Gender, Place & Culture: A Journal of Feminist Geography

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/cgpc20

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To cite this article: Masae Kato & Margaret Sleeboom-Faulkner (2012): Ova collection in Japan - making visible women's experience in male spaces, Gender, Place & Culture: A Journal of Feminist Geography, DOI:10.1080/0966369X.2012.709829

To link to this article: http://dx.doi.org/10.1080/0966369X.2012.709829

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Ova collection in Japan – making visible women’s experience in male spaces

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The role of women is essential in embryo creation and donation, as they undergo in vitro fertilisation (IVF) treatment for ova collection. Yet, it has often been pointed out that in the process of embryo donation women’s role is largely neglected, as if embryos come from nowhere. The procedure of embryo donation in Japan is a case in point. During field research in Japan, we found that women were of the view that the procedures of embryo donation are inhuman, cold and harsh, while specialists said that no value is attached to embryos in Japan and that women have no scruples about donating them. This article explores the cause of the gap in the perception of experiences of ova collection between women and IVF specialists. Our primary source of data was interview narratives with women undergoing IVF, IVF specialists, nurses, counsellors and policy makers. Field research was conducted in 2006–2008. We analysed the process and the ways in which women’s experiences of ova collection become invisible in Japanese socio-cultural contexts, including marriage, households and motherhood values in Japan. Our analysis critically draws on Marxist feminist theories, which enabled us to discuss the link among the production of embryos and ova, reproduction, ownership and gender. This theoretical framework also enabled us to view the case of Japan, paying particular attention to historical perspectives and specific cultural forms.

Keywords: Japan; embryo donation; women’s experience; ova collection; invisibility; Marxist feminist theories

Introduction

Ova donated to research usually derive from women undergoing in vitro fertilisation (IVF) treatment. Yet, it has been pointed out that in ova donation women are largely neglected, as if ova are simply available like fruit growing on trees (Dickenson 2007; Tsuge 2002). Interviews with women in Japan having IVF experience similarly show that women’s efforts are hardly acknowledged, including by IVF specialists and their husbands. Women explain how the only spaces where they feel they can communicate about their experience are virtual or anonymous, such as internet blogs using false names and anonymous locations. In sharp contrast, IVF specialists assert that technological advances have rendered ova collection painless, and IVF has become so generally accepted that women do not have any particular feelings about it. In the eyes of specialists, women’s painful experiences are invisible (Chiaki 2009).

The invisibility of women’s efforts in ova collection is reflected in state regulations regarding the procedures for embryo donation, revealing a gap between the regulations...
and many women’s experiences with ova collection. According to regulations in Japan, IVF clinics may ask women in writing if they want to have their frozen ova discarded or donated for research purposes (Yoshimura 2002). In interviews, many women reported that these questions are inhuman (hi-ningen-teki), improper and harsh. They feel that their efforts to produce ova and their experiences with IVF are not understood. In some cases, IVF specialists ask women whether they could use frozen ova for research, without explanation of the research purpose. In 2000, Japanese medical anthropologist Azumi Tsuge (2002) wrote that she had never come across interviewees who had been asked whether their ova could be used for research, be it on paper or verbally, let alone give an explanation of the research focus. According to Tsuge, many women fear that their ova will be used for research without their permission, or for someone else’s procreation. In our field research, too, we found women still had doubts and questions about the procedures of ova collection and embryo donation. However, the women we interviewed commented that they did not usually express their feelings to specialists. In this article, we explore why this is so.

Women’s complaints about inhumane medical treatment take two forms. First, most women do not view ova as a mere bodily produce (Kato and Sleeboom-Faulkner 2011), and fear that in a predominantly male, scientific world, ova will be treated as a mere research material. Second, they feel that available ova result from great efforts invested in IVF and that these efforts are not sufficiently appreciated and acknowledged. Analysing narratives of women undergoing IVF treatment and medical professionals, we realised that the problem is not confined to invisibility. This study suggests that although women’s efforts are sometimes visible to medical professionals, there is a critical gap between the ways the women and the medical professionals view women’s experiences of ova collection.

This article explores the cause of this gap in the perceptions of ova collection between women and IVF specialists. It examines how women become invisible in the ova collection process, and why their efforts sometimes do become visible to medical professionals. It is important to explore the gap in perceptions of women and IVF specialists, especially as policy-making bodies consist largely of medical doctors and specialists. Without awareness of this issue, new developments in technologies and guidelines could further alienate women experiencing ova collection as patients.

Research method
Our primary source of data is interview narratives. In 2006–2008, the first author interviewed 19 individuals with the experience of IVF within the last three years, 14 women and five husbands. The first author met these interviewees through mailing lists for women and couples with fertility problems (11), through mailing lists for midwives (6) and through women’s reproductive health movements (2). Nine of the interviewees are from Tokyo, seven are from the suburbs of Tokyo and three are from Osaka. The average age of the women is 37, and that of men is 39. Thus, this study analyses the narratives of 19 individuals regarding lived experiences of ova collection.

Of the 14 women, six had at least one child. There is a slight difference in viewing the process of ova donation between those who successfully had a child and who did not. Those with children tend to describe ova donation in terms of their gratitude to IVF specialists, while those without tend to express frustration and anger. Yet, in our observation, gratitude and anger and frustration all stem from similar views of ova collection pressures, which we discuss later. We did not find remarkable differences among those who have a child and
those who do not regarding the issue of their effort in ova collection per se, which include time, physical pain, money and lack of acknowledgement of these issues by IVF specialists.

We also refer to narratives of 15 obstetricians (three female and 12 male), five nurses (all female), four counsellors (all female), six scholars (three female, and three male) and four journalists (all female). All are specialised in the issues of obstetrics, IVF treatment and/or embryology. They are located in Tokyo, Kyoto, Osaka, Nagoya and their suburbs, and all were interviewed between 2006 and 2008. All these interviews were semi-structured, and the interview sessions lasted one to four hours. The purpose of the interviews was to learn about their ova collection experiences, and informed consent was taken in a written form. There is a sex imbalance among each occupation, but this is a reflection of societal gender division of labour in these occupations. The names of the interviewees in this study are all pseudonyms.

In this article, we focus on ova collection during IVF treatment, because it is the ova that are disentangled from the reproductive process in favour of activities and interests of an entirely different nature with potentially high exchange value. The ova concerned here were cryopreserved with an eye to future fertilisation. The women hope that their ova are of good quality and can be potentially used by them to give birth in future. In Japan, ova donation to infertile couples for a reproductive purpose is prohibited; the ova donation discussed is solely for the purpose of scientific research.

As the number of interviews is limited, we do not make generalisations about how women in Japan feel. Instead, we seek to elucidate patterns in the narratives regarding the invisibility of women’s efforts in ova collection embedded in Japanese reproductive cultures.

Prior research and theoretical challenges

Given the advanced age at which marriage typically occurs in Japan, infertility is becoming of wide concern both in academia and popular culture. The Ministry of Health, Labour and Welfare (2009b; MHLW hereafter) reported in 2007 that 94,110 women received in vitro fertilisation and pre-embryo transfer (IVF-ET) treatment. The number of couples with documented infertility problems and children born through IVF is increasing in Japan. According to the MHLW (2009a), the number of infertility counselling session increased from 1891 in 1999 to 17,756 in 2006. In Japanese academia, most studies on reproductive issues are conducted from a nursing point of view, focusing on the identification of psychological struggles (Hayasaka 2005) and counselling support systems (Akizuki et al. 2004). There is a rich ethnographic research on women’s IVF experiences. Yet, the general tendency is that these forms of research are local, in the sense of being confined both to personal experiences and to Japan.

Although many scholars have noted the issue of invisibility of women’s experiences in ova collection, to the best of our knowledge, there is no social-scientific research on the differences in perception between women and specialists. Japanese medical anthropologist Tsuge’s (1999) ethnographic research and her edited book on the issue of reproduction and pregnancy (Tsuge, Setsuko, and Ishiguro 2009) are two of the few social science studies on the topic, asking questions ranging from cultures of adoption and blood relations to the doctor–patient relationship. Though highly relevant here, they do not address the invisibility of women’s efforts and experiences in ova donation.

Internationally, there have been critical studies on the invisibility of women’s efforts in ova collection. To make women’s efforts visible, some scholars have suggested the consolidation of informed consent practice in embryo collection (Cohen 2000; Magnus and Cho 2005), and financial compensation for donations (Insoo 2006). Some scholars
question the moral aspects of altruism in the process of donation (Steinbrook 2006). There
is also the suggestion of ‘egg sharing’, where patients undergoing IVF would receive
treatment at reduced cost in exchange for some of the eggs collected during standard
treatment procedures (Newcastle University Press Office 2006). On the basis of narratives
of IVF clients, Parry (2006) indicates that the donation process itself is so stressful that
women become too vulnerable to make judgements regarding donation. Roberts and
Throsby (2008) note that IVF clients and medical professionals are unequal; hence, we
cannot use the practice of sharing, because sharing assumes equality among different
parties.

Anglo-American philosopher Dickenson (2007) suggests endowing women with
property rights to their ova to make women’s efforts visible. Her discussion is based on the
growing need for acknowledgement of the increasing use value of the ova in medical
therapy provision. Viewing ova as something with use value, the idea of ‘ova as property’,
then, is intended to empower women as its owner. Yet, this does not fit with notions of ova
expressed in the narratives of women during fieldwork in Japan. Why this is so is one of
the main theoretical questions explored in this article.

In discussing the (in)visibility of women’s efforts in ova collection, we examine
Marxist feminist theories, also used by Dickenson, for the following reasons. First, as
noted above, the use value of ova is more often discussed in Japan than cultural meanings
(Shimazono 2007). We agree that ova, in one respect, have use value. Perceiving ova in
this way, we view that women are the creators of ova who invested their labour power.
According to Marx, labour power is ‘the aggregate of the mental and physical capabilities
in a human being which he [sic] exercises whenever he [sic] produces a use-value of any
description’ (1970, 35), but women’s investment in ova creation is even more than labour
power as defined here. Her investment in ova collection cuts across domains of
reproduction (making a child) and production (ova with use value), public (IVF clinic) and
private (procreation as a private matter): further, her investment is not only capabilities,
but the emotional pain, time, travel and energy requisite to address social expectations. So,
instead of labour power, we use terms such as work, efforts and experiences to imply more
than labour-power can signify.

Second, we use Dickenson’s argument because a Marxist feminist theoretical
framework provides us with a strong analytic for examining how the practices of ova
collection travel across the spaces of both production and reproduction. It generates insight
into how women bring their daily experiences in reproduction (at home) to ova collection
(the clinic), and how cultures of marriage (husband and wife) and procreation (mother and
children) are reflected in the practice of ova collection (women and medical
professionals). In this article, we examine these questions in a Japanese cultural setting.
Next, we briefly discuss a Marxist feminist account of women’s efforts in ova collection.

Theory: Marxist feminist accounts of women’s experiences in ova collection

Two theoretical mechanisms allow women’s efforts to become invisible in ova collection
from a Marxist feminist perspective. First is the assumed ‘naturalness’ of women’s labour
(Dickenson 2007), and the other is the sexual contract (Pateman 1988). To understand the
invisibility of women’s efforts in ova collection, Dickenson uses the Marxist concept of
alienation, in which ‘labour always appears as repulsive, always as external forced labour,
and not labour as freedom and happiness’ (2007, 76). According to this view, ova
collection entails the depersonalisation and objectification of both women’s bodies and
ova (cf. Timmermans and Almeling 2009). Thus, IVF specialists do not need to pay attention to women’s personal experiences during ova collection.

Paradoxically, Marx himself did not apply the concept of alienation to labour within the reproductive domain, such as at home. Here lies a key to understanding why women become invisible in their efforts. To Marx, it was the capitalist system that produced alienation: ‘what women do, in giving life, is ... like what the earth does: it is natural, not social, and it cannot confer added value’ (Dickenson 2007, 55). Consequently, in the process of creating reproductive tissue, ‘the labour which women put into processes such as oocyte and cord blood extraction is not recognised, not counted as adding value to commodified products such as stem cell lines because women’s reproductive labour is not recognised in other contexts either’ (Dickenson 2007, 48). It is always already invisible.

Women typically do not have to apply creative effort to become pregnant. As long as she eats, sleeps and exercises well, the foetus grows automatically in her belly, unlike the process by which one creates, for example, a computer programme. Women’s biological functions appear natural. Because of this, it is widely accepted that it is instinctive to women to be engaged in reproductive activities (Stolcke 1981).

Here, the invisibility women’s efforts in ova collection can be accounted as follows. Alienation takes place in the process of ova collection, which should be sufficient reason to explain the invisibility, but the alienation itself is not even recognised because of the widely accepted belief that what women do in the domain of reproduction is natural, not externally forced. Women’s efforts are naturalised, invisible and therefore unacknowledged.

According to this logic, one may argue that women’s efforts in ova collection become invisible due to the way reproduction is viewed. Indeed, other ‘women’s work’, such as cleaning a house, birthing a child or cooking, has almost always been unacknowledged as work by, for example, state statistics. In addition, Dickenson (2007) argues, if services done at home had to be purchased in the market, they would possess a financial value. She further cites French feminist Marxist Christine Delphy (1984, 60, cited in Dickenson 2007):

[F]ar from it being the nature of the work performed by women which explains their relationship to production, it is their relations of production which explain why their work is excluded from the realm of value. It is women as economic agents who are excluded from the [exchange] market, not what they produce.

From this, it seems that the key is the fact that the egg donation work is done by women, and therefore alienation is unacknowledged, unlike the alienation produced through work done by men. What does this mean precisely? The concept of the ‘naturalness’ of women’s reproductive labour seems to be key.

The term ‘nature’ in this context reminds us of the ‘state of nature’ in social contract theory, and how political philosophy has viewed women’s subjectivity. Agreeing to the social contract is a process of man’s politicisation. In this process, men become civilised, rational, social and public beings. This agreement is made to forestall the invasion of another man’s property and to prevent war of all against all, according to the account of Hobbes (1946), or to keep men rational, according to Locke (1995). In this process, women are left out of the process of politicisation and remain natural (Pateman 1988) rather than political beings. This is mainly because, according to this political philosophy, she is emotional, illogical and private, devoid of the ability, or subjectivity, to become socialised (Pateman 1988).

What Pateman calls sexual contract, or marriage, is in fact twined with the social contract. Under a marriage contract, women were excluded from being ‘individuals’ and
remained natural resources. As such, they were allocated among men so that men do not have to fight over one woman, or social contract (Pateman 1988). Dickenson also discusses this point, and maintains that the devaluation of women’s efforts in work is not due to the kind of work they do. Rather, it is because the work is done by women, who ‘are not accorded the status of subject that they hold little or no property’ (Dickenson 2007, 28). Consequently, like colonies with abundant raw materials, ‘women’s bodies have long been assumed to be open and available’ (Dickenson 2007, 80) to men. What women ‘produce’, such as ova, is a natural resource available for exploitation.

Thus, according to John Locke, a will, intentionality or control to create something is seen as an expression of subjectivity in the process of creation, which eventually justifies property rights of the person who creates it. But in the case of women, creating something, such as ova, is regarded as ‘natural’. Women’s intentionality, control or subjectivity does not count. Citing Pateman, Dickenson (2007) also compares the marriage contract to consent to undergo IVF: just as a woman surrenders her rights to her husband upon marriage, so too does she surrender, under IVF treatment, her rights to IVF specialists.

As a counterargument, however, Dickenson provides a detailed account of how women actually invest their intentionality and control in the work of ova collection. Woman actually exercises subjectivity during IVF treatment – she travels to the clinic and undergoes hormonal treatments. The embryo also has potential economic use values, constituting property rights to women; as Dickenson suggests, this seems to be a logical solution. She uses Hegel’s concept of contract, where possession is not the main focus, but mutual recognition of subjectivity is the focus (Dickenson 2007). Thus, when Dickenson suggests the entitlement of property rights to women to their ova, this does not mean viewing ova as a commodity. Rather it acknowledges the intentionality and control of the efforts of women to produce them, instead of viewing that as natural. Dickenson’s argument is an appeal for acknowledgment of women’s intentionality and control in the process of ova collection, reflected in the title of her book, Property in the Body (2007).

Yet, in our study, the term ‘property’ does not fit in smoothly with the perceptions of women who donate ova after IVF treatment. Although Dickenson argues theoretically that ova should not be objects of possession, it may be confusing to use the term property. By looking at narratives of women’s experiences of ova collection, we consider what concept could best be used in Japan to make women’s efforts visible, and to acknowledge the subjectivity of women in ova collection.

The procedure of IVF-ET in Japan

Next, we review the procedures of IVF treatment in Japan, followed by narratives of women regarding their efforts during ova collection. We discuss these narratives in light of the process wherein women’s efforts become invisible in the culture of doctor–patient relationships, infertility and reproduction. Here, questions include how subjectivity, or control and intentionality of women, is viewed by IVF specialists, and how the analogy of marriage to IVF treatment appears in Japan. Finally, we discuss how women’s experiences in ova collection can be more acknowledged in Japan.

IVF treatment and ova collection are done in Japan basically in the same way as in other countries; treatment cycles for ovarian stimulation are started on the third day of menstruation, and injectable gonadotropins (usually follicle-stimulating hormone, FSH, analogues) are used under close monitoring for 10 days. Afterwards, at the very moment of ovulation, women come to the clinic for ova collection. This can occur at any time of day or nights. However, in Japan women usually have to visit the IVF clinic daily for 10 days
to receive injections. In the USA or UK, for example, a self-injection programme is used, and women can inject themselves at home or work. In Japan, only specialists are designed to inject FSH analogues. Specialists claim to be afraid of the possibility of ovarian explosion due to an excessive amount of injection by a woman herself at home.

The Japan Society of Obstetricians and Gynaecologists (JSOG) stipulates that not more than three embryos are to be placed in a woman’s womb after IVF to prevent multiple pregnancies (Yoshimura 2002). When couples choose to withdraw from treatment for a while, they usually choose to freeze the ova they have not used. Eventually, some frozen ova may be used later for fertilisation and pregnancy; others are offered to research, and the rest are discarded. To freeze ova, it costs from 30,000 to 45,000 yen (200–350 euros) per year.

The costs of IVF-ET are only partially covered by the Japanese national health insurance. Individuals pay most of the costs. This is a notable difference of IVF treatment in Japan compared to the countries where IVF is covered by national health insurance which include UK and the Netherlands, but not the USA. The costs range from 200,000 to 800,000 Japanese yen per cycle, depending on the number of collected ova and the services provided by clinics. There is no regulation on how many times a woman can undergo IVF treatment, so some women continue with treatment for many years without success. Among the 14 women we interviewed, 15 years was the longest history of IVF attempts, and 18 million yen (120,000 euros) was the largest amount spent on IVF treatment. Selling embryos is prohibited in Japan. So all the embryos donated to research or therapy are from IVF treatment, usually initially fertilised for procreation.

**Experiences of women on their efforts in ova collection**

Women narrate their efforts in ova collection in a wide variety of ways. We have analysed these and categorised them into **physical pain**, **psychological pain**, **monetary cost** and **time**.

**Physical pain**

Virtually all 14 women mentioned physical pain during ova collection. The most minor pain was expressed in the form of ‘pain like an injection’, and the greatest pain was expressed in the form of ‘I almost fell off the bed’. In addition to the pain during ova collection, the influence of hormonal injections was also expressed. Seven women stated that during the period of injection, they felt heavy and had pain in their abdomen or that their abdomen was swollen.

**Psychological pain**

Tsuge’s (1999) research also found that all her 11 female interviewees thought that becoming a mother was an unquestionable and automatic course of married life. It is not a matter of choice, but the path women are expected to take in Japan. In the present study, the 14 women most frequently commented on their failed identities as women, namely ‘I failed to become a woman’, and ‘I cannot let my husband hold his baby’. As these comments indicate, in Japanese society, marriage is essentially synonymous with procreation. In 2005, 96.4% of married couples have at least one child in Japan (MHLW 2005).

Irritation and disappointment were also expressed. Many of them mentioned that repeated IVF treatments without achieving pregnancy augmented a sense of failure and defeat: ‘I am doing this much; why can’t I become pregnant?’ Another frequently
observed psychological pain was a sense of loneliness. Many said that they did not feel sufficiently understood or supported by either their husbands or doctors. There was no place, nowhere, no one to share the experience with.

Hesitancy about initiating IVF treatment was expressed too. Although all of the women, in the end, received IVF treatment, all said that the step from artificial insemination (AIH) to IVF was not smooth. The most frequent concerns were IVF that is not natural (shizen janai), concerns about disability in a ‘test tube baby’ and side effects of the treatment for themselves. Many worried about early menopause because of hormone injections and uterine and ovarian cancer. Women in Finrrage-no-kai, a women’s reproductive health movement specialising in fertility problems, told us that resistance to IVF has decreased compared to 1983 when IVF was first carried out. Yet, they also said that there are doubts about IVF in society, and we too could observe that from the interview narratives. ¹

**Monetary cost**

All the interviewees stated that the cost of IVF-ET is too high. Ten women had to earn money having an extra job especially for IVF treatment, whereas four women did not have to do so because either their parents or parents-in-laws could afford the cost. More than half of the women, as well as men, stated that although specialists advised them to feel relaxed to become pregnant, it was difficult because they were worried about their financial situation and having to earn money for the treatment. Two couples said that they have quarrelled about deciding whose parents they should ask for financial support. The financial issue was described as a latent cause for disharmony within couples and their families. Interviewees compared the monetary expenditure in IVF-ET to the cost of buying a larger house, buying a new car and going on holiday twice.

**Time**

Among all the factors, loss of time was the most emphasised, especially the time to visit clinics for injections for 10–14 successive days and the time to go to clinics for ova collection, as well as the time to look for IVF clinics with good reputations. All the women mentioned the time spent on IVF treatment as huge. According to our data, women who work have the greatest problem in visiting IVF clinics. Therefore, they choose a clinic according to its geographical distance, rather than its reputation. Women without paid work tend to choose a clinic according to its reputation and its rate of successful fertilisation. In such cases, they sometimes travel to the clinic for more than one hour each way. Kayo (40s, Tokyo) said that she used to check in at the reception of the clinic at 11 am, waited for her turn, finished injection at 5 pm and returned home at 6 pm.

All in all, interviewees said that the effort they put in during IVF treatment had been enormous (taihen). Yet, they said nothing about their efforts to specialists or to society. In fact, they told us their stories in the first place because they hoped the situation might change and, second, because they have had no other opportunity to express these feelings. Before considering why they are silent, we next examine how IVF specialists talk about women’s efforts in ova collection.

**Narratives of IVF specialists**

How do IVF specialists view women’s experiences in ova collection? All in all, in our interviews of 15 specialists, there was hardly any acknowledgement of the efforts of
women during IVF treatment. Virtually, all the specialists either denied the presence of pain, or acknowledged the presence of pain, but said it was minimal (taishita-koto-nai). Five specialists commented that IVF technology is so developed that there is hardly any pain any more. Dr Harada (male, 50s, Tokyo), a professor and embryologist at one of the most renowned university hospitals, mentioned that there is hardly any hesitation today about ova collection or IVF among his clients. He went on to say that IVF has become so advanced that it has become accepted and deemed harmless for women. Dr Sugiyama (male, 40s, Kyoto) mentioned that ‘if ova collection is painful, it is their fault. I collect ova by inserting this tube like smooth river water (boku wa kawa ga nagareru youni sairan suru)’.

Four specialists acknowledged the efforts of women, including pain, but said that it is unavoidable. Dr Masaki (male, 50s, Tokyo), a professor and IVF specialist at a university hospital, said ‘the pain is not what he, a male doctor, would not be able to know about or make any judgement about, as it is women who feel this pain’. Dr Morita (male, 50s, Tokyo) said that every medical treatment is followed by pain. Regarding the cost of the treatment, most mentioned that it is expensive but, on the other hand, the value of a child is incomparable to the price of a car or a house. Cars or houses are temporary, but children are for the rest of one’s life. If couples truly want a child, they must not complain about money. Three specialists commented that IVF does not need to be reimbursed by the governmental health insurance because it is not a sickness. Unlike an illness, IVF is the choice of individuals, they said.

There are clearly differences in perception of ova collection experiences between specialists and individual women. Asked whether patients express their feelings to IVF specialists during the treatment, IVF specialists said that women hardly express their feelings. For this reason, they believe that ova collection is painless. Women, on the other hand, stated that they hardly dared to express their complaints or their pain. It seems here that both the silence of women and the lack of communication between women and specialists play key roles in the formation of differences in the perception of ova collection.

Why silent? Women’s accounts

Through exploring the reasons for women’s silence, this section discusses the invisibility of women’s efforts in the process of IVF. Seven women explained that they think that if they complained, specialists would not take them seriously during IVF treatment. Eight women said they did not want to bother specialists because they are busy, while five women said that they did not feel understood by specialists. To the latter, talking about pain is irrelevant to receiving good treatment. By staying silent, they tried to make the treatment process go as smoothly as possible. Some women also mentioned that their time with the specialist was too short to discuss anything personal about their experience.

According to MHWL research, a majority of patients, 43%, receive a diagnosis within three–10 minutes, while 17% are diagnosed in less than three minutes (Kato 2007, 34). The number of obstetricians (OBs) is decreasing: according to the available figures, 67 of 92 Red Cross hospitals in Japan are short of medical doctors (Kato 2007, 34). Thus, the average OB’s working hours are increasing and the time available for diagnosis is decreasing.

Interestingly, the reasons given for maintaining silence about their pain and experience with specialists are similar to the reasons women give for being silent with their husbands. Their comments included: ‘I do not want to bother him because he is busy with work’ (four women); ‘He does not have time to listen to me’ (three women); ‘If I complain, he might
not support me any more’ (four women); and ‘He does not understand what I am going through’ (three women). It is our perception based on this research that the relationship between women and specialists may become a pseudo-marriage relationship through IVF treatment. As procreation is a taken-for-granted event in married life in Japan, and IVF treatment for the purpose of procreation is part of married life, IVF specialists are taking over a role of the husband’s insemination. We explain the silence of women towards doctors through the ‘culture of virtue’ appropriate for wives in Japan. Margaret Lock cites research conducted by the Hakubundo Institute to explain the virtue of wives as follows:

When their husbands returned home, sometimes around midnight, they made sure that the bath water was hot enough for their husbands to drain away the stresses and strains of the work day. They took out the kimono their husbands would wear while sipping hot sake and eating dinner. They understood their husbands might not want to talk. ‘If I worked as hard as my husband did at his place of work, I wouldn’t want to talk much’, they thought ... They did not bother their husbands with household affairs or the problems they faced each day in raising children. Those were their responsibilities as housewives and mothers. (Hakuhodo Institute of Life and Living 1984, 111, cited in Lock 1993, 82-83)

As women are silent about problems concerning ‘raising children’, they are silent about fertility, as well. The pain and efforts associated with household matters, including procreation and ova collection, are not discussed. The patience (gaman) and endurance (nintai) of wives have historically been considered necessary virtues of married life (Borovoy 2005, 44) and they still prevail today. From her field research, the US specialist in East Asian studies, Amy Borovoy, cites a number of stories in which a woman stays silent even though a husband is drinking too much, or gambling with his colleagues. She does not intervene in what her husband does at work, outside the home where ‘production’ takes place. She is supposed to provide a cozy space at home, where reproduction of the family is to take place. Typically, a woman does not ask others for help to create a reproductive space. If she fails to do so, she is simply failing to fulfil her mission, both in her own eyes and those of others (Borovoy 2005, 74–6).

This boundary applies to fertility issues, as well. Fertility is a wife’s responsibility. The story of Mrs Hinata (34) from Osaka illustrates this. After 3 years of marriage, Mrs Hinata did not become pregnant. Even though they did not know the cause, Mrs Hinata’s mother-in-law did not allow her son to go for a check-up. The mother believed that it was Mrs Hinata’s fault, and she blamed her for not eating and exercising well. Yet, when Mrs Hinata finally did visit a doctor, she seemed to be fertile, while her husband turned out to be sterile. Nevertheless, Mrs Hinata did not defend herself against her mother-in-law. Mrs Hinata kept the problem to herself to avoid a fuss at home. She silently takes responsibility for reproductive matters, as most women do as well during ova collection.

Women’s silence can also be explained from the perspective of motherhood. Women are silent and patient towards their husbands to maintain harmony in the family and to protect the well-being of their children. Silence is seen as a virtue in women, further linked to an idealised image of motherhood. Regarding motherhood and silence, nine women expressed that complaining about pain and efforts was an irresponsible attitude in receiving IVF treatment as a prospective mother. Most women said that they were constantly worrying about being strong enough or ready to have a child. To reassure themselves that women were ready to have a child, they try to bear the pain and other negative experiences in silence. Similarly, several women said that they should not complain about money, because comparing money to the value of a child is not an attitude mothers should assume. This was expressed in what various women said: ‘All I do is for my future child’ (Eiko, 20s, Nagoya); ‘I should be able to endure anything for the child’ (Nobue, 30s, Osaka); and ‘By enduring all,
finally, I can become a good mother’ (Takako, 30s, Tokyo). In this way, endurance and silence during the treatment for the sake of having a child is likened to a qualification to become a good mother.

Israeli anthropologist Ivry (2006, 2007) has noted that in Japan medical doctors require pregnant women to do their best for their children during pregnancy, even at the cost of women’s free will to do what they might want to do. For instance, doctors ask women to refrain from going out during pregnancy and often they obey this instruction. Ivry (2007) also mentions that entrusting themselves to doctors is associated with the idea of taking responsibility as a prospective mother. In this vein, pregnant women are expected to grit their teeth, do their best, do not complain and sacrifice themselves. This mentality, or *ganbaru* culture, is found in every corner of Japanese society (Ivry 2006). Issues of reproduction and motherhood feature *ganbaru* culture because they concern the virtue of being a mother. Infertility is always already a negative phenomenon, causing women to feel that they have to do even more than their best. Thus, being silent during IVF treatment is linked to the maturity of women as prospective mothers – both physically and mentally – while complaining is linked to impatience, childishness and therefore not being ready to become a mother.

Virtually all the interviewees linked infertility problems with female identity and motherhood. Some saw childlessness as a sign of disqualification to become a mother. Others saw it as a failure to become a complete woman, and therefore they could not avoid making extra efforts (*shikata ga nai*). The silence of women during IVF treatment needs to be understood in the context that women receiving treatment are already feeling incompetent as women.

However, notably, not all the interviewees were silent about their pain and effort. Some told us that they stated to the specialists that they felt dull and heavy during the period of hormone injection or they felt pain during ova collection. However, they told us that they were either not taken seriously (two), told by specialists that compared to child delivery these problems are much smaller (two), or told by specialists that they were too sensitive to pain (one). Two interviewees also said that they were even shouted at and scolded by specialists (*donarareta*). Individuals then felt that discomforts and pain during IVF are necessary to having a child. The narrative of Ms Tateno, a full-time journalist in Tokyo (39), well elucidates all of these points:

I said ova collection was painful. Then the doctor shouted at me and said that I do not have enough patience. Later, the doctor asked my husband whether I am extremely sensitive to pain, my husband answered him that `Maybe she is’, and they both were laughing `Ahaha’. I was still lying in bed. Usually fertilisation is a moment of privacy, but they were laughing at the situation. I felt uncomfortable but I could not say anything further. There was an atmosphere in which I could not say anything.

Asked what precisely was the atmosphere in which she could not say anything, Tateno said:

`Usually, fertilisation takes place in privacy, like sexual intercourse. Strangely, the doctor is now between my husband and me, intervening in our intimate marriage life. This is already hard. If you are laughed at and your pain is denied in this way, of course you cannot say anything any more."

She continued to describe feeling a mixture of anger and shame. Anger came from the fact that she felt pain in a way she had not wanted to: she continued by saying, ‘pain in the vagina against one’s will is just like a rape experience’. Shame came from the fact that she could not conceive on her own. Another four women also mentioned that they had stopped
talking about the treatment to their specialists or their husbands because they did not feel understood. Tateno further explained that in the diagnosis room, she was not her usual self:

Later I found out the success rate of the [IVF] clinic was low. Why didn’t I notice this? I am a journalist, and normally sensitive to statistics. But in the clinic, when it came to the issue of infertility, I just became submissive.

At home, Tateno has organised her life around sharing responsibility for household chores with her husband. She recalls that the diagnosis room filled with medical knowledge and technologies, applied by a male specialist, made her unconsciously behave as a subdued and submissive woman, as she feels is normally expected from women in Japanese society. In the diagnosis room, Tateno does not feel that she can behave like her confident and rational self. Rather, she acts out the role of the women she believes she is expected to play in diagnostic spaces in front of a male specialist. In the diagnosis room, gender dynamics are pervasive influencing women’s usual sensibilities – being infertile and dependent on artificial insemination administered by a male expert arouses conflicting emotions in women who feel they have failed to bare children ‘naturally’.

We also found that specialists behave somewhat differently in the setting of IVF treatment compared to in other medical areas. Two of the 15 specialists were reported to have shouted at their clients, which is remarkable and uncommon in other areas of medicine in Japan. During our field research at other sites of medical treatment, such as genetic counselling or prenatal testing, we have never come across a situation where doctors shouted at their patients. Usually, doctors are afraid of complaints from their clients, especially given the increasing number of medical court cases (Kato 2007). In sharp contrast with other physicians, most IVF specialists even looked proud when saying that they silence, admonish or shout at women when they complain. In our view, this is because of the nature of infertility problem and IVF treatment. Genetic disorders or anxieties during pregnancies would not be associated with self-centredness. What then explain the attitudes of IVF specialists?

**What is ova collection? Accounts of specialists**

This section analyses the accounts of specialists of the process of ova collection. Three IVF specialists reported that they sometimes shout at women who complain about pain. Two counsellors also mentioned that they have witnessed specialists shouting at clients, as well. Dr Asano (late 50s, Osaka) said that he shouts at clients because complaints hinder his concentration on his practice. He continued to explain that his practice is for the sake of the clients even though it is painful, and therefore shouting is also for the sake of clients achieving their wishes (*kanja no shiawase no tame*). Dr Akiyama (late 40s, Tokyo) explained that because IVF treatment is a client’s own choice, they should not complain about anything in the process. From these statements, it is possible to observe that IVF treatment is viewed quite differently from treatment of disease. In the view of some specialists, complaining about what they themselves have chosen is unacceptable.

According to eight out of 15 IVF specialists, women are not patient enough during the treatment; they are selfish (*wagamama*). They view ‘new’ life styles, such as women having a job and get married at an advanced age, to be a deviation from the ‘natural’ course of life. Eight specialists mentioned that ‘women nowadays chase after a career, and they want to have children at the age of 40. But that is not in accordance with nature’ (male, 50s, University Hospital in Tokyo). ‘After 40 the blood pressure is higher, the body
is less flexible. Then they come to this clinic and ask me whether they still can become pregnant. The human body is not programmed for such a late pregnancy. They do stupid things’ (female, 40s, private clinic in Tokyo). All these comments were about women with careers. Being unnatural, to these specialists, has both biological (advanced age) and cultural (women with a job and postponing marriage) aspects. About housewives, too, some specialists said, ‘Some couples say that they do not want to have intercourse. They want to avoid the time and nuisance and therefore they come here for pregnancy. Sexual intercourse is natural. They are spoilt (amaeteiru) nowadays’ (male, University Hospital in Tokyo, 50s). ‘Eventually, to become pregnant with the help of others is an ultimate egotism. Previously, they became pregnant on their own’ (male, private clinic in Osaka, 50s). These views of medical professionals reflect Japanese cultures of reproduction and production. Women are deemed wholly responsible for the space of reproduction. And in her reproductive work, she should ideally not ask for help. If she does, she is spoilt and selfish. Such ideas are also internalised by women. Thus, IVF for them feels like a failure in fulfilling her role.

In sum, we discerned two images held by IVF specialists of women undergoing IVF treatment. One, as previously shown by medical anthropologist Tsuge, is the view that women with infertility problems are pitiful (funin no hito ha kawaisou: Tsuge 1999). Since they cannot become pregnant, they fail to lead the normal life course of women. In this study, this was illustrated by a specialist’s statement: ‘All I do is to help them to achieve their goals. This may be painful or burdensome.’ For IVF treatment specialists, it is a provision of kindness for women to realise their dreams (Tsuge 1999). But women who succeeded in having a child by IVF treatment also tend to recall the process of IVF treatment in terms of kindness from specialists. Their accounts of deciding to donate an ovum are mostly phrased in terms of ‘paying back gratitude’. According to the second view, women are ‘selfish’ (wagamama): we found that both ideas prevailed among IVF specialists: infertile women were both ‘pitiful’ and ‘selfish’. But how do these two images function to make women’s efforts invisible to IVF specialists? We next discuss this question by linking it to the concepts of ‘nature’ prevalent in Japan.

Discussion

At the beginning of this article, we discussed the Marxist feminist perspective, which explains the invisibility of women’s part in ova collection through the fact that women’s efforts are regarded as ‘natural’. Moreover, because a woman is considered as lacking in subjectivity, she is not entitled to have property rights to the collected ovum where she puts her effort (Dickenson 2007, 28).

From narratives, we indeed found that women’s efforts become invisible. Her work in reproductive space is taken for granted, seen to be ‘natural’ and to be discharged silently without being asked or asking others for help. At the same time, however, the narratives in this study also suggest that, in Japan’s socio-cultural setting, women’s effort in ova collection is, in fact, sometimes visible. It is seen as a penalty for women being infertile. Narratives from both specialists and women indicate this point, by referring to pain as ‘payment’ for becoming pregnant. The narratives also show the prevalence of a notion among IVF specialists that women undergoing IVF treatment are selfish, as they have postponed the timing of pregnancy after chasing their career and freedom. In this context, a woman’s efforts — physical, emotional and monetary — are seen to be the price for her self-centred life. Many IVF specialists are not aware of the hardships experienced during ova collection, largely because of women’s silence. But infertile women are often silent because they feel
they deserve their hardships. If IVF treatment fails, apart from not being ‘natural’, she has even failed to become pregnant through technology. Although women spend their time and money for IVF treatment with hardly any reimbursement from health insurance, women still feel guilty if they cannot conceive. When they do conceive, they feel grateful to IVF specialists even though they have to spend the money, time and effort to make it possible.

The ova have a potential use value, and, theoretically, Dickenson’s argument is right in that it implies the need for entitling embryo and ova ownership to women. To be sure, however, her claim is not to view embryo and ova as a commodity. She suggests acknowledgement of the subjectivity of women in ova collection, as she cites the idea of Hegelian contract theories, which are based on the idea of mutual respect between those who conclude a contract. Entitling property rights is one means to this end. Yet, the idea and vocabulary of ownership and property rights to the ova for Japanese women undergoing IVF is far from their minds. Women undergoing IVF are often in emotional confusion, panic and losing their self-confidence because of being infertile. Some interviews lasted a very long time, because women grasped the rare opportunity to talk about their IVF experience. As many negative ideas associated with IVF undermine infertile women’s social position, these women are far from concerned about claiming property right to ova or embryos.

Rather than entitling women with private rights to embryos, we suggest reflecting on fundamental questions about IVF in Japan. Why do women stay silent about IVF treatment? Why do women feel ashamed of infertility? Given that the number of infertile couples is on the increase in Japan, it is likely that the issue of ova donation will become a public issue. One reason for the increase in the number of infertile couples is, as claimed by the majority of IVF specialists, that women stay unmarried or do not wish to have intercourse. Women are blamed for this as being selfish. Indeed, marriage for many women is not attractive. As Borovoy (2005, 96) explains, for women to maintain both family and work is difficult in Japanese society, as husbands do not usually take part in household tasks.

Listening to women’s stories of ova collection, we often noticed that real problems of infertility lie deeper than infertility itself: many women expressed their dissatisfaction with marriage, sexuality problems and a lack of communication between husband and wife. Lack of acknowledgement of women’s well-being in the process of IVF treatment needs to be discussed using a vocabulary closer to women’s experiences in daily life. The question of (in)visibility of women in IVF is not confined to IVF. It needs to be discussed more broadly in the context of daily life. First, the experience of IVF affects gender relations in the domestic sphere and second, the vocabulary used in IVF treatment may alienate women from their efforts and feelings towards both ova and embryos. The vocabulary of property rights and ownership of ova is too far removed from women’s actual experience. Again, to find a vocabulary appropriate to the Japanese cultural setting may also require debates among scholars and women’s groups. And, third, critical examination of values associated with physical spaces, in this case the diagnosis room, is needed to understand the presumptions of those dominating the space in relation to those ‘visiting’ it. Production and reproduction are not just about work to be done, but about power relations between social groups and spaces of belonging, historically grown and associated with ideas about nature, work and labour division.

Acknowledgements
This work was supported by the Netherlands Organisation for Scientific Research (NWO) [grant number 32.630]. Our gratitude is extended to three anonymous reviewers.
Note
1. Interviews with Finrage-no-kai, on 11 May 2007, Tokyo. Finrage-no-kai, a network for infertile women in Japan, is a non-profit support group for infertile women established in 1991. Currently, it has some about 250 members. For more information, see http://www5c.biglobe.ne.jp/~finrrage/.

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**ABSTRACT TRANSLATIONS**

**Recoleccio´nd eo´vulos en Japo´n – visibilizar las experiencias de las mujeres en los espacios de los hombres**

El rol de las mujeres es esencial en la creación y donación de embriones, mientras pasan por el tratamiento de Fertilización in vitro (FIV) para la recolección de óvulos. Sin embargo, a menudo se ha señalado que en el proceso de la donación de embriones, el rol de las mujeres es mayormente ignorado, como si los embriones vinieran de ninguna parte. El procedimiento de la donación de embriones en Japón es un ejemplo de ello. Durante la investigación de campo en Japón, encontramos que las mujeres tenían la idea de que los procedimientos de donación de embriones son inhumanos, fríos y duros, mientras que los especialistas dijeron que no se le atribuye ningún valor a los embriones en Japón y que las mujeres no tienen reparos a la hora de donarlos. Este artículo estudia la causa de esta diferencia en la percepción de las experiencias de recolección de óvulos entre las mujeres y los especialistas en FIV. Nuestra primera fuente de datos fueron las narrativas de entrevistas con mujeres a quienes se les está practicando FIV, especialistas en FIV, enfermeras, consejeros y consejeras y los encargados de formular políticas. La investigación de campo fue llevada a cabo en 2006, 2007 y 2008. Analizamos los procesos y las maneras en las que las experiencias de las mujeres con la recolección de óvulos se vuelven invisibles en los contextos socioculturales de Japón, incluyendo los valores del matrimonio, el hogar, y la maternidad en Japón. Nuestro análisis se basa críticamente sobre las teorías feministas marxistas, que nos permiten discutir la relación entre la
producción de embriones y óvulos, la reproducción, la propiedad y el género. Este marco teórico también nos permite ver el caso de Japón, prestando particular atención a las perspectivas históricas y formas culturales específicas.

Palabras claves: Japón; donación de embriones; experiencias de mujeres; colección de óvulos; invisibilidad; teorías feministas marxistas

日本的卵子采集：在男性空间中看见女性经验

在胚胎的创造与捐赠中，女性必须经历试管婴儿胚胎植入（IVF）以采集卵子，故其角色至关重要。但女性在胚胎捐赠过程中的角色却广泛地被忽略，宛如胚胎是无中生有一般。日本胚胎采集过程的案例便可做为明证。我们在日本进行田野工作的过程中，发现纵使日本专家宣称卵子采集是价值中立，且女性对于捐赠胚胎并不会有所顾忌，女性却认为胚胎采集的过程是无人性，冰冷且残酷的。本文探讨导致女性与IVF专家对于胚胎采集认知差异的原因。我们的主要数据来自经历IVF的女性，IVF专家，护士，顾问以及政策制定者的访谈叙事，田野研究则在2006，2007与2008年间进行。我们分析女性的卵子采集经验在日本的社会文化脉络中“被隐形”的过程与方式，包含日本的婚姻，家户与母性价值观。我们的分析批判性地运用马克思主义女性主义理论，该理论让我们能够讨论胚胎与卵子的生产，再生产，所有权与性别之间的连结。此一理论框架同时让我们能够检视日本的案例，并特别关照历史的面向与特殊的文化形式。

关键词：日本; 胚胎捐赠; 女性经验; 卵子采集; 隐形性; 马克思女性主义理论