Making a Baby

A Social Investigation of Assisted Reproductive Technologies in and around Pretoria

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ABSTRACT

Making a baby is a chapter-based ethnography of infertility treatments and the people who make use of them in Gauteng. There are four chapters, starting with 'Behind the Curtain'. In the first chapter, the context, both historical and theoretical, of this work is given. Difficulties experienced in accessing people who are undergoing fertility treatments, difficulties in classifying the couples struggling to conceive discussed here as middle class (and why I choose to classify them as such) as well as outlining the history and development of infertility treatments in South Africa follows. Thereafter follows, a brief discussion of how other researchers have approached studying medical technologies, with special consideration for the work of Rayna Rapp. Following this is a discussion of who my informants are, and how my methodology was established and negotiated to effectively obtain the data enclosed here.

The second chapter, 'Testosterone', deals with the 'external' world of infertility treatments. I argue that the most significant factor in accessing fertility treatments is money. The second factor is the doctors, where they studied and specialised, how they become specialists, where they practice, and the networks within which they function. Between money and doctors we find the medicines that are prescribed and genderised into the social categories (male or female, in this case) that they fit into.

The third chapter, 'Oestrogen', deals with the internal world of fertility treatments. Internal in this context means both internal to a woman, and internal to the clinic rooms. The extreme levels of monitoring of the female body, the hospital that mimics the womb and finally, how these women attempt to become mothers, not just pregnant will be addressed in the chapter.

Finally, this work concludes with 'Making a Baby'. Here I show how the context, as expressed in the first chapter, informs both kinds of definitions of infertility – that of both the biomedical doctor, and that of the person undergoing such treatments. I show how the division between a body and a personality presupposes a unified body, especially when that division is expressed in an idiom of infertility treatments. I argue that social categories, technologies and technical knowledge related to infertility treatments are intimately related. Finally, I argue that in this process of making a baby, the nexus of this interrelationship is the category 'natural'.

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1. Introduction

'Making a baby' is a participant observation based study of the context of fertility treatments in and around the Gauteng province, mostly in Johannesburg and Pretoria. While originally an independent project, an outflow of my previous research on teenage pregnancy, it was incorporated into the project 'Stérilité et Assistance Médicale à la Procréation dans le contexte de la mondialisation (Prétoria, Ouagadougou, Paris)'[1] which was a collaborative effort funded by the Agence Nationale de la Recherche in Paris (the ANR), the Centre Population & Développement (CEPED), the University of Paris and the University of Pretoria. The aims of this project were to understand the disparity between the high prevalence of infertility amongst people of African origin, and the almost absolute lack of treatment facilities in the public healthcare systems of Africa. In this context, South Africa is an exception, having two clinics that treat infertility in public hospitals. Their funding is not simple, as there is no official government funding for such facilities[2], but they do function and provide quality care in a public context.

This study forms a counterpoint to much of the work produced by the project. The people featured here all have access to high technology fertility treatments. They are all well to do, have tertiary education and would not be what is stereotypically considered 'African' in the imagination of the rest of the world. Nevertheless, here they are, and I would argue that they are typical of people able to access such treatments throughout the African continent[3].

I thank the ANR for funding given, and for the opportunities to present my work in France on three occasions.

1 See http://amp.hypotheses.org
2 Patients pay themselves for much of the medication, while certain gynaecological investigations are government subsidised.
3 With a few exceptions, usually where there is medical research being done.

Description and Theory

Each chapter moves from a highly descriptive to a more theoretical discussion of the matter at hand. In this way, I mimic the clinical process of fertility treatments, where treatments move from data gathering, through a diagnosis, and finally to making sense of the process and why it failed or succeeded. The aims of the clinician and the patient also diverge more and more as this process happens - much as my aims diverge from those of the people who feature in my writing.

I struggle to find an ideal term for the people who feature here. Informants would be typical, but is not descriptive enough. It makes it difficult to distinguish between the doctor and the patient, or the sister of the patient, all who occupy very different roles in the context. Interviewees is too limiting a concept, much of the information presented comes from informal interaction, observation and online chit-chat, none of which follows the structure of a typical interview. 'Infertiles' turns an attribute of a person into their defining characteristic, and while it definitely can feel that way to those in the process at times, it is hardly appropriate to impose this on people. I settle for the clumsy 'people who struggle with infertility' or 'infertile people', neither satisfactory, but both better options.

I hope to, in this writing, firstly add to a literature gap in South African anthropology on the middle class, and secondly to contribute to the few and far between studies aimed at understanding the social operation of medical institutions. To fulfil the first aim, an account of how and why those engaged in making a baby here could be classified middle class, but more broadly, a case must be made for a South African middle class which the couples discussed here form part of. Much of this writing is devoted to the second aim. Details of the contrast between biomedical dogma and lived reality in the process of obtaining and undergoing assisted reproductive technologies make up the first two thirds of each chapter.

Using theory from Michel Foucault, Marc Augé and relevant medical anthropology allows me to interrogate a technicist understanding of the body. It allows me to probe some of the authority of medical science, something which is desperately necessary in the dehumanising and foreign world of

the doctor's office, the clinic or the hospital. Moreover, it allows me to rethink bodies as something more than a simple amalgamation of 'meat and sauce', with a personality (and one's value as a person) kept separate through various discursive mechanisms. I argue that this division supports and sustains the 'dehumanising'[4] nature of biomedicine, while at the same time supporting biomedical dogma's hegemony as the originator of the contents that make up what is natural.

I proposed that while biomedicine and the authority of biomedical practitioners is not uncontested in the lives of people undergoing fertility treatments (the authority of the doctor is often questioned and frequently circumnavigated in subtle ways, and alternative therapies are frequently used alongside biomedical practice) the category 'natural', and the desire to keep things 'as natural as possible' looms large in both the practitioners' and the patients' lives[5].

Biomedicine is a word that will come up frequently throughout this written work, yet is rather unclear in terms of what it is referring to, or supposed to refer to. On a superficial level, medical practitioners never use the term, simply calling their activity 'medicine' or 'medical practice'. By insisting on calling their work biomedicine, I distinguish their practice from that of medical practitioners that function outside of the hospital/clinic sphere such as traditional healers, Reiki practitioners or faith healers. I also am attempting to legitimise their practice in the reader's eyes by including these 'alternative healer's' activities in the blanket term 'medicine'. I am also attempting to create some unfamiliarity between the reader and biomedical practice, in the hope that this system, so often assumed to be normal, natural and distinct from social process is in fact a product of social processes as much as any other healing activity, carrying with it the biases inherent in all such activities.

In this context, biomedicine refers to the medical system that uses the tools, rituals and artefacts of those taught to practice it at university and medical technikons. It is regulated by the

4 By 'dehumanising' I mean that biomedicine reduces people to their component parts – blood, flesh, chemicals and the interaction between these parts. These interactions are said to be 'natural' as in, they occur without direct human intervention or creation. You are neither morally responsible for these parts or their interactions, nor are you in control of them – there is no agency.

5 More on this in Chapter 4.

Health Professionals Council of South Africa (the HPCSA). Specifically, we will look at biomedicine's set of concepts and practises and the practitioners thereof as it appears in Pretoria/Tshwane. To some extent, it is generalisable to a more global context - global meaning wherever there are medicines available based on a scientific conception of the body - certainly the practitioners would hold that this is the case. The literature used and the concepts borrowed and developed are international in scope, however, it would be presumptuous[6] to assume that a global, homogeneous biomedicine exists[7].

By situating biomedicine as a system embedded in historical context and local, social practice, we can investigate how these doctors, nurses, specialists and people struggling to conceive work together to 'make' a baby. In this way, making a baby should be understood as more than a physical act, and more than an emotional need. It is an amalgamation of forces: technological, social, economic and political that creates a baby. These same forces are upheld and supported by a powerful set of roles: 'mother', 'father', 'specialist' and 'baby'. Saying this, one should not underestimate how hard the participants in the process of baby making work to make the actions they take, the work they do, appear as natural as conceiving a child through sex. The very configuration of the roles played are both created based on what is considered 'natural', and serves to sustain this category.

Only if we make the familiar unusual can we see how it could (or sometimes, should) be different. By doing so I can situate the process of treating infertility in a social context and, more broadly, I can discuss how what we consider 'natural' can be problematic. The very definition of 'natural' is "existing in or derived from nature; not made or caused by humankind."[8], seemingly eliminating the possibility of any social influence on things labelled this way. What could be more 'natural' than procreation? Despite this, I hope to show how again and again the process of making babies is fundamentally embedded in social process, and how calling it 'natural' makes those social processes invisible, and precludes the possibility for choice, change or a challenge to the system as it

6 and irresponsible

7 The assumption of a global, homogeneous 'biomedicine' is however, a common occurrence in the literature. See for example Kleinman (1988).

8 From the Oxford English Dictionary.

stands now.

The Setting

I have briefly mentioned that South Africa is in some ways, an exception to the landscape of fertility treatments in a larger African context. We have both a functioning public, government subsidised healthcare system, and a functioning privately funded healthcare system. Our public system functions primarily through clinics, where even minor operations can be carried out, while more serious cases are referred to hospitals. Any South African citizen can go to any of these hospitals or clinics, though you will be moved to the regionally appropriate hospital if you are not in your home province. You will pay based on a sliding scale – this means that the more you earn, the more you will pay for your health care. If you are unemployed or have no income, your health care is free. Government hospitals have the reputation amongst wealthier South Africans of being poor healthcare institutions. In some cases, this is true. Funding is generally barely adequate, and many places have too few beds, too few medicines and too few doctors to deal with the numbers of patients. The hospitals that function well generally have additional income and labour streams – teaching hospitals attached to a university or research hospitals with funded research projects have more staff and more supplies.

In contrast, private hospitals are nearly inaccessible if you do not have money. Arriving at such a hospital, bleeding profusely, the first question is 'what is your medical aid' and 'here is our credit card facility' before they even attempt to stop the bleeding[9]. If you do not have either, you will be transferred to the nearest public facility. Monetary callousness aside, these hospitals are generally extremely well staffed, well supplied places, resembling hotels with luxurious lobbies, gift shops and restaurants more than sterile places of biomedical care.

South Africa has many fertility clinics, well advertised online and easy to find on maps. We even have some in government hospitals, making us a unique location in Africa. However, the clinics

9 I speak from personal experience.

themselves, while easy to find, are not easy to access. Entry is jealously guarded through a process of referrals by doctors (something you are only encouraged to do as a medical practitioner after your patients have been 'trying' for well over a year). The referring doctor cannot be a general practitioner either, the referral comes from a gynaecologist, usually only visited after being referred there by a general practitioner. This double referral system, and the absolute lack of government sponsorship for high technology fertility treatments means that to gain access is a time consuming and very expensive process. The treatments themselves also cost a small fortune – upwards of R50 000 per round of treatment[10].

Access to assisted reproductive technologies, then, is a privilege available to very few people. People who can afford high technology fertility treatments self-identify as middle class. Considering that there is no clearly defined benchmark for what a South African middle class might mean[11], but that socially and politically this is a very meaningful category, it bears defining. It does not take more than a cursory glance at our history, or our newspapers, to underscore my point. Certainly, the aims of creating a homogeneous group of "good whites", who are essentially middle class (Teppo 2004) by the pre-democratic government has had an enduring influence. Elements like Black economic empowerment - aimed at allowing historically marginalised people to enter the middle class (DTI 2004:6), and the raging debates on whether the National Health Initiative and the Gauteng Freeway Improvement Project would place "too much financial strain on the middle class, eliminating our most productive elements in society"[12] again focusses out attention on the importance of the middle class.

The middle class is a category that I would argue is distinguishable by its ability to access private services. This means that these are people that earn enough to have and sustain a medical aid[13] long term, to own private vehicles that allow them to entirely avoid existing public transport

10 See chapter two for a more detailed discussion.
11 As an example of the reigning confusion - 'middle class' is variously defines as earning more than R 50 000, R 100 000 or R 300 000 per year in the same document (van Aardt and Coetzee (2010).
12 Freely translated from a letter in Beeld, Monday 15 August.
13 Medical aids are similar to medical insurance, you pay them a monthly fee and they in turn pay for your treatments at private biomedical practices – with limits, fertility treatments are generally excluded.

structures, to access private schools and to pay for others to take care of the day to day maintenance of their homes. To do this, a substantial[14] income is necessary. Moreover, I would argue that the middle class as a group generally subscribes to an understanding of the world that separates the rational, scientific domain from the social, emotive domain; where authority is located firmly within the rational, scientific domain. This understanding is hardly exclusive to the middle class, however, the patterns of consumption that this belief entail requires a secure monetary base[15].

Broadly stating that the middle class ascribed to a dualistic world view is, of course, not particularly productive, especially considering that the dualisms that I am ascribing to the middle class have been critiqued in academia almost for as long as they have existed. Let me then reign in this ambitious statement to the realm of ethnographic analysis, and the contextual and social specificity that ethnography requires, and illustrate how, within a group of people undergoing fertility treatments in Pretoria/Tshwane, both the doctors and the patients subscribe to this distinction.

Privacy

All persons in this text, except myself and authors, have been given a pseudonym. However, due to the close nature of my informants[16], with the barest details they can identify who is speaking when, and since they read and re-read, with great patience, much of this text, they have long since figured out which pseudonym refers to which person. In cases where privacy was paramount, I give very little context and no pseudonym. To do this, I had to edit the field data that is relevant. While I have done my best to remain true to the original speaker's words, any field data presented must be taken as my interpretation of a situation.

14 in the context of South Africa

15 It is much more expensive to go to the doctor than it is to go to the Sangoma, for example, or at a basic level, access to university education is not something that is typically affordable outside of the middle class. The ability to make use of the technology that underpins a rational, scientific world view is a privilege of the wealthy.

16 They know each other, and in some cases, have known each other for years.

Chapters at a Glance

There are four chapters, starting with 'Behind the Curtain'. In the first chapter, I aim to give the context, both historical and theoretical, of this work. I discuss difficulties experienced in accessing people who are undergoing fertility treatments, difficulties in classifying the couples struggling to conceive discussed here as middle class (and why I choose to classify them as such) as well as outlining the history and development of infertility treatments in South Africa. Then I move on to how other researchers have approached studying medical technologies, with special consideration for the work of Rayna Rapp. Following this is a discussion of who my informants are, and how my methodology was established and negotiated to effectively obtain the data enclosed here.

The second chapter, 'Testosterone', deals with the 'external' world of infertility treatments. By 'external', I mean the broader context that forms the milieu for infertility treatments, specifically the movement of money and of people (both specialists and patients alike) in and out of clinics. The most significant factor in accessing fertility treatments is money. The second factor is the doctors, where they studied and specialised, how they become specialists, where they practice, and the networks within which they function. Between money and doctors we find the medicines that are prescribed and genderised into the social categories (male or female, in this case) that they fit into[17].

The third chapter, 'Oestrogen', deals with the internal world of fertility treatments. Internal in this context means both internal to a woman, and internal to the clinic rooms. The extreme levels of monitoring of the female body, the hospital that mimics the womb and finally, how these women attempt to become mothers, not just pregnant will be addressed in the chapter.

Finally, this work concludes with 'Making a Baby'. In this chapter, I will weave together the three threads I wrote about in the preceding chapters. I show how the context, as expressed in the first chapter, informs both kinds of definitions of infertility. I show how the division between a body and a

17 In a sense, this is like perfume, where 'sandalwood' would be considered a masculine scent, while 'rose' would be feminine, yet there is nothing inherently more male or more female about either – the scents have been 'genderised'.

personality presupposes a unified body, especially when that division is expressed in an idiom of infertility treatments. I argue that social categories, technologies and technical knowledge related to infertility treatments are intimately related. Finally, I argue that in this process of making a baby, the nexus of this interrelationship is the category 'natural'.

2. Behind the Curtain

My aunt and I sat down at her husband's big desk in the home office. He's a lawyer. She has a PhD in nursing. I was there to gain some preliminary information about the world of fertility treatments. I figured her uniquely qualified to help me, not only because of her training in medicine, but also because she has three lovely children, two of which were conceived through medical intervention. In the resulting conversation, she referred me to textbooks and nursing manuals. She also offered to phone her old professor, who supervised a varsity friend's Masters dissertation[18], so that I might obtain a copy of this document.

After speaking to my aunt, it seemed sensible to establish a site for my research. Luckily I found the telephone numbers of several private fertility clinics online. Being private institutions means that they follow some of the usual conventions of a business, including placing advertisements in places that are easy to find[19]. Using those numbers to make contact with doctors (specifically, gynaecologists and fertility specialists), the people I identified as the main gatekeepers of my field site, however, proved rather difficult. Their secretaries, answering the phone in a friendly and professional manner, quickly switched to curt and dismissive once they discovered I had no intention of becoming a patient[20]. Persistence paid off, though, and eventually I managed to speak to a few doctors directly and to email some others. They had all conducted research themselves. The only way to become a fertility specialist is by doing research on a Masters level. I felt positive, they were interested in my investigation, and curious about my methodological approach. I thought that because they had done their own research before, they would be more amenable to helping me than people who had never done so.

At the same time, through conversations with acquaintances and family friends, a rather large body of willing and eager informants was building up. "Just call me, and we'll set up an interview" is

18 Isabel Coetsee's *'Die Belewenis van Vroue Tydens Infertiliteitsbehandelinge'*, submitted as part of the degree MSc(nursing) at the Rand Afrikaans University in 1989.

19 See, in this regard http://www.getpregnant.co.za./clinics.asp, last accessed 2010-11-30.

20 Or that I am not willing to make an appointment which I will pay for, an acceptable alternative to becoming a patient. It is worth noting that approximately 30 minute appointments can cost up to R5000 without the help of medical aid.

an offer I received several times, unsolicited. The interviews would be similar to my preliminary talk with my aunt, a sit down taking about an hour, in a formal sitting room, home office, or coffee shop. Useful information, certainly, but by no means following my field manual to the letter. Basham (1978:25) isn't shy about it: "True ethnographic fieldwork demands that the researcher live among the people he studies and participate as fully as possible in their lives." Access to a clinic on a day-to-day basis was a necessity, I thought.

The only veto the fertility specialists placed upon my 'entering the field' was that the University of Pretoria give me clearance first. Of course, the University will not clear a Masters proposal if it is not doable (I must have access to my field site), leaving me at an impasse. At the time, I did not realise that the doctors knew this all too well. In fact, they were gently telling me that I will not be allowed into their clinics.

By that point, I knew that the same fertility specialists who work in Pretoria, also work in Johannesburg and in Cape Town[21]. Emails sent to other doctors asking for entrance into the field confirmed that they knew each other, with replies indicating that they knew about my research aims, and that they feel it is "not prudent at this time to go against the wishes of my colleagues" or that they "do not think that Femina Clinic[22] is a suitable place for Ms. Botha's study. We wish her all the best with her research."

Development of the ART

Assisted reproductive technology is a relatively new field in medicine, only really taking root internationally in the 1980s. Not too long ago, couples who could not conceive were interpreted as either having been punished for some religious infraction, or, at best, incredibly unfortunate. Men were socially sanctioned in divorcing women who were unable to give them a child. The stigma

21 Cape Town's Groote Schuur and Tygerberg hospitals are the places to go for fertility treatments. Many of the extremely costly procedures are not done anywhere else in South Africa.

22 As with all names in this writing , except those of published authors or prominent public places, this is a pseudonym.

attached to involuntary childlessness was especially severe in cases where it became known that it was the man, not the woman who was infertile. Usually, however, the possibility of male infertility was discounted entirely.

This had to change, both due to increasing acceptance of the techniques used to 'treat' infertility and because discounting male infertility is impossible in a medical-science context where both the male and the female body are considered machine-like in its functioning. There can be malfunctions within either machine. Despite this acknowledgement, today, almost all fertility procedures are applied to the female body[23].

Today, we know statistically that the incidence of male and female infertility is much the same (with perhaps slightly more infertile men than women). Despite this, at first, assisted reproductive techniques, or ART, were limited to external fertilisation for which an excellent sperm sample was required. This excluded couples where the man had a poor sperm profile and who were unwilling to utilise a sperm donor. Over time, laparoscopy and improved microscopes made the requirement for ideal sperm less critical, which enabled men with a less than ideal sperm profile to reap the benefits as well.

Assisted Reproductive Technologies in South Africa

Few people know that South Africa has the highest infertility rate[24] in sub-Saharan Africa, and one of the highest in the world, at between 15% and 20%[25] (Cooper *et al.* 2004:79; Kusari 2007:1). These figures, when combined with a bill of rights that guarantees "Everyone [a] right to access to

23 See chapter 3 for a complete list of available treatments, note that there are two procedures for men, while there are many available for women. The two procedures for men still involve the woman undergoing a concurrent procedure, usually implantation of a fertilised egg cell, which involves medically co-opting her hormonal cycle and several gynaecological visits.

24 Infertility is medically defined as the inability to conceive a child after twelve months of unprotected coitus with a single partner, done with the intention of having a child (Bernstein and Mattox 1982:209; Frank 1984:17). There is some disagreement on the actual length of time, with some specialists only diagnosing infertility after two years of trying-and-failing.

25 The global average is about 10.5%.

health care services, including reproductive health care..." (Statutes of the Republic of South Africa 1996:1255), makes it seem reasonable to expect infertility clinics in every state-funded hospital.

Assisted reproductive technologies[26], the blanket term for invasive techniques that attempt to treat infertility, have been available in South Africa since its popularisation in the 1980s. Before 1994, most public hospitals, which then served the white middle class exclusively[27], had fertility treatments. Today, there are no state-funded medical centres practising assisted reproductive technologies available[28]. To obtain fertility services one must have access to private hospitals or clinics[29].

Private hospitals are owned by Life Healthcare, Mediclinic and Netcare, with two independent hospitals also in operation. Excluding specialised clinics[30], there are over 100 private hospitals[31], but only fourteen public hospitals[32] in Gauteng. Only 20% of the population is served by private hospitals, the rest have no alternative but to go to public hospitals[33]. Public hospitals are generally perceived to be understaffed, under supplied places where you are believed to be more likely to come out worse than you went in, especially by the wealthier segments of South African society. There is some truth to this, many public hospitals are in a terrible condition.

Within private hospitals, fertility clinics that maintain assisted reproductive technologies are few and far between - only eleven independent or hospital-based clinics exist. They are clustered around the major cities and are linked in a network of exchange of specialists, ideas and patients that

26 Hereafter ART

27 as opposed to location hospitals, native hospitals, or simply 'clinics', who served the disenfranchised majority at that time

28 With two exceptions - Groote Schuur Hospital in Cape Town, and Steve Biko Academic Hospital in Pretoria, which are government funded teaching hospitals. They do not, however, provide government funded fertility treatments. Patients are still responsible for their own medicine and 'expendables', which can cost more than R18 000 per round of treatment. This is beyond the reach of most South Africans who rely on public healthcare.

29 What you do find in every public hospital or clinic is freely available contraception, and advertisements for free sterilisation.

30 Which are very unevenly distributed, with some HIV treatment centres in townships, while cardiac centres, psychiatric hospitals and dialisis/chemotherapy are almost exclusively in wealthier areas.

31 Manually counted, an incomplete list can be found at http://members.multimania.co.uk/children_of_fire/gautenghospitals.htm, accessed 2011-04-04.

32 In no particular order: Kalafong Hospital, Charlotte Maxeke Johannesburg Hospital, Chris Hani Baragwanath Hospital, Coronation Hospital, Helen Joseph Hospital, South Rand Hospital, Thembisa Hospital, Pretoria West Hospital, Tshwane District Hospital, Pholosong Hospital, Kopanong Hospital, Sebokeng Hospital and Natalspruit Hospital.

33 http://www.southafrica.info/about/health/health.htm, accessed 2011-04-04.

has at its locus Groote Schuur Hospital and Tygerberg Clinic in the Western Cape.

Fertility clinics are well advertised in certain spaces, spaces most accessible to the wealthy[34], but otherwise virtually invisible. Obtaining access to these clinics to become a patient is no easy matter either. One's house-doctor (who often first prescribes supplements as an attempt at treatment) must first refer you to a gynaecologist, who, after attempting to treat your infertility using medication[35], refers you to a fertility specialist. Besides being a long process, several additional barriers to access exist. Most significantly, one must have the monetary resources to maintain a medical aid[36] and the significant costs of fertility treatments. Without a medical aid, accessing gynaecologists in the private hospital settings where they can refer you to fertility specialists is very difficult[37]. Having a medical aid, however, does not cover the treatment expenses themselves. Infertility is not seen as a disease by the HPCSA, in stead, it is seen as a non-critical syndrome, so the treatment costs are not covered by the medical aids.

Assisted Reproductive Technologies in the Literature

Within South Africa there are several anthropological studies done within the field of medical anthropology, specifically on reproductive health. The work of Diane Cooper is exemplary. Her research is based in Khayelitsha, where she held interviews and found that while almost 90% of the women had received care after childbirth, that is the only care they received in terms of their "reproductive health" (Cooper and Pick 1997:48–52). She forms part of the Women's Health and Action Treatment Centre (WHARC), who published similar research carried out across South Africa, using Cooper's survey questionnaire (Morroni, Smit, McFadyen, *et al.* 2003). A problem with her (and

34 Specifically, via the internet or in gynaecologists' waiting rooms.
35 usually clomiphene (branded as clomid) is prescribed for at least one complete menstrual cycle.
36 A member funded scheme which helps to pay for medical treatment. Medical aids are the primary means of making private hospital care affordable. Basic plans start at about R1000 per month per member, to be taken in a context where minimum wage is about R1800 a month for full time employment.
37 You can pay the doctors independently. However, these prices are not regulated, and many doctors associated with one of the three major hospital groups are not allowed independent patients, making it restrictively expensive and difficult to find practitioners.

WHARC's) research is that they, despite being aware of the extent of infertility, to a large extent reflect the current state concerns - pregnancy is just another sexually transmitted disease that needs prevention[38].

If we focus our reading exclusively on work dealing with infertility, we find that there are several key themes in this research (Upton 2002; Coetsee 1989; Gravett 2009; Makoba 2006). Researchers are concerned with the perceptions and feelings of specifically women undergoing fertility treatments, or with the stigma attached to being infertile (especially regarding men in rural areas), primarily from a psychological, theological and nursing science perspective. This research calls itself feminist, but does not concern itself with questioning the stereotypical roles that women and men play, nor does it advocate a pro-women interpretation of these technologies. Instead, it is overly concerned with the emotional state of the participants in the study - an unfortunately inadequate attempt to move away from the privileging of a scientific stance. The word "narrative" appears very often as a methodological indication; qualitative interviews are the norm.

International anthropological research focussed on new medical technologies concerned with human reproduction is spearheaded by Ryana Rapp, who extensively studied amniocentesis (intra-uterine testing of unborn foetuses to determine whether these foetuses have any genetic diseases) in the United States of America. Her research focuses on 'non-American' population groups living in America who for the first time have access to such tests, thanks to new legislation and new medical aid schemes for 'lower income groups'. Her aim is to understand the clinical setting, one which she points out is overwhelmingly female, the meanings attached to the procedures carried out, and the decisions of the pregnant women following diagnosis. By immersing herself in the daily lives of laboratories that do amniocentesis and the women who undergo the procedure, she traces the impact this procedure has had in American society (Rapp 2000, Rapp 1999).

Along a similar vein, Balsamo and Hartouni, in two separate articles, argue that medical

38 "South Africa is faced with growing epidemics of HIV, other sexually transmitted infections and unintended pregnancy" (Morroni, *et al.* 2003:14).

technologies enables pregnancies to be placed under surveillance, and à *la* Foucault, regulated and controlled by the powerful. In their case the powerful are unequivocally white doctors, mostly male (Balsamo 1999; Hartouni 1999). Foucault looms large in both Rapp and Balsamo's work, a trend that continues through much of the research concerned with gender and medicine (see Martin (1999) and Lather (1999))[39].

The Stirrup Queens

Having been prevented from carrying out my study in the fertility clinics, but not dissuaded from my research, all that was left for me was to start phoning the numbers collected during my attempts to gain a field site. Luckily, they still remembered their intention to let me speak to them. Soon enough, I was invited to a support group for women undergoing infertility treatments, and the 15 women who are the members of this group became my primary informants. They started calling themselves "The Stirrup Queens" in May 2011, although the group had been in existence for about a year at that point in time. They met and organised themselves through the fertilicare support forum on the internet[40]. Their name is taken from a famous blog by an American woman who went through years of infertility treatments, and finally adopted two children.

They call themselves the Stirrup Queens because of their long experience of being in a gynaecologist's/ fertility specialist's chair. Their name refers to the stirrups a woman puts her feet in so that the doctor has easier access to her reproductive tract. I could not understand this name at first, my only personal references to stirrups involving horses. I had to have this explained to me by my mother, who, when told the name of the group, responded: "They can't call themselves that!" The actions taken in a gynaecologist's offices are usually something women talk about in private only, with great embarrassment, if it is spoken of at all. Here, they are wearing it as their badge of honour, often

39 See, in this regard, the chapter on "Docile Bodies" (Foucault 1977:135–230).

40 The blog that is their inspiration can be found here: http://www.stirrup-queens.com/ , and the forum that the Stirrup Queens frequent here: http://www.fertilicare.org/forum/forum.php , both last accessed 2012-04-18.

making others uncomfortable when they are confronted with this name.

The Stirrup Queens met fortnightly at first, later (from around June 2011) weekly. They almost always met at a member's house, who is also responsible for providing refreshments and tea for that meeting. Infrequently[41] the meeting will be held at a coffee shop. When they met in coffee shops, each member would pay for their own order. When meeting at a member's home, the hosting member determines the week's discussion topic. Because they meet at a member's house, and because most of them have very flexible schedules, interspersed with appointments they cannot miss or cancel at odd times, the meeting's time and date often varied, but usually took place on Tuesday afternoons.

The meetings have a standard format. As everyone arrives, they help themselves to fruit juice or tea[42]. Meetings start with the host greeting everyone; reminding them of the topic of the day's meeting (she would also have announced it at the previous meeting). If a new member is present, this would be followed by an introduction where each member, in turn, would state her name and occupation, husband's name and occupation, her track record with fertility treatments, finally concluding with her latest prognosis or emotional troubles. It was originally intended that each woman state something about herself at this point in the meeting, but very quickly, within the first meeting even, this became a recounting of fertility treatments and doctor's diagnoses.

If there is no new member present, each group member gives the group her latest updates on her treatments, pregnancy status, emotional troubles or recent events in her life. The host notes this down, at the end of the meeting she will do important announcements and well wishes for those who need it most - this is where she gets the information for that aspect of the meeting.

Usually, this takes an hour, to an hour and a half. This represents about half of the time that the meeting will take. At this point, the host serves refreshments: small finger foods like snack sandwiches, pastries, miniature quiches or cake. Tea and juice is also available, and most pour

41 In two years, this happened only twice.

42 For as long as I've known the Stirrup Queens, coffee has been considered detrimental to fertility, and is not offered.

themselves another drink. During the refreshment period, friendships within the group cluster together, and catch up on the week's gossip. Also, topics wander away from fertility related issues.

The break is ended by the host calling the group to order. She sets forth a detailed explanation of her topic for that day. Sometimes it is a debate she wishes to encourage, sometimes it is new information she wishes to share with the group, sometimes it is a personal story with a 'moral' to it that she believes the group can learn from. The topics range from ART techniques, various clinics, money and how to spend less money, medicine and which kinds work in which ways, emotions, interpersonal communication, specifically dealing with non-infertiles or dealing with spouses, even as far ranging as names for children, breastfeeding, natural versus caesarean section births, additional support such as gurus, reiki practitioners, acupuncturists, priests or spiritualists and finally, diet.

The meeting ends with the host calling attention to those most in need of support this week (this, almost without exception, includes every member), announcing results from tests for those who received them that week and announcing the host for next week. The host-to-be announces the next topic, the time and date of the next meeting, and closes the meeting with a wish to see everyone then.

As of the last date of editing this document, no member of the group has fallen pregnant.

All of the Stirrup Queens consider themselves to be members of the middle class. They are all married, all for more than five years. They are in their early thirties to early forties, their husbands are generally a year or two older. They live in notably exclusive suburbs in Pretoria, such as Waterkloof Ridge, Muckleneuk Rand and Lynnwood Manor in the city proper, and on housing estates to the East of the city such as Olympus, Mooikloof and Woodlands. The suburbs in the city are all on top of hills, while those to the East are on large, manicured plots where half-tame antelope, golf courses and horses flourish.

They go to mega-churches like the Moreletta Park Dutch Reformed church and the New Life Church in Lynnwood Road. Both of these churches, despite having developed from protestant

traditions, have some of the characteristics of charismatic churches - there is a lot of singing and organised clapping or dancing, a live band playing contemporary music accompanies the sermon, and in the New Life Church, part of the international congregation of New Life Churches, there are sometimes a religious healing, persons speaking in tongues, divine revelations and some rumours of spontaneous combustion[43]. They do not go to church regularly (perhaps four or five times a year)[44]. It is difficult for me to write about their religion without offending them. Perhaps I am exposing myself more than them here, my mother is extremely serious about her faith, and my father is a biblical scholar. My reflections in my field notes on the matter[45] are acerbic:

> *Dogma serves little more than as a justification for certain positions or an explanation for certain actions that others may question. It is a matter of convenience, when Christianity suits their aims, it is cited and enforced. When they wish to appear pious, God is called as their witness. When they wish to specially emphasize something or another, it is linked with God or Jesus. Dogma, is, of course, applied selectively by both the Stirrup Queens and the church's sermons. Much of the Biblical writings on wealth are ignored, while forgiveness and righteousness are stressed. In turn, this allows them to uphold a contradictory position in which they can judge others, and condemn others to hell, but they are exempt as the forgiven children of God. They do go to the pastor for infertility counselling, but this is usually directly related to them wanting comfort because their husband/wife/fertility specialist is "being unreasonable". The pastor can be seen as someone who holds some authority when you need someone to agree with your point of view so that you can win an argument, or feel justified in being angry. They invoke God as one of the reasons that things don't work out (specifically, that they are not falling pregnant) usually in contexts where they cannot directly put the blame on a person (sometimes their spouse, sometimes themselves, sometimes their parents) around them, because that person is present, or because blaming that person would not serve their aim in that situation. When they do go to church, it is most often*

43 Informal references will have to do, there has been no official survey of such incidences, but do see http://www.christianpost.com/news/new-life-pastor-asks-christians-to-embrace-speaking-in-tongues-44298/ for a reference on speaking in tongues, and see their facebook page for talk on spontaneous combustions https://www.facebook.com/pages/New-Life-Church/222129534477640?rf=111559455547388

44 "But we are just so busy" as it was explained to me.

45 From 20 May, 2011. The use of personal reflections in fieldwork has a difficult history in Anthropological writing. I side with Clifford, in that these reflections help situate and acknowledge the presence of the writer, so enforcing academic honesty (Clifford 1990).

because their parents are around.

This rather unflattering description should not be seen as any serious slight on the characters of the Stirrup Queens. In fact, this selective use of authority is one of the key themes I wish explore, but through the lens of biomedicine, not religion. In this choice, I am supported by the marginal position that the church plays in their lives.

It is no difficult leap for most South Africans, given only the information supplied above, to assume that these people are white and very wealthy. These characteristics are ascribed because of apartheid - a system that benefited a relatively small group of white, (mostly) Afrikaans speaking people at the cost of a great many. Apartheid has left South Africa with deep structural divisions that today has it ranked as one of the most unequal societies in the world[46]. All too often, these structural divisions are thought to be clearly visibly via the colour of your skin. Applying this generalisation to the people undergoing ART would be a mistake. Although the continuities with history are undeniable, there can be no argument that things are simply business as usual in terms of race relations. In fact, assuming that we can explain South Africa today by insisting on a direct, uncomplicated continuation of apartheid influence often does more harm than good. It obscures where change has happened, and indirectly perpetuates the system which it is insisting is problematic.

I would propose that understanding the complexities of South Africa today rests intimately entangled with an understanding of monetary inequality. In other words, it is very important to understand what the Stirrup Queens mean when they call themselves middle class, because that statement positions them in South African society in a very meaningful way.

Let us first look at a simple monetary criterion for establishing class boundaries. A quick glance at government literature shows that earning less than R 50 000, less than R 100 000 and less than R 300 000 per annum is variously classed as lower income groups (and thus not middle class) within the same document (van Aardt and Coetzee (2010)). This lack of clarity continues in popular

46 A GINI coefficient of 65 puts us at the second least equal country (http://www.businessinsider.com/most-unequal-countries-in-the-world-2011-10#2-south-africa-gini-650-38, last accessed 2012-04-18).

media, where high income earners are defined as earning more than R 72 000 per annum, while they place the middle class as earning more than R 27 000 per year (The Market Tree, 2003 (a) & (b)[47]. Neither of these amounts, however, even reflects a teacher's salary - a salary generally regarded amongst middle class South Africans as very low. This is as clear as mud.

As a married couple, the income of the support group members income typically exceeds R 200 000 a year[48]. This income primarily comes from the husband, as she is mostly a home-maker (a mother first, above all else) but she might have a job as well (just to keep busy[49]). Of the 15 women in the support group, representing 15 married couples, only two familial units earn less than that (and only slightly less). It is safe to say that this is a reasonable estimate for the bottom limit of income for couples who want to sustainably engage with fertility treatments.

Their incomes, then, do not easily place them within or outside of the middle class in terms of government literature. It makes more sense, in terms of a South African context, to speak of the middle class as a group with access to social services such as schools, electricity and medical care on a private basis.

What needs arguing for, however, is that it makes sense to speak of a South African middle class, and not a plurality of middle classes based on imagined or actual racial or cultural divisions. What follows are a set of life histories to try and illustrate this point.

Firstly, Karen, about 40 years old today. She would be classified as white on government forms.

> *My parents were very poor when they grew up, hey. My grandfather lost his farm, it was too expensive to keep it running, when my dad was about twelve. My father lived on a tiny plot of land with his mom. They weren't rich, but she kept the house neat, and, hey, between her and her seven children they managed a vegetable garden that helped a lot with food. She managed on a tiny pension from the government with the assistance of the women's*

47 At the same time, there is little doubt about what classifies a person as poor - the official poverty line is set at R 430 per month (Oosthuizen n.d: 9; Statistics South Africa 2007:10).

48 This figure represents salaried income - income from investments is difficult to calculate, although they do represent a substantial portion of the couple's assets (which allows them access to loans via banks, thus increasing their ability to get large sums of money together quickly).

49 These two corrections in parenthesis courtesy of the Stirrup Queens.

union. My grandfather died not long after losing the farm. My dad says losing the farm broke his father's heart. More likely, his heavy smoking caught up with him. In any case, when my father was sixteen, he had to find a job. Back then, that meant working on the railways, or in a post office. He got a job as a long distance train driver, hey, delivering coal from Sishen to Johannesburg's power generators. That meant that we moved a lot as children. I was in five schools, and my two brothers were in seven. He was rarely home for long, but hey, we didn't mind too much.

My mother came as a child with her parents from Poland. They were trying to escape an oppressive regime. I guess here in SA they would at least fall on the advantaged side of the oppressive regime, hey? She says she would never forgot the first time she saw my dad. He was barefoot and extremely dirty, running around like a wild boy through the streets of Vereeniging. Her mom took her across the street to avoid him. It was very difficult for them: Mom's parents barely spoke English, and everyone else spoke Afrikaans. Eventually they managed, after learning Afrikaans with the help of the reformed church. My grandparents found jobs, grandfather as a railway engineer and grandmother as a librarian.

My mom and dad met because both of our families were working for the railways, and their mothers met through the church. They married when mom and dad was only sixteen. I don't think they should have gotten married, hey, or at least, not stayed married, but they did. I think they made them marry, because mom was pregnant with me. This also added another reason that my father had to stop school and start working. After two more kids, mom discovered birth control. When we were younger, she would tell my youngest brother, who was a bit difficult as a teenager, that if she had only discovered the pill sooner she wouldn't have to deal with his crap now. It's the only time I ever heard her swear, hey[50]*. Things were different then anyway, it was not that unusual for young people to leave school before matric. Besides, hey, how else do you support a family? Now they're old, they live in a retirement village in Krugersdorp.*

So, after five schools, I went to the Rand Afrikaans University. The government paid for you to study teaching, nursing or social work, so I did social work. I'm very glad I don't have to do that anymore, hey. My husband

50 As spoken: "Toe ons jonger was het Ma vir my jongste broer, wie redelik wild was toe hy 'n tiener was, gesê dat as sy net die pil vroeër ontdek het, hoef sy nooit met sy kak te doen gehad het nie. Dis al wanneer Ma ooit gevloek het, hoorie".

went to the military right after school. They were conscripted in the 70's. Afterwards he started selling used cars, I met him when I went with my mother to try and get a cheap car for myself. Hey, he seemed so charming. I didn't even buy a car from there, they were all too expensive, and he still asked me out. BMW hired him two years later, and paid him what seemed like a gold-mine's worth of money to manage their new factory in Silverton. He did well, they moved him into a higher up kind of management later. He now does the distribution of those cars throughout South Africa. Like my dad, he travels a lot, since he has to go to Cape Town on business almost monthly. I stopped working right after we were married, when he got the job as the factory manager. I got restless at home, and started taking courses in money management. I still don't know how I convinced my husband to let me manage the finances, but hey, soon, it paid off. Nowadays, the interest from our investments comes close to his salary.

Then, Mary, about 35 (she disputes her birth certificate), who would be considered black.

I don't know too much about my grandparents. My husband still sees his family, from time to time. His grandmother is still alive. They're Mahlangu, from KwaMahlangu in the old KwaNdebele homeland. His dad is the brother of the chief there, or something. I think he doesn't take me along because he's ashamed of how much they actually live in a township. It might also be a language issue, I speak some bad Xhosa with a terrible accent, eish, alongside my English and nothing more.

My parents managed to get some schooling through the Methodist missionary schools, and both my mother and father managed to work as teachers for the missionary schools later. You see, when I was little, they sent me off to boarding school in England. I would stay with my aunt in England during most holidays, and only come home over June and July, when we had a longer break. This would only happen in the years that my parents considered it safe enough for me, so this happened only about five times in my twelve years of schooling. Hmm. Later, I went to university at WITS. It was difficult, I needed a pass to get on to campus, and even there they would think I'm stupid because I'm a black woman. I became involved in political rallies, despite my parents scorn. This made me drop out of university. Until 1990, when I married, I was barely scraping by in terms of money.

I used to get whatever odd jobs was available, including working as a domestic for an Afrikaans family. I didn't understand a word of it, but they spoke English to me, and they wanted me to teach their children English since I have a British accent.

My husband was a carpenter, and I still think I was an extra appealing marital prospect because my parents find the idea of lobola reprehensible (said with lots of laughter). I liked him, he made me laugh. He rallied with me in support of the ANC.

Everything changed, of course. Nelson Mandela became president, and, even better for us, they implemented BEE. That meant that I got a job in Telkom, as an assistant manager of the Pretoria North region. My husband was employed by the technicon to teach woodwork. Then he went into the department of education, serving on one of the curriculum advisory boards. Now he works for a large software company, as head of their training division. We own a nice house in Rosebank, and I have Rose come in to cook and clean.

Finally, Janine, 32. She would also officially be white.

My parents own a wine farm near Stellenbosch. That farm has been in the family for years. Once, we produced cheap wines for local consumption. Things were apparently difficult at that time. Sometimes my mom speaks of her mother having to recycle fabric a million times, each time for a slightly smaller child to wear, so that it would still look decent. Now, our sweet wines especially go all over the world and sell really well. Well, Australia is becoming competition, but nothing beats Stellenbosch wines, does it?

I studied journalism at Stellenbosch University. My husband is a defence lawyer, for the life of me I can't remember where he studied at this moment. He hoped to eventually become a judge when he started, but with BEE being what it is, it is unlikely that he ever will. Especially since he's close to retiring, it seems really unlikely that enough of the white judges will die or step down before he gets his chance.

These are three rather divergent stories, describing the history of women whose lives, nowadays, look largely identical. They have large cars, spend most of their time managing the household in some form

or another (most houses have a full-time staff of two or three people, usually one or two cleaners and a gardener/utility man). It is too small a sample set to make any definitive claims, but I would argue that wealthy South Africans' lives are similar to the extent that speaking of a 'middle class' is well justified.

Fieldwork to the Letter

Fieldwork is the anthropologist's primary data gathering tool. Fieldwork is contextualised by archival research and historical investigation, made cohesive through theory, but data gathered first hand, by being there in person, is the crux of the matter. Field work is quite simply defined as the act of going places and meeting people, usually with three characteristics. Firstly, the field site is new to the fieldworker, allowing her to use ignorance and basic comparative methods to build an understanding of the place being studied. Secondly, the field site is a single, stationary place, to help limit the level of complexity that an in-depth analysis requires. Finally, fieldwork involves participant observation as the primary data source (MacClancy 2002:4).

In this study, an attempt has been made to move away from studying the 'unknown' that is often advocated as a methodological necessity in anthropology. Typically, fieldwork uses newness and naiveté as investigative tools. To accomplish this, it was thought necessary to travel to a place where you know neither the language, nor the people. The time constraints, and the spatial constraints (there are only so many new places to discover) has made this mode of fieldwork increasingly outdated (MacClancy 2002:1).

South African middle class society is what I grew up in. I am steeped in middle class morality, and I have an Afrikaans, protestant background. This, to an extent, makes me part of the same ‘group’ as the stirrup queens. This is not a foreign land with a foreign language. This puts this study at risk of being biased and of not obtaining enough depth. On the subject of bias I am uncompromising: All work produced by humans is biased. I will attempt to show my biases, in order to best allow the reader

to judge the success or failure of this project. Regarding a lack of depth - it appears counter-intuitive to me that depth is created by the observance of shocking contrast. Adequate grasp of the language, being somewhat familiar with the history and social norms and familiarity with the surroundings surely aids in fieldwork?

A typical field site is located in a single location. When studying the middle class, this is impossible, unless the location is taken to be so large as to be insignificant as a boundary. Is it feasible to call my field site 'Gauteng'? This is also misleading. There are specific places in Gauteng where we will go, and others that simply do not form part of the places that the Stirrup Queens visit. It is also not simple to call this 'multi-sited ethnography' (Basham 1978:28-30), since there are no key places to visit consistently and constantly.

Conventional participant observation is also not able to be directly transplanted into this context. The role of a researcher is a familiar one to the largely university educated group of women that make up the Stirrup Queens. They expected me to behave like a social science researcher with a qualitative instrument: formal in my approach to them and direct in my questioning of personal matters, who would also be content with socially acceptable ways of answering such questions. When I failed to meet these expectations, they slotted me into another familiar category: that of the talk therapist. While I am neither a qualitative surveyor nor a talk therapist, these two established roles that I could fit into (especially at first) made a certain kind of data gathering instrument particularly suited to initial contact: the interview.

These interviews took place at places and times specified by the persons being interviewed. As much as possible, the views of everyone involved has been obtained (both partners in the case of a couple, other children, with parental permission, and close family). These early interviews I used to assemble illness narratives (Kleinman 1988). Illness narratives are like life histories, but they focus on the 'life history' of an illness. The formalised, diagnosis-centred way of talking that the interviews produced are quite suited to this form of structuring.

The greatest strength of an illness narrative is it regards the illness as inherently social in nature. This means that part of being ill is a certain cessation of normal functioning in society, and part of being cured is the ability to resume your societal duties, or the acceptance of a new societal position with different duties that are suitable to your new status.

Included in the illness narratives are be questions about money, shifting relationships during the process and timing of crucial events (such as disclosure of the fact that the couple is undergoing fertility treatments).

Much later in the field work process, I became inducted as a member of the Stirrup Queens, despite my "ridiculous lack of medical diagnosis". My official diagnosis on the part of the Stirrup Queens is a bad case of youth, and they insist that I will grow out of it. Clearly, the formal expectation that I be either a social scientist with a qualitative instrument, or a type of therapist wore away with time.

It might seem strange that I apply the term 'illness' to infertility. No one has ever died from having 'infertility', it has no symptoms other than the inability to conceive, it is not contagious nor does it cause any 'physical' suffering. Here, however, I use Kleinman's understanding of illness as "the innately human experience of symptoms and suffering" (1998:3). This is distinct from 'disease', which constitutes the 'thing' that doctors attempt to deal with. 'Disease' is the object of medicine. It has a pathological cause, that is something to pay attention to only insofar as it limits optimal bodily functionality[51], and a treatment regime that seeks to eliminate that cause. From a medical perspective, the disease called infertility is diagnosed once a person fails to conceive after a year of unprotected coitus with a single partner, with the intention of becoming pregnant. Implicitly, the ideal human body is a body free from pathogens, that functions optimally. Fertility technologies are thus, from the doctors perspective, a kind of treatment regime to alleviate a certain pathology - the inability of a specific male body to impregnate a specific female body, or of that female body to become

51 Bodily functionality has a very narrow meaning here, referring exclusively to an optimal functioning of biological processes.

impregnated. From the patients' perspective, however, fertility treatments are a means to end suffering caused by an inability to assume a desired social role, that of parenthood. Illness narratives captures both perspectives, the perspective of 'disease' on the part of practitioners, and that of 'illness' on the part of people undergoing fertility treatments, in a societally located narrative.

All interviews have been tape recorded, transcribed and annotated. Additionally, a log book has been kept keeping track of when, where and with whom what takes place. The log book became something of a field diary, filled with my reflections and observations at the time. This, combined with the interviews, are abundantly used throughout the text, italicised and indented.

Learning to Speak

I was not expecting language to be much trouble beyond learning a set of medical and biological terms I am unfamiliar with. These I learnt mostly from *Pregnancy, Birth and Parenthood* by Sheila Kritzinger (1995) and from *Nursing Care of the Childbearing Family* edited by Sherwen, Scoloveno and Weingarten (1995).

The moment I reached the internet forum, however, the language difficulties took on a completely new meaning:

> **"Fet#2 bfn**
>
> What more can I say? Another BFN.
>
> Dr has suggested we wait it out for one cycle and then try again on the next, which is probably what we are going to do. Just starting to feel panicy as we are running out of embies now... Guess I realise how lucky we are to have one LO already, so will just keep going through the motions of it all and then as my DH puts it, we'll cross the next bridge if need be. Wishing all my cycle buddies and everyone else luck for their cycles. [52]"

It was more than a little disturbing that after having talked to fertility specialists and patients

52 Shared on the Fertilicare forum, http://www.fertilicare.org/forum/showthread.php?16679-Fet-2-bfn, accessed 2011-07-11.

alike, I could enter a forum discussion, and fail to understand so completely. Luckily, the fertilicare forum has a list of terms that explains these acronyms[53]. Ten minutes later, the paragraph above made sense. They went to their specialist to get tested after a second attempted frozen embryo transfer(a FET or 'frozen embrio transfer'). The specialist told them it did not work (big fat negative - BFN), and suggested that they take a break from fertility treatments of about one month (one menstrual cycle). She is worried because she has very few viable embryos (affectionately called 'embies') left. This can mean that she is either approaching the end of her fertile period in her life, or that they have only a few frozen embryos left and she has no embryos of her own remaining (perhaps due to cancer or endometriosis). They also already have a child (little one (sometimes also loved one) - LO). Despite the doctor suggesting they take a break, they'll keep "going through the motions of it all" - something better know on the forums as "the baby dance". Basically, despite not being on an active treatment protocol, they will probably keep timing their intercourse, and she will probably keep monitoring her body. They'll keep this up until the next round of treatments.

Cycles takes on very many meanings here. In the literal sense, it refers to a women's menstrual cycle. Monitoring this cycle allows specialists to target treatments to the periods during which they will be most effective. Monitoring this cycle shows couples whether they have been successful or not in their attempts to get pregnant. Cycles also refer to treatment protocols, which can drag on for months on certain medications. The concentration of the drug present in the body is built up slowly, kept up at an intense level for a certain period (during which either a test or a procedure is performed, or conception is hoped to occur) and then slowly decreased to normal levels. Finally, cycle can refer to the life cycle. For particularly women suffering from infertility, the awareness that your fertile window is getting ever smaller can be an acute source of anxiety.

To avoid reproducing a glossary of terms, I will explain each term as it appears in a footnote from here onwards.

53 http://www.fertilicare.org/infertility-terms-and-acronyms.php, last accessed 2012-04-18

The Social System, Bodies and Biomedicine

Beyond learning the language of infertility, I have to adopt a theoretical language for writing this dissertation. It is easiest to develop my terminology if I start with my theoretical approach. This study aims to underline and explore three theoretical approaches to understanding social situations. Firstly, it is the insistence that the physical realm (or the realm of the hard sciences - measurable, testable and so on) and the emotive, social or intangible realm of society are in fact part and parcel of a social system.

Allow me to digress: a social system is an interconnected group of people and places that goes beyond a 'single' culture, world view, or language. Anthropological theory all too often deals with a single, conceptually-bounded group of people that they label a 'culture'[54]. This ascription is rarely functional in any urban context (not least of which because of the 'melting pot' nature of urban life) nor does it easily deal with people who are connected either symbolically, through their self-ascription to a group, or as family, and travel across vast areas. In terms of fertility treatments, not only are people involved with it impossible to ascribe to a single 'culture', but also they travel widely, interact with a great many people, and are influenced in thought and habit by a great many different historical lines of development – in a word, they are typically South African.

Beyond this, calling it a social system stresses the potential for change. Systems, as I understand them, are not static, but change. They mould to adapt to external influences beyond the systems predictive control, but they cannot mould and adapt in any manner. They mould and adapt based on what is there already.

Back to the interconnectedness of the physical and the spiritual[55]. In context, it means that western biomedicine is not a universal, scientific answer to the maladies of *homo sapiens sapiens,* but a system that both reflects and shapes the world view and understandings of a social system. Secondly, it is the assertion that that social system is not innate, natural or harmless. This social system is not a

54 See, as an extended example, Geertz's 1980 book on the Negara, or Sahlins' 1962 book on the Moala. Here, it is all too clear that the people are easily and unproblematically divisible into a concrete unit.

55 For lack of a better word.

complete, static 'entity' either[56]. Thirdly, and finally, it is the contention that one cannot understand gender as separate from bodies, nor the body as an innate, natural or harmless concept.

It is, by now, a familiar argument that science is not a separate entity, but instead reflects the society in which it was generated, and the interests of the dominant classes within that society (Franklin 2002:351). Within medical anthropology, this contention is especially relevant, since it forms the basic critique of the dominance of western biomedicine at the cost of all other discourses.

Placing infertility in the hands of biomedicine is not uncontested. In and of itself, being infertile is actually a desirable condition for almost the entirety of a middle class person's adult life. It is also not a simple 'disease', despite occupying this niche. You cannot die from infertility, but the medicines and treatment procedures can certainly kill you (if not directly, by causing cancer that manifests later in life).

Medical discourse would have it that as a physical, treatable medical condition, infertility is something that is separate from the fuzzy, emotional realm of society. It belongs in the clinic, where it is diagnosed and treated, just like any cancer or flu. The patient's experience of infertility, the broader context in which this occurrence takes place and the life history of the patient only matters in as much as it helps or hinders diagnosis and treatment. More broadly, however, I will argue that not only are these factors intrinsic to understanding the disease (Kleinman 1988), but they are constitutive of the disease itself. Infertility is only a disease (or anything at all, for that matter) within a context - a society, with certain understandings of the world, your body, what it means to be human. Moreover, infertility is not a in itself a neutral category - it is a privilege certain people can afford, it is a discourse of power and wealth. It supports and contests established gender roles and categories.

This disease is part and parcel of the creation and support structure of a social category - the wealthier classes. Surveillance and discipline (Foucault), and a willing complicity with the system, serves to create a certain kind of person, a certain kind of body and a certain kind of child.

56 For that matter, it is questionable whether it can be called an entity at all.

Reproduction, as I use it here, becomes a loaded term. It is not merely the making of the next generation that keeps the species going, but the inscription upon that next generation of a set of norms and values. I wish to push the intimate connection and indivisibility of the (so called) body and mind of humanity even further. There is no 'just a baby', or 'just a body'. Bodies, persons, (whole body persons?) are all already socialised long before they are even born. In turn, being an appropriate person reflects something of the society in which this appropriate person lives. It ties in with history, with conceptions of the body, with who is a criminal or not, with what is considered good or bad, what should be punished, and what should be encouraged.

It matters that medicine is 'biased' in this manner because through an assumption of universal authority, medicine is powerful. It reproduces and sustains gender categories that do violence to individuals. It enforces the primacy of a machine-like body, at the cost of difference. It becomes a part of a morality that operates on an unconscious level.

This brings us to the second pillar on which this work rests. Society constrains as much as it enables. As Geertz would have it, we are trapped in webs of significance that we ourselves have spun (1975 :5). In this manner, understanding how we create and continue these webs of significance is empowering. It allows us to exert deliberate control over what our world is, and how our world looks. More modestly, it allows us to ask whether we are 'ok' with the world we live in. Having said this, I must be careful not to over-state the empowering nature of our ability to create signification (knowledge-power, Foucault). At no point do I wish to deny that a world exists external to human experience. This whole analysis becomes ridiculous if you do not believe that what you are saying is somehow a reflection of some actual situation. The point is that that world constrains and enables certain things, but that we cannot know those things without a metaphor. By insisting that we can change the metaphor we use, I do not imply that we can change the physical extent of the world, merely the way those physical extents influence and impacts on us, and how we use those physical extents.

Finally, we must consider the relationship of the body and gender. Anthropological dogma would have it that there are two aspects to a person. The first aspect is their sex, which is their biological, chromosomally defined body. The study of sex belongs to the biologists and the doctors (specifically the gynaecologists and the urologists), and their concerns centre around the 'functions' that different 'bits and bobs' have. Then, there is their gender, which is a socially defined role sometimes linked with sexual appearance, sometimes not. Gender has been used to explain why women and men are ascribed different characteristics in different societies. It has been used as an empowering concept, using the argument: if we define gender, we can choose which gender we wish to be, and there can be more than two. We can also change what it would mean to be called a woman or a man. Many of these arguments, however, sustain a division between the body, and the socialised person. This division is untenable, because it makes the consistency of a body and a mind impossible. Gender is embodied, and bodies are gendered. Sex is gendered, as bodies are sexed.

3. Testosterone, Laboratories and Money

tes·tos·ter·one (ts-tst-rn) *noun.*

A steroid hormone and the most potent naturally occurring androgen that is formed by the interstitial cells of the testes, and possibly by the ovary and adrenal cortex, may be produced in nonglandular tissues from precursors such as androstenedione, and is used in the treatment of hypogonadism, cryptorchism, carcinomas, and menorrhagia[57].

"It's like rugby. The doctors are coaches, trying to whip their team into shape. His team, of course, is my little men. But the doctor's stuck with the b-team. So he puts them in fancier clothes, he invests in the best gyms. That way, he doesn't lose face when they inevitably lose. If you ask me, infertility treatments are about coaches not losing face - it's about testosterone." *Jan, 2011-03-14*

What is infertility?

Infertility is diagnosed after one year of unprotected, heterosexual coitus, with the intention of conceiving, has passed without fertilisation occurring (Bello *et al.* 2010:7)[58]. It is further divided into two types, primary and secondary infertility. Primary infertility is when the inability to conceive presents with the first attempt at conception. Secondary infertility is when the inability to conceive presents after previous, successful pregnancies with the same or a different partner[59]. Infertility is

57 http://www.thefreedictionary.com/testosterone, accessed 2011-06-26

58 There is some disagreement here, some specialists will only see patients (only consider patients infertile) after two years of failing to conceive. Some patients (due to advanced age or other contributing factors) will be considered infertile (eligible for treatment) after only 6 months. http://www.nordica.org/composite-117.htm, accessed 2011-06-27

59 http://medical-dictionary.thefreedictionary.com/infertility, accessed 2011-06-26

caused by problems with either the male[60] or female[61] partner. In both sexes, this can be caused by tubal blockages or malformations of the reproductive organs, where these characteristics are present from birth, an accident or deliberate manipulation such as sterilisation. Ovulation problems, endometriosis and malformed/absent ova are distinctly female problems, while low sperm counts and malformed sperm are male problems. 12% of all infertile couples are classified as having 'unknown factor' infertility[62].

There are a multitude of treatments available for infertility, thanks to the development of medically assisted reproductive technologies (Zachia *et al.* 2011:2). The primary invasive [63]ones available in South Africa are:

GIFT

Gamete intra-fallopian transfer, or GIFT, is a human fertilization technique in which male and female gametes are injected through a laparoscope into the fimbriated ends of the fallopian tubes. A small incision is made in the abdomen to accommodate the laparoscope (O'Toole 2003). The ova are prepared by hormone stimulation, and harvested laparoscopically. Because IVF has a much higher success rate, and is less invasive, this technique is performed rarely[64].

IUI

Intra-uterine insemination, or IUI, is the direct introduction of sperm into the uterus, using a tube, after ovulation. This technique is used in cases of unknown or female factor infertility (Segen 2002).

60 Diagnosed as 'male factor infertility', this category includes all possible causes for male infertility, whether it be blockages or sperm pathology. In South Africa, male factor accounts for 17% of all infertility cases (this figure excludes blockages and 'other' factors) (https://www.sartcorsonline.com/rptCSR_PublicMultYear.aspx?ClinicPKID=0, accessed 2011-06-27) This accounts for 40% of infertility cases in the USA (http://medical-dictionary.thefreedictionary.com/infertility, accessed 2011-06-28).

61 Diagnosed as 'tubal factor' (if it is a blockage), 'cervical factor' (if her cervix is abnormal) or 'female factor' (ovulation or egg cells are abnormal) infertility. In South Africa, this represents 19% of infertility patients, excluding tubal factor (https://www.sartcorsonline.com/rptCSR_PublicMultYear.aspx?ClinicPKID=0, accessed 2011-06-27). This accounts for 40% of infertility cases in the USA (http://medical-dictionary.thefreedictionary.com/infertility, accessed 2011-06-28).

62 The South African Reproductive Technology forum's 2009 statistics, https://www.sartcorsonline.com/rptCSR_PublicMultYear.aspx?ClinicPKID=0, accessed 2011-06-27, referring. It is ten percent according to: http://www.sandtonfertility.com/index-3.html, accessed 2011-06-28. In America, the rates of unexplained infertility are 3-4% http://medical-dictionary.thefreedictionary.com/infertility, accessed 2011-06-28

63 Invasive means treatments that penetrate the body, breaking through skin and entering orifices, as opposed to non-invasive procedures like taking medication.

64 http://www.sandtonfertility.com/gift.html, accessed 2011-06-27

Due to low success rates, and IVF is now preferred over this technique.

IVF

In-vitro fertilisation, or IVF (also called in-vitro), is the most commonly performed assisted reproductive technology. It is also the most successful technique[65], boasting a success rate of 20 - 35%[66]. An IVF procedure begins with stimulation of the ovaries, where ovulation was artificially enhanced to enable more than a single oocyte[67] to be ready for harvesting. A sperm sample from the man is also required, either provided by himself or removed from either his testes (TSE) or his epididymus (PESA) via needle aspiration. The female gamete is placed in the sperm sample, and fertilisation takes place in a laboratory. The fertilised egg cell is them implanted directly into the uterus[68].

ICSI

Intracytoplasmic sperm injection, or ICSI, is a laboratory technique to aid fertilisation where sperm motility is abnormal, or where there are very few spermatocytes available. A single spermatocyte is implanted into a prepared oocyte with a needle[69]. The fertilised egg resulting from this is monitored for several days (up to two weeks) in the laboratory. Once it is clear that there are no vacuoles in the egg cell (in other words, that fertilisation has occurred and is progressing normally), the egg cell is implanted directly into the woman's uterus, as with in-vitro. Many clinics only perform IVF with ICSI, due to the relatively higher success rate this provides.

There are two invasive techniques which are performed on men:

PESA

Percutaneous epididymal sperm aspiration, or PESA, involves inserting a needle into the epididymus

65 Especially when combined with ICSI.
66 http://www.sandtonfertility.com/index-3.html, accessed 2011-06-28; http://www.nordica.org/composite-118.htm, accessed 2011-06-27; http://www.nordica.org/composite-374.htm, accessed 2011-06-27. Note that success rates differ markedly between ages, from more than 60% for someone in their twenties, to less than 10% for someone in their early forties. Other techniques have an average success rate of around 10%.
67 Fertile egg cell.
68 http://medical-dictionary.thefreedictionary.com/in+vitro+fertilisation, accessed 2011-06-27
69 http://medical-dictionary.thefreedictionary.com/intracytoplasmic+sperm+injection, accessed 2011-06-27

to extract spermatozoa with the highest fertility characteristics. This procedure is performed on men with azoospermia caused by a blockage - usually a previous sterilisation procedure (Rumney n.d.:1-2)[70].

TSE

Testicular sperm aspiration, or TSE, involves inserting a needle into the testicle to extract spermatozoa. These spermatozoa are immature, making this procedure ineffective if not combined with the ICSI technique (Rumney n.d.:1-2)[71].

* * *

Sam and I arrived at the fertility specialist's rooms at the Kloof hospital half an hour early. It was not particularly warm for April, nevertheless, the air-conditioning was set at full blast. The walls were cheerfully painted in pastels, with prints of paintings along the corridor walls, and real paintings in the specialist's rooms. His secretary, in an office behind a wall with a window through which we communicate with her, was friendly. She checked Sam's appointment against her database, and asked us to sit down. The couches were faux leather, and quite soft. We sank down in them, Sam looking distinctly nervous. This is her first harvesting of her second round of in-vitro fertilisation. Today, the doctor will use a special needle to remove egg cells from her body that has been artificially stimulated into ripeness. Right now, however, what has her nervous is not the procedure.

At two places around the secretary's window there are printed posters that proclaim, in bold word-art: "all costs are the patient's responsibility", "consultation fee payable immediately - cards only, no cash" and "all medical aid claims are the responsibility of the patient".

Money

Rands and Cents

Fertility treatments are expensive. It is, however, quite difficult to quantify the complete cost of these procedures. Not only do costs differ from place to place, but the patients themselves bargain shop for the cheapest medicines. These costs are also spaced broadly, and continue over a matter of

70 http://encyclopedia.thefreedictionary.com/Per-cutaneous+Epididymal+Sperm+Aspiration and http://medical-dictionary.thefreedictionary.com/Percutaneous+Epididymal+Sperm+Aspiration, both accessed 2011-06-27

71 http://medical-dictionary.thefreedictionary.com/testicular+sperm+extraction, accessed 2011-06-27

years. A further complication is that different procedures have different costs. Patients also engage with fertility treatments for different amounts of time. However, it is possible to get some grasp of how much these treatments cost[72] by considering only one cycle of treatments[73] and breaking down the expenses into four categories: practitioner's fees, laboratory costs, procedure costs, and medicine costs.

Fertility Treatment Costs

Category	Details	Price
Practitioner's fees	Fertility Specialist	R 1,600
	Phlebotomist	R 200
	Gynaecologist (ultrasound)	R 400
	Gynaecologist (laproscopy)	R 400
Laboratory costs	Pathology Laboratory	R 1,000
	Fertility Laboratory	R 15, 000
Procedure costs	Ultrasound	R 1,000
	Laproscopy	R 5,000
	Fertility Procedure	R 20,000
Medicine costs	Nutritional supplements	R 900
	Hormone therapy (her)	R 1,500
	Human growth hormone	R 2,400
	Monitoring devices	R 2,000
	Stimulants (him)	R 600
	Aftercare	R 1,000
Total	**R53,000**	

The practitioner's fees begin with the first meeting with the specialist. You are referred by your gynaecologist, and although men often enough accompany their wives to the specialist for the first time, the meeting centres around her. These fees range from R400 to R800 (I have used R400 for my sums) for half an hour appointments, during which you spend most of your time filling in forms and answering questions. Also, during this initial meeting, the first battery of tests are assigned to diagnose your type of infertility. These tests include blood tests, which involve paying the phlebotomist/nurse

72 The amounts that follow are reasonable estimates for what it costs to undergo infertility treatments in Gauteng in 2010. Each year, these amounts increase by about 5-10%. My figures come from an average of actual expenses incurred by the members of the Stirrup Queens at the Kloof Clinic and Medforum Hospital (Pretoria), the Femina Clinic (Johannesburg, Randburg) and the Life-Birchmed Surgical Centre (Kempton Park).

73 One cycle of treatment in this instance is the point where the specialist is sought out, until the end result of this treatment. This is, at the shortest, about a month.

who will charge you around R200 (excluding laboratory fees, these I count below). You will undergo an ultrasound done by an endocrinologist/gynaecologists (about R400 in fees to the specialist).

You will see your specialist at least three more times. A second time, to discuss the findings of your tests and to assign a diagnosis and a treatment plan, but more likely, to find that more in-depth testing is necessary (and then on to a laparoscopy of your fallopian tubes - R400 to the necessary specialist, plus hospital fees, as well as a sample of your uterine lining off to the laboratory). The third meeting is then a final diagnosis, and an evaluation of how well the treatment plan is progressing. At this point, invasive procedures are scheduled. Your fourth meeting is an evaluation of how well those invasive procedures worked, and either a plan to monitor the pregnancy, or a further battery of tests to ascertain why the procedure did not work - effectively restarting the process.

Laboratory costs reflects how much you pay to the various laboratories that work behind the scenes to provide the data that the specialists interpret into a diagnosis. These costs come from the pathologists who do your blood tests and monitor the effect of the hormone therapy you are placed upon. They come from the fertility lab, where your egg cells and sperm are stored, and procedures such as ICSI and in-vitro are prepared.

Procedure costs are the costs you pay to hospitals and clinics for the use of their rooms. Laproscopies, ultrasounds, harvesting egg cells/ sperm cells, all the fertility procedures themselves (these range from R 10 000 to R 40 000, I have taken R 20 000 as an average[74]) and the additional personnel needed to enable these procedures such as anaesthetists and nurses are all here. Also, some procedures are not out-patient procedures, and require a hospital stay (usually no more than a night).

The final cost that needs taking into consideration is the medicine costs. From the first meeting with the specialist, medicine will be prescribed. Nutritional supplements like staminogro are typical, they cost about R 300 for a month's supply (I estimated that at least three months are

74 Nordica quotes much cheaper procedure costs on their website, as cited for 2003. I have no means of confirming these numbers, or extrapolating today's costs at that treatment centre (http://www.nordica.org/composite-209.htm, accessed 2011-06-27).

necessary). As the procedures become more focussed, hormone therapy (R 1,500 a month), human growth hormone supplements (R 2,400 a month) and the monitoring systems you need to check when you're ovulating all add up. Additionally, the male reproductive partner is often prescribed supplements that are little more than aphrodisiacs. Finally, it is the medicines used after the procedure - pain medication, continuing hormone therapy and continuing nutritional supplements that fall into this category.

As the table shows, a typical round of fertility treatments cost just more than R 50 000. Few people are lucky enough that their treatments work on the first try. For a great many, this has to be repeated four or more times.

Most other medical procedures are also expensive, especially in private hospitals. This cost is typically managed by paying a regular fee to a medical aid, with the idea that the medical aid will then make the large sums available when they are needed. Medical aid is expensive, a comprehensive plan that covers chronic medication, glasses and specialists appointments (such as dentists, gynaecologists and psychologists) costs around R3000 per month per person[75]. For those fortunate enough to be able to afford medical aid, the expense of fertility treatments still lands on their own pockets. What medical aid does, though, is give them access to the gatekeepers of fertility treatments. Private hospitals and gynaecologists associated with fertility clinics are accessible through medical aid, and it is through these channels that people are referred to the specialists, or find the specialists in the first place to refer themselves[76].

Money and Privilege

In South Africa, we have a public health system in which everyone is guaranteed a basic level of healthcare. These hospitals and clinics are, as a general rule, better staffed and equipped closer to cities, and even better staffed and equipped if they are also an academic hospital. Within the public

75 Figure averaged between Best Med, Discovery and Bonitas, three of the largest medical aid groups in South Africa. It is worth noting that adding a second or a third person to the medical aid does not double the cost, but increases it by about R1000 per person.

76 Not all fertility specialists accept patients who refer themselves.

healthcare system, however, infertility treatments do not feature on the agenda at all. No invasive procedures are available beyond pills (usually clomid). There are two notable exceptions - close to Cape Town, the Groote Schuur Hospital, and in Pretoria, the Steve Biko Hospital, both have centres where, between the University and research funding from the government, they manage to provide fertility treatments where the laboratory costs and the consultation with specialists are already paid for. Even so, it is difficult to estimate the cost of these procedures at less than R 20 000 - a sum far beyond the reach of most South Africans.

To establish which hospitals had fertility treatments or not, I phoned most of the hospitals in Gauteng. This was a telling exercise. Private hospitals more often than not referred me to their endocrinology unit, or their gynaecological unit, where they mostly explained that they offer Clomid[77], but not fertility treatments that made use of assisted reproductive technologies. In some cases, I was referred to their fertility clinic. Public hospitals were a very different experience. Despite the secretaries or nurses answering the phones being equally friendly and willing to help, my question "Does this hospital offer infertility treatments?" was mostly answered with a query regarding what infertility treatments were. At first I gave examples of the types of procedures, which led nowhere. Quite soon, I directly explained that it is medical help for people who are struggling to have a baby. That had me referred to the obstetrics and gynaecology unit, where the answer was always no[78]. One nurse quite frankly told me that the people they see should not be having more children. "There are too many of them already"[79].

This sentiment is echoed in how the government made contraceptive medications free for all women over 16 in South Africa. More telling is that at the Steve Biko Academic Hospital, the Silverton Clinic, the Walter Sisulu General Hospital, and at the Johannesburg General Hospital the rooms

77 A drug often prescribed by gynaecologists as a first-attempt treatment for couples who are struggling to conceive.

78 Interestingly enough, this negative answer included Steve Biko Academic Hospital, where an infertility unit does exist. Seems you have to find it yourself (via the internet), and contact it directly to gain access there.

79 Considering South Africa's apartheid legacy, it is worth clarifying that the nurse I was speaking to was most definitely a black woman.

around the Gyneocology and Endichrinology departments' secretary's office also have posters all around them - but unlike the private fertility clinic where I accompanied Sam, these posters were not about money. These posters all proclaim that sterilisation can be done here, for free.

The disjuncture between the desire to have children, the high infertility rate in South Africa, and the government funding provided for sterilisation can be related to what Basu (1997:5) would call the 'politicisation of fertility'. By 'politicisation of fertility', Basu means the "use of arguments based on theories of fertility to seek and design policies which may or may not have a direct bearing on fertility, but which are important in their own right or for other political reasons" (1997:5). For Basu, contraception or other measures that directly impact fertility would be excluded from this category, because they have a direct bearing on fertility.

There being "too many of them already" is a sentiment shared by the Stirrup Queens, who feel that having a child is precluded by having enough material resources to support the child. This does not mean food and clothing. This means the right kinds of foods, the right types of clothing, and a whole range of additional activities such as music lessons, athletics clubs with monthly fees, swimming lessons, extra math classes and, of course, trips overseas with the choir.

In other words, for the Stirrup Queens, if you are not at least marginally middle class you cannot afford children. Having them is both irresponsible (since you fail to give your children all the opportunities that they deserve) and perpetuates poverty by preventing the child from reaching its full potential. They directly relate poor education, poverty and a high birth rate. In this way, their opinion reflects the global consensus that less developed countries stand to benefit from a reduction in their fertility rate (Basu 1997:6).

An emphasis on the negative consequences for the family and the individual that high fertility has is fairly new, in contrast to a previous emphasis on the negative consequences for the economy and the country at large. In South Africa, a great deal of the policies to control black population groups, specifically black fertility, was informed by a public perception – that of the notion that the

black masses would overwhelm the poor, minority white groups – the so-called *swart gevaar*.[80] Basu (1997:9) captures this most eloquently, "the accusation of unbridled fertility by 'them' [is used] as a legitimation of such fears and antagonism in various categories of 'us'". The rhetoric was strongly informed by a developmental policy and downright racist idea: that black people lack the knowledge and wherewithal to save themselves from themselves, especially black women. Ideologically, then, the fertility policies (at least when seen from the eyes of the Stirrup Queens) are very different today. Now, instead of stopping the hordes from overwhelming 'us', the policies are for the good of the family, and the child. In practice, though, I struggle to see this difference as anything more than superficial, with one important change. Now, the appropriate group to be having children is defined by wealth, not skin colour[81].

In the 'new South Africa' wealth lies firmly in the hands of both black and white South Africans. For the vast majority of poor, black South Africans, however, things have not changed much. There are still invasive programs interfering with their lives (all on the basis of social development). They still have little access to schools, infrastructure and economic opportunities in the conventional sense. As Basu puts it, "the socio-political upshot of such communal politicisation of fertility is easy to see. … It reinforces and legitimises traditional antagonisms between two sides ... But even more dangerously, it is self-fulfilling because it hardens differences and the resolve to maintain those differences".

* * *

Despite these warnings and the clear instruction that you must pay immediately, Sam had arranged with the secretary to have the consultation fee electronically transferred. She is not a new patient here, so a relationship of trust has been established. She told me, in the car on the way over (I drove her) that this will, in all likelihood, be the last time they can afford to undergo fertility treatments of this nature.

80 Direct translation – black danger.
81 It must be noted that by far the majority of impoverished people are still dark skinned.

"It's just too much of a strain. The time - I can't work while the in-vitro is hectic - those hormones make you crazy. And then you have to wait for the outcome, which isn't always fast. Mostly the doctors say: "Maybe, wait a month and come back". Only one salary, even if it's just for a couple of months at a time, really makes you think hard about what is important. We wanted to redo the baby room, get in a designer and have everything perfect. I guess the baby has to be there first (chuckles). Now, the baby will be in a cot we got from my brother. It has to work this time, it just has to. If it doesn't, well, then it's over. We can't afford to increase the mortgage on the house again.[82]"

* * *

Sam spends a lot of her time shopping around for the best prices in medicines and treatments. This is a typical component of undergoing ART. The clinics acknowledge this also. Right from the very first moment where you need to buy the medication, you are given some choices – buy your medicine at the clinic, or buy it at a pharmacy, or, with the aid of a doctor, import it. The secretary often explains the pricing and even gives some pointers as to where it is cheaper or not. Almost all clinics sell some of the medication themselves (specifically the invasive fertility medicines such as Lucrin and Menopur), while very few pharmacies do. Other prescribed medicines, such as vitamin supplements, Clomid and folic acid tablets are not typically sold at fertility clinics, but are easily found at pharmacies. Most pharmacies will order the medication for you, but typically the fertility specialists want you to start immediately with the treatment (so that it will align with this month's menstrual cycle), making ordering, at least for the first few days' worth of medicine, not a likely option. This is all complicated by the fact that the clinics sell the medication variously more cheaply or more expensively than the pharmacies do, while pharmacies also charge very different amounts for the medication.

To help deal with this, and with the sheer cost of treatments, each and every fertility forum has a section dedicated to budgeting. In this subsection or thread, they keep track of where which

82 Quote from an interview held with Sam a week later.

medication is on special (especially Spermigro, a supplement, has specials at Dischem, a pharmacy and beauty-product shop, every few months) and where which medications are selling most cheaply. They keep a list of pharmacists willing to write up the medicine as something other than what it is so that the medical aid will pay for it. They also closely watch regulations and changes in medical aids themselves, as some programs, on occasion, for short periods, have funded fertility treatments under special conditions – leading to more than a few forum members changing their medical aid plans to that one (and suddenly developing various conditions, so as to fulfil the medical aid's conditions).

There is also an active debate on where the treatments themselves are cheapest. This is often weighed against the perceived quality of treatments and the perceived success rate. I must stress that these are perceived aspects. Few clinics make their statistics available, even fewer state what criteria they use to assemble these statistics. Many clinics simply exclude people who for whatever reason fail to use their medicine as directed, or fails to be operated on time[83] from their failure statistics, substantially bolstering their success rates. Some also include pregnancies that do not carry to term in their success rates. To a large extent, a well-mannered doctor who puts their patient at ease, and can convince them to believe in him/her fully, will be strongly recommended as a good doctor. These 'good' doctors will get support, regardless of the exact price of their consultations, or their actual success rates. Of course, to maintain their position as being 'good doctors' these specialists need to keep their patients convinced that the failure of their procedures are because of the vagaries of chance, or actions on the patients part, not on the part of the doctor. But, more on the matter of believing in your doctor later.

* * *

I picked up a magazine, the Vanity Fair, to distract her while we wait. Jewellery and then a discussion on the ethics of wearing diamonds followed [84]. Then the door opened, and the specialist called her in. I followed.

83 Either of these are as likely a result of the patient doing it wrong, as it is of the doctor giving the wrong information regarding dosage and use, or simply communal error on the timing of crucial points in the process such as the removal of ovocytes.

84 I was recently engaged at that point. For several weeks, that was a hot topic amongst the Stirrup Queens.

He was an exceptionally well groomed man. He greeted Sam, and with a wave of his hand made us sit upon two leather chairs opposite his immense desk. For a minute, he silently clicked around on his computer. There were no open files on his desk, no paper or pens. A few paperweights with pharmaceutical company names on them and a picture of who I assume are his wife and daughter was the only clutter. Some tissues neatly enclosed in a decoupaged box stood ready on the corner of the desk to our left.

On the wall to his right hung his qualifications. MD from the University of Cape Town, specialising in gynaecology, with his further qualification in reproductive endocrinology at the University of Pretoria. Next to these two was a vertical row of associations and professional organisations that the doctor belongs to.

Earlier, Sam had waxed lyrical about how wonderful this doctor is. Apparently, in stark contrast to her previous doctor, he actually cares about his patients, he's not in it for the money at all. He shows this by being especially attentive to you, always reading your file and keeping tabs on your progress by having his secretary call you at various points. He's also the first doctor to give her any real hope, she said, concluding with: "He even remembers my first name!"

Of doctors and clinics

You become a fertility specialist by obtaining your MD, and then specialising in gynaecology. Thereafter, you apply for allowance to do a further two year degree sub-specialising in reproductive endocrinology. This qualification is the equivalent of that of a neurosurgeon - and it shows in their consultation rates. The number of doctors that are fertility specialists is very small. They are all either students of each other, ex-classmates or acquaintances through the organisations they belong to and conferences they attend[85]. Most fertility specialists are male.

In addition to fertility specialists that carry out the procedures, specialised biologists trained to work with human ovocytes and spermatocytes are required. These embryologists often work almost exclusively in the laboratories, meeting patients only rarely. They are also, in contrast to the doctors,

85 At the start of my research, the reader may recall, they banded together to prevent me accessing their clinics.

mostly female.

Most doctors work in a clinic. To qualify as a clinic that may offer fertility treatments to the public, you need to have two full time specialists at the clinic. Broadly speaking, there are two types. The first kind is a clinic attached to a hospital, usually also associated with a medical aid scheme. The second type of clinic occupies a building, usually close to but not part of a hospital. Either type have some broad similarities. All prevent entry with a secretary or two. All have imposing lounge areas where one must sit and wait. All of them have posters up about money, and all of them have a giant wall somewhere covered in pictures of parents and babies, happily smiling. If you spend some time looking at this wall, you will find that the greatest majority of patients are white, hetero-normative couples. It's also worth noting that many of the photographs are of the same children, perhaps a year or two older in each one.

A large contributing factor to the success of a clinic is the ability of the doctor there to maintain himself or herself as a good doctor in the eyes of the population seeking fertility treatment. A doctor cannot rely on his or her incredible success rate to do this – there simply isn't a technique available that gives reliable results. Moreover, the process is painful and invasive, especially for women, making it increasingly difficult to maintain a position of authority. A great many doctors are labelled as rough handed (or worse, impotent), and all of the Stirrup Queens have at least one 'insert-expletive-of-choice-here' that they will never, ever go back to[86].

Whenever the Stirrup Queens talk about doctors, two things happen: A long list of complaints against doctors emerge, but also an almost religious belief in their current (or idealised) doctor was also revealed. This doctor could do no wrong. Sam believes firmly that her current doctor is one of these good doctors. Despite her insistence that he does not care about the money, she has been served with court papers about payment from him. She explained this as a "simple misunderstanding", which was rectified by increasing the mortgage on their house. Leonora has had several failed in-vitros

86 Charmaine phrased it this way.

at her current doctor, yet she also endorses him strongly by pointing to his fantastic success rate whenever a fellow Stirrup Queen complains about their current frustrations.

From an outsiders' perspective, both from the position of the doctor and from the position of being a patient, this collection of extremely negative and extremely positive feelings towards the various clinics and their practitioners seems fairly odd. Setting aside bedside manner, which will always have an impact on the perceived skill of the doctor, fertility clinics are overwhelmingly similar both in appearance and function.

In private practice, most clinics offer only ICSI treatments, and almost all procedures that the Stirrup Queens have undergone are In-vitro with ICSI. The various clinics' success rates differ by a few percentage points, and if queried, they explain their lower rating by stating that they draw more complex cases (because they are technologically superior), or they claim the other clinic is being mildly dishonest.

If it is a higher percentage rating, it is attributed to better staff, and better technology. Neither seems to me to be the case. Beyond a few exceptional individuals who are extremely hands on with their patients, the fertility doctors do not do much of the procedure at all, patients themselves do the day to day management of their medicines and their monitoring, and laboratories do the preparation of the sperm and the fertilisation of the egg. Implantation is a standard (if rather delicate) procedure, and the success or failure of the treatment hinges on the woman's body accepting or rejecting the ovocyte to as much as it hinges on the skill of the doctor. Moreover, almost all of these doctors are trained at the Groote Schuur hospital in Cape Town, with a few from the old H.F. Verwoerd hospital[87]. The machinery used for ICSI is generally same from place to place. Many clinics send their laboratory work to the same places, negating their claims to superior technology.

Given the great similarity of the clinics, why then are there these strong feelings about one or another? In part, this is attributable to the emotionally charged nature of the fertility treatment

87 Now the Steve Biko Academic Hospital, also now no longer training fertility specialists, but still training technicians and embriologists.

process. I wish to argue, though that this is also part of the marketing of fertility treatments and the concurrent commodification of bodies and babies. It also plays a part in establishing the routine of discipline that women and men undergoing fertility treatments submit to.

Creating and maintaining belief in their ability to assist with infertility problems is, to my mind, an essential part of the business of fertility treatments. It seems to me that the ability to charge as much as they do, and to keep control of the fertility market as much as they do, partly hinges on their patients believing that they are their only hope. This is, however, the perspective of an outsider, a person in the position of desperately trying to conceive may feel exactly the opposite – that the doctor is their only hope, and that they can charge whatever they want, as long as there's a child in the end.

Keeping out the Undesirables

It is worth considering why I was not allowed access to the clinics directly. I will suggest four possible reasons for their hesitancy in allowing me access, firstly, the hassle of having another person around, secondly, a fear of legal action, thirdly, fear of exposure of the extent to which these procedures are not effective, and finally, the disruption of the absolute belief in the doctor that the patients have.

An anthropologist takes up time and space while asking peculiar questions – a nuisance in itself, even when you take into account the cathartic and often enlightening impact anthropologists can have. In a busy medical practice, where time is literally money, both for the doctors and the patients that they consult with, even five minutes can be asking too much. The confidentiality and privacy of patients is of utmost concern, making the inclusion of any other person except the doctor and the patient problematic. Consent given by the patient does help in this regard.

A second consideration is the very reasonable concern that the doctors have for lawsuits. Because their patients are both wealthy and, typically, well educated, they know how to gain access to legal procedures that can help them get restitution should they believe the doctors have wronged them. With most of the procedures being rather ineffective, yet painful, expensive and invasive, and

dependent at times on keeping a very specific time schedule, it is easy for both emotions to run high, or for errors to occur. As a result, most of the doctors seem to be perpetually involved in one or more minor legal battles, usually settled out of court. Since I didn't get a chance to speak to a doctor in the private practice, this means that this is an impression that I got from speaking with the Stirrup Queens. All but two of them had made a legal action against their fertility specialist previously, all of which was settled out of court. I doubt this situation will improve now that our laws mandate two specialists per clinic that have certain qualification for it to be a legally functioning clinic – many older doctors continue to practice despite not having the more recently imposed qualifications, and out government units (at Steve Biko and Groote Schuur hospitals) don't meet those requirements, leaving the doctors extra vulnerable to legal action by disgruntled patients.

Thirdly, while it is fairly well known that, in the words of Charmaine: "any procedure the doctor performs might not work out", the exact level of ineffectiveness of the procedures are hidden away. It's not a case of "might not work out", it's a case of "probably won't work out". None of the Stirrup Queens are pregnant yet, and while they do represent a fairly extreme subset of people struggling with fertility, it is absolutely commonplace to have to go for three or four rounds of in-vitro or ICSI before a pregnancy occurs. The doctors do not press this strongly, neither do the patients want to hear this quite this bluntly – they tend to put emphasis on the chance of success, not of failure. They want a child, the doctor both wants to help and wants to make money. Despite the euphemistic nature of the discussions on the success rates of the procedures, the doctors must know that it works one in four times. Having this pointed out could cost them patients and could break down whatever reputation they try to uphold.

Finally, the reliance that the doctors have on the absolute belief in them from their patients makes the situation vulnerable to disruption. Someone who is not as emotionally invested in the outcome of the procedures, nor as emotionally invested in the continued support of patients is not likely to either believe fully in the doctor, nor as likely to be as disappointed when the procedure does

not work.

4. Oestrogen and other Mysteries

What is infertility?

"It's a great emptiness inside you. You walk around the mall, the city, you drive past schools. Everywhere people can see there is a woman without a child. The doctors make up some nice definition, two years of trying but not succeeding. (laughs) We've been trying for four years now. That's not that long, Leonora and Jan have been at it for seven. It's ***two hundred thousand rand****, that's what it is. It's being a pincussion. It's dissapointment. Yes, that's really it. Disappointment. Why did my body fail me like this?"*

Karen, 2011-04-25

GIFT

Linda is now in her mid-forties. Six years ago, when she approached a specialist for fertility treatments, the specialist gave her a choice of procedures. She has a scarred fallopian tube that was accidentally damaged by previous endometriosis. Her husband's sperm count was low, less than 5 million active sperm per millilitre. Additionally, his "swimmers" were misshapen. They had a chance of conceiving naturally, but that chance was very low.

The choices the doctor gave Linda were whether she would prefer in-vitro or a GIFT procedure. She was immediately charmed by GIFT simply because of what it is called. Her mind was completely made up, though, when the doctor explained the differences to her. With both in-vitro and gift, she would be given medicines to make her "super-ovulate", and the eight or more ova that become fertile will be removed by a small cut next to her hip. With both procedures, her husband would have to provide a cup full of "swimmers", and those swimmers would be washed and put through a special tube that stroked them with tiny hairs. This tube would teach them to finally swim straight, she explained, giggling as she did so. This is the point where the two procedures would be different for her. With in-vitro, they would fertilise the egg in a test tube, "swishing his swimmers and

my eggies together in a cold, sterile glass". Then they would be monitored in the laboratory, and the ones that "grew" would be implanted into Linda's uterus.

With GIFT, the "swimmers and eggie mixture" would be implanted directly into her fallopian tube, where fertilisation would have taken place under normal circumstances. There, they would be fertilised, descend into her womb, and grow. To her, this approximated the most 'normal' way of falling pregnant available to her husband and herself. As she put it "I don't want my baby to start in a cold, sterile environment. Everyone knows babies should be warm and close to their mother. This GIFT procedure, it really is a gift from God."

Linda's daughter is now almost six.

The turkey baster

There is general giggles amongst the Stirrup Queens. I asked them if any of them have had IUI, turns out, most of them had. Leonora told me:

"We don't call it that - IUI, I mean, or even the full name. It's 'the turkey baster', is what it is. The doctor takes this little tube, and with air pressure pushes sperm right into your uterus."

IUI, because it is relatively non-invasive (the female partner in the reproductive process isn't put on hormone therapy as long as her ovulation cycle is normal) used to be a first port of call for many fertility patients a few years ago. Because of the low success rate, though, nowadays this technique is rare, except where money is very tight. The worst of it is the monitoring, to determine when you're ovulating, and then, to coordinate that event with the doctor's schedule.

"It's easier to do when you're made to ovulate. That way, the doctor can decide when, and it fits into his schedule automatically. It's also perfectly predictable"

Somehow, I doubt it's as funny when you're in the doctor's chair, though. I cannot imagine this being very dignified, or even specifically comical. I said as much, and they agreed. The agreement was

interrupted with a pointed comment from Mary:

"Ah, but if hubby could shoot straight, it wouldn't be necessary to make a joke out of it. Seriously, if a doctor can do it with a little tube, surely his 'precision instrument' should find it even easier?"

Laughter follows, and the discussion topic changes.

In-vitro

I saw Sarah just after the egg retrieval process had happened. I was actually on my way to my car, going home after a particularly early start to the day. I had come to meet Sam at the fertility clinic for her check-up appointment at half past six in the morning, it was now seven am, and I was very ready for a cup of coffee. We passed each other in the hallway. Sarah looked completely confused, but she recognised me, even introduced me to her husband, who was, opposite a nurse, carefully walking her to a room where she can lie down and rest. They had her firmly grasped under each arm. Her speech was broken and slurred, they give you something of a general anaesthesia to retrieve egg cells, and her walking was made extra difficult because of the additional local anaesthesia in her abdominal region. The nurse smiled good-naturedly at her attempts at introducing us. After two or so tries, I interrupted her as gently as I could, and introduced myself to her husband. He'd heard of me, it's nice to meet me, call him Joe.

They had not stopped walking towards the recovery room during this process, so I found myself standing in the waiting area as they helped her lie down. In the waiting area there was coffee and tea available, so I asked Joe if he would mind if I sat with him in the waiting area for a moment or two while Sarah slept off the worst of the medication. Egg retrieval is an out-patient procedure; she will leave the clinic as soon as she is a little more awake. Joe looked to the nurse, she told him it usually takes no more than fifteen minutes for them to be recovered enough to leave. I think he decided fifteen minutes wouldn't be that bad, so he said he doesn't mind, but as soon as she's ready, they'll be leaving.

I asked him what he thought about all this, referring obliquely to the egg retrieval that had just happened. Joe answered that in-vitro is a wonderful procedure. At that point, with Sarah having just stumbled down a hallway in little more than a night robe, now sleeping off medication with at least two days of more-or-less severe discomfort to look forward to, wonderful didn't quite seem to fit. I asked why he called it wonderful. He told me to take out my recorder, he wanted Sarah to hear this too.

"I've been thinking about this for a long time. A long time.

We've been to every doctor. Every... tried everything.

...

I want children. Sarah wants children. The good Lord has decided that it won't be easy for us to do so. He has His reasons. I believe that. This in-vitro...

Well...

Let me just say that...

Sarah has told me I don't know what it's like ... that I don't feel it like she does. I don't have a mother's instinct that pushes me to want children. I don't have the needles and the pills. I sure don't have a doctor shoving his probes everywhere. She throws it in my face ... no ... no, that's not what I want her to hear. That doesn't matter. The hormones do it, to a large extent.

I do feel it. Every time we go to the specialist. It's been a long road to get here. There's been tests and embarrassment and a long, long period of sheer hopelessness. And the money. That she doesn't feel. She doesn't look at the bills.

...

Then, the Doctor[88] *put us on this path. Yes, Sarah had to keep taking those pills, and yes, it makes her sick. Who's there holding her hand and reminding her, and taking her tea? But this procedure has a schedule, it has hope. This morning, I did my bit. Now, they have collected eggs - her bit. It works out, almost like it should be.*

[deep sigh]

88 Edited, name removed. He is referring to the fertility specialist.

A man and a woman and there you go.

And now, just like every other man and woman who loves each other ... and I do love Sarah, even if she sometimes forgets.

Just like every other man and woman, we wait and see. But ...

We have the Doctor, and he will tell us what happens in the laboratory. We will know.

They got eight good-sized egg cells today, and six other ones that are a bit big or a bit small. That's fourteen chances.

That's why it's wonderful. Don't you see?

Fourteen chances.

And, we get to know how well it worked in just a few days.

Sarah, remember this. Remember that I am sitting outside all the time, waiting and hoping.

Just like you.

They'll put them back in a week or so, and then we'll hopefully have a little one on the way.

That will be thanks to all this, thanks to the pills and the needles that you hate so much, and all the hurt, we get fourteen chances...

At this point, the nurse came to us, and said that Sarah had called to Joe that she is ready to go home, cutting off whatever he might have said next. They came out together to leave as I was packing up my recorder. Joe told me to not play this to Sarah, he'd changed his mind. Sarah asked what he was talking about, he said never mind. She still looked a bit dazed, but much less drugged than a few minutes ago. She reminded me that the next Stirrup Queens meeting would be at her house, and to be early, she needed help with something beforehand.

I never got to have some coffee.

PESA/TSE

"The alternative to surgical reversals or reconstruction / repair is sperm retrieval by needle aspiration.

Above all, fresh ejaculated sperm is tops, and that dear friends sets the gold standard in fertility, naturally. Needle aspiration is normally quite quick and convenient, with only mild resultant pain or discomfort, and can be performed under a local anaesthetic, but I personally would prefer not thank you. And be warned, if you choose this option, make sure the performing physician is skilled, this technique in hapless hands has the propensity for mass destruction to the the very fine epididymis [sic] *and injury to the testicle/s. Please be absolutely sure that the physician knows his oats, and understands the importance of steering clear of the head of the epididymis* [sic] *where damage to the delta of minuscule canals would be very difficult to bypass or repair. Also, ask your physician to only work on the one side, and resort to the other only if things are not going to plan. Finally on this point, remember the number one doctrine of any doctor or surgeon is to first do no harm, and although this technique leaves little leeway for such an idyllic notion, damage control is important. Understandably you don't want to end up in the hands of a butcher, and I use this word with no apology, and for lack of a better one."*

by Allan Rumney - referred to by Ronald, when talking about needle aspiration on men[89].

Spermigro: not just for men

In much anthropological and biomedical literature, sex and gender are uncritically accepted as separate concepts (see, for example: Pick and Cooper 1997, Miller 2000 or Lock 2001). Sex is the biological nature of the human body. It is a given, concrete fact, that can be discovered and analysed, and it's expected behaviour predicted, through experimentation. Gender, on the other hand, is considered socially constructed or constituted. It is a fuzzy concept that explains why men and women act differently in different societies. It is the category that explains the expectations placed on a person based on their observed appearance. It is not given, but learnt, and it can be unlearnt or changed through individual action.

By making this distinction, one can argue that your character is not necessarily determined by

89 Ronald explained: "this guy (Rumney) pretty much said it all."

biology, but is largely shaped by society. But this division goes deeper than purely definitional or feminist aims. It also divides up work for anthropologists and medical doctors. Anthropologists concern themselves with the social functions, with gender, while doctors concern themselves with the biological functions, with the sexes.

Despite the long history of a critique of dualistic notions like the split between the person and the body outlined below, and the split between sex and gender outlined above, the division persists, and is especially pertinent in the context of fertility treatments. In the context of biomedicine, where arguably the body is the only point of interest, it is, in addition to the continuation of dualisms, curious to see to what extent an understanding of male and female bodies are understood in what I would consider gendered terms, and how this gendering is inscribed on a physical body as biological truths.

Biological truths, here, is an interesting term. On the one hand, it would seem to encompass that which is 'given', that which we simply grow into, and have little to no control over. Our height, our skeletal structure, our cranial features, the tone of our skin, the colour of our hair and eyes... These seemingly neutral features, however, are used as signs by other humans that define us in more than just our physical size and shape. Tallness is seen as a sign of authority and intelligence. Darker skin has a long history of being a sign of a lesser status. Social categories become part of what is 'given'. The examples I gave here, height and skin colour, have been exposed, discussed, and we generally acknowledge and work towards avoiding these biases. In biomedicine, however, much of these ascriptions are hidden, assumed to be 'natural', or simply the way that things are. In this way, social categories become biological truths.

* * *

I noticed them on Leonora's kitchen shelf, above the microwave, surrounded by Herbalife's 'Omega 3 essential fatty acids', Cal-C-Vita and some Dischem-brand aspirin. A pretty mundane box of pills, with a blue side panel, otherwise mostly white. A label stuck on them by the pharmacy indicated that it was a prescription.

What grabbed my attention was the medication's name, partly obscured by the pharmacy's label.

Absent-mindedly, I picked up the box to read more closely what the name of the medication was. I might have read incorrectly, my interpretation of symbols affected by our conversation. Leonora noticed what I'd picked up, and I apologised. She assures me that it's fine, but I still put the box down, embarrassed to be caught snooping, knocking over the aspirin in the process.

Spermigro, it said.

Prescribed for Leonora.

Two tablets, three times a day, to be taken with meals.

...

Definitely spermigro.

* * *

Spermigro[90] is a commonly prescribed nutritional supplement for people undergoing fertility treatments. From the website, it is an "exciting 5-in-1 combination supplement containing Amino Acids, Anti-oxidants, B-complex vitamins, Calcium and Vitamin D, as well as other essential vitamins and minerals that your body requires." It apparently "helps the body to help itself by providing all the fuel it needs to be in optimal working condition" and "helps to rejuvenate the cells in the body and thus can assist in improving sperm and egg quality"[91].

* * *

"Oh, come on Nina. It's not that strange.

It's called spermigro, that doesn't mean that's what it does, or only what it does. We've both - husband and I - been on it right from the start, alongside the very first prescription of clomid."

Leonora's scolding makes me feel even more embarrassed. She suggests:

"Why don't you read the insert, then you'll know?"

I open the box, and pull out the folded insert, printed on incredibly thin paper. It tells me that Spermigro is

90 Also sold as Staminogro.
91 From http://www.staminogro.com/index.php/en/, last accessed 2012-11-25.

manufactured by GlaxoSmithCline, and that the medication should only be used as indicated within this leaflet.

A barrage of medical terms follow, with exact percentages showing how much of each active ingredient there is present. About two thirds of the weight of the pill is inactive material to keep it all together, and neatly pill shaped. It also sports a new special gel covering layer, to help with swallowing the pill – but it's still the same trusted supplement.

Then comes the instructions. These pills are only for adults over 12 years of age.

You should take two pills, three times a day, but you should gradually build up to that dosage, starting with only one pill, in the morning, after breakfast.[92]

* * *

Dualisms

What the medicine is referring to when it says "adults over 12 years of age" is not what one would call an adult on a daily basis. They do not mean that you need to be legally over the age of consent, or legally an adult (able to vote, able to sign on contracts). The medicine is talking about an adult body, or, at least, a body nominally conforming to the weight and physiology of an adult human. It is assumed that no one over 12 will be denied this medication, despite the fact that a 13 year old will not be considered an adult. Not in a social setting, nor legally, where the age of adulthood is 18.

These dualisms – the distinction between one's body and one's social situation – are ever present in the everyday discourse of fertility patients. Charmaine arrived extremely upset at one of our[93] coffee dates. From my notes:

"Can you believe the cheek of that woman!"
Charmaine greets us at the coffee shop. Linda, Leonora, Karen and I have been there for about five minutes, and have ordered tea already.
Charmaine sits down.
"What woman?" Leonora asks.
"The girl at the pharmacy. You know, that blonde one?
I went in to get my order of kits on the way here. Well, she told me that perhaps we should consider praying more, in stead of just buying all these."
Charmaine pats her handbag.
"Clearly, praying is a much better way of convincing the husband's sperm to come out of hiding.

No caffeine, bad for conception

Ovulation and pregnancy test kits

92 It is worth noting that the instructions for Staminogro is different – up to four pills a day, taken at night after dinner. This is despite the product being absolutely identical in every way except for the packaging.

93 The self-styled 'Stirrup Queens', a support group, and myself

Maybe it will convert them all to some crazy egg cult, and all will be better. Just pray..."
Snorting, Charmaine says:
"Well, I told her: "It's a disease. It's called azoosperma. Maybe you should apply at a church for a job, that's clearly what you're qualified for." and I stomped out. Well, stomped halfway out, then stomped back to pay, and then stomped out properly. I think she muttered 'bitch' as I left."

Azoosperma - ejactulate contains no sperm

Taken from transcribed, recorded field interactions, dated 2011-05-10

What upset Charmaine here is not so much that she was told to pray, what upset her was the implication that prayer would be more effective than the medical interventions she and her husband were using. To Charmaine, it sounded like the pharmacist was challenging her claim to fertility being a disease – her claim that infertility is a bodily, scientific reality, and not an emotive or imagined, or even socially created problem. In effect, it sounded like the pharmacist was calling Charmaine irrational at best, or at worst, sinful.

Another very present dualism is, in a truly cartesian sense, the mental split between the body and the personality[94]. Doctors are largely responsible for the body, which is said to work in a more or less rigid scientific-biological and deterministic manner, as we shall see below. The personality is the locus of the essential characteristics of a person, their personality, memories and ability to reason is located here. These two are experienced as being in conflict in many women who are infertile. She understands her body as having failed her.

Until infertility gained recognition as a disease, it was most often considered the woman's fault, and exclusively a woman's problem. Often, it was explained as punishment for her having been unfaithful or otherwise socially degenerate – in lieu of the above discussion with Charmaine – it was because you or your husband had sinned. A biomedical understanding of the body, however, necessitates that we recognise that there are two, different reproductive organs, and that both can malfunction in various physiological ways. More pertinently, however, is that one's body is understood as being biologically primordial, and that the biological body is absolutely morally neutral. Being

94 This aspect of a person is variously called a 'mind', 'intelligence' or even a 'soul'.

unable to conceive due to one or more physical anomalies can never be your fault, or because of you having sinned. Nor can social interventions, like prayer, cure this disease that you have - biomedical experts, who understand, study and act upon the physical body are the only place you can get true help for this[95].

Recognising infertility as a disease definitively moves it outside of the realm of social judgement. What is discussed is the course of treatment, the various partial successes and clear failures of intervention strategies, and the failure of your body. It is never a question of how you failed, as a person, nor can any moral responsibility be ascribed to you if it is a disease. In the words of Karen, after a friend had remarked, trying to be humorous, that she can happily take her children, who were at the time running around screaming loudly in the shopping centre corridor:

> *"What would you do if I did just that... went over there and grabbed little Johan? I am not a bad person. I just want to be a mother. It's cruel that my body won't let me."*

The division between the biomedical body and the person is also very clear from the doctors' perspective. I asked a Fertilicare specialist[96], who had just had a consultation with one of the Stirrup Queens, how he might help a woman become a mother. Based on the lives of the Stirrup Queens, I was expecting him to explain a complete treatment regime, with food requirements, therapy sessions and a list of recommended alternative therapies. The specialist, however, answered:

> *"In-vitro fertilisation, or IVF (also called in-vitro), is the most commonly performed assisted reproductive technology. An IVF procedure begins with stimulation of the female's ovaries, where ovulation was artificially enhanced to enable more than a single oocyte to be ready for harvesting. The oocyte is removed using a specially designed needle. A sperm sample from the male is also required, either provided by manual stimulation or removed from either the testes or the epididymus via needle aspiration. The female gamete is placed in the sperm*

95 While this is true for the Stirrup Queens, there is a large and growing 'alternative healing' offering for fertility problems, and in more working class settings, the church (the Maruti, or iProfeti) or the traditional healers are still seen as the primary people to visit to cure infertility – the expense of treatments undoubtedly play a big role here.

96 A complete list of all specialists registered under the fertilicare banner is available at http://www.fertilicare.org/index.php.

sample, and fertilisation takes place in a laboratory. The fertilised egg cell is them implanted directly into the uterus."

When I told him about the other measures[97] that the Stirrup Queens took to aid conception, he explained that he did indeed know about these other factors, and that he believes it is important to "get your head in the right space to make his job easier." It is worth reproducing the whole answer here:

"A willing, healthy patient is much easier to deal with than an irrational woman desperate to be a mother. She must recognise that we are fixing a problem in her or her husband's bodies. They are responsible for fixing themselves. These things, the diet, the psychologist, the meditation – these things help them get their head in the right space to make the job easier for us. They must just never let their other 'alternative therapies' affect their real treatment regime, but I'm sure they know that."

Note how the only actual fertility treatments are the techniques and medications prescribed by the clinic. The rest is all peripheral, making those treatments, those medications, more effective. In this case, the only link between the person and the body is in their willingness to be complicit, and to follow instructions perfectly.

Biology as a Socially Constructed Concept

Let us return to the point that socially ascribed categories form an intimate part of a biological understanding of the body. In plainer terms, the dualisms (male/female) are not a neutral fact of existence, nor are they neutral in their application. The first and most obvious lack of neutrality is the privileging of biomedicine as the explanatory category for bodily phenomena like pregnancy, or the inability to conceive. The second lack of neutrality comes from the work of Ortner (1972). Ortner argues that the contrast between male and female bodies are a reflection of the debate of the difference between nature and culture. Nature is governed by predictable, natural laws. It is the primordial condition, and is fair, powerful and enduring. Culture, on the other hand, is chaotic, constantly changing, based on superstitious interpretations of natural phenomena and spuriously

97 Everything from 'fertility acupuncture' to special sessions with a spiritual guru to "allow the baby dust to settle" is part of the everyday life of the Stirrup Queens.

driven by habit - so called 'tradition'. If this disjunction reflects understands of male and female bodies, then maleness is structured, predictable, powerful and primordial, while the female acquires considerably less desirable traits.

Step back with me for a moment to that point where I am reading the *Spermigro* leaflet.

* * *

After the instructions came the indications and contra-indications.

For men, this pill will increase both the motility and the endurance of existing spermatocytes. It will strengthen his erection by encouraging healthy blood flow to his penis. He will also be able to maintain strenuous sexual activity for longer periods of time, because the amount of oxygen in his blood will be higher.

It might cause slight headaches, nausea, diarrhoea, and it increases the likelihood of dehydration.

For women, this pill prevents unnecessarily heavy bleeding during menstruation and may alleviate menstrual cramps. It makes the ovulation cycle more predictable. It decreases the likelihood that the egg cell will fail to attach to the uterine lining.

It might cause slight headaches, nausea, diarrhoea, and it increases the likelihood of dehydration.

* * *

It is worth underlining my point. For men, increased movement, endurance, strength and duration; positive enhancements. For women, minimisation, regulation, prevention of failure; keeping a chaotic system in check.

On infertility forums, advice columns and other social spaces where infertility is discussed, *Sperimigo* is often recommended by laypersons as a first stop to aid with conception. On the forums it is primarily found in the discussion groups discussing male problems, which might explain why the marketing team decided to name the product 'Spermigro'.

Despite the name of the product, it does not, and can not help an otherwise male produce healthier (or stronger, or faster) sperm. There is currently no product on the market that can do this.

From the forum member Optimus[98]:

> *... it's just a vitamin supplement and should be looked at as such. If one does have a serious vitamin deficiency that has a detrimental effect on spermatogenisys [sic], then a vitamin supplement *might* help. Also, in my case, the deficiency would have to be in one of the elements that are Not in other vitamin tablets (I have been taking Supradyn Complete A-Zinc regularly for the past year); namely, amino acids, etc*[99].

Significantly, the information sheet contained within the packaging gives specific indications and contra-indications for male and female bodies. The association of maleness with strength and order, and the pill's ability to enhance these characteristics, and femaleness with decay and chaos, and the pill's ability to prohibit these characteristics reflects Ortner's (1972) argument directly. Stepping aside from the societal bias in favour of keeping the male body intact, the crucial matter here is how a biomedical pamphlet reflects societally ascribed traits to men and women.

This is not an isolated incident. In the same forum thread I quoted from above, Optimus stated:

> *"... like the early thoughts that testosterone supplements made one more of a man were disproved and after investigation found to be showing exactly the opposite ...".*[100]

This is a discussion about the medical effects that testosterone had on male bodies. However, it is unclear how the idea that testosterone increasing your sperm count, and being "more of a man" is related, unless the sexually male body and the gender we call 'man' are linked. If 'male' and 'female', presumed to be biologically defined, neutral, biomedical concepts, reflect and perpetuate social understandings of what it means to be a man or a woman, it becomes untenable to maintain a rigid distinction between biomedicine and society.

The distinction between biomedicine and society maintains a power imbalance in favour of the doctors and those lucky enough to be able to pay their fees. This is not necessarily a problem on it's

98 His online pseudonym.
99 Taken from http://www.fertilicare.org/forum/showthread.php?4009-Staminogro/page2
100 From http://www.fertilicare.org/forum/showthread.php?4009-Staminogro/page2, last accessed 2010-08-27.

own, however, considering the persisting unfairness of the South African context due to apartheid and the discrimination of women because of an implicit masculine bias, this unequal power distribution no longer seems so harmless. By insisting that biomedicine has access to knowledge that is prior to society, that biomedicine has unprecedented access to and a superior understanding of the the human body, by maintaining itself as separate from the discourse and constructed nature of everyday life, we cannot begin to challenge this lack of fairness, nor the conception of woman as inherently chaotic or on the verge of complete break-down. We also keep the socially determined superior knowledge, access, understanding and the power that this brings as something that only the wealthy can access – which in effect perpetuates much of the previous regime's bias.

The Laboratory Womb

If we accept that since earliest times, women have been associated with chaos and lack of predictability (Ortner 1972), and that this understanding is still alive and well in medical parlance and popular understanding today, a woman's most chaotic feature, having children, has to be monitored and regulated like a laboratory in order for there to be any hope for fertility treatments to work. There is no magic to this logical leap, if science is controlled, regulated and predictable, and it is these features that make science potent, and women are none of these things, one must change women in order for science to be effective. This change is implemented in two ways. Firstly, physically. Fertility interventions are primarily applied to female bodies. Secondly, by monitoring and control. Women are taught a process of categorising and watching their bodies, submitting the data they gather to doctors, with the idea that this will allow their doctors[101] to impose some control.

Specialist Bias to Women

A quick overview over fertility techniques shows a rather dramatic difference between the interventions available to women and to men. There are a great many for women, but for men, there is

101 It is important to note that the control is not in the hands of the woman, but in the hands of the doctor. It is he or she that makes the decisions regarding timing of hormone interventions, procedures and ultimately, if factors conspire to give the desired outcome, conception and birth.

one, with two variations – needle into the epididymus, or needle into the testicle. She is given a medication regimen where she needs to inject herself up to three times a day, with sometimes two different products at one setting, and is placed on hormone regulatory medications in combination with stimulants to promote ovulation, while he is given some vitamin supplements.

ICSI is often pointed to as the first technique that can really combat male infertility, because sub-par sperm can be injected directly into the ovocyte, eliminating the need for the sperm to get itself lodged in there. To me this is an ironic statement because this technique requires the same medicine and procedures that a typical IVF would need – which requires an immense time commitment from the woman, and she is affected the most by the medication and the procedures that they follow.

Perhaps my protest is unfounded. After all, male bodies cannot provide the necessary biological support for bearing children. Additionally, the male reproductive system is said to be so delicate, and so irreversibly damageable, that interventions there must be a last, desperate attempt. The fact is, though, that the female system is also delicate, and also easy to damage. So much so that in our public sector healthcare, tubal factor infertility is the biggest cause of difficulty in having children (Steward-Smythe and van Iddekinge 2003:142-3). This would imply that it is more appropriate to damage the female reproductive system than the male one, that the male system is so massively valuable as an intact system that damaging it, no matter the degree of damage, is not even worth considering. Many men are quite clear on this, Alan Rumney whom I have already quoted "personally would prefer not thank you". Amongst the husbands of the Stirrup Queens this is the general opinion also, despite a few of them having had sperm aspirated.

Additionally, that fertility treatments should be much more invasively applied to the female than to the male body does not seem like a fact grounded in biology. The procedures are carried out on her, even when her body is able to conceive normally. Specifically, they apply hormone therapy to take control of her monthly cycle regardless of whether her cycle is normal or not, arguing that if she

is further regulated it will aid in conception. Additionally, the substantial proportion of unexplained fertility, where they are unable to conceive despite biomedical tests confirming normally functioning reproductive systems on both him and her, prompts me to pause. Why is it so natural to invade her body despite a lack of plausible medical cause?

Fertility specialists are almost exclusively gynaecologists, with a few obstetricians amongst them. Medical science pertaining to the male reproductive organ, however, falls under urology. In South Africa, it is not possible to be both a urologist and a gynaecologist (Rumney n.d.:1). That fertility specialists are largely not specialists in the male reproductive system goes a long way to provide a possible explanation for why there are a plethora of (moderately) successful techniques to aid female infertility, but almost no techniques to aid male infertility.[102] It also goes some way to explain why the techniques are built around the female reproductive system. The doctors are simply doing what they know, and what they know is the female body.

The most telling absence is in terms of medicine. Allowing that the female body is going to be more affected by having children than the male body, one cannot brush aside the lack in medication for men, at least in a biomedical context. There is successful hormone therapy for women, but:

> *" I was told by this man[103], to my face, that there is no known substance that will significantly raise the sperm count and/or quality of a normal, disease-free man on a good diet.[104]"*

I think there is more to this than simply an accident of the specialisation of doctors. Regulating and controlling the female body specifically is rooted in a conception of women as out of control, regulated only by the moon (if that). She cannot control herself, she is emotional, she is vulnerable to her own body – these 'wisdoms' dominate our everyday and, most worryingly, our scientific understanding of the female reproductive system. Ask a middle class South African woman

102 There is one exception, Dr. Sherman, J. Silber. He is considered the world's foremost leading expert in male infertility. He is also the only surgeon that can predictably and successfully repair vasectomies. His website: http://www.infertile.com/, accessed 2011-06-27.

103 Referring to Dr. Silber, who serves on the internet forums as the ultimate last word.

104 As stated by Durbanflyboy, on the Fertilicare support forums (http://www.fertilicare.org/forum/showthread.php?4009-Staminogro, accessed 2011-06-27). This post is from 2008, but the discussion was ongoing in 2012.

about her menstrual cycle, specifically about PMS, and see what she answers – self-deprecation and despair over a lack of control over her own emotions are typical, as well as a claim that it's not her fault, it's her hormones that make her that way. Look into our writing on menopause, where destruction and decay reign supreme. Both of these conditions related to the female reproductive system (and in both cases, of which the scientific existence is debatable) show women as creatures that cannot be held accountable for their actions (like children) and that need medical intervention to be made more in control. A lot of the medication treating infertility do exactly this – take control her reproductive cycle.

* * *

Charmaine: See my chart - I'm slightly warmer today than yesterday. This means I'm about two days away from ovulating.

Me: How do you measure your temperature?

Charmaine pulls out a drawer, and picks up a white pen-like item.

Charmaine: Well, here is my thermometer, it's one of those digital ones. I have to place it in my ear, like this.

She puts the tip of the 'pen' into her ear, and pushes a button. A faint beep indicates that it has done it's measurement.

Charmaine: See? Here on the display, it shows 37.51. This is a special thermometer, you know? Most models only measure up to a tenth of a degree, this one can do up to a hundredth. It helps with accuracy - accuracy is everything.

I run my hand over some of the other things in the drawer as Charmaine writes the time and her temperature in a special note above the block on her chart that she uses to keep track of her regular temperature measurements.

Me: What are these things for?

She points at her chart.

Charmaine: I need to keep track of a great many things. I need to measure how much I pee every day, see (pointing) here's a special jug for that. It's shaped to help make it easier, and let me tell you, it was one of the

best buys we've made yet in this whole business. After that, I need to know which hormones are present in my pee, that's what these sticks are there for.

She picks up three tubes, when she uncapped them card strips with a spongy area on the one tip fell out.

Charmaine: That one (she points at one with a pinkish tip) measures how much oestrogen there is, it helps the doctor stop short of giving me OHS[105]*. That one (picks up one with a white tip) measures something the doctor called general hormone levels. That makes sure that I'm balanced. Then that last one, that one is a pregnancy test. It's not really necessary, and a bit silly, I guess, since they sometimes give false positives or false negatives with all these hormones. I just want to know, you know?*

Then I weigh myself. The scale used to be in the bathroom, now it lives under this cabinet (she pushes at the scale with the tip of her shoe). I have to keep my weight under 65, otherwise the doctor won't continue treatments. Being too fat apparently makes it harder to conceive. I wish someone would tell my friend that. He's huge, and he has three illegitimate children. Seriously?

Me: On the positive side, at least this is one way to keep thin.

Charmaine: Yeah, you're one to talk. (Laughing). But it's true, I've never been this thin in my whole life. Well, not since I was eighteen. The hormones make me ravenous, though. It's normal, according to the doctor.

But back to what you asked about. There are other things to this process - here (she points to the chart) is where we fill in when he injects me or when I inject myself, and here (points) is where we keep track of how long embies have been either frozen, in the laboratory in one of their incubator machines, or implanted in me.

This column is where we mark when we try. Every four days. Sometimes less, it depends on what the doctor told us, and where in my cycle I am.

Here (traces the line) is where we write when the next appointment is - as you can see, it's next Friday.

Lastly, I graph everything on the back side of the chart (she flips it over).

Three lines on the graph has three deep gouges in it, where the fertility process was not successful and they stopped monitoring her so closely.

105 Ovarian hyper-stimulation syndrome, a painful condition where the ovaries are constantly releasing fluid and proteins. Reaching a state of hyper-stimulation also means the strength of medication must be reduced, making most ARTs unlikely to be performed.

One has been kept up continuously, the line representing her weight. I can see how it fluctuates, the scale on the side shows that these are fluctuations of less than two units.

Me: How do you know what the units are? You've got everything on the same axes.

Charmaine: Well, it differs for each thing, but I know what they are. It's the same as on the other side. Weight in kilograms, hormones in parts per million. Urine volume in millilitres.

* * *

Discipline and Patience

For fertility treatments to be effective, doctors require an immense amount of information about bodily functions – there can be no question about this. To perform any fertility procedure, doctors need to know at what point a woman is in her menstrual cycle[106]. Additionally, a great many procedures require exact knowledge of when a woman is ovulating, something she cannot know through experience. They also need to keep track of her blood pressure, hormone levels and weight. To get this information, doctors encourage women undergoing fertility treatments to start a series of monitoring procedures – as Charmaine explained to me above. Some doctors provide charts for the women to complete, some require that they create their own charts. In other cases, the women start up their own charts long before advised by a fertility specialist, usually inspired by information she found online. In addition to these self-measurements, doctors request regular blood tests to be carried out, usually before and after each procedure done on women, during the period where she is under intense hormone therapy[107], and once, before a sperm sample is collected (either by donation or by needle aspiration) from her husband.

There is a great irony to the care and precision with which this monitoring is carried out and insisted upon by the doctors. Charmaine's thermometer in her ear, despite it being 'accurate' up to one hundredth of a degree, does not represent her core body temperature, or for that matter, the temperature of her reproductive organs, the temperature that is relevant to predicting ovulation with

106 Often, they pre-empt any uncertainty by regulating her menstrual cycle with medication – ironically, this is usually done with standard prescription birth control.

107 Especially if the doctor suspects that she may be at risk for ovarian hyper-stimulation.

the accuracy that the doctors claim they require. The dip-stick she uses to check her oestrogen levels in her urine does not help predict hyper-stimulation, a blood test does. Oestrogen in the urine reflects the medicines she is taking more than it reflects the concentration of the hormone in her blood stream or uterine lining - much more relevant information to the success of the procedure to be carried out, or to the dangers of these procedures to her.

The monitoring devices that the doctors use to inform their next actions are the blood tests and internal examinations carried out by the doctors, not the myriad tests and detailed charts the Stirrup Queens keep. If my argument follows, it is these monitoring techniques and the discipline to carry them out consistently that internalise the understanding of a female body as an entity that is unpredictable and unstable.

* * *

Me: This is kind of interesting, these charts.

Charmaine: It's all quite interesting. But it also gets tedious. Sometimes I forget, and if the treatment fails after I've forgotten, I wonder if maybe it's not my fault. What if something happened at that moment, during that time when I wasn't watching? I can't believe how much goes on in my body, and how little we're aware of it all. (She sighs.)

So many things to watch and keep under control.

Pincussions, Herbal Tea and Yoga at Sunrise

Amongst people undergoing fertility treatments, it is well knows that the success rates are low. While the Stirrup Queens may firmly believe in their current doctor, they are not naïve regarding their odds for success. Part of managing the disparity between needing to keep their spirits up while being subjected to an invasive treatment regimen with a relatively low chance for success is in accessing alternative therapies. I've previously pointed out that fertility doctors largely ignore these practices as long as they feel it does not interfere with their protocols. To this effect, the Stirrup Queens largely

don't tell their doctors. Many of them drink herbal cleansing mixtures containing mild diuretics or follow special diets that do not conform to what would conventionally be considered healthy. These diets may contain no red meat, no eggs, sometimes no dairy products. In many cases a part of the food pyramid is not eaten.

While I do not want to minimise the extent to which the Stirrup Queens (and 'good' patients in general) are under the authority of the doctor, it is worth pointing out that almost without exception alternative therapies and therapeutic activities are part of the fertility treatment plan. These alternative treatments, like for example, 'old wives' advice (like sleeping with your feet pointing in the opposite direction of the rotation of the earth, to help sperm swim in the right direction) forms a body of practice that resists the absolute authority of biomedicine, and helps to maintain alternative discourses of self and the body.

Under Her Skin

> [108]*We were one of those magic couples, at least, so it seemed to us. The first time we were lucky enough to get a pregnancy, but it ended in a miscarriage three weeks in – the doctor said the egg was rejected. I guess it was as bit too soon to be celebrating.*
>
> *It wasn't too sad, after a little bit, because we now have proof – we can get pregnant. It may take a little bit more needles than the typical impregnation, but it can be done. So, after a two month break, the doctor said we could come back, and we did.*
>
> *Three more tries and nothing happened. The first one of these something went wrong with the scheduling, and they removed my ovocytes too late – they were too big, too far gone to work well. Second one I only stimulated very slightly, only three developed. One seemed promising in the lab, but none were worth implanting in the end. By the third one, the financial strain was really telling its toll, especially since they gave me a much higher dosage of medicine than before. It just costs a small fortune. Everything seemed ok, they got 10 from me. My husband's*

108 Quoted from a Stirrup Queen, she did not wish to be identified.

sperm did their job well, three was implanted back in. That's the maximum nowadays, to prevent multiple pregnancies. But none of them implanted at all. They just went out as fast as they went in.

It was the one after that that I really want to talk about now. In an absolute sense, this was our fifth try.

It was unbelievable – it worked! I stimulated well it seemed, but only three were removed on removal day. All three were fertilised successfully, all three were implanted. All three started growing. Not only were we having a baby, we were having triplets!

You must remember that by now, we actually had taken out a short term loan to help pay for this last try – with the higher dosages of medicine it was nearly R10 000 for three weeks just on medication, and that's without all the other costs in leave time and doctors fees, and the procedures themselves aren't easy either.

Regardless, it worked, it was all worth it. After a month I decided to resign, it was always our intention that I be a stay at home mom. I hadn't been at work much the past year anyway, so my boss wasn't surprised. We'd manage the loan, my husband said. That, and with it being triplets, the gynae was concerned that I should at all costs not overtax myself.

Two months in we started decorating the baby room. It went slowly, the first step was just to empty it out. It was an odds and ends room before, supposedly my office. My mom and I would spend hours in shops looking at little baby shoes. My husband and I were arguing about names. It was fantastic.

Then, close to three and a half months in, I suddenly felt moisture down there.

I thought I had had an accident, I rushed to the toilet. But immediately there was dread in my stomach.

I sat down on the loo. When I looked down at my panties I nearly screamed. It was blood.

I felt them coming down, trapped on the loo while this happened.

I wasn't sad, I was angry. Very angry.

As the lumps came down all I could think of was one thousand Rand... two thousand Rand... three thousand Rand... I got to nine thousand before I started crying.

5. Conclusion: Making a Baby

We have thus far seen how infertility can be defined in many ways, and how those definitions reflect the context that they are made in. We have met the Stirrup Queens, and lived with them through some of their most trying times. We have gotten to know the female body in a new way, as a set of graphs and measurements categorising an unfamiliar, hard to control system that is unfamiliar even to the person who the graphs and measurements are about. We have seen how doctors take control of this system (or, at least, attempt to), and we have seen men reduced to little more than a contributor of sperm (sometimes, inadequate sperm). We have gotten to know the emotional toll of infertility treatments that do not succeed, and we have seen how this process is attempted to be explained as natural.

What remains is to show how exactly infertility is bound up in the context it is identified in, and how the duality of bodies we have come to know here in merely an artefact of speech – we are one whole person, not just a body and just a personality. It is also worth spending some time discussing how the technological and the social are again interconnected, and are very much not the separate worlds the doctors try to persuade us they are. Lastly, we need to return to the concept 'natural'.

Infertility: Bound by the context

Infertility has been defined in two main ways in this writing. Firstly, it was defined medically, formally put as a diagnosis made "after one year of unprotected, heterosexual coitus, with the intention of conceiving, has passed without fertilisation occurring" (Bello *et al.* 2010:7). In this definition, it is largely functional, the point where a person might either now access specialist level fertility treatments, or the point where a specialist would consider treating a person. The second definition was given as primarily a social one, the lack of a child, the yearning, wanting and desperate

attempts to get that child, and the lack of ability to fulfil that need through 'ordinary' means. In this definition, there is seemingly no function, markedly a lack of a function, one that does nothing more than to potentially isolate you socially and stigmatise your marriage.

These two definitions are both intimately tied up with the context in which they function.

In fact, I would go so far as to say that infertility outside of the middle class South African context means something entirely different. It could mean no children to provide for you when you are old – not a concern ever raised by the Stirrup Queens. It could mean a disbanding of marriages, a sense of worthlessness (in some circles, women are still primarily valued for their ability to have children). The keenly felt lack of a child as described here, and the official 'two years of trying without becoming pregnant' is specific to the context.

A matter of bodies

Infertility treatments are intended to take action upon a physical body. That is the whole premise upon which biomedical interventions are based – that bodies are understandable systems that work according to explainable cause and resultant effect, and that you can alter the effect by adressing the cause. By ensuring that an egg is fertilised, you can help ensure a pregnancy and hopefully a child. By ensuring that the woman ovulates at a certain time, by monitoring the processes, you can again produce an effect – a baby. On the other hand, it is thought that neither positive thinking, nor positive talk will be able to affect the physical body in this way. However, I hope that I have conclusively shown that neither process is so easily separated from the other. The clinical descriptions of the processes of fertility treatments and the highly emotional experiences of those treatments must be read as one and the same occurrence to get any kind of understanding of the situation.

In the same manner, this division of a person into a body that is nothing more than a mechanical object upon which you can act, and that somehow is linked with a personality that has little

to no influence on that body always already presupposes that these two things, separated by words, by ideas, and by an attempt to isolate moral responsibility, can only ever be one and the same thing. One can only understand what it is to be a person undergoing fertility treatments if you get beyond the duality of body and mind.

The interconnectedness of the social and the technical

[109]Nurse: Are you still there?

Me: Yes, my recorder is on though, is that ok?

Nurse: I guess so, but I mean, all the patents are gone now. It's just us doing paperwork. And the lab staff – but you're not interested in that, are you? You're here to look at the social aspects of infertility?

Me: Well, it's all part of the same system, isn't it?

Nurse: No, there's the patients and what they feel, and that's where you come in. Then there's this technical stuff, but don't you even worry about it. We've got it under control.

Biomedical practitioners work very hard to hide the effects of social convention on their practice. The first, and most direct contrary example, lies in how I had to struggle to get access to contexts where only the initiated – in this case, scientists and specialists – are allowed to go. Secondly is an example that shows how the technical sphere of biomedicine is always already contained and influenced by a social system is contained in the means of accessing biomedicine. The second example is the gender bias in the treatments and in the interventions themselves – both in their primary application to the female body, and in their greater command of time from the woman. The third, and final example to show how the social and the technical are interrelated lies with the 'creation' of the baby. The baby is discursively either an embryo, a foetus or a baby depending on where and when it is being talked about.

109 From one of my first recordings at a fertility clinic, sitting in the waiting area outside of the procedure room.

Firstly, the small except above serves to illustrate just some of the deep seated belief that there is a social realm, and there is a technical realm, and the two are separate. Yet, the biologists talk about rugby as they work, and the doctors gossip in the hallways. More tellingly, the separation here serves to maintain a power inequality – it keeps the work done by doctors and specialists mysterious and outside of common knowledge.

Secondly, as we have seen, to access biomedical fertility treatments, you need access to a healthcare system that requires you to be a member of the middle class, and polices this with a monetary barrier to entry followed up by a system of medical aids that ensures that this money is not simply acquired once off, but sustained over many years. You need to be able to travel, at least to the nearest fertility clinic, but typically to another city, and sometimes even to another province to get 'the best' care. Moreover, you need to be able to devote the time that could otherwise have been spent being economically productive of one of the two members of the couple (specifically, the woman) to this process. All of this is an outflow of the government not providing any sponsorship for infertility care, and a lack of concern for infertility treatments amongst medical aids as well. In effect, we are saying that the ability to have children artificially is something only the wealthiest may have. We are policing, socially, access to health care, based on ideas of appropriate parenthood.

Thirdly, we apply the treatments almost exclusively to female bodies. It is no big leap to show how ideals of motherhood – the available, at home and caring mother – are linked to this. This kind of motherhood again requires a marriage, a supportive partner that takes on the responsibility for monetary provision nearly exclusively. In this way, it creates, supports and encourages women as a less authoritative partner, one who cares not one who decides. More sinisterly, the fact that most of the treatments are invasive towards women underscores the belief that female bodies are more chaotic, and more morally acceptable to invade with medical intervention.

Fourthly and finally, the fertilised egg only becomes a baby once it has a mother and a father. I mean that quite literally, I do not mean that there needs to be merely an egg and a sperm, since both

of these can come from donors, people who would never be called 'mom' or 'dad' in the context. The point where this embryo becomes a child is the point where she is declared "going to be a mother". The child itself is created by a social milieu, and not just by the act of fertilisation.

In this way, we can see that the social and the technical are inseparably part of the same context.

"Nothing natural about it!"

Throughout, one category comes up again and again. The nature of bodies, as something natural, while persons are created socially. The naturalness of the outside, while the technology inside the lab is clearly not so. The natural distinction between a body and a person, between a woman and a man, between a baby, a foetus and a child. The naturalness of keeping the social apart from the technological. It is striking that this very repetitive category is never questioned in and of itself.

'Natural', in the sense that it is separate from human intervention, in the sense that it is biological truth, is a recent invention, coming up with the first awareness of the decay of the environment in the 1940's. Broader than this, though, my personal first encounters with this term is biblical, where 'man' is told by God that 'he' must rule over nature, and make it useful to 'himself'. It is a denial of the animal nature of our species – we are somehow apart from the rest of the world that we act upon. It is likewise a denial of responsibility for our actions, if it is merely 'natural', then no one is responsible.

However, the very distinction between these things is suspect. It is untenable to hold a separation between humanity and 'nature', given that we are part and parcel of that second category. It is equally untenable to say that the ideal biomedical body, one that functions perfectly as textbooks indicate a body should, is a 'natural' one – no one has such a body!

It is always complex to write about sex, partly because the vast majority of the time, it happens

when no one is watching (arguably, intimately part of the experience is privacy). But that does not mean that the act itself is not culturally constrained, made up of rules that are largely arbitrary, and filled with meaning that is only there because humans ascribe it. It is as 'natural' and act as "a child shaken into conception in a tube in a centrifuge", as one Stirrup Queen so eloquently put it.

> [110]*So, we're going to be a mom and a dad now, aren't we? I guess so. It's hard to believe that we're supposed to now just go off and 'have' a baby, after all that. It's been years and years of trying and trying and trying. And now, I go to the nursery and I don't have to inject myself.*
>
> *We don't even want to have sex right now. It just seems wrong, after all this, to do it 'naturally'. Almost like it would make the contrast between what we've been through all this time, and now the wait, less 'natural'.*
>
> *Gods that's a funny word. 'Natural'. So often the doctor would say "just like it would have happened naturally". Well, doctor, thank you for everything, but there's nothing natural about a child shaken into conception in a tube in a centrifuge, then injected into my womb through a needle!*

I find it somewhat ironic, then, that both the doctors and the people undergoing fertility treatments work so hard at attempting to make their choices seem 'natural'. If this category is a socially defined one, then surely any means of making a child is as socially constrained as any other. The crux of the matter here is then that 'nature' is not an arbitrary category. Perhaps it is the largely Christian influenced backgrounds of the people discussed here, and it is something of the fear that they are 'playing God' by making babies in laboratories that informs their insistence on making the process as 'natural' as possible.

Perhaps it is an attempt to avoid stigma on the part of the child – that the child might be seen as somehow different, or not as 'human' as other children because of the nature of its conception. Perhaps it is a last effort at hiding their own bodies's inabilities from themselves? Perhaps a way of justifying why they are able to still have (or attempt to have) children when 'nature' has made their

110 Excerpt from a letter from a Stirrup Queen, sent on 2013-08-06 to me.

bodies in such a way as to preclude that possibility?

All of these speculations likely form a part of it, but more tellingly is the denial of power and privilege inherent in the ability to make a baby using high technology fertility treatments. By working hard, and insisting on the 'natural' nature of what they are doing, no one here is at any point confronted with the shear privilege of their ability to even access these treatments in the first place. At no point does anyone even wonder what they would have done, how they would have managed, had there not been the money for these treatments. This does not mean that the money is not dear, that they do not still at times struggle to finance this venture, but it does mean that they are simply 'having children', without the knowledge that their wealth largely places them in a separate, small group.

Finally, I would like to suggest that the category 'natural' is a powerful one, in the sense that there is a select group of people that we have given the power to decide what is, and is not, natural. These people, broadly speaking, are scientists, but in the context of this study, these people are fertility specialists. Are we truly content with letting white, wealthy male doctors decide what is 'normal', 'natural' (and following from this, appropriate) for bodies? For the reproductive process? For making babies?

No. There is in fact nothing natural about it.

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