

The Experience of Reproductive Suffering: An Anthropological and Sociological Approach to Social Pressure Regarding Infertility

Cristina Lázaro-Pérez^{1*}, Piedad Miñarro-Casau²

¹ Department of Political Science, Social Anthropology and Public Finance University de Murcia, Murcia, Spain. Orcid: <https://orcid.org/0000-0002-1316-0201>

² Department of Sociology University of Murcia, Murcia, Spain. Orcid: <https://orcid.org/0000-0001-8635-179X>

*Corresponding Author:

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ABSTRACT

The problem of infertility is not only medical, but also a social, moral, and political issue. This article aims to analyze the problem of infertility from an anthropological and sociological perspective, focusing on the experiences of women and men who have undergone assisted reproductive treatments in Spain and Latin America in urban and peripheral contexts. The methodology used includes a theoretical review with an ethnographic design, as well as in-depth interviews and life histories. The findings reveal that infertility influences people's identity, altering their family relationships, their experience with their bodies, their daily routines, and their perception of social acceptance. Furthermore, it is shown that the growth in reproductive technology has created, in addition to opportunities for conception, inequalities related to social class, gender, and access to treatment. The research also shows that infertility is a form of suffering produced by society, that it manifests unequally, and that biomedical institutions play a significant role in this regard, acting as both beacons of hope and emotional marketplaces. From a social science perspective, infertility allows for the analysis of contemporary social pressures regarding the body and gender, as well as reproductive neoliberalism and current changes in family and kinship.

Keywords: infertility, kinship, reproductive suffering, assisted reproduction, medical anthropology, sociology of the family.

INTRODUCTION

Infertility has a quality that affects society: it is both an internal and an external matter. While it occurs within the body, sometimes silently, it becomes a family topic, a medical issue, an economic concern, and sometimes a moral spectacle (Greil et al., 2011; Bell, 2019). In family gatherings, it appears disguised as an innocent question "So, when are you going to have children?"—a phrase that often falls on couples like a heavy burden.

In recent decades, infertility has become more visible in public life. Assisted reproductive technologies are expanding, people are postponing motherhood, medicine is intervening in reproduction, and fertility clinics are appearing in the media (European IVF Monitoring Consortium, 2022; World Health Organization, 2023). Thus, assisted reproductive technologies, delayed motherhood, the medicalization of reproduction, and the presence of fertility clinics are changing how society understands reproductive capacity (Inhorn & Patrizio, 2015). Even so, and although reproduction is central to Western cultural discourse, infertility remains an experience marked by silence, shame, and private anguish (Bell, 2019; Greil et al., 2011).

In this regard, anthropology has historically pointed out that reproduction is not only a biological matter but also a social process that shapes family structures, legacies, ethical and moral beliefs, personal fulfillment, social

integration, and emotional maturity (Ginsburg & Rapp, 1995; Franklin, 2013). Therefore, infertility is more than just an impediment to conception; it is also a break from what are considered normal life trajectories (Becker, 2000; Bell, 2019).

For all these reasons, this research seeks to understand how infertility is experienced in the social lives of people who continue to organize most of their expectations and affections around reproduction. This issue is especially important in a changing context where technological advances are at their peak. Currently, there are more technologies to assist reproduction than ever before (European IVF Monitoring Consortium, 2022). At the same time, more people are experiencing the profound sense of failure that comes with being unable to reproduce (World Health Organization, 2023; Bell, 2019). Modernity promised to emancipate individuals from traditional mandates; however, motherhood and fatherhood continue to operate as silent forms of social legitimacy (Inhorn, 2020; Franklin, 2013).

Societies that for decades controlled women's sexuality with a religious obsession to prevent unwanted pregnancies now paradoxically create lucrative industries to assist in conception (Franklin, 2013; Thompson, 2005). Women's bodies are still monitored; only the form of control has changed. Previously, religious morality and the rule of abstinence dominated. Today, medical technology and the idea of fertility planning govern the social process of reproduction (Foucault, 1978; Thompson, 2005). This transformation does not signify emancipation; it signifies a shift in the mechanisms of bodily regulation that warrants critical analysis (Foucault, 1978; Rose, 2007). Even so, this industry, far removed from narratives related to economic issues and inequality, has helped those who wish to have children, especially certain family models such as single-parent or same-sex parent families (Mamo, 2007; Inhorn, 2020). The main objective of this research is to understand how people construct meaning around infertility and how this experience is shaped by broader social and cultural structures. It begins with the idea that infertility is a culturally produced and unequally distributed social problem (Greil et al., 2011; Inhorn & Patrizio, 2015). Throughout the article, the moral, emotional, and political dimensions of contemporary reproduction are examined, paying particular attention to the relationships between body, gender, and inequality (Ginsburg & Rapp, 1995; Inhorn, 2020).

THEORETICAL FRAMEWORK:

Kinship Anthropology, Biopolitics, and Reproductive Suffering

Kinship anthropology asserts that family is not merely biological, but rather something people create based on symbols, obligations, and cultural narratives. David Schneider's (1968) studies on kinship in the United States demonstrated that family is not solely biological. Janet Carsten's (2000) revisions of the concept of "relatedness" also confirm the significance of kinship, which is no longer understood solely as consanguinity. Kinship is now viewed as a set of affective and social practices. Faye Ginsburg and Rayna Rapp (1991) showed that reproduction is a space where power relations, inequality, and social regulation are observed. In this space, the reproductive body is constantly influenced by medical institutions, religious discourses, and state policies.

However, even with these theoretical advances, biological reproduction continues to carry significant symbolic weight. In many cultural contexts, having a biological child remains proof of family continuity, social maturity, and personal success (Franklin, 1997; Becker, 2000). Infertility, therefore, becomes highly stigmatizing. Erving Goffman (1963) stated that stigma is a devaluing characteristic that causes people to see the individual as less complete and normal. Fieldwork interviews indicate that infertility functions as an identity wound that is difficult to express publicly. Participants describe infertility by saying they feel incomplete, flawed, or out of step with their social circles. Each participant speaks of infertility as a wound that cannot be expressed.

From a Foucauldian perspective, assisted reproduction is seen as a biopolitical device. Fertility clinics act upon the body and manipulate hope, temporality, and expectation (Foucault, 1978). Medical language transforms reproductive life into a series of metrics, including ovarian reserve, embryo quality, fertile age, and success rate. The body is described in percentages. The medicalization of everyday life is a form of governmentality that inseparably links biological and social norms (Foucault, 1991).

Arthur Kleinman (1977) defines societal suffering as the pain created by institutional structures and political processes. In cases of infertility, suffering arises not only from the inability to conceive but also from societal pressure to become a mother or father and from cultural narratives that portray bodily reproduction as a destiny to be fulfilled. Another concept is stratified reproduction, developed by Shellee Colen (1995). This concept helps us understand how some groups receive support to have children while others encounter barriers of money, law, or symbolism. Reproductive technologies do not eliminate social inequalities; rather, they often exacerbate or alter them.

Finally, infertility can be analyzed through contemporary ideas about time and liminality. Victor Turner (1969) argued that liminal states are transitional moments in which the usual categories of identity and belonging are

suspended. Infertile individuals often describe feeling trapped in a suspended time, surrounded by hormonal cycles, medical tests, and the expectation of pregnancy. However, the crucial point is that this liminality does not last only days or weeks, like the rituals Turner studied. It can last for years, and this can alter personal relationships, career paths, and bodily experiences. Sometimes, these changes are irreversible.

Science and technology studies contribute to these theoretical frameworks by observing how reproductive technologies are not neutral tools but rather culturally charged artifacts that generate new forms of kinship and new definitions of nature and culture. Reproductive technologies generate new forms of bodily agency (Franklin, 2013). Charis Thompson (2005) studied this process and called it "ontological choreography." She explained that fertility clinics simultaneously organize several spheres: the medical, the legal, the familial, and the emotional. Fertility clinics shape patients, gametes, embryos, and ultimately, parents, and their organization compels decisions about which aspects of reproduction are natural and which are technologically advanced. The decisions made by the fertility clinic affect the people involved and change how the family is organized.

2.2 Sociological Analysis: Infertility as a Social Phenomenon

From a sociological perspective, infertility has become a social, cultural, and political phenomenon that transcends the biological. Their analysis allows us to identify how social structures, cultural values, economic inequalities, and gender dynamics shape the experience of the people involved.

Infertility has been extensively medicalized, meaning that the body's reproductive capacity is redefined within a biomedical framework. This process transforms the body into a clinical project managed by metrics and technologies (Greil, 2002). According to Foucault (1976), this phenomenon is related to biopolitics, as reproduction becomes an arena where the state, institutions, and medicine regulate bodies and populations.

This medicalization has led women to internalize biomedical language through terms such as "low ovarian reserve" or "implantation failure," which redefines their relationship with their bodies. Furthermore, intensive medicalization transforms treatment into an experience of surveillance and control, where the body loses its intimacy and becomes an object of medical intervention (Helosvuori, 2020).

On the other hand, regarding equality in access to assisted reproductive technologies (ART), this is modulated by economic factors, gender, and sexual orientation. In many contexts, ART is privatized, which generates class inequalities. People with higher economic resources can afford multiple cycles, while others face economic and cultural barriers that exclude them from accessing these technologies (Leyra Fatou, Ayala Rubio & Cubillos Vega, 2023).

This phenomenon is conceptualized as "stratified reproduction" (Colen, 1995), where certain social groups have greater support to reproduce, while others face legal, economic, and symbolic obstacles. Furthermore, the privatization of treatments generates an "economy of hope" (Thompson, 2005), in which people prolong reproductive attempts, often accumulating financial debt.

On the other hand, socially, infertility remains a highly stigmatized experience (Goffman, 1963). Parenthood that does not occur at the stage of life considered appropriate by society generates feelings of shame, guilt, and isolation in those who cannot conceive.

In this sense, women bear the greatest emotional, social, and medical burden because they are the ones who predominantly undergo fertility treatments. Messages such as "your biological clock is ticking" or "just relax and it will happen" lead to reproduction being considered not only a personal desire but also a normalized social expectation (Greil, McQuillan & Slauson-Blevins, 2011).

This pressure can be alleviated by certain social networks and digital platforms such as Telegram, Instagram, or forums where people find information and emotional support, share experiences, and create bonds of solidarity beyond traditional kinship-based social circles (Helosvuori, 2020). As Carsten (2000) states, kinship is constructed through social and affective practices, and social networks have contributed to the generation of new kinship structures beyond the nuclear family. Consequently, many people are questioning traditional values and more inclusive concepts of family and care. This transformation is often a consequence of suffering, but it reflects the human capacity to reframe complex experiences (Bestard, 2004).

METHODOLOGY

This research adopts a qualitative approach. The tools used were semi-structured interviews, life histories, and participant observation to analyze the experiences and institutional contexts in which infertility occurs.

The study period spans from January 2024 to February 2026 and employed an ethnographic strategy in the cities of Murcia, Valencia, Mexico City, and Buenos Aires.

Seventy-four semi-structured interviews, eighteen life histories, participation in eight support groups, and digital ethnography in forums and social networks were conducted.

The participants included heterosexual women and men, lesbian couples, gay men involved in surrogacy processes, and single women.

The research incorporates ongoing methodological reflection on the role of the researcher and the management of the emotional dimensions of fieldwork.

All participants provided informed consent, and confidentiality was guaranteed using pseudonyms.

RESULTS

The research results confirm that infertility is an experience that affects the construction of identity and social relationships. Although family models have evolved in recent decades, current society still associates motherhood and fatherhood with personal fulfillment.

A 36-year-old woman, a participant in Mexico City, explained:

"I never thought being a mother would be so important to me until I discovered that perhaps I couldn't be one. Suddenly I felt like something was broken inside me."

People who have difficulty conceiving suffer social pressure, which, in the case of women, is associated with traditional gender roles. This pressure causes emotional distress that manifests as feelings of failure and questioning of their identity.

A 41-year-old woman says she has frequently heard comments such as: "You focused too much on your career," "And when are you going to have children," "Your biological clock is ticking," or "Relax and you'll see what happens."

Another finding is the change that occurs in body image. Treatments, checkups, and protocols interfere with daily life and the rhythm of life, and continuous medical supervision can cause the body to lose its sense of ownership. It should be noted that, although in most cases it is the woman who undergoes treatment, the physical and emotional burden falls primarily on her.

Medical terminology shapes how patients integrate their own identity. Certain expressions such as "implantation failure," "low ovarian reserve," or "low-quality embryo" were used daily by the interviewees, meaning that some of this clinical vocabulary has been adopted and appropriated to redefine their relationship with their own bodies. This could indicate that the patients themselves need to use these terms to understand and manage their experience.

The need to medicalize the body to make it more receptive to treatment and improve the likelihood of conception generates a contradiction that has been documented in this study on multiple occasions. Technology that helps generate life becomes something that destroys naturalness, intimacy, and enjoyment. Some men interviewed reported feeling uncomfortable because they perceived themselves as almost external to the medical process; that is, while women took center stage in medical and pharmacological treatments, men saw themselves as "administrative assistants of the pregnancy," as one informant from Buenos Aires expressed it.

In most cases we observed, women were the ones who kept up with medical appointments, took an interest in the protocols to follow, oversaw the administration of medication, and bore the daily burden of the unpredictable and the uncertainties. In this sense, both clinical and family narratives normalized the asymmetry in relation to the roles adopted in the treatments.

A gynecologist interviewed in Murcia commented:

"In the end, the body we have to prepare is hers."

A 36-year-old woman described it this way: "My body was no longer mine. It was a medical project. Everything was measured: hormones, eggs, endometrium, weight, schedules. Even sexual desire seemed organized by a calendar."

Reproductive technologies are seen as an alternative and, in some cases, the last hope for conception, but the possibility of repeating treatments almost indefinitely if unsuccessful can lead to dependency. Furthermore, the financial costs of private treatments represent a significant limitation for those who cannot afford them and who also do not meet the requirements for accessing the public system, producing significant inequalities based on socioeconomic level.

During the fieldwork, private fertility clinics were positioned as the generators of reproductive hope. Assisted reproductive treatments have a dual nature: on the one hand, they offer a real chance of achieving pregnancy, and on the other hand, they prolong hope, creating a kind of "addiction to possibility," as several interviewees pointed out. There's a feeling that there might always be something that hasn't been tried in previous attempts, something that could be the key to conception. A 39-year-old Mexican woman succinctly explained this feeling: "The clinic always gave me options to continue the treatment; they don't tell you to give up. It's as if hope is maintained as long as there are financial means to continue." This doesn't mean the clinics are acting in bad faith; rather, hope persists as long as the treatment continues, and the treatment continues as long as patients pay for it. This somewhat dehumanizes the process, as it fails to address the emotional needs of those who have faced an infertility diagnosis or are undergoing assisted reproductive technology. The emotional burden and suffering associated with all of this are further exacerbated when financial considerations take precedence.

In this regard, although treatment through the public system was available, the waiting times and the age limit that prevented delays in treatment meant that many people had to resort to private clinics. Several informants (from Murcia and Mexico) stated that fertility treatments in the private sector were expensive and forced them to go into debt. Consequently, some went directly to private clinics, which also created another double paradox: on the one hand, they had the possibility of undergoing the necessary treatments to achieve pregnancy, but on the other hand, this depended on their ability to afford them.

An informant from Valencia, sounding somewhat exhausted but lucid, recounted: "After a while, my partner and I stopped checking our bank account; it was causing us more stress." From a sociological perspective, this testimony reveals something significant: the hope of reproduction is sometimes a form of emotional economy where everything done has an intention that transcends purely economic, even though the latter is crucial to achieving it. These two aspects, which initially appear unrelated, do run parallel to each other, sharing a common goal.

The research revealed inequalities related to sexual orientation and marital status. Some single women and lesbian couples reported experiencing institutional discrimination or even administrative problems in their reproductive process, especially regarding public policies, work-life balance, maternity leave, and even the fact that not all administrative procedures recognize diverse family options, making it impossible to access certain processes, unlike heteronormative families. This highlights that, although there has been significant technological progress, advancement in other, more administrative and formal aspects is more subtle.

Another important finding is the uncertainty surrounding the outcome of fertility treatments and the pressure related to reproductive age. This leads to a continuous restructuring of personal, professional, and family plans, contributing to emotional exhaustion.

A 42-year-old woman from Valencia said: "I started a single-parent family, and when my daughter was born, I had the same amount of leave as parent in a two-parent family. My daughter received half the amount of family care as children in two-parent families." A 41-year-old woman said, "I tried to apply for a school lunch scholarship for my son, but they asked for the father's information. Since we are a single parent, I couldn't provide it, and they wouldn't let me finish the process, so we lost that assistance."

Assisted reproduction treatments require a very specific timeline, which is one of the most important and often overlooked aspects of reproductive suffering. The interviewees described how their lives revolved around the treatment: waiting for tests, the treatment cycles, waiting for embryo viability, the transfer, and the two-week wait. This timeline affected all areas of their lives, taking precedence over everything else, such as relationships, work, and other personal projects.

Many of the women interviewed used metaphors to describe this stage: A 39-year-old man from Valencia said, "It feels like my life has been stuck for three years." Another 37-year-old patient from Buenos Aires expressed something similar but emphasized a social aspect of the experience: "It wasn't that my body was on strike, it's that I felt like everything around me stopped while everyone else's lives went on." This perception of time standing still, experienced by the women, led to decisions that affected their work lives, life plans, and social relationships.

Some couples put their lives on hold or changed their plans: "just in case the treatment works," "it's better to leave it until after we know the results," "I was afraid to live a normal life or travel in case it wasn't good for implantation." Sometimes they not only stopped doing things in case the treatment didn't work, but quite the opposite, in case it did work, so they would be ready for the pregnancy and the baby. In other words, they conditioned their future and their present on the possibility of receiving the longed-for news. In anthropology, this is reminiscent of Victor Turner's liminal states, where the conditions of identity and belonging are temporarily suspended. But in the case of infertility, this transition phase can last much longer, even years, and can profoundly mark a person's life more than the rites of passage known in the discipline and which are ethnographically delimited.

According to those interviewed, one of the most difficult factors to manage is uncertainty. Infertility and reproductive treatments offer no guarantee of time or success. Furthermore, age, especially for women, adds to the constant state of anxiety and hope. Their optimal fertility declines drastically after age 30, creating more pressure and adding urgency and unease about the increasingly likely possibility of having to resort to egg donation. A 38-year-old woman from Murcia said: "My fear is that I will have to resort to egg donation because at 38 I still haven't been able to become a mother with my own eggs."

A 41-year-old woman from Murcia said, "When I went for a consultation, they told me that my best option would be double donation, since I don't have a partner and after 40 it's not considered viable. The other options, besides being minimal, could be lengthy, expensive, and risky for both me and the baby".

Two women, aged 34 and 35, from Valencia, said, "My partner and I had to resort to male gamete donation, since we are a same-sex couple. The conflict arose when deciding which of us was the most suitable to donate the egg, as we both had the same chances. The interesting thing about this whole process is that the person who donates the egg isn't the one who carries the pregnancy, so we both actively participate in the process."

Regarding social relationships, infertility alters certain family and social ties. Some people prefer to keep their treatments secret to avoid questions, judgments, or evaluations, which can lead to social isolation. Man, 40 years old, Murcia: “We had to resort to sperm donation because I suffer from azoospermia. My wife had to undergo fertility treatments, first artificial insemination and then in vitro fertilization. Today we are parents of a 5-year-old boy. Our families don't know that we had to resort to these techniques. We're afraid they won't feel that our son is their family.”

Woman, 43 years old, Mexico: “I had to resort to double donation because I was a single mother at 41. Obviously, the sperm donation was clear, but I never mentioned that the egg was also donated. People talk a lot without knowing what it means for a woman to carry a baby. My daughter is mine, even though she came from another cell. I've also shared information with her. No one has the right to judge me.” Man, 36 years old, Mexico: “As a society, we have a problem judging everything. We think our beliefs are universal truths. There's a strange morality that judges us for not having children on the one hand, and on the other, judges us for resorting to assisted reproduction. I've even heard people say we buy children. It's really a bit painful.”

However, new support and kinship networks are also emerging through help groups and networks based on shared experiences. These new forms of kinship are sometimes more relevant than the traditional family.

In this sense, digital platforms play a fundamental role, with social networks acting as sources of information and emotional support.

Woman, 33 years old, Buenos Aires: “Thanks to the support group at the association I attend, I've understood the true meaning of being a father and mother.”

Woman, 35 years old; Mexico: “I feel great belonging to the single mothers group; we're like a tribe. We all have something very important in common: our sons and daughters.”

Man and woman, 37 and 36 years old, Valencia: “As a couple, it's been wonderful for us to belong to a group where we share our stories and feel welcomed. Our families weren't as understanding.”

Woman, 39 years old, Murcia: “I felt like this group of people knew more about me than my own family or friends.” This is because of everything they shared, from the diagnosis to having a baby at home, which is more difficult for people who haven't had that personal experience. Some said they felt understood without needing explanations and that they felt more emotionally supported than with their lifelong support groups. In this sense, testimonials like the following make a lot of sense:

Woman, 40 years old, Valencia: “Throughout the whole process, I understood that family is more than just having genes from the same origin. The people in the support groups made me feel like they were more like family than my own.”

Woman, 38 years old, Murcia: “My family viewed my decisions with suspicion. Sometimes they made me feel like what I was doing wasn't right, telling me what other people would think. Other times they ignored me and wouldn't talk to me about it, hoping to discourage me from wanting to be a mother. However, in the association, I felt understood and valued.”

These support groups, including the online ones, where women from different geographical backgrounds, ages, and treatment backgrounds share everything from ultrasound photos to advice and information about treatments and clinics, proved significantly important to the interviewees. However, this large group was sometimes stressful and psychologically exhausting, as members were often given a lot of information and success rates, but other times, when our informants didn't achieve success, they felt a sense of failure that added to their existing feelings.

Woman, 36 years old, Mexico: “At first, I was happy to see the women in the group talking about their pregnancies, but as I experienced implantation failures, it made me angry to read their messages.”

Woman, 38 years old, Buenos Aires: “I thought I would be the next to announce my pregnancy, but it took time. Every time a woman announced hers, it upset me, so I left the group.”

Infertility is more than just the inability to conceive; it changes the structure of family relationships, involving all members. Sometimes they offer support, and other times they cause more pain with certain types of comments that, while not done with the intention to hurt, can still create pain. This is why information about treatments, and even the entire process, is often kept secret, sometimes to the point of women never knowing they have chosen this option to have their desired child.

Many of the testimonies gathered pointed to the feeling of living a double life. On the one hand, they acted normally at social gatherings, and on the other, they organized their lives around the tasks involved in the treatment, such as injections, ultrasounds, and even implantation failures or miscarriages.

In this sense, and given the emotional intensity of their experience, many women exhibited avoidance behaviors, such as children's birthday parties and family celebrations, which led to a certain isolation, adding to the distress already suffered from the infertility diagnosis itself.

Woman, 34 years old, Mexico: "It was difficult for me to go to children's parties or attend family celebrations because it could be hard for me. I knew they were going to ask me questions, and I couldn't give explanations; quite the opposite."

Woman, 35 years old, Buenos Aires: "It hurt me a lot to see mothers and fathers with their children at my friends' children's birthday parties. I wondered why I couldn't be one of those mothers."

In short, the results show that infertility has a series of contributing factors, such as social factors, marital status, gender, and sexual orientation. Currently, assisted reproductive technologies help with conception, but there is a limiting factor stemming from the socioeconomic context of those who experience infertility. Therefore, infertility is not only a physical condition but also a structural problem, influenced by the individual's subjective experience and social and cultural norms.

DISCUSSION

The results show that infertility is not only a health diagnosis. Cultural norms related to gender and kinship exert a strong influence on the personal experience of being unable to conceive (Greil, McQuillan, & Slauson-Blevins, 2011). This experience can be understood from disciplines such as anthropology and sociology. Discourses surrounding infertility reveal that the experience of motherhood continues to be significant in the construction of femininity in contemporary society, despite significant changes in gender roles (Greil, McQuillan, & Slauson-Blevins, 2011). In fact, the association between reproductive capacity and female fulfillment remains very strong.

Consequently, the effects that this norm often generates, as documented in this work, are that people who cannot conceive go through a process of genetic grief and biological loss coupled with a frustrating medical treatment process. Furthermore, it is important to highlight the social threats associated with this situation, such as the sense of belonging to a group, social standing, and even gender identity.

In this sense, the suffering derived from this reproductive process is part of the experience of infertility, which arises from social structures that value and normalize the act of conceiving (Helosvuori, 2020). Thus, reproductive suffering, as we have seen, is part of the social structure.

The informants reported experiencing guilt, shame, feelings of failure, and isolation. These emotions are not only associated with the reproductive process but also arise in situations and environments that legitimize and promote family and kinship models and ties that conform to the established standards of normality in those contexts. These environments continue to stigmatize, even unconsciously, personal histories and life paths that do not conform to the normalized reproductive sequence (Miall, 1989). The privatization of suffering and its confinement to the private sphere prevents collective discussion of the problem and its recognition as a public issue.

This study demonstrates that reproductive technologies can help achieve pregnancy and offspring, but limited public coverage and the privatization of treatments can generate inequality, as they are often prohibitively expensive. Thus, for some, the problem of infertility may disappear, but not for others, who may also experience a significant sense of exclusion (Leyra Fatou, Ayala Rubio, and Cubillos Vega, 2023).

Comparatively, Spanish and Latin American contexts show very similar patterns of reproductive suffering, despite cultural, social, and institutional differences. In both contexts, there is a prevailing pressure to conform to the reproductive norms of each culture and an imbalance in the distribution of responsibilities related to treatment. The emotional burden associated with the possibility of becoming parents through assisted reproductive technologies persists, and informal networks of emotional support emerge to help manage this process. These patterns appear in all the contexts studied. This suggests that contemporary infertility is a transcultural phenomenon structured by the logic of global biomedical capitalism, although clearly mediated by the specificities of each local context (Moll, Ross, and Team, 2023).

From an anthropological perspective, infertility reveals changes in kinship. Infertility shows that kinship no longer depends solely on bodily reproduction. Reproductive technologies offer ways to create a family and allow for families to have more members or variations. Culture continues to value and prefer reproduction that utilizes genes and the body. This cultural preference generates a tension between the possibilities offered by reproductive technologies and the values that culture places on them. This tension arises between the family and the values of society. In this sense, infertility opens a window into how kinship changes with the advent of reproductive technologies, and this difference creates a tension that society must confront (Bestard, 2004). The paradox is that, in many cases, reproductive failure itself forces people to question these value systems and develop more flexible and inclusive concepts of family, care, and belonging.

Fieldwork demonstrates the importance of support spaces, both in-person and digital, which serve as places where people recognize one another and share experiences that are often silenced in other contexts. People generate solidarity and companionship that is helpful because these spaces do not require translation or institutional approval. The existence and vitality of these informal communities reveal, by contrast, the shortcomings of formal

systems—medical, familial, and professional—in providing emotional support to those experiencing infertility (Helosvuori, 2020).

CONCLUSIONS

Infertility is a profound anthropological and sociological phenomenon because it reveals how bodies, emotions, and family relationships are shaped by cultural and political structures. This article has shown that infertility cannot be reduced to an individual medical condition. It is a socially produced experience that affects identities, temporalities, and forms of belonging, and its understanding requires an analysis that simultaneously considers the biological, cultural, economic, and political dimensions of the phenomenon.

The people interviewed described infertility as a rupture in their lives, a rupture that brings isolation, uncertainty, and social pressure. The inability to conceive makes sense in a society that continues to view biological reproduction as a sign of normality and belonging. The fieldwork also showed that people can give new meaning to their experiences, create different forms of kinship, and build caring communities that challenge traditional family models. This capacity for reinterpretation should not be romanticized: it generally emerges from intense and prolonged suffering and should not be used as an argument to naturalize the structural conditions that produce that suffering.

This study also highlighted the inequalities that permeate access to reproductive technologies. Social class, gender, and sexual orientation decisively condition the possibilities for treatment and social recognition. Reproductive technologies, far from constituting a universal, neutral technical solution to the problem of infertility, operate within pre-existing social structures that amplify inequalities while simultaneously opening new possibilities. This dual nature requires consideration not only of biomedical advances but also of the implications of the privatization of clinics that facilitate desired reproduction, but under specific social and economic conditions.

Therefore, from various fields such as anthropology and sociology, it is necessary to question certain social discourses that consider motherhood an obligation or biological reproduction the only form of family. When infertility is considered a social problem, the burden of individual guilt is transferred to the structural conditions of the social context that generate the suffering associated with infertility. This shift has political consequences. It indicates that public policies must guarantee equitable access to fertility treatments, recognize different family structures, and address the cultural narratives that generate stigma and silence. Institutional recognition of reproductive suffering as a public health and social justice issue, and not merely as an individual medical matter, would constitute a first step in this direction.

Currently, reproductive biomedicine is advancing, and fertility is becoming a business. Anthropological and sociological analysis provide tools for understanding the moral, emotional, and political aspects of reproduction. Sociological analysis examines the class, gender, and power structures that influence access to treatments and shows how reproductive suffering is distributed unequally. Anthropology can record how people experience these structures, reinterpret them, resist them, or become trapped within them. The union of these two disciplinary traditions is both possible and necessary. It allows us to explain the complexity of infertility, a phenomenon that lies at the intersection of the intimate and the political.

Infertility forces us to rethink kinships beyond biology. When attempts to have children fail, people create community, care, and intimacy. The emotional toll is heavy. Amidst this emotional toll, unexpected bonds emerge, bonds that demonstrate that kinship is never solely a matter of blood. Kinship is also, and above all, a way of imagining who stands by people when the stories they tell about life no longer suffice. And perhaps therein lies the most revealing paradox of all: in societies obsessed with producing biological life, many people discover that emotional survival depends, above all, on the social bonds that sustain them.

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