"Happy Accident?" Couples' Reproductive Decision-making and the Role of Gender, Power and Reproductive Autonomy in the Netherlands:

A Reflection on the Applicability of the Findings in High-fertility Contexts

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Introduction

Globally, research and interventions on fertility often focus on women and their reproductive autonomy in high-fertility contexts. Reproductive autonomy concerns the power to decide and control one's contraceptive use, pregnancy and child bearing (Upadhyay et al., 2014). However, individual, female-focused conceptualisations of reproductive autonomy overlook the role of men and couple dynamics in explaining and understanding fertility outcomes (Sahay, 2020). Although the need to involve men in reproductive health and fertility research and interventions is increasingly being recognised (Hardee, 2020), a knowledge and attention gap remains with regard to the importance of couple dynamics in reproductive decision-making processes.

Being a low-fertility context, only a few studies have focused on reproductive autonomy and couples' reproductive decision-making in the Netherlands (e.g. Matar, Höglund, Segerdahl, & Kihlbom, 2020). However, partners do not necessarily desire the same number of children (Duvander, Fahlén, Brandén, & Ohlsson-Wijk, 2020). For instance, research shows that Dutch women have higher desired fertility than men, and that they do not always achieve their desired fertility: rather, women's actual achieved fertility is comparable to men's desired fertility (Eurostat, 2021; OECD, 2011).

In contrast to many high-fertility contexts, fertility explanatory factors such as access to contraception, education and gender inequality are less profound in the Netherlands. Yet, this makes it interesting to study couple dynamics in this context because it may uncover power dynamics and other relevant interactions that go beyond these well-studied indicators. Therefore, the objective of this Share-Net small grant study was to better understand couples' reproductive decision-making processes in the Netherlands, with specific attention to the role of gender, power and reproductive autonomy; and -based on those findings- to develop a tool that can support couples in this decision-making process. A reproductive justice perspective was applied to study the couples' perceived opportunities to exercise (1) their right to have a(nother) child under the conditions of one's choosing and (2) their right not to have a(nother) child, thereby taking into account the perceived power dynamics internal and external to the couple (Ross, 2017).

This reflection explains the study approach, main findings and resulting tool that was developed for couples in the Netherlands. Then, it discusses into what extent the findings and resulting tool could be applicable for couples in other contexts, particularly high-fertility contexts.

Methods

Dyadic in-depth interviews were conducted between October 2021-July 2022 with 21 couples: 11 identified as cisgender and heterosexual, and 10 as lesbian, homosexual, bisexual and/or transgender (LGBT). Ten couples did not have children, the other 11 couples were expecting or had 1-4 children. Three participants had children with a previous partner. The participants were aged 26-54 years old.

Although participants were purposively recruited with a wide variety of background characteristics, a majority of the participants was white, higher educated and not religious. Several participants indicated disabilities, such as autism, ADHD and physical disabilities. The interviews took 2 hours and 29 minutes on average, and they were audio and video recorded and transcribed verbatim. To validate the findings, the preliminary findings were discussed in a focus group discussion with 4 fertility desire therapists, organised and led by sexologist Sanderijn van der Doef. At moment of writing, the data are still being analysed and, as such, the findings in this document should be considered preliminary.

Findings

The preliminary findings show how couples can find it difficult to discuss their discrepant fertility desires. The "heart's desire" for another child by one partner was often met with concerns from the other partner related to tiredness, not having enough time for themselves, and physically and mentally not having the energy or capability to care for an additional child. Gendered power inequality was found when male partners took a firm or more 'rational' position, or when female partners showed stronger communication skills or more topical knowledge. However, it should be noted that these differences could also be attributed to the partner desiring a(nother) child being more proactive in initiating the conversations. In the heterosexual relationships this was often the female partner.

For some couples, a divergent fertility desire could lead to perceived interdependency, as partners could fear that 'not giving in' to their partner's desire could lead to breaking up the relationship. It was also noted that contraceptive use, or the lack thereof, could play a role in partner's reproductive autonomy within heterosexual couples. For instance, some women wanted to have another child but no longer used hormonal contraception, for various reasons. However, this increased the chance for pregnancy, also when the male partner did not want to have another child. Several men, who did not want to have another child, did not seem to be aware of long-acting reversible male methods, and they seemed hesitant to have a vasectomy. This left them with few opportunities to prevent pregnancy, such as condom use and natural family planning.

A comparison between the cis heterosexual and LGBT couples showed that gender identity and sexual orientation play a role in participants' degree of reproductive autonomy. First of all, it seemed easier for the LGBT couples to discuss their fertility desires. One reason could be because they started the conversation earlier on in the relationship - knowing that trying to have children would require a long trajectory. Another reason could be that the trajectory implies that the couple needs to conduct research on the various options and that there are many decisions to be taken, which may structure and breakdown the bigger conversation into many smaller, manageable conversations. Lastly, the LGBT couples would need to verbally decide on whether they want to have children. This is different in the case of fertile heterosexual couples, where pregnancy could also occur while still undecided, for instance shaped by interpretations of non-verbal communication, mutual assumptions, a lack of contraceptive use, and a desire to let nature decide when they were in doubt themselves.

Compared to the heterosexual couples, the LGBT couples seemed more aware of various trajectories to have children. This showed the heteronormative discourse that shapes many fertility decision-making processes in the Netherlands. For instance, whereas most heterosexual couples only considered having biological children, LGBT couples more often discussed options such as adoption, foster care, a sperm or egg donor, surrogacy, and co-parenting with another couple or single parent.

The options they perceived also shed light on how individuals can desire only components of the event, e.g. to have a biological child, to be pregnant, to breast feed a baby or to raise a child. For instance, in the interviews with LGBT couples, some women indicated a desire to become a parent but they did not desire to be pregnant or to give birth. Or they discussed that one partner would become pregnant but with the egg of the other partner. In contrast, the heterosexual couples usually only considered whether they wanted to have a(nother) child, without distinguishing these various components as separate choices.

It could be argued that being able to consider more options and trajectories increases the reproductive autonomy of LGBT couples but it mainly shows how *not* being able to conceive via sexual intercourse strongly limits their reproductive autonomy because they are forced to consider options that are often more insecure, complex, time-consuming and expensive.

Also, the Dutch legislation could decrease options for LGBT couples, in some cases also compared to sub fertile heterosexual couples. Examples of this are found in opportunities to find a surrogate (i.e. the Dutch law does not allow individuals to publicly announce, for instance on social media, that they are looking for a surrogate mother), to assign legal parents, parental leave and reimbursements for fertility treatments. Some LGBT couples could feel forced to make their fertility desire public because they needed to use their network to find a surrogate or donor. For some, this was very uncomfortable when they felt that they had to self-disclose their sexual orientation (again) or if outsiders would inquire about the process when they themselves did not feel like sharing. The many perceived options could also lead to choice-related stress, for instance, when LGBT couples felt that the choice for a known or unknown donor needed to work out perfectly. A participant expressed how much more relaxed it would have been to just 'walk into a bar, hit on a man and become pregnant from a one-night stand'. Furthermore, LGBT couples' fertility process could feel more vulnerable, expensive, complicated and less spontaneous compared to fertile heterosexual couples.

Another heteronormative discourse was found in a higher sociocultural expectation for heterosexual couples to have children compared to LGBT couples. This was exemplified by a participant who identified as bisexual: in a previous relationship with a man, her friends, family and even she herself had expected them to have children. However, now that she was in a relationship with a woman, it felt like they could develop their fertility desire from scratch. Another example came from a male participant who grew up in the 'Bible belt', a relative religious area in the Netherlands: as a young person, he had felt that he needed to choose between self-disclosing his sexual orientation and becoming a father, as he did not feel that the two could coexist.

Lastly, some participants with disabilities doubted whether they would have the mental or physical capacity to take care of a(nother) child, even when they did desire having children. In such cases, they indicated that external support could be useful, such as governmental subsidies for cleaning support, day care or a planning coach.

The tool

One of the main findings was that couples can find it difficult to discuss their fertility desire, especially when they know they have divergent desires. Miscommunication and tensions could arise when partners diminished their verbal communication and started to interpret each other's nonverbal behaviour and develop assumptions about what their partner wanted. Also, partners could find it

difficult to create a good moment to discuss, or to know what to ask each other. Therefore, we created so-called 'conversation game cards'. The cards consist of 43 questions categorised in 4 themes: (1) Whether you want to have children or not, (2) When to have children, (3) How you envision your lives with or without having children, and (4) Different ways to become parents. The tool also includes some communication tips and sources for further information or support. In a moment and place comfortable to both of them, couples can draw cards from the set of game cards in front of them, and take turns to ask their partner the questions on the cards.

We envision that this approach will: (1) lower the barrier for partners to have this conversation with their partner, (2) start these conversations early on in the relationship before pressure and sensitivity around the topic arise, (3) help partners to discuss topics they had not yet realised could be relevant for them to discuss or were afraid to discuss, (4) encourage them to listen to their partner's views rather than interpreting and creating assumptions, and (5) encourage exploration of various scenarios *together* rather than feeling that a divergent opinion needs to be defended.

Reflection on the relevance of the tool for couples in high-fertility contexts

As discussed in the introduction, level of education and access to contraception can for a large part explain why women in high-fertility contexts can have more children than they wanted or planned for (Bongaarts, Frank, & Lesthaeghe, 1984). The concept of reproductive justice (Ross, 2017) helps to reflect on the multidimensional power dynamics that shape reproductive autonomy and decision-making at the individual and couple level in various contexts. For instance, high-fertility contexts, such as in sub-Saharan Africa, can be considered predominantly collectivist, patriarchal contexts that view individual and couple autonomy subordinate to social expectations (Fatehi, Priestley, & Taasoobshirazi, 2020). As a result, women may have reduced reproductive autonomy due to pronatalist sociocultural expectations and norms that expect the men within couples to decide on fertility (Casterline, 2017; Sarnak & Gemmill, 2022). Furthermore, high-fertility contexts are often heteronormative societies that do not acknowledge, or even legally allow, the expression of gender identity and sexual orientation of LGBT individuals and couples, let alone the realisation of their fertility desire and the specific care this may require (Agénor et al., 2020; Nyanzi, 2013).

The study in the Netherlands showed that couples can find it difficult to discuss their divergent fertility desires, and that there are power dynamics within the couple that can steer both the conversation and the fertility outcome. These included gendered power dynamics but also dynamics related to communication skills and character traits. The conversation cards game could support couples to have these conversations, and perhaps this format could also work in high-fertility contexts. However, we believe that a mere translation of the tool will not suffice because the contents and perhaps also the format will need to be contextualised. At least, the following issues should be considered.

First of all, in the relatively individualised Dutch culture, individuals and couples are usually considered to be the main decision-makers regarding their own fertility. However, in more collectivist societies family members and community expectations could be more influential. So, a community may not consider fertility to be an autonomous individual or couple choice.

Second, patriarchal norms may instruct the man to decide about fertility and leave the woman with little agency to initiate this conversation or act upon her own fertility desire. In contexts dealing with gendered power inequalities and high incidence of gender-based violence, it should be considered into

what extent couples will be able to have fertility desire discussions, also if a tool such as the conversation cards game is available (Iliyasu et al., 2016; Sharifi, Jamali, Larki, & Roudsari, 2022).

Third, the conversation cards game includes questions that are relevant for LGBT and sub fertile heterosexual couples. In societies where fertility is even more strictly embedded in a heteronormative discourse, compared to the Netherlands, the part of the tool that discusses different ways to become parents may not be accepted or understood. Furthermore, the findings showed that Dutch legislation and culture restrict opportunities for reproductive autonomy, and that particular groups are unequally affected by these restrictions. Such barriers may even be higher in other contexts, especially in high-fertility and low- and middle-income contexts, for instance with regard to opportunities for fertility treatments, contraception and safe abortion. Also, in low- and middle-income contexts fewer resources and acceptance may be available for individuals with disability to enjoy their reproductive autonomy (Acharya & Yang, 2022; Johnson & Nabaneh, 2022).

Finally, religion, income and educational inequalities within couples, and other aspects that may be relevant for couples in high-fertility contexts were not extensively taken into account in the study in the Netherlands. This further justifies the need to contextualise the content and format of the tool when implemented in other countries.

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