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'All planned babies must be born':
Women's experience of infertility and assisted
reproductive technologies in Hungary

Intersections. EEJSP

8(3): 30-47.

<https://doi.org/10.17356/ieejsp.v8i3.874>

<https://intersections.tk.hu>

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Abstract

In recent years, the issue of reproduction has been increasingly thematized in Hungarian political discourse. This has not only occurred at the discursive level, but the government has also introduced new policies regarding reproduction and family life, thus new regulations have been introduced concerning the medical practice of IVF and other ART which have affected practices associated with infertility. The article aims to discuss the ways that policies and discourses shape the views of women struggling with infertility. The medical and political discourse seems to emphasize the responsibility of women in relation to fertility-related issues, despite the fact that the problem also affects men. Furthermore, with the increased surveillance of women undergoing assisted reproductive treatment, the importance of the latter's self-reflexivity, discipline, and responsibility is emphasized. To discuss these issues, the article uses a multi-method approach. The primary data source is in-depth narrative interviews with IVF participants, supplemented by the analysis of political discourses about childbearing and infertility which help in the examination of how different policies and discourses shape individual experiences and desires. I argue that recent policies on IVF and related medical discourses and practices can potentially emphasize the responsibility of women. Women who cannot or do not want to reproduce may be presented as selfish or treated with pity, and these notions are intensified due to the government's explicit pronatalist agenda, which only supports those who conform to conservative heteronormative reproductive standards.

Keywords: infertility; assisted reproductive technologies; reproduction; biopolitics; population policy

1 Introduction

This article aims to describe different factors associated with participation in IVF treatment in Hungary; the main research question is whether policy changes and the conservative discourse on gender roles appear in participants' individual reasoning for choosing IVF. Another important goal was to show how different discourses and narratives about femininity appear in personal experiences regarding childbearing and IVF.

In recent years there has been a growing tendency to discuss reproductive issues in Hungarian political discourse. This interest in women's reproductive capacity not only has affected symbolic matters but has also appeared in policymaking. The new measures are often framed as family-friendly policies. In parallel, the government started a media campaign to popularize family life and values and declared 2018 the Year of Families. In 2020 a new ministry was created which is responsible for family and youth policy matters. The current President of Hungary, formerly State Secretary for Family Affairs, Katalin Novák explicitly stated that the government's motivation for supporting families is to stop the population decline, which is, according to Prime Minister Viktor Orbán, one of the most crucial problems Hungary is facing today. Based on these tendencies, it is not surprising that infertility and assisted reproductive technologies (ART) have come to the attention of current Hungarian political discourse and policymaking. At the end of 2019, the government nationalized private IVF clinics and made infertility-related drugs free of charge. In parallel with this, a new scientific institution was created called the National Human Reproduction Laboratory, which received significant state support. The head of the laboratory stated that the institution aims to ease Hungary's demographic crisis; therefore, the main goal is to help make up for 'the missing 300 thousand children who cannot be born because of infertility'. The laboratory's mission is to conduct research about infertility-related questions and popularize new technologies to raise the success rate of ART. Members of Fidesz, the ruling party in Hungary, often refer to themselves as the only political force that prioritizes fertility. With the slogan 'all planned babies must be born', the government's explicit intention is to help people who struggle with infertility, while on the other hand having the broader motivation of stopping population decline.

However, they are not the first to attempt this, as discourses and policies on this matter have existed for a long time. For example, state-socialist Hungary adopted legislation such as an abortion ban in the 1950s; moreover, demographic issues were topics of intense public debate among intellectuals in the state-socialist era (Adamik, 2012; Heller et al., 1990). Hungarian discourse about the decline in the number of newly born children has often tended to place the blame on women's participation in paid employment, the eradication of traditional family values, and access to abortion (Kövér, 2015). Women are often portrayed as those responsible for the fate of the nation and humankind per se; thus, it is they who should be held accountable for demographic changes, according to this ideology (Ginsburg & Rapp, 1991). From this perspective, examining discourses about infertility and associated technologies is crucial for understanding the country's reproductive regime, because this can show how (political) power treats women who do not reproduce 'as expected'.

This paper aims to analyse the relationship between personal experiences of IVF treatment and the public discourses that target infertility. The main goals of the research were to give voice to women who are participating in assisted reproduction procedures, to understand how the experience of infertility affects everyday life and practices, and to identify how these experiences are affected by the different agents that shape reproduction regimes.

Feminist methodologies emphasize the importance of inquiring into women's experiences and narratives because it is crucial to collect women's accounts of their own lives to understand how they construct their experiences with infertility (Oakley, 1981), thereby creating knowledge. Without this perspective we cannot fully understand how different discourses affect individual life decisions. In this regard, state legislation must be taken into account. State support has covered the cost of five rounds of IVF treatment per person since

2017, although the rate of support has increased since then because if a woman participating in an infertility program has a child due to one of the first five treatments, she becomes eligible for an additional four state-funded tries, given that she is willing to undergo the IVF procedure again.

Through the increase in support for fertility treatments and political discourse on population decline, the state encourages women to participate in infertility treatment. At the individual level, giving up on the option to participate in IVF treatment can potentially lead to self-recrimination because one may feel that one has not tried everything possible to successfully become pregnant. For the sake of understanding the connection between reproduction and different power relations, the article first briefly presents theoretical approaches related to the issue of biopower, then shows why it is crucial to examine patients' experiences in the medical field. In the second part of the article, ten in-depth interviews are analysed in order to understand how infertility-related issues interlock with wider social processes.

2 Why does reproduction matter?

The state has an interest in regulating private matters that affect individual life decisions, and in this regard Foucault (1990) argues such techniques could be defined as 'biopower'. The main task of power is to organize individual and collective forces to maintain economic development, the basis of which is the reproduction of the population; therefore, population policy is an essential political tool. According to Foucault, biopower not only creates regulations and legislation but has a strong influence on designating the worthiness of people in society. Furthermore, Rose (1990) points out that power practices that seek to influence mental inclinations and abilities (for instance, the social construction of institutions such as the family) can elicit strong emotional reactions and feelings at an individual level, and have the ability to shape identity. The new truth regimes are associated with subjectivity as they are intended to stimulate those who they affect and influence their desire to maximize individual capacity (Rose, 1990). As Memmi (2003) argues, biopolitics nowadays appears in new forms. State legislation exists in this regard but policies are typically not normative nor prohibitive; instead, they promote responsibility to their users. As a consequence, a discourse of surveillance appears in conversations with the representatives of different state-regulated institutions (Memmi, 2003).

In the case of infertility, the latter representatives belong to the medical field. Hence, medical professionals have a substantial role in individual decision making connected to reproduction since doctors have the proficiency to interpret what is happening in the patient's body and provide information and insight which form the basis of decision making. In this sense, medical professionals play an indispensable role in articulating individual choices – i.e., a doctor can suggest whether to continue IVF after unsuccessful treatment, but the final decision will be the patient's responsibility. Further analysing the phenomenon, Memmi adds that with the invention of new technologies which have made it possible to visualize what is happening inside the body (e.g. prenatal screening devices), new terrains of body surveillance have emerged. While discussing what can be seen on a monitor, medical professionals can also manipulate patients' feelings through how they formulate their sentences (Memmi, 2003; 2012; Petchesky, 1987). ART expands this visibility even more because the bodily processes of fertilization become visible long before conception, thus have the potential to extend patients' responsibility in time.

However, it is not only the state and its representatives that are concerned about these processes; reproduction is not only regulated by local powers but global market relations too, as some scholars who are interested in the capitalization of biomedicine have noted (Rose, 2009). As Russel (1994) argues, capitalism encourages the commodification of reproduction, which is particularly true in the case of ART. As several authors have shown, ART uproots the distinction between the oppositions of public and private, and of nature and culture, as it frames conception through an institutional lens (Franklin, 2013; Haraway, 1991; Thompson, 2005). The relations involved in this matter merge into a phenomenon which cannot be fully understood as a local and state-regulated problem, but rather as a global, transnational issue – as growing numbers of people travel abroad in order to participate in treatments which are forbidden or too expensive in their home countries (Inhorn & Birenbaum-Carmeli, 2008; Nahman, 2016). This shows how, with the technology of in-vitro fertilization, new agents with economic interests can enter the realm of reproduction. For instance, in the case of egg donation and surrogacy, the human body becomes an investment, and market relations and personal qualities shape the product's price (Malmqvist & Zeiler, 2016). One may rent one's own body parts to another, but the practices that have become available due to the invention of in-vitro fertilization usually involve a third party; namely, fertility clinics that intend to profit from such bodily exchanges.

It is also essential to examine how infertility is constructed in the medical field. Several authors have shown that the sciences related to the body can also be understood as cultural systems that reflect ideologies about how gendered bodies should behave (Ehrenreich & English, 2010; Laqueur, 1990). This cannot be separated from the medicalization process, which has also affected the construction of infertility. As individuals enter the realm of healthcare, the health-disease categorization, in addition to the individual perceptions and definitions thereof, becomes located within an institutional framework whereby medical authorities define health-disease on scales based on specific criteria. This process can also be viewed as a transition between the private and public spheres. The problem (illness) then ceases to appear as a personal matter but rather as the shared problem of several actors that requires collaboration for its solution (Thompson, 2005). In this respect, infertility is special because the individual does not become infertile or 'ill' until they decide to have a child, hence infertility does not usually become a reality for underlying pathological reasons but is instead declared when the desire for a child is articulated (Greil et al., 2011)

Another important consideration is how social conditions are constructed at the institutional level – i.e., within the reproduction clinic. According to Foucault, one of the characteristics of any medical environment is that the individual appears objectified within the medical context: during examinations undertaken at a clinic the patient is not usually present as an active participant but regarded as an objectified body to be examined (Foucault, 1994). Nevertheless, during the IVF process the individual or the couple need to attend numerous medical consultations at which, in addition to making decisions, self-presentation becomes an important aspect. According to Thompson (2005), part of the process involves how the couple applying for IVF treatment construct their own relationships in the institutional space. Hence, it becomes important for the couple to 'behave well' – i.e., to act according to social norms and be polite with each other as well as with doctors and assistants. It is also in the couple's interest to show that they have a stable and well-functioning relationship or they may be considered 'unworthy' of having a child by the professionals. If their beha-

viour does not meet the expectations of the professional staff, they may find themselves in a disadvantageous situation – which reveals another aspect of the power relations between the patient and the medical field.

The professional and scientific environment surrounding infertility is dominated by men, which may lead to women's perspectives and needs being less well articulated within the walls of such institutions. On the other hand, it is important to see that infertility can affect men as well, but related treatments such as IVF or insemination are performed on women, typically in the form of invasive interventions affecting the female reproductive organs. In contrast, male fertility treatments are performed outside the man's body, and if the problem is not localized in the case of the woman, she continues to be the focus of medical monitoring. It is she who has to become the patient, as the embryo(s) are implanted in her uterus during the IVF treatment. It is also the woman who needs to take more medication, undergo hormone stimulation, attend ultrasound check-ups, and then receive an implant, and – provided the IVF procedure is successful – give birth, or if there is a problem, have a miscarriage at the end of the process. Nevertheless, the medical discourses surrounding ART often do not reflect on women; instead, they tend to focus on the couple as a male-female ensemble; and what is more, the embryo, the future child, becomes the centre of attention (Van Der Ploeg, 2004).

Women who cannot or do not want to reproduce may be presented as selfish or treated with pity. The present conservative anti-liberal government strengthens the notion that for women the most sacred duty is to become a mother, thus the focus is not on women's well-being but on the usage of their reproductive capacities to stop population decline. Moreover, direct and indirect pressure to participate in IVF can also come from the microenvironment, such as from a partner or family members, but IVF-related legislation also shapes the related decisions (Throsby, 2004).

3 Methodology

Ten in-depth narrative interviews were conducted with women who had participated in IVF. In order to find participants, interview invitations were posted in thematic peer-support Facebook groups for women who were participating in IVF treatment. Despite the large group membership, only six women replied; the rest were found using the snowball technique. This may indicate that infertility is a stigmatized experience: some of the interviewees mentioned that they felt that talking about infertility is taboo, and they chose to give interviews because they wanted to make infertility and IVF experiences more visible. Due to the COVID-19 pandemic, all interviews except for one were conducted online. The length of the interviews varied between one-and-a-half and three hours. Participants were asked to relate their life stories in the context of the infertility experience and IVF treatment. Most participants were in their late 30s or at the beginning of their 40s, the youngest participant being 33 years old and the oldest 44. Seven women were participating in the IVF process when we conducted the interviews; most of them had had several IVF and inseminations before. Three participants had biological children from a previously successful IVF treatment, and one had adopted a child. Six out of ten women were living in Budapest; the others in rural areas. Seven of them possessed college degrees, and three of them had a medium-level education. All of them were employed when the interviews were conducted. All of the par-

ticipants were married – two of them had decided to get married because they felt it was the easiest way to prove their relationship status, which is required for participation in the IVF treatment. Interviewees' names and personal information have been anonymized. In the individual narratives, infertility is almost always described as a stressful experience, which can destabilize the identity of the affected women. The analysis of the interviews aims to show how different actors and discourses interlocked with the individual narratives of infertility. In the analysis, thematic topics were outlined, including the reasons for delayed childbearing, the effect of state-funded IVF on individual decisions, financing IVF treatment, criticism of the medical field, and the effect of medical imaging throughout the treatment.

4 Discourse about family and the transformation of IVF regulations

Since 2014 Hungary has adopted new social policies and measures which mainly target heterosexual families who have or are planning to have children. However, several studies have shown that these new measures primarily address those in a better socioeconomic position, as they can only be claimed on the basis of insurance connected to income (Fodor, 2022; Szikra, 2018). Moreover, the so-called anti-liberal, conservative political agenda also strengthens narratives that focus on the demographic crisis, and as a consequence popularizes pronatalist ideologies and in parallel rejects immigration. As prime minister Viktor Orbán said at a Demographic Conference 'Our opinion is that we must solve the demographic problems by relying on our own resources'.

The main political narratives associated with gender equality have also been transformed. The conservative government has started an anti-gender discourse which has had numerous consequences such as the rejection of the ratification of the Istanbul Convention, and a ban on gender studies in Hungary. The emphasis is not on gender equality but on the importance of family and traditional values. In the mainstream political discourse femininity is sentimentalized and connected to motherhood and carework (Fodor, 2022). For instance, State Secretary of Family Affairs Katalin Novák published a video entitled 'How can a woman be successful?' in which she said 'Let's experience the beauty and harmony arising from the difference between men and women. Dare to say yes to having children! Dare to be there where no one else can replace us!'. Womanhood, femininity, and gender inequalities are essentialized. Reproduction and care are shaped as women's responsibilities and childbearing is a simple matter of choice in this narrative. According to the Hungarian Constitution, the family is an ensemble of a woman and a man with their children. Those who do not reproduce are considered outside of the natural order of the sexes because they do not fit with the conservative heteronormative standards of the government.

The nationalization of fertility centres and the increase in state support for drugs fits the pronatalist ideology of the nation, yet access to fertility treatment is not open to every Hungarian citizen. According to the law, both heterosexual couples and single women may claim state-supported IVF, but the claimant has to present medical proof of their infertility, thus non-infertile single women cannot attend fertility treatment, and lesbian couples are also excluded. The maximum age of the applicants is also regulated: women cannot receive state-supported treatment at over 45 years of age, whereas there is no age limit for male participants. Gamete donation is allowed in Hungary but egg and embryo donation must

happen on an altruistic basis. On the other hand, sperm can be purchased from Hungarian and foreign sperm banks, but insurance does not cover the cost of this process. It is a well-known medical fact that the success of IVF and fertility decreases with age, while treatment for older patients is more liable to be successful if donor gametes or previously frozen eggs are used. However, egg freezing is illegal in Hungary except for in some cases when the claimant's reproductive health is at risk. The geographical locations of the fertility centres are also crucial in terms of examining access; there are twelve institutions in Hungary; seven are located in the capital Budapest and the others in bigger rural cities, but there are no clinics in Northeast Hungary where the population has a lower average income and socio-economic status (KSH, 2021), thus accessing fertility treatment may be more challenging.

5 Decisions associated with childbearing and the use of IVF and ART

Participant narratives reveal that even though public political discourses often blame women's emancipation for population decline, in reality the timing of childbearing is a multi-dimensional issue that cannot be reduced to simple explanations. It is a well-known fact that fertility decreases with age, but in Hungary, as in most European countries, the time of having a first child is increasingly being delayed. According to census data, in 2011 11.2 per cent of women over the age of 41 did not have children (Szabó, 2015). Highly educated women in the capital city of Budapest are overrepresented among the childless, but one should also note that they are not the only ones in this group, as unhealthy relationships, poor housing conditions, uncertain labour market prospects, as well as expectations regarding childbearing can also be important factors in having a child at a later stage of life, or not wanting offspring at all (Szalma & Takács, 2014).

Analysis of the interviews showed that delayed childbearing is related to fertility problems, but the reasons for postponement can vary from person to person; we cannot say that the only reason for this decision is higher education or socioeconomic status. Participant narratives highlighted that delayed childbearing often could not be described as a 'decision' because in many cases it was not a conscious choice, but certain circumstances had led to postponement. Six participants started childbearing after they turned 35. Seven out of ten women had, as they described it, a good financial status. However, this group cannot be seen as homogeneous; one woman claimed that the reason for her delayed childbearing is that she had been focused on her career before, while other participants said that circumstances had not been suitable; for example, they had faced expectations from within their microenvironment, while others had relationship problems such as infidelity, or issues with the substance abuse of a partner. Angéla (44), a highly educated woman who had gone through eight rounds of IVF before, mentioned that even though she had wanted children for a long time, her husband was not ready to start a family. Angéla now thinks that postponed childbearing is her fault. 'I could have been more determined'. She feels that she is responsible for the situation: 'I didn't pursue my own goal in this regard. Sometimes I think if I had really wanted a child... because, you know, they say it happens to you if you really want something. But that's just this new-age nonsense. At least this is what I'm comforting myself with' (Angéla, 44). Angéla's narrative illustrates rational explanations for postponed childbearing; she knows the reasons for the delay but still blames herself for the situation, even though it was

her husband who did not want a child earlier on. The responsibility for childbearing is associated with women, which manifests in individual reasoning and subjective experiences, as well as in public discourses that blame women for population decline and the low fertility rate.

5.1 Social expectations about childbearing

The discourse about the constraints of childbearing almost exclusively addresses women, although reproduction according to the traditional political narrative is only desirable within a heteronormative frame that designates the appropriate age of the women. For instance, the 'biological clock' is a female construction; women who wish to reproduce at an older age are often portrayed as irresponsible or selfish; however, older men do not face the same judgment (Thorsby, 2004). Teenage motherhood also falls outside the normative reproductive age, thus is constructed as a stigmatized experience (Yardley, 2008). Angela mentioned that she had experienced intense pressure from a young age to avoid unwanted pregnancies. Now she thinks that these warnings had implanted a sense of anxiety about getting pregnant later on in her life. 'But if I could do it all through once again, I wouldn't be so scared that I might – and I'm not saying this against my husband right now – I wouldn't be so afraid I might get pregnant [...], I wouldn't be as terrified of an unwanted pregnancy. Now I am just afraid that the desired pregnancy will not happen'. Angéla's narrative highlights how women are faced with norms about reproduction from the age they reach puberty. First, the taboo of teenage pregnancy can generate long-term fears about childbearing, as happened with Angéla. According to her, it was partly this fear that may be held accountable for her delay in childbearing. Later in her life she experienced this 'fear' from the opposite direction – namely, that she could not conform to societal norms and fulfil her subjective desire to have children and become a mother. These intense pressures, which range along the axis of prohibition and coercion of reproduction, primarily target girls and women and can manifest in self-blaming, as in the case of Angéla, who on the one hand rationally knows that her infertility is not her fault, but in her narrative acknowledges explicit feelings of shame and self-criticism.

Rebeka, a 40-year-old lower-class woman from a rural area, delayed childbearing because she felt the intense pressure to become pregnant at the age of 18 from her own and her husband's family: 'I was very young, and they always asked me when I would get pregnant: "why the wait!? You are an idiot if you don't want it yet!"' (Rebeka, 40). This excerpt shows how even though childbearing is an individual decision, societal norms affect decision-making. In the women's microenvironment, having children right after finishing school was almost obligatory; their reproductive decisions were under inspection by those who had already completed the normative task of bearing children. Angéla and Rebeka have very different societal backgrounds, thus the (micro)surveillance of reproductive decisions manifested in different ways; for Angéla, having children at a young age was not an option because she had to finish higher education and then start her career. For Rebeka, it was the other way round; she was expected to start a family after finishing mid-level education; this corresponds to the notion that delayed childbearing might be more usual for those of a higher socioeconomic status, but the women's narratives shows that we obviously cannot demarcate a homogenous group in this regard, in contrast to the government's primary discourse that infertility can affect any member of society despite educational or income status. What these two narratives have in common is that the respondents faced expectations about reproduction at both the micro and macro level.

Although Rebeka, at the age of nineteen, had not conceived for a year after trying, she started using birth control again. She wanted to wait with childbearing until she 'felt ready' – in a way, she was confronted with the expectations of her environment: 'We didn't even use birth control for a year, but I didn't get pregnant, and everyone was nagging me, and of course they didn't know that we hadn't been using contraception. It was so frustrating, and I decided that I didn't wanna get pregnant yet'. Nonetheless, Rebeka's decision can be interpreted as that she successfully managed to break through the expectations evinced towards her. However, she feels ambivalent about this choice: 'It was because of me that we started this [IVF process] so late, because I wasn't ready for it yet. I'm aware that if I had decided sooner we might not be here – but we might be as well; who knows? Because of this, I blamed myself a little bit, and sometimes I questioned what kind of woman I was that I didn't want a child when others already had a child or two. But I couldn't do it – it took me a while to get there, and I can't blame myself for that'. Fertility/reproduction, as stated before, is framed as women's responsibility; this can be seen in Rebeka's narrative when she questions her womanhood because of her desire to postpone childbearing. Motherhood in this narrative is inseparable from the construction of femininity. The notion that infertility means that one is not a 'real' woman is a recurrent topic in participants' narratives; for instance, one respondent said that 'I feel like a half-ready woman' because she cannot have a child 'the natural way'.

Most participants said they decided to have children when they had created adequate material and emotional conditions, such as having their own house and a stable long-term relationship. For example, one participant Judit (37), who had wanted to have children from a very young age, mentioned that she had had several long-term relationships, but none of her previous partners wanted to have a child yet; this was among the reasons she thought the relationships had ended. However, when she met her present husband, he had expressed that he wanted to have children with her very early on. 'That night was so memorable, and I said to him "okay, then I will stop smoking", and I did, and I started to take prenatal vitamins; overall, I started taking care of myself so that the baby could come, but it didn't [come]'. The woman's narrative shows that she was determined to have a child; she was only waiting for the right partner to come in order to conceive. She and her husband decided to have children together one month after they met. However, her partner was not willing to give up smoking and consuming alcohol; it was Judit who started paying attention to her health in the hope of a future pregnancy.

5.2 Micro effects of fertility policies

Discourses around IVF also involve prohibitions about quitting the treatment. As Thorsby (2004) argues, whether to proceed with IVF can hardly be described as neutral decision as several factors impact the process, including one's partner, family members, and the provision of funding. Stopping IVF is portrayed as a failure. In these discourses, successful IVF is only a matter of trying harder. For instance, in online forums one recurrent topic involves disapproval of stopping IVF before a successful treatment has occurred; with the available state support, the discourse of prohibition may become more potent because it manifest not only as a personal subjective feeling, but as giving up on a material opportunity. Even though some participants started to think about quitting IVF after several unsuccessful

treatments, they did not want to give up mainly because state-funded opportunities were available. For example, Szilvi, who has had four rounds of IVF, said: 'Yes, we are thinking about having a fifth [round of IVF], but I'll tell you honestly, I have gone through a lot of pain and misery, and I'm a little bit afraid of doing it again. I have my daughter now [adopted]. What will happen to her if I become ill or something? So I feel that I'm between two fires. My heart says that if I don't try it again, I will regret it later' (Szilvi, 33). Szilvi explicitly stated that she is only considering the subsequent treatment because she would not need to pay for it. She feels that if she does not try she will waste an opportunity, even though she has had two extrauterine pregnancies from the previous rounds of IVF, and her doctor told her that she has a significant chance of a high-risk pregnancy if she conceives. It can be seen that IVF, in Szilvi's case, is connected with anxiety, both bodily and emotional. These worries are linked to the well-being of her adopted child.

Another participant also reflected on the effect of state funding. After three unsuccessful rounds of IVF and several inseminations, Andi started considering adoption, but said 'I decided that as long as there is a state-funded option, I won't give up on having my own biological child' (Andi 35). This shows another effect of the state funding for IVF: namely, that it might strengthen the importance awarded to biological kinship. Kinship is a crucial question regarding IVF; the solution for infertility could be the adoption of a child, but in the main narratives a genetic relationship is usually constituted as 'real' parenthood. Seven out of ten participants expressed that they wanted to have a genetic connection with their future child, although three of the participants said that they would consider adoption if the next round of IVF were unsuccessful. Kata, a 36-year-old woman who has a biological child from previous IVF treatment, said, 'I would like to experience pregnancy and breastfeeding once again, and I would feel a little better if I had a child whom I could take care of, so to speak, from the start, during pregnancy, so that the baby's mental and physical well-being depends on me. With a careless pregnancy, you might get a child of an alcoholic, or a drug addict mother... so this also has [is associated with] its own mental and physical health risks.' Kata and her husband are now considering IVF using donated eggs, which is strictly regulated in Hungary, but the treatment could be done under market conditions in neighbouring Slovakia or the Czech Republic for a relatively low cost.

We can assume that such medical services have become more prevalent in the last few years among Hungarian couples; for instance, foreign fertility clinics in the Czech Republic and Slovakia and even in Ukraine have Hungarian websites and offer Hungarian patients translators. For Kata, the experience of bodily closeness and the prenatal period is extremely meaningful; this notion of closeness could substitute for a real genetic connection; this may be one reason to choose IVF with donated eggs instead of adoption. At the same time, Kata is not entirely against adoption because 'if all else fails, it will be adoption because the desire to raise a baby and diaper [sic] him and everything is strong in me'. For her, the issue is not only about biological kinship, but bodily connection is prioritized, thus adoption is a real, if final option. This shows that the experience of pregnancy is strongly connected to the process of becoming a 'real mother'. Other than that, we can see that there are normative ideals about optimal pregnancies, which, as many feminist scholars have shown, are linked to the medicalization process which has turned pregnancy into a highly surveilled phenomenon (Ehrenreich & English, 2010); accordingly, if a pregnant woman is not behaving in line with medical norms, she is perceived to be endangering her future baby.

5.3 IVF and conservatism

Another ambivalent factor that influences even individual-level decisions is the conservative and Christian orientation (support for religious norms and strong involvement of churches in public life and politics) of the current government. Despite the large amount of state funding, IVF is a controversial technology that has not always been supported by the government. Fidesz, the ruling party of Hungary, governs in coalition with KDNP; both describe themselves as Christian conservative parties, and their representatives constantly emphasize the importance of Christian values on a discursive level. Although we cannot say that they are connected to any specific Christian religion, they enjoy the support of the Hungarian Catholic Church, yet Christian dogmas do not have a direct impact on policymaking (Ádám & Bozóki, 2016). According to Catholicism, IVF and other ART treatments are sinful because they are acts against nature. The Catholic Church believes that life starts at conception; thus, one of the main issues with IVF treatment is that the process usually involves embryo freezing; after the treatment, the unimplanted embryos are often used in scientific research, or in some cases medical staff destroy the unused embryos, which runs counter to this religious dogma (Radkowska-Walkowicz, 2018). One of the leading bishops in Hungary, András Veres, has expressed criticism of such state support and demanded a ban on IVF and other ART in Hungary. Orbán, the leader of the ruling party, stated that one of the reasons behind the nationalization of the fertility centres is that the government could then supervise what happens in these institutions. On the other hand, as mentioned before, the government also stated that they support IVF for demographic reasons. One participant who had had IVF before the increase in state support reflected on the political reasons for funding ART: 'They [government actors] said that IVF is from the devil, and it's artificial, and so on, so the whole political attitude was kinda religious. But they changed their attitude because there are hardly any Hungarians left, so it doesn't matter at what cost, the goal is to increase the number of Hungarians' (Hédi, 42). Based on this, it appears that several actors are shaping the discourse around ART; religious narratives are present in Hungarian society and affect the representation of IVF. In the end, the effect of religious dogmas in policymaking related to IVF is less influential than the demographic aspirations of the Hungarian government.

Three research participants mentioned the issue of the relationship between religion and IVF in the interviews; one of them described herself as Catholic, but she felt that having a child was more important to her than the Catholic opinion about IVF: 'I had this ambivalent feeling, is it ethical, is it okay to play God? But the desire to have a baby was stronger than this' (Hédi, 42). IVF is a good example of how religious discourse can lead to blame in relation to these techniques, yet the Church often states that life without children is worthless. Veronika, a participant who lives in a rural area, told me that she often hides the fact that she is participating in IVF because she feels that people judge her for this decision, although she was reaffirmed in her decision by her strongly Catholic relative: 'I told her that we want a baby, and she nailed the question: "are you using IVF?" and I was completely frozen and told her the truth. She told me that she knows it's not easy, and you need a lot of strength to do that.' The woman was relieved that even though her relative was Catholic, she was not against IVF and was compassionate. This shows that even though the Catholic Church is formally against ART, this does not necessarily mean that people who consider themselves religious are critical of the technology. For instance, one Polish study showed that while most Polish citizens are Catholic, 75 per cent of Poles can accept the use of ARTs in the case of infertility (Radkowska-Walkowicz, 2018).

6 Women's experiences and the medical field

Even though IVF and other form of ART are state-funded in Hungary, most participants stated that they had spent a significant amount of money on the treatment, although most had started their first IVF cycle before the new legislation on ART had been introduced in Hungary. All women were participating in state-funded IVF, but some had to finance the treatments by themselves because they had completed the five state-funded rounds of treatment. Angéla, who has had eight rounds of IVF, said that 'other people invest in real estate, we invest in having a baby'. This illustrates how the usage of ART moves childbearing from a private individual experience to a public commodified process, which cannot be understood without acknowledging the processes of capitalization associated with childbearing. Moreover, these processes not only affect material practices but may transform the notion of childbearing at the individual level – for instance, in Angéla's narrative, we can sense that the project of having a baby has a price, thus childbearing might become objectified. In countries where ART is only available under market conditions, some authors theorize that it serves as an implicitly eugenic attempt to regulate the reproduction of 'unworthy' people (Daar, 2017). In Hungary, the construction of 'unworthy' patients is based on social class affiliation, gender, sexual orientation, and age. For instance, women older than 45 are excluded from state-funded IVF participation, but there is no age restriction regarding male participants. On the other hand, the chance of successful IVF at this age is meagre, and while some techniques could increase the chance of getting pregnant, these are strictly regulated. For instance, egg freezing is only available for women who work in dangerous environments or have an illness that endangers their reproductive capacity. Other technologies are also not available in Hungary, such as egg and embryo donation under market conditions.

Another aspect of having state-funded IVF is that there is that usually a long waiting list for the treatment; most research participants mentioned that they had to wait several months before their first appointment with infertility physicians, and most women reported that they applied to have additional examinations in the market-based medical sector to speed up the process. One participant, Judit, faced a year-long waiting list before she could be treated with IVF. However, her doctor offered her an opportunity: 'He said if I don't want to lose out on a state-funded occasion but I don't have enough money I am lucky because a Swiss pharma company is doing a study at the fertility clinic, and if I were willing to participate they would pay for the IVF and all additional costs. I would only have to take a pill before the IVF. We had spent almost a million [forints] by then, so I agreed' (Judit, 37). The woman's experience shows that there are actors other than the patients and the state who have an interest in infertility-related medical treatment. This correlates with the idea that under capitalist relations practices associated with childbearing are increasingly commodified, thus the private matter of wanting children may be transformed into a phenomenon of market interest. Pharmaceutical companies have financial interests in this area, so in this case we can say the female body becomes a new area of capital investment, with the patient's body being an object in this relation (Mies, 1987; Russel, 1994). The doctor's reasoning/role in persuading the patient to accept such support is unchallengeable, which fits the concept of delegated biopolitics, but in this case the physician represented the company's interests instead of those of the state.

State-funded IVF can be helpful for people struggling with infertility, particularly for those who have lower socioeconomic status. However, according to the interview parti-

participants, there are several downsides to it. Most interview participants expressed some form of criticism towards the medical professionals and fertility clinics. The majority of participants felt that most doctors do not have enough time or interest to examine the causes of infertility and decide to start in-vitro fertilization before doing proper medical examinations. Participants described this as a highly frustrating experience because, in some cases, their infertility remained unexplained. Unexplained infertility is often the target of psychological discourse; four out of ten participants had unexplained infertility and three of them had started researching the psychological reasons that could lie behind their problems and had attended psychotherapy in the hope of solving their fertility-related challenges.

Mainstream psychological discourse about infertility may interpret the problem as related to women, which can lead to self-blame, even though the dysfunction of the male reproductive organs can cause infertility. Psychological discourses may target women because research has pointed out that infertile women display more distress than their male partners, thus they might need more support from psychological professionals (Deka & Sarma, 2010). Moreover, males are less likely to seek help when facing mental health issues (Addis & Mahalik, 2003). An analysis of practices associated with pregnancy and birth showed that discourse and information regarding childbirth and foetal development almost exclusively targets women (Rapp, 2000). This also seems to hold true in relation to the psychological practices connected to fertility issues. Emese, a 40-year-old woman who had unexplained infertility, said: 'I had a friend who had a closed fallopian tube – in her case it was evident and their first IVF was successful because they knew what had caused it, it had a real physical reason. But it's hard when you have no reason, and then you realize that it must be psychological'. After several unsuccessful rounds of IVF, Emese attended psychotherapy, where she mainly discussed questions related to her femininity; afterwards, she decided to quit her job at a multinational company where she was in a leading position. The reason for this decision was because she thought that she and her partner might have fertility issues because she was in a better financial and occupational position than her husband, which destabilized the 'natural' gender roles between them. This kind of psychological explanation involves a normative approach regarding gender roles and the gendered division of labour.

One participant who had unexplained infertility expressed her criticism of the medical field: 'Doctors don't really care about finding the reasons because it's probably too expensive, and in most places they think one round of IVF will succeed, and that's it'. These concerns regarding the quality of medical care are common, and show that medical and governmental aspirations may promote the use of ART instead of finding the cause of infertility and treating it with a less invasive procedure, thereby putting women in a less advantageous position (Ryan, 2009). For example, one participant mentioned that she had experienced long periods and strong menstrual cramps; she described these symptoms as almost unbearable, thus she went to her gynaecologist. 'He never examined me with a pelvic ultrasound, and he said that my symptoms must be psychological because I had had so much trauma in the past'. Feminist analysis has shown that women's pain is more likely to be seen as caused by psychological issues than biological ones. This respondents' narrative strengthened this notion, as she was later diagnosed with endometriosis, which in many cases is disregarded by medical professionals because cramps are seen as a natural part of menstruation (Cleghorn, 2021).

Furthermore, there were cases when infertility remained unexplained because it was due to male reproductive dysfunction, but doctors only examined issues with women and did not recommend semen analysis or any other tests on the men. 'I have to say, they were

absolutely careless. I had to apply for the semen analysis and a lot of other medical check-ups on my own account'. This shows that infertility and reproduction are often associated with women even by trained medical professionals; discourses and practices target women's bodies and construct infertility as a problem related to women's reproductive organs. This might have consequences in medical practice, such as not investigating male infertility properly. The blaming of women for infertility appeared in the context of treatment and in the participants' microenvironment as families and friends often suggested that the problem could be the women's fault. 'My mother-in-law said that it is certain that it is not her son who has the problem, but me, and this caused me such remorse that I cried for weeks' (Kata, 36). Later on, the doctors realized that the problem lay with Kata's husband, but the interview excerpt highlights that reproductive matters are constructed as women's responsibility, which can lead to severe psychological distress.

Criticism of IVF treatment is often targeted at the behaviour of medical professionals. Participants mentioned doctors' statements that devalued women and their experiences¹; for example, when Hédi asked for help because she had had ovarian hyperstimulation syndrome, which is a severe health complication, her first doctor said that 'women are always whining, I don't like that'. Most participants mentioned that the medical professionals were indifferent to the patient's situation. For example, while discussing an unsuccessful attempt at IVF one doctor used a football metaphor: 'he said it hit the goal post, but it will be a goal next time'. Another participant told me a story about her first visit to her new doctor: 'I asked the doc what kind of vitamins I should take – I had written down on a piece of paper what I had taken before, what my gynaecologist had said – and he said "you take whatever you want" in a very insulting way.' As described before, infertility-related medical professionals are typically men, who may disregard women's needs in the course of treatment. Participants often described the IVF clinic as a factory, and felt that their bodies were alienated while participating in the procedure.

One of the defining aspects of the experiences related to IVF treatment is that participants' bodies are monitored long before conception, which is inseparable from the medicalization of pregnancy and childbearing. IVF involves several stages; first ovarian stimulation, when patients are injected with growth hormones; after this, patients undergo egg retrieval; and at the end, the participant has the embryo implanted in her uterus. These processes are carefully (visually) inspected, not exclusively by doctors but also by the patients themselves. Several authors have noted that the effect of imaging technologies goes further than just showing the patient what is happening in her body; images about internal procedures cannot be interpreted without expertise in the medical field, thus when the patient sees, for instance, ultrasound pictures of her uterus, they need the help of the physician to decode the visual information.

Those who have the knowledge to make sense of the images do not just interpret but represent notions about bodily processes, hence these interpretations cannot be separated

¹ There are two women's organizations in Hungary that target mistreatment and violence against women in the medical field connected to the period of childbearing; the Emma Association and *Másállapotot a Szülészetben* (Change in Obstetrics). These organizations gather personal experiences, spread information, and provide support to women from conception to the postpartum period. The main goal is to establish a woman-centred medical system and highlight the problematic experiences women face in the field of obstetrics.

from the intentions and viewpoints of the medical professionals. This affects the patient's consciousness; subjective experience connected to one's own body is shaped by this medical gaze (Rapp, 1997). It can also be interpreted as the possibility to observe the internal processes of the female body, although the observed person is associated with more responsibility and is put under psychological pressure (Takács, 2015). Producing visual images has another consequence; the personalization of the embryo (Vicsek & Szolnoki, 2015): the interview excerpt above shows how this process is interpreted at the individual level: 'By default, a woman does not care for her follicles if she has a spontaneous pregnancy. No-one is looking at her follicles. Here, I can already see my baby in the follicle, my future baby. It's so interesting, it's important, it's there every day – all your thoughts are about whether the follicles are growing' (Rebeka, 40). Self-monitoring usually becomes extremely important in these cases, potentially leading to greater psychological distress and self-blame if the procedure is unsuccessful.

The desired pregnancy seems to come closer, with the possibility to see what happens before conception. The woman recognizes the difference between her situation and that of someone who can conceive naturally and reflects on how the IVF procedure is altering her consciousness through the powerful images that technological development has made possible. 'You can see them [the embryos] under the microscope. You see that beautiful blastocyst state, it's moving and it's evolving. And their only task is to implant, and if the IVF is unsuccessful, you die a little with them' (Judit 37). Here, it can be seen how the embryos are associated with human characteristics; this might be interpreted as meaning the attachment to the child-to-be-born starts early on in pregnancy, thus an unsuccessful IVF treatment can be similar to the experience of a miscarriage at the emotional level. One participant, Kata, described her feelings after an unsuccessful IVF in this way: 'I cried a lot every day for almost half a year, and I always said to myself "why is this happening to me? Maybe I don't deserve a baby, maybe we don't deserve a baby". We lost it very early on [after a week], but I couldn't let it go because it started growing inside me. I got a little chance, I saw that the baby was coming and wanted to come to us.' This narrative shows the difference between natural conception and childbearing with IVF. In the case of the former, women usually do not even know about the early stages of pregnancy, but with ART the monitoring of one's body is increased, resulting in severe emotional distress that usually affects the female member of the couple more.

7 Conclusion

The demographic aspirations of the Hungarian government are explicitly present in the political discourse around infertility. The increase in state support for ART can be beneficial for people struggling with infertility, but it is important to see that Hungarian policies associated with these technologies might not help those whose socioeconomic status is lower because the additional costs of the medical procedures can be high. Moreover, state legislation excludes groups (for instance, non-infertile single women, and lesbian couples) from treatment. This shows that the state has a strong influence on designating 'worthy' patients. According to the conservative political discourse, IVF should only be used to maintain traditional families that correspond to heteronormative reproductive standards. However, with the medicalization of childbearing-related practices, new territories of surveillance have

emerged. This has affected the construction of infertility: with the help of ART infertility has become 'curable', but one has to participate in medical treatment, which means that a private problem becomes a public institutionalized one that involves demands for an increase in responsibility regarding one's body. In the case of infertility this process mostly affects women, even though the problem can be the male reproductive organs. The analysis of the interviews was designed to show how different practices and discourse about infertility and ART affect the lives of women who participate in IVF treatment. The effect of state-funded IVF can be advantageous but we should note that medical practices and expectations about childbearing put women in a position whereby the problem is constructed as their responsibility. This can lead to self-blame and increased self-monitoring, thus for most women infertility becomes an extremely stressful experience.

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