Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life*, edited by Shirley Lindenbaum and Margaret Lock, 81–107. Berkeley: University of California Press.
- Goodwin, Dawn, Catherine Pope, Maggie Mort, and Andrew Smith. 2003. "Ethics and Ethnography: An Experiential Account." *Qualitative Health Research* 13 (4): 567–577.
- Green, Judith, and Nicki Thorogood. 2004. *Qualitative Methods for Health Research*. London: Sage Publications.
- Greil, Arthur L. 1991a. "A Secret Stigma: The Analogy between Infertility and Chronic Illness and Disability." In *Advances in Medical Sociology*, edited by Gary L. Albrecht and Judith A. Levy, 2nd ed., 17–37. London: JAI Press.
- . 1991b. *Not yet Pregnant: Infertile Couples in Contemporary America*. New Brunswick, NJ: Rutgers University Press.
- . 2002. "Infertile Bodies: Medicalization, Metaphor, and Agency." In *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies*, edited by Marcia C. Inhorn and Frank van Balen, 101–118. Berkeley: University of California Press.
- Grosz, Elizabeth. 1994. *Volatile Bodies: Towards a Corporeal Feminism*. Bloomington, IN: Indiana University Press.
- Gunson, Jessica Shipman. 2010. "More Natural but Less Normal': Reconsidering Medicalisation and Agency through Women's Accounts of Menstrual Suppression." *Social Science and Medicine* 71 (7): 1324–1331.
- Gupta, Jyotsna Agnihotri, and Annemiek Richters. 2008. "Embodied Subjects and Fragmented Objects: Women's Bodies, Assisted Reproduction Technologies and the Right to Self-Determination." *Journal of Bioethical Inquiry* 5 (4): 239–249.
- Gurtin, Zeynep B. 2012a. "Assisted Reproduction in Secular Turkey: Regulation, Rhetoric, and the Role of Religion." In *Islam and Assisted Reproductive Technologies: Sunni and Shia Perspectives*, edited by Marcia C. Inhorn and Soraya Tremayne, 285–310. Oxford: Berghahn Books.
- . 2012b. "Practitioners as Interface Agents between the Local and the Global: The Localization of IVF in Turkey." In *Reproductive Technologies as Global Form: Ethnographies of Knowledge, Practices, and Transnational Encounters*, edited by Michi Knecht, Maren Klotz, and Stefan Beck, 81–110. Frankfurt-on-Main: Campus Verlag.

- Handwerker, Lisa. 2002. "The Politics of Making Modern Babies in China: Reproductive Technologies and The 'new' eugenics." In *Infertility Around the Globe: New Thinking on Childlessness, Gender and Reproductive Technologies*, edited by Marcia C. Inhorn and Frank Van Balen, 298–314. Berkeley: University of California Press.
- Haraway, Donna J. 1988. "Situated Knowledges : The Science Question in Feminism and the Privilege of Partial Perspective." *Feminist Studies* 14 (3): 575–599.
- . 1991. *Simians, Cyborgs, and Women: The Reinvention of Nature*. New York: Routledge.
- Henao, Hernán Delgado. 1997. "Un Hombre En Casa La Imagen Del Padre Hoy Papeles Y Valores Que Destacan 400 Encuestados En Medellín. [A man in the image of the father today: Roles and values that highlight 400 respondents in Medellin]" *Revista Nomadas* 6.
- Henwood, Flis, Sally Wyatt, Angie Hart, and Julie Smith. 2003. "'Ignorance Is Bliss Sometimes': Constraints on the Emergence of the 'Informed Patient' in the Changing Landscapes of Health Information." *Sociology of Health & Illness* 25 (6): 589–607.
- Hollos, Marida, Ulla Larsen, Oka Obono, and Bruce Whitehouse. 2009. "The Problem of Infertility in High Fertility Populations: Meanings, Consequences and Coping Mechanisms in Two Nigerian Communities." *Social Science and Medicine* 68 (11): 2061–2068.
- Holm, Soren. 2009. "The Medicalization of Reproduction: A 30 Year Retrospective." In *Reprogen-Ethics and the Future of Gender*, edited by F. Simonstein, 43:29–36. Springer Science+Business Media.
- Holstein, James A., and Jaber F. Gubrium. 2004. "The Active Interview." In *Qualitative Research: Theory, Method and Practice*, edited by David Silverman, 140–161. London: Sage Publications.
- Horbst, Viola. 2012a. "Assisted Reproductive Technologies in Mali: Asymmetries and Frictions." In *Reproductive Technologies as Global Form: Ethnographies of Knowledge, Practices, and Transnational Encounters*, edited by Michi Knecht, Maren Klotz, and Stefan Beck, 161–196. Frankfurt-on-Main: Campus Verlag.
- . 2012b. "'You Need Someone in a Grand Boubou' – Barriers and Means to Access ARTs in West Africa." *Facts, Views and Visions in ObGyn* 21 (21): 46–52.

- Howson, Alexandra. 1998. "Embodied Obligation: The Female Body and Health Surveillance." In *The Body in Everyday Life*, edited by Sarah Nettleton and Jonathan Watson, 218–240. New York: Routledge.
- Howson, Alexandra, and David Inglis. 2001. "The Body in Sociology: Tensions Inside and Outside Sociological Thought." *Sociological Review* 49 (3): 297–317.
- Hutchings, Kemberly. 2013. "Choosers or Losers" feminist Ethical and Political Agency in a Plural and Unequal World." In *Gender, Agency, and Coercion*, edited by Sumi Madhok, Anne Phillips, and Kalpana Wilson, 29–46. New York: Palgrave Macmillan.
- Illich, Ivan. 1976. *Medical Nemesis: The Expropriation of Health*. New York: Pantheon Books.
- Inhorn, Marcia C. 1994. *Quest for Conception: Gender, Infertility and Egyptian Medical Traditions*. Philadelphia: University of Pennsylvania Press.
- . 2003a. "Global Infertility and the Globalization of New Reproductive Technologies: Illustrations from Egypt." *Social Science and Medicine* 56: 1837–1851.
- . 2003b. *Local Babies, Global Science: Gender, Religion, and in Vitro Fertilization in Egypt*. New Brunswick, NJ: Routledge.
- . 2004. "Privacy, Privatization, and the Politics of Patronage: Ethnographic Challenges to Penetrating the Secret World of Middle Eastern, Hospital-Based in Vitro Fertilization." *Social Science & Medicine* 59: 2095–2108.
- . 2007. "Masturbation, Semen Collection and Men's IVF Experiences: Anxieties in the Muslim World." *Body & Society* 13 (3): 37–53.
- . 2011. "Globalization and Gametes: Reproductive 'Tourism,' Islamic Bioethics, and Middle Eastern Modernity." *Anthropology & Medicine* 18 (1): 87–103.
- . 2012. *The New Arab Man: Emergent Masculinities, Technologies, and Islam in the Middle East*. Princeton, NJ: Princeton University Press.
- Inhorn, Marcia C., and Daphna Birenbaum-Carmeli. 2008. "Assisted Reproductive Technologies and Culture Change." *Annual Review of Anthropology* 37 (1): 177–196.

- Inhorn, Marcia C., and Frank Van Balen (eds). 2002. *Infertility around the Global: New Thinking on Childlessness, Gender, and Reproductive Technologies*. Berkeley: University of California Press.
- Inhorn, Marcia C., Tine Tjornhoj-Thomsen, Helene Goldberg, and Maruska la Cour Mosegaard (eds). 2009. *Reconceiving the Second Sex: Men, Masculinities, and Reproduction*. New York: Berghahn Books.
- Jeffery, Patricia, and Roger Jeffery. 2008. "‘Money Itself Discriminates’: Obstetric Emergencies in the Time of Liberalisation." *Contributions to Indian Sociology* 42 (1): 59–91.
- Jenkins, Gwynne L. 2002. "Childlessness, Adoption, and Milagro de Dios in Costa Rica." In *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies*, edited by Marcia C. Inhorn and Frank van Balen, 171–189. Berkeley: University of California Press.
- Jenkins, Nicholas. 2014. "Dementia and the Inter-Embodied Self." *Social Theory & Health* 12: 125–137.
- Johansson, Peter, Magnus Oléni, and Bengt Fridlund. 2002. "Patient Satisfaction with Nursing Care in the Context of Health Care : A Literature Study." *Scandinavian Journal of Caring Sciences* 16: 337–344.
- Jordan, Brigitte. 1993[1978]. *The Birth of Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. 4th ed. Prospect Heights, IL: Waveland Press.
- Klein, Renate, and Robyn Rowland. 1988. "Women as Test-Sites for Fertility Drugs: Clomiphene Citrate and Hormonal Cocktails." *Reproductive and Genetic Engineering: Journal of International Feminist Analysis* 1 (3).
- Klein, Renate D., and Robyn Rowland. 1989. "Hormone Cocktails: Women as Test-Sites for Fertility Drugs." *Women’s Studies International Forum* 12: 333–348.
- Kleinman, Arthur. 1995. *Writing at the Margin: Discourse between Anthropology and Medicine*. Berkeley: University of California Press.
- Koenig, Barbara. 1988. "The Technological Imperative in Medical Practice: The Social Cration of a Routine Treatment." In *Biomedicine Examined*, edited by Margaret Lock and Deborah Gordon, 465–496. Boston: Kluwer Academic Publishers.
- Konrad, Monica. 2005. *Nameless Relations: Anonymity, Melanesia and Reproductive Gift Exchange between British Ova Donors and Recipients*. New York: Berghahn Books.

- Koster-Oyekan, Winny. 1999. "Infertility among Yoruba Women: Perceptions on Causes, Treatments and Consequences." *African Journal of Reproductive Health* 3 (1): 13–26.
- Laqueur, Thomas. 1990. *Making Sex: Body and Gender from the Greeks to Freud*. Cambridge, MA: Harvard University Press.
- Leder, Drew. 1990. *The Absent Body*. Chicago: University of Chicago Press.
- Legard, Robin, Jill Keegan, and Kit Ward. 2003. "In-Depth Interviews." In *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, edited by Jane Ritchie and Jane Lewis, 138–169. London: Sage Publications.
- Levine, Daniel H. 1985. "Continuities in Colombia." *Journal of Latin American Studies* 17: 295.
- . 1992. *Popular Voices in Latin American Catholicism*. Princeton, NJ: Princeton University Press.
- Lewis, Jane. 2003. "Design Issues." In *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, edited by Jane Ritchie and Jane Lewis, 47–76. London: Sage Publications.
- Lippman, Abby. 1999. "Embodied Knowledge and Making Sense of Prenatal Diagnosis." *Journal of Genetic Counseling* 8 (5): 255–274.
- Lock, Margaret. 1993. "Cultivating the Body: Anthropology and Epistemologies of Bodily Practice and Knowledge." *Annual Review of Anthropology* 22: 133–155.
- Lock, Margaret, and Patricia A. Kaufert. 1998. "Introduction." In *Pragmatic Women and Body Politics*, edited by Margaret Lock and Patricia A. Kaufert, 1–27. Cambridge: Cambridge University Press.
- Long, Debbi, Cynthia Hunter, and Sjaak van der Geest. 2008. "When the Field Is a Ward or a Clinic: Hospital Ethnography." *Anthropology & Medicine* 15 (2): 71–78.
- Lorber, Judith. 1989. "Choice, Gift, or Patriarchal Bargain? Women's Consent to in Vitro Fertilization in Male Infertility." *Hypatia* 4 (3): 23–36.
- Low, Setha M. 1994. "Embodied Metaphors: Nerves as Lived Experience." In *Embodiment and Experience: The Existential Ground of Culture and Self*, edited by Thomas J. Csordas, 139–162. Cambridge: Cambridge University Press.

- Lupton, Deborah. 1997a. "Consumerism, Reflexivity and the Medical Encounter." *Social Science & Medicine* 45 (3): 373–81.
- . 1997b. "Foucault and the Medicalisation Critique." In *Foucault: Health and Medicine*, edited by Alan Petersen and Robin Bunton, 94–110. London: Routledge.
- . 2013. *The Social Worlds of the Unborn*. New York: Palgrave Macmillan.
- Lyon, Margot L., and Jack M. Barbalet. 1994. "Society's Body: Emotion and the 'Somatization' of Social Theory." In *Embodiment and Experience: The Existential Ground of Culture and Self*, edited by Thomas J. Csordas, 48–66. Cambridge: Cambridge University Press.
- Madhok, Sumi. 2013. "Action, Agency, Coercion: Reformatting Agency for Oppressive Context." In *Gender, Agency, and Coercion. Thinking Gender in Transnational Times*, edited by Sumi Madhok, Anne Phillips, and Kalpana Wilson, 102–121. London: Palgrave Macmillan.
- Madhok, Sumi, Anne Phillips, and Kalpana Wilson. 2013. "Introduction." In *Gender, Agency, and Coercion: Thinking Gender in Transnational Times*, edited by Sumi Madhok, Anne Phillips, and Kalpana Wilson, 1–13. London: Palgrave Macmillan.
- Mayes, Christopher. 2009. "Pastoral Power and the Confessing Subject in Patient-Centred Communication." *Journal of Bioethical Inquiry* 6 (4): 483–493.
- McGuire, Meredith B. 1988. *Ritual Healing in Suburban America*. New Brunswick, NJ: Rutgers University Press.
- McMahon, C. A., C. Tennant, J. Ungerer, and D. Saunders. 1999. "'Don't Count Your Chickens': A Comparative Study of the Experience of Pregnancy after IVF Conception." *Journal of Reproductive and Infant Psychology* 17 (4): 345–356.
- McMahon, Catherine A., Judy A. Ungerer, Janet Beaurepaire, Christopher Tennant, and Douglas Saunders. 1997. "Anxiety during Pregnancy and Fetal Attachment after in-Vitro Fertilization Conception." *Human Reproduction* 12 (1): 176–187.
- Menning, Barbara E. 1980. "The Emotional Needs of Infertile Couples." *Fertility and Sterility* 34 (4): 313–319.
- Merchant, Carolyn. 1980. *The Death of Nature: Women, Ecology and the Scientific Revolution*. San Francisco: Harper and Row.

- Merleau-Ponty, Maurice. 1962. *Phenomenology of Perception*. Evanston, IL: Northwestern University Press.
- Miller, Tina, and Mary Boulton. 2007. "Changing Constructions of Informed Consent: Qualitative Research and Complex Social Worlds." *Social Science and Medicine* 65: 2199–2211.
- Minhi-ha, Trinh T. 1999. "Write Your Body and the Body in Theory." In *Feminist Theory and the Body: A Reader*, edited by Janet Price and Margrit Shildrick, 258–266. Edinburgh: Edinburgh University Press.
- Ministerio de la Protección Social. 2007. "Guía Para La Detección Temprana de Las Alteraciones Del Embarazo [Guide for the Early Detection Pregnancy Alterations]." Bogota. <http://www.nacer.udea.edu.co/pdf/capacitaciones/hc/08-deteccion.pdf>.
- Mitchell, Lisa M., and Eugenia Georges. 1997. "Cross-Cultural Cyborgs: Greek and Canadian Women's Discourses on Fetal Ultrasound." *Feminist Studies* 23 (2): 373–401.
- . 1998. "Baby's First Picture: The Cyborg Fetus of Ultrasound Imaging." In *Cyborg Babies: From Techno-Sex to Techno-Tots*, edited by Robbie Davis-Floyd and Joseph Dumit, 105–124. New York: Routledge.
- Mitchell, Lisa M. 2001. *Baby's First Picture: Ultrasound and the Politics of Fetal Subjects*. Toronto: University of Toronto Press.
- Mitchinson, Wendy. 1998. "Agency, Diversity, and Constraints: Women and Their Physicians, Canada, 1850-1950." In *The Politics of Women's Health: Exploring Agency and Autonomy*, edited by Susan Sherwin, 122–149. Philadelphia: Temple University Press.
- Modell, Judith. 1989. "Last Chance Babies: Interpretations of Parenthood in an in Vitro Fertilization Program." *Medical Anthropology Quarterly* 3 (2): 124–138.
- Mol, Annemarie, and Marc Berg. 1998. "Differences in Medicine: An Introduction." In *Differences in Medicine: Unraveling Practices, Techniques, and Bodies*, edited by Mark Berg and Annemarie Mol, 1–12. London: Duke University Press.
- Mol, Annemarie, and John Law. 2004. "Embodied Action, Enacted Bodies: The Example of Hypoglycaemia." *Body & Society* 10 (2-3): 43–62.
- Monarch, James H. 1993. *Childless, No Choice: The Experience of Involuntary Childlessness*. New York: Routledge.



- Morgan, Kathryn Pauly. 1998. "Contested Bodies, Contested Knowledges: Women, Health, and the Politics of Medicalization." In *The Politics of Women's Health: Exploring Agency and Autonomy*, edited by Susan Sherwin, 83–121. Philadelphia: Temple University Press.
- Morgan, Martha I, and Mónica María Alzate Buitrago. 1992. "Constitution-Making in a Time of Cholera: Women and the 1991 Constitution." *Yale Journal of Law and Feminism* 4 (353): 353–413.
- Mullings, Beverley. 1999. "Insider or Outsider, Both or Neither: Some Dilemmas of Interviewing in a Cross-Cultural Setting." *Geoforum* 30 (4): 337–350.
- Mullings, Leith. 1995. "Households Headed by Women: The Politics of Race, Class, and Gender." In *Conceiving the New World Order: The Global Politics of Reproduction*, 122–139. Berkeley: University of California Press.
- Nash, Meredith. 2007. "From 'bump' to 'baby': Gazing at the Foetus in 4D." *Philament Surveillance* (June): 1–25.
- Nettleton, Sarah, and Jonathan Watson. 1998. "The Body in Everyday Life: An Introduction." In *The Body in Everyday Life*, edited by Sarah Nettleton and Jonathan Watson, 1–23. New York: Routledge.
- Nichter, Mark. 1998. "The Mission within the Madness: Self-Initiated Medicalization as Expression of Agency." In *Pragmatic Women and Body Politics*, edited by Margaret Lock and Patricia A. Kaufert, 327–353. Cambridge: Cambridge University Press.
- Oakley, Ann. 1981. "Interviewing Women: A Contradiction in Terms." In *Doing Feminist Research*, edited by Helen Roberts, 30–61. London: Routledge & Kegan Paul Ltd.
- Obregón, Diana. 2002. "Building National Medicine: Leprosy and Power in Colombia, 1870-1910." *Society for the Social History of Medicine* 15 (1): 89–108.
- . 2003a. "The Anti-Leprosy Campaign in Colombia: The Rhetoric of Hygiene and Science, 1920-1940." *História, Ciências, Saúde-Manguinhos* 10 (supplement 1): 179–207.
- . 2003b. "The State, Physicians, and Leprosy in Modern Colombia." In *Disease in the History of Modern Latin America: From Malaria to AIDS*, edited by Diego Armus, 130–157. London: Duke University Press.
- Olarte Sierra, Maria Fernandez. 2010. "Achieving the Desirable Nation: Abortion and Antenatal Testing in Colombia." PhD Dissertation. Institute of Social Science Research. University of Amsterdam.

- Olivius, Katarina, Barbro Friden, Kersti Lundin, and Christina Bergh. 2002. "Cumulative Probability of Live Birth after Three in Vitro Fertilization/intracytoplasmic Sperm Injection Cycles." *Fertility and Sterility* 77 (3): 505–510.
- Ortner, Sherry B. 2006. *Anthropology and Social Theory: Culture, Power, and the Acting Subject*. London: Duke University Press.
- Palmer, Julie. 2009. "Seeing and Knowing : Ultrasound Images in the Contemporary Abortion Debate." *Feminist Studies* 10 (2): 173–189.
- Pappas, Gregory. 1990. "Some Implications for the Study of the Doctor-Patient Interaction: Power, Structure, and Agency in the Works of Howard Waitzkin and Arthur Kleinman." *Social Science & Medicine* 30 (2): 199–204.
- Parry, Sarah. 2006. "(Re)constructing Embryos in Stem Cell Research: Exploring the Meaning of Embryos for People Involved in Fertility Treatments." *Social Science and Medicine* 62 (10): 2349–2359.
- Parsons, Talcott. 1951a. "Illness and the Role of the Physician: A Sociological Perspective." *American Journal of Orthopsychiatry* 21 (3): 452–460.
- . 1951b. *The Social System*. London: Routledge & Kegan Paul Ltd.
- . 1954. "Psychology and Sociology." In *For a Science of Social Man: Convergences in Anthropology, Psychology, and Sociology*, edited by John Philip Gillin, 67–101. New York: Macmillan Press LTD.
- . 1975. "The Sick Role and the Role of the Physician Reconsidered." *The Milbank Memorial Fund Quarterly. Health and Society* 53 (3): 257–78.
- Pashigian, Melissa J. 2002. "Conceiving the Happy Family: Infertility and Marital Politics in Northern Vietnam." In *Infertility Around the Globe: New Thinking on Childlessness, Gender and Reproductive Technologies*, edited by Marcia C. Inhorn and Frank van Balen, 134–151. Berkeley: University of California Press.
- . 2009. "The Womb, Infertility, and the Vicissitudes of Kin-Relatedness in Vietnam." *Journal of Vietnamese Studies* 4 (2): 34–68.
- Paxson, Heather. 2002. "Rationalizing Sex: Family Planning and the Making of Modern Lovers in Urban Greece." *American Ethnologist* 29 (2): 307–334.
- Perrotta, Manuela. 2008. "The Organizational Construction of the Body." In *Women in Biotechnology: Creating Interfaces*, edited by Francesca Molino and Flavia Zucco, 171–181. New York: Springer.

- Perry, Guillermo. 2011. "Guillermo Perry Explora Las Innovaciones de La Carta de 1991 [Guillermo Perry Explores the Innovations of the 1991 Constitution]." *El Tiempo*, June 28. [http://www.eltiempo.com/politica/ARTICULO-WEB-NEW\\_NOTA\\_INTERIOR-9747064.html](http://www.eltiempo.com/politica/ARTICULO-WEB-NEW_NOTA_INTERIOR-9747064.html).
- Petchesky, Rosalind Pollack. 1990[1984]. *Abortion and Woman's Choice: The State, Sexuality, and Reproductive Freedom*. Edited by Revised Edition. Boston: Northeastern University Press.
- Peters, Toni. 2012. "Colombia's Average Wage Less than Half Global Average." *Colombia Reports*, April 13. <http://colombiareports.com/colombias-average-salary-lower-than-global-average/>.
- Plaza, Beatriz, Ana B. Barona, and Norman Hearst. 2001. "Managed Competition for the Poor or Poorly Managed Competition? Lessons from the Colombian Health Reform Experience." *Health Policy and Planning* 16 (Suppl 2): 44–51.
- Plechner, Deborah. 2000. "Women, Medicine, and Sociology: Thoughts on the Need for a Critical Feminist Perspective." *Health, Illness, and Use of Care: The Impact of Social Factors* 18: 69–94.
- Poulin, Michelle. 2010. "Reporting on First Sexual Experience: The Importance of Interviewer-Respondent Interaction." *Demographic Research* 22 (11): 237–288.
- Price, Janet, and Margrit Shildrick. 1999. "After the Binary: Introduction." In *Feminist Theory and the Body: A Reader*, edited by Janet Price and Margrit Shildrick, 217–219. Edinburgh: Edinburgh University Press.
- Punch, Maurice. 1994. "Politics and Ethics in Qualitative Research." In *Handbook of Qualitative Research*, edited by Norman Denzin and Yvonna Lincoln, 83–98. Thousand Oaks, CA: Sage Publications.
- Puyana, Yolanda V. 2003. "Cambios Y Permanencias En La Paternidad Y La Maternidad [Change and Stability in Paternity and Maternity]." In *Padres Y Madres En Cinco Ciudades Colombianas: Cambios Y Permanencias Permanencia [Fathers and Mothers En Five Colombian Cities: Changes and Stability]*, edited by Yolanda V. Puyana, 46–76. Bogota: Almudena Editores.
- Puyana, Yolanda V., Claudia Mosquera, Amparo Micolta, María Cristina Maldonado, Doris Lamus, Ximena Usech, Pilar Morad, Gloria Bonilla, Blanca Jiménez, and María Dominique de Suremain. 2003. "Introduction." In *Padres Y Madres En Cinco Ciudades Colombianas: Cambios Y Permanencias [Fathers and Mothers En Five Colombian Cities: Changes and Stability]*, edited by Yolanda V. Puyana, 5–11. Bogota: Almudena Editores.

- Rapp, Rayna. 1988. "Moral Pioneers: Women, Men and Fetuses on a Frontier of Reproductive Technology." *Women & Health* 13 (1-2): 101-117.
- . 1997. "Real-Time Fetus: The Role of the Sonogram in the Age of Monitored Reproduction." In *Cyborgs and Citadels: Anthropological Interventions in Emerging Sciences and Technologies*, 31-48. Santa Fe, NM: School of American Research Press.
- . 1999. *Test Women, Testing the Fetus: The Social Impact of Amniocentesis in America*. New York: Routledge.
- . 2011. "Reproductive Entanglements: Body, State, and Culture in the Dys/regulation of Child-Bearing." *Social Research: An International Quarterly* 78 (3): 693-718.
- Raspberry, Kelly Amanda. 2007. "Conflicted Conception: An Ethnography of Assisted Reproduction Practices in Argentina." PhD Dissertation. Department of Anthropology. University of North Carolina at Chapel Hill.
- Raymond, Janice. 1984. "Feminist Ethics, Ecology, and Vision." In *Test-Tube Women: What Future for Motherhood?*, edited by Rita Arditti, Renate D. Klein, and Shelley Minden, 427-437. London: Pandora Press.
- Raymond, Janice. 1993. *Women as Wombs: Reproductive Technologies and the Battle over Women's Freedom*. San Francisco: Harper.
- Restrepo, H.E., and H. Valencia. 2002. "Implementations of a New Health System in Colombia: Is This Favorable for Health Determinants?" *Journal of Epidemiology and Community Health* 56: 742-743.
- Richardson, Ruth. 1988. *Death, Dissection and the Destitute*. New York: Routledge & Kegan Paul Ltd.
- Roberts, Celia M. 2002. "Successful Aging with Hormone Replacement Therapy: It May Be Sexist, but What If It Works." *Science as Culture* 11 (1): 39-59.
- Roberts, Elizabeth F. S. 2006. "God's Laboratory: Religious Rationalities and Modernity in Ecuadorian in Vitro Fertilization." *Culture, Medicine and Psychiatry* 30 (4): 507-36.
- . 2007. "Extra Embryos: The Ethics of Cryopreservation in Ecuador and Elsewhere." *American Ethnologist* 34 (1): 181-199.
- . 2008. "Biology, Sociality and Reproductive Modernity in Ecuadorian in-Vitro Fertilization: The Particulars of Place." In *Biosocialities, Genetics and the Social Sciences: Making Biologies and Identities*, edited by Sahra Gibbon and Carlos Novas, 79-97. New York: Routledge.

- . 2009. "The Traffic Between Women: Female Alliance and Familial Egg Donation in Ecuador." In *Assisted Reproduction, Testing Genes: Global Encounters with New Biotechnologies*, edited by Daphna Birenbaum-Carmeli and Marcia C. Inhorn, 113–143. New York: Berghahn Books.
- . 2012. *God's Laboratory: Assisted Reproduction in the Andes*. Berkeley: University of California Press.
- Roberts, Julie. 2012. "'Wakey Wakey Baby': Narrating Four-Dimensional (4D) Bonding Scans." *Sociology of Health and Illness* 34 (2): 299–314.
- Rodriguez, Juan Francisco. 2012. "Land Readjustment Experience in Colombia." Report. UN Habitat for a Better Urban Future.
- Rose, Nikolas. 2007a. "Beyond Medicalisation." *The Lancet* 369: 700–702.
- . 2007b. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton, NJ: Princeton University Press.
- Rothman, Barbara K. 1984. "The Meanings of Choice in Reproductive Technology." In *Test-Tube Women: What Future for Motherhood?*, edited by Rita Arditti, Renate D. Klein, and Shelley Minden, 22–33. London: Pandora Press.
- . 1993 [1986]. *The Tentative Pregnancy: How Amniocentesis Changes the Experience of Motherhood*. New York: W. W. Norton & Company.
- Rowland, Robyn. 1987. "Technology and Motherhood: Reproductive Choice Reconsidered." *Signs* 12 (3): 512–528.
- . 1992. *Living Laboratories: Women and Reproductive Technologies*. Bloomington, IN: Indiana University Press.
- Rueda-García, Nicolás. 2003. "The Case of Bogotá D.C., Colombia." Bogota. UN-Habitat, Understanding Slums: Case Studies for the Global Report 2003.
- Safford, Frank, and Marco Palacios. 2002. *Colombia: Fragmented Land, Divided Society*. New York: Oxford University Press.
- Sandelowski, Margarete J. 1990. "Failures of Volition: Female Agency and Infertility in Historical Perspective." *Signs* (3): 475–499.
- . 1991. "Compelled to Try: The Never-Enough Quality of Conceptive Technology." *Medical Anthropology Quarterly* 5 (1): 29–47.
- . 1993. *With Child in Mind: Studies of the Personal Encounter with Infertility*. Philadelphia: University of Pennsylvania Press.

- . 1994. "Separate, but Less Unequal: Fetal Ultrasonography and the Transformation of Expectant Mother/father." *Gender and Society* 8 (2): 230–245.
- . 1995. "A Theory of the Transition to Parenthood of Infertile Couples." *Research in Nursing & Health* 18: 123–132. doi:10.1002/nur.4770180206.
- Sawicki, J. 1991. *Disciplining Foucault: Feminism, Power, and the Body*. London: Routledge.
- Schutz, Alfred. 1962. *Collected Papers I: The Problem of Social Reality*. The Hague: Martinus Nijhof.
- Sewell, William H. 1992. "A Theory of Structure: Duality, Agency, and Transformation." *American Journal of Sociology* 98 (1): 1–29.
- Sharp, Lesley A. 2000. "The Commodification of the Body and Its Parts." *Annual Review of Anthropology* 29: 287–328.
- Sherwin, Susan. 1998. "A Rational Approach to Autonomy in Health Care." In *The Politics of Women's Health: Exploring Agency and Autonomy*, edited by Susan Sherwin, 19–47. Philadelphia: Temple University Press.
- Shilling, Chris. 1991. "Educating the Body: Physical Capital and the Production of Social Inequalities." *Sociology* 25 (4): 653–72.
- Shilling, Chris, and Philip A. Mellor. 1996. "Embodiment, Structuration Theory and Modernity: Mind/Body Dualism and the Repression of Sensuality." *Body & Society* 2 (4): 1–15.
- Spallone, Patricia. 1989. *Beyond Conception: The New Politics of Reproduction*. London: Macmillan Press LTD.
- Strathern, Marilyn. 1992a. *After Nature: English Kinship in the Late Twentieth Century*. Cambridge: Cambridge University Press.
- . 1992b. *Reproducing the Future: Anthropology, Kinship, and the New Reproductive Technologies*. New York: Routledge.
- Sulik, Gayle A, and Astrid Eich-Krohm. 2008. "No Longer a Patient: The Social Construction of the Medical Consumer." *Advances in Medical Sociology* 10: 3–28.
- Sullivan, Mark. 1986. "In What Sense Is Contemporary Medicine Dualistic?" *Culture, Medicine and Psychiatry* 10: 331–350.

- Sundby, Johanne. 1997. "Infertility in the Gambia: Traditional and Modern Health Care." *Patient Education and Counseling* 31 (1): 29–37.
- Sundby, Johanne, and Aileen Jacobus. 2001. "Health and Traditional Care in Infertility: Experiences from the Gambia and Zimbabwe." In *Women and Infertility in Sub-Saharan Africa*, edited by Ties Boerma and Ziada Mgalla, 257–268. Amsterdam: KIT.
- Svendsen, Mette N. 2011. "Articulating Potentiality: Notes on the Delineation of the Blank Figure in Human Embryonic Stem Cell Research." *Cultural Anthropology* 26 (3): 414–437.
- Synnott, Anthony. 1992. "Tomb, Temple, Machine and Self: The Social Construction of the Body." *The British Journal of Sociology* 43 (1): 79–110.
- Taussig, Karen-Sue, Klaus Hoeyer, and Stefan Helmreich. 2013. "The Anthropology of Potentiality in Biomedicine." *Current Anthropology* 54 (S7): S3–S14.
- Taussig, Michael. 2012. *Beauty and the Beast*. Chicago: University of Chicago Press.
- Thomas, Florence. 2013. "Y Las Conquistas Femeninas: La Maternidad a Cualquier Precio? And the feminist Conquistas: Maternity at whatever price?]" *El Tiempo*, February 13. <http://www.eltiempo.com/archivo/documento/CMS-12591846>.
- Thompson, Charis. 2005. *Making Parents: The Ontological Choreography of Reproductive Technologies*. Cambridge, MA: MIT Press.
- Throsby, Karen. 2002. "'Calling It a Day': The Decision to End IVF Treatment." PhD Dissertation. Gender Institute. London School of Economics.
- . 2004. *When IVF Fails: Feminism, Infertility and the Negotiation of Normality*. Houndmills: Palgrave.
- . 2010. "'Doing What Comes naturally...' Negotiating Normality in Accounts of IVF Failure." In *Governing the Female Body: Gender, Health, and Networks of Power*, edited by Lori Reed and Paula Saukko, 233–252. Albany, NY: State University of New York Press.
- Timmermans, Stefan, and Iddo Tavory. 2007. "Advancing Ethnographic Research through Grounded Theory Practice." In *The SAGE Handbook of Grounded Theory*, edited by Antony Bryant and Kathy Charmaz, 493–513. London: Sage Publications.

- Tjørnhøj-Thomsen, Tine. 2005. "Close Encounters with Infertility and Procreative Technologies." In *Managing Uncertainty: Ethnographic Studies of Illness, Risk and the Struggle*, edited by Rochard Jenkins, Hanne Jessen, and Vibeke Steffen, 71–91. Copenhagen: Museum Tusulanum Press.
- Tremayne, Soraya. 2009. "Law, Ethics, and Donor Technologies in Shia Iran." In *Assisting Reproduction, Testing Genes: Global Encounters with New Biotechnologies*, edited by Daphna Birenbaum-Carmeli and Marcia C. Inhorn, 144–163. Oxford: Berghahn Books.
- . 2012. "The 'down Side' of Gamete Donation: Challenging 'happy Family' rhetoric in Iran." In *Islam and Assisted Reproductive Technologies: Sunni and Shia Perspectives*, edited by Marcia C. Inhorn and Soraya Tremayne, 130–156. Oxford: Berghahn Books.
- Turner, Barry A. 1994. "Patterns of Crisis Behavior: A Qualitative Enquiry." In *Analyzing Qualitative Data*, edited by Alan Bryman and Robert G. Burgess, 195–215. London: Routledge.
- Turner, Bryan S. 1987. *Medical Power and Social Knowledge*. London: Sage Publications.
- . 1992. *Regulating Bodies: Essays in Medical Sociology*. New York: Routledge.
- Turner, Victor W. 1991[1969]. *The Ritual Process: Structure and Anti-Structure*. Ithaca, NY: Cornell University Press.
- Valdés, Teresa, and José Olavarría. 1998. "Ser Hombre En Santiago de Chile: A Pesar de Todo, Un Mismo Modelo [To be a man in Santiago, Chile: In spite of everything, the same model]." In *Masculinidades Y Equidad de Género En América Latina [Masculinities and gender equality in Latin America]*, edited by Teresa Valdés and José Olavarría, 12–36. Santiago, Chile: FLACSO/UNFPA.
- van Balen, Frank, and Trudie Gerrits. 2001. "Quality of Infertility Care in Poor-Resource Areas and the Introduction of New Reproductive Technologies." *Human Reproduction* 16: 215–219.
- van Balen, Frank, and Marcia C. Inhorn (eds). 2002. "Introduction. Interpreting Infertility: A View from the Social Sciences." In *Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies*. Berkeley: University of California Press.
- van der Geest, Sjaak, and Kaja Finkler. 2004. "Hospital Ethnography: Introduction." *Social Science & Medicine* 59 (10): 1995–2001.



- van der Ploeg, I. 2004. "Only Angels Can Do without Skin': on Reproductive Technology's Hybrids and the Politics of Body Boundaries." *Body & Society* 10 (2-3): 153-181.
- Viveros Vigoya, M. 2001. "Contemporary Latin American Perspectives on Masculinity." *Men and Masculinities* 3 (3): 237-260.
- Waskul, Dennis D, and Phillip Vannini. 2006. "Introduction: The Body in Symbolic Interaction." In *Body/Embodiment: Symbolic Interaction and the Sociology of the Body*, 1-18. Burlington, VA: Ashgate Publishing Company.
- Watson, Lynne, Jeanette Irwin, and Sharon Michalske. 1991. "Researcher as Friend: Methods of the Interviewer in a Longitudinal Study." *Qualitative Health Research* 1 (4): 497-514.
- Whiteford, Linda M, and Lois Gonzalez. 1995. "Stigma: The Hidden Burden of Infertility." *Social Science & Medicine* 40: 27-36.
- Whittaker, Andrea. 2014. "Patriarchal Bargains and Assisted Reproductive Treatment in Thailand." *Gender, Technology and Development* 18 (1): 9-31.
- . 2015. *Thai in Vitro: Gender, Culture and Assisted Reproduction*. New York: Berghahn.
- Wind, Gitte. 2008. "Negotiated Interactive Observation: Doing Fieldwork in Hospital Settings." *Anthropology & Medicine* 15 (2): 79-89.
- Yamin, Alicia Ely, and Oscar Parra-Vera. 2009. "How Do Courts Set Health Policy? The Case of the Colombian Constitutional Court." *PLoS Medicine* 6 (2): 0147-0150.
- Young, Iris Marion. 1990. *Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory*. Bloomington, IN: Indiana University Press.
- Zaman, Shahaduz, and Papreen Nahar. 2011. "Searching for a Lost Cow." *Medische Antropologie* 23 (1): 153-164.
- Zegers-Hochschild, Fernando, Juan Enrique Schwarze, Carolina Musri, and Javier Crosby. 2009. *Registro Latinoamericano de Reproducción Asistida [Latin American Registry of Assisted Reproduction]*. Santiago, Chile: Latin American Network of Assisted Reproduction.
- Zola, Irving K. 1972. "Medicine as an Institution of Social Control." *The Sociological Review* 20 (4): 487-504.