“You drowned me in tears, where did you go?”
Narratives of Reproductive Loss and Grief in Middle-Class India

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Fig.1. Waiting area at an infertility clinic in Kolkata

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Acknowledgements

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[1] If not indicated otherwise, all photographs were taken by Pallabi Roy.

[2] Image retrieved from https://www.pinterest.com/pin/718324209289123236/

[3] Image retrieved from https://www.advertgallery.com/newspaper/nova-ivi-fertility-20000-ivf-pregnancies-in-11-months-ad/

[4] Photo credit: Ms. Royina Saha.

List of Abbreviations

ART	Assisted Reproductive Technology
DI	Donor Insemination
ED	Erectile Dysfunction
ESHRE	European Society for Human Reproduction and Embryology
ET	Embryo Transfer
HSG	Hysterosalpingogram/Hysterosalpingography
ICMR	Indian Council of Medical Research
ICSI	Intracytoplasmic Sperm Injection
IUI	Intrauterine Insemination
IVF	In-Vitro Fertilisation
OT	Operation Theatre
PCOS	Polycystic Ovarian Syndrome
PGD	Pre-implantation Genetic Diagnosis
PGS	Pre-implantation Genetic Screening
SANDS	Stillbirth and Neonatal Death Charity
SRT	Selective Reproductive Technology
TESA	Testicular/Epididymal Sperm Aspiration
TVS	Transvaginal Scan

Notes on Transliteration

All transliterated words from Bengali and Hindi have been italicised. The Bengali and Hindi or Sanskrit words which are commonly used in Anglicised spelling in the relevant academic literature, such as *Bhadralok* (gentility), *Annaprashan* (rice-eating ceremony), and *Samskaras* (sacraments), are spelled in these conventional ways, too. Names and other proper nouns are also spelled as they are commonly written in English (e.g. Kolkata, Ganges). The remaining Bengali and Hindi words in this dissertation are transliterated according to the standard system of transliteration. For instance, "dh" is used for the aspirated da, long vowels are marked with diacritics, retroflexes have an underdot (e.g. "ṛ"), and the overdot is used to indicate a nasal sound (e.g. "ṅ").

In Bengali, the medial *a* is usually pronounced more as an "o" than an "a". Accordingly, I have transliterated some of the words with slight alterations to remain closer to the actual Bengali pronunciations (see Lamb, 2000, p. xvii). For instance, I use *nām koron* for "naming ceremony" instead of the Hindi pronunciation of *nām karan*. In addition, the letter "s" is pronounced in Bengali as "sh". Thus, for instance, I spell the Bengali word for "child" as *shontān* and not *santān.*

Chapter 1. Introduction

> "Why did you give me so much pain? What did you get in return?
> You drowned me in tears, where did you go?
> Whenever the sky is full of stars, whenever the moon smiles gently,
> In the canvas of my heart, it is only your picture that floats.
> Do not know, I do not know why, do not know, I do not know why.
> Perhaps I have seen you, perhaps I have thought of you,
> Perhaps I have known you, that is just how you know me too,
> Don't know, I don't know why, don't know, I don't know why."[5]

A former school teacher and an Indian classical singer, 34-year old Maya sang the aforementioned self-composed song during our interview. The poignant lyrics reflected her experiences following the first miscarriage in the 17th week of her pregnancy. Within the next two years, she experienced three successive first-trimester miscarriages. When we met for the first time in 2018, she was undergoing her first In-Vitro Fertilization (IVF) treatment cycle. Recounting her reproductive experiences, Maya said,

> "It is actually normal birth that's a miracle. Everything from start to end has to be perfect and only then a healthy baby is born. People do not realise that *not* [her emphasis] being able to have a child is actually much more common that people would like to believe. I have learnt this lesson well from my own case. The people in my life - my husband, my parents, my sister, my close friends - they all tell me to forget about those mishaps but some things simply cannot be erased from the mind of a mother. Some things stay with you forever…Time heals many wounds but I have not been able to forget those painful moments even today. I had never thought, in my wildest of dreams, that my life would take such a turn. Does anyone ever imagine such things will happen to them? Each time it happened, I did not how to react initially. I just felt as if everything had become dark in front of my eyes. I did not know what to do next. All the dreams and plans I had made for my child, they simply scattered. And not once, not twice, I have experienced the same pain four times *teary-eyed*. My husband and I have started IVF with immense hope. It's the best route for couples like us to have a baby. We have placed all our dreams and hope in Dr. Sen's [infertility specialist] hands. To be honest, I do not know if I have any mental energy and strength left inside me to handle another mishap. I honestly do not know what I will do if the IVF does not work. At the end, whatever happens, is the wish of the One above all of us, isn't it?

The present study is about reproductive disruptions which result(ed) in profoundly disrupted life trajectories. More specifically, it is about the gendered experiences of reproductive loss and the ensuing grief among married couples located in the middle-class setting of urban Kolkata in West Bengal, India. The study, however, is as much about loss and grief as it is about

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[5] I have translated the Bengali lyrics into English.

the couples' persistent struggles to resume normalcy[6] in their disrupted lives, most notably by pursuing assisted reproduction in order to achieve reproductive success.

Maya Chatterjee is one of the many female interlocutors in my study who had experienced reproductive loss and was undergoing technology-mediated conception in order to have a child. Similar to the reproductive disruptions[7] in her life, the ethnographic accounts in this study show that trajectories of conception, pregnancy, and childbirth are not always linear and do not always end in delightful stories of reproductive success. Reproduction, indeed, cannot be seen as a taken-for-granted process as in many cases, this process goes awry (see Inhorn, 2007). There are manifold causes which are implicated in the term reproductive loss, such as medical termination of pregnancy, abortion, (recurrent) miscarriage(s), ectopic pregnancy, perinatal death, stillbirth, neonatal death, unsuccessful assisted conception, and infertility[8]. As I demonstrate throughout this study, such non-normative and often, unanticipated occurrence(s) of loss, tend to cause intense forms of physical, emotional, and psychological distress in the couples' lives. As such, the biosocial[9] event(s) of reproductive loss(es) not only disrupt the reproductive trajectory of women and men, but they also disrupt their understandings of conception, pregnancy, and childbirth as a linear process, the naturalness of biology and kinship, the supposedly normal functioning of their bodies, their normative gender identities, their normal marital and sexual relationships, the seamless

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[6] According to Becker (2000, p. 34), "views of normalcy are affected by factors such as ethnicity, gender, age, and income level, as well as by life experiences. They are based on ideas about what 'most people' do and normalcy is, thus, defined in terms of particular cultural images. Although not everyone has the same interpretation of what constitutes normalcy in a given situation, there is a huge overlap in how people in the same society define normalcy". The ideas of what constitutes normalcy, thus, lies at the core of the prevailing sociocultural discourses and people tend to refer to such dominant social discourses for identifying what is 'normal' (ibid, p. 35).

[7] The term 'reproductive disruptions' includes a vast array of reproductive health issues such as infertility, "local practices detrimental to safe pregnancy and birth; conflicting reproductive goals between women and men; miscommunications between pregnant women and health care personnel; cultural anxieties over gamete donation and surrogacy; the contested meanings of abortion; the uneven globalization of new genetic, pharmaceutical, assisted reproductive technologies, and untoward reproductive practices" (Inhorn, 2007, p. x).

[8] See Appendix 1 for a description of the types of reproductive loss which have been explored in this study.

[9] Brigitte Jordan has argued that childbirth is a biosocial event i.e. it is an event where both biology and the social "come together in very special ways" (Jordan 1978, p. 1 in Alex and Polit, 2016, p. 7). Petchesky (1987, p. 285) has defined pregnancy as a "biosocial experience" which acts on women's bodies in different ways which impacts how women relate to reproductive technologies. Accordingly, I suggest that reproductive loss also needs to be understood as a biosocial event which necessitates an acknowledgement of both the biological basis as well as the social aspects in order to understand how women (and men) experience such a loss and also how they simultaneously or subsequently engage with reproductive technologies.

continuity of their life trajectories as well as their imagined future(s) (see Baker, 2004; Becker, 1994, 2000; Becker and Nachtigall, 1992; Franklin, 1997; Inhorn, 2009; Layne, 2003).

Based on the ethnographic accounts in my study, I make a three-tiered argument towards gaining a nuanced understanding of the diverse and complex experiences of reproductive loss of middle-class couples in urban Kolkata. My first argument is that the aspirational values, ethos, and practices of the 'Indian middle-class'[10], such as modernity[11], increased consumption of biomedical services and reproductive technologies, and the desire to emotionally and financially invest[12] in raising one or two 'normal' children circumscribe the couples' reproductive experiences and thus create a particular version of reproductive loss – one in which the loss of a wished-for child takes on heightened meaning. Situated within such experiences and lived realities of loss and grief, I show that notions about and meanings of female and male bodies, gender roles, conception, pregnancy, parenthood, foetal and embryonic personhood, marriage, and grief are significantly shaped by biomedically informed notions and practices as well as the particularities of belonging to the middle-class in contemporary India.

However, it is not only the context of 21st century, globalizing, urban, middle-class India and biomedicalised reproduction which leads to the constitution and experiences of a specific kind of reproductive loss. Indeed, my second argument is that the occurrence of reproductive loss(es), the ensuing grief, and the multiple attempts at assisted conception to achieve reproductive success, constitute a context in which the roles and meanings of the actors and entities involved in it, especially of the women and men undergoing the reproductive treatment(s), and even their emotions, are not pre-ordained or fixed. Instead, these roles, meanings, and emotions are continuously *enacted* (Mol, 2002) and defined in specific ways. As I will show in the following chapters, these multiple enactments are significantly shaped,

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[10] As a heuristic device, I will be using the term 'Indian middle-class' throughout this dissertation while recognising that it is certainly not a homogenous class category as discussed later in this chapter.

[11] The term 'modernity' or 'modern', as Latour (1993, p. 10) has pointed out, comes in several versions, and it does not necessarily stand for a contrast to the archaic and 'traditional' past. In this study, I draw on Bharadwaj's understanding of 'modern' (2016, p. 13) who suggests that "at its most elementary, in India today, to be modern is to be anchored in the spatial configuration of the new and in the temporal dimension of the now". He argues that "tradition, far from being antithetical to the spatial and temporal project of the 'new-now', produces exceptional and contingent modernities that (re)animate the then in the here and now" (ibid).

[12] Scheper-Hughes (1992, p. 402) argues that the language of "investment" is "*our* cultural idiom, the language of the free market, in which infants are perceived as valuable biological and social commodities".

constrained and/or controlled by a range of human and non-human actors, such as the medical practitioners and medical technologies.

This study, however, is not only about the structural or systemic constraints (such as the medical and technological demands) and the ideological constraints (such as gender norms, gendered expressions of emotions, and culturally specific meanings attached to reproduction, parenthood, kinship, family) which restrict women's agentic capacities and movements. Instead, based on my ethnographic engagements with the couples, my third argument is that as actors-enacted (Law and Mol, 2008), they were not only being acted upon in one way or another but they also utilised diverse forms of "constrained but strategic agency" (Shaw 2016, p. 150) by collaborating or negotiating with other actors as a way of coping with their loss and also in order to move closer to their desired outcome of reproductive success. Furthermore, it was not only the female interlocutors who were enacted in certain ways by the other actors, but I show that various actors, entities, and concepts were simultaneously enacted in relation to one another during various encounters. For example, within the clinical spaces, biogenetic relatedness and the personhood of foetuses were enacted by medical practitioners and thus, took on certain meanings for the couples. Across the ethnographic chapters, I demonstrate that these multiple enactments are intricately intertwined and that together they constitute an integral part of the wider canvas within which the middle-class women experienced reproductive loss, grief, and attempted to achieve reproductive success by pursuing assisted conception. In addition, I also illustrate that mobilising different forms of agentic capacities allowed the female (and some male) interlocutors to give meaning to their disruptive reproductive experiences as well their disrupted personal relationships beyond the clinical spaces. Indeed, throughout this study, I demonstrate that within various sets of constraints, human agency is visible even in the smallest of activities, even when an actor is ostensibly passive (Mulling 1995, p. 133 in Ginsburg and Rapp 1995, p. 11; see also Shaw, 2016).

1.1. Conception of the Study, Significance, and Limitations

The present study was conceptualised as a result of my serendipitous encounter in 2014 with material artefacts that had been prepared for a 28-week old baby who had died in-utero. As I was rummaging through some books in my professor and former supervisor, Prof. Naraindas's office in Jawaharlal Nehru University, New Delhi, I chanced upon a white cloth pouch embroidered with frills. I asked him what it was and he told me to take a look inside it. On opening it, I saw a pair of white mittens and socks, a tiny woollen cap, and a book with poems about the "departed angel". I also saw a document, several pages long, detailing the deceased baby's funeral ceremony at a chapel. Below the pastor's initial words in that document, it stated – "Michael Jackson's 'Heal the World' plays in the background". After a few minutes of scrutinizing everything inside the pouch, I was rather curious to know more about this ceremony for a deceased baby – an event completely new for me. I learnt from my professor that he had recently attended the funeral of that baby in Australia. I also learnt from him that some bereaved Australian couples could now decide whether they wanted an open or closed casket for their deceased child, whether they wished to have an official ceremony in the chapel or whether they wanted a quiet burial in their garden. He further informed me that as part of creating and preserving memories, couples had the choice of getting customised silver or gold-plated hand or foot prints of their deceased baby. I eventually learnt about grieving practices and rituals which were performed in the United Kingdom as well. I spent the rest of that day ruminating over this newfound information. I wondered why I had never heard about such practices and rituals within public discourse in India. Were these practices and rituals unique to the 'Global North' and had they always existed? Or did they also exist in the 'Global South' but were largely enshrouded in cultural silence? Specifically, what were the experiences of people who suffered reproductive loss in the Indian context wherein statistical data points towards one of the highest rates of stillbirths and neonatal deaths in the world?[13] What was done with the bodies of the dead babies? How and where were they disposed? There were several unanswered questions in my mind and as my professor aptly pointed out, this was a fertile ground for anthropological research.

Inspired by the conversation with my professor on perinatal death as a form of reproductive loss and the rituals for coping with the resulting grief and bereavement, I began engaging with the available and relevant literature. Soon, I noticed that most of the research on the themes of reproductive loss and grief had been conducted in the Euro-American context and the focus was significantly more on women's experiences while men's experiences of loss had been relegated to the margins – a pattern which I realised during my own research was almost impossible to avoid given that women's bodies were the de facto locus of the reproductive processes and almost all treatments (see Keane, 2009; Komaromy, 2012; Layne, 2003;

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[13] See https://www.who.int/maternal_child_adolescent/epidemiology/stillbirth/en/ ; https://data.unicef.org/topic/child-survival/neonatal-mortality/

Moulder, 1994; Murphy, 2012a, 2012b; Peel and Cain, 2012; Thompson, 2012; Van der Sijpt, 2018). I also realised that there was a discernible absence of anthropological research on reproductive loss and the subsequent grief and bereavement in the South Asian context. The studies available on India were predominantly confined to pregnancy loss, childlessness, and death rituals within rural settings and the focus was on female narratives (for e.g., see Jeffery and Jeffery, 1996; Otten, 2016; Pinto, 2008b; Polit, 2016; Roberts, et al. 2012, 2011). There seemed to be a distinct blind spot concerning empirical research on reproductive loss in urban, middle-class India. As Donner (2008, p. 33) has convincingly pointed out, there seems to be a traditionalist academic bias within anthropology towards rural field sites, especially in South Asia, and there seems to be an unease when the focus of fieldwork is an urban site.

In addition, there seems to be an implicit assumption in the public discourse in India (and perhaps even within academia to a certain extent) that educated people who belong to urban spaces and are socioeconomically privileged, will necessarily be more aware, have greater access to resources, have more knowledge about how to grapple with an occurrence of reproductive loss, and also know how to resolve their ‘problem’ of involuntary childlessness as compared to economically disenfranchised people. Could it be that within anthropological research on reproductive issues, there has been an implicit privileging of certain sections of the society (women, the rural poor) because they are (relatively) underprivileged? While the Indian middle-class has been the focus of study for many scholars as I have discussed later in this chapter, not much is known about how women and men from this class background experience reproductive loss and how they cope with the resulting grief. As such, my study contributes to the inadequate theorizing of the intricately entangled themes of reproductive loss, involuntary childlessness, assisted conception, and grief in the contemporary, globalizing, urban, and middle-class Indian setting. The findings of my study also add to the literature on the interplay between gender, marriage, sexuality, and reproduction among the middle-class milieu in India which scholars have noted are themes that for a long time had been engaged with tangentially and have been granted academic attention rather recently (see Donner, 2008; Puri, 1999; Saavala, 2013; Sen, Biswas and Dhawan, 2011; Twamley, 2014; Uberoi, 2005)[14]. Finally, the wider significance of this study lies in its contribution to the lacunae in

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[14] Anthropological discussions had articulated the questions of sexuality in India in largely “muted and hypostatised ways” for a relatively long time (John and Nair 1998, p. 22), until the emergence of pioneering research such as Kalpana Ram’s (1994) research in rural Tamil Nadu, Karen Kapadia’s (1995) research in Tamil

anthropological research on reproduction, involuntary childlessness, loss, foetal and/or baby death, and grief and bereavement in the South Asian context.

While the strength of this research lies in the ethnographic details of the diverse yet intertwined themes regarding reproductive loss and grief in middle-class India, my data certainly has its limitations. For instance, my research engages specifically with the narratives and experiences of Hindu married couples who fit within the heteronormative discourse. Moreover, my study does not consider the impact which facets of popular culture, especially the (social) media, have on the reproductive experiences and treatment-seeking practices of childless couples. I hope that with its modest contributions to the broader, contemporary scholarship in medical anthropology and the anthropology of gender, my study opens up possibilities for research on the above-mentioned understudied topics.

1.2. Research Questions and Areas of Investigation

Childbearing is one of the most important components in the discursively normal progression of adult life in pronatalist and heteronormative societies and a culturally mandated obligation after marriage, especially in some parts of the world including India. Bearing this in mind, I wanted to enquire about married women and men's motivations and reasons for wanting to have children and in the process, problematise the notion of wanting to have children as a 'natural desire'. I wanted to explore whether there were any gendered contrasts in how the women and men articulated their ostensibly nature desire to procreate and to become a parent and whether the couples' "desperate" desire (see Franklin, 1990, 1997) for a child was related to their understanding of *becoming* a woman or a man. In other words, I wanted to gain insights about how having a child was potentially understood by individuals as a precondition for becoming a complete gendered and social person in the pronatalist Indian context. I was especially curious to know why some of the couples, especially the women, were subjecting themselves to immense physical and emotional exhaustion by undergoing years of infertility treatments, at times despite repeated treatment failures. Next, I intended to find out how actors other than the childless couples who had experienced reproductive loss, such as the medical practitioners and reproductive technologies (as "non-human actants", Latour, 2005) shaped and influenced the couples' experiences of reproductive

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Nadu on 'proper' female sexuality among the lower castes, Prem Chowdhary's (1997) study on male and female sexuality in rural north India, and Veena Das's (1996) study on gender, sexuality and law (ibid, p. 22-23).

loss(es) and their treatment-seeking practices. In order to do so, I observed various medical procedures in which different reproductive technologies were administered by the practitioners within the infertility clinics – the ethnographic details of some of these treatments and technologies will be discussed in the forthcoming chapters.

Further, I wanted to identify the ways in which middle-class women and men grieved for and coped with the episode(s) of reproductive loss. Given that events such as stillbirth (and I assume, all forms of reproductive loss), are largely shrouded in secrecy in rural India (see Jefferey and Jefferey, 1996; Roberts et al., 2012; for exception, see Pinto, 2008b), there were several questions which intrigued me. To my knowledge, and as previously mentioned, there is a stark absence of in-depth anthropological research in India that has concerned itself with the ways through which individuals grieve and cope with reproductive loss among the middle-class milieus. An exception is Mammen's (1995, p. 99) study on perinatal loss in a private hospital in Bangalore which showed that after the loss, bereaved women were encouraged by their doctors to try again, even though the women reportedly experienced significant emotional distress. Mammen's study, however, left many questions unexplored. What happens to the foetus or the baby after the loss? Who decides how and where it is to be disposed? How do medical practitioners approach such a situation and (how) do they play a role in helping couples process their grief? How do the couples grieve and cope with this loss? What kind of social support do they receive? Are there ways in which the dead foetus/baby is memorialised? Do the couples (together or individually) participate in any formalised mourning rituals (if at all they exist)? How do women and men make sense of such an experience? These questions led me to engaging in conversations with my interlocutors about their retrospective accounts of the occurrence of loss. It also led me to visiting a Hindu burial ground[15] in Kolkata (see chapter five) and having an informal dialogue subsequently with a Hindu priest to gain further insight regarding death rituals for deceased babies.

One of the most important themes which emerged during the interviews and informal conversations with my female interlocutors was how their conjugal lives, and especially their sex lives, had been affected in the aftermath of reproductive loss and even more intensely

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[15] My first visit to the Muraripukur Hindu burial ground was during my pilot study in 2015 along with Prof. Harish Naraindas. During our first visit, it was Prof. Naraindas who interviewed a caretaker while I mediated between the two for purposes of translation from English to Bengali and vice versa. See chapter five for more details.

during the subsequent ordeal of (unsuccessful) assisted conception and recurrent treatment failures. I engaged in dialogues with them about the various attempts they made to restore a sense of normalcy in their conjugal lives. Questions regarding their understanding of marriage, their roles in it, and 'acceptable' forms of female desire and sexuality were explored in this context. Finally, instead of exclusively focusing on women's experiences, I also wanted to include men's aspirations and motivations regarding fatherhood and their lived realities of experiencing reproductive loss and grief. This involved asking questions to my male interlocutors regarding their desire to become a father and the importance they attached to fathering a biological child. With a few men, the conversations resulted in discussions and insights into the anxieties they faced when they engaged in certain practices within the infertility clinics such as masturbation for semen collection or about undergoing medical procedures directed towards potentially treating male infertility.

In the section below, I engage with the terms of reproductive loss, grief, bereavement, and mourning in order to offer conceptual clarity and this would also mark the starting point for an elaborate review of relevant literature.

1.3. Conceptualising Reproductive Loss, Grief, Bereavement, and Mourning

According to Martin and Doka (2002, p. 12), loss refers to "being deprived of or ceasing to have something that one formerly possessed or to which one was attached". According to the authors, losses can be manifested in various ways, but particularly in three ways. One is in the form of a "physical loss" wherein someone loses someone or something tangible, the second is "relational loss" wherein a relationship with someone whom we are attached to is lost, and the third is "symbolic loss" which entails a loss of something intangible such as dreams or faith (ibid, p. 12). Drawing from Martin and Doka's explanation, my theorization of reproductive loss involves understanding it as a rather unique form of loss which includes physical, relational, and/or symbolic loss. The loss of a late-term baby (physical loss), the loss of the imagined and anticipated parent-child relationship (relational loss), and/or the loss of a foetus in the early stages of pregnancy as an intangible loss or the loss of imagined conception in the light of being unable to conceive (symbolic loss) – all these forms of loss, which are often not mutually exclusive, can be encapsulated within the comprehensive rubric of reproductive loss.

The anthropological study of reproductive loss as a topic on its own merit emerged in the early 2000s which is relatively recent compared to research on other reproductive issues, such as the medicalisation of childbirth, involuntary childlessness, and abortion (Komaromy et al., 2007; see also Gray and Lassance, 2003, p. 98). In their influential edited volume about reproductive loss, Sarah Earle, Carol Komaromy, and Linda Layne have conceptualised reproductive loss as:

> not only to refer to experiences of early and late miscarriage, termination of pregnancy, stillbirth, perinatal and infant death, as well as maternal death – but also to other kinds of losses relating to reproduction including the loss of 'normal' reproductive experience such as that associated with infertility, assisted reproduction and the medicalisation of pregnancies, labours and deliveries defined as 'high risk'…to address non-normative reproduction to include the curtailment of reproductive futures and desires, whether by individual action or by social structures (Earle, Komaromy and Layne, 2012, p. 1-2).

The authors have also listed out the different forms of reproductive loss according to medical definitions while stating that these forms or categories are not descriptive and should instead, be seen as exploratory (Earle, Komaromy and Layne 2012, p. 206-207). In category I, they included infertility, unsuccessful assisted conception, and repeated early miscarriages – forms of loss which entail a loss of reproductive identity and the loss of the imagined child. Category II includes early/late miscarriage, stillbirth, neonatal death, infant death, and termination of pregnancy for medical reasons – forms of loss which entail the loss of an imagined, healthy child and the loss of parent status. Finally, category III includes termination of pregnancy for non-medical reasons which entails the loss of pregnancy but also the possible loss of the imagined child. My study portrays accounts of couples who have experienced one or more of the forms of reproductive loss as listed in category I and II insofar as I seek to represent a diversity in how the couples experienced loss but to ultimately show that notwithstanding the form and stage of loss, they suffered from a profound sense of grief and bereavement.

The conventionally used term within the established scholarship to describe non-normative reproductive experiences that does not result in the birth of a live or 'viable' baby is 'pregnancy loss'. According to the guidelines of the European Society of Human Reproduction and Embryology (ESHRE, 2017), pregnancy loss is defined as "the spontaneous demise of a pregnancy before the foetus reaches viability". While pregnancy loss is the more generic term used by medical practitioners in the Euro-American countries (as well as by the practitioners in my study), terms such as 'early embryo loss', 'first-trimester pregnancy loss', or 'second-trimester pregnancy loss' might be used when gestation-specific reference is required (ESHRE, 2017). However, as the term suggests, pregnancy loss includes only those experiences of loss which a woman experiences *after* she becomes pregnant. For the women who are unable to conceive and men who are unable to father a child, the term 'infertility' has been used both within medical literature as well as in social science research. I, however, use the all-inclusive term of reproductive loss to indicate not only the experiences of loss which couples experience after the woman has conceived and at any stage of gestation, but also the experiences of unsuccessful (assisted) conception and 'failed' pregnancies despite undergoing infertility treatment(s). Moreover, unlike the term pregnancy loss which implies a woman's embodied[16] loss, I use the term reproductive loss to indicate a loss experienced by both women and men, even if it is not necessarily physically embodied by men[17].

According to Martin and Doka (2000, p. 14), 'grief' is an individual's reaction and response to the experience of loss. Any experience of loss and the ensuing grief can lead to wide-ranging reactions such as physical reactions (headaches, nausea, loss of appetite, insomnia, pain), affective reactions (sadness, anger, guilt, anxiety, jealousy, fear, shame), cognitive reactions (obsessive thinking, inability to concentrate, disorientation), spiritual reactions (searching for meaning) and/or certain behavioural experiences (crying, social withdrawal, absentmindedness, increase in consumption of alcohol, avoiding or seeking reminders of the loss) (ibid, p. 16-19). Komaromy et al. (2007, p. 1) note that most of the studies on grief are rooted in psychological and psychodynamic theories and according to these theories, after some initial short period of grieving, the bereaved individual should let go and move on. The main drawback of these theories, as argued by Komaromy et al., is that anyone who does not grieve as per this paradigm of letting go and moving on is considered to be abnormal or pathological (ibid). Indeed, some scholars have recently argued that there is no particular way of grieving and that individuals should be given the freedom to express their grief in a manner of their choice (for e.g., see Gray and Lassance, 2003; Komaromy et al., 2007; Lovell, 1997). Martin and Doka (2000, p. 30) have distinguished the two most common patterns of grieving

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[16] I follow Csordas (1994, p. 3) to understand embodiment as the body which is transformed from an object to an agent i.e. "the body as an experiencing agent" which has been employed by scholars in anthropological analysis of several topics such as illness pain (and religious healing amongst others (ibid).

[17] This is not to claim that this is the only way of understanding reproductive loss and future research might give rise to other conceptualisations.

which are influenced by gender, although not determined by it. The first is the “intuitive pattern” wherein individuals, primarily women, experience and express grief through adaptive strategies in an affective and emotionally expressive way. The second is the “instrumental pattern”, typically followed by men, wherein grief is expressed physically, such as through restlessness or cognition. While grief refers to an individual’s diverse reactions and responses to loss, bereavement refers to the objective reality of loss according to the field of thanatology i.e. the scientific study of death (Doka, 1989). As such, it is possible for an individual to experience bereavement without an intense grief reaction (see Martin and Doka, 2000).

Although people use the terms grief and mourning interchangeably, Homans argues that strictly speaking they are not the same:

> On the one hand, grief refers to the ‘feelings of sorrow, anger, guilt, and confusion which occur when one experiences the loss of an attachment figure. On the other hand, mourning refers to the ‘culturally constructed social response to the loss of an individual’. Grief is a painful emotion that is, so to speak, looking for a ‘cure’. Mourning is a ritual, that so to speak, ‘heals’ the pain of grief…In a nutshell, grief is an emotion, mourning a grief-infused symbolic action. Both are a response to the loss of an attachment (Homans 2000, p. 2-3).

In the Encyclopaedia of Death, mourning has been defined by Doka as “the culturally patterned expressions or rituals that accompany loss and allow others to recognize that one has become bereaved” (Doka, 1989b, p. 126 in Homans, 2000, p. 23). The various mourning rituals are based on the type of loss, the relationship and attachment to who or what is lost, the circumstances surrounding the loss, prior experiences of loss, the individual’s personality, social variables (such as age and gender) and personal variables (such as health and lifestyle management) (ibid). In his text *Mourning and Melancholy* written in 1917, Freud was one of the first scholars to have discussed mourning as a hard and long process to get detached from the lost object of love (Väisänen, 1999, p. 14). Although, there can be forms of grief which are devoid of any externalised rituals (e.g. grief during or after divorce), the process of mourning usually involves formal, externalised rituals, and/or other outward manifestations of the loss (Martin and Doka, 2000, p. 23). Performing mourning rituals enables the bereaved individual to acknowledge the loss, react to it, make sense of the loss, give meaning to it, and eventually adapt to their life after the loss and reinvest in newer relationships (ibid, p. 23-24).

Homans (2000, p. 3) outlines a schema for how individuals usually process an episode of loss:

attachment → loss → grieving → mourning → reattachment

Following the event of loss, Homans notes that specific cultures have clothed this above schema or pattern with their own particular needs, habits, and customs in order to grieve and mourn. In different societies, people use available cultural scripts to construct and express meanings that are particular and personal to them in order to make sense of their loss and grief (Valentine, 2008, p. 2). But what about the loss of the wished-for child where a couple experiences "death at the beginning of life" (Lovell, 1997, p. 29)? What kind of patterns, needs, habits, and customs are followed by individuals to grieve and mourn? Are there any cultural scripts for the bereaved couples to turn to for making sense of their experiences? As I will eventually show in this study, reproductive loss, especially after conception and at any stage of gestation, is indeed "saddled with the ambiguity of alluding to bereavement while avoiding commitment to the claim that a death has occurred exactly" (Martel, 2014, p. 332). With no obvious dying process, with no'body' to eulogize in most cases, these unusual and unanticipated deaths are often treated as a different kind of event (Lovell, 1997, p. 35). Experiences of reproductive loss are, therefore, often not viewed as 'proper' bereavements and tend to be socially devalued and largely unrecognised in the social context because there appears to be no 'person' to grieve for (ibid., p. 29) – a phenomenon which I will elaborate on in chapter five and which also existed until the late 1970s and early 1980s in the Euro-American context, as I discuss below.

1.3.1. Grieving Practices and Mourning Rituals: The Euro-American Context

As mentioned earlier in this chapter, anthropological research on the experiences of grief, bereavement, mourning rituals, and coping strategies following reproductive loss has largely been limited to the Euro-American context (Abboud and Liamputtong, 2005, p. 4; Callister, 2014, p. 2). Moreover, research on these topics was mostly conducted after the 1970s, as earlier, infant mortality (or any kind of gestational loss) and the proper disposal of dead foetuses/babies were not accorded much significance in western societies (Kelly, 2007, p. 24; see also Layne, 2003; Leon, 2008; Lovell, 1997). In one of the seminal ethnographic studies on pregnancy loss in the United States, Layne (2003, p. 60) notes that, as in most other parts in the world, at the end of a normal pregnancy the new role of the woman as a mother is established through "rites of incorporation", which include sending flowers, cards and/or gifts to the hospital or her home, in-person visits by family and friends, and being addressed as a "mother". But what happens when a pregnancy ends without a live birth? In such cases, there are no such formalised and socially accepted rites and the event of loss is enshrouded in a "culture of silence" (ibid, p. 68). Until three decades ago, hospitals in North America did not have the required practices and protocols for bereaved parents for the disposal of their deceased child and neither were there any official rituals beyond the medical setting for the couple to grieve (see Layne, 2003). During the 1980-90s, many women in North America, "were caught in the middle of two contradictory sets of cultural forces – the increasingly important role of the foetus in the public imaginary [in relation to the discourses on abortion], and a deep-seated cultural taboo concerning pregnancy loss", notes Layne (2000, p. 322). Pregnancy loss, therefore, was considered a medical event and not as a significant death, "even though the first faint positive on a home pregnancy test is increasingly construed as indicative of the beginning of life" (Layne, 2003, p. 16).

A similar pattern of the non-recognition of loss has been documented in other western societies as well. For instance, Kelly (2007, p. 24) writes that in Northern Ireland, deceased babies who were not baptised were not allowed to be buried until the 1960s, while in the United Kingdom until recently, funeral directors would unceremoniously place stillborn babies at the foot of an adult coffin without anyone else's knowledge. In the mid-1970s, most bereaved parents in the UK were not told where their babies were buried and neither could they put their baby's name on the stillbirth certificate[18]. Lovell (1983, p. 757) notes that until the 1980s in the UK, women would lose their status as "mother" and "patient" simultaneously after having experienced stillbirths in hospitals. She writes,

> Maternity units are geared to the production of live babies. When this goes wrong, there is the practical problem about what to do with the maternity patient – *is* she a patient? – who has no baby to be weighed, bathed and fed. Such a mother – or is she a mother? – disturbs the equilibrium and is a reminder of failure. Failures need to be hidden. Hospitals seem to have no physical or psychological space for such a person, and the problem of a woman who seemed to have no legitimate role was often 'solved' by sending her home with what felt (to the woman) like indecent haste (Lovell, 1983, p. 757, author's emphasis).

Consequently, for the "de-mothered" woman, routine procedures, such as taking the woman's pulse and temperature, would cease after she had suffered a loss (ibid). Aldridge (2008, p. 23) has similarly observed that until the early 1980s, pregnancy losses (including stillbirth at full term) in the UK were not considered in the same light as other bereavements. The hospital protocol was to whisk the dead baby away from the parents as soon as possible

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[18] https://www.sands.org.uk/about-sands/who-we-are/our-history

without giving them a chance to see their baby[19] (ibid). For a long time, stillbirths in the UK were rendered as an "intangible" loss entailing the loss of parental hope and dreams for the child (Murphy, 2012b, p. 476). Pregnancy losses which occurred early on in the pregnancy were accorded even lesser significance and women were simply encouraged to try again (ibid).

In late 19th century Australia, the inexperienced medical professionals rarely paid attention to infant mortality and the varying outcomes of pregnancy and childbirth were largely left to the ministrations of women, writes Thompson (2012, p. 168). Historically in Australia, Pearce (2015) explains that a baby's death was considered to be a taboo subject within the hospital premises as well as within local communities and dead babies were legally unrecognised as 'persons'. To save the mother from any unnecessary grief, the hospital staff deemed it as best practice to handle dead babies and pre-term infants which were termed as "products of conception" and were usually disposed as hospital waste (Pearce, 2015). Additionally, until the mid-20th century, it was common practice in Australia that after stillbirth, women were placed back into the shared maternity wards of the hospital which indicated the stoicism expected from women despite undergoing a significant loss (Thompson, 2012, p. 170).

It was only as late as the late 1970s that pregnancy loss had begun to be increasingly recognised as a significant phenomenon in several Euro-American countries – a phenomenon which was socially and medically recognised as traumatic and capable of producing intense grief and anxiety (Garrod and Pascal, 2018; O'Leary and Warland, 2013). For instance, in the late twentieth century, perinatal deaths and stillbirths in Britain were accounted for in statistical reports (Lovell, 1997, p. 36). Meanwhile, in North America, physicians Kennell, Slyter, and Klaus (1971, p. 37) conducted a novel study wherein they recognised and described women's patterns of grieving and mourning processes when their babies died. The coverage of these issues by the national press in these countries resulted in a substantial surge in related research (ibid). By the 1980s, the reality about the frequency of pregnancy losses and the importance of social support for the bereaved women and men started to surface in the western countries due to several other factors. An important contributing factor was the creation of the Stillbirth and Neonatal Death Charity (SANDS)[20] in 1977 in Britain, followed by

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[19] https://www.sands.org.uk/about-sands/who-we-are/our-history

[20] SANDS was founded by Hazelanne Lewis, a psychiatric social worker, after she and few other bereaved parents who were devasted by the death of their babies had not received any social acknowledgement and understanding of the significance and impact of their loss. When Lewis wrote to national newspapers asking

the emergence of other similar pregnancy loss support organisations[21]. In 1988, the issue of pregnancy loss gained more prominence in the public discourse in the US when President Ronald Reagan declared October as the Pregnancy and Infant Loss awareness month[22] in recognition of the unique grief which bereaved parents experienced[23]. Another important factor was that the grief caused by these losses was being increasingly recognised and treated by health care professionals as a psychosocial issue (Martel, 2014, p. 332). Many hospitals in Britain and North America started introducing bereavement support protocols, although not all hospitals have adopted such practices even in contemporary times (ibid). Nevertheless, in order to enable the process of grieving the loss of the "ambiguously defined baby", almost all clinicians in the western societies started encouraging bereaved parents to see and have tactile contact with their deceased babies, to create mementos of their babies' existence as a part of making memories, and to have a funeral service, if they so desired (Leon, 2008). The importance of women having physical or visual contact with their dying or critically ill babies was gradually being understood by health professionals and social workers as producing beneficial results for the women by letting them grieve and cope with the loss instead of harming them, as had been believed for many years[24] (Helmrath and Steinitz, 1978 in Thompson, 2012, p. 173).

The memorialising of the deceased child became a burgeoning topic of academic interest since the 1980s although there is still a dearth of anthropological research in non-western societies. The available research in the western societies indicates that memorialising the "unborn child" (Lupton, 2013, p. 26) in the form of hand and footprints, by keeping locks of hair and by

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other bereaved parents to contact her and share their stories, her request was met with an avalanche of replies from all over Britain and these revealed a vast unrecognised need for support and information for such parents and families; see https://www.sands.org.uk/about-sands/who-we-are/our-history

[21] Some prominent examples are Share Pregnancy and Infant Loss Support, International Stillbirth Alliance, The Miscarriage Association, The Centre for Loss in Multiple Birth, Helping after Neonatal Death (HAND), The Ectopic Pregnancy Trust, MISS Foundation, The Compassionate Friends emerged in United States and United Kingdom with some of them with branches in Canada, Australia, and New Zealand and few European countries.

[22] In 2002, October 15th was declared as the Pregnancy and Infant Loss Remembrance Day in the United States, although it is not officially legislated.

[23] Reagan said: "When a child loses his parent, they are called an orphan. When a spouse loses her or his partner, they are called a widow or widower. When parents lose their child, there isn't a word to describe them. This month recognizes the loss so many parents experience across the United States and around the world. It is also meant to inform and provide resources for parents who have lost children due to miscarriage, ectopic pregnancy, molar pregnancy, stillbirths, birth defects, SIDS [Sudden Infant Death Syndrome], and other causes" (Mack 2019).

[24] However, some studies suggest that women who had no contact with the foetus/baby had the least levels of depression as compared to women who saw or held their dead baby (Kersting and Wagner, 2012, p. 189).

performing rituals such as naming the baby, organising a funeral, and formally saying goodbye are comforting acts for the grieving women and men that further allow them to acknowledge and honor the deceased child's personhood (see Davidsson-Bremborg, 2012; Godel, 2007; Gray and Lassance, 2003; Keane, 2009; Laakso and Paunonen-Ilmonen, 2002; Layne, 2000, 2003). In the last three decades, couples who have experienced stillbirth, for instance in Sweden, are encouraged not only to hold their deceased child but also to take pictures, often by a professional photographer (Davidsson Bremborg, 2012, p. 161). These kinds of photographs are used by the parents in several ways – while some keep them away privately, others show them to other people, as a way of "reconstructing, reinforcing and continuing the biography of the family" (Godel, 2007, p. 259). These photos are also commonly used on memorial pages on the internet and Davidsson Bremborg's (2012, p. 163) study shows that the internet has been revolutionary for bereaved parents as it gives them the chance contact other parents who have had similar experiences as well. Further, in describing the practice of memorialising babies, Woodthorpe (2012) has written about the presence of "baby gardens" in the UK – a distinct, bounded space for the "lost offspring" which provides a sense of community as if in a crèche or nursery. Within such gardens, she notes that typically there is a small low lying grave marker or plaque to identify the child and mementoes are left around this by the bereaved parents (Woodthorpe, 2012, p. 146). The function of these bounded baby gardens, notes Woodthorpe, lies largely in offering protection to the deceased babies from the external world as they are perceived as vulnerable and also in establishing a special status for the child "as belonging to a clearly defined community" (ibid, p. 148-149).

Next, I engage in a discussion about the biomedicalisation of reproduction and involuntary childlessness. This is crucial for the present study as biomedicalised reproduction constitutes a major part of the framework within which the childless couples in Kolkata wished to achieve reproductive success. Additionally, it is also one of the discursive contexts which significantly defined the couples' experiences of involuntary childlessness, reproductive loss, reproductive failure, grief, and bereavement and shaped the meanings they attached to conception, pregnancy, foetal and embryonic personhood, as well as the concomitant gender roles.

1.4. The (Bio) Medicalisation of Reproduction

The concept of medicalisation was framed by Irving Zola in 1972 in an essay which theorised the extension of "medical jurisdiction, authority, and practices into increasingly broader areas of people's lives" (Clarke et al., 2010, p. 50) and relatedly, as an institution of social control (Riska, 2010, p. 147). The process of medicalisation represents one of the most significant transformations of the 20th century and is intimately linked with and co-constitutive of modernity and enlightenment (Nordqvist, 2011, p. 1662). As various scholars have adequately explained, the process of medicalisation entails the re-conceptualisation and redefinition of human experiences and social phenomena which were previously outside the framework of medicine as problems in need of medical attention and intervention (Becker and Nachtigall, 1992, p. 456; see also Mohr, 2018, p. 26; Nordqvist, 2011, p. 1662; Van Hollen, 2003, p. 11). The impetus for medicalisation may occur when a social status (such as old age and menopause) is considered ambiguous, deviant, or in some way marginal to social norms and expectations, therefore not readily fitting within a society's cultural systems (Becker and Arnold, 1986). According to Scheper-Hughes and Lock (1987, p. 27) "…the proliferation of disease categories has resulted in an increasingly restricted view of what is normal and has created a sick and deviant majority". Medicalising an apparently deviant condition, thus, is one of the primary ways of attempting to bridge the gap between what is considered as the normative and the non-normative (Nachtigall, 1992, p. 457). As a form of social control and as a means of gaining power over individuals, the medical community's attempts to redefine certain events, behaviours, and problems as diseases has been criticised by several scholars over the years (Lock, 1993, p. 257; see also Conrad, 1992; Lupton, 1997b; Nachtigall, 1992). According to Lupton, the central to the ideals of the medicalisation critique is the notion that

> "individuals should not have their autonomy constrained by more powerful others" as critics argue that "becoming 'medicalised' denies rational, independent human action by allowing members of an authoritative group to dictate to others how they should behave (Lupton, 1997b, p. 96).

Central to the justification of the medicalisation of childbirth in particular is the concept that "every pregnant woman and her baby are at risk until it was proved otherwise", according to Oakley (1993, p. 135 in Gatrell, 2005, p. 54). The medicalisation of childbirth has been defined by Van Hollen as

> "the process whereby the medical establishment, as an institution with standardised professional guidelines, incorporates birth into the category of disease and requires that a medical professional oversee the birth process and determine treatment (Van Hollen, 2003, p. 11)".

A “non-medicalised” birth, however, does not imply that no medical care of treatment was given because in India, and in many other societies of the world, a wide variety of non-medical practices are used to ensure a risk-free child delivery (ibid, p. 11). Van Hollen further argues that this process of medicalizing childbirth entails a pathologizing of the normal pregnant-birthing body by placing birth under the domain of the professional doctor. Feminist scholars, such as Adrienne Rich and Ann Oakley, also note that “the medicalisation and technicalization of reproduction and childbirth has come to be seen as a metaphor for the control of women by men” (Gatrell, 2005, p. 54). However, as Riessman (1983, p. 3) has argued in the case of the medicalisation of reproduction, women are not merely passive victims of medical ascendancy and “to cast them solely in a passive role is to perpetuate the very kinds of assumptions about women that feminists have been trying to challenge”. As I will show in chapters three and four, the female interlocutors in my study utilised diverse forms of agency within the ‘biomedicalised’ clinical spaces in order to move closer to achieve their desired outcome of having a ‘normal’ child.

Although the term ‘biomedicalisation’ had made its academic debut by late 1980s, it was conceptually developed by Adele Clarke and her colleagues in the early 2000s in light of the importance of biomedicine and biotechnology in contemporary society (Mohr, 2018, p. 26). According to Clarke et al., the term biomedicalisation is used to indicate

> “the increasingly complex, multisited, multidirectional process of medicalisation that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine (Clarke et al., 2010, p. 47)”.

Herein, the “bio” in biomedicalisation refers to the “transformations of both the human and nonhuman made possible by technoscientific innovations such as molecular biology, biotechnologies, genomization, transplant medicine, and new medical technologies” (ibid). Thus, unlike medicalised practices that exercise *control over* medical phenomena, biomedicalised practices emphasise *transformations* of those phenomena and of bodies, largely through technoscientific innovations (Martel, 2014, p. 332; see also Clarke et al., 2010, p. 54-55). According to Martel (2014, p. 332), within the realm of biomedicalised reproduction, it is technologies that “rewrite classifications of being alive, bead dead, and being pregnant”, thereby, complicating how bereaved individuals experience their grief of what they have lost.

For my research purposes, I have examined the biomedicalisation of reproduction wherein my interest lies not only in how women's bodies were controlled within medical spaces by the human and non-human actors but also in the multiple ways in which certain reproductive technologies and biomedical practices shaped the women's reproductive experiences and the meanings they attached to conception, pregnancy, foetal and embryonic personhood, reproductive loss, the loss of their desired baby, and coping with the ensuing grief.

As part of biomedically controlling and transforming reproduction in the western world, Drife (2002, p. 311-312) notes that it was only in 17th century Britain that childbirth was first facilitated with instruments such as the obstetric forceps to fit around the baby's head. The other important development in the history of obstetrics which contributed to placing childbirth within the biomedical realm was the introduction of the caesarean section. With the introduction of forceps and caesarean and subsequently with the machine metaphors[25] used in medicine to describe the pregnant female body in the 17th and 18th centuries, childbirth started to be dominated by biomedical and technological expertise (Drife 2002, p. 312). According to Riessman (1983, p. 50), while there is nothing inherent in either pregnancy or childbirth which necessitates routine medical scrutiny, both are, nevertheless, considered as biomedical events in contemporary times.

In the Indian subcontinent, the institutionalization of medicalised childbirth commenced during the late 19th century when the first maternity wards were established in Chennai and Kolkata. Among the middle-class and upper caste women in India, the biomedicalised discourse of childbirth with its technological interventions managed to evacuate the mother from the central position and instead, allotted a discursive focus on the child (Jolly, 1998). Within this "project of modernizing maternities"[26] among the Bengali *Bhadralōka* (Bengali

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[25] Martin (1987, p. 54) has explained that medical practice treats the woman's body, and more specifically the uterus, as the machine and the doctor is the mechanic or technician who "fixes" it. Furthermore, according to Martin, when a person is treated as a machine by science and it is assumed that the body can be 'fixed' by medical manipulations, then "it ignores, and it encourages us to ignore, other aspects of our selves, such as our emotions or our relations with other people" (ibid, p. 19-20). However, she adds that it is not sufficient to only look at the machine/mechanic metaphor but also the "production metaphor" in order to further understand how relationships of power and control operate in the medical setting (ibid, p. 57). According to this metaphor, the woman is viewed as the "labourer" whose "machine" (uterus) produces the "product" (baby) and in this context, the doctor might be more like a factory supervisor or even an owner who fixes and controls that machine (ibid).

[26] The impact of 'modernity' on childbirth is not, however, a monolithic process as Van Hollen (2003, p. 4) demonstrates in her rich ethnographic study in Tamil Nadu. She notes that in contrast to North American women who tend to criticise the overuse of technology as they feel that a hospital birth denies them of a

middle-class) "improvement not only meant the medicalization of pregnancy, birth and the post-partum period but the discipline of mother love itself" (Ram and Jolly, 1998, p. 4 in Donner 2008, p. 50). As Donner (2003) discovered during her research in urban Kolkata, by the late 20th century, the prevalent medicalisation of reproduction was reflected in the hospitalised births and elective Caesarean sections which had become the norm among the middle classes[27]. In the era of globalization, Donner (2008, p. 93) notes that this view of reproduction has led to the emergence of 'Western' practices related to pregnancy and childbirth (such as antenatal checks, amniocentesis, and interventionist deliveries) largely overshadowing "older models of successful procreation which involved notions of religious virtue". The norm of hospital births, elective Caesareans as the delivery of choice, and access to a range of biomedical techniques and technologies – all of these biomedical practices shape the making and sustaining of the modern middle-class milieu in India, argues Donner.

However, Donner (2003, p. 333-334) also argues that while reasons such as the prestige value of high-tech, state-of-the art medical treatment, and privatisation of medical care were cited as reasons by her middle-class female interlocutors to have chosen elective Caesareans, such decisions need to be understood in relation to these women's domestic setting. "Home" births (as opposed to hospitalised births), writes Donner, might imply romanticised notions of a "safe haven, an assumed sense of belonging, and an imaginary female space" (ibid, p. 334). However, for Donner's female interlocutors, the meaning of 'home' was much more ambivalent and therefore, they rendered their evaluation of extra-domestic relationships with doctors and new technologies as positive. Donner claims that while different modes of childbearing are certainly related to class-based identities, they are not merely reflective of economic standing or access to specialist services in urban areas. In other words, Donner argues that the middle-class value of consumption is not the only reason for why women access medicalised services during childbirth. Instead, by opting for elective Caesareans,

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"natural woman-centred experience" (ibid, p. 213), the rural poor Tamil women in her study often complained about being denied technological interventions which they felt they needed and were entitled to (ibid, p. 213-214). As such, Van Hollen argues that the idea of a 'modern birth' and (bio)medicalisation of childbirth takes on a different meaning in rural Tamil Nadu than that described by feminist scholars in the West.

[27] Such practices can be located in the larger discourse where 'safe childbirth' in hospital settings under the supervision of the trained medical practitioners was promoted by state policies in early 2000s (supported by global agencies such as UNICEF and the World Bank) as opposed to 'risky childbirth' at home which is attended to by the 'untrained traditional *dai* (midwife) (Naraindas, 2009, p. 96); Also, this is in stark contrast to more than 70 percent of births in rural India which take place at home (ibid, p. 95).

Donner notes that women exercise their agency in that they seek to forego the allegedly faster restoration of physical strength attributed to “normal” birth. Furthermore, according to Donner (2003, p. 335) women desire “a fast, scheduled, and specialised procedure” which instils them with a sense of control inside the hospital setting and also allows them to successfully manage pain (as psychological suffering) by relocating the “pollution” of “normal” birth outside the house. The middle-class women felt supported by the legitimising discourse of medicalised childbirth wherein, Donner writes, “they can voice preferences, expect assistance, and negotiate specific aspects of antenatal and postpartum care” (ibid). Further, she explains that this allows women to feel relatively empowered within the context of medicalised childbirth as they can negotiate notions of individual preference, duty, and responsibility outside the constraints of their patriarchal family ideology (ibid, p. 335-336).

While under some conditions (bio)medicalisation tends to be an encroachment into people’s social lives, at other times, it is a welcome resource for ameliorating and making sense of social lives (Mamo, 2007). Many individuals have turned to (bio)medical discourses and services repeatedly “as a matter of everyday pragmatism to meet their goals”, observes Mamo (ibid, p. 53). This observation finds credence in my study wherein for the middle-class couples, their disruptive experiences of reproductive loss, primarily in the form of infertility and/or having experienced loss(es) despite natural conception, reportedly led them into the biomedicalised world of assisted conception to accomplish their goal of having a child. As research in the Euro-American context has also shown, the ‘failure’ to bear children can be socially construed as deviant and involuntarily childless individuals frequently turn to biomedical treatments which offers the hope that they will overcome this unwanted childlessness (Becker and Nachtigall, 1992, p. 458; see Franklin, 1997 for a discussion on In-Vitro Fertilisation as ‘hope’ technology). Indeed, as I discuss in chapters three and four, the biomedicalised spaces of the infertility clinics in Kolkata were not only sites where the reproductive technologies were enacted by the medical practitioners, but also where the (intended) conception, (unintended) loss and failure, and subsequent grief were enacted by the couples who were seeking assisted reproduction.

As I have mentioned earlier, my understanding of reproductive loss and involuntary childlessness is not limited to infertility and this study is rather about the diverse forms of loss including infertility. However, most couples in my study pursued infertility treatments after experiencing loss in the form of unsuccessful conception or gestational loss(es) after natural conception, and also experienced various forms of loss while undergoing these treatments. As such, the discussion on biomedicalisation would remain inadequate without outlining the historical developments in the understanding of infertility and the emergence of infertility treatments. As I show below, these developments lay the groundwork for understanding the modern-day reproductive and treatment-seeking practices of the couples in my study.

1.4.1. The (Bio)medicalisation of Involuntary Childlessness

For most of human history, sterility was viewed primarily as a social or moral issue, and not as a problem which required medical attention (Mamo, 2007, p. 25). Defined as an inability to conceive either due to "natural" circumstances (such as one's age and length of marriage) or due to personal matters (such as one's mental, moral, and sexual habits), sterility was often socially believed to denote "a barren mind and body" (ibid, p. 25). For women, physical signs resembling men, old age, and fatness suggested "disordered sexual health" and were considered as potential causes of being sterile (ibid). However, according to Morice et al. (1995, p. 497), the concern with involuntary childlessness is not modern or novel and it has been a medical preoccupation since the dawn of human history. For instance, inspired by the Egyptians on how to diagnose infertility, the father of modern medicine, Hippocrates, cited several reasons which could cause infertility, such as cervical malposition or excessive menstrual flow which rendered the uterus incapable of fixing the 'seed' (ibid, p. 498). There were various treatments, such as, dilating the cervix and inserting a hollow leaden probe into the uterus which allowed emollient substances to be poured in (ibid, p. 500). More prominently, the recasting of childlessness as a biological pathology, rather than as moral degeneracy, happened only over the course of the eighteenth and nineteenth centuries (Mamo, 2007, p. 25). During this time, the disciplines of medicine, biology, and genetics developed into male-dominated academic disciplines and women's voices were rendered invisible (ibid). By the tail end of the 19th century, biomedical practices had consolidated professional jurisdiction over medical 'problems' and had also profoundly altered *where to* and *whom* people could turn to in order to understand and make meaning of their bodily and social experiences[28] (ibid). This was the historical juncture during which women's bodies and

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[28] Prior to this period, women in the western world did not seek medical intervention to understand, and let alone solve, their inability to conceive and instead, they turned to God and clergy (Mamo, 2007, p. 25).

their reproductive processes had become central sites of biomedicalisation, and additionally, the medical classification of infertility had replaced that of sterility (see Riessman, 1983).

It was the latter half of the Renaissance era which saw the development of what were to be the starters for modern scientific technologies and also the beginnings of modern infertility treatments (Morice et al., 1995, p. 502). Along with the invention of the microscope, other events, such as the introduction of the speculum, the first scientific description of the fertilization process, and the publication of many medical treatises which dealt specifically with infertility, propelled the process of the medicalisation of infertility (ibid). By the late 19th century, surgeries were being performed to ostensibly restore fertility (Mamo, 2007, p. 26). Infertility, during this period, was almost always associated with women and it was a rarity to consider that men could also be infertile (ibid). Kniebiehler and Fouquet (1983 in Morice et al., 1995, p. 503) have written about the dual attitude that the society had towards women, where on the one hand medical progress was being made in understanding the causes of infertility but on the other hand, the prevalent notion of "a woman's apparent constitutional fragility" meant that women were seen as the de-facto infertile partner. Hundreds of years later, although the male infertile body is no longer free from medical surveillance and medical manipulation (Inhorn, 2007, p. 38), the female body continues to be focus of the "clinical gaze" (Foucault, [1973]2012) in infertility diagnostics and treatments – an observation which was repeatedly and glaringly obvious during my fieldwork.

In early 20th century, there was an emergence of new scientifically based approaches to assisted reproduction including many technological advancements and developments that lay the foundation for contemporary infertility treatments (Mamo, 2007, p. 26)[29]. The most important breakthrough in the modern history of biomedicalisation of childlessness happened in 1978 in United Kingdom with the successful embryo transfer and birth of the first 'test-tube baby', Louise Brown, using the process of In-Vitro Fertilization (IVF) by Dr. Robert Edwards and Dr. Patrick Steptoe (Annavarapu, 2013, p. 3). Subsequently, the year

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[29] For instance, the first experimental artificial insemination (or what was then known as "artificial impregnation") with donor sperm happened in 1909 in Philadelphia (Mamo 2007, p. 26). However, this experiment received severe backlash as the "naturalness" of reproduction came into question along with its assumed antinatalism and its eugenic implications. Mamo explains that this experiment had 'threatened' the foundation of American kinship (established by marriage and blood) and critics spoke of the "bastardization" and "illegitimacy" of children conceived in this manner which would result in the entire 'family' being stigmatised.

1985 saw the first Intratubal Gamete Transfer (GIFT) in Irvine, USA followed by Intra-Uterine Insemination (IUI) in New Brunswick, Canada in 1986 (Ludwig, 1996). The most recent breakthrough was that of the Intracytoplasmic Sperm Injection (ICSI) in the 1980s and the first successful pregnancy resulting in the birth of a healthy baby using this technique occurred in Brussels in 1992 (Palermo et al., 2009). Over the last four decades, infertility treatments by assisted reproductive technologies (ARTs) have fundamentally altered the ways of reproduction, despite their (on average) 30 percent "success rate", i.e. the rate of live births after the treatments (Neyer and Bernardi, 2011, p. 1).

By the 1960s, the reproductive technologies of ultrasound, foetal monitoring, and amniocentesis had already brought pregnancy and childbirth into the realm of biomedicine in the Euro-American countries (Becker and Nachtigall, 1992, p. 457). Simultaneously, the issue of involuntary childlessness, which was defined as the "unwanted absence of children", was being engaged with by the western medical community (ibid). As a result of delayed childbearing during this time, the number of involuntarily childless individuals were on the rise, which resulted in an increasing number of childless people seeking medical intervention (ibid). In tandem, an increasing number of physicians began specialising in reproductive endocrinology and placed the spotlight on infertility and this was further corroborated with the simultaneous advancement in reproductive technologies (ibid). By the early 1980s, the involuntary childlessness had been successfully replaced with the medicalised problem of infertility and this shift was underlined by a discourse progressively dominated by biomedicine (ibid). It became the job of infertility specialists (and gynaecologists) to identify 'symptoms', 'defects' or 'abnormalities', primarily in the female reproductive system, to diagnose infertility as a disease (ibid). In 1993, infertility was finally classified as an official disease category requiring medical intervention when it first appeared in the *International Classification of Diseases* published by the World Health Organization (Mamo, 2007, p. 30).

By the mid-1990s, the topics of infertility, involuntary childlessness, assisted conception, and ARTs had occupied prime spot on the research radar of anthropologists globally[30]. Extensive

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[30] For example, research has demonstrated how IVF becomes a 'way of life' for childless couples and sheds light on the pervasive consumer culture in relation to ARTs (for e.g., see Franklin, 1997; Becker, 2000; Thompson, 2005); how the development and practice of ARTs is shaped by local moral worlds (Kleinman 1992) as well as national aspirations and programmes in the 'Global South' (for e.g., see Bharadwaj, 2016; Handwerker, 2002; Inhorn, 2003a, 2003b; Kahn, 2000; Pashigan, 2002; Sundby, 2002); how ARTs have shaped 'reproductive tourism'

research on these topics shows that assisted conception is well-established internationally, having as long a history in India[31] (since the late 1970s), as for example, in the US, UK or Australia and as such, it is by no means a 'western' practice, notes Franklin (1997, p. 81). In order to unpack the development and presence of assisted conception in contemporary India next, I rely on Aditya Bharadwaj's (2016) account of the emergence of assisted conception within the public-private dialectic which largely characterises the Indian health care system.

1.4.2. The Development of the Infertility industry in India

Bharadwaj (2016, p. 113) explains that given the Indian government's priority and commitment towards controlling population growth and implementing family planning and welfare policies in the early 1990s, resources were not allocated to the curative aspects of health care (i.e. pronatalist, infertility treatments), which ran contrary to such an antinatalist concern[32]. However, the entry of the private sector as a chief contributor to biomedical management of infertility in India, according to Bharadwaj, is not only a response to an unmet health need of childless treatment seekers in both rural and urban areas but it was also due to the rapid expansion of the private health care sector itself (ibid)[33]. Despite the paucity of nation-wide data on growth trends in the private health care sector, early estimates showed that in the 1990s, nearly 70 percent of all primary medical care and over 40 percent of all hospital care was under the private health sector (ibid, p. 114). Such an expansion is further reflected, for instance, through the rise in number of private hospitals wherein a three-fold increase from 1973 to 1993 was reported in comparison to public hospitals which had not even doubled in the same time period (ibid). Moreover, recent developments suggest that

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globally and the crossing of international borders by childless couples as a way of circumventing local and ethical restrictions and to seek better and/or affordable treatment options (for e.g., see Inhorn, 2003b; Inhorn and Gürtin, 2011).

[31] The birth of the world's second 'test-tube baby' was announced by Dr. Subhas Kumar Mukerji in Kolkata on 3 October 1978, however, his claim was contested because he did not publish the bulk of his research in standard peer-reviewed journals (Bharadwaj, 2016, p. 91). As such, India's official entry into the world of assisted conception was with the birth of the first 'scientifically documented' test-tube baby, a girl named Harsha, on 6 August 1986.

[32] During the 1960s and 1970s, international organisations underlined by the development discourse were urging 'Third World' countries like India to work on population control "in order to reap the benefits of economic development" (Annavarapu, 2013, p. 5). The focus, therefore, during this period, and progressing up till the 1990s, was on sterilisation technologies and medical intervention which could impede population growth.

[33] Nevertheless, under a mixed economy model in India, several scholars have noted that the private and public health care sectors have established a protracted symbiotic coexistence (Bharadwaj, 2016, p. 114).

corporate hospitals chains (e.g. Apollo, Fortis, Max) account for 10 percent of the private hospital markets (Kanjilal and Mazumdar, 2013 in Bharadwaj 2016, p. 114). A visit to any of these hospital chains reflects an overwhelming majority of middle- and upper middle-class patient group, and not only an availability of cosmopolitan services and advanced biomedical treatments but also a posh interior as I also observed in the infertility clinics in Kolkata. Despite the general lack of regulating mechanisms controlling the application and spread of the private health care sector, numerous studies have indicated the high level of dependency that people (from urban and rural areas due to an absence of curative services or of qualified medical practitioners in the latter) have on the private sector, thereby, dismissing the illusion that the public sector is the primary health care provider in India (Bharadwaj, 2016, p. 115). In addition, Indian state policies, such as, reduction in import duties on high-technology medical equipment, recognition of medical care as an industry, incentivisation of financial institutions to provide long-term capital for hospital projects, allowing industries to invest in multinational collaborations with private hospitals, and consenting to foreign collaborations, resulted in the promotion of the private health care sector (ibid, p. 116). Finally, given the general disenchantment in the public sector health workforce in addition to other factors such as better monetary returns and minimal state interference, the private sector in India continues to lure a significant number of doctors, notes Bharadwaj (ibid).

The arrival of assisted conception in India, Bharadwaj (2016, p. 118) further explains, can be better understood against the above-mentioned backdrop of the interaction between the public-private health care sectors, and especially since high-tech infertility management in India originated in the state sector. The first scientifically recognised breakthrough of the birth of the IVF baby Harsha on 6th August 1986 was a result of the collaboration between the Institute of Research in Reproduction that was controlled by the Indian Council of Medical Research (ICMR) and a Mumbai-based public hospital (ibid). According to ICMR's annual report (1986-1987), that particular IVF practice was justified in a state-controlled research institute "by positioning the diagnosis and treatment of infertility as 'complementary to an effective Family Welfare Program'" (ICMR, 1986, p. 47 in ibid, p. 118). As long as the development of the IVF project was heralded as an essential aspect of developing effective anti-fertility interventions, its presence and state-support was justifiable (ibid). However, Bharadwaj states that "the promise of using a pronatalist technology to perfect and deliver antinatalist technologies" remained a mere promise and was, indeed, never actualised (ibid).

Disagreements amongst the project members ultimately resulted in the final demise of the public sector's "fleeting but significant tryst" with assisted conception and by the end of the 1980s, assisted conception was almost entirely taken over by the private sector (ibid).

To ensure the smooth running of the private assisted conception clinics, the person establishing the clinic had to ensure an optimal clinical infrastructure as well as a steady inflow of patients (Bharadwaj, 2016, p. 119). However, Bharadwaj observed during his research in the early 1990s that this was a huge problem due to various infrastructure-related obstacles, such as getting spares for medical equipment. As a result, routine practice in the ART sector in the newly economically liberalised Indian state in 1991[34] became highly stressful (ibid, p. 121). Notwithstanding that, there has been a mushrooming of infertility clinics since the early 2000s resulting in the creation of an "infertility industry" in urban India and this was possible due to several factors (Annavarapu, 2013, p. 3; Kohli, 2017). For instance, Nadimpally, Marwah, and Shenoi (2011, p. 4) note that ART providers have couched the rise in infertility clinics as a demand and supply issue. The providers claim that due to the rampant and steadily rising cases of infertility and childlessness, ARTs have become the "need of the hour", and as such, they are merely responding to the couples' "desperate" demands to become parents (ibid)[35]. However, according to Nadimpally, Marwah and Shenoi, this language of demand and supply and the market rhetoric takes advantage of the pervasive ideology of pronatalism and patriarchy along with the stronghold of the private health care sector which is inadequately regulated and neither does it face competition from the public sector, thus promoting itself unchallenged (ibid, p. 4). Indeed, the images, language, and slogans, used to promote ARTs as the final and only hope for childless couples (see chapter three), serves to reinforce the state of childlessness as an acute misfortune. Last but not the least, another factor which has contributed to the growth of the fertility industry in India is that not only has it become cheaper to establish ART clinics[36] since 2010 but also such an

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[34] In 1991, a group of 34 scientists from all over India had a meeting and created the Indian Society for Assisted Reproduction (ISAR) and its headquarters since then have been in Mumbai. Currently, it is the largest infertility society in India and has more than 3,600 medical practitioners; see http://www.isarindia.net/index.php

[35] See Franklin (1997, p. 183) for a discussion on women becoming disparate as a result of infertility treatment(s).

[36] As of 2011, it costs around Rs. 40 lakhs to establish an infertility clinic in India (Bharadwaj, 2016, p. 122). The ease of establishing clinics can be seen in the data which indicates that the numbers of these clinics are steadily rising and as of 2018, there are 1,577 clinics, at least the ones which are officially registered (Sharma, 2018).

establishment has become far easier given that earlier obstacles such as duty on imported equipment have drastically declined (Pratap, 2011 in Bharadwaj, 2016, p. 122).

Furthermore, in order to secure a regular patient inflow, cost-cutting measures through transnational collaborations is a popular route taken by ART doctors in contemporary times (Bharadwaj, 2016, p. 122-123). For instance, a German-Indian medical company called Morpheus set up centres in India and offered a second IVF cycle at "no extra cost procedural cost" if the first cycle did not result in pregnancy (ibid, p. 124). Reducing the procedural costs and offering cheaper "IVF packages" for the monetarily disenfranchised patients was one of the main ways in which the infertility doctors in my study also ensured a steady patient-inflow as the high costs, especially for IVF, was the biggest hurdle for these patients (see also Bharadwaj, 2016, p. 125, 228). In contrast, for my middle-class interlocutors, the treatment costs were not cited as an obstacle in seeking multiple treatment cycles to have a (preferably) biological child, if necessary.

However, as I will show in my study, for my interlocutors, the occurrence of reproductive loss, for instance, through unsuccessful assisted conception or treatment failure(s), became all the more distressing and a challenge to grapple with within such a biomedicalised domain of assisted reproduction. As Van Hollen (2003, p. 217) points out, such a biomedicalised context entails the "biomedical myth" of the possibility of conquering death through medical technologies which offer a façade or an illusion of control. Indeed, the developments in medical science and reproductive technologies have assured that the rapid medicalisation of human fertility reckons with an illusion of omnipotence within the domain of reproductive healthcare (see also Davis-Floyd, 1994; Franklin, 1997; Layne, 2003; Van Hollen, 2003). An episode of reproductive loss, then, contradicts the medical norms of correct reproductive embodiment as it disrupts the biomedical myth of linear progress implicit in the 'technobirthing' discourses (Layne, 2003, p. 176; see also David-Floyd, 1992). In this context of modernity and biomedical progress, for the financially affluent Indian middle-class couples in my study who had/have access to assisted reproduction, the loss of their wished-for child was devastating and evoked powerful emotions of distress and disbelief while also disrupting their understanding of reproduction as a linear and natural stage of life progression.

Herein, I wish to point out that it was not only the context of biomedicalised (assisted) reproduction which shaped the non-normative reproductive experiences of my interlocutors but also their middle-class identity. In order to gain a deeper insight into the socio-cultural and economic context in which my middle-class interlocutors lead their lives and that informs the values, morals, and ethos which underline their reproductive aspirations and practices, I provide an overview of some seminal literature on the 'Indian middle-class' in the next section. As I will show in the remaining dissertation, akin to the biomedicalisation of reproduction, the middle-class setting is, indeed, another important contextual setting which shapes my interlocutors' experiences of reproductive loss and the ways in which they understand procreation, loss, marriage, and gender roles.

1.5. The Indian Middle-Class(es)[37]

As an entry point into my research, I intentionally selected the middle-class interlocutors based on their economic ability to afford the required infertility treatment(s) in order to achieve reproductive success. My presumptive criterion for this selection stemmed not only from my own assumption about people from a certain milieu being able to afford these treatments without any financial impediments but also from demographic literature and contemporary discourse where economic markers are used to suggest a homogenous, urban Indian middle-class (see Jodhka and Prakash, 2016; Sridharan, 2004). However, several scholars have argued that the middle classes in India should rather be conceptualised in terms of lifestyle and culture instead of relying exclusively on economic indicators (for e.g., see Béteille, 2003 in Donner, 2008, p. 60; see also Brosius, 2010; Dickey, 2012; Donner and De Neve, 2011; Fernandes, 2006; Gilbertson, 2014; Mathur. 2010; Radhakrishnan, 2011). Indeed, my research data eventually revealed that the "middleclassness" of my interlocutors was not limited to their income. I draw on Donner and De Neve (2011, p. 12) to identify "middleclassness" as a concept "that refers simultaneously to class location at an individual level and to the experience of class as a broader category". Instead of using class as a noun, middleclassness emphasises that class status is reproduced through daily relational practices.

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[37] Even though this study is located in Kolkata which has a majority of Bengali inhabitations, I do not engage specifically with literature on the *Bhadralōka* (gentle man) and the *Bhadramōhila* (gentle woman) which refer to the men and women of the Bengali middle-class. Instead, I look at the Indian middle-class in general since my group of interlocutors were not just Bengalis but roughly 15% of them were Marwaris or Baniyas, originally largely Hindi-speaking merchant communities from Rajasthan and/or Gujarat, many of whom moved to Kolkata over two centuries ago (see Parson, 2012 for a discussion on the settlement of Marwaris in Kolkata).

As such, along with economic markers, certain middle-class values and ethos (that I describe shortly) shaped my interlocutors' experiences and enactment of reproductive loss, their seemingly natural desire to have a child, their consumption of reproductive technologies, and also their gendered enactments within the clinics and in their marital relationships. I start this discussion by offering an insight into the complexities involved in conceptualising the middle-class in India. As Donner and De Neve (2011, p. 7) have argued, the aim of such a conceptualization is not to "fulfil an epistemic ambition of defining, once and for all, the correct classification, of 'discovering' the real boundaries of the middle-class". Instead, I seek to discuss the heterogeneity within the "great Indian middle-class" (Varma, 2007) followed by a brief description of the specific practices and shared values among this class group which are germane for the subsequent analysis of my ethnographic findings.

1.5.1. Challenges in Defining 'The Indian Middle-Class'

The term middle-class, as noted by Jodhka and Prakash (2016, p. 4), is not novel in the present-day Indian landscape and was heralded under the British colonial rule by the introduction of a Western-style secular education system, the industrial economy, and a new administrative system. Nonetheless, scholarly attempts at defining the Indian middle-class have been accompanied with conceptual and theoretical scepticism (Donner, 2011, p. 1). According to Donner (2008, p. 60), the English term "middle-class" emerged since India's independence in 1947 as "a common denominator through which specific sections of the modern Indian society speak about their own perception of society and their role in nation building". However, until the 1960s and 1970s, the Indian middle-class as a colonial creation was a small and exclusive club (Varma, 2007, p. xviii). It was ultimately with the Nehruvian phase of nation building, the introduction of economic reforms, and neo-liberal policies in the early 1990s which catapulted the term and the category of the middle-class into limelight, both within academic and popular discourse (Jodhka and Prakash, 2016, p. xvii, xi). With the onset of globalization, economic development, incentivization of private capital, and investments by foreign capital, the rates of the Indian economy were significantly increasing and so was the engagement of the "new" Indian middle-class with this growing economy (ibid, p. 5). According to Radhakrishnan (2011, p. 42), what appears to be "new" about this class is not its composition but rather its "symbolic privilege" in representing the nation as reproduced in a new socio-political climate. This new middle-class, writes Mazzarella (2010, p. 2), has effectively replaced the older Nehruvian middle-class with its “mounting illiberality and incivility in politics, a crass new consumerism, and a disorienting fragmentation of the national imagery”. As Varma (2007, p. ix) has also pointed out, consumerism was no longer considered as a dirty word and notions of Gandhian austerity and Nehruvian socialism had been disowned. As the economy kept expanding, the size of the new middle-class in India also grew and along with its expansion in numbers, it also kept getting richer and internally more diverse (Jodhka and Prakash, 2016, p. 6).

However, as Jodhka and Prakash (2016, p. xvii-xviii) have asked – “What does it mean to be middle-class in India today?” Does belonging to the Indian middle-class refer to a certain income bracket and/or are there certain values which make the middle-class Indians aspire to a certain kind of lifestyle?” The middle-class has always been a source of theoretical vexation and it has remained a challenging task to reach a consensus at defining the contours of the disputed Indian middle-class given the ambiguity about the fuzzy boundaries of membership in this class group (Sen, 2014, p. 59-60). The intermediate position of the middle-class between the upper and the working classes is the only commonly agreed upon criteria in defining the middle-class according to different theoretical approaches (ibid, p. 60). Nevertheless, as has been pointed out by several scholars, the new Indian middle-class is not an undifferentiated group and as such, the internal differences within this class category should not be overlooked (see Beinhocker, Farrell and Zainulbhai, 2007; Brosius, 2010; Fernandes, 2006; Jodhka and Prakash, 2016; Mazzarella, 2010; Sridharan, 2004). Comprising roughly 40 percent of India’s population as of 2019 (estimated to be 63 percent by 2047, Gupta, 2002), depending on the measures used, the estimated size of the middle classes ranges between 78 million to 604 million, thus indicating the many layers which constitute the heterogeneity of this class category (Ramanathan and Ramanathan, 2019). Within such a diverse category, people can identify themselves (or be identified) as lower middle-class, middle middle-class and upper middle-class.

Despite the scholarly scepticism in defining the middle-class, studies have shown that in contemporary India, especially in the expanding urban centres, an increasing number of citizens describe themselves as being “in the middle”, wherein they situate themselves between “the poor” and “the rich” (Donner and De Neve, 2011, p. 3). Research suggests that different groups within the middle-classes are most commonly classified into the “upper”, “in between” or “lower” segments in relation to income, and these segmented groups are also marked by other identities such as caste, religion or ethnicity which further sharpen identity politics (Jodhka and Prakash, 2016; Scrase and Ganguly-Scrase, 2011; Sridharan, 2004). Thus, broadly speaking, the Indian middle-class can be described as the group of people who are located in between the small, albeit privileged, economically superior cosmopolitan upper-class and the vast percentage of the population who is generally described as underprivileged and poor (Donner, 2008, p. 60). In her study in Kolkata, Donner discovered that through such a self-description of being situated in the middle and as not so privileged, Bengali middle-class people distinguished themselves from those who are in the upper strata of the society who they considered as "money oriented, uncultured, [with a] laissez-faire lifestyle" (ibid). The Bengali middle-class also distinguished themselves from the poor who "can afford to be more relaxed about education, sex, women's work and the future because they have nothing to lose" as opposed to the middle-class who have a reputation to preserve (ibid, p. 60-61).

However, as Liechty (2003, p. 37) has argued in his study of urban Nepalis in Kathmandu, class is a constantly re-enacted "cultural project" and it is "never a 'thing' that exists by itself, prior to, or outside of, its actual performance in everyday life". Referring to a similar trope of approaching class as *process* rather than *object* (Liechty, 2003, p. 37), Sen (2014, p. 60) suggests that social classes have a processual character, rather than a permanent one, which implies that any definition of the middle-class is not fixed. The definitional parameters of the class categories, therefore, tend to keep shifting based on which practices and cultural artefacts give the group(s) meaning at a certain period in time (ibid). As such, defining the Indian middle-class, given its heterogeneity and processual character, continues to remain an intellectual challenge.

Notwithstanding such a challenge, Fernandes and Heller (2006, p. 496) argue that the difficulties in defining the Indian middle-class can partially be overcome by focusing on the specific class practices through which the middle class reproduces itself. They further claim that the contours of the new Indian middle-class "can be grasped only as *class-in-practice*, that is, as a class defined by its politics and the everyday practices through which it reproduces its privileged position" (ibid). As Liechty (2003) has accurately pointed out, class identities, practices, and lived experiences are not merely afterthoughts tackled on to the pre-existing classes but rather they enter into the very *making* of classes. The emergence of the new Indian middle-class is, indeed, shaped by certain "practices and values which attach meaning to membership of a specific status group and life-worlds" (Donner and De Neve, 2011, p. 3). In her study of the middle-class in Tamil Nadu, Dickey (2012, p. 560) similarly observes that there is little stasis in how people of this class describe their experiences and instead, there is an emphasis on "the continuous need to perform behaviours that will support their claims to class standing". According to Dickey, class is not only a determining structure, but also a process which produces and is produced by social interactions and groups' economic, cultural, and social capital (ibid, p. 562). Based on this understanding of class as processual, relational, and enacted through certain practices, this research serves to make a commentary on how the interlocutors in my study enacted their middleclassness and how certain common denominators of their class position, such as shared values and ethos, influenced and shaped their reproductive practices and experiences. It is these common denominators and a shared cultural imagination, argues Donner (2008, p. 61), that makes "middle-class lives in India, and indeed beyond, comparable and a space of a globalising Indian middle-class culture coherent".

1.5.2. Practices, Ethos, and Shared Values of the (New) Indian Middle-Class

Conroy (1998) writes that one of the most important traits that characterise the new burgeoning Indian middle-class is its "consumer culture" – a culture which is marked by a considerable increase in consumption practices and aspirations for privileged lifestyles (see also Brosius, 2010; Fernandes, 2006). According to Appadurai and Breckenridge (1995, p. 5), as "a modality of social life in contemporary India, consumption represents a prime site for the complex production of modern middle-class identities". Furthermore, Jodhka and Prakash (2016, p. xx) point out that the middle-class person as an economic agent is seen as a "consumer par excellence" and for this person, consumption is not merely an act of economic rationality but also an important source of identity (ibid, p. xviii-xx). Similarly, Mathur (2010, p. 220) remarks that the social standing of middle-class Indians is characterised by the possession and use of consumer goods for communicating style and individuality. Middle-class lifestyles, therefore, are increasingly characterised by engaging in "conspicuous consumption"," alternative shopping habits"[38], and also by replacing train or bus journeys with air travel (ibid). The acquisition of status symbols, therefore, is used by the middle-class in

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[38] For instance, middle-class people, writes Mathur (2010, p. 220), play with fashion styles that were previously not within reach. Such alternative shopping habits and trends, she argues, are one of the ways in which the Indian middle-classes are able to display their social standing.

constructing its middleclassness, notes Mathur (ibid, p. 219). One of the most prominent middle-class status symbols are manifested for instance, through preferential visits to “new quasi-public spaces” or modernist spaces of consumption, such as, modern departmental stores and shopping malls which allows middle-class consumers to distance themselves from those who are not a part of this class category (Voyce 2007, p. 2055; see also Mathur, 2010). Such a “consumer culture”, according to Mathur (2010, p. 220-221), is not merely an indicator of the wealth and affluence of the middle-class but also of “people’s search for meaning in their lives through the practice of consumption”. These markers are also a means for middle-class Indians, explains Mathur, to entrench their own class position and to estimate the position of others in the society (ibid, p. 220). It is this particular kind of urban class-based lifestyle and specific consumption practices which are, thus, considered desirable and form the core of middle-class aspirational values (see also Donner, 2008, p. 29-30). The middleclassness of the couples in my study, as I show in in the third chapter, was one of the important factors related to their consumption of modern biomedical and the latest, high-tech facilities which was reportedly their most reliable option to have a child.

However, as Donner and De Neve (2011, p. 9) remark, the consumption of commodities is not “the sole interpretive and experiential framework of India’s middle-class subjects”. Several recent studies have shown that it is inadequate to understand the enactment of middleclassness in India solely through consumerist acts (for e.g., see Donner, 2008, 2003; Donner and De Neve, 2011; Fernandes, 2006; Gilbertson, 2014; Radhakrishnan, 2011). Instead, themes of social mobility, family planning, educational strategies, professional worlds, honor and respectability, gender relations, gendered bodies, sexuality, along with caste-based identities, language, and religion are equally important to understanding the enactment, representation, and reproduction of contemporary middleclassness. For instance, one of the visible common denominators of the middle-class population, according to Donner (2008), are the modern residential neighbourhoods. As Donner states, neighbourhoods are not only sites of fieldwork, but also spaces which “represent distinct histories that together make up the framework within which local perceptions of class, social change, and modernity are viewed” (ibid, p. 4-5). An essential part of Kolkata’s urban landscape, these modern neighbourhoods as I observed during my fieldwork, are distinguished from the other neighbourhoods by their new social, educational, and architectural patterns. I gradually learned that all my interlocutors lived in modern, cosmopolitan, and popularly considered as posh neighbourhoods of urban Kolkata. The majority of these couples lived in gated communities with high rise buildings while there were a few who had their own apartments. On visiting some of these interlocutors at their homes to conduct interviews, I noticed that each of the residential complexes had multiple security cameras inside the premises and there were two or three security guards who maintained a record of who was entering the premises at what time. In addition, these complexes often included an indoor gym, a kindergarten, a swimming pool, a grocery store, a salon, and a large space for private car parking. Indeed, this way of life is a lifestyle distinctive to the cityscape in Kolkata (and in other metropolises) and is representative of the aspirational, upwardly mobile, and modern middle-class inhabitants.

Interestingly, in the progressive pursuit of modernity, the Indian middle-classes have employed traditional resources while simultaneously adopting western ideas. As scholars have suggested, modernity for middle-class Indians does not necessarily indicate a complete disowning of traditional aspects of daily practices (see Bharadwaj, 2016; Mathur, 2010). Rather, for the Indian middle-class milieu, the process of consumption with the goal of maintaining status is circumscribed by a rather implicit adherence to 'traditional values'. For instance, Bharadwaj (2016, p. 18) explains how the seemingly disparate domains of the 'traditional' and the 'modern' overlap within the world of assisted conception wherein middle-class infertile couples participate in a culture-specific engagement with the treatments. As such, the Indian middle-class did not simply emerge as a "modernizing agent out of its traditional moorings" and it is not detached from its past history (Jodhka and Prakash, 2016, p. 29). Instead, in certain cases, the middle-class champions certain 'traditions' while actively representing and constructing "local level sectarian identities" (ibid). Varma phrases the changes towards becoming modern while still holding on to traditions within the contemporary urban Indian middle-class in an amusing manner:

> "Tradition and change continue to happily coexist in India, and the average middle class person is, in more ways than one, a good example of a harmonious schizophrenic. In fact, as I have argued more than once, the Indian mind is not a cupboard, but a chest of drawers: pull out one drawer and it could have a keyboard with a 21st century person's fingers on it; pull out another and it could be a ring for the same person by a quack claiming to be an expert on horoscopes (Varma, 2007, p. xxiii)".

A suitable illustration of the championing of tradition by the modern Indian middle-classes is prominently visible in the importance attached to the stability of the family, necessity of heterosexual marriage, and women's roles as 'suitable' wives and 'good' mothers (see chapter six). The aspects of belonging to the Indian middle-class are particularly articulated through notions of "morality and respectability, gendered identities, material cultures, and the symbolic role of family values as a marker of Indian modernity" (Donner and De Neve, 2011, p. 3). Based on decades of research in middle-class Kolkata, Donner (2008) demonstrates the ways in which Hindu middle-class identities are reproduced through the role of the woman as the housewife and stay-at-home mother in order to produce "the ideal family". She observes how middle-class women's lives in contemporary India are defined by their "service" to the husband and children, which is often in opposition to earlier and more collective ways of marriage and parenting (Donner, 2008, p. 37). For Donner, it is within such important sites of marriage, motherhood, and family as middle-class institutions that one can understand the wider sociocultural transformations occurring in present-day India. Donner, thus, argues that

> "although the middle-classes may appear as highly stratified, a specific ideal form of domesticity and gender relations—along with the values, consumption patterns, and the lifecycle expectations that go with it—are significant markers of such middle-class identities (Donner, 2003, p. 306-307)".

Another pivotal aspect which is has become increasingly common in the enactment of middleclassness in 21st century urban India and which significantly informs the analysis of my research findings is the rise of smaller sized families, as discussed next.

1.5.3. The Rise of Single-Child Families and Emotional Investment in Children

Among poor, lower socio-economic class groups where there are large families with several children, anthropological studies have shown that pregnancy loss or child loss does not always result in intense grief and it might not necessarily be enshrouded in cultural silence. For instance, Pinto's (2008a, p. 370) study in the poverty-stricken parts of Uttar Pradesh shows that conversations about pregnancy loss and grief are exchanged regularly and stories of infant and child death are in abundance, thus, forming a part of everyday interaction. On similar lines, Van Hollen (2003) has observed in rural Tamil Nadu that infant deaths were routine and while speaking about the children who had survived and those who had died, Tamil women did not emphasise the deaths.

In one the most prominent studies on the themes of child death, mother love, and maternal bonding, Nancy Scheper-Hughes (1992) notes that there is an absence of deep grieving or a profound sense of loss accompanying the death of each and every "fragile child" in the Brazilian shantytown where she conducted her research (ibid, p. 402). She has shown that in a town characterised by its pernicious conditions, including hunger and poverty, there is a presence of maternal detachment and indifference towards infants and babies who are judged as too weak or too vulnerable to survive, thus questioning the notion of maternal love and bonding as natural. Phrasing this as the "old reproductive strategy", Scheper-Hughes explains that her female research participants did not keep a balance sheet on their offspring and instead, many women tried raising as many as God sees fit to send them (ibid, p. 401).

Taking inspiration from Scheper-Hughes' aforementioned research, I show in my study that the reproductive aspirations as part of the "new reproductive strategy" (Scheper-Hughes, 1992, p. 401-402), entail the Indian middle-class's proclivity to emotionally and financially investing heavily in one or two 'normal' children. As Scheper-Hughes has credibly argued, such changes in reproductive strategies or preferences where the focus shifts from having multiple children to lesser infants, affect

> perceptions of human life, personhood, life stages (including the "invention" of modern childhood and adolescence), and family roles and social sentiments (including mother love). They also alter perceptions concerning the relative value of the individual as measured against the collectivity (whether nuclear or extended family, lineage, or community). Modern notions of mother love derive, in the first instance, from a "new" reproductive "strategy": to give birth to few infants and to heavily "invest" (emotionally as well as materially) in each one from birth onward (Scheper-Hughes, 1992, p. 402).

Accordingly, one of my foremost arguments in this study is that it is such an intensely desired child as part of the new reproductive strategy that creates not only an intense form of maternal attachment and bonding long before birth or in some cases, even before conception, but also results in a profound sense of loss and grief. I further argue that the experiences of loss and grief takes on a rather heightened meaning for these women as a result of the biomedical practitioners and medical technologies ascribing unconditional personhood to the unborn child but only until the episode of loss has occurred. As soon as the loss has transpired, the personhood of that unborn child is deemed insignificant by these external actors and the bereaved, grieving women are pushed into conceiving again.

The new reproductive strategy is corroborated by Basu and Desai (2016a, p. 4) who have pointed out that following the second demographic transition in mid-20th century, there is a growing trend to have one-child families among the middle classes in India which bears resemblance to the reproductive preferences of the global middle classes (see also Donner, 2008, p. 92). Data on families at different parities in Basu and Desai's study show that one-child families are overwhelmingly concentrated among the more privileged sections of the Indian society i.e. the urban, upper caste, and middle- or upper-class milieu[39]. Media reports in India also point towards this trend where the term ‘DISK’ or ‘Double Income, Single Kid’ has been used to describe this phenomenon that has been on the rise since the beginning of the 21st century (Madhavan, 2007; see also Varma, 2016). It seems that Kolkata, which is my city of research, tops the country for having the highest number of one-child families (Sen, 2012). According to Basu and Desai (2016a, p. 17), a primary reason for this growing phenomenon all across the urban Indian cities is related to aspirations for social mobility among the middle classes through the advancement of one’s children by investing in them. With the growing public recognition of the poor quality of education offered by a wide range of government educational institutions, middle-class couples tend to enrol their child in English-medium private schools and commonly rely on private tutoring to supplement school learning for which they usually pay extravagant amounts of money (Basu and Desai, 2016a, p. 17; Varma, 2007, p. xxiii). These alternatives, however, are expensive and thus, restrict couples to have more than a child (or at the most, two) (Basu and Desai, 2016a, p. 12)[40]. The grooming of the one or two children by middle-class Indian parents starts very early in life as there is an increasing level of competition for employment among this milieu and a strong desire to succeed (Varma, 2007, p. xxiii).[41] Such an urgency among the parents for immaculate grooming is evident in the rush for admissions to play school, sometimes as early as when the mother is pregnant. As I will illustrate in the course of this study, the desire to have one or two ‘normal’ babies was expressed by nearly all the married couples in my study. Based on ethnographic

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[39] While one-child families account for barely 5 percent of Indian families, they form 13 percent of families living in metropolitan Indian cities (Basu and Desai, 2016, p. 6). It is interesting to see that about 40 percent of the families who had one child stopped in spite of the child being a daughter (ibid). Furthermore, statistics reveal that the southern, eastern, and north-eastern regions of India have a larger number of one-child families than the rest of the country (ibid).

[40] Statistical data suggests that there is a clear distinction between one-child families (or two-child families) in India compared to large families (i.e. three or more children) in relation to investments in children’s education (Basu and Desai, 2016a, p. 12). Data also suggests that statistically expenditure on children’s education is higher by 40 percent in one-child middle-class families in India than in families with three or more children, while two-children families fall in-between (ibid, p. 12). Reports further show that children from one-child families are 1.56 times as likely to be in a private school than families with more children (ibid).

[41] Other factors, such as increasing age of marriage, rising female labour force participation, rise in divorce rates have a small but discernible impact on the rise of single-child families among the Indian middle classes – small because as Kaur and Palriwala (2013 in Basu and Desai, 2016a, p. 13) have noted, despite gradual changes, even educated Indian middle-class families operate on a rather ‘conventional’ dynamic in regard to marriage, age of childbearing, and women’s economic contributions as compared to western or some East Asian countries.

engagements with the women and other actors in my study, I will demonstrate that there is an escalated sense of emotional investment in the desired child and a deep sense of attachment and enthusiasm about that child's imagined future even before birth.

Within middle-class India and broadly within the South Asian context, the articulation of such an aforementioned reproductive desire and parenthood finds social acceptance and legitimacy conventionally within the confines of heterosexual marriage. In the next section, I present a discussion of the pervasive pronatalist ideology and normative life stages of marriage and parenthood which inform my interlocutors' understanding of a normal life progression within the Hindu[42] normative order in India. A discussion of these topics is important given that marriage was not only the starting point of my interlocutors' reproductive trajectories but also one of the most important sites to be disrupted in the aftermath of reproductive loss (see chapter six).

1.6. Pronatalism, Marriage, and Parenthood: Making Gendered and Social Personhood

Pronatalism is used to refer to the ideology according to which having children is assumed to be a natural and inevitable part of being an adult woman or man (Ulrich and Weatherall, 2000, p. 323). It refers to any attitude or policy that is pro-birth, that encourages reproduction, and that exalts the role of parenthood (Peck and Senderowitz, 1974, p. 2. According to Veevers (1980 in Peck and Senderowitz, 1974, p. 46), there are four primary beliefs that characterise the pronatalist discourse in general: (1) children strengthen marriage and are an indispensable expression of marital love; (2) they are essential to the physical and mental well-being of men and women, particularly women; (3) having children confirms masculine and feminine sexual identity and competence, and (4) parenthood is an innately determined need. Found in nearly all institutions of a society, pronatalist ideologies can be reflected in a question as simple as – "When are you going to start your family" or subtly in statements about tax exemptions for one's children (Monach, 1993, p. 45).

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[42] Drawing on the understanding of a Hindu religious community from one of India's most prominent historians, Romila Thapar (1989, p. 209-210), I understand the 'Hindu normative order' as common religious identity which is used by the people of this community as the basis for an ideology – a common identity which "tends to iron out diversity and insists on conformity". According to modern Indian history, although Hinduism is an amorphous and diversified religion with a non-linear historical progression, Thapar (1989) argues that there is nevertheless a clearly defined Hindu community and a particular ideology, part of which encourages the idea that Brahmanism and Hinduism are synonymous.

Inhorn (1996) explains that in non-western settings, apart from the presumed personal happiness and satisfaction of childbearing and parenthood, three common reasons can be cited for childbearing, based on social, economic, and political rationales. Using the example of pronatalism in Egypt, she writes that the first rationale is people's desire for social security or the conviction that children are necessary to ensure the survival of the parents and families, for instance, through their labour contributions and later by supporting their aging parents in the absence of pensions, health insurance, nursing homes, and other forms of support for the elderly (Inhorn, 1996, p. 235). The desire for social power is the second reason to want children who are seen as a valuable power resource, particularly for women who are confronted with patriarchal social relations within their marriage and households (ibid, p. 14). The third reason is the desire for social perpetuity or the perceived need to continue group structures, especially kin-based extended family systems (ibid., p. 255).

In the South Asian context, there exists a pronounced pronatalist ideology wherein children are highly desired, heterosexual marriage is highly valued, and parenthood is mandatory and is seen as the natural, desired, and rather inevitable consequence of marriage. In such a context, involuntary childlessness is considered socially unacceptable, while voluntary childlessness is deemed as nearly inconceivable (see Culley and Hudson, 2009; Nandy, 2013). The various Hindu scriptures and ancient law codes which compile and organise the code of conduct, such as the *Dharmashastras*, which includes the *Manusmriti*, are replete with references to marriage as a sacrosanct and social institution and to the importance of childbirth, particularly for women[43]. These classical Hindu texts, among other things, also prescribe the ideal Hindu 'way of life', in which four obligatory tenets should be followed by a man or woman – *Dharma* (duty, morality), *Artha* (prosperity, wealth), *Kama* (love, sex, pleasure) and *Moksha* (salvation, spirituality) (Singh and Nath, 2010, p. 21). These texts

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[43] In Hindu religious and social discourse, an individual's transition into a new social position or status is symbolised by life-cycle rituals known as *samskaras* or sacraments. According to the Hindu theory of sacraments, there are five groups: prenatal, childhood, educational, marriage, and funeral (Pandey, 1969, p. ix in Naraindas, 2009, p. 98). In accordance with this understanding of sacraments, the *Ashrama* system in Hinduism prescribes four stages or life cycle rituals through which a male person ought to progress to "actualize his potential" – *Brahmacharya* (student and bachelorhood), *Grihastha* (marriage and children), *Vanaprastha* (retirement and handing over responsibilities to the next generation) and *Sanyasa* (renunciation) (Singh and Nath, 2010, p. 9). For a Hindu woman, however, the four stages of the life cycle are different. Her life begins with *Grihastha* (marriage), which leads directly to *Garbadhan* (impregnation), *Pum-savana* (giving birth to a male child) and, finally, to the goal of *Moksha* (salvation) (Alex, 2016, p. 109).

further explain that it is through marriage that a person can fulfil these obligations and ideals towards the family and society and it is also only through fulfilling the 'duty' of marriage and procreation (preferably of a son)[44] can true salvation be attained (Sriram and Navalkar, 2013, p. 280-281). Marriage, therefore, is socially perceived not only as the prerequisite for establishing a household, sexual intercourse, childbearing, and childrearing, but it is through this obligatory religious sacrament that a Hindu man and woman can be enriched and can attain biological, emotional, social, and spiritual fulfilment and development – aspects which (apparently) cannot be attained in isolation (Singh and Nath, 2010, p. 24). Particularly, for women in India, according to the normal social biography, the dominant and pervasive ideology of pronatalism mandates biological parenthood, for which heterosexual marriage is a discursive prerequisite. ,In other words, is also only within the bounds of marriage, that a (hetero)sexual relationship is socially and morally accepted and sanctioned. A historical analysis of intimate relations in the Indian context reveals "a continuous hegemonic status conferred to conjugality despite its being *one* of the *many* relationships of gender", write Sen, Biswas and Dhawan (2011, p. 2). Within this heteronormative discursive setting, the primary objective of marriage is then to reproduce the social order through caste and class endogamy which further emphasises the importance of conjugality as producing the only legitimate family structure. It is not a surprise that *all* the couples whom I encountered at the infertility clinics in Kolkata were married as it was their married status which made them acceptable candidates who could legitimately seek assisted conception. Even in globalising India, Sen, Biswas and Dhawan (2011, p. 7) argue that marriage is "being updated, glamorised while not losing any of its old, standard functions as the bedrock of reproduction, caste and communities". In modern India, marriage is *the* social institution which still legitimises, socially sanctions, and gives legal recognition to filial ties (Kaur and Palriwala, 2014, p. 4).

In the last decade, one of the most seminal anthropological studies on marriage and motherhood within the Indian urban and middle-class population has been conducted by Henrike Donner in Kolkata. Based on her observations, Donner (2008) explains that it is only

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[44] For a woman in India, the birth of a child is not only a rite of passage and an accomplishment which reaffirms her move from her natal to the affinal home, but is also salvific if it is a male child (Naraindas, 2009, p. 98-99). According to Hindu belief, men without sons (*putra*) would be sent to a tortuous hell named *put* after death. The Sanskrit word for son is *putra* because only sons can save their fathers from being sent to hell and thus attaining salvation (Bharadwaj, 2003, p. 1870; Dasgupta and Dasgupta, 2010, p. 134; Naraindas, 2009, p. 101).

by getting married that a person follows the rules set and accepted by the wider society. During her study, she discovered that the rules, customs, and realities of marriage are used by her interlocutors to speak about women's identities as modern middle-class subjects and it is only through the first step of marriage and subsequently through giving birth to a child that a woman ostensibly attains maturity. As Donner (2008, p. 65) writes, marriage in India "constitutes a life-cycle ritual, and is thus necessary to make a person into a full human being, a process of mental as well as physical transformation through sexual activity, reproduction and nurture". In chapter six, I offer a detailed discussion of the morals and values such as sexual propriety and chaste heterosexuality that are socially expected of middle-class Indian women in order for them to fulfil the roles of the 'good wife' and the 'good mother'.

1.6.1. The Norm of (Legitimate) Motherhood

In the Indian context, parenthood is one of the most important aspects of marriages for most couples and conception and childbirth are an expected outcome of their sexual relationship. It is well-documented that irrespective of the sociocultural and religious background, procreation and parenthood in India are the most (visibly) defining goals in the lives of individuals and prime significance is attached to women attaining motherhood. According to Manu, the ancient codifier of Hindu social conduct, a mother is the most venerable of persons in society (Dasgupta and Dasgupta, 2010, p. 133). In the Indian society where the achievement of biological motherhood is intimately tied to increase in social status, prestige, power and self-esteem, the non-reproductive sexuality of a woman is sufficient to constitute 'abnormality' (Thadani, 1999, p. 151 in Nandy, 2013, p. 54). For a woman in India, her individual identity is subsumed under her identity as a mother, even more so than as a wife, and motherhood is glorified to a nearly divine status (Dasgupta and Dasgupta, 2010, p. 133). As Nandy (2013, p. 53) writes, "naturalisation and normalisation of mothering and the heteronormative family continue to pitch "mother" as the apex of womanhood"[45]. She further

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[45] Studies in the western countries have shown that parenthood as a part of adult life seems to be taken for granted and is seen as an inevitable rite of passage, as a biological need, as a prime indicator of sex role socialization, a sign of maturity, and a reaffirmation of an individual's adult status (Hoffman and Levant, 1985, p. 197; see also Bartholomaeus and Riggs, 2017; Letherby, 2002). The experience of becoming a parent and especially that of having the first baby is regarded as a transitional and transformative experience for (and by) women, (Umberson, Pudrovska and Reczek, 2010, p. 612-13). Feminist scholar Ann Oakley (1981, p. 24 in Gatrell, 2005, p. 52) writes that the first childbirth for a woman is a turning point which implies that the woman has now become a mother and this new identity affects the woman's life incurably as the child becomes an eternal theme

notes that Hindu religious discourse is replete with the need for women to become mothers, while popular culture, including Indian cinema, and the State's reproductive and child health policy, are also steeped in essentialising women as mothers (ibid., p. 54). However, women in India are seen as "ideal" mothers only under certain conditions – when she bears a son and perhaps the most crucial qualification to fulfil the need of biological childbearing and to gain social acceptance as a mother, is heterosexual marriage – as described in the previous section. Thus, for socially 'acceptable' women, biology is destiny, but for socially 'unacceptable' or Other women (single, menopausal, or queer women), the demands of biology are, or should be restricted to social sanctions (see Krishnaraj, 2010; Letherby, 2002; Meyers, 2001).

Within the sociological study of reproduction and motherhood, the dismantling of the seemingly natural desire of motherhood has been a central focus of feminist thought (Neyer and Bernardi, 2011, p. 3). Significant feminist research has demonstrated that motherhood as natural has been culturally, historically, legally, politically, and philosophically constructed (ibid., p. 6). Even though under certain circumstances of economic or social compulsions women 'consent' to motherhood as a contractual arrangement, there seems to be an "ongoing recognition of deep, visceral satisfactions to be derived from mothering" (Aneja and Vaidya, 2016, p. xvi). According to Ulrich and Weatherall (2000, p. 328), the discursive construction of motherhood as biological destiny is problematic in several ways as it denies women agency by construing them as being governed by forces beyond their conscious control as well as by limiting the identities available to them while instead valorising the biological links between mother and child. Refuting the assumption of motherhood as an inherent drive in women, de Beauvoir (1956) has popularly argued that the decision to become a mother is never performed in complete liberty and is rather enforced. Other scholars such as Pateman (1988, 1989 in Neyer and Bernardi, 2011, p. 6) argued that the relegation of women and motherhood to nature was a consequence of the patriarchal construction of sexual difference. The association of maternity with women's nature conflates biological and social motherhood and in doing so, denies that motherhood is a form of labour

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in her life. In writing about the "matrigyno-idolatry" discourse, Meyers (2001, p. 759) argues that the doctrine of "true womanhood" dictates childbearing as women's destiny according to which motherhood is seen as the only creditable form of fulfilment for women, and a mother is epitomised as "a beatific, munificent dispenser of love and forgiveness". Certainly then, the discourse of parenthood and motherhood in the western world are not that vastly different from the pronatalist South Asian setting.

(Neyer and Bernardi, 2011, p. 6). The essentialised notions of maternal love, maternal bonding, and maternal instinct have been critiqued by anthropologist Nancy Scheper-Hughes (1992, p. 314) who raises the question of whether the love of a mother is natural or at least “an expectable, womanly script” in a context where “scarcity and death have made that love frantic” (ibid., p. 15). As I have mentioned earlier, Scheper-Hughes has argued that maternal thinking and practices are socio-culturally produced rather than determined by a psychobiological script of innate emotions as has been suggested in the biomedical literature on maternal bonding and on feminist scholarship on maternal sentiments. She dismantles the notion that the love of a mother is natural or innate and argues that maternal behaviour and thinking is rather contingent on the sociocultural, material, and structural conditions including hunger, poverty, and labour structures which produces certain forms of affect (see Pinto, 2008b, p. 183). Indeed, Scheper-Hughes’ study points towards different patterns of maternal thinking and feelings which are constitutive of “a multiplicity of truths conforming to radically different experiences of reproduction and motherhood” (1992, p. 402).

However, as discussed earlier in this chapter, given the contextual backdrop of Indian middle-class values, the biomedicalised practices and understandings of reproduction, and the centrality accorded to procreation and the importance attached to motherhood in the making of gendered and social personhood for a woman, reproductive disruptions within a woman’s life course tends to result in complex experiences of loss, grief, bereavement, distress, and stigmatization, and reflexive questions about gender identities as I will explicate in the remaining dissertation. Indeed, research in other cultural settings also provides evidence that women without children represent the ‘Other’ in a society where motherhood is privileged above other womanly attributes (Letherby, 2002). In any pronatalist setting, therefore, women who do not have children, either by choice or due to biological and/or social circumstances, and those who have achieved motherhood in ‘different’ ways as opposed to biological motherhood (such as infertility treatments or adoption), have reported feeling excluded in various situations (see Letherby, 2002; Mehta and Kapadia, 2008; Nandy, 2013).

While research has shed light on the stigma and ostracization experienced by childless women in India (for e.g., see Bharadwaj, 2016; Neff, 1994; Riessman, 2000; Widge, 2003), only a limited number of studies have shown that childless men in India also suffer socially and personally, as I discuss next. This discussion will subsequently inform chapter seven on men, masculinities, and reproductive loss.

1.6.2. The Marginalised Reproductive Experiences of Men

The dearth of research on men's reproductive experiences and reproductive health has been pointed out by several scholars (for e.g., see Hinton and Miller, 2013; Malik and Coulson, 2008; Throsby and Gill, 2004). According to Inhorn et al. (2009, p. 2-3), the marginalization of men as the "second sex" in matters of reproduction is an oversight that needs to be remedied within anthropological research and it is only by paying close attention to men's reproductive experiences can they be included in the "reproductive imaginary". The relationship between men's intentions, desires, and emotive responses towards fatherhood and how men contribute to reproductive decisions are understudied and, thereby, not sufficiently understood (see Bartholomeus and Riggs, 2017; Culley, Hudson and Lohan, 2013; Dudgeon and Inhorn, 2009, 2004; Hanna and Gough, 2015; Hadley and Hanley, 2011; Lee, 2011). Even lesser attention has been paid to understanding reproductive loss from a male perspective (Robson, 2002, p. 189) and men's experiences of and attitudes towards "reproductive impairment" and reproductive loss have become topics of research only in the recent past (Dudgeon and Inhorn, 2009, p. 89). Indeed, there has been a severe neglect in research regarding the relationship between loss, grief, and notions of masculinity(-ies), and our understanding of these themes are very much in its infancy (Thompson, 1997, p. 86-87).

It has been observed by researchers that the cultural association between femininity and motherhood and the clinical focus on (heterosexual) women's bodies in relation to both the diagnosis and treatment of infertility is the primary reason why men's reproductive experiences have been vastly overlooked (see Culley, Hudson and Lohan, 2013; Dolan and Coe, 2011; Herrera, 2013; Inhorn et al., 2009; McCreight, 2004; Throsby and Gill, 2004). Conventionally, research has focused more on a gendered understanding of who is more distressed that has resulted in the framing of research questions towards female experiences of infertility, involuntary childlessness, and pregnancy loss (see Greil et al., 2010; Jordan and Revenson, 1999; Llyod, 1996). Although childlessness and infertility, similar to most other reproductive issues, are seen as a "woman's problem", Inhorn (2003, p. 237) argues that it needs to be acknowledged that "the biological aetiology of infertility does not reside solely or even largely in the female reproductive tract[46]" and that men are the sole cause or a vital contributing factor to infertility in more than half of all couples around the globe[47]. Despite such conspicuous evidence, the primary reason for women bearing the social burden for infertility (and I would add reproductive loss) is that "women's bodies bear the 'proof' of infertility through their failure to achieve pregnancy and childbirth, whereas men's bodies hide the evidence of reproductive defect", argues Inhorn (ibid., p. 238). In addition, Inhorn notes that the other reason for women being stigmatised more than men is the patriarchal ideology that is entrenched deeply in societies and that is significantly responsible for the asymmetrical gender relations which accompany infertility worldwide (ibid.).

In his study of masculinity and fatherhood, Collier (2001 in Puri, 1999, p. 526), writes that it is only since the 1980s that there has been a massive growth in the study of fatherhood in the Euro-American countries. He claims that this was partly a reaction to the increasing number of feminist studies on motherhood during that period and a desire of men to redress the balance. While men were seen more as the provider for the family in contrast to the mother who was to play the caregiving role, recent studies show that there is a perceived shift in identity by men themselves when they become fathers. For instance, Carlson, Abbie and Edleson (2015) have found that some North American men began to develop their "fatherhood identity" as first-time fathers during their transition to fatherhood. The study states that first-time fatherhood is like a "developmental engine" which "appears to get ignited during the prenatal period or when the man learns he will become a father" (Carlson, Abbie, and Edleson, 2015, p. 198). With the transition to fatherhood, men also experience the social expectations and the challenges of how to negotiate the social expectations and discursive norms of parenthood. Fatherhood in Euro-American countries has, thus, been

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[46] Inhorn (2003a, p. 237-238) lists many causes which can result in male infertility such as low total volume of the ejaculate, irregularities in the pH of the seminal fluid, hyper viscosity of the seminal fluid or presence of pus (from infection) in the seminal fluid (a problem in countries where sexually transmitted diseases go untreated), low sperm count (oligospermia), an absence of sperm (azoospermia), poor sperm motility (asthenospermia), and abnormal sperm morphology (teratospermia). Interestingly, the pathogenesis of most of the causes of male infertility remain idiopathic and the conventional therapies for the treatment are largely unproven and ineffective (ibid., p. 238). Interestingly but not so surprisingly, I noticed during my research that none of these reasons were mentioned in the informational pamphlets of the infertility clinics and neither were they listed by the doctors during the initial doctor-patient consultations.

[47] This finding is based on one of the most comprehensive epidemiological study of infertility in recent times which was conducted by WHO and it included 5,800 infertile couples at thirty-three medical centres in twenty-two countries (Inhorn, 2003, p. 237).

shown to be a socially important normative role in an adult man's life and an important component of a culturally determined "package deal" which comprises of four main elements i.e. marriage, parenthood, stable employment, and owning a house (see Townsend, 2002).

Although research on fatherhood is limited within the South Asian context (Sriram, 2011, p. 626), let me outline some recent and important findings. In their study in south India, Osella and Osella (2006, p. 41) have observed that fatherhood and marriage for South Asian men are indubitably a considerable aspect of enacting their "compulsory active heterosexuality" and masculinities. Likewise, Pujari and Unisa (2014) have argued that becoming a biological father is one of the most crucial and intense forms for a man to assert his manhood in India. Besides, research by Saraf and Srivastava (2011) and Sriram (2008) has also shown that middle-class fathers in urban India are more involved in their child's life and are more emotionally invested in the child's growth and future which indicates the presence of newer forms of fathering (see chapter seven). This can be understood in contrast to the fathers' role in earlier times wherein they who were considered to have a limited role in their children's' lives (at least from the initial years till the children were of school-going age) and were characterised as being affectively distant, the stern disciplinarian, the provider, and the family's moral guardian (Sriram and Navalkar, 2013, p. 281; Kakar, 1981 in Sriram and Navalka, 2013, p. 281). In contemporary urban India, Saraff and Srivastava (2008) have identified seven dimensions of the role of an 'ideal father' – caretaker, surety, economic provider, playmate and friend, role model, family head, and resource. Their research findings revealed that while caretaking was viewed by men nowadays as one of the most important attributes of an ideal father, for others, it was playing the role of the economic provider and/or role model.

While the societal pressures for (heterosexual, married) women in India to become mothers is more intense and pervasive in comparison to men, studies have found that in such highly pronatalist societies men also face social pressure to adhere to the norms of fatherhood in order to fulfil their masculine role (for e.g., see Chowdhry, 2005, Pujari and Unisa, 2014). Chowdhry (2005) observes that in rural north India, while the first step towards becoming male and achieving manliness is marriage, the second and more pivotal step is to father a child and until that second step is complete, the man will not be fully considered a 'real man'. The available studies on male childlessness in India have shown, that akin to many other societies, a man who is unable to prove his virility by impregnating his wife is seen to be lacking in manliness (see Chowdhry, 2005; Osella and Osella, 2004; Pujari and Unisa, 2014). In public discourse, childless men are often derogatorily referred to as *napunsaka* (neuter gender), *chakka* or *hijaṛā* (eunuch), *tuccha* (worthless), and/or *nāmarda* (literally translating into not a man) (Mehta and Kapadia, 2008, p. 441; Pujari and Unisa, 2014, p. 23, 33).

Pujari and Unisa's (2014) recent research on childless men in rural south India captures men's voices and their experiences of infertility and also examines the consequences of childlessness for men on four levels i.e. marital, family, community, and personal. Feelings of depression, anger, loss of social status, anxiety, and the social pressure to re-marry were common among most of the male respondents (Pujari and Unisa, 2014, p. 35). The lack of a biological child affected the social relations of these men and in fear of being ridiculed, they avoided village gatherings (ibid.). Among the various coping strategies used by them to grapple with childlessness, the most common ones were to work for longer hours, turning to alcoholism, social service at the community level, watching television at home, and praying to God (ibid., p. 36-37; see chapter five). Bharadwaj's (2003) study in India also shows that most men feel so humiliated by their ('invisible') (in)fertility and resultant lack of (biological) fatherhood, that they would rather opt for donor insemination than adoption to render their fertility 'visible' through their pregnant wife's body (see chapter seven).

1.7. Overview of Chapters

As is evident from the engagement with literature so far, this study engages with several themes given that an in-depth study of the experiences of reproductive loss and grief warrants that I pay attention to the prominent topics which emerged and/or developed during my research period. To that end, this dissertation is divided into eight chapters, including five ethnographic chapters wherein using different vantage points, I trace the disrupted life trajectories of middle-class couples in Kolkata as an outcome of their experiences of reproductive loss and grief as well as their trials and tribulations to achieve reproductive success to finally resume normalcy in their conjugal lives. To reiterate, the ethnographic elaborations allow me to demonstrate that the couples' experiences of loss and grief were produced in a specifically middle-class Indian landscape in 21st century urban India where reproductive aspirations and related practices are enacted in an increasingly biomedicalised realm. I also show that various gendered roles, entities, and emotions were enacted during diverse social interactions among the range of actors and it is these multiple enactments which ultimately constitute the couples' reproductive experiences of loss and grief. Finally, I show that even though the agency of the interlocutors, especially of the women, was constrained by prevalent discourses or by the various actors on multiple occasions, the women utilised multiple forms of constrained agency.

In Chapter one, I introduced the study, the main arguments, birth of the study, its significance, and research questions. Then, I offered conceptual clarity on the terms which I will be using in this study i.e. reproductive loss, grief, bereavement, and mourning. Next, I engaged in a discussion of the contextual and discursive frameworks within which this study is embedded i.e. the biomedicalisation of reproduction and the ethos of the Indian middle-classes. Finally, I discussed the normative discourses prevalent in the South Asian context which underline the reproductive experiences of the female and male interlocutors in my study i.e. pronatalism, marriage, and the norms of motherhood and fatherhood.

In order to examine and analyse the various research themes in a study, a researcher can employ one or more theoretical 'lenses' or 'tools' to approach a particular issue and focus attention on particular aspects of it. As such, in Chapter two, I engage with the three theoretical lenses which I have applied in this study – 'Enactment' (Mol, 2002), 'Gendered performativity' (Butler, 1990, 1993), and multiple understandings of 'Agency' (Burkitt, 2013; Cussins, 1998; Latour, 2005; Law and Mol, 2008; Ortner, 2006; Rapp, 2011; Shaw, 2016). I describe how a combination of these lenses enabled me to gain nuanced insights into the female and male interlocutors' experiences of reproductive loss and grief as well as to address questions regarding why this loss became a disruptive life event, what they lost, their coping mechanisms, and how their marriages as well as their gendered and sexual selves were negatively impacted. The chapter ends with a discussion about the research design and methodology followed by a description of the research sites i.e. the three infertility clinics.

In Chapter three, my main argument is that the reproductive technologies as "non-human actants" (Latour, 2005) performed an agentic and mediating role insofar as they effected and shaped the social interactions between the actors in the infertility clinics as well as influenced the women's reproductive experiences. I show that during the medical procedures which necessitated technological 'rituals of submission'[48] ([focusing on Transvaginal ultrasound scan

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[48] I am grateful to Prof. Dr. Karin Polit for proposing the term "rituals of submission" during a doctoral colloquium.

(TVS) and Hysterosalpingogram (HSG)], women were commonly enacted by the medical practitioners as submissive patient-bodies[49]. In this process, I show that women’s agency to make any decisions regarding their own bodies or to question the practitioner’s decisions was constrained. However, I also show that women were not merely compliant and objectified patient-bodies but instead, they exercised various forms of constrained agency by participating in the medical encounters and engaging with the technologies in order to gain a sense of control over their treatment experiences as well as to move closer to having a ‘normal’ child. In the chapter’s second half, I show that the visualising technology of ultrasound facilitated the enactment of foetal and embryonic personhood – enactments which augmented women’s experiences of ‘what’ they had lost. I further discuss how despite multiple treatment failures, most women continued pursuing subsequent treatments. Drawing on the seminal research of Franklin (1997, 2013) and Sandelowski (1991), I show that by responding to and creating the desire among childless women and/or couples, the ‘pull’ of the reproductive technologies (especially IVF), compelled most of the female interlocutors to undergo repeated treatment cycles. I conclude by addressing an interesting paradox wherein I discuss that although most of the female interlocutors acknowledged the instrumental role performed by the reproductive technologies in their journey towards conception, the same technologies were not remotely blamed when they experienced reproductive loss. Instead, they rationalised their reproductive loss and reproductive failure by blaming other factors. Taking cue from Franklin (1997), I argue that the agentic capacity of these technologies was invisibilised by the female interlocutors as it was only by maintaining their faith in these technologies, could they continue to maintain the hope of having a child.

In Chapter four, I shift my attention from the role of the reproductive technologies to that of the medical practitioners who, I show, performed a seminal role in the childless couples’ reproductive journeys. I argue that various negotiations and collaborations were made between the actors in the infertility clinics in order for both parties to achieve reproductive success. The chapter begins by addressing the ways in which the practitioners influenced, shaped, and controlled the interactions with the patients and/or couples as well as the

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[49] Although the term ‘patient’ implies “a passive and compliant individual who aims to overcome an illness” (Parsons, 1951a in Shaw, 2016, p. 35), I use the word ‘patient’ throughout this study as it was used by the practitioners to refer to the women at the infertility clinics and the women also referred to themselves using the same term during our conversations.

meanings which the latter attached to the topics of conception, procreation, relatedness[50], parenthood, and gender roles. I show that the practitioners reproduced and naturalised the importance of biogenetic relatedness in making a 'normal' family and they also essentialised dominant gender scripts for both women and men. I then show that by employing different forms of 'disciplinary' mechanisms (Foucault, [1975]1995)[51], the doctors enacted 'good patients' who were compliant and displayed unquestioned faith in the doctors' knowledge and professional abilities and in the process, the doctors established their authority and the hierarchy in the medical settings while constraining the women's and/or couples' agentic capacities. I examine three prominent mechanisms performed by the doctors – discouraging women and/or couples from asking excessive questions, ensuring that the patients and/or couples are obedient, and praising women and/or couples for diligently performing their roles as 'ideal' patients. Finally, I show that some practitioners selectively performed and juggled extended roles as friend, confidante, and counsellor in order to actualise the best way in which they thought they could achieve reproductive success and also to ensure that their patients did not leave them for another doctor who would offer them the desired therapeutic intimacy. Throughout this chapter, I highlight women's agentic maneuverings despite being purportedly enacted by the practitioners as submissive patients. As such, another argument herein is that not only were the doctors enacting 'good patients', but the women were also utilising forms of constrained agency, both actively and passively, in enacting themselves as 'good patients' in order to work towards the common goal of a successful conception and pregnancy.

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[50] I follow Carsten's (2000, p. 1) understanding of "relatedness" which she conceptualises as an idiom or term which indicates how people in specific localities describe what "being related" means and how it is enacted between/among themselves instead of taking the content of 'kinship' for granted. She uses 'relatedness' to "convey, however unsatisfactorily, a move away from pre-given analytic opposition between the biological and the social on which much of anthropological study of kinship has rested" (ibid., p. 4).

[51] I draw on Foucault's [1975] (1995)] understanding of 'discipline' (as a modality of power) insofar as how through the process of (bio)medicalisation, medical practitioners in my study employed their disciplinary power through certain mechanisms based on which they enacted the female interlocutors as docile patients. In doing so, the practitioners engaged in medical surveillance where through those mechanisms, the patients were 'objectified' wherein their capacities, gestures, movements, and behaviours were regulated (Sawicki, 1991 p. 67; see also Thompson, 2005; see chapter three and four). However, it is not only medical surveillance that is achieved through disciplining, but as I will show, women as agents also engaged in "self-surveillance" (based on Bentham's concept of the Panopticon which ensures that people behave in expected ways (Foucault, [1975]1995, p. 195-228).

In Chapter five, I am concerned with the bereaved female interlocutors' accounts of unrecognised reproductive loss and "disenfranchised grief" (Doka, 1989, p. 4). My central argument is that even though the women's agency to grieve and mourn for their reproductive loss was repeatedly denied by the other actors, they nevertheless utilised diverse forms of constrained agency to process their grief and by giving meaning to their experiences of 'what' they had lost. I firstly focus on how the bereaved women were not allowed to have any contact with their dead baby, even if a woman so desired. Women were excluded from the decision-making process regarding the baby's disposal and it was usually the mothers-in-law who made the decisions while the husbands performed the death rituals, if at all. I show how the denial and exclusion of women from these practices was done based on the other actors' well-meaning intentions of wanting to protect the women from being traumatised further. However, I offer examples to show that these intentions were based on gendered stereotypes about women's apparent emotional fragility and them being emotionally incapacitated to take any rational decisions. Further, I discuss how these interlocutors were pushed by the other actors to forget the incident, move on, and try to conceive again soon after the loss. I discuss how early term losses were accorded the least amount of significance by the other actors and were treated as non-events or medical events, even though the women regarded it as a significant loss. The chapter's second half deals with how my female interlocutors utilised their constrained but strategic agency by enacting themselves as mothers (mostly liminally) who had experienced a significant embodied loss of a (potential) child – a recognition of the motherhood identity and baby's personhood which had not been accorded to them by others. I end this chapter by illustrating the gendered expression of grief by describing a male interlocutor's account of coping with reproductive loss and grief as a point of comparison.

Based on the female interlocutors' narratives of how their marriage and sex lives were normal before the occurrence of reproductive loss and how in the aftermath of loss, their marital relationships were inundated with regular conflicts and waning sexual intimacy, in Chapter six I argue that marriage was undeniably one of the most profoundly distraught sites as a result of reproductive disruptions. This was the only chapter that was not a part of my research design prior to my fieldwork. Instead, this chapter's thematic concerns developed from the interviews with some of the female interlocutors, who on their own volition, spoke at length and emphasised on how intensely their marriage had been affected due to the absence of a child and also as a result of the stress of undergoing infertility treatments. I start with a discussion of the making of the ‘good wife’ and ‘good mother’ among the middle classes in India (see Donner, 2008). Subsequently, I show that in order to gain a semblance of normalcy in their conjugal lives, the women tried involving their husbands in various everyday activities and they also made attempts to initiate sexually intimate acts. Relatedly, my second argument in this chapter is that women utilised their sexual agency within their constrained conjugal lives not only because they wished to resume normalcy in their marriage but also because they wanted to be seen by their spouses as more than mere reproductive bodies. However, the transgression of the culturally prescribed middle-class morals for an Indian wife by some of the female interlocutors through desiring sex, despite their failed reproductive abilities, was deemed immoral or dishonorable by the respective husbands. Further, I show how the escalating marital conflicts resulted in a few women contemplating divorce. However, instead of enacting themselves as oppressed victims in their marriage, I show that the women exercised their agency, for instance, by negotiating with their circumstances and making decisions which allowed them to adapt to their constraints. To end, I engage in a brief discussion about how women in modern-day love marriages represented themselves as agentic whose marital relationships, despite being distressed, were reportedly in a better position than women in traditionally arranged marriages who were enacted as being devoid of agency and whose relationships were presumably suffering more in the absence of a child.

Chapter seven engages with the male interlocutors’ reproductive aspirations, motivations, experiences, and practices and based on which, I explore their enactment of ‘multiple masculinities’ or how there are different ways of being men. Following a discussion of normative masculinities based on relevant literature, I introduce cases of male interlocutors who desired fatherhood and those who questioned the naturalness of desiring fatherhood. I argue that these men enacted forms of “caring masculinities” (Elliot, 2015) and “emergent masculinities” (Inhorn, 2012), respectively – forms of masculinities which cannot be accounted for by the conceptual framework of “hegemonic masculinity” (Connell, 2005). I then look at the case of another interlocutor who enacted his ‘manliness’ by displaying compassion and concern towards his grieving wife while also adhering to specific characteristics of normative masculinities, specifically, “restrictive emotionality” (Jansz, 2000). I also discuss the example of an interlocutor who had been diagnosed as infertile and who enacted forms of what I refer to as “vulnerable masculinities” by transgressing the gendered norm of emotional stoicism during our interview. In the second half of the chapter, I look at the practices of semen collection, donor insemination, and ARTs directed towards ‘treating’ male infertility and discuss the men’s concerns, anxieties, and their enactment of masculinities within the biomedical spaces of infertility clinics. I argue that the process of semen collection and having a child through donor insemination threatened the male interlocutors’ enactment of a ‘real man’ and fostered feelings about the loss of their ‘manhood’. I also argue that the availability of ARTs (such as Testicular Epidydimal Sperm Aspiration) compelled men to enact normative masculinities, even if it meant suffering from forms of “embodied agony” (Inhorn, 2007, p. 49) by undergoing painful medical procedures, as long as it allowed them to establish biogenetic paternity. I end this penultimate chapter with a discussion about the invisible but prevalent hierarchy of preferences regarding having a child and the practice of adoption posing the biggest threat to men’s understandings of relatedness and also to their enactment of normative masculinities.

Finally, in Chapter eight, I recapitulate the ethnographic findings and tie the threads of the arguments from the preceding chapters – the middle-class and biomedicalised discursive context, multiple enactments of various actors, gender roles, concepts, entities, and emotions, and the diverse forms of (constrained but strategic) agentic movements – all of which come together to shape the married couples’ experiences of reproductive loss, grief, and their attempts to achieve reproductive success in the globalising, urban, 21st century Indian landscape. I conclude that with a discussion of the implications of this study and the scope for further research in relation to contemporary issues related to reproduction.

Chapter 2. Theoretical Framework, Research Methodology, and Research Setting

The present chapter is divided into two parts. In the first part, I describe the theoretical lenses which have enabled the analysis of the research data and will serve as the conceptual framework for this study followed by a description of the research design and methodology. In the second part, I briefly describe the broader research setting of Kolkata and then shift my attention to the three infertility clinics which were my primary research sites.

PART I

2.1. Theoretical Framework

As I have mentioned in the introductory chapter, this ethnographic study is concerned with the disruptive and gendered experiences of reproductive loss and grief of involuntarily childless middle-class couples in urban Kolkata. While the word “experiences” is frequently used in qualitative research, it is rarely defined (Denny, 2009, p. 286). Kleinman and Seeman (2000, p. 234) define experience as a representation of the “intersubjective, felt flow of events, bodily processes and life trajectory which always takes place within a social context”. By acknowledging that experiences do not occur in a vacuum and that there is an important link between the personal, the cultural, and the social, Kleinman (1992, p. 128) writes that anthropologically, experience refers to “an interpersonal, intersubjective realm of engagements, transactions, communications, and other social activities”. Thus, an experience, according to Kleinman, should be seen as “a flow, a medium moving between and within persons that is the condition for, as well as the achievement of, actions and transactions” (ibid.). Furthermore, he explains that experiences are part of “local moral worlds”, the contours of which “are recognizable as a particular form of life, a local way of being human” (ibid., p. 129). Following Kleinman’s conceptualisation of experience, I seek to unravel the multi-layered experiences of reproductive loss and the ensuing grief by analysing the various social interactions, practices, and engagements which, as I will show, are deeply embedded within the local moral worlds and shaped by the discourses around pronatalism, heteronormativity, normative gender roles, biomedicalised reproduction, and middle-class ethos in India. I now engage with the three theoretical lenses and conceptual tools which I apply in this study in order to unpack and analyse my research findings.

2.1.1. Enactment

In her landmark book, *The Body Multiple: Ontology in Medical Practice* (2002), Annemarie Mol utilises insights from Actor-Network Theory (ANT) and uses the term 'Enactment' to describe the multiple *doings* in medical practice and how objects or entities are constituted in these *doings*. Based on an ethnography of atherosclerosis in the lower limb, Mol explains that the doings or enactments of the disease of atherosclerosis manifest themselves in relational networks between human and non-human entities, such as patients, healthcare personnel, medical equipment, protocols and so on. Locating her study in a hospital in a Dutch town, she introduces the multiple ways in which a series of different practices are undertaken by different actors in different sites in order to enact atherosclerosis. Mol (2002, p. 6) argues that the same disease can be "multiple" even within the same patient as "no object, no body, no disease, is singular". Her central thesis is explained in the following passage from her book:

> If practices are foregrounded there is no longer a single passive object in the middle, waiting to be seen from the point of view of seemingly endless series of perspectives. Instead, objects come into being – and disappear – with the practices in which they are manipulated. And since the object of manipulation tends to differ from one practice to another, reality multiplies. The body, the patient, the disease, the doctor, the technician, the technology: all of these are more than one. More than singular. This begs the question of how they are related. For even if objects differ from one practice to another, there are relations between these practices. Thus, far from necessarily falling into fragments, multiple objects tend to hang together somehow. Attending to the multiplicity of reality opens up the possibility of studying this remarkable achievement (Mol, 2002, p. 5).

It is clear from the content above that Mol is proposing a theory of practice*,* what she refers to as "praxiography" or a story of practices, within which human action is treated as being entangled with its physical surroundings (ibid., p. 31). Given that these entanglements are heterogenous and constantly shifting, she argues that the human body is multiple, but not plural. The enacted object, in this case atherosclerosis, is, therefore, "more than one, but less than many" (ibid., p. 55). Mol's study, thus, is a detailed exploration of the object 'multiple', and this object or entity is 'enacted' – not constructed, signified or performed – by multiple practices (Saldanha, 2003, p. 425). Instead of using metaphors such as 'construct' or 'performance', Mol (2002, p. 32-33) chooses the term 'enact' to suggest that activities take place while leaving the actors vague. She further clarifies that the term 'enact' also suggests that "in the act, and only then and there, something *is* – being enacted", unlike the term ‘performance’ which suggests that there might be a backstage where the actual reality might be hiding (ibid.).

Let me briefly expand on what Mol refers to when she claims that a disease is done differently in different sites by different actors. For instance, she describes how the disease of atherosclerosis is enacted differently in a consulting room by a doctor and in a pathology lab by a pathology resident. She explains that based on certain questions and a physical examination, the disease of atherosclerosis is done in the consulting room by the doctor only when the patient comes to the doctor and tells him/her about the pain. Until the patient comes to the doctor, the patient is suffering from a certain kind of pain and does not have that disease yet. In other words, the patient does not enact atherosclerosis by her/himself. However, this is not to say that it is the doctor who brings the disease into being. Rather, the doctor needs a patient to make the diagnosis of atherosclerosis. As such, Mol argues that at least two people are required in the consulting room for the diagnosis and the subsequent enactment of the disease of atherosclerosis. There are other elements too, she notes, which contribute to the enactment, such as the desk in the room, the chair, paperwork, and so on. These other elements, however, are ‘variables’ which can either be present in the room or not, and it is the patient-body which is indispensable for clinical diagnosis. The enactment of the disease needs this patient-body and this body must cooperate with the doctor. Unlike the interaction between the doctor and patient which enacts the disease, Mol describes how in the pathology lab, the pathology resident enacts atherosclerosis by making it visible under a microscope (see chapter three for a discussion on the enactment of foetal and embryonic personhood). As such, the enactment of atherosclerosis is dependent on the microscope as much as it is dependent on the pathologist, the doctor, the patient, and other elements inside the hospital. Thus, Mol (2002, p. 31-32) argues that the “disease” that ethnographers describe is never alone and it does not stand by itself – “it depends on *everything* and *everyone* that is active while it is being practiced. This disease is being done” (emphasis mine).

Instead of being concerned with epistemological questions of how medicine knows its objects, she shows how medicine interacts with and shapes its objects through varied practices. Indeed, Mol convincingly demonstrates that there are many ways of not just knowing an object but also practising it. Each way of practising does or enact a different version of ‘the’ object. Hence, it is not simply ‘an object’, but more than one. An object multiple”.

Consequently, what an object becomes or what the outcome(s) of an event is, is an effect of the changing practices or the changing “ontological choreographies” (Law and Lien, 2012, p. 368). In understanding the practices, the choreography, the relations and the enactment(s), difference and multiplicity can be discovered, Law and Lien explain that the differences and multiplicities, as one can observe, are chained together, and the “object multiple” is “sometimes and somehow held together in a precarious choreography of overlapping practices that sustains it…” (ibid., p. 372).

Taking cue from the discussion so far, I argue that the experiences of reproductive loss among the middle-class married couples in my study are constituted not by plural but rather multiple enactments or doings of various gender roles, entities, concepts, emotions, and relations between the various actors. And it is these multiple enactments which I seek to demonstrate in the due course of this study. In each ethnographic chapter, I demonstrate these multiple enactments in different situational contexts through different practices located within the shared discursive spaces of the actors. For instance, the enactment of the women as ‘good patients’ by the medical practitioners, the enactment of foetal and embryonic personhood, the enactment of women as emotionally fragile and men as emotionally stoic by the external actors, and so on. I situate my understanding of the meanings of these roles, entities, and emotions as not being preordained or fixed but rather that I show that they are continually enacted through the practices and dynamic social interactions between the actors and often, by the actors themselves. Given that these practices and social interactions are embedded within existing social discourses of pronatalism, heteronormativity, normative gendered roles, biomedicalised reproduction, and middleclassness in India, the multiple enactments also unfold within and are shaped by these discourses. The theoretical exercise I, therefore, engage in is to unpack these enactments and ultimately show how like the parts of a puzzle or an “intricately coordinated crowd” (Mol, 2002, p. vii-viii), they all come together or can be assembled in framing the couples’ experiences of reproductive loss, grief, and their attempts to achieve reproductive success.

These multiple enactments, as I will also show, entail the constraining of agency, primarily of women, either discursively or by other actors, usually based on gendered essentialisations. However, as I will highlight, it is also within these constrained circumstances, that my female (and male) interlocutors utilised diverse forms of agency instead of being passive bystanders.

In order to illustrate the enactment of gender roles and the agentic manoeuverings of my interlocutors, I apply two theoretical lenses – Judith Butler's theory of gender performativity and the diverse conceptualisation(s) of agency as more than mere acts of choice or resistance.

2.1.2. Gender Performativity

The topic of reproduction is deeply intertwined with gender and sexuality. The present project of exploring reproductive experiences would remain an incomplete endeavour if I did not analyse the role of gender, given that the married women and men's experiences of reproductive loss and grief in my study were profoundly gendered. In order to gain a better understanding of doing (and undoing) gender[52] or the enactment (and subversion) of normative gender roles, I engage with the Butler's theorisation of gender performativity. I draw on this theorisation to show how in different (heteronormative) sites, such as infertility clinics and heterosexual marriage, the women and men performed their 'femininity(-ies)' and 'masculinity(-ies)' through a repetition of discursively gendered acts. Moreover, I show that it is within these discursive sites that the women and men as agents performed subversive or transgressive acts. In addition, I use ethnographic vignettes to illustrate that these normative gender roles were essentialised and reified by the medical practitioners during medical encounters. I argue that such essentialisations sustain and reproduce these gender roles, resulting in further reification of the 'feminine' woman and the 'masculine' man as imagined within the heteronormative and pronatalist discourse in middle class India and within the broader South Asian context. Based on an analysis of the various reiterative (and transgressive) gendered practices by the actors in the context of reproductive loss, childlessness, and grief, in the following ethnographic chapters, I demonstrate how a 'gendered subject' is continually enacted rather than being a preordained identity.

Butler (1988, p. 520) questions the very 'essence' of a person as a male or female or masculine and feminine and contests the reification of gender and naturalisation of gender concepts. Gender, according to her, is not just a social construct, but it is an "embodied set of signs" which is "practiced, attained, and created through performativity and is not a pre-existing essence that constitutes a person" (Butler, 1990 in Polit, 2006, p. 16-17). Butler (1996, p. 112) distinguishes between 'performance' and 'performativity' by stating that the former

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[52] A point of departure for many subsequent scholarly texts, West and Zimmerman's article titled 'Doing Gender' (1987) argues that gender is not something we *are*, but something we *do*.

presumes a subject, whereas the latter contests the very notion of a subject. Both the body and gender are not preordained, fixed facts of nature and instead, she (1988, p. 520) argues that they should be understood as "constructed identities" or "performative accomplishments" which the audience, and the actors themselves, come to believe and to perform in the mode of belief. In other words, the gendered body is performed and (re)produced in an ongoing process wherein gender categories such as female/male, woman/man, girl/boy, are brought into *being* performatively, in particular, through performative speech acts i.e. "speech acts that bring into being that which they name" (Butler, 1996, p. 112). In this regard, Butler suggests that performativity is "the vehicle through which ontological effects are established" (ibid.).

For Butler, bodies are gendered from the beginning of social existence, which implies that there is no such thing as a 'natural' body which pre-exists its cultural inscriptions. She takes a compelling anti-essentialist stance to assert that gender categories are not imported into any culture or society from the 'nature' outside but is rather fundamentally *shaped* through discourse(s). The body and gendered identity both substitute "an active process of embodying certain cultural and historical possibilities" and the gendered body is "the legacy of 'sedimented acts' rather than a predetermined or foreclosed structure, essence, or fact, whether natural, cultural or linguistic" (Butler, 1988, p. 521-523). Such a sedimentation over time produces "a set of corporeal styles which, in reified form, appear as the natural configuration of bodies into sexes which exist in a binary relation to each other", argues Butler (1988, p. 524). Furthermore, Butler argues that "the life world of gender relations is constituted, at least partially, through the concrete and historically mediated *acts* of individuals" – acts which are continually performed and sustained (ibid., p. 523). Thus, the central tenet of Butler's (1990, p. xv) performativity theory is that gender performativity is not a singular, random or deliberate act, but rather it is a repetition and a ritual which "achieves its effects through its naturalisation in the context of a body understood, in part, as a culturally temporal duration". Gender, therefore, is constantly made and remade through the repetition of norms and practices.

In understanding performativity as a reiterative practice, Butler (1993, p. xii) further argues that performativity is produced through discourse(s) which "produces the phenomena that it regulates and constrains". As such, an individual is not free to choose which particular gender roles he or she will perform. Instead, she argues that there are ‘scripts’ and a limited number of ‘costumes’ within a regulatory and constrained framework from which the subject has to make a choice as to which gender he or she wants to perform on a daily basis (Butler, 1990 in Salih, 2002, p. 56). Salih notes that for Butler, with the repetition of performative acts, these scripts and costumes become socially sanctioned and not adhering to these might result in social ostracization (ibid.). One case of such a socially sanctioned script is the “heterosexual matrix”, which is unconsciously embodied by actors, writes Butler (1988). According to this injunction, heterosexuality is the de-facto sexual orientation in a society which is then recurrently reproduced and concealed through the cultivation of bodies into discrete sexes with ostensibly 'natural' appearances and 'natural' heterosexual dispositions (ibid., p. 524). In regard to marriage, for example, Butler (1990, p. 72) explains that the discourse of the heterosexual matrix establishes the confines of a heterosexually-based system wherein the ‘masculine’ is desiring of the ‘feminine’, thus assuring and legitimising the reproduction of human beings. Any disruption in these prescribed performances within a marriage can potentially lead to condemnation and/or ostracization of the disruptor (see chapter six).

Butler’s theorisation of gender performativity has been critiqued by several scholars who suggest that her theory does not account for individual agency (see Boucher, 2006; McNay, 2003; Webster, 2000). McNay (2003, p. 143) notes that for Butler, it is the norms which precede the subject’s performance rather than the other way around, thus, implying that the subject has no agency in the way he or she acts. One of Butler’s prominent critics, Benhabib (1995, p. 20-21), claims that Butler’s postmodern theory of performativity is deterministic as it does not allow for the subject’s autonomy, choice, and self-determination. According to Benhabib, Butler’s theory does not offer “a sufficiently thick and rich account of gender formation that would also explain the capacities of human agents for self-determination” (ibid., p. 110). Benhabib further argues that Butler’s argument that subjects are constituted by discursive structures gives too much power to the discourse itself and too little power to the individual. The subject’s capacity for self-reflection, or reflexivity, is essential to the subject’s agency, and it is this reflexivity which Butler does not acknowledge in her theory of performativity, argues Benhabib (ibid., p. 21).

However, critical of Benhabib’s formulations of the autonomous and self-determining individual, Butler (1995, p. 42) later suggested that such formulations reject the “situated” and the “constituted” character of subjectivity. Such formulations, she argues, disavow that subjects always act from and within a cultural schema and that the subjects are constituted by and through those very acts (ibid). She notes that “to claim that the subject is constituted is not to claim that it is determined; on the contrary, the constituted character of the subject is the very precondition of agency” (ibid., p. 46). Thus, Butler contests Benhabib’s claim that having an account of subjects as constituted by the discourses is to posit the subjects as being determined. In her lectures titled *Kritik der ethischen Gewalt* (2003 in Magnus, 2006, p. 99-100), Butler no longer understands subjectivity and agency solely in terms of the discourse that produces it. Rejecting the idea of determinism, Butler acknowledges the transformative potentials of individuals, thus implying the possibility of individual initiative (ibid., p. 100). In *Undoing Gender* (2004, p. 7), Butler no longer defines the subject as essentially subjected but as having the agency to participate in the discursive processes that define his or her existence. It is the social world and discourses within it, she writes which supports and enables the exercise of individual agency. As such, for Butler (2003 in Magnus, 2006, p. 100), ““discourse” no longer appears as an abstract entity to which subjects must submit and it rather formulates the space in which subjects may stage their communicative interaction”. In addition, Butler draws attention to the intersubjective domain within which agency is established and sustained (ibid). And this intersubjective encounter, according to Butler, is contingent on the discursive norms. She explains,

> If gender is a kind of doing, an incessant activity performed, in part, without one’s knowing and without one’s willing, it is not for that reason automatic or mechanical. On the contrary, it is a practice of improvisation within a scene of constraint. Moreover, one does not “do” one’s gender alone. One is always “doing” with or for another, even if the other is only imaginary (Butler, 2004, p. 1).

According to Butler, it is the very act of the repetition of discursive norms which then provides individuals with the possibility for subverting those norms. It is, indeed, in the instability of the subjects and in this variation of subjects repeating and/or subverting norms that she locates agency, thus being highly critical of Benhabib’s claim that a subject must be “stable” or “grounded” in order for agency to be possible (Webster, 2000, p. 8). She, therefore, argues that the subject is “the site of endless transformation and resignification insofar as its constituted character is never fixed but always in process” (Butler, 1995b in Webster, 2000, p. 8). As Polit (2006, p. 22-23) argues, Butler never denied the existence of agency and instead, argued that a subject's agency is determined by the underlying constraints of existing social discourse(s) and it is within such a discursive framework, that acts of disobedience occur[53].

Butler's conceptualisation of agency within the constraints of pre-existing discourses raises the question of who is doing the *doing*? In other words, if agency lies with the actor who is enacting another actor, then what about the agency of the actor being enacted? Does it imply that the enacted actor is passive (see Law and Mol, 2008, p. 66)? If not, then how do we understand the agency of the "actor-enacted" (see Mol and Law, 2004) in the specific context of reproductive loss and childlessness in middle-class India? The following discussion of agency serves as the third theoretical lens which enables me to address these questions.

2.1.3. Agency

Since the late 1980s, the topic of agency has been prominent in the social sciences, especially in the humanities (Sax, 2006, p. 473). In most scholarly writings, the assumption is that agency "is a capability or power exercised by individual persons" (ibid.). Within the social sciences, agency has commonly been understood as "having to do with the individual, hence the term 'agent' or 'actor'" (Burkitt, 2013, p. 323; see also Ortner, 2016, p. 129). Sociologists such as Anthony Giddens and Margaret Archer have defined agency in terms of an actor's reflexivity because they argue that a person is an agent "precisely at the point of consciously choosing a course of action in circumstances where we could have acted otherwise" (Archer, 2003, Giddens, 1979, 1984 in Burkitt, 2016, p. 323). Moreover, Sax (2006, p. 473-474) notes that 'agency' has often been understood in contrast to 'structure', "and the central problematic concerns the ways in which persons pursue their individual projects and interests within the multiple, more-or-less constraining structures of society" (see also Ortner, 2006, p. 130). The understanding of agency, Sax (2006, p. 474) further notes, has usually been conflated with resistance, when for instance, feminist scholars have "focused on women's agency in resisting patriarchal structures". Burkitt (2013) is also critical of the conceptualisation of the 'agent' as the "doer of an action" or a person who takes an "active role" in order to produce a desired effect. In his understanding of agency as socially constituted and relational, Burkitt argues that individuals should be seen as "interactants" rather than as singular agents. He also argues that

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[53] According to Polit (2006, p. 23), a valid criticism for Butler would be that she leaves her analysis and arguments at a theoretical level and never actually uses ethnographic data to corroborate her theory.

agency should be understood as "people producing particular effects in the world on each other through their relational connections and joint actions, whether or not those effects are reflexively produced" (ibid., p. 323). With a similar focus on agency as relational, Ortner (2006, p. 130) envisages individuals with agency, or "social agents", as always being socially embedded or as being involved in "the multiplicity of social relations in which they are enmeshed". While all social actors for Ortner "have" agency, she does not imagine the actors to be "free" agents or unfettered individuals and instead, argues that they are always embedded in webs of relations:

> …individuals or persons or subjects are always embedded in webs of relations, whether of affection and solidarity, or of power and rivalry, or frequently of some mixture of the two. Whatever "agency" they seem to "have" as individuals, is in reality something that is always in fact interactively negotiated. In this sense, they are never free agents, not only in the sense that they do not have the freedom to formulate and realize their own goals in a social vacuum, but also in the sense that they do not have the ability to fully control those relations towards their own ends. As truly and inescapably social beings, they can only work within the many webs of relations that make up their social worlds (Ortner, 2006, p. 151-152).

This leads me to a brief discussion of Actor Network Theory (ANT) which might seem like a detour to the reader but is actually essential in order to further explicate the understanding of agency as relational and as distributed not only among human actors but additionally, among human actors and non-human actants.

Bruno Latour (2005, p. 4) argues that unlike conventional sociology whose basic tenet is to assume that there are a priori social relations and other social aggregates in regard to explaining any social element or aspect, the ANT makes no such assumptions. For Latour, the 'social' is not limited to some exclusive human domain(s) separate from economic, political or ecological processes (ibid., p. 4-5). Rather, it includes relations that exist between humans as well as other beings, things, substances, and particles in specific situations, thus constituting any action and its final outcome (ibid.). He posits that humans should not be ascribed a privileged position in the outcome of a certain situation and human agency is not necessarily more important than non-human agency in constituting social relations (ibid., p. 76). He also states that there is a symmetry between all elements of a network insofar as the non-human entities along with human beings have the potential to influence a situation and its outcome. According to the ANT's "symmetry principle", Latour (2005, p. 76) does not argue for a symmetry between humans and non-humans. Instead, he argues that to be symmetric implies that agency is distributed within a network. Thus, for Latour, nonhuman entities can be understood as mediators that add something to a chain of interaction(s) or continually modify relations between human actors (Sayes, 2014, p. 138). In other words, it is the agentic capacity of the nonhuman entities that mediates the interactions and relations between humans and their social world.

All nonhuman entities, according to Latour, can be termed as "actants" which have agency in a situation and can be equally important and influential as the human "actors" in a network. To that end, Latour (2005, p. 54) draws an important distinction between "actors" and "actants". While he understands "actors" as conscious and reflexive with their own theories and understanding of a particular situation, "actants" in a network according to him are conceptualised as distinct entities or objects which effect each other and also effect the actors (ibid.). As such, an actor does not act alone and rather, as Law and Mol (2008, p. 58) have also argued, because "acting and being enacted go together" which implies that agency lies with the actor when it is acting and also when it is being *enacted* upon. In other words, an "actor-enacted" acts in collaboration with and in relation to other actors and actants while also being acted *upon* in one way or another (Law and Mol, 2008, p. 72-73). As we have seen in the discussion of Enactment earlier in this chapter, an actor is enacted differently by other actors or actants, depending on the context, which results in multiplicity and not plurality – it is multiple because an actor is not unified and a "slightly different" actor is done in each practice (Law and Mol, 2008, p. 65). However, varied the actor is enacted, the various versions of that actor are related to each other in complex and intricate practices and, on a day-to-day basis, these practices all come together (ibid., p. 65-66).

As it will become clearer in the ensuing ethnographic chapters, the concept of actor-enacted based on the ANT and on Mol's understanding of enactment is necessary to understand how actors act and are enacted upon at the same time, how agency is relational, how multiple forms of agencies are distributed within a network, how human actors and non-human actants influence the myriad ways in which social interactions occur, and how such interactions lead to certain outcomes. Moreover, applying tenets of the ANT enables me to (partially) trace the lives of the married couples who have experienced reproductive loss without "fractioning their lives and without making isolated cut-outs, monitoring what happens in a network" (Rossi and Pereira, 2014, p. 32). The application of ANT additionally allows me to recognise the intricate and mutually constitutive character of the human and the technological, as I specifically show in chapter three. The use of ANT as an auxiliary methodological and analytical tool, therefore, allowed me as a researcher to explore narratives wherein the interlocutors engaged in agential acts of meaning-making and how they forged new paths and new webs in their social networks.

This brings me now to the conceptualisation of agency as employed in my study – agency not only as the power to act, acts of resistance, and/or free will, wherein action and agency become almost indistinguishable but, as Sax (2006, p 474; addition mine) writes, the capacity or "the ability to transform the[ir] world". According to Polit (2006, p. 5), Sax's definition of agency assumes that "all human beings are active participants in their world, constantly creating and recreating themselves and their social fields". In her study of female agency in rural North India, Polit takes cue from Sax to define agency as "the capacity to actively take part in the creation and recreation of one's world" (ibid., p. 340). Further, Charis Cussins (1998, p. 168-169; later Charis Thompson, 2005) in her study of ARTs in North America writes that agency refers to "actions that we attribute to people or claim for ourselves, actions whose definition and attribution make up the moral fabric of our lives, and in line with which we assign locally plausible and enforceable networks of accountability". Cussins additionally argues that "what it is to be a subject changes in ways that are a result of, and simultaneously, proof of a person's agency" (ibid., p. 169). I specifically follow Cussins's (1998)/Thompson's (2005) conceptualisation of agency in the two following chapters to demonstrate how the female interlocutors in my study were not only enacted as 'good patients' by the medical practitioners but they also enacted themselves in the same role and willingly engaged with the actors and actants in the clinical settings in order to achieve their goal of having a child.

Furthermore, I draw significantly on Malissa Shaw's (2016, p. 19) research on assisted conception in Colombia where like other aforementioned anthropologists, she recognizes agency as more than just choice alone and not restricted to the ability of an actor to act freely. Shaw stresses on the need to view agency as both active and passive so as to not restrict the conceptualisation of the "diverse agentic movements of individuals" (ibid., p. 33). Based on her research findings, she suggests that the agentive capacities of her female interlocutors could be observed in their multiple acts of reflection and renegotiation throughout the process of undergoing infertility treatments and beyond, thus, conceptualising agency as processual and as not exercised at a single moment. Further, Shaw states that even though a person's choices may be constrained, that does not mean that the person is devoid of agency (ibid., p. 29). Instead of positing agency and coercion or constraint as mutually exclusive, Shaw follows Madhok, Philips and Wilson (2013) to suggest that agency and constraints coexist and are intertwined in complex relationships. Also, as Rapp (2011, p. 703) notes, even though there are situations where a woman's choices are constrained, she is nonetheless capable of exercising "real agency". In writing about constraints and agency in the 'Global South', it has been pointed out by Madhok, Philips and Wilson (2013, p. 2-3) that it is not as if the 'Global North' is "the privileged location of agency and progress", while the Global South is characterised by "coercion, violence, oppression and subjugation" (see also Polit, 2006, p. 4). The authors argue that such a reductive dichotomy limits or disregards the agency of actors in the 'Global South' and it would remiss "to see agency as the antithesis of coercion, as if the measure of how much agency we have is how little coercion has been exercised" (Madhok, Philips and Wilson, 2013, p. ,2-3).

Based on this discussion of agency, in the forthcoming chapters I will demonstrate that the female and male interlocutors in my study exercised diverse forms of "constrained but strategic agency" (Shaw, 2016, p. 150). I understand the agency of the married women and men as processual i.e. not as manifested in a single act at a particular time but rather as a phenomenon which unfolds during their entire reproductive journey and also within their conjugal lives (see also Shaw, 2016, p. 62). Further, I also understand agency as manifested in the actors' capacity, especially the women, to engage in acts of meaning-making, despite, or co-constituted by, the constrained or coercive circumstances. Moreover, I argue that the childless and bereaved female interlocutors were not merely helpless, subdued, and/or oppressed victims. Rather, I understand them as active participants in their local moral worlds who exercised their constrained agency in order to give meaning to the loss of their desired child and to make sense of the disruptions caused in the aftermath of that loss, particularly within their marital relationships. In addition, I understand agency as relational, which implies that the various actors and actants enact each other and thereby create perceptible differences or exert palpable influence in the outcomes of the situations which I will illustrate shortly. Finally, I also understand these forms of agency as being exercised not in a social vacuum, but rather in shared discursive spaces and as contingent on existing social discourses.

2.2. Research Design and Research Methodology

> "…ethnography is at its best when it gives voice to people's lived experiences by including narratives and stories as essential components of the ethnographic text" (Inhorn, 2009, p. 30).

In order to garner data on the personal and sensitive experiences of reproductive loss, the relevant social interactions, and the multiple enactments which constitute these experiences and interactions, the present research has been approached with a preference for the *de rigueur* for anthropological studies i.e. ethnographic research. The study operated within an interpretative paradigm, using qualitative methods of data collection as a means to capture the subjective meanings of experiences that would have been nearly impossible to capture through quantitative survey methods. Using semi-structured interviews and participant observation as my primary qualitative methods of inquiry enabled me to (re)formulate the contours of my research objectives and research questions. During the course of my fieldwork, I adjusted my questions and foci according to the information I received from the interviews and the observations I made within the infertility clinics. Further, the analytical potential of exploring the meanings and accounts that people offer, rather than relying merely on statistical data, is another key strength of qualitative research (Chen, 2014, p. 42). As such, with a qualitative orientation for research, the strength of this study lies in its commitment to ethnographic details.

2.2.1. Research Methods

I conducted my fieldwork in two phases for a total duration of ten months across three infertility clinics in urban Kolkata[54]. For reasons of confidentiality and anonymity, I will refer to the clinics as Infertility Clinic A, B, and C throughout this study. The first phase of my fieldwork lasted from October 2016 to March 2017 and the second phase from December 2017 to March 2018. After conducting the interviews in the first period, I manually coded the interviews thematically. For nearly six months, I gradually but constantly refined the codes, recurrent themes, and the emerging patterns that informed my focused formulation of the follow-up interviews in the second phase. I further discovered some gaps in my research such as certain questions I had missed asking the practitioners and married couples which

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[54] Before conducting fieldwork, I conducted a pilot study at infertility clinic A for four weeks between January and February 2015 in order to determine the feasibility and scope of my intended research.

necessitated the follow-up interviews. At the end of my fieldwork, I refined and identified the key themes and findings, and subsequently, created elaborate documents on my laptop with the various case studies, interviews, and ethnographic sketches.

Not unlike most ethnographic studies, I relied on participant observation and semi-structured interviews as the main research tools for data collection. Participant observation was my first primary research tool as I wanted to familiarise myself with the enactment of practices, processes, and interactions within the clinical settings as well as to build a rapport with the multiple actors I encountered during the fieldwork. As scholars have noted, exploring medical institutions offers a prism through which the values, norms, and ideas of the wider society can be examined in context-specific ways (Good, 1994; Lazarus, 1988; Shaw, 2016). Conducting an ethnography in clinical spaces also allows for "greater depth of understanding than, for example, interviews with patients and their families outside of the hospital", note Long, Hunter and Geest (2008, p. 76). Moreover, by investigating the dynamic clinical environment, inner workings, and social interactions among the actors provides a window into gaining a nuanced understanding of the wider sociocultural meanings and societal discourses within which they are embedded and enacted. Thus, by engaging in participant observation, my intention was to literally "hang around" the clinics which facilitated my observations based on the actors' tacit non-verbal behaviour as well as by allowing me to participate in informal conversations (and eventually as a quasi-staff member in two of the infertility clinics).

I spent five to six days a week across the infertility clinics depending on each clinic's schedule. In infertility clinic B and C, I had the opportunity to observe 1,190 doctor-patient interactions, interactions of the patients with other practitioners (such as the nurses, lab technician, and embryologist), and various medical procedures. While I was allowed to observe the other spaces, interactions, and medical procedures in clinic A, I was not granted permission to observe doctor-patient consultations inside the infertility specialist's "chamber"[55] in infertility clinic A[56]. I was told by the infertility specialist that the presence of an unknown person in his chamber might exacerbate their ongoing stress.

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[55] The term "chamber" was used by all actors inside the clinic to refer to the doctor's room.

[56] Inhorn (2004) and Shaw (2016) briefly refer to the power-dynamics between medical practitioners and ethnographers within medical settings in the Middle East and Latin America, respectively, in order to illustrate

When I was not observing any consultations, I would shadow one of the practitioners. I had been given a white lab coat in all the clinics which along with my female gender had legitimised my access and movement within the clinics, especially in the medical procedure rooms. I was able to observe more than 750 ultrasound scans (including transvaginal and abdominal scans), 10 Intra-Uterine Inseminations (IUIs), 27 oocyte retrievals and 33 embryo transfers as part of the In-Vitro Fertilization (IVF) process, eight Hysterosalpingograms (HSGs), few rounds of semen washing, two Testicular Sperm Aspirations (TESA), two hysteroscopies, and four laparoscopies (see Appendix 2). I also observed two caesarean deliveries in private hospitals, one of which was the birth of an “IVF-baby”.

During my fieldwork, I was simultaneously the “semi-insider” and the “semi-outsider” at the clinics. Neither was I formally participating in any of the clinics as a patient, a patients’ accompanying family member, medical personnel, or clinic staff and nor was I exclusively a passive onlooker who was observing the events inside the clinics. As I started spending an increasing amount of time at the clinics, I had been attributed the role of a quasi-staff member by the senior level medical practitioners. For instance, I was often asked to do certain basic tasks by the doctors, such as calling in women from the waiting rooms for their consultations or to write down observations from the ultrasound scan in case the nurse was occupied elsewhere. On few occasions, I was asked to tie or untie the surgical gowns that a doctor would wear during a surgical procedure in case the nurse was not immediately available to do the same. I was also allowed to attend and sometimes share my thoughts during informal staff meetings at two of the clinics. I assume that my regular presence in the clinic, whether in the form of hanging out in the waiting room or while marginally assisting the practitioners, eventually helped my prospective female interlocutors feel at ease during the subsequent interviews and informal dialogues as they gathered that I was, in a certain way, involved in the clinic’s workings. This dynamic but blurred position of being somewhere between a complete “insider” and a complete “outsider” allowed me to explore facets of the clinics which were not accessible to an outsider and simultaneously, to maintain distance so as to remain critical of the interactions and practices I was observing (see Shaw, 2016, p. 71).

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how doctors as gatekeepers can restrict the accessibility of ethnographers, thus shaping the development of the research to some extent.

The second primary research tool to garner data in my study was semi-structured interviews. Certain elements of the life course perspective were loosely tied into the semi-structured interviews with my interlocutors through questions such as "Have you always wanted a child?" or "What are your future plans in case this (infertility) treatment cycle fails?". I had hoped that such questions would enable them to articulate their responses temporally and to also locate their lived experiences within the events of their larger life course. Within the dialogues where the women shared personal and intimate life stories with me, I paid attention to the prominent and recurrent narratives. Taking cue from Becker's (1997) study of disrupted lives and meaning making, I chose to focus on such narratives embedded within the interviews as the primary path for examining the interlocutor's experiences regarding reproductive loss and the ways in which such reproductive disruptions had further disrupted other parts of their lives. As Becker (1997, p. 26) writes, "the narrative process enables the narrator to develop creative ways of interpreting disruption and to draw together disparate aspects of the disruption into a cohesive whole". My aim, therefore, was to understand *how* the interlocutors in my study narrated their experiences of reproductive disruptions and *which* aspects they referred to, focused on in a prolonged manner, or themes they invoked to frame and situate their reproductive experiences.

I conducted interviews with 53 married women, 17 married men, 16 medical practitioners (including four infertility specialists, one gynaecologist, three nurses, one embryologist, one ultrasound clinician, one pathologist, two andrologists, one counsellor, and one assistant to the infertility specialist), two gravediggers, one medical examiner at a Hindu burial ground, and Hindu priest. On average, most of the interviews with the women lasted for two hours while with the men, the interviews rarely exceeded an hour. Given their hectic schedules, most of the interviews and informal conversations with the medical practitioners happened during their working hours within the clinics. While the Marwari couples spoke in Hindi combined with English, the Bengali couples spoke in Bengali combined with English. The medical practitioners spoke largely in English.

Before conducting interviews with the couples, I usually sat with them in a separate room inside the infertility clinics to conduct an introductory dialogue with them and to apprise them about my research. I then informed them about the complete anonymisation and confidentiality regarding their names and personal details. Once I received verbal consent from the interlocutors, I asked them about where and when they would prefer being interviewed. Most interviews were conducted inside the infertility clinics while the remaining interviews were conducted at the interlocutors’ homes, at cafés or once at a restaurant, depending on which of these venues was most convenient and comfortable for the interlocutors. When I conducted the first round of interviews with two couples, I immediately realised that the men and women were quite hesitant to speak comfortably in front of their spouse. While the men would barely say anything, the women offered cursory responses to my questions. I could sense that the women were most likely quite uncomfortable speaking about certain topics in front of their respective husband and vice-versa. I eventually decided to interview the wife and husband separately and this logistical decision of mine was well received. Furthermore, although my initial plan was to record the interviews, I realised during the first two interviews that the presence of a recorder was proving to be a hindrance in the women and men feeling comfortable while speaking. Once they noticed the recorder being played, there was an unmistakeable shift in their body language and they would look at the recorder intermittently. I decided to rely on making handwritten notes and soon realised that in the absence of the recorder, I was able to make the women as well as the men (at least those who agreed to be interviewed) feel much more at ease and consequently, I was also able to gather substantial data.

The primary idea behind the interviews was to let the interlocutors lead the flow while focusing on areas that were of interest to them. When necessary, I made prompts to encourage the interlocutors to talk about specific topics of research interest. Such prompting was hardly necessary in the interviews with the female interlocutors as they spoke extensively about a multitude of topics. Most of the interviews with the female interlocutors was emotionally challenging for both them and for me as these sessions entailed the women sharing an intimate and difficult subject. In most of the interviews, it almost immediately dawned upon me that despite the painful subject, most of the women were quite eager to share their experiences as this was perhaps the first time someone wanted to hear them out. On the other hand, most of the male interlocutors needed a significant amount of prompting as they narrated their experiences or answered my questions as curtly as possible. Most of them told me to ask direct questions instead of keeping the interview open-ended. Speaking to men was indeed one of the most challenging methodological hurdles which I faced during my pilot study and based on it, I had anticipated the possibility of encountering it again[57]. Of the 53 female interlocutors I interviewed, I was able to interview only 17 of their husbands. The other husbands had either declined from being interviewed when I approached them or informed me via their wives that they would feel awkward in getting interviewed. I presume my gender might also have been an additional cause for their awkwardness.

2.2.2. Selection of the Interlocutors

The access to the infertility clinics in Kolkata was made possible by my relatives whose names I shall not mention due to privacy reasons. I was introduced to most of the married couples by the medical practitioners at the three infertility clinics[58]. While I met most of my female interlocutors at these clinics, there were five women whom I did not meet in the capacity of 'patients'. Three of these women had already given birth before I had commenced my fieldwork, one woman wished to adopt, and one of them had (circumstantially) transitioned from 'childless' to 'childfree'[59] (see chapter eight). One of my initial concerns was that the couples who had been asked by the practitioners to speak to me might have agreed to do so as an obligation to the practitioners (see also Shaw, 2016, p. 72-73). Thus, I would specifically ask the couples separately and ensure whether they were comfortable in being interviewed.

I chose to interview women (and men) who had experienced various forms of reproductive loss and who were at different junctures in their reproductive trajectories in order to have a representative group[60]. The women I selected finally were those who had experienced one or more episodes of reproductive loss after having conceived naturally, those who were not able

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[57] Lloyd (1996) notes that the lack of male experiences of infertility within sociological and anthropological literature, is due to the major difficulty faced by researchers in gaining access to male respondents and also, the high male non-response rates. In this regard, some researchers have observed that as women tend to verbalise their feelings more than men do, most of what is known about infertility is from the female perspective (see Pujari and Unisa, 2014, p. 24; see also Lamichhane, 2022).

[58] See Inhorn (2003b, p. 24) and Thompson (2005, p. 83) who wrote about accessing patients as interlocutors through the mediation of doctors in their studies on infertility and ARTs in Egypt and the US, respectively.

[59] It was the doctors who suggested the names of the first four women and I accidentally met the fifth woman at infertility clinic A which is inside a diagnostic centre and she had come there for an annual health check-up.

[60] Although I met hundreds of women and men at the clinics and engaged in informal conversation with most of them, the final selection of the 53 couples was done using the random-purposive (or purposeful) and snowball method of sampling. A central practice of qualitative research, the random-purposive sampling allowed me to select and focus on certain couples from the numerous couples who visited the three infertility clinics (see Patton 2015). In addition, the snowball sampling method was useful for my research purposes as within the social networks of identified interlocutors, I was able to find other potential interlocutors for my study.

to conceive despite trying naturally for a year or more, those who experienced loss after pursuing assisted conception, and those who had achieved reproductive success after having spent years undergoing medical intervention and could offer retrospective accounts. The reader will notice that in all the translated ethnographic excerpts throughout the study, the word ‘trying’ (*cheshta* in Bengali and *koshish* in Hindi) presents itself recurrently since it was also used by the female and male interlocutors in their reproductive narratives on multiple occasions. For these individuals/couples, the experiences of reproductive loss had provided them with the realisation that the tenet that an egg and sperm automatically create a baby is a flawed narrative and instead it is a process which often requires multiple attempts.

I want to mention here that even though my initial plan was to include reproductive experiences of both women and men, my attention and research focus became unavoidably directed towards the women’s experiences. During participant observation at the infertility clinics, I noticed that it was exclusively the women who were addressed as the ‘patient’ by the practitioners in all three infertility clinics, irrespective of which partner was diagnosed as infertile. Even if it was the male partner who had to undergo male-factor infertility surgery, the ‘patient’ list at each clinic had only the women’s names on it while the men were referred to as the patient’s husband. Throughout the process of assisted conception, from the first consultation, till the time the women gave birth, they were addressed as patients.

Besides the shared experiences of reproductive loss, certain common criteria as described below were considered before I confirmed the final list of couples.

The study is based on the basic premise that marriage is a prerequisite for childbirth in India or rather that in middle-class India, heterosexual marriage is the socio-culturally and morally acceptable framework within which couples can or should procreate (see chapter one). This was also a self-evident criterion because all the couples who visited the infertility clinics were in married. Moreover, in a pronatalist Indian context, marriage became the crucial heteronormative site where the desire for procreation, reproductive loss, the resulting grief, and aftermath of the loss were enacted by the women and men (see chapter six).

The age group of the married couples in was between their thirties and forties (except for one woman who was in her fifties). This was not an age bracket that I had decided before commencing fieldwork but this seemed to be the average age range of the middle-class couples as compared to the couples from the lower socioeconomic strata where the women were mostly in their early to mid-twenties.

All the women and men were middle-class, educated (with an undergraduate degree minimum), working professionals who lived in cosmopolitan neighbourhoods of urban Kolkata. As far as the class background of the interlocutors was concerned, it was initially based on economic markers i.e. the ability of the couples to afford the infertility treatments, often for years. Unlike some couples who travelled from distant villages or rural hinterlands and who mortgaged their land, sold their property to seek infertility treatment(s) and/or took bank loans, middle-class couples did not have such dire financial limitations. However, economic markers were not the sole criterion for the couples to be categorised as middle-class. Instead, parameters such as their role as consumers of biomedical services and reproductive technologies, their residential location, and their (symbolic) representation of themselves as 'modern subjects' reaffirmed their middleclassness (see chapter one).

Before commencing my research, I did not have any specifications about selecting interlocutors from a particular religious background. However, during the pilot study and subsequently during the fieldwork, I found that the majority of the couples who visited the infertility clinics were *Hindus*. On perusing the monthly patient files at infertility clinic B, for instance, I noticed that more than 80 percent of the couples who had visited this clinic were Hindus, around 15 percent were Muslims, and the rest were either Christians or Sikhs. Furthermore, amongst the Hindu married couples, almost 85 percent were Bengalis and the rest were Marwaris. Interestingly, but not unexpectedly, all the infertility specialists (and most of the other medical personnel) at the three infertility clinics were Hindus and (presumably) from upper caste groups.

PART II

2.3. The Research Setting: Kolkata

My regional focus was Kolkata, erstwhile Calcutta, the capital city of the state of West Bengal. It is third largest Indian city area wise and as of 2021, it has a population of around 15.1 million inhabitants. Located in eastern India, this metropolitan city includes a majority of the Bengali population in India, along with a significant number of people from other communities, especially Marwaris, Biharis, and Gujaratis. While Hindus are the largest religious group at 78 percent of the population, Muslims constitute 20 percent of the city, followed by 0.9 percent of Christians and 0.5 percent of Jains (see Kolkata Population 2019). According to the Family Planning Association of India, the Total Fertility Rate[61] (TFR) in Kolkata in 2014 was 1.2, which is half the rate of India's average TFR (2.4), thereby making it one of the lowest in India (Pandey, 2017). Despite having a low TFR, Kolkata has several ART clinics which reportedly offer treatments at relatively lower prices as compared to clinics in other Indian metropolitan cities (Basu and Mitra, 2013; Sharma, 2018).

Fig. 2. Kolkata, West Bengal[62]

Kolkata is broadly divided into North Kolkata and South Kolkata. North Kolkata is the city's older part characterised by its narrow lanes and heritage buildings. There is a distinct characteristic of the northern part which distinguishes it from the more urban and cosmopolitan localities of South Kolkata, whether that is related to the architecture or the socioeconomic background of the residents. For instance, high-rise buildings and gated residential communities are much more common in South Kolkata whereas in north Kolkata, single-storey buildings are the norm. However, in the last couple of decades, many neighbourhoods in North Kolkata have increasingly taken on the flavour of a cosmopolitan

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[61] The TFR is defined by the WHO as the "total number of children born or likely to be born to a woman in her lifetime if she were subject to the prevailing rate of age-specific fertility in the population"; see http://www.searo.who.int/entity/health_situation_trends/data/chi/TFR/en/

[62] Retrieved from: https://www.pinterest.com/pin/718324209289123236/

and urban settlement, as I discovered during my fieldwork and also previously during summer vacations with the family.

The city of Kolkata became the ideal research site for me because firstly, it was my kind relatives (also medical professionals) who helped me in gaining access to the infertility clinics. Moreover, my position as an insider who had a certain degree of cultural familiarity with the city helped me in furthering my decision on Kolkata as my research location. As a Bengali myself, my introduction to the city of Kolkata happened for the first time when I was a few months old as a considerable part of my family lived in that city. It would not be misplaced to say that my familiarity with Kolkata had commenced and has continued for a significant part of my adulthood. Having gained a certain amount of understanding over the years in regard to the city's cultural nuances, I reckon that it helped me in developing the initial rapport with my interlocutors without any significant obstacles. Last but not the least, due to the sensitive research themes of reproductive loss and grief, I had to ensure that the interlocutors were at ease in narrating their personal experiences about a profoundly private and delicate subject matter and I also did not want to get lost in translation. As such, being able to communicate with them in the lingua franca i.e. Bengali, English and/or Hindi was essential and this also made my interlocutors feel at ease.

I will now offer a description of my primary research sites i.e. the three infertility clinics and also a glimpse into the medical practitioners who are at the helm of these clinics.

2.3.1. Infertility Clinic A

Infertility clinic A is situated within the premises of a pathology laboratory and is nestled within an urban, middle-class neighbourhood. Akin to the two other clinics, clinic A is also surrounded by a few cafes, restaurants, a supermarket, and other shops. The clinic's signboard states "Infertility Consultation (IVF and IUI)" and a smaller placard below it framed by hard-to-miss sparkling lights has the name of the infertility specialist, Dr. Ganguly, and his medical qualification (Fellow in Assisted Reproduction) in bold red letters. Unlike the two other infertility clinics which were self-reliant as they provided all the necessary services for infertility treatments within the clinics' premises (except for child delivery which would happen at an affiliated private hospital), clinic A offered a specific set of services and treatments. These included consultations with Dr. Ganguly and initial diagnostic procedures related to male and female infertility such as ultrasound scans and sperm collection. For the procedures of IUI and IVF following the diagnostic procedures, the couples were sent by Dr. Ganguly to the private hospital with which he has been affiliated for a long time.

An infertility specialist for more than two decades, Dr. Ganguly pursued his initial medical training in India and a specialised degree in reproductive medicine from abroad. He held his chamber for consultations with the patients thrice a week in the evenings and the rest of the week he practiced at the private hospital. Based on conversations with the clinic staff and the couples at this clinic as well as by looking at the patient testimonies on the clinic's website, I discovered that Dr. Ganguly was one of the most popular infertility specialists in West Bengal. His popularity and reputation stemmed from his high "success rate" and the "take-home-baby rate" (see chapter three). Within the infertility industry, Dr. Ganguly had his set of competitors (including the other infertility specialists in my study) who criticised him for being money-minded and for treating his medical practice like a business. As, one of the infertility specialists said during one of our informal conversations:

> "That man only knows how to make money! He might be a good doctor but I think he is in this profession for the fame and money, not for helping people. It seems like he is doing a business. He has a great appetite for money! Just see for yourself, he has patients at two places [referring to the clinic and hospital]! He keeps taking on more patients every day because he knows very well that people will keep coming. And the more people come, the better it is for him! I have heard that he has more than fifty patients on the same day. Can you imagine what quality of treatment each patient must be getting? Money, money, that's all that ultimately matters to him!"

Despite such professional criticism, Dr. Ganguly's patients, especially the ones who had conceived and given birth under his medical guidance, had nothing but compliments and high praises for him. Also, some of my female interlocutors pointed out while giggling and blushing that they also liked him because they thought he was handsome and smart. As one of the female interlocutors said with a wink, "He was a visual treat!" His charisma and 'success rates' certainly attracted a large number of couples at the clinic as I observed during my fieldwork. Each day, there were at least three or four new couples who came for consultation.

According to the guidelines of the Indian Council of Medical Research (ICMR; see The Assisted Reproductive Technologies (Regulation) Rules 2010), each infertility clinic in India is supposed to have a uniform interior design with certain minimum requirements. This uniformity in designing, according to Bharadwaj (2016, p. 214), makes every clinic remarkably consistent in their structural organisation. On entering the diagnostic centre, which would transform into infertility clinic A on three evenings each week, one comes across the waiting area with its grey sofas, a glass table-top on the side with magazines and newspapers in English, Hindi, and Bengali, a 54-inch flat screen television which usually had some Hindi or Bengali movie song or the daily news playing on it (see Fig. 3). It was a common affair for the women in the waiting area to interact with each other, especially the women who had been coming to the clinic for a prolonged period. The men on the other hand, usually engaged themselves in reading the newspaper or scrolling through their mobile phones. Carmeli and Birenbaum-Carmeli (1994, p. 673) have similarly observed that it was common for women in their own study conducted in Israel and Canada to converse with each other while waiting for the doctors or before their medical procedures. This was a form of women giving each other social support and assistance in helping each other cope with their predicaments, according to the authors. The men's behaviour, however, as I also observed during my fieldwork, were entirely different. Contrary to the women, the men never approached fellow men. Such an avoidance by the men seemed to "reflect and constitute men's feelings of anomie in the context of infertility treatments", explain Carmeli and Birenbaum-Carmeli (1994, p. 673; see also Lamichhane, 2022).

Fig.3. Waiting area, Infertility clinic A

The waiting area in these clinics was one of the most quintessential spaces where I had the possibility to conduct a significant part of hanging out during participant observation. This was also the space where I spent hours engaging in informal conversations with the couples (mostly women) and the clinic staff. In his seminal study of procreative technologies in India, Bharadwaj (2016, p. 215) notes that the space of the waiting area, which is the focal point of such clinics, reflects a predominantly urban and upper-middle-class ethos, and access to any other part of the clinic has to be gained by crossing this space. Aptly describing the significance and ambiguity of the waiting area as the "liminal space", Bharadwaj explains,

> To many, this clinical space is the first introduction to the 'world of conception'. A clinic's lobby appears to respond to the infertile quest for conception in two broad ways: first, by reinforcing their sense of impending conception; and second, by providing an element of informality that allows patients to normalise key aspects of their treatment procedures…it is in this space that the 'core' interaction in the clinics – both amongst the patients and between the patient and the clinical bureaucracy takes – unfolds. This waiting space is also a junction where the inside and the outside of the clinic intersect. Routes to the doctor's chambers, the laboratories, sonography room, culture rooms, rest rooms, patients' wards and semen collection rooms, etc., all pass through the lobby or connect with this waiting area in some circuitous way. In this sense, waiting areas in IVF clinic occupy an ambiguous place. While lying at the very heart of the clinic they appear to be outside of its clinical bounds. This liminality is peculiar to this space as it mediates the outside world and the clinical world within. Given this unique vantage, the waiting area also serves as an introduction to the clinic and the clinical expertise (Bharadwaj, 2016, p. 215-216).

As a researcher, this space warranted that I reconsider the contours of reproductive loss and involuntary childlessness even before the couples had consulted the doctor. Indeed, the couples who came to these clinics had already experienced reproductive loss having 'failed' at conceiving without medical intervention or having experienced the death of their desired baby at a certain point during the pregnancy. In this regard, speaking of "double loss", "multiple losses", and her admiration of the couples undergoing infertility treatments for years, the head nurse at clinic A, Nurse Shanti said during an interview,

> "Every patient who comes here has been unsuccessful at becoming pregnant or they are women whose babies have died in-utero during the pregnancy or it was a case of stillbirth. That kind of sadness and pain is beyond the imagination of people who have never had these experiences. So, the couples who come here, most of them already come feeling extremely sad and depressed. In a certain sense, it is a double loss for these patients. And for those couples who cannot have a baby even after trying with treatments for many years, I would say, that for them it is the experience of multiple losses. Hats off to these couples who keep trying for years!"

Regarding the protocol of seeking infertility treatment at clinic A (which was similar to the two other clinics), the new couples would first have to get in touch with the receptionist via an email or phone call to get an appointment with Dr. Ganguly. Due to the high inflow of patients, it was common for couples to wait for a couple of weeks before they could get a confirmed appointment. On the day of the appointment, the woman and the person accompanying her usually arrived well before the doctor. During the weekdays, the woman was usually accompanied by her mother-in-law or sometimes, by her own mother. During the weekends or if the appointment was late in the evening, some appointments were scheduled as late as 21:00 or 22:00, and most women were accompanied by their respective husbands. The moment Dr. Ganguly would enter the clinic, he would be greeted by the staff. With a fast gait, a fleeting smile, and a slight head nod, he would head straight to his chamber which was located adjacent to the waiting area for the patients and right outside there was a signboard which stated in English and Bengali," Sex determination is a criminal offence and is not practiced here". The same signboard was also present at the other infertility clinics. The evening's proceedings would usually start with his right-hand (wo)man, Nurse Shanti, heading in his room with tea and the list of patients for that particular day. When it was a couple's turn for consultation, the wife's i.e. the patient's, name would be loudly announced in the waiting area by the receptionist or Nurse Shanti. On hearing Dr. Ganguly's bell, the woman and the accompanying family member (referred to as "patient party" by the clinic staff) would be sent inside the doctor's chamber. There were thirty-five to forty patients each evening and a consultation usually lasted for ten minutes. I noticed that a few couples would wait for hours at a stretch, sometimes until as later as 23:00, to not miss the possibility of having a fleeting conversation with Dr. Ganguly before he left the clinic.

2.3.2. Infertility Clinic B

With a team of fifteen people, inclusive of medical and non-medical staff, infertility clinic B was established in 2014 by Dr. Sen and it is located in one of the most cosmopolitan neighbourhoods in south Kolkata. Clinic B is a "one-man show", as infertility specialist, Dr. Sen said himself during one of our conversations. After completing his education in obstetrics and gynaecology in India, Dr. Sen had spent more than a decade abroad to specialise in assisted reproduction while also offering lectures at a foreign university. He returned to India in 2010 because as he said, "I wanted to use my knowledge to help people in my own country". Along with his various medical engagements which I will describe shortly, Dr. Sen mentioned during one of our conversations that he is a firm believer in philanthropy. He told me that he had been involved in charity work for several years. Every Christmas, he reportedly donates a substantial amount of money to an NGO for children who have been diagnosed with terminal illnesses. Dr. Sen also told me about his love for children and that he had 'adopted' 300 children, half of whom were from a cancer institute and the rest were from an NGO for underprivileged children and children with genetic or chromosomal abnormalities. He told me that he had asked his financially affluent patients to make monetary contributions to these two organisations instead of bringing him expensive gifts or boxes of sweets. With a grin on his face, he added,

> "A 1000 IVF babies and adopting 1000 children, that's the extended family I want in my life! After that, I will think of retirement!"

On a November morning in 2016, I made my way to clinic B for the first time to meet Dr. Sen. I had scheduled an appointment with Dr. Sen's secretary earlier that week and I was told to since the doctor usually had an extremely hectic schedule, I must be punctual. Dr. Sen's hectic schedule understandably resulted from not only working as clinic B's Medical Director, but also due to his other professional commitments. He was the chief IVF consultant at a private hospital and a visiting infertility specialist at another hospital. Since 2012, he visited these hospitals intermittently for consultations, for performing infertility-related medical procedures, and for also performing child deliveries. Dr. Sen was also the Scientific Director at another IVF centre in a neighbouring town in West Bengal as well as the Medical Director of a clinic in a village. Regarding his future plans, Dr. Sen reportedly wishes to start a one-of-its-kind Recurrent Miscarriage clinic with state-of-the-art facilities.

On the day I was scheduled to meet Dr. Sen for the first time, I fortunately made it to the clinic on time. After the initial pleasantries and after I had apprised him about my research objectives, Dr. Sen asked his secretary to give me a white lab coat which I was instructed to wear at all times as long as I was inside the clinic. Having fulfilled the formalities, I started my research at clinic B the following day and spent nearly six months there during which my routine involved going to the clinic from Monday to Saturday and staying there from 10 am till around 6 pm. There were several days when I would reach before Dr. Sen had arrived. I used that time to engage in free-flowing conversations with the staff in order to gain a deeper insight into their roles as well as into the inner workings of the clinic. Once in a while, I would utilise this time to make my field notes or read some literature on infertility available in the small clinic library. Since I spent the most time conducting fieldwork at clinic B as compared to the two other clinics, I also gathered most of my ethnographic data from this site.

Dr. Sen had no reservations in me sitting in his chamber and observing the consultations between him and the couples. He had asked me to sit next to him or next to the couples during the ongoing consultations. Every now and then, he would voluntarily explain medical terminologies or complicated medical cases to me while simultaneously interacting with the patients and/or couples. Whenever a couple would enter his room, Dr. Sen would first introduce me to them and then inform them about the reason for my presence[63]. He had also asked me to accompany him whenever he would go on hospital rounds (to “monitor” the women who had become pregnant after undergoing treatment at his clinic) or to perform some any procedure on a freelance basis at another hospital.

Fig.4. Ground floor, Infertility clinic B

As mentioned in the previously in clinic A’s description, all three clinics, and clinic B was no exception, had largely similar infrastructure. Located in a five-storey building which was formerly a residential building, clinic B’s ground floor has the reception, a few chairs and a small sofa, Dr. Sen’s secretary’s room, a room for the Human Resources manager[64], the pathological laboratory for blood work and other tests (such as semen analysis), the men’s room for semen collection and semen donation, and a unisex toilet. Walking up the stairs to the first floor, one is greeted by a host of smiling baby photos in frames and a sign on the wall which states in Bengali that sex determination is not done at this clinic (see Fig. 4). The same sign is also present in the ultrasound room on the first floor.

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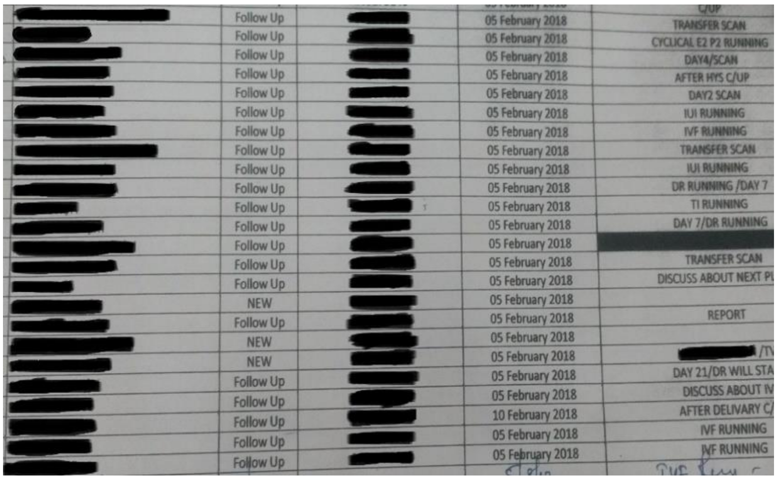
[63] Dr. Sen mostly introduced me to the couples as a psychologist instead of an anthropologist. He would tell them that I was interested in learning about their “mental condition” and that I was a PhD student from Germany. When I eventually told Dr. Sen that I was an anthropologist and not a psychologist, he said, “Yes, I know. But many Indian people would not know what is anthropology. It’s easier if I tell them you are a psychologist. Most of them are so stressed and depressed. This way, they would be more willing to speak to you”. In spite of what Dr. Sen said, during the interviews, I would inform the interviewee that I am an anthropologist. I told them that unlike a psychologist who tries to understand about mental health, I study the socio-cultural aspects in people’s lives. This newfound information did not deter any of the interlocutors from being interviewed.

[64] The HR manager had resigned three weeks after I had started my fieldwork. As his room was unoccupied, it had been allotted to me for conducting my interviews, for making my fieldnotes, and for using the computer.

Along with the ultrasound scanning room, the first floor has Dr. Sen's chamber, the andrology room, and the room for the Patient relations manager (who is also the "in-house counsellor" according to Dr. Sen). The surgical procedures of the infertility treatments are performed on the clinic's third floor. The fourth floor functions as the ward for the patients to rest after the surgical procedures and in case they need to stay overnight. Finally, the fifth floor has a third waiting area with a television and an attached kitchen-cum-café where the staff meets for lunch and snacks and beverages are available for the couples. This waiting area is specifically reserved for couples who have an appointment scheduled later in the day. In case, they arrived early, which often happened with couples who travelled from distant locations, they had the possibility of waiting inside the premises until they could meet Dr. Sen.

On a regular day at clinic B, the couples (or the female patient with an accompanying family member) usually started coming in by 9:30-10 am, in order to get their names first on the 'patient list' of that day (see Fig. 5). As the couples kept pouring in, the receptionist prepared a computerised list of the patients' name (i.e. the wife's name), residential address, phone number, and whether that patient had come for a new or follow-up consultation.



[redacted]	Follow Up	[redacted]	05 February 2018	TRANSFER SCAN
[redacted]	Follow Up	[redacted]	05 February 2018	CYCLICAL E2 P2 RUNNING
[redacted]	Follow Up	[redacted]	05 February 2018	DAY4/SCAN
[redacted]	Follow Up	[redacted]	05 February 2018	AFTER HYS C/UP
[redacted]	Follow Up	[redacted]	05 February 2018	DAY2 SCAN
[redacted]	Follow Up	[redacted]	05 February 2018	IUI RUNNING
[redacted]	Follow Up	[redacted]	05 February 2018	IVF RUNNING
[redacted]	Follow Up	[redacted]	05 February 2018	TRANSFER SCAN
[redacted]	Follow Up	[redacted]	05 February 2018	IUI RUNNING
[redacted]	Follow Up	[redacted]	05 February 2018	DR RUNNING /DAY 7
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[redacted]	Follow Up	[redacted]	05 February 2018	IVF RUNNING

Fig. 5. List of Patients, Infertility clinic B

Once three copies of this list had been prepared (the list was updated throughout the day), the receptionist placed one copy in Dr. Sen's chamber, the second in the room of the Patient relations manager, and the third she kept with herself. As soon as Dr. Sen arrived, which was usually around noon, the consultations for the day would commence[65]. He would announce

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[65] On days when Dr. Sen would be engaged with work at the other medical institutions, he would not reach the clinic before noon or even later. On other days when he did not have any professional engagements elsewhere,

the name of the first patient on a microphone. He would also use this microphone intermittently to make other announcements from his room or to call any of his staff members to his room. This well-rehearsed ritual of Dr. Sen calling in the patients and then telling them to undergo the required scans or tests, continued throughout the day. Usually, there were 20 to 25 patients each day, including at least a couple of new patients. It was not uncommon for most of the former patients to touch Dr. Sen's feet and taking his blessings before starting the consultation (see chapter three).

2.3.3. Infertility Clinic C

Established in 2015 as a department of a private multispecialty hospital, infertility clinic C is the newest of the three clinics. This clinic was founded by the hospital's founder and Managing Director who was a practicing gynaecologist and obstetrician for more than forty years. Unlike the other departments of this hospital, the clinic has a separate building designated to it which is situated beside the hospital. Clinic C also has a separate billboard highlighting its name right below the hospital's name, a privilege not accorded to any other department of the hospital. The founder's daughter, Dr. Bose, who holds undergraduate degrees in medicine, clinical embryology, and business administration, is clinic C's embryologist as well as person in-charge. In one of our initial conversations, I was informed by Dr. Bose that this is one of the few infertility clinics in the city which has a majority of female employees. She told me that having female doctors and female employees made the female patients feel at ease and more comfortable when they underwent invasive medical procedures.

On the first floor of the clinic's building is the gynaecology department. Unlike clinic A and B where couples were sent to the infertility specialists on referral from gynaecologists located at other clinics/hospitals, clinic C housed its in-house gynaecologist who would send the patients from the first floor to the second floor whenever he diagnosed any problem related to childlessness. The clinic's starting point is a swanky interior which includes the reception and waiting area with leather couches, a flat screen television, some magazines, and brochures of the clinic (see Fig.6). I noticed that Dr. Bose often spoke to some of the women (or their husbands) about the treatments, or addressed the women's queries and concerns,

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he would reach the clinic around 10 am. There were also days when he would arrive even earlier in case a patient was scheduled to undergo a medical procedure at the clinic.

quite loudly and openly, in the waiting area itself. Even the nurses and receptionists would often have conversations with the patients and/or couples rather loudly in the waiting area.

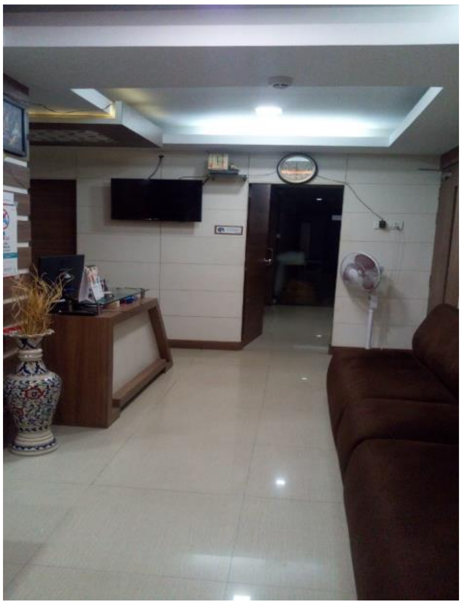


Fig.6. Waiting area, first floor, Infertility clinic C

Although infertility and reproduction are culturally considered to be private issues, the public nature of the conversations between the practitioners and the patients was an interesting aspect in this clinic (and also to some extent in clinic A and B). Having made a similar observation in his research, Bharadwaj (2016, p. 217-218) points out that

> "some of the most private and intimate moments of the treatment process are rendered openly public here, as the day-to-day rigours of seeking medical assistance culminate in the total demystification of private aspects of the treatment process".

This informal transgression of the public-private domain by clinicians and patients alike makes the waiting areas at the infertility clinics in India quite different from those, for instance, in the US where Thompson (2005, p. 242) speaks of a "rehearsed choreography of privacy".

The waiting area leads to the doctor's chamber, the ultrasound scan room, the IUI room, and an adjoining andrology lab. The second and third floors of the clinic has beds for the female patients who have to stay for longer durations or overnight after an invasive medical procedure. The fourth floor has yet another waiting area with a small television, a big digital clock, and a framed photo of a hugging mother and child (see Fig.7). Usually while the wives underwent a medical procedure, I saw the husbands sitting patiently in this waiting area. The operation theatre, the embryology lab, a toilet, a changing room for the doctors, and a room where the staff gathered to have lunch or a tea/coffee break, are also located on this floor.

Fig.7. Waiting area, fourth floor, Infertility clinic C

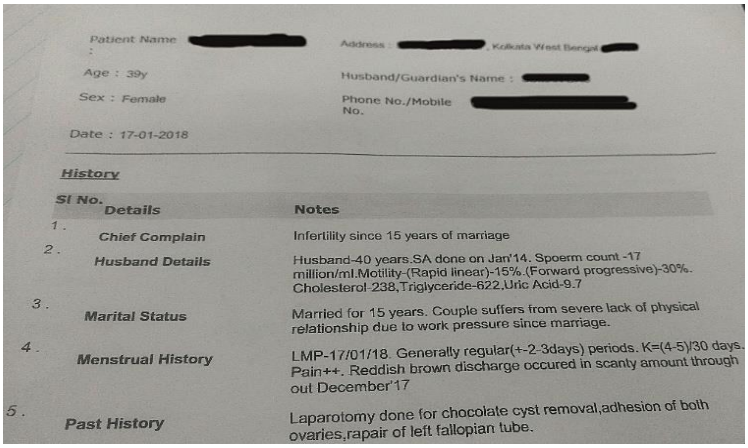
The clinic remains open six days a week and the infertility specialist, Dr. Chatterjee, came to the clinic thrice a week – the remaining days she practiced in her private clinic. Although the timings on the clinic C's website and brochure show the working hours as 10 am to 7 pm, the couples started coming in by as early as 8:30 am because the sooner they arrived, the sooner they would be able to meet Dr. Chatterjee and /or Dr. Bose. However, the two doctors usually arrived between 11:00 and noon, unless there was a medical procedure that had to be conducted earlier in the morning. On most days, before these two doctors arrived, I would reach the clinic and ask the receptionist for the day's schedule and patient list. Accordingly, I would either wait and converse with the people in the waiting area or I would go to the fourth floor and put on my assigned scrubs so that I could observe the medical procedure(s) scheduled for that day.

Speaking of medical procedures, in the following chapter, I examine the ways in which the reproductive technologies as non-human actors or actants (Latour 2005) performed a pivotal role in mediating, modifying, and shaping the doctor-patient interactions during such procedures as well as contributing to the women's experiences of reproductive loss, reproductive failure, and their journey towards wanting to achieve reproductive success by pursuing technology-mediated conception.

Chapter 3. Instrumental yet Invisibilised: The Role of Reproductive Technologies

3.1. Introduction

A regular day at infertility clinic B entailed Dr. Sen meeting new couples for their first consultation before meeting the couples who were undergoing treatments and had come for follow-up consultations. The process started with Dr. Sen using the microphone on his desk to announce the name of the first new patient (i.e. the woman) from the 'patient list' for that day that had been prepared beforehand by the clinic's receptionist (see chapter two). On hearing her name, that woman and her husband[66] would approach Dr. Sen's chamber and stand at the entrance, waiting for his permission to enter the room.



Patient Name : [redacted]
Address : [redacted], Kolkata West Bengal [redacted]
Age : 39y
Husband/Guardian's Name : [redacted]
Sex : Female
Phone No./Mobile No. [redacted]
Date : 17-01-2018

History

Sl No.	Details	Notes
1 .	Chief Complain	Infertility since 15 years of marriage
2 .	Husband Details	Husband-40 years.SA done on Jan'14. Spoerm count -17 million/ml.Motility-(Rapid linear)-15%.(Forward progressive)-30%. Cholesterol-238,Triglyceride-622,Uric Acid-9.7
3 .	Marital Status	Married for 15 years. Couple suffers from severe lack of physical relationship due to work pressure since marriage.
4 .	Menstrual History	LMP-17/01/18. Generally regular(+-2-3days) periods. K=(4-5)/30 days. Pain++. Reddish brown discharge occured in scanty amount through out December'17
5 .	Past History	Laparotomy done for chocolate cyst removal,adhesion of both ovaries,rapair of left fallopian tube.

Fig.8. An example of Patient history, Infertility clinic B

With a warm welcome, Dr. Sen would ask the couple to take a seat and ask them about their "problem" (he commonly used the Bengali word *shomoshyā* or Hindi word *samasyā*) and who had sent them to his clinic. Once the couple told him about the referral[67] and presented their issue, Dr. Sen would review the patient history[68] file on the computer (see Fig.8) that had been

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[66] For the first consultation, couples would come together to the clinic. For follow-up consultations, medical examinations, and treatment related-procedures, the woman was accompanied either by her husband or any other family member.

[67] In most cases, the couples were sent by their gynaecologists to Dr. Sen. In some cases, the couples would have read about Dr. Sen in popular magazines where Clinic B was frequently advertised or had found his address and the clinic's details online. There were also a few couples who were told about clinic B from their close friends or relatives who had been former 'successful' patients.

[68] A "Patient history" file included details about the husband and wife such as contact details, occupations, the couple's chief complain, years of marriage, respective ages, duration of trying to conceive, the wife's menstrual (ir)regularity, her obstetric history, any medications either partner has been taking, and other infertility tests the couple might have undergone before. Only the husband was asked about his intake of alcohol and if he smoked cigarettes. This document with the initial details of the couple was the central inscription around which the

prepared by the junior doctor earlier that day[69]. Subsequently, Dr. Sen would tell the husband to sit in the waiting area while he "investigated" the woman with a "TVS" to decide how to proceed. The couple was not told what the abbreviation stood for and what the procedure entailed. He would then tell the woman to go to the toilet and to go in the adjoining room where she would be given further instructions by the nurse.

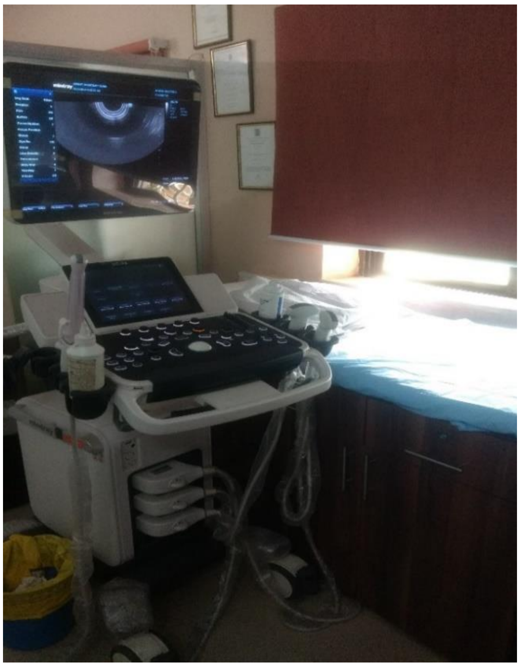

Fig.9. Ultrasound room, Infertility clinic B

As soon as the woman entered the ultrasound room (see Fig. 9), the nurse would instruct her to remove the underwear (and the lower garment, if she was wearing one), and lie down on the bed with her knees bent upwards. While the woman would do as told, the nurse would clean the ultrasound probe with a tissue[70], apply ultrasound gel on the probe's head, and then envelop it with a condom. Once the woman would lie down on the bed, the nurse would cover the lower half of the woman's body with a white sheet. Often, the junior doctor would start the scan and then she or the nurse would ask Dr. Sen to come inside the room[71].

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infertility specialist structured a plan of action, arrived at a diagnosis, and accordingly initiated a treatment plan (see Thompson, 2005, p. 100).

[69] Before any couple met Dr. Sen, it was the junior doctor's responsibility to meet the new couple and ask them a set of standardized questions in order to prepare the patient history file.

[70] The probe or transducer is approximately two to three centimetres in diameter and white in colour.

[71] In clinic A and B, since it was male practitioners who performed the ultrasound, they were called inside the room by the nurse after the women had removed their lower garments and were covered with a sheet. In clinic C, since the infertility specialist who performed the TVS was a woman, she would be in the room throughout.

On entering the room, Dr. Sen would wear a set of disposable gloves and position himself on the stool placed next to the bed or stand opposite the ultrasound machine in order to perform the scan. Over the next five minutes or so, Dr. Sen would ask the woman to part her legs, insert the probe, and maneuver it to capture images of her reproductive organs from different orientations as he simultaneously measured them on the screen. Usually, he would start by looking at the uterus and the endometrium followed by measuring the size of each ovary and counting the approximate number of eggs in each ovary. He would state the observations and measurements loudly so that the junior doctor (or sometimes the nurse) could record it in the woman's medical file. On finishing the scan, Dr. Sen would take out the probe, remove his gloves, throw them in the dustbin, and leave the room without saying anything. The nurse would then hand a tissue roll to the woman, tell her to clean up, put on her clothes, and then sit in the waiting area until her name was called out. While the woman would put on her clothes and/or after she had left the room, the nurse would clean up the bed, removing the condom from the probe and replace it with a sterile condom. She would also print the ultrasound images and add them to the woman's patient record file. She would then wait for the next woman to be sent inside. The same steps were repeated each day, dozens of times, by the various actors involved.

Once in a while, Dr. Sen would tell the junior doctor and me if there was an "odd" or "abnormal" image visible on the ultrasound monitor. In such cases, he would explain the situation to me in English using medical terminologies instead of directly addressing or informing the woman whom he was talking about. If this happened, there were a few women who would ask Dr. Sen before he left the room whether everything was alright or "normal" with them. He would ask them not to be worried and to meet him in his chamber. Thompson (2005, p. 100) notes that judgements of normality and abnormality are commonly made during such routine diagnostic tests by the physicians in infertility clinics. Such judgements, she argues, are based on "idealized topographic representation" in the physician's head that is derived from a standardised anatomy textbook depiction of a woman's pelvic region (ibid.). However, Thompson further notes that such topographic knowledge is embodied in the physician's skilled "recognizing things as thus and so" rather than as an ideal mental type (ibid.). Through a skilled repertoire of recognition based on the enormous body of practical knowledge having performed the same thing several times over the years, the physician is able to manipulate technological instruments and therefore, "normalise" the work required to render what is normal or abnormal (ibid.).

This ethnographic description is of the ontologically well-choreographed technological ritual (see Thompson, 2005) of the transvaginal ultrasound scan (TVS), a diagnostic test which was performed multiple times a day at infertility clinic B[72]. For the couples who had experienced reproductive loss and who pursued medical intervention in their quest for a (preferably) genetically-related child, the TVS was the first black-boxed[73] and routinised[74] reproductive technology, the first among many others, which the women encountered in the biomedical setting of an infertility clinic. Within this world of technology-mediated conception, the biological and natural function of fertilisation is meant to be achieved with "technological assistance" which will help the couples in their journey to achieve reproductive success (Franklin, 1997, p. 208). As such, the present chapter is largely concerned with reproductive technologies which as actants or non-human actors (Latour, 2005) effect, contribute to, and shape experiences, situations, and interactions between actors and other actants within the infertility clinics. As discussed in chapter two, an actant is defined as any entity which possesses force, causality, and efficacy in the sense of modifying other actors or entities through a series of actions and interventions (Latour, 2005, p. 76).

As such, my first argument in this chapter is that as non-human actors with agentic capacity, reproductive or medical technologies perform a pivotal role in producing a "perceptible difference" (Latour, 2005, p. 76) insofar as they act as mediators which shape doctor-patient interactions, contribute to women's disrupted reproductive experiences, as well as play an instrumental role in the women's journey to achieve reproductive success. Indeed, as one of the most indispensable entities within infertility clinics, reproductive technologies perform a

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[72] The protocol for performing TVS remained the same at infertility clinic A and C barring minor details such as the colour of the sheet used to cover the woman's body or the brand of the condom used to envelop the probe.
[73] Latour (1987, p. 2-3) defines the "black-box" as anything which is presented by the practitioner as being too complex, and thus, instead of questioning it, people should only be concerned with the input and output and not with the inner working of the box. In the study of ARTs, Thompson (2005, p. 47) has described black-boxing as "the process whereby facts and technologies become stabilized and generally taken as true".
[74] The process of routinization, according to Wahlberg and Gammeltoft (2018, p. 14) suggests "a gradual take up and acceptance of a medical technology such that it becomes a normalized part of daily life, in the sense that it is available to and used by its intended users in a routine manner, albeit surrounded by all manner of socioeconomic or cultural barriers".

central role in the enactment of (intended) conception as well as the (unintended) outcomes of reproductive loss and reproductive failure.

The parallel focus in this chapter along with the agency of the technologies is also on the agency of the women on whose apparently complaint and docile bodies these technologies were enacted by the practitioners. As sociologist Charis Thompson (2005, p. 178-179) has argued, although the subjugating and disciplining effects of reproductive technologies cannot be denied, infertility clinics are, nevertheless, "instructive places to look for the possible coexistence of objectification, agency, and subjectivity". Thompson explains that it is by actively participating in the objectification of her body at certain times that a woman manifests her agency and it is through that objectification, that she enacts her subjectivity (ibid., p. 179-181). In resonance with Thompson's line of argument, this chapter also explores how in spite of the various constraints within the infertility clinics, the female interlocutors in my study utilised multiple forms of their agency to often objectify their own bodies.

In the first section of this chapter, I am concerned with how reproductive technologies facilitate the gendered enactment of women as compliant female patient-bodies by the medical practitioners. I show that during various medical procedures, the practitioners enacted a female patient-body which is submissive and passive – a patient-body which does not question or challenge the practitioner's instructions and complies with the demands of the technologies. I also show that while performing the procedures, the practitioners reiterated gendered stereotypes to delegitimise women's pain, infantilise them, and at times engage in forms of what I term as "pre-obstetric violence" in order to coerce and tame a "difficult" woman to undergo the procedures. In addition, I show that the practitioners use forms of "epistemic disciplining" (Thompson, 2005), for instance, by controlling women's epistemic capital by giving them inadequate information beforehand about the procedures and/or the treatments. Based on ethnographic descriptions, I claim that the practitioners constrained the women's agency in order to maintain their medical authority and to also ensure that the technologies are successfully enacted without any interruptions from the women. Therefore, I suggest that it is the successful application of these technologies which helps the practitioners move closer to creating a 'miracle baby' (see Franklin, 1997, p. 147) that helps them further in sustaining (or even increasing) their own professional reputation in the market as well as the clinic's 'success rates' and 'take-home baby' rate. However, as I show with examples, even within such a constrained environment where the women were constantly enacted as docile patients, it was within their patient-roles that they utilised their agency, for example, by, (not) wanting to acquire information about certain procedures.

In the second section, I elaborate on women's utilisation of agentic capacity during constraining and controlling medical encounters. As an example, I show how some female interlocutors, particularly those who had experienced reproductive loss and then conceived after pursuing ARTs, voluntarily and eagerly engaged in an interactive venture with the other actors and actants in the clinics in order to enact foetal personhood. Based on such illustrations and existing literature, I suggest that they preferred the increased medical surveillance via the visualising technology of the ultrasound in order to gain a sense of control by ensuring that their baby was normal and also so that they could try and avoid another occurrence of reproductive loss (see Petchesky, 1987). Indeed, as has been argued by Thompson (2005), I also show that despite being objectified by the reproductive technologies and the practitioners, the female interlocutors objectified their own bodies by actively deciding to submit themselves to the medical demands of the technologies and the practitioners in order to move closer to their goal of achieving of reproductive success.

The third section is concerned with how the technology of abdominal ultrasound imaging facilitates the practitioners' enactment of foetal and embryonic personhood – a theme which is well-researched in the Euro-American settings but has not received much academic attention in the South Asian or specifically within the Indian context. I show how such an enactment of personhood by the well-meaning practitioners to stimulate maternal bonding can potentially amplify women's experiences of being pregnant with a sentient baby and not just a foetus. I also show how the practitioners modified their usage of the terms of embryo, foetus, and baby during the procedures and after an episode of reproductive loss in the form of treatment failure(s) which, I argue, informs (and often confounds) women's experiences and conceptualisation of *what* they have lost. Moreover, I show that particularly after the occurrence of reproductive loss in the initial stages of gestation, even though the doctors disregard the loss and refer to the lost product of conception as insignificant, some women nevertheless conceptualised their experience as that of losing a potential child – a conceptualisation which was made possible because of the ultrasound technology and the practitioner's subsequent interpretation of the preliminary foetal images as a 'real baby'.

Finally, in the fourth section I address an interesting paradox. Most of my female interlocutors continued undergoing treatments as the first attempt at any of the ARTs rarely resulted in conception and/or a successful pregnancy. Despite recurrent treatment failures, they kept pursuing these treatments hoping to achieve reproductive success – hope and desire which was responded to and created by the technologies (Franklin, 1997) as well as hope which was associated with the "pull" of the technologies (Sandelowski, 1991). Although pursuing these technologies were seen as the unavoidable route to achieving reproductive success by the middle-class women and/or couples, they reportedly did not consider the technologies as playing a role in the negative treatment outcomes. Instead, I show that when making sense of their experiences of loss and reconciling with their reproductive 'failure', women attributed agency to other actants and/or factors such as God and destiny[75] which they understood as having contributed to the undesirable reproductive outcome(s). As such, I argue that even though the achievement of reproductive success for the women relied on technology-mediated conception, they nevertheless invisibilised the agency of the reproductive technologies in their retrospective narratives of reproductive loss and reproductive failure.

3.2. Technological Rituals of Submission

Herein, I explore two technological rituals of submission performed routinely in infertility clinics – Transvaginal ultrasound scan (TVS) and Hysterosalpingogram (HSG). Neither of these technologies have been explored in the existing body of anthropological literature on ARTs in South Asia. Based on a description of how these technological rituals are performed, I demonstrate the objectification of women by the medical practitioners, reiteration of certain gendered stereotypes, and forms of epistemic disciplining and in doing so, I claim that the practitioners constrained the women's agency by enacting compliant female patient-bodies.

3.2.1. Transvaginal Ultrasound: The First Technological 'Ritual of Submission'

As I have described at the beginning of this chapter, TVS is the first technological tool and the first stage of medical intervention in infertility clinics used by infertility specialists to examine whether the woman has a 'problem'. I was informed by the ultrasound clinician at clinic A that

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[75] Naraindas (2017) explains that non-human entities such as gods, deities, demons, ancestors, spirits, ghosts, etc. are actors with agency and they have a relationship with and a possible effect on human life (see also Sax, 2009). As I show intermittently across this study, these religious and cosmological agents are often invoked by the actors (couples as well as medical practitioners) as having an undeniable role to play in the treatment outcomes and also in their making sense of their experiences of reproductive loss.

TVS, where transvaginal means across or through the vagina, was used routinely during infertility treatments in India since the late 1990s[76] as it provided clearer images of the female pelvic organs in contrast to abdominal ultrasound. I was further told by him that this safe, cheap, and effective diagnostic test allowed a patient's vagina, cervix, uterus, and the ovaries to be examined for potential "abnormalities" such as uterine fibroids, tumours, Polycystic Ovarian Syndrome (PCOS), Endometriosis (see Appendix 2), and/or a very thin endometrial lining – abnormalities which according to the clinician (and the other practitioners in my study) are not conducive for a 'normal' pregnancy and might pose a hindrance to natural conception.

As I observed at the infertility clinics, the TVS is the only test which was conducted several times in the entire process of undergoing infertility treatments. A preliminary scan was followed by a series of scans (usually four) at regular intervals for the Folliculometry test in which the growth of the woman's ovarian follicles was monitored. Based on the acquired information, the infertility specialist decided whether the current medications should be continued, whether the dosage of those medications need to be altered, and/or how and when the infertility treatment should proceed thereon. Each time a treatment cycle failed and a woman started a new cycle, she had to undergo the series of vaginal scans all over again. Even when a woman conceived after undergoing a treatment, the TVS was used to detect foetal heartbeat between the 6th-8th weeks of pregnancy. As an infertility specialist said:

> "See in any case, IVF or IUI pregnancies are usually high-risk pregnancies and we do not want to take any chances. With TVS, we can get a better view inside the uterus. And if the woman gets to know that everything is normal, then she will go home with a big peace of mind. After all, unlike women who conceive normally, these are women who have been trying for a very long time. Once these women can hear their baby's heartbeat, then they go back home with a smile. In some cases, we also do TVS in the first trimester. This is for those cases where the woman has had recurrent miscarriages before. We don't want to take any chances."

I also observed during my fieldwork that women who had been pursuing assisted conception for an extended period of time were accustomed to the procedure of TVS. They knew exactly which steps they had to follow and displayed no hesitation when they entered the ultrasound room. I noticed that they did not require any instructions from the doctor or the nurse and they objectified their bodies by submitting themselves to this technological ritual. As Shaw (2016, p. 182-183) has also observed in her study, with the increasing number of ultrasounds

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[76] Since the mid-1980s, TVS had largely replaced abdominal ultrasound in infertility clinics in the Euro-American countries (Thompson, 2005, p. 194).

that women underwent during the treatments, their perception of the procedure as intriguing or mysterious as it may have appeared during the initial diagnosis was diminished. In contrast, for women who were going to undergo TVS for the first time, their nervous disposition and hesitant body language before, during, and after the scan was apparent (perhaps more so to me as the outsider in the room). The nervousness was not surprising given that when a woman walk into the ultrasound room for her first TVS, she had not been provided with any information by the practitioners regarding what TVS meant or what the procedure entailed[77].

For most women undergoing TVS for the first time, I noted a common pattern. When a woman entered the room and was instructed by a nurse (or the doctor's female assistant) to remove her lower garments and underwear, most women were visibly embarrassed and awkward. The women wearing saris would hesitantly lift it up and remove their underwear while softly asking the nurse where they could keep it. Women who were wearing jeans or *salwār-kamīz* would hesitate or fumble with their clothes, while there were others who would blush and/or look uncomfortable while taking off their underwear. Often, there were a few women who looked visibly embarrassed to remove their underwear while standing. So, they would sit on the bed, cover themselves with the white sheet lying on the patients' bed, and then remove their underwear. Such behaviour would often result in the nurses sarcastically telling them, "What's there to be so ashamed of? This is my job. I'm not here to look at you" or "I'm also a woman, what are you so ashamed of?" Such statements would usually evoke a nervous smile from the women while they managed to do the needful and lie down on the patient bed.

The new female patients who were told by the doctor to undergo a TVS during their menstrual cycle were the most shy and hesitant when they were asked by the nurse to take off their underwear. They would whisper to the nurse that they were on their periods and that they were worried about staining the bedsheet. The nurse would curtly ask them to not worry about the blood as she would place a disposable sheet under them. When the women finally removed their underwear, they would place it upside down on the floor or they would cover it with their other clothes in a way that hid their sanitary pad completely. In case a stained sanitary pad was not well-hidden by the woman, the nurse would cover the pad or turn it upside down with the presumable intention of removing it from the male doctor's sight. On

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[77] I make the assumption that women did not know about the TVS beforehand. It could be argued that perhaps the women had read about it earlier or heard about it from someone else. While that is entirely possible, my assumption is primarily based on my observations and the subsequent dialogues with my female interlocutors.

one such occasion, while covering a pad, a nurse scolded the woman lying on the bed: “You should have covered this properly. Don’t you know Sir [the doctor] will be coming here?” The shame that women felt in undergoing an invasive procedure during their periods or about the sight of their blood-stained sanitary pad in a male doctor’s presence was not surprising given the culture of period shaming in India. The cultural message which most Indian women and most women around the world receive since puberty is that their menstrual blood is shameful, dirty, and polluting and this often results in them attempting to conceal any visible signs of this/the blood (see Abraham, 2001; Roberts, 2004).

During the hundreds of vaginal ultrasounds I witnessed at the infertility clinics, almost none of the women displayed any signs of pain or physical discomfort during the scan. For most women, the initial flinch of their body was presumably caused by the insertion of the ultrasound probe into their vagina by the practitioner who usually did so abruptly without giving the women any verbal indication that the procedure was about to begin. Quite often, women who were undergoing TVS for the first time would ask the nurse before the procedure whether they would feel any pain. The usual responses were, “It will not hurt. So many women have this scan daily,” or “No, it will take a few minutes so just keep lying quietly till the doctor comes,” or “Nothing to worry about, just take deep breaths.” On one such occasion when a woman asked the nurse at clinic B if the procedure was painful, after giving her a perfunctory response, the nurse leaned in closer to me and whispered,

> “Some women can’t endure even a little pain. A little pain or uneasiness and they do so much drama! If they can’t tolerate this minor thing, how will they go through the rest of the treatment? They don’t know that the pain of childbirth is nothing compared to the pain from these treatments. Women these days don’t understand that becoming a mother is not that simple. A woman has to suffer through a lot of pain, not just physically but also emotionally, before she can become a mother.”

In all the clinics, even minor non-verbal displays, whether it was physical squirming or verbally expressed discomfort by a woman, it would elicit remarks from the practitioner(s), with comments such as, “How will I do my job if you move so much?” or “Nobody else does like this, why are you behaving like this?”. At other times, the women would have to hear a practitioner make statements, such as, “Just endure it a little bit more, I am nearly done” or “This is hardly any pain at all!”. Either by reprimands or placatory statements, the practitioners ensured that the women’s experience of pain or discomfort did not hamper the successful application of the technologies. There were three cases in particular where the women expressed severe pain during the TVS. Although such cases could be considered as rare and anomalous, I would like to present the case of one female interlocutor whose experience of undergoing the TVS was fraught with intense pain. The purpose for presenting this case study is to highlight the marginalization and infantilization of women’s pain by medical practitioners as well as the enactment of normative gender stereotypes.

3.2.1.1. “My dear, let’s get it over with”: Treatment First, Pain Second

With a white sheet covering her body below the waist and knees bent upwards, Rina had been lying on the bed for a quarter of an hour. Even though the junior doctor, Dr. Kapoor, was present in the room, Rina’s TVS had not yet started. I was curious about the reason for delay as usually Dr. Kapoor would start the scan and Dr. Sen would conduct the scan further. I asked Nurse Sapna who was present in the room whether we were waiting for something. She took me aside and said in a hushed tone that they were waiting for Dr. Sen to end his ongoing consultation as only he could “handle” this patient. She then told me that she and Dr. Kapoor would need to assist Dr. Sen because this patient did not allow anybody else to touch her and that she created a lot of trouble and “a lot of drama” in her previous scans. A few minutes later, Dr. Sen walked into the room and on greeting Rina, she responded with a faint smile and a hardly audible “hello sir”. A conversation started between Dr. Sen and Rina regarding how she was doing and this was an unanticipated sight as I had rarely seen him converse with any patient during the scans. I was unable to comprehend why he told Rina to not be scared this time. This was the first time he said anything of this sort to a patient.

As soon as Dr. Sen picked up the probe, Rina’s body language became visibly tense and she clasped her knees and legs together. While telling her to relax and part her legs, Dr. Sen tried inserting the probe inside her vagina. Immediately, she shrieked and attempted to shut her legs again and her sudden movement forced Dr. Sen to take the probe out. She looked scared and told him that she wanted to leave and that she could have this test on another day. As Rina was trying to remove the sheet covering her lower body, Nurse Sapna and Dr. Kapoor tried to physically place her back into the supine position even though Rina showed vigorous physical resistance. Dr. Sen asked the other practitioners to step aside and told everyone to calm down. He then walked up to Rina, and while stroking the top of her head, said,

> "Why are you doing this, my dear[78]? The longer it takes, the more unbearable it will be for you. We also don't like seeing you in pain. So, please try to be calm. Take deep breaths. It will take me only a minute. Think of nice things! Don't be so scared. You have done this so many times before. It's not painful at all! How will you have a baby if you keep complaining of so much pain? Okay? Be brave! You are soon going to be a mother of a beautiful baby. But if you keep behaving like this my dear, then how will I give you a baby, tell me?"

After what I would describe as a light physical struggle between Rina, Nurse Sapna, and Dr. Kapoor, it was Dr. Sen's words which seemed to have temporarily placated her. However, once again, as soon as the probe was inserted, Rina raised herself halfway up while loudly shrieking and telling Dr. Sen to stop. Despite her requests, when Dr. Sen tried pushing the probe inside again, Rina tried to stop the procedure by lightly slapping away Dr. Sen's hand which was holding the probe. The junior doctor and the nurse tried to push Rina back as he kept trying to manoeuvre the probe. Angrily, the junior doctor said to Rina,

> "Just give Dr. Sen two more minutes. How will the test get done if you keep saying it's hurting? So many women have a TVS daily. We know it doesn't hurt as much as you are showing it is. It's all in your head. Just endure it a little longer. The more you move, the longer it will take."

Despite what the practitioners were saying, Rina was crying while physically twisting and turning her body in a way which would potentially deter Dr. Sen from inserting the probe inside. Looking irritated, Dr. Sen raised his voice and said to the nurse and the junior doctor,

> "I don't understand what you both are doing. This is not a new thing for us, is it? We have faced this situation before. Hold her arms down if need be. One of you hold her from the shoulders and the other one keep her legs apart. If she keeps moving like this, I can't do or see anything properly. And this probe might also break! Can't you both understand that her shouting and crying like this is going to scare other patients outside! Please calm her down! Just hold her tight for two minutes!"

While the other practitioners tried again to restrain Rina, Dr. Sen looked at her and gently said,

> "You know how expensive this probe is? It's more than 3 lakh rupees [approximately 3,700€]! You don't want this to break, right? So come on now, be a good girl. My dear, let's get it over with. The sooner you calm down, the sooner your body will be relaxed and then you won't feel any pain. I need to do this scan otherwise I will not be able to proceed with IVF. Please let me do this. Just two minutes, I promise this will be over before you know it. We know you are a brave girl, isn't it? Come on, let me try one last time. I promise my dear, one last time and this torture will be over. Here, look at me, just look at me, don't look anywhere else, and count for sixty seconds. That's all. I will be done before you finish counting, okay?"

In tears and with beads of sweat on her upper lip, Rina resumed her supine position. After keeping the probe inside for a minute or so during which Rina had her yes tightly shut, lips

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[78] Dr. Sen interchangeably used the words "dear" and the Bengali word "*shonā*" which is also a term of endearment and loosely translates to dear in English.

pursed, and her hands clasping on to the bedsheet, Dr. Sen took the probe out, smiled, and told her that the "the torture" was over and she could relax. The moment the probe was taken out, Rina sighed heavily while wiping away her tears. Dr. Sen went up to her, patted her head and said, "You are a brave girl! I am proud of you!". She responded softly, "Thank you, sir."

Once Dr. Sen and I were outside Rina's earshot, he told me that Rina had a medical condition called Vaginismus, which was quite severe in her case, which also meant that she had never engaged in "proper" penetrative sexual intercourse and for her, the ultrasound probe was "an alien object". He said that this rare condition was especially common among those women who generally have a discomfort with and are stressed about engaging in sexual intercourse. When I asked Dr. Sen about a treatment[79] for this condition, he said,

> "There's no benefit. A treatment for vaginismus would require her to masturbate and I'm certain that like most Indian women, this patients has also never masturbated and neither would she do it now. See, female masturbation is a taboo in a country like India. So, I don't want to suggest her any treatment for this. She's already extremely stressed. I don't want to add to it by creating another problem for her. I just want to give her a baby as soon as possible. I don't like putting her through this torture every time."

After observing two more of these harrowing experiences at clinic C, I asked the infertility specialist, Dr. Chatterjee, why women were not treated for Vaginismus first before undergoing infertility treatments. She was of the same opinion as Dr. Sen and with a chuckle, she said,

> "Have you gone mad?! It would be absurd because female masturbation is anyway such a taboo topic in India. If I start recommending this to my patients who have Vaginismus, they probably won't return thinking I am a shameless doctor! It's not possible in our country. All this works in foreign countries. People here anyway have such little information about sex. It's actually scary how little people know about sex and what's even scarier is that many people have some major misconceptions about sex. So it's better that as doctors we just do our job and the women can find some temporary way to deal with their pain during the TVS and other treatments. My job is to give them a baby and that's what the patients also want. Once they go from the clinic with a baby in their hands, they will forget all this pain. Besides, they need to learn how to endure pain. How will they carry a full term pregnancy and give birth if they can't handle this minor pain? It's not such a big deal actually. Some women also do a lot of drama unnecessarily. They start crying simply out of fear that it might hurt them. If I stop because of their pain, then how will I do the scan or any other procedure? No pain, no gain!"

Dr. Chatterjee's quote of "no pain, no gain" suggested that in order to achieve reproductive success, women should be prepared to suffer through pain – physical and emotional pain – which as Franklin (1997, p. 184) notes is an inevitable part of undergoing infertility treatments.

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[79] Treatment for Vaginismus usually includes the use of Vaginal Trainers which are tampon-shaped objects in different sizes to help a woman gradually get used to having something inserted into her vagina. Psychosexual therapy, relaxation techniques, and pelvic floor exercises are also recommended as treatment options (see https://www.nhs.uk/conditions/vaginismus/#treatment).

Dr. Chatterjee's statements also suggested that some women's reactions to pain are exaggerated (implied by the use of the word "drama" – also a word which was used by the nurse in Rina's case) and in order for her to successfully conduct the procedures, she has to ignore the pain. Her job, as she said, is to send the patients home with a baby and for that, she has to focus on treating the women instead of spending her time managing their pain. For Rina and the two other women, the "legitimacy of fertility" and the "illegitimacy of [their] pain" (Barua and Naraindas, 2015) in both the doctors' statements suggested that the latter's priority was to *resolve* women's childlessness and fulfil their professional goal of achieving reproductive success instead of treating them for other medical conditions such as Vaginismus (see also Meerabeau, 1999, p. 1508).

Before I engage in a further discussion of how the technologies mediated or facilitated the interactions inside the clinics, let me describe the second technological ritual of submission.

3.2.2. Hysterosalpingogram (HSG): The Second Technological Ritual of Submission

The HSG is another ritualised diagnostic test which women seeking assisted conception are told to undergo by infertility specialists before making a decision about the treatment plan. Similar to the TVS, the HSG allows the practitioner to assimilate the female patient-body to a familiar topography wherein the body's relevant physical or functional deviations from the 'normal' are located (Thompson, 2005, p. 99). This test entails the use of X-ray scanning to examine inside a woman's fallopian tube and uterine cavity in order to see if any blockage in the form of tumour masses, adhesions, and/or uterine fibroids can be detected. The presence of a tubal blockage was cited by the practitioners in the clinics as one of the prime reasons for a woman being unable to conceive naturally as the blockage impedes fertilisation. The test procedure involves injecting radiopaque dye (visible under X-ray) in the uterine cavity through the vagina and cervix to see if the dye freely spills out of the both the fallopian tubes in which case the X-ray images as diagnostic evidence indicate that there are no blockages. I was informed by one nurse and as was also evident during my observation of the procedure, the insertion of the dye usually caused a female patient to feel significant pain if a tubal blockage was present. From the time a patient entered the room and till she left, this invasive procedure took about thirty minutes. While Thompson (2005, p. 101) notes in her study in the US that viewing of the HSG image is delayed until the X-ray film is developed, the practitioners performing the HSG in my study made their conclusive diagnosis immediately after the procedure based on the images they observed on the computer screen where the X-ray images had been captured. The couple was given the X-ray images during their subsequent consultation with the infertility specialist where the HSG test results were discussed in order to decide the next plan of action. For ethnographic elaboration and to comment about the control of patients' epistemic capital by practitioners, I present the case study below.

3.2.2.1. "Why do you need to know?": Controlling and Manipulating Patients' Agency and Epistemic Capital

As I was shadowing nurse Shanti during the first month of fieldwork, she informed me that a patient was going to undergo an HSG test. I learned that this was the first clinic that the patient, Deboshri and her husband Pradip, were visiting as they had not had a baby despite trying for two years. I was asked by nurse Shanti to wait in the room where the HSG was to be conducted while she called Deboshri. I made my way to an air-conditioned room where I noticed some medical equipment attached to a hard surface resembling a white table-top (which I would shortly learn was the patient's bed). In addition, there were two computers and a corner of the room was separated with curtains while the adjacent corner had a vertical panel creating a divide between the table-top and the wall.

A few minutes later, Nurse Shanti walked in with Deboshri and introduced us. Deboshri and I engaged in an informal conversation during which I told her about my research and asked her whether it was alright for her that I stay in the room during the procedure. She agreed and as we were talking, two young men walked into the room. Nurse Shanti informed me that one of those men was the X-ray technician and the other man was his assistant. At this point, Nurse Shanti instructed Deboshri to step behind the curtains, remove her jeans and underwear, wrap herself with a towel which was already placed there, and to then lie down on the bed i.e. the white table top with her knees bent upwards. After doing what Deboshri was instructed to do, Nurse Shanti covered the lower part of her body with a sheet and removed the towel. Without informing her what was about to happen, Nurse Shanti administered two injections on Deboshri's arm. While administering the injections, she told Deboshri that the injections were a precaution measure to alleviate any potential pain during or after the procedure[80].

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[80] The first injection was a tetanus shot to prevent bacterial infection and the second one had a painkiller since the procedure could cause a high degree of pain for many women during and also after the procedure is over – information which I gained after the procedure from Nurse Shanti on having asked her.

Deboshri then asked Nurse Shanti what the test entailed and whether it would be painful, to which the latter replied,

> "Will you understand if I tell you what the test is? It's just a simple X-ray. And why do you need to know? Just do what the doctor says. It won't hurt. So many women get this test done regularly. It's a routine procedure. I've given you the required injections so you won't feel much pain. You will be slightly uncomfortable but it will not take long, so tolerate it. And don't move when the doctor starts."

After saying this, Nurse Shanti left the room and shortly thereafter, clinics A's consulting gynaecologist, Dr. Pal, walked into the room followed by the nurse. He was greeted by the staff as well as by Deboshri and me. After acknowledging with a head nod, he sanitised his hands with a disinfectant and asked Nurse Shanti whether I was a junior doctor (presumably because of the white lab coat I was wearing while holding on to a pen and notebook). She introduced us and told him that I was observing medical procedures in infertility clinics as part of my doctoral research. Meanwhile, everybody in the room was handed sleeveless jackets by the X-ray technician's assistant. I was told to put on the protective vest during the X-ray as it would offer protection from the harmful X-rays. The doctor asked Nurse Shanti for the patient's name and he sat on the stool which allowed him to gain easy access to Deboshri's exposed vagina. Instead of asking or telling her to part her legs, he manually parted them. Since I was standing closer to Deboshri's head, Dr. Pal asked me to stand next to him so that he could explain the procedure and also for a close observation. He did not ask Deboshri if she was comfortable with my close presence and observation. As I moved next to Dr. Pal, he said to me, "I'm sure you are aware of the female reproductive organs so I'm not going to explain that." I nodded affirmatively after which he started explaining the tools that he would use and told me that this test was usually perfumed seven to ten days after a woman's menstrual cycle or right before ovulation. Without wearing surgical gloves and without saying anything to Deboshri, he began cleaning her vagina[81]. He inserted a metal speculum and used a cotton ball soaked in disinfectant to sterilise the opening of the vaginal canal. The abrupt insertion of the speculum resulted in Deboshri wincing and squirming and Dr. Pal told her to stay still. She pursed her lips and complied. Dr. Pal told Nurse Shanti that he needed a bigger speculum as

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[81] I had noticed that the doctors performing a diagnostic test would often not wear surgical gloves. While everyone else present in the procedure room, including myself, would be held to high standards of sterility by the nurse, it seemed that the doctor did not have to adhere to the same standards. For instance, I was reprimanded a couples of times by the nurses for wearing a surgical cap incorrectly or for not covering my face with the mask properly. In this regard, Thompson (2005, p. 84) who had similar observations during her research notes that only the doctors performing the procedures could take liberty with sterility procedures.

the patient's vagina was too tight. Once the bigger speculum was inserted, Dr. Pal inserted a thin catheter and pushed a water-soluble dark blue dye into the cervix. Deboshri started squirming again and softly said, "It's hurting, sir", to which Dr. Pal replied,

> "Why are you constantly moving, my dear? How will I do the test like this? If you keep moving, the test will not go well. Please stop moving and let me do this properly. Just relax your body."

He then asked Nurse Shanti if she had given Deboshri the painkiller, to which the nurse said that she had done so right before the procedure. Sounding unhappy, Dr. Pal sighed and said,

> "Oh god! How many times have I said that the painkiller needs to be given to the patient at least half an hour before the procedure. The medicine takes time. Naturally, she is in pain now because the medicine hasn't started working yet. Shanti, do I need to teach you all this? For how long have you been doing this? Anyway, for now, hold her leg properly, see that she doesn't move again. I don't want to repeat the test. Poor girl (*bechāri mēẏē*) is anyway suffering."

After apologising to the doctor, Nurse Shanti wrapped one of her arms around Deboshri's right bent knee and held the left knee tightly with her other arm in order to keep the legs apart. Since Dr. Pal was unable to insert the dye properly the first time, he made his second attempt. This time, Deboshri started wincing and faintly crying to which the nurse told her to "not behave like a small child". As soon the dye had been inserted, I was told by the nurse to move behind the wooden panel as she and the doctor also did the same. The X-ray technician's assistant moved the X-ray machine over Deboshri's lower body, waited for a few seconds, and then moved the machine away. Once the X-ray had been conducted, the images of Deboshri's fallopian tubes and uterine cavity appeared on the computer screen. The procedure was repeated three times as the X-ray technician said that the first scan had produced hazy images. Finally, after three successive attempts of inserting the dye, Dr. Pal asked the X-ray technician to show him the images. He asked me to come forward and see the images as well. He told Nurse Shanti and me that the patient (he never referred to Deboshri by her name throughout the procedure) had a retroverted uterus (i.e. when it is tilted backwards) and that there was a small tumour in her right fallopian tube. Dr. Pal disinfected his hands and walked out.

Still on the bed, Deboshri was looking around, as she had not yet been told by anyone whether the procedure was indeed over. She looked at me, asking me whether she could get up. Before I could respond, Nurse Shanti, who was speaking to the X-ray technician, came over to Deboshri and handed her some cotton, told her to clean up, put on her clothes and told her to sit in the waiting room. Deboshri how much time it would take for the pain to subside, to which the nurse smiled and said,

> "Don't worry about it. You will be fine soon. If it hurts too much, just take another Ibuprofen with a Pan-D or Pan-40 [antacids]. You girls nowadays are too delicate! Just a little pain and you start behaving like a child. God only knows how you all will go through labour pain! So much drama in such a minor procedure! No wonder you women all want to have caesarean sections! Anyway, go outside and wait, I will call you and your husband soon."

I followed Nurse Shanti to Dr. Pal's room where he told her to send the patient and her husband to his room in ten minutes. As I was chatting with Dr. Pal and answering his questions about my research project, Deboshri and her husband, Pradip, knocked on the door. The couple was informed by him that due to the tumour resulting in tubal blockage, the chances natural conception without treatment was indeed low and that Dr. Ganguly (clinic A's infertility specialist who had told Deboshri in the first place to undergo the HSG) would tell them what needed to be done next. Pradip asked Dr. Pal about their chances of having a baby, to which he smiled and said, "Don't worry. You are in good hands. Dr. Ganguly will ensure that you get a healthy and beautiful baby. You have come to the right place!" With this, the conversation between the doctor and couple came to an end and having thanked the doctor, the couple left the room.

According to lay understanding and a gendered discourse of pain, culture, and embodiment, women are ostensibly equipped with superior capacities for enduring pain which can be linked to their reproductive functioning, unlike men who have no such biological preparation, explains Bendelow (1993, p. 289). He further explains that according to such a discursive framework, female experiences which exposes them to severe pain, particularly during childbirth, implies that their pain is not to be acknowledged seriously, but rather should be considered as a part of their nature and duty (ibid., p. 289). This apparent naturalness of women's pain also meant that their complaints of embodied pain tend to be taken less seriously than men's pain or it can result in women's pain being completely ignored by physicians (ibid., p. 209, 289). Recent research has shown that there is indeed a disparity and gender bias in the medical community regarding the acknowledgement and treatment of women's pain as compared to men's pain (Denny, 2009; Hoffman and Tarzian, 2001; Kiesel, 2017; Samulowitz et al., 2018). While men are seen as brave for enduring their pain and not expressing it, women are seen as emotional or hysterical for expressing their pain (Samulowitz et al., 2018; see also Locke, 2011). Moreover, Denny (2009, p. 993) points out that the pain of some conditions has special status and is almost reified, for instance, the pain of cancer is undisputed and is accepted without visible proof. Whereas, other conditions experienced by women, such as menstrual pain or the pain of endometriosis, which are short-lived, are trivialised and equated with malingering and often, distrusted by doctors (ibid., p. 994).

Although the research findings above are located in the western context, similar explanations could be applied to my research findings. Rina and Deboshri's case studies of undergoing TVS and HSG, respectively, showed that while Deboshri did not display her pain overtly, for Rina it was an intensely painful procedure. However, the practitioners in both cases viewed the women's pain as dramatic, implying an exaggeration, and thereby marginalizing the legitimacy of their embodied pain. Furthermore, while both women expressed their pain verbally and/or non-verbally, they were reprimanded by their respective practitioners for hindering their successful application of the technologies. The practitioners in this process reiterated gendered stereotypes that they ought to be able to endure pain because as women they should know how to endure pain given their roles as potential mothers who would partake in childbirth. If not by reprimands, then in order to coax the women into submissively undergoing the procedures, the practitioners infantilised them treating adult women like children who need to be placated. For instance, the doctors used phrases such as "good girl" and "my dear" which in a medical setting could be deemed as patronising. Such performative speech acts, as has been proposed by Butler (1990), sustain, reproduce, and reify gendered stereotypes which tend to characterise women as hyperemotional and as irrational persons who akin to children are incapable of deciding what is best for them, thus, necessitating the need to be told by rational adults what should be done, when and how.

However, when Rina was unable to tolerate the pain, she was chastised by Nurse Sapna who said that women behave like children and cannot endure even minor pain. Similarly, in Deboshri's case, Nurse Shanti said that "girls" these days cannot tolerate the pain for a minor procedure and further implied that women nowadays opt for caesarean births because they are incapable of bearing the pain of normal childbirth. Ironically, on the one hand, the female patients would be spoken to like children in order to mollify them so that they would undergo the procedure without any apparent "theatrics". Yet on the other hand, the same women would be scolded for behaving like children if they cried or shouted in pain. It would, therefore, not be an exaggeration to state that the medical practitioners simultaneously disciplined the female patients through controlling and manipulating them during the medical procedures in order to enact compliant female patient-bodies so as to not hinder the pace of the procedures and to move as fast as possible from one patient to the next.

In addition, I suggest, at the risk of provocation, that Rina's and Deboshri's encounters with the ritualised reproductive technologies of TVS and HSG were not only defined by experiences of delegitimised pain and infantilisation but also by forms of what I term as "pre-obstetric violence" directed towards them by their respective practitioners. Of the many forms of discrimination and violence against women globally, obstetric violence has come to be recognised as a socio-legal[82] category not too long ago and it focuses on lived experiences of women during labour and childbirth (Chattopadhayay, Mishra and Jacob, 2017; Sadler et al., 2016). This kind of violence is directed towards pregnant women by doctors, for instance, by administering unwanted episiotomies, neglect during childbirth, disrespectful treatment, physical and verbal violence (see Chattopadhayay, Mishra and Jacob, 2017, Diaz-Tello, 2016; Shabot,, 2015). However, for Rina and Deboshri, their encounter with a certain degree of violence, such as in the form of disrespectful treatment, delegitimization of pain, and even physical violence had begun long before the childbirth or even conception. For instance, even though Rina was repeatedly expressing her pain verbally and physically, she was being physically coerced by the practitioners to undergo TVS. Despite her refusal, the practitioners tried restraining her on the multiple times so that the scan could be conducted successfully. In Deboshri's case, the nurse forcefully pushed her legs apart despite her wincing and crying in pain. Deboshri was also treated as a de-personalised patient-body by the gynaecologist who did not address her directly during the entire procedure or even when he was explaining the test results to the other actors in the room. Indeed, both women were coerced into the procedures regardless of their resistance which not only reveals an invalidation and unrecognition of their pain but also disrespect towards their bodily integrity (see Chattopadhayay, Mishra and Jacob, 2017). Rina and Deboshri's cases, along with other such cases during my fieldwork allow me to expand the current ambit and conceptualisation of

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[82] In 2007, Venezuela became the first country to formally defined obstetric violence and codify it as one of the 19 kinds of punishable forms of violence against women (Sadler et al., 2016). According to the Organic Law on the Right of Women to a Life Free of Violence, obstetric violence is defined as "the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanising treatment, an abuse of medicalisation and pathologization of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life" (ibid., p. 50).

obstetric violence which focuses on violence against women primarily by male practitioners specifically during labour and childbirth. I argue that acts of pre-obstetric violence by male *and* female practitioners towards women can commence much before the labour of childbirth and such coercive acts facilitated by the reproductive technologies restrain or erase female patients' agency, bodily integrity, and bodily autonomy during their reproductive journey(s).

The constraints on the female patients' agency by the medical practitioners is additionally visible in the ways in which the latter disciplines the patients by controlling and manipulating the amount of information being provided – a theme I also discuss in the next chapter. As such, it is not only through reprimands, mollification, and/or infantilisation but also the mechanism of "silent altruism" (Katz, 1984, 1985 in Lazarus, 1988, p. 45-46) using which doctors tend to manipulate their relationship with the female patients to enact compliant patient-bodies and effect therapeutic ends rather than providing information which facilitates joint decision-making between the actors. Such a mechanism entails assuming the mutual interest and trust between the doctor and the patient and the latter following the doctor's orders. I apply Thompson's concept of "epistemic disciplining" who uses this term to denote one of the significant ways in which patients in infertility clinics are objectified by controlling the amount and kind of knowledge that is relayed. She explains that as technical experts, gatekeepers, and the providers of reproductive technologies and healthcare, practitioners control much of the information relevant to medical encounters and parcel it out in ways to manage patients and expedite their work. As such, the epistemic capital of the patients, argues Thompson (2005, p. 200), is altered and expanded during their entire time they spend in these clinical spaces that are inundated with a wide range of information. Examining the interactions in the clinics through the lens of epistemic disciplining, therefore, allows an understanding of how female patients are made to submit to the demands of the technologies and the practitioners. Further, according to Lupton (1997b, p. 96), the lack of information from the practitioners about the procedures positions the female patients as vulnerable supplicants who have few opportunities to ask questions or challenge the doctors' decisions. For instance, when Deboshri asked about the HSG procedure, Nurse Shanti said, "Will you understand if I tell you what the test is?" and "Why do you need to know?" Such condescending statements suggest not only an infantilisation of the patient but also reveal power relations and the practitioners' attempts to maintain the hierarchy between themselves and the patients (see chapter four for a discussion on hierarchy and unequally distributed power in infertility clinics:

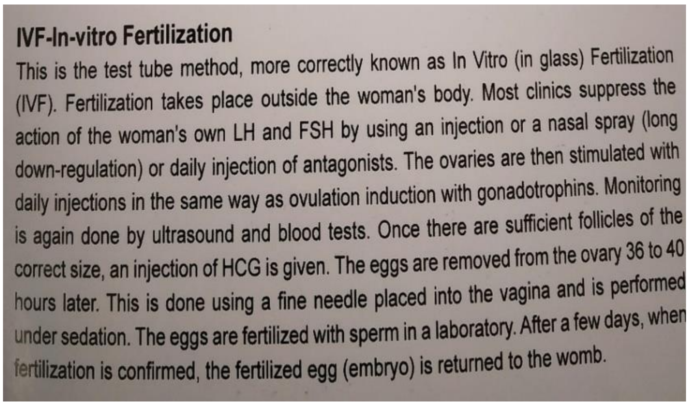
see also Shaw, 2016). Indeed, none of the practitioners in my study said anything to the new female patients before the medical procedures that could help them know what they were about to experience and/or prepare them in any way to undergo invasive procedures which might cause some degree of pain or discomfort. The non-disclosure of the procedure's details prior to it being performed is, therefore, an effective way used by practitioners to symbolically impose their medical authority on patients. In regard to the obtaining their therapeutic objectives and in order to establish a behaviour pattern among the patients, Fainzang (2002, p. 127-128) suggests that doctors often give out information to patients with the motive to allow patients to make a decision that ultimately confirms to their medical opinion. It is also not uncommon for doctors to retain information even about the risks of a particular treatment (ibid.). While some doctors choose to stay silent about the possible after effects of a treatment (or procedure), others might actively discourage their patients from gaining too much information (see Fainzang, 2002, p. 127).

Indeed, as I observed time and again, the information provided to the women and/or couples by the practitioners regarding any of the reproductive technologies or medical procedures was vague, piecemeal, and in scientific language which was understandably inaccessible to people with a non-medical background (see also Shaw, 2016, p. 152-153). One of the first encounters that people have with such technical language is in the pamphlets handed over by the receptionist as soon as a new couple entered the clinics. Even though the pamphlets are supposed to be informing the couples about the technological treatments and procedures they need to undergo to achieve reproductive success, the gap(s) in the information makes everything appear seamless, achievable, and without any likelihood of failing. Moreover, the pamphlets are only in English which basically makes it impossible for people from the lower socioeconomic strata to gain any kind of information right away. Even for English-speakers, understanding much of the information is not a cakewalk given the overt usage of medicalised language. Consider the following description of "Ovulation Induction", which is one of the initial stages of IUI and IVF as described in one clinic's pamphlet:

> The term is usually used for stimulation of the development of ovarian follicles to reverse anovulation or oligoovulation. In any case, ovarian stimulation (stimulating the development of oocytes) is often used in conjunction with ovulation trigger. Ovarian hyper stimulation (OHSS) may be a side effect of ovulation induction.

In simple terms, ovulation induction refers to the procedure of using hormonal injections and medicines to artificially facilitate the growth of the eggs inside the ovaries. However, as is evident from the passage above, the procedure's description only uses medicalised terms. The fact that this procedure involves monitoring the development of eggs through a series of transvaginal scans is not mentioned at all. Also, nowhere in the pamphlet is it mentioned that prior to this procedure, the woman would have to undergo an HSG test to ensure that there is no blockage in the fallopian tube or uterine cavity.

Let us also take a look at the description of IVF in the same pamphlet (see Fig. 10). A closer look at the description shows how certain terms have been used without offering any explanation. Abbreviations such as LH and FSH, HCG, and phrases such as daily injection of antagonists and gonadotrophins – none of these terms are explained either in the pamphlet nor during the consultations by the doctors. Although it mentions here that monitoring will be done via ultrasound, it does not mention that it will be an invasive transvaginal ultrasound.



IVF-In-vitro Fertilization

This is the test tube method, more correctly known as In Vitro (in glass) Fertilization (IVF). Fertilization takes place outside the woman's body. Most clinics suppress the action of the woman's own LH and FSH by using an injection or a nasal spray (long down-regulation) or daily injection of antagonists. The ovaries are then stimulated with daily injections in the same way as ovulation induction with gonadotrophins. Monitoring is again done by ultrasound and blood tests. Once there are sufficient follicles of the correct size, an injection of HCG is given. The eggs are removed from the ovary 36 to 40 hours later. This is done using a fine needle placed into the vagina and is performed under sedation. The eggs are fertilized with sperm in a laboratory. After a few days, when fertilization is confirmed, the fertilized egg (embryo) is returned to the womb.

Fig.10. IVF 'explained', Infertility clinic B's pamphlet

Also, the entire description is presented like an uninterrupted process. The pamphlet does not clarify, and neither do the practitioners eventually, that each stage of the IVF cycle has the potential to fail which would mean that the procedure would have to be started from scratch (see also Franklin, 1997, p. 152). Evidently, the information in such pamphlets is limited to mentioning the ARTs and the preliminary (and often associated) diagnostic tests which are part of the overall treatment are conspicuously absent. (I also observed during the consultations and learnt from my interviews that unlike in the case of ARTs, verbal or written consent had not been taken from the couples before the routine tests of TVS and HSG[83] that

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[83] According to The Assisted Reproductive Technologies [Regulation] Rules (2010, p. 11) in India, "as prescribed in Section 20 of the Act, the ART clinic shall obtain a written consent from the couple before conducting any ART

are procedures that can potentially cause some women severe pain and discomfort.) Finally, the mystery behind the working of these technologies also adds significantly to their sacralisation (Naraindas, 2015) and miraculous quality – technologies which can be understood, accessed, and enacted only by the medical experts. The incomplete information, apparent seamlessness, technical language, and sacralisation of the technologies, are, therefore, important ways in which these technologies, even the ones which are routinized rituals such as TVS and HSG, are black-boxed for the patients which additionally contributes to the latter's epistemic capital being controlled and manipulated.

My intention, however, is not to offer a purely reductionist argument wherein biomedicalisation only constrains or limits female agency with hardly any scope for resistance or meaning-making by the women. Instead, I suggest that during the medical encounters, the female patients actively or passively utilised forms of constrained agency. For instance, some women exercised their agency by not seeking information and rather, preferred not having excessive information about any procedures or treatments as limiting their exposure to information reportedly helped them in feeling normal and having less anxiety. For instance, one female interlocutor, Latika Bose, whose embryo transfer process I describe later in this chapter (see section 3.4), said in our conversation weeks later:

> "To be honest, if I knew about the procedure beforehand, I think I would have been quite stressed and scared! Sometimes ignorance is truly bliss! So yes, I think it was better that I did not ask anything about it to Dr. Chatterjee. I trust what she is doing. I anyway might not have understood whatever she said. If I understood so much, I would have been a doctor myself!"

Latika's statements reflects what Shaw (2016, p. 155) terms as "conscious inaction" and "desired ignorance" and this can be interpreted as her exercising strategic agency through an adaptive approach in order to manage her emotions and to prevent the stress and fear of undergoing infertility treatments. Similar observations have been made by other researchers who explain how some patients or couples wished for paternalistic doctors whom they could

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procedure, as specified in Form D, in a language that the couple understands". As such, taking informed consent from the couple in accessible language is mandatory before the patient undergoes any ART whether that is IUI with husband's or donor sperm, oocyte retrieval, embryo transfer, IVF, IVF with intracytoplasmic sperm injection (ICSI), embryo freezing, sperm storage or surrogacy. Interestingly, TVS and HSG are mentioned only a couple of times in the draft of the ART Rules (TVS is mentioned 4 times and HSG is mentioned once). I presume that unlike ARTs which require taking informed consent from the women and/or couples, the rituals of TVS and HSG are understood as *minor* diagnostic tests, despite being enacted through invasive procedures which can often result in intensely painful experiences for some women.

trust given the latter's medical expertise and experience (Inhorn, 2003b, p. 73; Roberts, 2008, p. 84-85). But the patients' reinforcement of the doctor's authoritative position by letting him/her take charge and choosing to not acquire relevant information does not necessarily imply that the patients' choice in hoping for a positive treatment outcome was diminished (Shaw, 2016, p. 156). As such, in her decision to stay uninformed about the procedure and permitting the doctor to control the medical procedure, Latika decided to refrain from actively participating in the event while entrusting authority to her doctor. As Shaw (2016, p. 159) rightly notes, a patient's lack of participation does not mean that she was unable to exercise her agency. Instead, her agency took an inactive form which nevertheless entailed an active decision-making process. Latika's supposed non-action can, thus, be understood as "a hidden form of agency" (ibid., p. 159) which reportedly helped her in being less anxious and in embracing the doctor's expertise and knowledge. As such, whether it is by ignoring or accepting the pain during a procedure or by cooperating with the medical practitioners while undergoing the treatments, these decisive actions by the women are indeed illustrative of forms of constrained but strategic agency. As Cussins (1998, p. 178-179) has aptly noted, "the patients do not so much let themselves be treated like objects to comply with the physician as comply with the physician to let themselves be treated like objects".

In the following section, I shift my focus to the technology of abdominal ultrasound which as the modern pregnancy ritual has become the most routinised of all reproductive technologies since the late 1970s (Price, 2003, p. 93). Like TVS and HSG, abdominal ultrasound also allows practitioners to visualise women's bodies internally, thus objectifying the patient-body and in doing so, enacting a specific kind of patient-body which can be regulated. I show that ultrasound was not only used by the practitioners to achieve medical surveillance and to enact foetal personhood but it was also used by the female patients for their own satisfaction about having a 'normal' baby as well as to engage in self-surveillance by gaining a sense of control over their pregnancy, having experienced reproductive loss previously.

3.3. Abdominal Ultrasound: The Pregnancy Ritual

> "I am a man of science and I follow science. Science does not lie. I tell my patients that there is no harm in having faith in God. It's alright to have faith as long as it is not conflated with science. See, it is simple. Medical science is actually a combination of three things: science of course, is the first, then comes intuition and lastly, common sense. I don't believe in hearsay or what patients' earlier reports show. So, for me doing an ultrasound is of utmost importance. I want to see it myself because I know that my own eyes cannot fool me. Until I see it myself, I will not believe anything.

> I monitor all my patients based on what I see on the screen. And I also want the patient to see for herself. Which is why unlike most other clinics, I have a flat screen TV opposite the patient so she can see what I also see on the ultrasound machine's screen. I have installed the LCD screen (see Fig.11) in this clinic only for the patient's satisfaction. I don't understand why other clinics don't do the same. Transparency is very important for me. I make no compromises there. Patients believe what they see with their own eyes. Look, ultimately, it's quite simple. Will you believe me more if I say something or if I show you that same thing? At the end of the day, what you see, is what you will believe. And that's a rule I follow strictly – both for myself and for my patients. Patients should not go home thinking that I gave them false information or that I cheated them in any way."

Fig.11. LCD screen on the wall for patients to see ultrasound images, Infertility clinic B

Several ethnographic studies on pregnancy and childbirth have shown that in contemporary times, ultrasound tests are embedded in cultural discourses as a normal part of pregnancy and as an expected and essential part of the modern obstetrical repertoire (see Black, 1992a; Gammeltoft, 2007; Harris et al., 2004; Price, 2003). Given the ubiquity of ultrasound scanning and imaging as part of prenatal screening and testing techniques, it was not a surprise that the medical practitioners in my study were also heavily reliant on this technology. As we can see in Dr. Sen's quote above, performing the ultrasound scan was his way of demonstrating his objectivity which he related to his unequivocal belief in science and its infallibility[84]. Being able to visualise the images of the patient's reproductive organs or the foetus himself using

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[84] Criticisms and disapproval about the apparent neutrality of science and the inseparability of objective scientific content from its sociocultural context has been well-documented by several scholars for more than three decades (see Casper, 1994; Franklin, 1997; Latour, 1987; Martin, 1987, 1991; Mitchell, 2001; Morgan, 2009; Oakley, 1984; Petchesky, 1987; Price, 2003; Steinberg, 1990; Thompson, 2005).

the ultrasound technology and also enabling the patient to do the same was crucial for him in order to maintain transparency in his medical practice. Referring to himself as a "man of science" and by stating that "science does not lie", Dr. Sen actively aligned himself with a model of science which generates empirical facts[85]. However, as Thompson (2005, p. 102) explains, being able to read ultrasound scans which involve possessing the routinised skills by which the epistemic norms of seeing, feeling, and knowing are enacted – all these form a large part of what it means to be a medical practitioner within the site of an infertility clinic. As Franklin (1997, p. 150-151) has also pointed out, the visual interpretation of ultrasound scans is a learned and acquired skill which transforms an experience of seeing "nothing" to one where both the clinician and patient come to "see". In other words, how to read or see a scan is not an objective or neutral fact which is underlined by scientific certainty. Rather, the process of reading or seeing an ultrasound image is a learned practice which is developed, interpreted, and then represented in a culturally specific context. Consequently, even though Dr. Sen emphasised the importance he attaches to the so-called objectivity and scientific certainty of ultrasound imaging, his interpretation of the ultrasound scans and foetal images are strongly embedded in dominant discourses around foetal personhood which are located in the wider discursive context of the biomedicalisation of pregnancy and childbirth.

3.3.1. The Enactment of Foetal Personhood and Maternal Bonding

A common observation during my fieldwork was that the practitioners always addressed the foetus as "a baby" during an ultrasound scan to detect foetal heartbeat (as well as during subsequent ultrasounds). Given that sex determination is illegal in India, none of the practitioners used any specific term which indicated the sex of the foetus/baby during the ultrasound scan, and thus referred to the foetus/baby as an 'it'. The gender-neutral word baby (*shontān* or *bāchā*) was commonly used when the practitioners communicated with Bengali patients and the word baby or *bachā* was used with Hindi-speaking patients. However, when the practitioner spoke to me or when he/she spoke to a colleague, the product of conception was more often than not referred to as a foetus.

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[85] It was interesting to note that although Dr. Sen made a clear distinction between having faith in God and scientific empiricism, in chapter five I will highlight the contradiction to show how he (and other practitioners) resorted to clinical theodicies while explaining the reasons for negative treatment outcomes to the patients.

The process of an ultrasound scan entailed the practitioner spending the first few minutes in establishing foetal viability followed by initiating the process of finding a 'suitable' image to show the pregnant woman. The attribution of foetal personhood by the practitioners while performing the ultrasound was reportedly done to encourage bonding between the woman and her child. As clinic A's ultrasound clinician told me:

> "See, up to eight 8 weeks, it's an embryo and the heartbeat can usually be detected by around six or seven weeks. In some rare cases, the heartbeat can only be detected in the ninth or tenth week. After the ninth week till the time it is born, it's a foetus. But these are all medical terms. As clinicians or doctors, when we speak to our patients, we don't the use the word foetus. We prefer not to. We simply address it as a baby. We know that for the patient, however far along she is in her pregnancy, for her, her husband, her family, she is carrying a baby. The women feel more attached when we talk this way. They see their baby on the computer screen and their faces light up. Some smile, some cry. Ultimately, for us it is important that there's mother-child bonding. Just imagine if you were pregnant and your doctor said your foetus is healthy and doing well. Would you feel a strong connection to it? So, for this reason we always address it as a baby."

When the clinician says, "they see their baby on the computer screen and their faces light up", he seems to suggest that women know what to look for and they know what is to be seen. However, it is actually he who shows them an image, which he identifies as the baby – a process of interpreting which he has learned over time and thereby, acquired a certain set of skills which facilitate this process. As Mitchell (2001, p. 120) notes, for most untrained viewers, ultrasound images are confusing and consequently, pregnant women are heavily dependent on the practitioner's interpretive accounts of the image in order to see their "baby amidst the swirling grey mass of echoes". She argues that seeing is not a natural activity and the practitioners who interpret the ultrasound images do so in specific ways by searching for any anomalies, improving the image resolution, and finding a cute image of the foetus/baby to show to the expectant parent(s) (ibid., p. 116). The 'naturalness' of the foetus is, indeed, constituted through the very technology which seems to locate it objectively (ibid., p. 11).

Besides, based on the clinician's statements above, which were also echoed by the other practitioners, the practitioners' views about enacting foetal personhood in order to encourage maternal bonding and attachment with the baby are embedded in and informed by a specific biomedical context where the technology of ultrasound transforms the foetus into a person. My findings and arguments in this regard are similar to research conducted in the Euro-American context which demonstrates that the process of ultrasound scanning involves an inevitable enactment of foetal personhood by physicians who hope to stimulate a certain degree of emotional attachment and bonding where the pregnant woman ostensibly develops a connection not with the foetus, but with the foetus as a person (see Mitchell, 2001). Several studies since the 1980s have been conducted in western countries on ultrasound imaging to show how this technology contributes to the visuality of the foetus and how 'the foetus'[86] has become the primary patient while the pregnant woman is treated as the secondary patient (for e.g., see Black, 1992a; Duden, 1993; Harris et al., 2004; Layne, 2003; Lupton, 2013; Mitchell and Georges, 1997; Oakley, 1984; Petchesky, 1987; Price, 2003; Taylor, 1998; Thompson, 2005). In the Indian context, anthropological research on ultrasound imaging has been largely limited to the topics of foetal sex determination, sex-selective abortion, and female foeticide in rural settings (for e.g., see Patel, 2007a, 2007b; Unnithan-Kumar, 2010, 2004). There is an absence of empirical research on how doctors enact foetal (or embryonic) personhood using ultrasound imaging in assisted conception among middle-class Indians.

The enactment of foetal personhood via ultrasound scanning and the ensuing maternal-foetal bonding, however, needs to be understood as a context specific process. For instance, Unnithan-Kumar's study (2010) in Rajasthan shows that there is a lack of emotional engagement of lower-class pregnant women with foetal images. She argues that this is primarily due to the lack of communication between the sonologist and the pregnant woman. Unlike in my study where Dr. Sen had an LCD screen especially placed for the women to see the foetus/baby during the ultrasound scan, Unnithan-Kumar observed that the computer monitor was not even turned towards the Rajasthani women and, thus, they did not get to see any images at all. And even if they did, Unnithan-Kumar writes that the women failed to understand or recognise what it is that they were supposed to be seeing. She further explains that the sonologist provided the women with two pieces of information – whether everything was okay and less directly, whether the women were getting a wished-for boy. As such, the pleasure involved in seeing the forthcoming baby and the opportunity to socialise with it as

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[86] In her book, *Icons of Life* (2009), Lynn Morgan dismantles the assumption that there is such a thing as *the* embryo or *the* foetus. Morgan's research shows that the contemporary understanding of the terms 'embryo', 'foetus' and 'baby' are conceptualised in a particular hegemonic and medicalised discourse – the origins of which Morgan traces back to the Carnegie Human Embryo Collection project in Washington in the early twentieth century where thousands of human embryos and foetal specimens were collected, "anonymised, detached from patient histories, rendered impersonal, and incorporated into the authoritative regime of science" (ibid., p. 46). The embryological view of human development, claims Morgan, is not based on any belief or ideology, but simply rests on the "knowledge" produced by the embryologists. As such, she argues that what is referred to as an "embryo" or a "foetus" is a social construct and it is not "a stable ontological thing" and there is "…a recent, tenuous, and ever-shifting social consensus about the meanings we are willing (though not without controversy) to ascribe" to this entity (ibid., p. 94).

documented in studies in the western countries, or even in my study, was not a part of the ultrasound practices in Unnithan-Kumar's study. Instead, for the women in Rajasthan, their emotions were intertwined with the foetal sex, as knowing that it was a boy, alleviated the moral dilemma of aborting an unwanted female child. Unnithan-Kumar suggests that the use of the ultrasound technology in rural India instead of promoting maternal bonding with the baby is seen to be offering the women with some peace of mind as it is seen to fix' the label of abnormality attached to the conception of girls.

In contrast to Unnithan-Kumar's research, the enactment of foetal personhood via ultrasound imaging for the female interlocutors in my study who had experienced reproductive loss was related to them having a normal baby and to ascertain that their pregnancy would result in a positive outcome – reasons which were more important for them than knowing the baby's sex. And it was the enactment of foetal personhood by the practitioners using the ultrasound technology that significantly contributed to the pregnant women's enactment of the same. The ultrasound images, foetal heartbeat sounds, diagnostic practices, and other reproductive technologies act(ed) to configure and attribute meaning to the unborn child in diverse ways. Consider the following interaction depicting the ultrasound scan being performed by Dr. Sen at clinic B on a woman who was in the 27th week of her IVF-pregnancy. Throughout the conversation, he addressed the foetus without revealing its sex. (In the Bengali language, it is possible to speak of a person without referring to a particular sex.)

> Dr. Sen (Dr.): Oh, it is not easy to do the scan. Your baby keeps moving constantly! You better start going to the gym and become more fit. You will have to run after this little one all day long! *laughed*
>
> Patient (P): Yes Dr. Sen, I am happy to do all the running around. As you know, it has been a long wait for me and my family.
>
> Dr.: Yes, I know, I know. You do not have to be sad any longer. Your happiness will be in your arms very soon. Look, look here. Can you see how fast your baby is moving the two legs? *laughed* Oh God! This baby of yours will be mischievous, I can see it already! It looks like it is going to be a football player or a dancer! *laughed*
>
> P: If I am tired of running around, I will bring it to you. *smiled*
>
> Dr.: *laughed loudly* Of course, I am always happy to see these naughty ones I have created with my very own hands. You will see, they will not do any mischief around me! *looked at me* Honestly! I find it so strange. When the parents bring their children here, they sit quietly in my lap and do not make any mischief. The parents are also surprised to see that the same child who creates a ruckus at home, is sitting here without making a single sound!"
>
> Dr. Sen looked at me and said with a beaming smile on his face,

> "The child will think who is this strange man whose lap I am sitting on? If only it knew that this is the same strange man who has created me!"

The scan ended with the woman asking Dr. Sen if everything was normal with her baby to which he assured her that she had nothing to worry about.

This dialogue reveals the way in which Dr. Sen attributed personhood to the foetus by speaking of the image in a way which not only included showing the woman foetal movement as a sign of the baby's normalcy but also by suggesting that her baby already reflects certain physical characteristics which indicates a possible future profession. Such an enactment of foetal personhood, writes Mitchell (2001, p. 118), is regularly performed by practitioners to encourage the pregnant woman to bond with an allegedly sentient and acting baby with humanlike features and traits. In such an enactment, Dr. Sen ascribes agency to the foetus by describing it as a person who is actively not allowing him to conduct the scan properly. Thus, the ultrasound technology was being used not only as a tool for increased medical surveillance and for encouraging mother-child bonding but also for enacting foetal personhood wherein the foetus was established as a separate entity who is a person in its own right and who apparently displays a human personality with distinctive qualities. The accomplishment of foetal personhood is, therefore, achieved in this biomedical space through the interactions between the human actors (doctor, pregnant woman, nurse) and the non-human actants (ultrasound monitor, probe, ultrasound gel, the foetus[87], and so on). It is the technology of ultrasound imaging which, indeed, facilitates the visibility of the foetus by bringing the unborn entity into existence. However, this very enactment of foetal or embryonic personhood and maternal bonding is not acknowledged by the practitioners if and when the women experience reproductive loss as I will show later in this chapter and also in chapter five.

The enactment of foetal personhood in biomedical sites using the visualising technology of ultrasound is in stark contrast to the anthropological understandings of personhood or what it means to be a person. The question of how personhood is ascribed and how one becomes a social person is not a novel one. Anthropologists have been interested in the social ascription of personhood since Marcel Mauss' pioneering work in the 1970s on the idea of the 'person' which he understood as unstable and in flux (Christoffersen-Deb, 2012, p. 577). A wide range of anthropological studies have documented that personhood is not an inherent attribute or

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[87] See Casper (1994) for a discussion on the foetus as a non-human actant with agency.

that it does not emerge as an automatic status. It is rather a social project which is constructed varying greatly over time, between different stages of a life cycle, and within and across cultures (for e.g., see Alex, 2016; Christoffersen-Deb, 2012; Conklin and Morgan, 1996; Daniels, 1984 in Beckmann, 2018; Davis-Floyd, 1994; Ginsburg and Rapp, 1995; Kaufman and Morgan, 2005; Lamb, 2000; Layne, 2003; Mitchell, 2001; Morgan, 1996, 2009; Scheper-Hughes, 1985, 1992; Polit, 2006, 2016; Rapp, 1999). For instance, Conklin and Morgan (1996, p. 674) have observed that among the Wari of Amazonian Brazil, Wari personhood is, "acquired gradually and incrementally as an individual interacts with other people and incorporates their bodily fluids". Unlike the Wari who enact the body and personhood as social entities, the understanding of body in the North American biomedical setting is purely material, as it is nature and not culture which endows the "precultural material body with the features that make it a person", argue Conklin and Morgan (1996, p. 687). In her study in rural West Bengal, Lamb (2000, p. 13) has shown that her interlocutors experienced their personhood through social ties and that they understood their bodies as including "wider processes and substances than those directly tangible or limited to their own bodily boundaries". Another example is of Polit's (2016) study in Chamoli where she notes that a child's first steps into attaining personhood (and social agency) are made possible through rituals which give him or her social identity, such as naming the child which gives the child official recognition as a member of the father's lineage.

In contrast to such a processual and relational understanding of personhood, the discursive meanings attached to foetal personhood within the realm of biomedicalised reproduction tend to coalesce around individualism, biology, and technology (Mitchell, 2001, p. 8). Foetal personhood, thus, gets defined on the basis of physical features, such as the number of cells, morphological completeness, chromosomal composition, and bodily functioning and temporal events such as conception, first trimester, twenty weeks, and birth (ibid.). And the most compelling evidence for evaluating and categorising these aspects comes from the biomedical practices, technologies (particularly ultrasound imaging), and discourses of medical science (ibid.). As Lupton (2013, p. 2) also notes, in cultures were biomedical understandings of the unborn are predominant, the meanings associated with the unborn entities have become more rigid and less ambiguous. Indeed, as I have shown in this section, ultrasound images are used by medical practitioners to ascribe personhood to the foetus by seeing and showing the pregnant woman her baby, while describing it by pointing out humanlike features (usually tiny hands and feet) and gestures like sleeping. The ultrasound images, foetal heartbeat sounds, diagnostic practices, and reproductive technologies, hence, act to configure and attribute meaning to the unborn child in diverse ways.

Despite its ubiquitous acceptance as the *sine qua non* for pregnancy in modern-day biomedicine, ultrasound technology has been widely critiqued in various feminist and anthropological studies insofar as it leads to a technocratic takeover of pregnancy and childbirth resulting in an increased surveillance and biomedicalisation of the pregnant body (see Davis-Floyd, 1994). Studies have also shown that ultrasound scanning gives the foetus a distinct identity at very early stages of gestation, enables a separation of the foetus and woman, privileges foetal health over the woman's health, and ultimately replaces women's embodied experiences with technological monitoring (Gammeltoft, 2007, p. 135). However, Gammeltoft argues that such critique has been largely speculative and was primarily based on the researchers' presumptions and political agendas instead of being based on empirical data which prioritises women's lived experiences of pregnancy and childbirth. As such, some anthropological studies conducted in Greece, Australia, Canada, and the United States have explored how women subjectively experience ultrasound scans (for e.g., see Georges, 1996, Harris et al., 2004; Mitchell, 2001; Taylor, 1998 cited in Gammeltoft, 2007, p. 135; see also Petchesky, 1987). These studies have shown that far from feeling victimised, women frequently expressed a sense of elation and direct participation in the imaging process and visualising the foetus not only created a feeling of intimacy and belonging but also offered a reassuring sense of predictability and control. As we have seen in the conversation earlier in this section (p. 117), the pregnant woman's primary concern was to have a normal baby. In her case, as with the other female interlocutors in my study who underwent ultrasound scans after a treatment-induced pregnancy, the sex of the child was never brought into question.

While the topic women's interactions with ultrasound imaging has been fairly studied in the western context, it has received scant anthropological attention in the Indian context (for exception, see Unnithan-Kumar, 2010, 2004). More specifically, Indian women's engagement with the ultrasound technology after having experienced reproductive loss and then having achieved pregnancy via assisted conception has not been explored at all. As such, in the following section I describe the case of one such female interlocutor who experienced a miscarriage, had 'failed' treatment cycles, and then finally conceived via IVF. Like many other female interlocutors, I show how she voluntarily engaged with the ultrasound process as a way of gaining knowledge about the desired baby's health and also to acquire a sense of control over their pregnancy. It is, indeed, in examining the lived experiences of women's engagement with reproductive technologies and in understanding the ways in which they submit their bodies to the clinical gaze (Foucault, [1973]2012) that I examine how women utilise forms of constrained, reproductive, and medicalised agency (Morgan, 1998)[88].

3.3.2. "I am happy to have regular ultrasound tests": Women's (Voluntary) Participation in Ultrasound Imaging

I met Khushi and her husband Raj for the first time in the waiting area of infertility clinic A. As I engaged in a conversation with the couple, I discovered that Khushi was six months pregnant and she had an ultrasound appointment scheduled that day. While we were talking, Khushi's name was announced by the receptionist so she and I headed to the ultrasound room. When we entered, the ultrasound clinician's assistant told us to wait behind the curtain as the earlier patient was still inside. Khushi took out a thin book from her purse and started reading it softly but fervently. On taking a closer look, I realised she was reading the *Hanumāna Chālīsā*[89]. With a quick glance towards me, Khushi told me that chanting these hymns before her check-ups gave her mental strength. She then touched her abdomen gently and added that she would not feel at peace until she found out that everything was normal with her baby. I wished her good luck after which she returned to her prayer book and resumed chanting the verses. The space where Khushi and I were waiting was separated by a green curtain from the room where the ultrasound scan was going to be performed. Regardless, the conversation between the people inside that room was audible to us. I heard the clinician telling the woman that everything was fine with her pregnancy and instead of worrying too much, she should start eating healthier food as she was now eating for two people. The curtain was then pulled back by the assistant and the previous patient walked out.

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[88] Medicalised agency is the process by which "individual members of the culture internalise, use, actively support, and demand the use of medicalising concepts, discourse and practices and when they not only comply with but seek active involvement in medical technologies claiming medical discourse and vocabularies as their own" (Morgan, 1998, p. 96).

[89] The *Hanumāna Chālīsā* is a prayer book about the Hindu God Hanuman, the monkey God. Revered as the remover of problems, he is feared by death and is regarded as the most popular guardian of the Hindu deities.

After greeting the clinician with a *namaste*, Khushi placed herself on the bed. The assistant came forward and without saying anything to Khushi, pushed her sari a couple of inches below the navel. The clinician then told the assistant to bring in the patient's husband so that he could also see the scan. I wondered why the husband was being called inside the room considering that women undergoing the scan were usually unaccompanied. Once the husband arrived, the clinician started the procedure. Without saying anything, he applied ultrasound gel on Khushi's lower abdomen and started moving the transducer over it. I noticed that Khushi was constantly murmuring (which from what I could vaguely comprehend seemed like religious chants) and looking anxiously at the clinician while intermittently craning her neck to look at the ultrasound monitor. The assistant told Khushi to stay still so that the scan could be done properly. The clinician continued looking at the monitor for a couple of minutes without uttering a word. There was pin drop silence in the room when a whooshing sound emerged from the ultrasound machine. With a long drawn breath and a "hmmm", he told Khushi to slowly turn on her right side. Immediately, she started crying and with a quivering voice asked whether there was some problem with her baby, to which the clinician said,

> "Oh! Why are you crying suddenly? Didn't you hear the heartbeat? Listen, hear that? [referring to the whooshing sound] It's fine. I just need to be sure, that's all. Everything is fine. Relax and take deep breaths. I just want to check. Why do you become so nervous? Relax, relax."
>
> The assistant leaned towards me and whispered,
>
> "She always starts crying. Everything is fine but she keeps crying. That's why we call her husband whenever he comes with her so that if she gets worse, then he can take care of her. We have few patients like her who cry all the time."
>
> When the clinician had not said anything for a few more minutes, Khushi asked,
>
> "Why did you ask me to turn on my side, sir? Is there anything wrong with my baby? What is happening? Is my baby okay? Please tell me. Please sir, let me see my baby once."
>
> Raj at this point gently told Khushi to let the doctor do his job peacefully and asked her to stop crying. The clinician turned the screen towards Khushi and said,
>
> "Okay, you first need to stop crying. Look here (pointed his finger to the screen). You see here? See that's your baby. Why are you crying unnecessarily? If you keep crying like this and feel so nervous, how will I focus and do my job? Look, it seems to be sleeping peacefully. See, your baby is so calm and you are behaving like this, crying needlessly. Can you see? *pointed with fingers and traced the fingers on the "baby's" body parts* That's the head, those are the arms, the right arm seems to be tucked under his chin and that's the stomach. See, everything is absolutely fine! You get tensed without any reason! Don't worry so much, it's not good for your baby's health! Stay happy, eat good food, watch good things. Don't watch the dramatic soap operas *laughed* and just relax. Don't spend your entire day worrying about this. Your baby is completely normal. Okay? Happy? *Khushi nodded* Come, get up, I am done."

Raj stepped forward to help Khushi get up from the bed and the assistant handed over tissues so that she could wipe her abdomen. The clinician informed the couple that there was nothing of concern and that their baby was "absolutely healthy and normal". He further told Raj to take care of Khushi and to remind her that she should not worry excessively and unnecessarily. Once again Khushi asked the clinician whether he had really seen that everything was alright. He smiled and told her to stop worrying as her stress would affect the baby's health. He then told his assistant to bring in the next patient.

While Khushi was adjusting her sari before leaving the room, Raj softly said to me,

> "Actually, we are both very scared. She's crying because of our last time. We had a mishap in the fifth month. So this time we are both very nervous. Khushi is more nervous than me, but that's natural."

Once the couple left the room, the clinician said to me,

> "See this is why I told the husband to stay here. This patient panics a lot. Everything is fine but still she keeps on crying. It's difficult to handle such patients. Some women cry too much, unnecessarily. If I am telling them that there's no reason to worry, then they shouldn't be crying like this. When they start crying a lot, then I ask the husband to take care of them. Having the husband in the room helps them. Otherwise I don't allow anybody else."

In my interview with Khushi a few days later, I learnt that after her miscarriage in the second trimester, she had conceived with the second IVF cycle. On asking her whether the doctor had informed her about how many ultrasound scans she would have, she said,

> "No, we have not been told about the exact number but so far I have had five. When we met in the clinic, that was my fifth ultrasound appointment. I'm not sure how many more scans I will have. The next one is scheduled at the end of the next month. Actually, I think it's better that we have monthly ultrasound appointments. That would be the best. I will be mentally at peace knowing that everything is fine with our baby. I would definitely want to know how our baby is growing and that everything is normal. We have already gone through a very bad time once, so we do not wish to take any risk this time. Whatever Dr. Ganguly [infertility specialist] says is best for the baby, I will do that."

During Khushi's ultrasound appointment, the images were used by the clinician not only to confirm the viability of her pregnancy but to also indicate the 'realness of her baby by showing her the foetal movements and by making her hear the foetal heartbeat. In doing so, the clinician enacted the foetus as a person who was apparently calm, unlike Khushi herself. Visual and aural elements were deployed by the clinician while performing the scan to incarnate foetal personhood – elements whose recognition by the pregnant woman as well is often seen as an expression of good mothering (Howes-Mischel, 2016). Moreover, Khushi's anxiety and nervousness about something being wrong with her baby is reflective of what Layne (2003, p.

173) describes as the loss of innocence and naivety related to the notion that pregnancy and childbirth is a linear process. Layne (2003, p. 198) writes that when occurrences of seemingly normal events of pregnancy end in loss, the "virtue of innocence and confidence in the adequacy of one's own understanding of the world" is challenged. Thus, women who have experienced reproductive loss (at least) once are significantly more nervous during another pregnancy as their understanding of a seemingly normal event is challenged and they now have the knowledge that pregnancy does not necessarily result in the birth of a healthy or normal child (Layne, 2003; Petchesky, 1987). Additionally, it has been observed in studies on pregnancy loss that women who have experienced loss fear the failure of another subsequent loss (Van and Meleis, 2003, p. 34). As one infertility specialist pointed out:

> "Once patients have lost their first baby after their first treatment cycle, they begin come for increased consultations, they want continuous medical supervision by my staff even more diligently than before as a way to cope with the loss suffered from the earlier treatment failure and to also make another attempt at a positive pregnancy outcome. They start to rethink pregnancy in a way which distances it from the idea that pregnancy and childbirth are normal events wherein any woman can conceive and give birth without any complications and they actually start to perceive it as a risky phenomenon."

Another female interlocutor, Kanika, who had given birth to twins after having conceived from the fourth IVF cycle which was preceded by a perinatal death at 26 weeks, also said that she had undergone an ultrasound scan each month to ensure that her babies were normal. Below is an excerpt of my dialogue with Kanika where she speaks of her insistence on undergoing more ultrasound scans in the last month of her pregnancy as she was scared that "the worst would happen again":

> Ethnographer (E): I was told by an ultrasound clinician that four ultrasounds in a pregnancy are enough. But you said you had one scan each month?
>
> Kanika (K): In the last few weeks before my delivery date, I was so scared that something bad would happen that I went to Dr. Ganguly for a scan twice. I needed that satisfaction in my heart that everything was fine. I could not have handled another mishap. I had no energy in my body left to try again. My husband used to say that I had gone mad because I was bothering Dr. Ganguly all the time but I didn't care. I was worried constantly that something would go wrong. I was having sleepless nights. I could hardly eat but I forced myself because I knew that I had to eat properly for my children. My mind would only have negative thoughts. I was constantly scared! See even when I remember that time now, it gives me goose bumps! *showed me her arms*
>
> E: Hmmm, I understand. It must have been a very difficult time for you…So, Dr. Ganguly told you to have a scan each week at the end?
>
> K: No, nothing like that. Actually, I would call him or Nurse Shanti all the time. Even if it was a minor problem, I would call one of them. I couldn't stop thinking that the worst would happen again. I insisted to Dr. Ganguly that, sir, please do a scan each week in the last month of my pregnancy. He said that it

> would be foolish to do an ultrasound weekly and nobody does that. But I insisted a lot! I was begging him because I wanted to know that my babies were fine. Actually, in the end, the babies weren't moving much so I was scared a lot. So I had two scans in the last month. After the ultrasound, Dr. Ganguly told me that the babies had become big so there wasn't much space for them to move. It was only when he showed me the photo of my babies sleeping calmly that I took a sigh of relief.
>
> E: That's good to know. I am happy that everything went well finally…But how did you know that your babies were sleeping?
>
> K: He [Dr. Ganguly] showed them to me. He made me hear their heartbeats and since there wasn't any other movement, he told me they were sleeping peacefully *smiled* I was so relieved! I felt like I could breathe again!

When I had asked the medical practitioners at the infertility clinics about the number of ultrasound scans for a pregnant woman, I was given a unanimous response that there are four mandatory ultrasound scans. The first which is known as Dating scan is conducted in the first trimester in the sixth or seventh week to check for foetal heartbeat. This is followed by the second scan in the early stages of the second trimester known as the Chromosomal scan (also known as the First Trimester scan) between 12 to 14 weeks to detect any chromosomal foetal abnormality. The third is the Anatomy scan that is conducted in the second trimester between 20 to 22 weeks to check whether all the foetal organs are normal. The final ultrasound scan is called the Growth scan and it is performed in the third trimester between 28 to 32 weeks which is roughly a few weeks before the scheduled date of delivery. However, a caveat was stated by the practitioners that for women who had conceived using infertility treatments, especially in cases of IVF pregnancies, an increased number of ultrasound scans were performed as these were considered to be "high-risk pregnancies" that could potentially result in miscarriages, especially with older women. So, instead of the mandated number of ultrasound scans, women with IVF pregnancies, reportedly underwent as many as 10 to 12 scans, which is more than the double the number of scans in 'normal' pregnancies. As we can see from Kanika's statements above, she was more than pleased to participate in the multiple ultrasound scans and did not question the need for them given that her primary concern was to avoid another occurrence of reproductive loss.

Cussins (1998, p. 167) states that studies in medical sociology and feminist studies tend to portray the female patient availing reproductive technologies as "paradigmatic of the objectified patient, supposed either to be helpless and saved by technologies, or to be victimised by them". For such presumably helpless women, the technologies and predominantly male physicians come forward as saviours, without whom the women would be unable to fulfil the normative role of becoming a mother (ibid., p. 167). She argues that as a victim, the woman who seeks medical intervention to become pregnant is turned into an object of study whose body then becomes a site of medical experiments and the woman is "reduced to a mere physical presence in the name of procedures that rarely work" (ibid.). She further argues that in such a representation of the childless woman as helpless and/or a passive victim, the woman is attributed no active agency and thus, all the values and virtues, as well as the criticism accrues to the doctors and the technology . As such, the woman is seen as a person who has no choice, or no voice, in the shaping and application of the reproductive technologies. Such a woman, Cussins remarks, is then seen as "at best as someone who happens to benefit from her objectification in the clinic by being one of the lucky ones to get pregnant" (ibid.). Contrary to this monolithic representation of the female patient who lacks agency, Cussins claims that as an objectified user, the woman is neither helpless nor a victim. Rather, she suggests that "the woman's objectification, naturalization, and bureaucratization involve her active participation, and are managed by herself as crucially as by the practitioners, procedures, and instruments" (ibid.).

Similar arguments have been made by Sawicki (1991, p. 85) who has also observed that in engaging with reproductive technologies, not only do women become the focus of medical surveillance and being disciplined but they simultaneously police their own bodies and adopt a clinical gaze. In this regard, Shaw (2016, p. 52) has argued that women's engagement with disciplining biomedical technologies and practices can be viewed as empowering instead of seeing the women as passive dupes or oppressed victims. Following the arguments of these scholars, I, too, do not see Khushi, Kanika, and the other female interlocutors in my study merely as helpless and passive victims who have no role to play in the process of ultrasound imaging. Instead, by allowing the doctor to perform the ultrasound scans frequently, they enabled the enactment of the reproductive technology on their bodies and in the process, oriented themselves as objects of study and medical intervention. Indeed, these women enacted their patient-status by willingly submitting to the clinical gaze to achieve reproductive success and it is in doing so, that they utilised forms of reproductive and medicalised agency.

Furthermore, Gammeltoft (2007, p. 142) notes that the use of ultrasound scanning during pregnancy is celebrated in popular discourse as a modern, safe, and advanced form of medical care even though the vast majority of women in her study in Vietnam expressed considerable uncertainty regarding the safety of ultrasound testing. This was in contrast to the female interlocutors in my study who did not raise the issue of safety when they spoke of the multiple ultrasounds they were willingly undergoing. Similar to the interlocutors of other studies, such as Layne's (2001) study in the United States and Harris et al.'s (2004) study in Australia, my female interlocutors, as we have seen in Khushi and Kanika's case, did not voice any concerns or scepticism about undergoing multiple ultrasound scans. In Kanika's case, she was actually the one who insisted on having two scans in her last month of pregnancy. For women who had a history of reproductive loss and who had then conceived (sometimes after several attempts) via assisted conception, their eagerness to participate in regular ultrasound scans was, indeed, related to their foremost concern of avoiding any potential risk to the 'normal' growth and health of their baby. Having the knowledge of having seen images of their baby and hearing their baby's heartbeat gave them a sense of reassurance they needed in order to alleviate their anxieties. The control that women sought over the reproductive process, a process which had been disrupted (several times) earlier, was, therefore, offered by the promise of knowledge and in this sense, the technologies were instrumental in allowing women to gain this knowledge by seeing, hearing, and knowing (see Franklin, 1997, p. 151).

As such, women had faith in and a positive response to the practitioner's performance of the ultrasound imaging which acted as "a window on a womb" (Zechmeister, 2001, p. 391) and that in turn, considerably facilitated their enactment of foetal personhood. Khushi, Kanika, and other women in similar situations certainly responded positively when the practitioner performing the ultrasound addressed the foetus as a baby. However, in the following section, I show that reproductive technologies can also contribute to women's experience of reproductive loss by augmenting their sense of loss of *what* they have lost. In order to make this argument, I turn my attention from foetal personhood to embryonic personhood – an attribution of personhood which has been made possible by the development in the field of embryology and related technoscientific advancements. I show that while a female interlocutor wants to grieve for the loss of her 'babies' after a failed embryo transfer, she is not accorded the same acknowledgment by the practitioners. In this regard, Layne (2003, p. 89) notes that it is "striking that the impact of sonogram images on those whose pregnancies end without a live birth has either been ignored or viewed as less important".

3.4. The Enactment of Embryonic Personhood: Reproductive Loss Amplified

On a December morning, Latika was scheduled for an embryo transfer (ET) for her first IVF cycle following three unsuccessful IUI cycles. After putting on the required outfit (i.e. scrubs, surgical mask, and surgical cap) , I went inside the Operation Theatre (OT, see Fig. 12).

Fig.12. Operation Theatre, Infertility clinic C

I saw that the embryologist, Dr. Bose, and the head nurse were already present. As Dr. Bose and I started a conversation, we walked towards the embryology lab (see Fig. 13) which was adjacent to the OT.

Fig. 13. Embryology Lab, Infertility clinic C

I asked if I could take a look at the embryos before the procedure started and my request was granted. As I was looking through the microscope, I was told by Dr. Bose that of the three embryos which looked like miniscule circular globules , one of them was a blastocyst which referred to a mature embryo as compared to the others. The chances of conception with a blastocyst embryo, she informed me, are relatively higher. I then asked Dr. Bose about the protocol of how many embryos can be transferred at a time, to which she said:

> "Well, the protocol is to transfer two embryos maximum. Actually, doctors in most western countries are now pushing for a single embryo transfer. But if a woman is older, then it's best not to waste time. Whenever we see that a woman is in her late thirties or older, then we prefer to do multiple embryo transfer. It also depends on the embryo's quality. See, the older the woman gets, the quality of her eggs keeps deteriorating, in which case the embryo's quality also gets affected. You might know this already, but basically we grade the embryos – I, II, III, and IV[90]. It is actually rare to have all Grade I embryos. Usually, we transfer Grade II or sometimes, a mixture of II and III. It ultimately depends on the quality of the eggs and sperm. In Latika's case, I do not have a Grade I embryo. Right now I have one Grade II and two Grade III embryos. We had retrieved seven eggs from her so the rest of the eggs are frozen if we need to make embryos again for a second IVF. See, multiple embryos can result in multiple pregnancies and that can be risky, especially with older women. But like I said, the older a woman gets, the more desperate she becomes to have a child. So, we try to increase the success rate from the beginning. If one pregnancy needs to be removed later by foetal reduction[91], then that can be done easily in the first few weeks. In fact, we encourage our patients to not have three pregnancies at a time. Ultimately, the patients want faster results and we just want to do what's best for them."
>
> As Dr. Bose was explaining, the infertility specialist, Dr. Chatterjee, walked into the room and the following conversation ensued between her and Dr. Bose:
>
> Dr. Chatterjee (Dr. C): So, how are things looking? Any good ones?
>
> Dr. Bose (Dr. B): One of them looks good. Grade II, blastocyst. It looks quite promising. I am not happy with the other two [embryos]. They don't look that good.
>
> Dr. C: Okay, let's see what happens. But you are certain about the blastocyst?
>
> Dr. B: Yes, absolutely. I checked twice. I was happy with it. Come, see for yourself.
>
> After looking through the microscope for a few seconds, Dr. Chatterjee said,
>
> Dr. C: Oh yes, one of them looks very beautiful[92]! In this case, I think it would be better if I transfer two instead of three. I don't want it to get risky.

---

[90] The pioneers of IVF, Robert Edwards and embryologist Jennifer Hartshorne (1991), wrote that it is on examining the magnified images of the embryos, or what is called the "visual assessment of embryo morphology", that the embryos would be graded according to how well they were fragmented and so on. This grading process is dependent on looking at embryos under a microscope. Developed by The Society for Assisted Reproductive Technology (SART) in 2006, the current embryo grading system are "good", "fair", and "poor" (Hossain et al., 2016, p. 141). The ESHRE is working to develop a unifying grading method in order to select the one or two best embryos in the interest of transferring fewer embryos with the aim to assess embryos based on their viability and implantation potential so that relatively lower quality embryos can be avoided from being transferred (ibid., p. 141-142).

[91] I was informed that for IVF-pregnancies, the higher the number of foetuses, the higher the risk for the woman and the foetuses. Yet, three embryos were frequently transferred to achieve a "success rate" or a "good-enough" pregnancy rate in the infertility clinics, especially in the case of women who were in their late thirties and above.

[92] Dr. Chatterjee referred to the blastocyst embryo as *khūb shundōr* which literally means very beautiful. Shaw (2016, p. 216) notes that in the laboratory, embryos are often labelled as "beautiful" when they display 'ideal'

> Dr. B: Hmmm, you might be right. You decide, I am leaving it on you.
>
> Dr. C: Well, I think it's best to transfer two. She's not old so she can try again if this cycle doesn't work, isn't it?
>
> Dr. B: True, you are right. Okay, let's go ahead with two then[93].

During the ongoing exchange between the two doctors, Latika was brought into the OT by the head nurse. In a green gown which was loosely tied at the back and with a loosely fitted head cap, Latika was told by the nurse to lie down on the surgical bed. Once she was on the bed, the nurse told Latika to place her legs on the stirrups after which her feet were strapped on the stirrups with Velcro straps. The nurse covered Latika's body with a green sheet, wrapped her legs with individual pieces of green cloth, and kept her vaginal canal exposed. The nurse took Latika's hands and placed it on either side of her head while telling her to stay absolutely still during the procedure. Unlike during the procedure of egg retrieval which was deemed rather painful and could often be a lengthy procedure, women were not sedated with general anaesthesia during ET.

I stood a couple of steps behind Dr. Chatterjee while she placed herself on a stool in front of Latika's exposed region. On Dr. Chatterjee's right hand was the metal table on which the surgical tools had been placed beforehand. Latika was then told by Dr. Chatterjee to slide her body down a little at which point the nurse dimmed the lights and switched on a bright light which focused on Latika's vagina. The nurse stood next to Latika, squirted some ultrasound gel on her abdomen, and rubbed it around with the ultrasound transducer. Meanwhile, Dr. Chatterjee used a cotton swab to clean the vaginal opening following which she inserted a speculum inside to check if there was any obstruction or blood in the cervix. She used forceps to hold a gauze soaked in sterile water which she used to remove any vaginal mucus. When Dr. Chatterjee was sterilising the vagina, I could see that Latika had shut her eyes, scrunched up her face, and let out a soft whimper. Dr. Chatterjee then performed a transvaginal ultrasound to check Latika's pelvic organs, specifically the urinary bladder. On seeing that the bladder was partially full, Dr. Chatterjee uttered a loud sigh and the following dialogue ensued:

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morphology, characteristics which contribute to their viability. Such adjectives might also indicate the life potential of the embryos (ibid).

[93] In my interview with Latika later, I found out that although she had been informed prior to the ET that three embryos would be transferred in her uterus, she had not been informed about the doctors' spontaneous change in decision to transfer two instead of three embryos until after the procedure.

> Dr. Chatterjee: “What is this? Can you see this? How am I supposed to do this now? How many times do I have to tell you that make sure the patient does not go to the toilet before the procedure?”[94]
>
> Nurse (feebly): “Ma’am, I must not have been in the room when she went to the toilet. Should I bring water for her to drink now?”
>
> Dr. Chatterjee (irritated): “No need. You should have checked on her before. I am not going to wait here while you make her drink water. I have other patients waiting.”

Subsequently, Dr. Chatterjee picked up the catheter from the table of tools and curved the tip. She pushed the catheter through the vagina as she looked at the monitor to guide her hands in order to ensure that she was entering correctly and to determine where she had to stop and this led to Latika shrieking in pain. Dr. Chatterjee pulled the catheter out and mumbled, “This is not going in smoothly”. She curved the catheter’s tip more and inserted it once more. Latika shrieked again and the catheter was extracted. Dr. Chatterjee then told Latika, “Please don’t shout like this. I am not hurting you intentionally, right? Try to be still, take deep breaths, I need to try again.” Finally, on Dr. Chatterjee’s third attempt, the catheter went through the vagina, cervix, and into the uterus. This made Dr. Chatterjee sigh in relief and she immediately shouted, “Ready! Come!”. While announcing her entry, Dr. Bose walked into the room cautiously with a catheter which had the embryos on it[95]. Dr. Chatterjee took that catheter and pushed it inside the other catheter. In a motion which resembled a syringe being pushed, the embryos had been pushed inside the uterus within seconds. Dr. Bose rushed back to the embryology lab to check under the microscope whether all embryos had been successfully transferred. As Dr. Chatterjee was taking out the other catheter followed by checking the cervix once again, Dr. Bose loudly announced from the lab, “All clear!”. That was the confirmation of the pivotal moment that the embryos had been successfully transferred – a moment which could potentially result in a conception in the following two weeks. Except for Latika, all of us in the OT could suddenly see two white dots floating on the computer monitor. At that point, Dr. Chatterjee turned the monitor towards Latika:

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[94] The ET procedure is supposed to be conducted after the patient has a full urinary bladder in order to have a better visualisation of the uterus. Scholars have explained that the medical requirement of having a full bladder before infertility-related procedures shows how the female patient-body is ‘prepared’ for the clinical gaze even before she enters the OT (Franklin, 1997; Shaw, 2016).

[95] While the infertility specialist prepared the patients’ vaginal canal for the transfer, the embryologist simultaneously prepared the embryos in the lab by carefully aspirating the embryos into a catheter from a petri dish. The latter process needs to be performed with utmost care to avoid causing future complications, thereby acknowledging the fragility and the importance of the embryos (see also Shaw, 2016, p. 215).

> Dr. Chatterjee: “Can you see? *pointed at the white dots with her fingers* There, can you see these two white dots? Those are your two babies. What do you want? Boy or girl?
>
> Latika: *in a soft voice* Whatever God wants. I just want them to be healthy.
>
> Dr. Chatterjee: Good, that’s the spirit! Now you pray to God and we all will also pray for you. Stay positive. Okay? Tell Santa Claus that this would be your best Christmas gift! *laughed – other practitioners laughed as well* All the best!”

As Dr. Chatterjee removed her surgical gloves and proceeded downstairs to attend to the other patients, the head nurse removed the Velcro straps and the cloth from Latika’s legs, covered her up with a sheet, and pushed her bed along with a male nurse (who had been called inside the room) towards the recovery ward. From the time Latika was brought into the room, till she was taken out, nearly thirty minutes had passed. As per the clinic’s protocol, she would be kept under observation for a few hours and then be discharged.

That same evening, after the day’s events had ended at the clinic, the embryologist, Dr. Bose and I were having a chat while sipping tea. As we were talking, the OT’s head nurse came inside to ask whether Latika could be discharged. Dr. Bose told the nurse to first call Latika’s husband so that he could drive her home and then bring Latika to the room where we were sitting. A quarter of an hour later, a little unsteady on her feet, Latika walked in the room, while holding on to the nurse. Dr. Bose asked her to take a seat till her husband arrived and asked how she was doing. Latika responded saying that she was feeling some pain but nothing that she could not tolerate. She was told by Dr. Bose that the pain would subside shortly. She was further told that she should avoid lifting anything heavy for the next two weeks and get as much bed rest as possible. Latika was then instructed to take a home-pregnancy test after the two weeks and an HcG blood test to confirm her pregnancy. She was supposed to accordingly inform the clinic about the result and if it was positive, she was told to schedule an appointment in four to six week for a TVS to detect the “baby’s” heartbeat.

A few weeks later, I learnt from Dr. Bose that Latika’s tests had shown that the implantation of the embryos had failed. The following excerpt is from the consultation that between Latika and the infertility specialist, Dr. Chatterjee, some days after the negative test results:

> Dr. Chatterjee: I’m really sorry. Both Dr. Bose and I were quite hopeful that at least one of the embryos would implant but these things are so uncertain.
>
> Latika: *weeping* Dr. Chatterjee, you told me that the transfer went well. Then why did this happen? Did I do something wrong?

> Dr.: It did go well. I showed you the embryos, isn't it? *Latika nodded* But there is nothing anybody can do about the implantation. I'm sure you didn't do anything wrong. And see, I can only transfer the embryos. You are young, you should try again. You should see this as a positive thing. It would have been much more painful for you if there was a problem in the later stage like some of my other patients. That situation is much worse. At your stage, it was basically nothing so don't be too upset. You saw, it was only two dots. We will try again, okay? Don't lose hope.

In my interview with Latika when she was undergoing her second IVF cycle two months later, we spoke about her experience of the aforementioned ET. She told me that she had started thinking of names for her "babies" when she had reached home that day after the procedure:

> "My husband wanted only one child but I had always wanted two children. It didn't matter if it was a girl or boy. I have a sibling so I thought that siblings are better. So when Dr. Chatterjee had shown me those two white dots on the screen, I thought to myself, that this is God's way of telling me that I will be a mother of two babies. I reached home that day and spent hours online looking for names for them. My husband told me I shouldn't be so excited already but I couldn't stop myself. But then when my pregnancy test was negative, I couldn't believe it. I should have heard my husband's advice…I had been waiting for so long…Dr. Chatterjee said that it was nothing, but I did see my two babies inside my body and then I couldn't give them a home…It's my body but I don't seem to know what is happening inside. I don't know what will happen this time but I am hoping for the best."

Not being able to give her "babies" a home inside her body and not being able to control her body was an upsetting and alienating experience for Latika. According to Clarke, Matthews and Matthews (2006, p. 103), "the inability of the self to control the body is a source of frustration and sadness and comes as a painful surprise". Such an experience of being unable to control the body intensifies the perceived alienation of the self from the body (ibid.). As Latika said, it is her body, but she did not know what was happening inside. Research in Euro-American countries has also shown that in not being able to sustain a pregnancy or in not being able to give birth to normal children despite having access to modern biomedical services, women held themselves accountable and questioned their own maternal competence (Landsman, 2000; Murphy, 2012b). Such an internalisation by women is significantly influenced by the dominant cultural ideology, as has been observed by researchers in different parts of the world, where the responsibility for reproduction and the accountability for the absence of a child within marriage is placed on women and in women's bodies (for e.g., see Allison, 2010; Bennett, 2012; Inhorn, 2006, 2003a; Shaw, 2016; Whittaker, 2014). Furthermore, by comparing Latika's situation to other women, Dr. Chatterjee implied that Latika was not pregnant enough and thus, her loss was deemed lesser than the other women who had experienced late-stage pregnancy losses.

Latika's experience of undergoing an ET and her experience of loss which was devalued and regarded as a non-event (Rajan and Oakley, 1993) illustrates how doctors enact 'conditional personhood' (Martel, 2014) and tend to adjust the usage of terminologies depending on the context without displaying the necessary (and expected?) sensitivity to the effect those altered terminologies can potentially have on the grieving persons' experiences of loss. Although Dr. Chatterjee had addressed the two embryos as "two babies" after the transfer, during the post-loss consultation she mentioned that they were merely "two white dots" and "nothing" had been lost. However, as we saw in Latika's interview excerpt, she had enacted the embryos as babies with names – babies which she had seen, or rather, which she had been shown on the ultrasound monitor. Thus, Latika's embodied experience of having seen her babies inside her womb, an experience which emphasised the embryos' life potential, was completely overlooked by Dr. Bose (see also Shaw, 2016, p. 212). The attribution of embryonic personhood by Dr. Chatterjee, which was facilitated by ultrasound technology had, indeed, contributed to the reality of the pregnancy for Latika even before the pregnancy was viable.

In her study on pregnancy loss, Berend (2010, p. 245) describes certain distinctive ways in which reproductive technologies contribute to the sense of reproductive loss, a topic which she claims remains largely unacknowledged from the existing body of literature. One of these ways, writes Berend (2010, p. 247), is by trying to maximise results. For instance, it was not uncommon for multiple embryos to be transferred into a woman's uterus in the infertility clinics in my study, as we saw above in Latika case's. in order to achieve higher 'success' rates. However, Berend (2010, p. 247) has rightly pointed out that transferring multiple embryos increases "both expectations of success and the likelihood of multiple pregnancy with its higher chance of miscarriage, complications, and even infant death". For instance, take a look at the case of another female interlocutor, Papia Ghosh, who had conceived in her first IVF cycle (two embryos had been transferred) but eventually experienced a miscarriage in the 9th week. During the post-miscarriage consultation, the doctor had reportedly explained to Papia and her husband that a miscarriage that early-on in her pregnancy meant that what she had miscarried was "just clots, lumps of blood and cells, and nothing more". In disagreement with the doctor, Papia said:

> "It's strange because one never thinks something like this would happen to me. These are stories you hear from others. But when I had my miscarriage, I was initially numb. I had stopped eating and sleeping. I wasn't able to swallow a morsel of food. I couldn't breathe at night and would I barely sleep. I started

> having panic attacks and the first time it happened, I thought I was going to die. I felt like my heart would explode. I spent most of my day crying in my room because I kept thinking why did this happen to me. Sir [Dr. Ganguly] said it was just clots, lumps of blood and cells, nothing more. But I had seen my babies during the ultrasound. I had heard their heartbeat. People can say anything they want to but I don't have to believe that. They were not the ones who were pregnant. They didn't have to face the pain."

Both Papia and Latika evidently enacted the personhood of their wished-for child from the moment they had an embryo transfer and from when they were shown their 'babies' on the monitor. To reiterate, visualizing the potential child would not have been possible without the ultrasound technology which enacted the floating embryos as indicating potential life – viable embryos in a viable womb which have the potential to develop into the future children as imagined by the women (Shaw, 2016, p. 224). However, the very actors, i.e. the medical practitioners, who encouraged the woman in the enactment of embryonic personhood, disregarded the loss of the 'protoperson' (Layne, 2003, p. 240) as a profound episode and acted as if nothing significant happened. Layne explains that if a pregnancy is known and desired, then even if there no 'person' who is lost after an event of pregnancy loss, the would-be mothers may have already begun the process of constructing a new person and it is this "protoperson" that is part of what is lost and mourned (ibid.).

Thus, the embryonic personhood facilitated by the ultrasound images on the one hand and the doctors' explanations of the treatment outcome as a non-event on the other resulted in complicated experience of loss and as such, the sense of what was lost was augmented for women like Latika, Papia, and other female interlocutors who shared similar narratives of reproductive loss. Indeed, as I observed on several occasions during my fieldwork, despite the profound bereavement which women experienced after an early stage loss, especially those women who had been trying to conceive for a long time, their loss and grief was "discursively structured as a medical procedure producing medical waste, but not as an emotional moment requiring support" (Martel, 2014, p. 332).

It is important to highlight a caveat here that the above-mentioned experiences of enacting embryonic personhood were specific to women after their *first* IVF cycle. Women in my study who had experienced several early miscarriages after multiple embryo transfers (i.e. multiple IVF cycles) did not personify the transferred embryos by referring to them as 'babies'. During the interviews, they used the term embryos (or the word *bhrūṇa* which is same in Bengali and Hindi) and did not display any attachment to *what* they had lost. Phrases such as "the doctor said the embryos did not stick to my uterus", "the implantation of the embryos did not happen properly", and "the embryos did not stay in my womb" were commonly used by the women when describing their experiences of loss after multiple embryo transfers. There was a sense of pragmatic detachment after the first failed IVF cycle given that they were well aware that these procedures might not result in conception, and even if it did, there was a chance of miscarriage or other complications.

So far in this chapter, we have seen that as non-human actants, the reproductive technologies, such as TVS, HSG, abdominal ultrasound, and ET play a crucial and agentic role in shaping and facilitating doctor-patient interactions, multiple enactments (such as gendered enactment of the female patient-body by the practitioners and enactment of foetal and embryonic personhood), and the female interlocutors' reproductive experiences of loss. In the next section, I explore a paradox wherein I show that on the one hand, while women were dependent on the conceptive technologies to achieve conception, on the other hand, they invisibilised the agentive capacity of those very technologies.

3.5. The Invisibilised Agency of Reproductive Technologies

> "Everybody doesn't come to this world with the same destiny. My husband and I have been trying for more than ten years but we don't want to give up hope yet. So far, we have tried everything. In the last IVF, sir [doctor] had told me that my chances were good since he had transferred three embryos. But then also…I can't understand why this is happening repeatedly. Sir couldn't give any reason either. He said this happens with some women…I know that he is trying his best but maybe it is just our luck. Certain things in life can't be forced. Let's see what happens this time. We are trying one last time. You know, what hurts me the most is to see that so many couples who also started with us at this clinic have gone home with beautiful babies. I think that if they can have this happiness, then why can't I? I sometimes ask myself why I am unable to become pregnant easily like other women. I have often thought that there is something wrong with my body. I have spent many days and nights crying while thinking about these things. I wondered that maybe I did something very bad in my past life and this is God's way of making me atone for my sins. Maybe all this is a result of my karma. I don't know what it is...But I don't want to lose hope yet. I always pray to Durga *Ma* [Goddess Durga], maybe she will listen to me this time. Miracles can happen, isn't it? *I nodded* *Ma* knows that my husband and I have been waiting for so long…But if it doesn't happen this time either, then we will accept it as our destiny. We need to put a full stop somewhere. People always don't get what they want. We gave it our best, there is nothing more we could have done. That's how we will console ourselves. Maybe my womb was never meant to carry a baby. Right now, we are trying our best to be positive. Ultimately what will happen - that is not in our hands."
> (Chaaya Ghatak)

The above excerpt is from my interview with 39-year-old Chaaya, a former bank manager, who along with her husband had decided to undergo a fourth IVF cycle. Unlike the women in Shaw's (2016) study who had a diminished faith in the ability of the IVF technology after the treatment failure(s), Chaaya and other female interlocutors in similar circumstances in my study, continued expressing their faith in the technology (and in the practitioner's ability) by choosing to undergo subsequent IVF cycles. Although Chaaya was hopeful that the next cycle would be a success, she would accept it as her destiny and stop trying further in case that did not happen. In this regard, my findings resonate with Shaw's (2016) study wherein after multiple treatment failures, women exercised their agency by grappling, negotiating, and ultimately making decisions on whether they wanted to try again or as Chaaya said, "put a full stop" to the treatments. Interestingly, even though other actants and actors were a part of her narrative, the efficacy of the reproductive technologies was never brought into question.

However, unlike Chaaya, there were other female interlocutors who wanted to continue with the treatments despite multiple failed cycles. The following excerpt is of Sumita who was undergoing her sixth IVF cycle. She had experienced three first-trimester miscarriages and two of the IVF cycles had not resulted in conception:

> "I honestly don't remember the last time I had a normal life. For more than two years, this is all I have been doing. I don't understand why I am unable to keep a pregnancy till the end. I feel like my mind and heart want this but my body is not supporting me for some reason. The doctors also don't have a reason for why this is happening. It's not as if I never became pregnant. Dr. Chatterjee had said that if I hadn't conceived even once then I should stop trying but I did conceive three times. She did mention that it could be because of my age. She said my eggs weren't of very good quality. She suggested we use donor eggs but I wanted to try with my own eggs. I wanted to be sure that I have tried my best before using a donor. Sometimes I wonder if I did this to myself. I wonder if it were my mistakes that led me to this day in my life. Perhaps I waited for too long. I got married quite late as I was always ambitious about having a successful career. Maybe I shouldn't have waited for so long. Maybe whatever I'm thinking is just me trying to find a justification for what is happening now. At the end of the day, it's all written here *pointed towards her forehead* We can try finding a hundred reasons but destiny is something that cannot be erased. I'm just hoping that this time it works. I'm trying to be optimistic, it's not easy, but I'm trying. I'm giving everything I have into this last attempt with my own eggs. If it doesn't happen, then I will try with donor [eggs]…I have spent so much time doing this, I don't want to give up yet. Maybe the One up there will see my hard work and reward me for it *smiled*"

Sumita's account of loss and perceived failure reveals how she reflected on their own "mistakes" which according to her, may have resulted in her childlessness and led to her ongoing reproductive struggles. She indicated that her professional ambitions which resulted in a late marriage could be a factor for her childlessness. While Sumita questioned her own body for not supporting the pregnancies, she did not speak of the fallibility of the technologies and instead, found other reasons to understand why she was unable to achieve reproductive success. Her decision to keep trying, eventually with donor eggs if necessary, reveals the faith that she continues to display in the reproductive technologies which is characterised by "the *potential* for success, the *chance* of pregnancy, and the "*what if*" that encompasses assisted conceptive technologies" (Shaw, 2016, p. 277, author's emphasis).

The average 'take-home baby rate'[96] after an IVF cycle in infertility clinics in India is reported at 20-30 percent per cycle, although this has not been substantiated by any studies (ICMR, 2000). However, some studies have shown that the actual take-home baby rate after pursuing IVF is much lower than reported by many of these clinics (Srinivasan, 1999; Widge, 2000)[97]. As I observed in my research, of the 37 female interlocutors who had undergone IVF, only nine women[98] had achieved reproductive success that is less than 20 percent of the total and the majority of them were still pursuing treatments. My reason for highlighting these numbers herein is to illustrate that the success rate of an IVF cycle is, indeed, significantly low (other treatments such as IUI have even lower success rates), as has also been well-documented in other studies (for e.g., see Becker, 2000; Bharadwaj, 2003; Franklin, 1997; Hawkins, 2013; Thompson, 2005). Moreover, what success refers to remains ambiguous – does it refer to the conception, a viable pregnancy, or a live birth? The "positive pregnancy" rate i.e. when the ß-HcG levels are high and a gestational sac is visible or the foetal heartbeat can be detected, is often reported in informational brochures and websites of infertility clinics to be as high as 50 percent. Even though there is a distinction between the success rates of conception and of giving birth, this distinction was never articulated to the couples in my study when they consulted with the infertility specialist about their chances of having a baby. Given that the success rates of assisted conceptive technologies such as IVF are rather low in praxis, it is understandable why the conception from such technologies creates the impression that every baby is a 'miracle baby' (see Franklin, 1997, p. 147).

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[96] The "positive pregnancy" rate i.e. when the ß-HcG levels are high and a gestational sac is visible or the foetal heartbeat can be detected, is often reported in informational brochures and websites of infertility clinics as 50 percent. Even though there is a distinction between the success rates of conception and of giving birth, this distinction was never articulated to the couples in my study when they consulted with the infertility specialist about their chances of having a baby.

[97] A similar discrepancy has been noted by Ploeg (2001, p. 26) who writes that success rates for IVF range from anywhere between 10-15 percent and 30-40 percent in popular media in the US.

[98] Three women had given birth before my fieldwork had started, two women had given birth during my fieldwork, and four women had a baby after my fieldwork period was over (as I eventually learnt from my conversations with my interlocutors despite my fieldwork having ended).

Despite the high rates of failure in conception after undergoing IVF and the lack of concrete reasons provided by the doctor for the treatment failure (see chapter five), Chaaya, Sumita, and most of the other female interlocutors (and their respective husbands) had nevertheless decided to pursue subsequent IVF cycles. The question which arises then is that what are the factors which compel women (and couples) to continue pursuing such biomedical treatments, particularly IVF? The pervasive pronatalist ideology and the constant social and internalised stigma of childlessness, particularly for/on women, are two common reasons.

Fig.14. Online advertising celebrating reproductive success stories[99]

In addition, the presence of advertisements in the public discourse (see Fig. 14) celebrating a higher number of achieved pregnancies and featuring buzzwords such as the "highest success rates" is another factor which contributes to women (and couples) feeling that availing such "world-class" facilities and high-tech treatments supervised by "renowned experts" is the most feasible option to bear a child. In order to have a deeper insight into why women are compelled to undergo multiple IVF cycles, it would be prudent at this point in the discussion to briefly engage with the relevant scholarship of Sarah Franklin and Margarete Sandelowski.

According to Franklin (2006, p. 549), when women agree to undergo consecutive fertility treatments, it involves them placing their faith and trust in medical science and technologies

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[99] Image retrieved from https://www.advertgallery.com/newspaper/nova-ivi-fertility-20000-ivf-pregnancies-in-11-months-ad/ ; I would like to draw attention here to the happy, nuclear family, with a fair-skinned son.

as well as in the abilities of the specialists. Franklin (1997, p. 154) notes that women muster greater physical, emotional, and psychological determination in order to maintain faith in the enabling potential of IVF. For many women, the emotional work involved in undergoing IVF entails the need to balance their hope for success in the future IVF cycle(s) against the awareness of the likelihood of failure (ibid.). Speaking of the IVF mentality, Franklin writes,

> Hope for success and preparedness for failure are the opposing extremes of the IVF mentality which must be held together, and somehow balanced. This 'balance' between opposing potentialities was always difficult, and often unsuccessful. Too much hope was seen to lead to devastating disappointment. Too much preparedness for failure was seen as potentially damaging to the outcome, as in a self-fulfilling prophecy, or by creating a level of discouragement incompatible with continued treatment (Franklin, 1997, p. 154-155).

Franklin argues that for women repeatedly undergoing IVF and then being able to have a child is seen as an achievement which gives women a sense of accomplishment (ibid., p. 164). As such, when women commence medical treatment for infertility, they engage with a model of conception which is no longer a taken for granted event but it is something that has to be achieved (ibid., p. 144). As one of my female interlocutors, Kanika, who had given birth to twins after years of trying with assisted conception, said:

> "When I wasn't getting pregnant with IVF, I kept thinking it's my bad luck. I thought about my friend who had her baby in the very first attempt with IVF. See, nobody can change what is written in our destiny. The doctors did their best. Sometimes there's nothing to blame. There were times when I blamed my body. I thought maybe my body was defective. But my hard work and faith in Dr. Ganguly finally gave me the fruits of my labour! Today I am a proud mother who has her two precious gems [the twins]…it feels like the biggest achievement of my life. Nothing else I have done in life has given me this amount of happiness *smiled*"

Although Kanika initially blamed her destiny and luck for the experiences of reproductive loss and saw her body as defective, according to her, it was her fruits of labour combined with her faith in the doctor which finally made her a proud mother of her two precious gems. She saw the birth of her children after her prolonged perseverance as the biggest achievement in her life which gave her unparalleled joy. Kanika's narrative of tenacity and stubborn dedication and women's accounts of giving their best were common tropes used during my conversations with the female interlocutors and these tropes indicated their expectations of being rewarded with a child if they did whatever it took (see Berend, 2010, p. 245-246). These technologies, therefore, not only *create* hope but they also *respond* to and create the desire and augment the desperateness of childless couples – desire not only for a child but also to achieve a parenthood identity (Franklin, 1997, p. 183). Moreover, with the gamut of treatment options available, women feel as if they have no choice but to try and if the attempt fails, then they must try again (Berend, 2010, p. 245). Thus, Franklin (1997, p. 192) writes that as a "hope technology", IVF promises childless couples with the hope to succeed and even if it does not always lead to a successful outcome and is expected to fail, IVF is the most desirable option and the last resort for childless couples to have a biological child. Similarly, Throsby (2006, p. 84) has explained that currently, IVF is the most sophisticated mainstream fertility treatment available to childless couples and "it is this position within the hierarchy of treatments that forms the basis for claims for IVF as definitive". Thus, for couples attempting to have children, undergoing IVF offers them the reassurance that they have explored the most advanced technological avenue, thus pre-empting future regrets of not having tried enough (ibid., p. 84).

As Franklin (1997, p. 10) additionally notes, the distinctiveness of IVF derives from its enactment through a series of progressive stages wherein each stage involves the likelihood of failure such as the failure to produce sufficient eggs, failed implantation of the embryo in the uterus, and so on. The failure of (or after) any one stage means that the procedure has to be started again which necessitates not only a renewed sense of hope but also a renewed anxiety and apprehension of potential failure once again for the woman (ibid., p. 152). As such, the achievement in one stage compels the woman to move to another stage. However, when a particular stage fails, then women are compelled to start the treatment again as they had never been *that* close to achieving pregnancy before (ibid.,; see also Sandelowski, 1991, p. 39). Thus, it is not only the hope embodied by the conceptive technologies which compels women to continue undergoing treatments. As Sandelowski (1991, p. 36) argues, the never-enough or repetitive and persistent quality of these technologies is a key factor which compels women to keep trying despite repeated treatment failures. Such a compelling trait of the ARTs, explains Sandelowski, is derived not from cultural imperatives, such as pronatalist values and patriarchal agendas, but rather from the nature of the technology itself and how it operates (ibid., p. 39). She further explains that with reproductive technologies like IVF, the process of conception is transformed from an "inchoate event into consciously lived states of achievement and failure" where each stage has the potential to take the woman closer to becoming pregnant (ibid.).

Even with the emotional and physical fatigue which the women in my study reportedly experienced while undergoing the treatments continually, the compelling nature of the reproductive technologies became a crucial factor which fuelled their impetus to repeat and persist by placing their renewed hopes in these treatments (see Sandelowski, 1991, p. 36). Their accounts also reflected that they were balancing themselves on a tightrope implying an emotional balancing act which required them to be optimistic and maintain their tacit faith in the technology but also to embrace the uncertainty and be mentally prepared that the treatment might fail again. Women recognised the gamble they were making by pursuing another IVF cycle (see chapter five) but it was their agentic decision to undergo another treatment cycle which offered them even a limited possibility of pregnancy as compared to foregoing any treatment completely (see also Shaw, 2016, p. 281). It could, of course, also be eminently possible that some of these women were pushed by their husbands or other family members to undergo repeated IVF cycles or treatment in general, as I discuss in chapter five.

Nonetheless, the female interlocutors often displayed different ways of making sense and coping if they had failed treatments, again. While for some women, they spoke about accepting that not having a child was a part of their destiny, there were others who were determined about trying again, even if it meant opting for donor eggs. In either case, choosing to continue or foregoing the treatment after one final attempt was one of the few aspects that the women had some degree of control over while undergoing assisted conception. While managing their expectations regarding treatments which could potentially fail, these women spoke about giving it their best and hoping that their forthcoming attempt at IVF would give them their desired outcome which entailed a successful conception, a normal pregnancy, a normal take-home baby, and a parenthood identity.

Interestingly, as I also mentioned earlier, none of the women held the technologies accountable for contributing to and/or shaping their experience of reproductive loss and reproductive failure. Even when those technologies failed in producing reproductive success, instead of questioning or condemning the efficacy of IVF and the associated technologies, women exercised their agency by making sense of their loss in different ways. The Bengali phrase *"āmāra bhāgyo khārāpa"* (my destiny is bad) or the Hindi phrase *"kharāba kismata"* (bad fate or destiny) was used by some of the female interlocutors indicating that the events of loss in their lives was something which could not be altered or controlled. A few women, like Sumita, wondered if their experiences of loss, childlessness, and infertility were a consequence of the procrastination owing to their professional ambition which resulted in childbearing at a late age. Chaaya, on the other hand, contemplated on whether her loss and childlessness was a penance for the mistakes she had made in her previous life[100]. The disruption in the process of conception and birth caused the women to feel responsible and guilty and they blamed themselves, especially their bodies, as a way of making sense of their loss. This was not particularly surprising because as Thompson (2005, p. 94) has rightly pointed out, regardless of whether the cause of infertility lies with the woman or man, ultimately it is the woman's body which must accept the embryos for conception to occur. Indeed, doubting their own body's capacity to bear a child was the most prominent theme which emerged in all my female interlocutors' accounts of reproductive loss and reproductive failure while undergoing assisted conception. While Chaaya framed her loss by saying that her womb was perhaps not meant to gestate, Sumita was reflective about why her body was not supporting her in carrying a pregnancy till full term. The other women also engaged reflexively in similar thoughts and concerns during our conversations. Accordingly, I argue that in the absence of a concrete medical explanation by medical practitioners for the reproductive loss and treatment failure (see chapter five), Chaaya, Sumita and other women pathologised their own bodies, blamed themselves and their past choices and consequently, lost faith in their physical ability to conceive and remain pregnant (see also Shaw, 2016, p. 270). These explanations offered women an idiosyncratic framework within which they could make sense, give meaning, and direction to an unexpected juncture in their reproductive lives (see Van der Sijpt, 2018). As Franklin (1997) has also argued, women did not want to hold the conceptive technologies responsible and found other reasons to rationalise their experiences of loss and failure as it was only by maintaining faith in these technologies that they could fulfil their ultimate goal of achieving reproductive success. The pull of these technologies (Sandelowski, 1991) and the hope and desire which they embody (Franklin, 1997) made women disregard or invisibilise the agentic capacity of these technologies in contributing to occurrences of loss and failure, and instead, increasingly augmented the desire for a child. Furthermore, the self-imposed self-blaming and guilt felt by women is to some extent an internalisation by women of reified cultural and moral imperatives in a pronatalist context where women are primarily held responsible if the process of reproduction goes awry. Indeed, research has shown that women in India are usually heavily stigmatised, shamed, and ostracised if and when they are unable

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[100] This is contrary to findings of other studies in which women did not consider their infertility and involuntary childlessness as a 'punishment' for their past transgressions (see Braverman, 1997, p. 223; Shaw, 2016, p. ,270).

to have a child and also that in such circumstances, women commonly engage in self-blame (see Bharadwaj, 2003, 2016; Neff, 1994; Riessman, 2000; Widge, 2002).

3.5.1. “This was the most reliable option for us”: *Only* ARTs for middle-class couples?

In regard to the repeated consumption of conceptive technologies, especially IVF, and the women’s (and couples’) tacit faith in these technologies, I wish to highlight one final point which contributes to the discussion of why the women (and couples) in my study pursued multiple treatment cycles despite the high rates of treatment failure. I suggest that the recurrent consumption of IVF (and other biomedical technologies) is a template for the enactment as well as the representation of middleclassness by the educated and modern women and/or couples in urban Kolkata[101]. Consider the following response by one of the female interlocutors, Maya Chatterjee, when I asked her whether she and her husband had thought about pursuing any other treatment option other than IVF:

> “Oh no, we did not want to waste any time. We knew that this was the most reliable option for us. We know of few couples who tried other treatments *I asked which ones* – one couple we knew had tried homeopathy for a year but nothing happened…Money was not a problem for us so we decided to avoid wasting time with other options. This couple I’m telling you about, they also finally had a beautiful boy after IVF. We have heard many such positive stories from other people about these hi-fi[102] treatments. So, we didn’t think about going for any other treatment. When modern science has given us the option, then why shouldn’t we use it, isn’t it? I’m just hoping that everything works out.”

Research has highlighted how IVF is considered by the consumers as a symbol of modernity and progress and that pursuing IVF can be a way of solidifying one’s social status. For instance, Roberts’ (2006, 2008) study in Ecuador shows that the middle-class couples who participated in high-tech endeavours such as IVF presented themselves as modern subjects. Roberts (2008, p. 93) writes that for these couples, their social status is established through such biomedical interventions which separate the elite classes in Ecuador from the functioning bodies of poor, rural, black or Indian women. Similar observations about high-tech reproductive technologies acting as powerful signifiers of modernity have also been made by Handwerker (2002) in her study of infertility in China. Handwerker writes that in the post-1980 global market, Western

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[101] See Becker (2000, p. 250) where she argues that technology as a template of culture is not only where normalcy is both resisted and reaffirmed but also through which enactment and transformation of cultural practice occurs.

[102] The term “hi-fi” here is a colloquial, Indianized English term that implies the high, fancy, or even modern characteristics of something or someone.

medicine (biomedicine) in China has been equated with modernity and prestige which has resulted in the increasing incorporation of Western biomedical techniques into the competitive Chinese market (ibid., p. 305). She notes that although infertile Chinese women seek out and use both traditional Chinese medicine and biomedicine, they ultimately place their hopes in the miracles brought forth by Chinese medical specialists who have been trained in the West with the latest technologies (ibid.).

Maya Chatterjee's view in the interview excerpt above about "other" treatments not being as reliable as IVF and the miracle of modern science was not an isolated case and there were several other women and men in my study who shared her opinion about the latest technologies and "hi-fi" treatments which result in positive reproductive stories. As I discovered, none of the couples in my study had reportedly resorted to any other treatment options apart from pursuing ARTs[103]. My argument then is that the middleclassness of the interlocutors is reflected not only through their consumption of infertility treatments, but more specifically in their accounts about the *exclusive* pursuit of modern biomedical infertility treatments and the latest technologies while seemingly not having sought alternative or traditional therapeutic options which, thus, allowed and helped them in sustaining and consolidating their class position. Moreover, I suggest that such a practice of consumption is emblematic not only of their middleclassness vis-à-vis their economic affluence but it also reveals their middle-class ethos of modernity. As Bharadwaj (2016, p. 17) has noted, "the presence of biomedicine, encompassing assisted conception as a biotechnological means of bypassing infertility is a fine example of a modern institution in contemporary India". The infertility clinics with their swanky interiors, the presence of high-tech technologies, and as also described in the clinics' pamphlets, the exclusive pursuit of ARTs, often repeatedly – these, represent modernist sites and modern practices of consumption by the middle-class interlocutors. (see Selin, 2009, p. xiv where she writes about medical practices, such as caesarean births, which in many circumstances have become a "status choice", rather than a medical choice). Finally, I suggest that those who repeatedly underwent infertility treatments were doing so not only because they *should* (as educated and modern people who are socially

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[103] While I am aware of the possibility that some couples could have explored treatment options other than ARTs, I presume that they probably did not share those accounts with me under the assumption that I, as their researcher, was a modern subject. And thus, their self-representation also as middle-class modern subjects was defined by modern values and ideas where being modern was related to their pursuit of high-tech ARTs.

expected to avail the necessary biomedical interventions), but also because they *could* (owing to their financial stability) – which was in stark contrast to the economically disenfranchised couples who could not afford more than one IVF cycle having spent a large fraction of their economic resources to secure barely enough money for that one cycle.

3.6. Conclusion

In the pursuit of the wished-for baby, complex and dynamic interactions between various actors and actants were involved in constituting the women's reproductive experiences. As I have shown in this chapter, the entities in the infertility clinics as actors-enacted are all relationally linked with each other wherein they all make a difference to each other by acting but also by being enacted by the others. As such, the chapter's overall first argument was that the reproductive technologies as non-human actants affected, contributed to, and shaped women's experiences of reproductive loss, reproductive failure, as well as their desire and hope to achieve reproductive success. I initially used the examples of TVS and HSG as the two routinised technological rituals of submission to show that the practitioners enacted docile and compliant female patient-bodies in order to successfully apply the technologies as well as to maintain their medical authority. Such an enactment was achieved, for instance, delegitimising the pain expressed by the female patients, by infantilising them, and by performing what I refer to as pre-obstetric violence. I have also shown that through forms of epistemic disciplining (Thompson, 2005), such as black-boxing the technologies and not providing women with adequate information before medical procedures, the practitioners controlled women's epistemic capital. Using various examples, I have shown that while applying the technologies and by controlling the women's epistemic capital, the practitioners enacted the women as passive patient-bodies and in doing so, constrained their agency.

Relatedly my second main argument in this chapter is that it was within these constraints that women exercised their strategic, reproductive, and medicalised agency, both actively and passively, in order to move closer to their desired outcome of reproductive success as well as to gain control over the achieved conception and pregnancy. Women's agentic capacities were reflected, for instance, in their decisions to (not) ask for information about a procedure, in allowing the doctor to make the decision for them, and in deliberating over whether they wanted to continue or stop pursuing treatments. They also utilised their agency by actively participating in the ultrasound process in order to gain a sense of control over their pregnancy, given their earlier experiences of reproductive loss. In this regard, I have shown this form of participation in the ritual of ultrasound scanning to see and hear their baby provided them with the knowledge and the respite that their child is ‘normal’. Visualising technologies, therefore, served an instrumental purpose for women in their reproductive journey to achieve reproductive success and also to avoid another occurrence of reproductive loss. In this discussion, I have also shown that when using ultrasound images, the doctors engaged in enacting embryonic and foetal personhood to encourage maternal bonding. This process not only shaped the middle-class women’s understanding of their pregnancy and what they were gestating but also produced a new form of emotional attachment with the wished-for baby. However, upon the occurrence of treatment failure or reproductive loss (especially in early stage loss), the practitioners no longer addressed the embryo or the foetus as a baby and treated the women’s loss as an insignificant episode even though the women themselves considered the ‘lost product of conception’ as a ‘real baby’.

In the last section, I have shown that the technologies’ agency is obfuscated in women’s accounts of reproductive loss and reproductive failure, in favour of the relationship that exists between the human actors and other non-human actants. As such, even though women were compelled by the technologies and pursued technology-mediated conception to achieve reproductive success, they invisibilised the agentic capacity and participation of those very technologies in their accounts of reproductive loss and reproductive failure. While the women spoke of their own failures and attributed agency to non-human entities such as destiny, luck, and God, none of them made any reference to the efficacy of the technologies in contributing to or shaping their experience of unwanted treatment outcomes. Drawing on Franklin (1997) and Sandelowski (1991), I have discussed that it is by maintaining their faith in these technologies that the women (and couples) can sustain the hope and fulfil their desire of achieving reproductive success. Finally, I argued that one of the important factors which compelled the middle-class couples to seek biomedical conceptive technologies (instead of additionally exploring ‘traditional’ treatment options) is strongly tied to the notions of modernity and progress which is fundamental to asserting and continually enacting their class position and identities.

While my focus in the present chapter has been on the agentic role of certain reproductive technologies, it was fairly evident that the medical practitioners played an extremely crucial role in not only administering those technologies but in also shaping how women and couples understand and enact their reproductive experiences. As such, I take that theme forward in the following chapter wherein I pay exclusive attention to the infertility specialists who take centre-stage in the couples' reproductive success stories while the technologies are relegated to the role of accessories utilised in achieving that success. My concern then is with the pivotal role(s) performed by the infertility specialists as well as other practitioners (such as the nurses) who as key actors in the clinical settings significantly shaped women's/couples' experiences of reproductive loss, the meanings the couples attached to relatedness, family, and gender roles, as well as their journey towards hoping to achieve reproductive success.

Chapter 4. Enacting 'Good Patients': The Role(s) of Medical Practitioners

4.1. Introduction

As I entered infertility clinic B for the first time, I could not help but notice the pin-up boards on each floor that were covered with baby photos. One such board was titled "Wall of Fame". These photos were either only of the babies or of the infertility specialist, Dr. Sen, holding the baby(-ies) in his arms with a beaming smile. In a few photos, the baby's mother would be standing next to him. When I asked Dr. Sen about these photos, he told me,

> "These photos are like a ray of hope for each couple who comes to my clinic. People who come here are already depressed. They need to be given the hope that they too can go home as the proud parents of a healthy baby. Couples gain strength when they see that there are others like them who were suffering from the same problem but who are now the happy parents of a beautiful baby."

Once in a while, a couple who had recently had a baby under Dr. Sen's medical supervision would bring that baby to be blessed by him. The couple would usually enter the doctor's chamber after being sent in by the receptionist, place the baby in his arms, and finally touch his feet to be blessed. After blessing the child and the couple, Dr. Sen would spend a few minutes playing with the child and ask the couple how the child was doing, whether he/she was naughty or calm, if he/she slept well at night and so on. While holding a baby during one such occasion, Dr. Sen looked at me with a grin and said,

> "It's hard to believe, right? From microscopic cells, I created this person lying here on my lap. Really, I think this is a big achievement and there's nothing else I would do. By giving people the most important happiness in their lives, I feel extremely content. The joy on the faces of the couples makes me proud about doing a good and worthwhile thing in life."

The brief conversation between Dr. Sen and the couple would be followed by him handing over his phone to either parent (or sometimes to me) asking to be photographed with the baby. He would tell the couple that the photo(s) would be added on the clinic's photo board as well as get uploaded on the photo gallery of the clinic's website. Similar to the pin-up boards, the photos on this website also largely included photos of individual babies or of Dr. Sen with a baby and only a few photos included the mother. Barring a couple of photos, either on the website's gallery or on the pin-up boards, a baby's father was generally absent from the photos. In the rare photos which included both parents, it was Dr. Sen who stood in-between the couple, holding the baby while the parents stood on his either side.

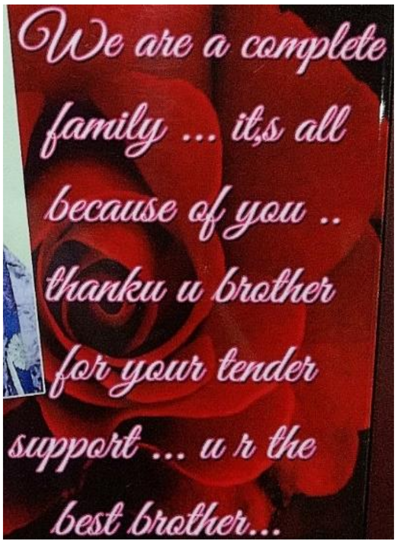

Fig. 15. Half of a framed photo gifted to the infertility specialist (the other half had a photo of the 'IVF baby')

In his research on infertility and procreative technologies in India, Bharadwaj (2016, p. 217) claims that "ART-conceived babies are much more than a simple medical resolution of infertility; they are highly prized medical trophies for which doctors compete as a sign of their achievement". As I mentioned in the sketch above, the absence of the child's parents in most photos, especially of the father, emphasises the primacy of the doctor as the medical expert in having enabled conception (see Bharadwaj, 2016, p. 217). The couples who had experienced reproductive loss and then had a baby following medical intervention at the infertility clinics commonly referred to the infertility specialists as the Divine or God-like figure without whom they would not have become a complete family. While the couples' laudatory statements for the doctor can be seen as expressions of gratitude, the doctor's primacy in the baby photos are indicative of the triumphs of the individual doctor in achieving reproductive success, rather than as successes of the reproductive technologies, the efforts of other medical practitioners involved in the treatments (such as the embryologist, lab technician, andrologist, and nurses), or of the couple's perseverance and relentless physical, emotional, and financial struggle (see Bharadwaj, 2016, p. 217). As such, material artefacts inside clinic B – including the baby photos, Dr. Sen's awards, or the media coverage of his professional accomplishments – these are forms of (subliminal) messaging which ultimately elevate and corroborate the doctor's credibility and reputation. Dr. Sen and his performance, therefore, get foregrounded as the star performer (reiterated by himself and by the couples too) in a childless couple's journey of trying to achieve reproductive success, while other actors and actants are consigned to the background. As Dr. Sen said in one of our informal dialogues, infertility clinic B is a "one-man show" (see chapter two).

To that end, the present chapter's main concern is to explore how as "benevolent magicians" (Brody, 1987, p. 152), they perform a critical role in influencing, shaping, and controlling the women's/couples' experiences of reproductive loss, treatment-seeking practices, and their attempts towards achieving reproductive success. In the first section, I show that the doctors reproduced, reinforced, and naturalised discourses around pronatalism, kinship, and normative gender roles, thereby, shaping the meanings which women and/or couples' attach to concepts of relatedness, parenthood, and a 'normal' family. Although assisted reproduction offers various possibilities of establishing non-traditional families wherein genetic ties have been partly severed or dislocated (see Appleby and Karnein, 2014, p. 93), I show that the infertility specialists in my study as "moral arbiters of health matters" (Brody, 1987, p. 154) accentuated the role played by genetic ties as established primarily through the sharing of biological substances[104] and shared physical resemblance in creating a normative family structure. I also show that the doctors essentialised gender roles in which women were characterised as inherently maternal and emotionally fragile in contrast to men.

In the second section, I argue that the achievement of reproductive success is not only an accomplishment for the childless couples but also for the infertility specialists. The latter performs the role of the benevolent magician and well-wisher who (seemingly) single-handedly creates a 'miracle baby' (see Franklin, 1997, p. 147). As Dr. Sen said in the description earlier, he had "created" a person which was his "big achievement". In order to manifest this achievement, I show that doctors disciplined the women in various ways in order to enact "good patients" (see Lorber, 1975) i.e. submissive and compliant patients who should ideally display unquestioned trust in them and in this process. In doing so, they constrained the women's agency to make decisions about their own bodies or about the treatment(s) right from the beginning of the treatment and often, even before the treatment had commenced. The reader will notice herein that the discipling of the female patients by the medical practitioners is a theme that was also discussed in the previous chapter. While the focus in

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[104] Biological substances i.e. eggs and sperm, are discursively understood as being transmitted through genes and containing inheritable traits (physical/biological and sociocultural/behavioural) between the source i.e. biogenetic parent to the recipient i.e. child (see Edwards, 2014; Shaw,, 2016, 2018).

that chapter was on the agential role played by certain reproductive technologies as mediators and facilitators in the doctor-patient interactions, my focus at present is on the disciplining of women (and men) by the practitioners within clinical settings but not during any medical procedures or administering of technologies per se. As Lupton has pointed out (1997b, p. 99), the central strategies of exercising disciplinary power in a medical encounter is not primarily through direct coercion or violence but rather through convincing the patients that certain ways of behaving and thinking are appropriate for them. Such disciplining, was achieved by the infertility specialists, for instance, by reprimanding the women and/or couples for asking an excessive number of questions during consultations and instead by encouraging them to repose complete trust in their expert advice.

However, following Shaw (2016, who draws on Foucault, 1984), I show that power does not reside solely with the infertility specialists. Instead, it is distributed amongst the actors within the clinic, albeit disparately, and consequently, the interactions and events cannot be understood simply as the infertility specialists exerting their authority on the women and/or the couples. As such, my second concern in this chapter is to demonstrate that instead of the submissive patient-roles in which the women were purportedly enacted by the practitioners, the women exercised their strategic, reproductive, and medicalised agency in several ways. My argument is that not only were the doctors enacting 'good patients' but the women drew on diverse forms of agency co-constituted by constraints to become or to enact themselves as 'good patients' where the aim of all the actors was to in due course achieve reproductive success. Indeed, the attempts to achieve reproductive success is manifested through a "collective enterprise" (Bourdieu, 1990, p. 68 in Shaw 2016, p. 143) between all the actors in a clinic and not as an individual actor's efforts. Thus, I show that even though the infertility specialists (re)presented themselves as the primary actors who (can) create and give a baby to a childless couple, ultimately, it was the various agentic actors (and actants) involved in dynamic social interactions within the clinical settings that negotiated and collaborated with each other in order to achieve reproductive success as the final desired outcome (see also Shaw, 2016, p. 141-143). And it is within such dynamics that certain gender roles, relations, and concepts (such as that of relatedness) were enacted by the actors – enactments which were a pivotal part of the women's/couples' disruptive reproductive trajectories.

Finally, in the third section, I show that the practitioners actively positioned themselves and built relationships with patients and /or couples in the way(s) in which they thought they could best achieve reproductive success, whether that was exclusively in the capacity of a medical expert or by performing and juggling extended roles as a confidante or counsellor. I argue that practitioners who enacted roles beyond that of a medical expert did so not only to establish a human touch with the patients (see Bharadwaj, 2016, p. 224) but also as part of their professional requirement in order to ensure that the patients do not opt for another clinic where they could find the emotional refuge they were searching for. In this section, I once again illustrate women's utilisation of strategic agency wherein they consciously and actively searched for practitioners with whom they could create a relationship of therapeutic intimacy as a way of coping with their distressed lives.

4.2. Enactment of (Biogenetic) Relatedness and (Normative) Gender Roles

Since the 1990s, several anthropological and sociological studies have shown that the process of defining kinship in the context of reproductive biomedicine is highly flexible, adjustable, and strategic which is in contrast to the earlier legal, social and/or 'natural' convention which claimed that a biological or blood relationship is unalterable (Hayden, 1995, Inhorn, 1994, Ragoné, 1994, Kahn, 2000 in Franklin, 2013, p. 750; see also Carsten, 2011; Strathern, 1992). These studies have examined how ARTs have the potential to disrupt essentialised notions about heterosexuality, conjugality, monogamy, family lineage, and genetic continuity as they have opened up a multitude of reproductive pathways and kinship configurations wherein relatedness in a family can be enacted in several ways (Franklin, 2013, p. 751; see also Freeman, 2014; Hudson and Culley, 2014; Shaw, 2018). In this section, however, I show that although assisted reproduction offers various possibilities of establishing 'unconventional' families which are not founded only on biogenetic ties, the infertility specialists, and even the nurses in my study, discouraged the involvement of "reproductive others", i.e. donor gametes, especially at the beginning of couples' assisted reproductive journey. Instead, they encouraged couples to achieve conception with their own biological substances. Based on ethnographic portraits, I argue that the medical practitioners reproduced, reinforced, and essentialised the enactment of biogenetic relatedness in the making of a 'normal' family through genetic continuity, particularly by emphasising the importance of shared resemblance and similar behavioural traits and in doing so, they also routinely essentialised dominant gender roles and normative gender scripts in relation to family, parenthood, and marriage.

4.2.1. “It’s a matter of genes, after all.”

While biology conventionally seems to have had a foundational function in establishing relatedness and kinship in ‘the West’[105] in non-western settings there has traditionally been a blurring between the boundaries of the biological and the social, explains Carsten (2000, p. 4; see also Franklin, 1993). It was in the early 1990s that based on her research in New Guinea, British anthropologist Marilyn Strathern challenged the fundamental assumption in the Euro-American world regarding the conflation of the ‘natural facts’ of reproduction and social parenthood (Strathern, 1992 in Lock and Nguyen, 2018, p. 223). Strathern pointed out that a study of ARTs can expose the way in which the concept of human kinship as supposedly rooted in facts of nature is rather constructed. That biology is both “made and bred” or is “socially-processed nature” has been established by Franklin (2003, p. 63,82) in her discussion of re-thinking the nature-culture binary.

Indeed, in different parts of the world, biological and genetic, or “biogenetic relatedness” is continuously done or enacted in diverse ways within certain local contexts, rather than using kinship as the primary lens to analyse the structures in such societies (Shaw, 2018, p. 281). Such a reconceptualization of kinship has historically occurred alongside the emergence of studies on assisted conception, adoption, and gay and lesbian kinship which have focused on how new forms of kinship are produced and not predetermined (ibid.). Studies have also shown that individuals around the world create meaningful connections and experiences in the enactment of relatedness based on various bodily substances[106], such as blood and breast milk, and not necessarily based on the contribution of genetic substances (for e.g., see Pande, 2009; Roberts, 2008; Shaw, 2018).

Unlike the discursive Euro-American understanding of kinship, South Asian understandings of kinship do not necessarily bifurcate nurturance and biology (see Majumdar, 2017). Rather,

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[105] Kinship in American societies, according to David Schneider, has been primarily understood as being organised according to two systems – the order of nature i.e. by blood and the order of law i.e. through marriage (Carsten, 2011, p. 21). Blood relations emphasise that relations based on blood are enduring and cannot be severed and also that “kinship is whatever the biogenetic relationship is” (Schneider, 1980, p. 23 in Carsten, 2011, p. 21).

[106] See Carsten (2011) in which she describes the importance of ‘substance(s)’ as an analytic device in examining the anthropology of kinship as well as in the understandings of the body and the person.

scholars have shown that relatedness in South Asia is frequently invoked and enacted in the identification of multiple ties of belonging and kinship instead of the sharing of genetic ties (see Carsten, 2000; Lamb, 2000; Lambert, 2000; Majumdar, 2017; Pande, 2009). For instance, in her rich ethnography of aging, gender, and body in West Bengal, Sarah Lamb (2000, p. 36) explains that kinship ties are strongly associated with, for one, the "sharing of the same body" wherein *pindas* or body particles are passed down from ancestors. Moreover, she explains that it is not only the sharing of blood as a bodily substance which creates and sustains the notion of a family, but also the sharing of other substances, mixings, and exchanges (ibid., p. 36). Thus, the sharing and exchanging of bodily substances, but also "food, possessions, words, affections, and places of residence" was understood by Lamb's interlocutors as a principal way of enacting relatedness and kinship in a processual manner (ibid., p. 37). In north India, Helen Lambert (2000) notes that social relatedness and social parenthood have traditionally existed in the making of kinship ties within a family. She writes that "locally recognised forms of relatedness are not confined to connections of shared bodily substances based on birth/ancestry, but extend beyond these to ties based on shared locality, adoption (of children and of in-marrying women), and nurturance, including feeding" (ibid., p. 74). Another example is of Amrita Pande's (2009) study of surrogacy in India, where she argues that by strategically establishing creative and flexible forms of kinship ties with the other actors involved in the surrogacy process, surrogates disrupt theories of relatedness that are based solely on biology and procreation. She suggests that surrogates in her study enacted their kinship ties through shared bodily substances (blood and breast milk), shared company and in the labour (sweat) of gestation and of giving birth (ibid., p. 380). In understanding how kinship is established through shared bodily substances, Pande, thus, shows that the biological ties with the genetic parent are deemphasised which ultimately challenges established hierarchies in kin relationships "where genes and the male seed triumph above all" (ibid.).

Contrary to such research located in South Asia which establishes that biology does not necessarily have a foundational function in establishing relatedness, the medical practitioners in my study advocated an understanding of relatedness based on genetic essentialism which resembles the Euro-American discourse where biology and nature have been the grounding for the social (see Carsten, 2000, p. 3). They stressed the importance of shared physical resemblance between the parents and child and in the process, enacted relatedness as biogenetically mediated – an enactment which was rendered possible in the world of assisted conception. To illustrate my point, consider the interaction below at infertility clinic B.

Nidhi and Suraj, both in their early forties, had been trying to conceive for more than seven years. After undergoing two cycles each of IUI and IVF with another infertility specialist, and having experienced two miscarriages, the couple had come to Dr. Sen. The following excerpt is from the conversation between Nidhi and Dr. Sen during their first consultation:

> Nidhi (N): Sir, I don't know what else we can do. We have been trying for several years. What should we do, Sir? We have come to you with great hope.
>
> Dr. Sen: Okay, firstly, don't give up. You have come to me for the first time, this is your first meeting with me. We will try our best. What's the point of worrying so much? Let me look at your previous reports and then we will see what's the best course of action. *after perusing through the couple's reports* I think you should start IVF because of your age and also I can see from your last report that your egg quality is not good. No point in wasting time with IUI again. If you want, we can start from your next menstrual cycle.
>
> N: Hmmm okay. *looked at her husband and then said to the doctor* But sir, you said my egg quality is not good. Our last doctor also said the same thing. I have already miscarried twice. Should we try with a donor [eggs]? Would you suggest that? My husband and I have talked about this and we would be fine with it.
>
> Dr. Sen: I would advise you to first try with your own eggs and then if that doesn't work the first or second time, then we can try with donor eggs. I will do a TVS and if I see that you still have some eggs left, then we should definitely try once with your eggs. I don't want you to complain later that sir, why didn't we didn't try with my eggs first.
>
> N: But sir, what if I have another miscarriage? I don't want to take any risk this time.
>
> Dr. Sen: I'm just thinking what's best for you here. Look, it is fine if you choose to go for a donor. It's actually more money for me! But, later, if you have some doubt in your heart, then? Then, you will point fingers at me, say that the doctor didn't tell us that I could use my own eggs. Ultimately, everybody wants that they should be able to see their own reflection in their child. Isn't it? It's a matter of genes, after all *smiled as the couple nodded* It is true for every man and woman. Such feelings cannot be repressed. Who would not want to see their own features and mannerisms in their child? It's the world's most natural desire to have…You are only saying this now because you think you might have another miscarriage but I think you will regret your decision in the future if you don't try with your own eggs. Also, what is the guarantee that you won't have a miscarriage with a donor? Have you read somewhere or know from somewhere that pregnancy with donor eggs doesn't result in miscarriages? *Nidhi nodded her head to indicate a no* So, go home, think about it before making a final decision. I have told you what I think is the best way to proceed in your case."
>
> N: Yes sir, you are right. I think we should use my eggs first and then see what happens *looked at husband who nodded in agreement* If you think this is the best for us then we will do that. We just want to go home with a healthy baby, that's all.

> Dr. Sen: Excellent! I am very happy that you understood my point. I am also here to make sure you have a healthy baby! Good decision! Now go outside and meet the nurse. She will tell you what needs to be done, after which I will do a TVS.

I regularly observed during consultations that if some women wished to reframe their desire of having a biological child in order to try and circumvent another episode of reproductive loss, Dr. Sen pushed them to rethink their decision. As we can see in the dialogue above, even though Nidhi was considering the use of donor eggs to avoid another potential miscarriage, Dr. Sen convinced her to undergo IVF with her own eggs first in case she eventually regretted her decision of having a genetically unrelated child. He placed considerable emphasis on the apparent naturalness of desiring a biological child who would reflect the parents' features and mannerisms. In doing so, he reiterated the notion that the desire to have a child with genetic ties emerges because of a powerful genetic drive to procreate (see Franklin, 1997, p. 91). In this regard, studies have actually shown that physical resemblance is commonly regarded as an important marker in order to establish biogenetic relatedness (for e.g., see Hudson and Culley, 2014). Such a similarity and resemblance between parent(s) and child seemingly confer a sense of belonging and also allows the family to be integrated within the larger community, thereby, avoiding any social risks of social ostracism and stigma which visible difference(s) between parent(s) and child may carry (Hudson and Culley, 2014, p. 238-239). Such a discourse on resemblance "reinforces the assumed natural order of things and supports a hierarchy of legitimacy" in which only a clear physical resemblance to the parents (or family members) confers a greater degree of legitimacy to the kinship ties[107], explain Becker, Butler and Nachtigall (2005, p. 1301). It might be worthwhile to mention here that a couple of the female interlocutors in my study were reportedly persuaded by their family members to opt for intrafamilial sperm donation (the woman's father-in-law or brother-in-law were the prime candidates) in order to maintain biological ties with the family and to also ensure that the child shared a certain degree of physical resemblance with the family members. I witnessed these women approaching infertility specialists with such requests but always in the absence of their

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[107] However, in their study on adoption within Catalan families, Marre and Bestad (2009, p. 65) have argued that resemblance is a rather socially constructed lens which is not necessarily based on genetic transmission. Instead, they show that resemblance can be either physical and/or moral and these resemblances are used to *enact* the relations between the adopted child with the larger family.

husbands. However, their requests would be denied as the doctors would inform them that the sperm donor had to be anonymous due to ethical reasons outlined by the ICMR.

Furthermore, Franklin (1993, p. 30) has argued that while ARTs might have partially disrupted the apparently natural kinship ties based on biology and the natural basis for nuclear families and heterosexual marriage, these technologies have, nevertheless, provided the occasion for reconsolidating them. In the same vein, Chavkin (2010, p. 9) has pointed out that in the globalised world of ARTs, certain hierarchies still seem to hold sway – "the genetic (gametes: sperm now joined by ova) trumps gestation and the biologic trumps care". As such, and rather unsurprisingly, the woman's and/or couple's (apparent) natural desire of having a genetically related child was reinforced by the medical practitioners in my study during various medical encounters, irrespective of the woman expressing her desire to use donor gametes in order to avoid the occurrence of another episode of reproductive loss. Based on my findings, I then argue that the understanding that relatedness ought to be established through the sharing of biogenetic substances[108] is, indeed, strongly embedded in the creation of a 'normal' family within the domain of assisted conception in 21st century India and it takes precedence over the making of families which are not established via genetic ties.

It is also interesting to note that in the conversation between Nidhi and Dr. Sen, the latter rationalised his medical advice by stating that his advice was in Nidhi's best interest so that she does not have any future regrets about not conceiving with her own eggs. Brody (1987, p. 154) has pointed out that women who are trying to become pregnant are usually quite vulnerable given their stressful circumstances. Thus, it is difficult for women, as well as for doctors, suggests Brody, to understand that their best interests might not be served by a doctor's reinforcement of her so-called natural desire to become a mother, even when the doctor is motivated by a wish to relieve the woman from her longing for a child. He adds,

> The doctor who accepts such "desperation" as normal, and justifying extreme measures to gratify it, may unwittingly be defending a set of cultural values that require re-examination. Most important, the

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[108] The couples in my study who desired genetic ties through assisted reproduction often found themselves in conflicting situations where their potential child could have the genetic material of only one intended parent (if donor sperm or donor egg was required) or of neither parents (if both donor sperm and donor egg i.e. a donor embryo was required). I observed that most couples reluctantly accepted the use of donor gametes and there was a distinct hierarchy involved in selecting from the options available to have a child (see Hudson and Culley, 2014) – see chapter seven for further discussion on this topic.

> patient in this situation may have lost an opportunity to discover her own actual best interest (Brody, 1987, p. 154).

In the next section, I explore the second essentialist trope which was perpetuated by the medical practitioners which is the natural desire of every woman to become a mother wherein motherhood was enacted as the chief path for women to fulfil their lives.

4.2.2. "Women are born to be mothers…"

Married for six years, Megha was unable to conceive despite trying with her husband, Utpal, for several years. Eventually, the couple decided to consult Dr. Sen having read about him in a popular Bengali magazine. They had consulted with an infertility specialist earlier but after two IUI cycles and one IVF cycle resulting in a biochemical pregnancy (see Appendix 1), the couple decided to find another doctor. The previous infertility specialist had advised the couple to try with donor eggs as that would increase the chances of conception. While Utpal was comfortable with this advice, Megha was insistent that she wanted to use her own eggs as the following excerpt demonstrates:

> Megha (M): Sir, I am being completely honest with you. The main reason I wanted to change my doctor is because he kept talking about using a donor. But sir, I want to keep trying with my own eggs. If you tell me I have no eggs or bad quality eggs, then I can understand but otherwise why should I use a donor?
>
> Utpal: Sir, she's just being stubborn! I don't see what the problem is! How does it matter where the egg comes from? I have told her so many times that ultimately the baby will grow inside her body, but she refuses to listen to me. We should only think of having a healthy baby but she- *was interrupted by Megha*.
>
> M: Sir, you don't listen to him please. We have been fighting about this a lot in the last few months. It's important to me but he doesn't understand this.
>
> After a couple of minutes of the couple bickering about how they do not understand each other, Dr. Sen, smiled and said,
>
> "Look Utpal, women have this desire inside them. It's hard for men to understand this feeling. But because of the many years that I have been in this profession, I understand this desire and this maternal feeling. It is completely natural. Women are born to be mothers so it's very natural for her or any woman to talk like this. In my entire career, I have never met a woman who did not want to become a mother by first trying with her own eggs. If she does not have a problem then why should she go for a donor? And tell me, would you be comfortable if instead of donor eggs we had to use donor sperm? Would you not be worried knowing that the child will only resemble your wife and not you? I understand why she's talking like this. She wants the child to be a combination of both you and her. Her demands are completely natural. Understood? For now, let us do some basic blood tests and a TVS to see how things are inside her. After that, we can see what to do next. I am sure we can use

> her eggs. She has not crossed forty yet so we still have hope. Don't fight and let's see what the test reports and scan show. Okay?"

Thanking Dr. Sen, Megha said she was happy that he could make her husband understand "a woman's heart's desire".

According to Franklin (2002, p. 308-309), "the so-called biological facts of sexual reproduction are produced to confirm the rigid binarism of sex categories by encoding them as pre-existing "natural" differences". Regarding the denaturalisation of biological facts, Franklin points out that Butler's Gender Trouble (1990) which recast the relation of sex to gender, or biology to embodiment, and remains as one of the most influential works to emerge from within feminist scholarship in the 1990s. Butler's theorisation of gender performativity (see chapter two) radically repositions allegedly natural gender roles and gender categories by proposing that these roles and categories are rather performed. She disrupts the assumption that a binary difference between female and male exists as a presocial fact and instead argues that gender is an embodied performance or stylised repetition of acts. In addition, several scholars have also dismantled the notion of motherhood as an innate 'feminine' characteristic and have established that it is socially 'constructed' to a significant extent (see chapter one).

Such performative gestures of gender categories is distinctly visible in the world of assisted conception where the socially prescribed gender roles are enacted even more rigorously. For instance, in her study on ARTs in North America, Thompson (2005) has shown that the naturalised biological and gendered categories of 'female' and 'male' are reproduced and essentialised recurrently within the predominantly heteronormative biomedical sites of infertility clinics. She observed that female patients (and men too) need to, and are rather made to, continually pass, socially and biologically, as the gender to which they have been assigned (ibid., p. 118). She further points out that within such clinics where the ontology of gender is destabilised because women and men are unable to perform normative gender roles, it becomes all the more important for the actors involved to enact the gender categories more prominently. As such, there is a consistent enactment of dominant gender roles inside these clinics, both biologically and socially, or as Thompson argues, there is a noticeable hypergender-appropriate behaviour (ibid.).

In the conversation above between Megha and Dr. Sen, Megha insisted on using her own eggs for conception. When her husband interrupted her by saying that what mattered was a healthy baby which would grow inside her body (thus, enacting relatedness by blood), Dr. Sen explained to the husband that it was 'natural' for Megha to be persistent about conceiving with her own eggs. Similar to Nidhi's case previously, Dr. Sen once again reiterated that physical resemblance was essential in establishing relatedness. He further explained that such a desire and maternal feeling was something he had observed among all the women he had met in his career. Indeed, it was common for Dr. Sen (as well as for the other practitioners in my study) to reproduce, reiterate, naturalise or normalise the desire for motherhood as a "feminine universal" (Stearney, 1994).

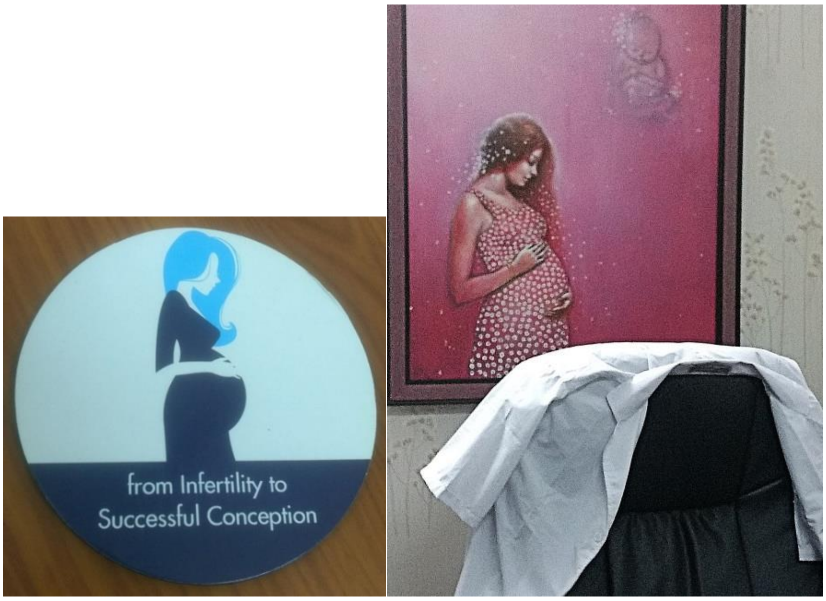

Fig.16. Visual artefacts displaying motherhood: A coaster on Dr. Sen's table (left) and a painting behind his chair (right).

That women apparently perform the natural roles of childbearing and mothering due to their given "God-given maternal instinct, a kind of primordial drive fuelling women's motherhood desires", has also been documented by anthropologist Marcia Inhorn (1996, p. 60) based on her ethnographic engagements with her interlocutors in Egypt. While Inhorn's interlocutors belonged to the lower socioeconomic strata in Egypt, my observations among the Indian middle-class milieu pursuing assisted conception at the infertility clinics in India nonetheless resonates with her findings. The message that motherhood was an inevitable life goal for women, that women are born to be mothers, and that motherhood and womanhood were inextricably intertwined was also displayed in the otherwise regular visual artefacts inside the infertility clinics (see Fig. 16). These artefacts, I suggest, played an important role in creating subliminal messages for the patients and/or couples inside these clinics by reiterating the woman's role as central to the narrative of conception and childbirth. Indeed, in all my time spent conducting fieldwork in the three infertility clinics in Kolkata, I had rarely come across any image (either inside the clinics' premises or on the clinics' websites) where it was only the father with the baby. The images were usually of a cheerful, nuclear, heteronormative family with child or more commonly, the images were of a (fair-skinned) pregnant woman or a woman holding a (fair-skinned, blue-eyed) child (see Fig. 17).

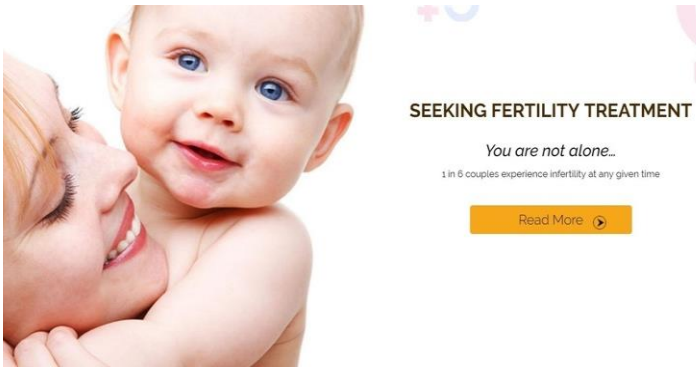

Fig.17. An image on the homepage of Infertility clinic C's website

Moreover, the practitioners not only essentialised feminine roles of women as mothers, but also enacted men as not sharing the same innate desire to become a parent. This is reflected in Dr. Sen's statement when he tells Megha's husband that "it is hard for men to understand this [maternal] feeling". Dr. Sen proceeded to enact the husband's role as the stoic male partner who was supposed to take care of his wife, thus indirectly also enacting the woman as the de facto emotionally vulnerable spouse. Research has shown that it is quite common for medical personnel to assume that it is the man who would be emotionally strong and thereby, expect him to deal with various logistical decisions and arrangements, especially at a time when the woman is enacted as being physically and emotionally incapacitated (Peppers & Knapp 1980). Normative gender scripts were, thus, often attributed to the husbands by the practitioners in my study and while experiences of loss present(ed) major challenges for both the wives and husbands, such rigid sex-role stereotyping only added to the pressure and distress (see also Thompson 2005, p. 119). To illustrate my point further, let us consider another example from one of the consultations at infertility clinic C where when a couple visited Dr. Chatterjee after experiencing a miscarriage, she said looking at the husband,

> "Please take her home and look after her. Ask her what she feels like doing. Take a few days off work, spend time with her. Make sure she doesn't go into depression. See, it's very easy for women to be depressed after such mishaps. Physically and emotionally women have to suffer a lot when they face

> the pressure to have a child. But if she miscarries, then the suffering is much worse. At that time, they need their husbands to support them mentally. So, it's your job as her husband to ensure that she feels emotionally strong before we start treatment again. She lost a baby, naturally, she feels the pain much more. So, you have to look after her. Take her to nice restaurants, take her shopping, do whatever she likes to do. Distract her, otherwise, she will spend all her day sitting inside the house and crying. Understood? I want you to update me about her situation in a few days."

Dr. Chatterjee had assumed that the wife must be grieving more than the man on account of being a woman who had suffered an embodied loss and thus, told the husband to look after his wife and to ensure that she is distracted by engaging herself with her choice of activities. Interestingly, her examples of what a woman likes was restricted to restaurants and shopping.

It was not only the infertility specialists but also other practitioners who enacted the female patients and their husbands in normative gender roles. When I asked Nurse Shanti in infertility clinic A about how she convinced couples to try again after treatment failure(s), she said,

> "Generally, I convince the wife and she convinces her husband. Rarely has any wife not been convinced by what I tell her. I speak honestly to the woman. I tell her - life without children means nothing. You can have crores of rupees but nothing matters ultimately if you don't have a child. Your husband can go outside the house and have lots of fun, but you can't, why? Because you're a lady. You're a woman. For you, your life will be incomplete and meaningless without a child. A child is what a woman requires to have a fulfilled life. As women, God has given us this power to give birth. We need to fulfil the duty God has given us. We are meant to have children otherwise we will always have a big gap in our lives. I tell them, don't give up, don't lose hope, be optimistic…Some women who have been trying for several years will be completely dejected and often tell me that maybe they were not meant to be mothers. I tell them, why would God make you a woman if you weren't meant to become a mother? There's a reason women have periods, there's a reason we have a uterus, a womb. So yes, I explain these things to them and convince them to undergo treatment again."

Despite having guessed what Nurse Shanti was referring to, I asked her what she meant by saying that husbands would "go outside and have lots of fun", to which she laughed and said,

> "Oh, you know what I mean! When men don't have fun at home, when they don't have a reason to be at home, they find other women outside to have fun with! This is how most men are! It's their nature, you see. Society doesn't raise fingers at them but if women do anything like this, then immediately there will be character assassination. People will judge women for not having a child but nobody will judge the men. Women need children for a wholesome life and to also ensure that their husband doesn't look for satisfaction elsewhere. You will notice, couples who have children, their marriages are better. I have seen it from own professional experience. The men with children are more committed to their marriage, to their wives, and to their family. But couples without children, the men tend to stray otherwise the marriage ends in a divorce. I know several couples whose marriages ended because the woman couldn't give the man a child. You will not hear any woman admit this because it will put her in a bad light, that she couldn't keep her husband in the marriage. But it's true. So, yes, this is why I tell the women that they need to have a child."

Nurse Shanti’s rationale for convincing women who had experienced treatment failure to undergo another treatment cycle and her explanation of husbands “having fun” reflected the emphasis she placed on a woman’s duty to have a child and on the female body which has been bestowed with the power by God to procreate. She also spoke of the ‘masculine nature’ according to which he could become a philanderer if his wife did not bear a child. The nurse’s statements about marriage also suggested that a marital relationship is better and more stable when a couple has children as compared to childless married couples. The husband’s commitment towards his family, marriage, and wife was greater when the wife had given him a child, according to the nurse – a view she had developed based on her professional experience. The nurse’s understanding of fulfilling a marriage by having children is certainly not limited and peculiar to the Indian sociocultural setting. In her study of assisted conception in Britain, Franklin (1997, p. 139) explains that the gaps in a childless marriage which are created by the discovery of infertility (and I would say, reproductive loss in general) refers to “an incomplete conjugality”. According to the interlocutors in Franklin’s study, it is only by having biological children who embody a combination of the genetic material of both parents that the fractured conjugal relationship between a man and a woman can be healed and reaffirmed (ibid.). Franklin explains that the “big gap” in the couple’s conjugal life, which Nurse Shanti also pointed towards, is the disruptive gap in “life’s progression”, a gap which describes a sense of loss on many fronts – a “mechanical gap” in a woman’s reproductive physiology which needs to be bridged, the gaps in the woman’s marriage, and the gaps in her female identity because she is not yet a mother and thus, not a “complete woman” (ibid., p. 139).

In the following section, I continue the discussion about the important role played by medical practitioners in shaping the reproductive journeys of the couples. In particular, I examine the disciplinary mechanisms performed by the doctors in order to enact ‘good patients’ and the patients’ strategic manoeuvering between moments of active and passive agency in order to enact themselves as ‘good patients’.

4.3. Enacting ‘Good Patients’ and Becoming ‘Good Patients’

In this section I demonstrate that the infertility specialists in my study enacted ‘good patients’ – patients who should be obedient, follow the doctor’s instructions, and not be very assertive or inquisitive. In examining how the doctors enacted or *produced “*good patients” and how the couples *became “*good patients”, both with the goal of achieving reproductive success, I also discuss how power in such clinical spaces is not confined solely to the infertility specialists, even though it seems that way based on a cursory observation of the internal workings the clinics. Based on a Foucauldian understanding of power as productive, and not merely repressive, I follow Shaw (2016) to show that power is distributed, even if disparately, among the multiple actors involved in the infertility clinics who collectively and collaboratively use their position, expertise, and knowledge to achieve the final goal of reproductive success.

4.3.1. ‘Good patients’ do not ask “too many questions”

After asking the routine set of questions about their medical history to every new couple, Dr. Sen would ask whether they knew how a woman became pregnant. Barring a few couples who responded with a rather tentative yes, the rest of them said they had a vague idea or no idea at all[109]. Whatever the responses, it was followed by Dr. Sen using a model of the female reproductive tract (see Fig. 18) to explain the process of conception. There was no model of the male reproductive system and neither was it ever mentioned.

Fig. 18. Model of female reproductive tract

By pointing to the different parts of the model, Dr. Sen’s explanation of conception in a mixture of English and Bengali or Hindi usually proceeded in the following manner:

> “These are the two ovaries. This is the uterus and the tube on either side of it is called the fallopian tube. Each month, eggs are produced in the ovary and one egg moves to the fallopian tubes and waits there. When you have sex, the fastest sperm moves towards the egg in the tube and if everything is normal,

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[109] Most couples from the lower socioeconomic background said they did not know how conception happened. The couples who said yes were primarily from the middle-class background and these couples, for the most part, were unable to respond using established ‘scientific’ terms such as fallopian tubes and fertilization.

> the egg and sperm fertilise to make an embryo[110]. Then the embryo implants itself in the uterus and finally a baby grows inside the womb. So for everything to work normally, we have to ensure that the ovaries, eggs, tubes, uterus, sperm – everything has to be alright. Understood?"

Most couples would indicate that they had understood by nodding their heads. On one such instance, after a couple's had left the room, Dr. Sen said to me,

> "People are very ignorant. That's the main issue. I've met couples who have absolutely no idea how pregnancy works. People don't even know where to ejaculate. They do it between the thighs and think it will lead to pregnancy! Even the educated couples who come to me for a baby are clueless about such issues. When I ask them how pregnancy happens, they look at each other or look at me with a blank expression! They say they have a vague idea but I'm certain that most of them would have the wrong information."

He added that it was a real pity that sex education was not offered in India where people truly needed it. He then said that he had seen most patients refraining from asking any questions to doctors regarding sex or infertility because they were uncomfortable but more importantly, the hesitation to ask questions was reportedly related to the "blind trust" which people placed in doctors. Critical of doctors being worshipped by patients, Dr. Sen said,

> "People don't want to ask questions to the doctor. They say, whatever you say, we will do that. This blind trust is not good as many doctors take advantage of this. Patients should be encouraged to think for themselves. What I do is I lay out all the options in front of them, as honestly as possible. Then I tell them to take some time and think about it before deciding. It's very important for patients to be in a situation where they are completely informed about their options before they can decide. I give my opinion only if they insist or if it's an urgent or complicated medical situation which is why my conscience is clear. Doctors in our country are worshipped and many of them tend to use their position of authority for the wrong reasons. Actually, it's not very surprising when they behave like this because this is how their medical college professors behaved with them. I personally know and have heard stories from some friends and colleagues that these professors are highly disrespectful to their medical students as well as to their patients. I've seen one such professor with his foot on a dead patient's table while lecturing his students in college! If this is how teachers behave, what will the young doctors learn from them about respecting patients? It's indeed a very sad state of affairs."

Dr. Sen went on to explain that some patients came to him with so much faith in him that if he told those people that they would bear an offspring by jumping from the second floor of a building, then that is what people would start doing. According to him, it was this kind of faith and blind trust in doctors which was taken advantage of by many dishonest doctors in India. Unlike those doctors, Dr. Sen mentioned that he encouraged his patients to ask questions and clarify their doubts instead of believing everything he said. He also stated that although he

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[110] That gender stereotypes are hidden within the scientific language of biology has been discussed and critiqued by Emily Martin (1991, 1987). In the conventional 'scientific' explanation of the process of conception, Martin (1991, p. 489) explains that while the egg is largely seen as passive ('feminine'), the sperm is seen as being invariably active ('masculine') through its movement.

would let couples know that ultimately it was their decision regarding the course of treatment, most couples invariably relied on him for the final decision. He then said that the problem in India was that most people believed in “quantity over quality” which is why doctors were chosen based on their popularity which was primarily indicated by the number of patients a doctor had. In this regard, he said:

> “Their [patients’] logic is that if that doctor has more patients, then he must be really good. But what these people don’t realise is that such a doctor does not have sufficient time and patience to treat each couple as an individual case.”

It was interesting, however, to notice that in contrast to what Dr. Sen told me about him encouraging his patients to ask questions, when a patient and/or couple did ask several questions, he was discernibly agitated. For instance, during one of the consultations, a woman asked him about her chances of success at the different treatments, the advantages and disadvantages of one treatment over the other, whether the medical procedures would be painful, the possibility of sedation during the procedures, the chances of miscarriage in an IUI or IVF due to her age and so on. While Dr. Sen responded to her first couple of questions with a smile, her subsequent questions evidently did not bode well with him. With arms crossed over his chest and a waning smile, he answered her remaining questions as curtly as possible. The woman’s husband subsequently asked Dr. Sen why he was suggesting IVF instead of IUI because according to his online research an IUI could also be successful. At this point, Dr. Sen told the couple that since they were not able to trust his medical knowledge and advice, they should find another doctor who could cater to their needs. He also told the couple that he would be uncomfortable in accepting patients who were unable to repose their complete trust in their doctor’s advice. As soon as the couple left, Dr. Sen said to me,

> “See this happens only in India. I’ve never seen this in England. Nobody asks so many questions to their doctor. Only here you will find that somebody who has never played football will comment on why a team lost. Or someone who has never held a cricket bat will comment on how Sachin Tendulkar should have played. This is a big problem. I encourage people to read and learn and be aware but they don’t understand that we have spent decades doing our job! They will read something on the internet and think they know everything! Such half-baked knowledge is very dangerous! People these days have become Google-doctors! You saw how the wife was asking me so many questions? And they haven’t even started any treatment yet! Can you imagine if she didn’t conceive then how many questions she would ask me? I have no patience for such patients. I have so many patients every day. If I start giving so much time to one couple, when will I see the rest? I have to be fair to everyone…People sometimes forget that we are sitting on the other side of this table for a reason. Without trusting us, how are they going to move ahead? I keep reminding my patients that they need to have faith in me because only then they will go home from here with a healthy baby. Too many questions are not going to help them!”

As is quite clear from the illustration here, Dr. Sen was not comfortable with people questioning his medical advice and asking him to justify why he had taken a certain medical decision. I often noticed him becoming annoyed with patients and/or couples who asked “too many questions” based on knowledge acquired from the internet – couples whom he referred to as “Google-doctors” or “self-trained doctors with half-baked knowledge”.

The infertility specialist at clinic C, Dr. Chatterjee, shared Dr. Sen’s sentiments as she said the following exasperatedly to one couple who had asked several questions:

> “Listen, why don’t you do one thing? Why don’t you sit in my chair and I’ll sit where you are? If I am telling you to follow some instruction, then please do it without asking so many questions. I have been doing this for a long time so I know what I’m saying. Oh God! So many questions! Why this, why that? I don’t have so much time, okay? I have other patients waiting for me. Please trust what I’m saying otherwise there’s no benefit of doing any of this.”

My focus in this section and overall chapter is focused on the key relationships between those who control the medical care, have access to the technologies and medicine, and administer the technologies, i.e. the doctors, and those who consume such services and treatments, i.e. the patients. Several scholars have shown that within such asymmetrical power relations, the position of power lies largely with the doctor (see Ainsworth-Vaughn, 1997; Lazarus, 1988; Morgan, 1998; Pilnick and Dingwall, 2011; Taussig, 1980). According to Lazarus (1988, p. 45), such asymmetrical power relations in medical encounters and the dominant position of the doctor “rests on the structural asymmetry of resources: who in the situation controls the medical knowledge and technology”. Moreover, during doctor-patient interactions, Ainsworth-Vaughn (1997, p. 282) notes that questions claim the turn-taking right of who will be the next speaker and the person who asks the questions claims the right to control the discussion. Furthermore, Waitzkin (1984) comments that regarding the sociolinguistic nature of communication, doctors usually tend to maintain high control that involves largely questions initiated by them and a neglect of patients’ life world(s). As such, questions asked by patients can challenge the doctors’ position of power and indicate the power that patients might possess in medical encounters. As I observed in the clinics, doctors did not wish to relinquish their power by allowing patients to ask too many questions or by divulging too much information (ibid., p. 282). Indeed, as a principal disciplinary method, the infertility specialists in my study did not encourage patients to ask many questions (in spite of what Dr. Sen said to me during our informal conversation) and withheld a certain amount of information in order to perhaps ensure that the potentiality of patients to criticise the doctor for making any mistakes is minimised (see also Lorber, 1975, p. 214). For Lazarus (1988, p. 45), deciding the rules of patient behaviour, as well as control of patients' access to and understanding of information on which treatment decisions are made – all of these aspects combined create "a world of power for the medical profession". He further explains that the unequal access to resources necessarily implies a relationship in which one actor is more autonomous while the other actor is more dependent (see also Taussig, 1980). As a result of such an asymmetrical distribution of power where the doctor controls the situation, they do not negotiate and rather co-opt the patients. Not allowing couples to ask too many questions during medical encounters in the clinics was, therefore, an important way in which doctors controlled the patients'/couples' epistemic capital in order to maintain their position of authority and power. The doctor-patient relationship and interaction can, indeed, be seen as an extension of power relationships in the wider society (Lazarus, 1988, p. 45). As I have shown in the illustrations, in order to maintain their position of power and control, Dr. Sen and Dr. Chatterjee expected a certain behaviour of the patients who as 'good patients' should be compliant, display deference along with complete trust and faith in the doctor's medical advice and decisions. I continue to highlight the asymmetrical power relations in the clinics in the following sub-section in which I also show that the failure to perform the role of a 'good patient' often resulted in the patients getting scolded and blamed for the occurrence of reproductive loss.

4.3.2. 'Good patients' are obedient

Although I was not allowed to observe the doctor-patient consultations at infertility clinic A (see chapter two), I noticed even from outside the doctor's chamber that Dr. Ganguly often shouted at couples during the consultations. On one such occasion, while I was sitting in the waiting area speaking to a clinic staff, I (and presumably everyone else alongside me) heard Dr. Ganguly shouting at one of the couples while the door of his room was partially open:

> "What have you come here for? Is this some kind of circus? If you can't follow my instructions properly, then how I am going to do my job! Go to another doctor who will tolerate all this carelessness! I don't need patients who cannot follow simple instructions! I have enough work as it is, I don't need patients like you who will disobey me! It was such a simple thing! If you had any confusion, why didn't you call [nurse] Shanti? I don't understand you people! You all want miracles but you don't want to put in the required effort! Only sir this and sir that! Now please leave, I have other patients waiting for me."

When I asked the staff member about what was going on inside, she told me that the patient party must have done something wrong which had resulted in the doctor's outburst. A few minutes later, I saw the said-patient party walk out of the doctor's chamber with the woman in tears. After a brief conversation with the receptionist, the couple left the clinic.

A few days after that incident, I chanced on seeing the same woman in the clinic's waiting area, sitting by herself, flipping through a magazine. I approached her, introduced myself, and struck up a conversation. 33-year-old Mukti, who was a former employee [111] at a multinational company had been coming to Dr. Ganguly for six months. She was undergoing her first IUI cycle as four months of Timed Intercourse (see chapter six) previously had not helped her conceive. I asked Mukti about what had happened in the doctor's chamber the previous week and the following dialogue ensued:

> Mukti: Actually, it wasn't sir's fault. He was right – it was our fault. He told us that we have to take the injections sub-cut [subcutaneous][112] but my husband didn't do it properly the first time. I tried it myself the second time but it didn't happen correctly. I had thought I would be able to do it properly myself. I didn't want to bother sir or Shanti *dī*[113]. But one of us should have asked. Now sir has said that because the injections weren't taken properly, we have to start again. I don't know why we didn't ask for help. We thought it would be easy… From now on, my husband and I will do everything as sir says. We don't mind the shouting. Just like parents scold their children when children make a mistake, we know that sir also scolded us because he ultimately wants the best for us *smiled*. We just want a healthy baby, that is what ultimately matters to us. For that, we can handle any scolding from sir.
>
> Ethnographer: Yes, I understand…were you or your husband told or shown by Dr. Ganguly or any nurse on how to administer a sub-cut injection?
>
> Mukti: No, we weren't shown by anyone. I had seen many patients who come here and they were also told to take sub-cut injections by themselves. I don't think anybody is taught how to do it. I think it's easy which is why sir had said that we could do it at home. Maybe if we had been more careful about it then we could have done it correctly ourselves too.

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[111] Mukti, like many of the female interlocutors in my study who were undergoing IVF, had quit her job due to the physical, emotional, and time demands of this treatment (see Franklin, 1997 where she discusses that undergoing IVF dominates a woman's life considerably and eventually, that treatment becomes 'a way of life').

[112] A subcutaneous or "subcut" injection is used to administer the hormonal drug into the woman's abdomen or thigh in the tissue layer between the skin and the muscle as part of infertility treatments. These injections have to be taken by the woman before the treatment to stimulate the development of the woman's eggs. Unlike infertility clinic A, in clinic B and C, I had seen one of the nurses teaching women how to administer the injection before she was sent home with the injections. Depending on the treatment protocol, eight to ten injections are required by a woman for each treatment cycle. As I was told by the female interlocutors who were undergoing (or had undergone) multiple cycles of IVF, the subcut injections were very painful and a few women told me how they had become sore and had bluish marks on their skin from taking the injections repeatedly.

[113] A short form for the Bengali (and Hindi) word *didi* which means elder sister, *dī* was used commonly by the women and men at the infertility clinics to address the nurses.

Neither Mukti nor her husband had been given a demonstration of how to administer a subcutaneous hormonal injection and it was somehow presumed by the doctor that they would have the required knowledge. However, when the couple was unable to administer the injections, they were shouted at by the doctor for being unable to do a "simple thing" and for not putting in the effort that patients *should*. Instead of holding the practitioners accountable for not having shown her how to administer the injection, Mukti seemed to have accepted that it was her and her husband's fault for not having asked the nurse. Her statements, additionally, also show that she was willing to accept the doctor's reprimands in order to achieve her final goal of a pregnancy. She rationalised and accepted Dr. Ganguly's scolding by stating that it was similar to a parent scolding a child when the latter makes a mistake. Mukti's comparison of a parent-child relationship to a doctor-patient relationship is suggestive of the paternalistic doctor-patient model as discussed by Parsons and Fox (1952). In the description of the patient's "sick role" within the paternalistic model, Parsons (1951) notes that the doctor's role was to direct and prescribe, while the patient's role was to obediently cooperate in order to overcome the sickness. The analogy drawn by Mukti of the doctor to a parent is, therefore, legitimised by her condoning his role as a disciplinarian who corrects 'bad' or 'inappropriate' patient behaviour (see Beseicker and Beseicker, 1993, p. 47). Moreover, by asking Mukti to find another doctor, Dr. Ganguly performed the role of a disciplinarian who could potentially withdraw his support and legitimisation of the patient's sick-role status due to the patient's non-compliance and inability to follow a given set of instructions. Mukti's decision, herein, to obediently follow the doctor's instructions emerges from her *need* of the doctor's guidance in order to conceive. As such, by her own volition, and indicative of her agency even in her apparent passivity, Mukti was ready to submit to the medical demands because it was only by doing so that she would move closer to achieving reproductive success.

My conversation with Mukti also reflects a pattern which I noted in my conversations with the other female interlocutors – that doctors had their patients' best interests at heart. There were hardly any complaints or accusations of any kind of wrongdoing or ill-treatment from the female (or even male) interlocutors about the infertility specialist who was treating them at present[114]. I argue that what the women and/or couples in my study sought was

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[114] There were only a couple of female interlocutors who criticised their previous doctors and nurses with whose help they were unable to achieve reproductive success.

practitioner-mediated conception along with, and perhaps more than technology-mediated conception. My claim is that not only did the couples need to have faith in the potential of the technologies, as I have discussed in chapter three, but they also utilised their strategic agency, in both active and passive forms, in order to place their faith in the practitioners' expertise. Ultimately it was the doctor who was regarded by the women (and the men) as the protagonist who would "give them a baby" (a phrase commonly used by the interlocutors). Indeed, several female interlocutors expressed that even though one is living in an era of sophisticated technology, they would be able to undergo the treatments and conceive only with the guidance of the "right" doctor who would not cheat them. For instance, Maya said,

> "However advanced medical science is, without good doctors, there is no benefit for couples like us. We need good doctors to tell us what's best for us. See, nobody wants to go to a doctor right away. No married couple would want that. So if a couple does see a doctor, it's because we *had* to. At that time, that doctor becomes our God. We have nowhere else to go. The doctor is the only person we can trust who will give us good advice and guide us in the right direction. Everyone else is busy judging and taunting us. So yes, having the right doctor who will not cheat us or who will not take us for a ride becomes very important."

In this regard, Bharadwaj (2016, p. 223-224) explains that patients express their trust in the doctor's ability to

> perform a miracle by a feat of medical prestidigitation, rather than in the superiority of the technologies. Interventions like IVF assume meaning only in the context of an able physician, who has the expertise to apply technology to create the desired outcome – pregnancy. In assuming the primacy of the technician over the technique, some patients place themselves in a situation where they are left to adulate and worship the expert as a last resort.

In addition, as we can see from Mukti's case, it was not only she who had decided to place her complete faith in the doctor but it was also the doctor who expected unquestioned compliance. It was a common occurrence at the infertility clinics that the doctors would become angry, irritated or disappointed when patient(s) failed to follow instructions and/or display their trust in the doctors' intentions and medical expertise. Quite often, the infertility specialists would get quite angry if a patient and/or couple in any way indicated that the doctor should put in more effort in cases where the previous treatment cycle(s) had not shown the desired results. In order to illustrate this aspect, let me introduce the case of 36-year old Nisha who was undergoing IVF treatment at infertility clinic C.

As Nisha was lying on the bed for the TVS to be performed, she told Dr. Chatterjee that she was hoping that this would be her last IVF as she was getting mentally and physically exhausted given the prolonged period of treatments as well as the immense pressure she was facing from her in-laws and relatives. She further added,

> "Dr. Chatterjee, I know you are doing everything you can but if you could please try harder this time. My husband and I have all our hopes pinned on you."
>
> Dr. Chatterjee looked at Nisha and said angrily in an elevated voice,
>
> "What did you just say? Will you repeat that? Are you trying to tell me that I don't do my job properly? If you are so unhappy with me, then please go to somebody else. I don't need a patient who doesn't have faith in me. Please leave if you like, I have many other patients who trust me blindly. They don't tell me how to do my job. What is this way of speaking to me? Are you trying to tell me that I didn't do my job properly the last time and this time I should pay more attention? Is that what you are saying? And please don't tell me that you are exhausted. If you are so exhausted then don't do all of this and don't come to me saying that you want a baby. Your mental pressure is not because of me. Tell your in-laws who put this mental pressure on you. Am I telling you to have these treatments? You came to me. I don't understand you people. You all want a baby but you are not willing to be give it time. You think we are having fun here? Or do you think it's magic? I wave a wand and you get a baby? I have so many patients I have to think about. You are not the only patient I have. Please be careful of what you say in front of me from next time. Think twice before speaking. Understood? *Nisha nodded and apologised* Fine, now let me do my job."
>
> After the scan was over and Nisha had left the room, Dr. Chatterjee turned towards me and as said as she removed the disposable gloves,
>
> "This patient has a complete package of metabolic issues. Type one diabetes, high blood pressure, hyperthyroidism, and PCOS – you name it and she has it! Getting her pregnant is one of my biggest challenges so far in my career. It will be a miracle if she becomes pregnant and has a normal baby. I understand that she has been trying for very long. But you tell me, how can I not lose my temper if she tells me how to do my job? How can she tell me that I should try more this time? I also want to give her a baby but she needs to trust that I am doing my best! I give my best to all my patients but they also need to understand that everything is not in my hands. Some things are written here *pointed to her forehead*."

Dr. Chatterjee had made it clear to Nisha that if she could not trust her completely like her other patients, then she should find another doctor.

As I have mentioned earlier, the doctor-patient relationships in my study were largely indicative of the paternalistic model which suggests that since the doctor possesses the knowledge, expertise, and experience required to make appropriate medical decisions, the implication is that the patient ought to comply with the doctor's decisions (see Beseicker and Beseicker 1993, p. 46). The lack of the patients' technical expertise to make informed decisions and their (apparent) inability to evaluate the risks and uncertainties that accompany major medical decisions are reasons used by the medical personnel to justify the doctors' dominance in determining the required medical course of action. The doctor's dominant position is, therefore, reflective of the existing power hierarchy within the infertility clinics, which is certainly not to imply that the other actors in the clinic are devoid of agency. Rather, as Shaw (2016, p. 142) perceptively points out, the power hierarchy within a clinic emerges from the distribution of knowledge/power where different actors have different levels of expertise based on their medical training, experience, and position in the clinic. For instance, the level of expertise and knowledge between an infertility specialist and an embryologist or an embryologist and a nurse would be different which would confer a different level of power and authority to each practitioner. Even between two people with the same designation, for instance, between two infertility specialists, there would be a difference in the prestige and power one has over the other based on his/her training, knowledge, and experience. As Thompson (2005, p. 142) also explains, like other arenas of expert technical culture, the culture of infertility medicine also intrinsically includes "marking and differentiating skills and expertise (and the social, hierarchical roles that go with these notions)". Within such a setting, whenever a patient and/or couple failed to accept that the doctor is the expert and did not trust the medical advice and/or failed to adhere to it, then disapproval was expressed by the doctor, especially if the latter perceived that the occurrence of reproductive loss was a result of the patient's disobedience. For instance, when any couple experienced reproductive loss after conception, Dr. Sen would usually spend an extended amount of time (as compared to a regular consultation) to offer words of comfort and moral support to the grieving woman and/or couple.[115] However, in certain cases, as I show in the next ethnographic sketch, he showed minimal interest in offering any kind of consolation and expressed his disappointment to the patient and/or couple for not having followed his instructions diligently.

Rashi and her husband, Sanjay, had been trying to have a child for more than two years. The couple had started consulting Dr. Sen after Rashi was unable to conceive under the medical supervision of the previous infertility specialist and when she did finally conceive with IVF, she had an early miscarriage. Although she had conceived once again with IVF under Dr. Sen's guidance, Rashi experienced a miscarriage in the ninth week of her pregnancy. After the incident, when the grieving couple came to meet Dr. Sen, Rashi immediately started crying. While she kept crying for a couple of minutes, Dr. Sen didn't say anything or even look at her as he kept typing something on his computer. A few minutes later, he turned towards the couple and the conversation below followed between her and the doctor.

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[115] As I show in chapter five, the words of comfort offered by the doctors were mostly related to convincing the women to undergo another treatment cycle.

> Rashi (R): “I don’t know what to do Dr. Sen! I don’t know why the mishap happened the second time. I was so careful the entire time. Please help me! Please tell me what I need to do now. Why is this happening with me?”
>
> Dr. Sen (Dr.): I’m sorry for your loss but please don’t cry like this. I have patients waiting outside and they can hear you. They will be affected by this.
>
> R: Sorry, Dr. Sen. Actually, you have so many women who come here and go home with beautiful babies. Then why can’t I be one of those fortunate women? Is it my fate? Am I never supposed to have a child?
>
> Dr.: Please don’t say such things. Look, sometimes it’s better to have a change of hands. Maybe you should try with another doctor. Sometimes when patients change their doctor, then they get the results they want. Maybe you should also do that.
>
> R: No Dr. Sen, we want to stay with you. We will try again but please promise me that the next IVF will work.
>
> Dr: *sounded agitated* You are behaving like a child. How can I promise you anything? Can you promise me that the implantation will happen after I transfer the embryos? If you can’t promise that, then how can I? You can go and try with some other doctor who has a greater success rate, some clinic where 10 out of 10 patients have become pregnant and gone home with a baby. But let me guarantee you that you will not find such a place. So, please try to understand that I can’t do anything new here except for trying again with the same process. And I can’t guarantee you a 100% success rate. It’s your decision finally. So, take your time and then let me know what you have decided.
>
> R: Yes, but we want to stay with you…I just don’t understand why this happened again.
>
> Dr: I know you are upset so I don’t wish to say anything which will upset you further. Look, my other patients are very obedient. They do exactly what I tell them to do, word by word. But you and your husband were not willing to listen to me. I had told you several times that your chances will be better with donor embryos but neither of you were ready to listen to me. You both did not respect my decision which I had made based on my experience while sitting on this chair for years. I don’t like it at all when patients think they know better than me. That is disrespectful to my years of practice and hard work which I have done to sit here on this chair. So, I request to please continue with me only if you are willing to listen to everything I say. Otherwise, as I have said, please find another doctor. I won’t mind at all.

The conversation which lasted for no longer than ten minutes ended with Rashi telling Dr. Sen that she would try again with him and the couple promised him that they would listen to everything he told them to do in their next attempt. As they left the room, Dr. Sen told me,

> “This couple makes me very upset. They always challenged every decision I made. They never had complete faith in me. From the beginning they would ask me unnecessary questions – why this, why that. So, yes, it’s sad whenever such an incident happens, but frankly speaking, I am hardly surprised that she had a miscarriage. Although there is no concrete reason for why this happened because miscarriages are quite common in IVF pregnancies, it could have probably been avoided if they had opted for donor embryos. I told them several times that they should go for donor embryos because the wife’s eggs were of poor quality and so the embryos I had transferred were not of good quality from the start. But they both insisted on using their own eggs and sperm. I was actually surprised when she conceived because I had assumed that implantation would not happen…It’s sad to see them like this but they never paid proper attention to what I told them to do. They always thought they knew

> better…This can actually be a problem with some people. They think they know better than the doctor. But we have been learning and practicing for years so it makes me upset and angry when they don't respect our decision. I am actually disappointed with this couple. They could have probably prevented this sad incident if they had followed my advice. I tell all my patients, if you don't to listen to me, then why bother coming to me at all? If they know everything, why come to me? It's a pity. I feel bad for them and I want to help them, that's why I am here, but they also need to have faith in me. They need to trust that I whatever I say or do is only for their benefit. But some people don't get it. So, I tell them it's better if they find someone else…You have seen for yourself, I have patients who follow every single word that comes out from my mouth. I am not saying they have to worship me. In fact, I tell my patients not to treat me like God but it's important that they respect me and have faith in me."

According to Dr. Sen, the reason that Rashi had a miscarriage was because she had not paid attention to his advice which he considered as a form of disrespect. Shaw (2016, p. 140) explains that doctors' privileged position and authority in medical encounters partially stems from their elite background, the power granted to them by the State as well as from their high levels of university education, advanced training, and the resulting medical knowledge which they obtain over time. Citing Foucault (1997), Shaw writes that knowledge and power

> "constitute a symbiotic relationship: as more knowledge is obtained an increase in power will follow, and every expansion of power will be accompanied by an increase in knowledge; the two are interconnected and reflexive of one another" (Shaw, 2016, p. 141).

She further notes that in Colombia, historically only people from the higher socio-economic strata have had the resources to access such university education. She explains that the costs of studying in a medical school greatly limits who can apply to such schools, thus reproducing the local perspective that doctors are commonly from wealthy backgrounds. Similarly, in my study, all the infertility specialists had pursued their medical education at some of the best public universities in India and then continued pursuing their specialised training in reproductive biomedicine abroad. The education and training acquired over time (and partially also the prestige attached to their clinic's popularity and their elite lifestyle[116]) had imbued these doctors with a certain authority based on which they expected their patients to respect them and have faith in their medical decisions. Indeed, while expressing their disapproval of a patient's behaviour and failure to perform the role of a 'good patient', the infertility specialists in my study commonly alluded to their medical knowledge and expertise that they had gained over the years and that, thus, gave them the authority to give medical advice and make the warranted medical decisions.

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[116] My claim of the doctors in my study having an elite lifestyle is based on the conversations I have had with them in non-medical spaces such as restaurants, along with their attire, and their posts and photos on social media which depict a certain kind of life they lead which in India can only be afforded by a handful.

Although no concrete evidence was stated by Dr. Sen which suggested the cause for the miscarriage, a later conversation with Rashi suggested that she had accepted that her miscarriage had happened because she had disobeyed Dr. Sen and she blamed herself (and her husband) for the mishap. In tears, Rashi told me:

> "If I had heard what Dr. Sen told us, then the miscarriage wouldn't have happened. I would have been pregnant today and I wouldn't have to start another IVF. There's no point in blaming Dr. Sen here. I can understand why he was upset with us. Dr. Sen only thinks of his patient's wellbeing and he doesn't say things just to make money like other doctors. I told Sanjay that from now we will do everything that Dr. Sen tells us. If listening to him gives us a baby, then we are happy to do as he says."

Although the doctors' reactions when patients did not obey their instructions or when they questioned their medical advice and expertise were not overt forms of coercion in disciplining the patient, it did, however, indicate to the patient and/or couple that certain forms of behaviour as a patient were unacceptable. Chattopadhayay, Mishra and Jacob (2017, p. 8) have also observed in their study in India that the reprimands by the medical practitioners are "consistent with ideas of disciplined bodies that ought to be presented in an appropriate fashion for institutional examinations". Rashi had seemingly reconciled to the idea that achieving reproductive success meant that she *had* to be an obedient patient – a 'good patient' who did not question the doctor's instructions. In the case of childless individuals/couples who are commonly represented as "desperate" and "willing to do whatever it takes" (see Franklin, 1990) to bear a child, the presumption that doctors know what is best for their patients takes on a heightened sensitivity (see Price, 2003, p. 88). And as I have shown in this section, the female interlocutors Mukti, Nisha, and Rashi had accepted that in order for them to bear a child, they would have to enact the role of a 'good patient' which primarily involved them being obedient and displaying complete trust and confidence in the decisions of the infertility specialists.

However, reprimanding patients and/or couples or expecting obedience were not the only ways in which doctors exercised their disciplinary power. For instance, as I show next, in infertility clinic B, Dr. Sen often disciplined his patients through positive reinforcement when they did what he deemed as the behaviour of an ideal, responsible, and 'good patient'.

4.3.3. 'Good patients' are praised and appreciated

On one afternoon at infertility clinic B, when a couple finished their consultation and had left the room, Dr. Sen, looking very irritated, said to me,

> "You saw what just happened. If you didn't see it with your own eyes, you would think I am making up stories. This patient's previous doctor suggested some medicines but didn't bother writing on the prescription for how many days she should take those medicines! I fail to understand how doctors can be so careless! I'm so fed up. I sometimes think I'll leave all of this. I can't tell you how often I come across doctors who have done a shabby job. And it's because of those doctors that patients develop a mistrust in doctors. The problem is that I can't keep doing everybody else's jobs. Nobody is meticulous. It's so frustrating! You should write something about the frustration some doctors have to go through because of the shabby job done by other doctors. I will fund this research. You'll only get tired of writing. See, I am very meticulous and this is one of the most important things I learnt during my training abroad. Being meticulous and organised is essential to one's professional and even personal life. One can avoid many simple mistakes by just being a little meticulous. Unfortunately, this is one such thing which the majority of doctors in India don't take very seriously. So many errors and medical casualties could be avoided in this country if only the doctors were more meticulous."

Dr. Sen would often mention how his upbringing and socialisation were responsible for how he behaved with his patients in his medical career. He spoke of his father's teachings and his decade-long medical training abroad which taught him, among other things, the importance of meticulousness and diligence. I had observed staff meetings that Dr. Sen would specifically organise to remind his staff that clinic B's efficiency depended on how well-organised, thorough, and careful everyone was in doing their respective tasks. Lazarus (1988, p. 46) points out that medical judgements are usually influenced by a doctor's "personal values, education, choice of speciality, scientific convictions, and economic needs". Brody (1987, p. 155) similarly notes that physicians are "prisoners" of occupational prejudices, desire for professional success, and their personal background, if not state policies. As such, the interactions between doctors and patients are not only circumscribed by a biomedical model but are also shaped by the actors' perceptions founded on class and gender, writes Lazarus (1988, p. 46). Indeed, doctors-patient interactions and the doctors' decision-making process is significantly affected by a range of factors, including their socialisation and training.

Furthermore, Dr. Sen also pointed out that many medical accidents in India could be sidestepped if only other doctors were as meticulous and diligent as him. It was not only other doctors from whom Dr. Sen expected a certain degree of meticulousness, but also from his patients, as is reflected in his quote below:

> "I don't like it at all when patients don't show as much as diligence as I do in my work. It doesn't make me happy at all. Now tell me, if they lose a report or a scan or something else, how I am supposed to proceed? Do I have the time to make them repeat those things? They need to understand that if I don't see their reports and scans properly, then I won't know what step I need to take next. There is a reason I ask all my patients to file all their papers. How difficult is to keep everything organised? Some patients make these careless mistakes and then if something goes wrong, then immediately all

> blame will be placed on the doctor. This is why I am always so cautious with my work. I don't want to make any mistakes and I also want my patients to understand how I work so that they can follow me."

When any patients and/or couples were unable to show certain reports, scans or medical bills, Dr. Sen would respond with irritation regarding their "inappropriate" and "callous" patient behaviour. One such example was when a female interlocutor, Asha, who was about to start her first IVF cycle said that she had accidentally misplaced her a test (HSG) report that she had been given by her previous doctor. To this, Dr. Sen told Asha and her husband,

> "I understand you both are busy, we all are. Everyone these days is busy. But we have to first decide what our priorities are. You are investing a lot of money and time in this treatment. This should be your priority. Everything else can be side-lined for now, isn't it? *the couple nodded[117]* How can you misplace an important report? That means we will have to do the same test again which means we will waste more time and you will waste more money. Is that what you want? *Asha and her husband replied with a soft no* Look, this will not be successful if only I give it my best. I am very careful and organised and I have trained my staff to also work like me. As my patients, you need to understand this. I will not accept such careless behaviour after this, understood? *the couple responded affirmatively* If you want me to be a good doctor, then you also have to a good patient. Only then we will win this battle! So, from next time, I want to see that everything is kept properly in your file. *Asha said that she will ensure this mistake is not repeated* Okay, now don't sulk like children. Don't feel bad if I scold you because I am only saying all this to ensure that you go home from here with a baby. That's all I want. And that will only happen when you listen to me carefully."

However, for the patients and/or couples who followed his instructions with precision, Dr. Sen showered them with praises. He also congratulated the patients when they had their documents well-organised. There were a few occasions when if Dr. Sen was impressed with a couple's meticulousness, he would call some of the clinic staff to his chamber and say for instance, "Look, just look at this! (as he flipped through the patient's medical file) This is how things should be done". On one such instance, Dr. Sen made his staff applaud a couple who had labelled their medical reports, organised them chronologically, and had made copies of all documents in case they misplaced the original. On seeing this, Dr. Sen said to the couple, "I am incredibly happy to see this! All patients should see you both as a role model! Excellent!". On other similar occasions, he would use terms such as "good and responsible patient" or "ideal patient" and comment about how "such patients" made his job easier. Thus, in order to discipline the patients effectively, Dr. Sen used strategies such as positive reinforcement

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[117] Regarding interruptions made by the patient during a medical encounter, a patient's non-interruptive style (such as "yes" or "m-hm") was "in accord with social rules of appropriateness" for avoiding overlapping talk, (Ainsworth-Vaughn, 1997, p. 285).

wherein he praised women and/or couples for behaving like ‘good patients’ i.e. patients who were responsible and meticulous, like the doctor himself.

Based on the examples so far in this section, I have discussed how the infertility specialists performed certain disciplinary mechanisms in order to enact the women and/or couples as ‘good patients’. However, as Shaw (2016, p. 137) rightly argues, it would be over-simplified to visualise power inside the clinics in a linear or hierarchical manner. As such, it is important to point out that even if the infertility specialist may possess the most authority and medical knowledge within the clinic that accords him/her in a dominant position, reproductive success cannot be achieved solely based on his/her expertise (Shaw, 2016, p. 143). Rather, for the performance of the clinic’s “collective enterprise” (Bourdieu, 1990, p. 68 in Shaw, 2016, p. 143) which in this case is achieving conception, the infertility specialist must rely on the knowledge and expertise of the other actors (and actants) in the clinic. As Mol (2002, p. 21) has also pointed out, “however shared or solitary perspectives may be [between actors], the practice of diagnosing and treating diseases inevitably requires cooperation”. Moreover, given the complexity of fertility treatments, such as IVF that involves different stages where each stage has a specialised function, there is not just one doctor who possesses the authority and knowledge to perform the entire treatment by himself/herself. Instead, each medical personnel performs specialised tasks based on their specialised education and role which ultimately creates a collaborative environment where the multiple actors and actants come together in order to achieve reproductive success (Shaw, 2016, p. 141-143). Power, therefore, does not reside only with the doctor and is rather multiple and shared, even if asymmetrically, amongst the actors and actants where they all need each other to work together towards achieving conception.

While the infertility specialists enacted the (primarily female) interlocutors as ‘good patients’ and constrained their agency in various ways, the interlocutors were not mere passive victims. Instead, as I have shown, they drew on forms of constrained but strategic agency in order to become or enact themselves as ‘good patients’, for instance, by accepting the doctor’s reprimands and/or by agreeing to trust the doctor’s capabilities. As Shaw (2016) has also shown in her study, the apparent dichotomy of active agent (i.e. doctor) and passive victim (i.e. patient) restricts the understanding of the multifaceted nature of agency and how it is utilised within constraints by the patients. To elaborate further, I will now present some other examples in order to show how women and/or couples exercised diverse forms of agency and also how power is, indeed, distributed among the actors within the clinical settings.

4.3.4. Consumer-Patients and Distributed Power in Infertility Clinics

It would certainly be an oversimplification and erroneous claim that the doctor-patient relationships in the infertility clinics in Kolkata were based solely on a paternalistic model where the power resided only with the doctor. Instead, I suggest that for many of my interlocutors, the doctor-patient relationships were a marriage of the paternalistic model with a model of "consumerist transaction" (Beisecker and Beisecker, 1993, p. 50). Based on this model, the women and/or couples as consumers decided which doctor is the best fit for them and who would help them in achieving their goal of reproductive success. Consider the following interview excerpt of Neeta who was one of the handful of female interlocutors who had achieved reproductive success after several years of undergoing multiple infertility treatments. Speaking of her experience with her doctor(s), Neeta recounted:

> "For me and my family, Dr. Ganguly is an incarnation of God because he gave me my son. But because of my negative experiences with other doctors before him, I have to admit that I was a little doubtful about his intentions before I met him. I kept thinking that maybe he is also like the other doctors. I had started thinking that for doctors this is just a big business and this is why they tell patients to do IVF repeatedly only to make lots of money. Otherwise what could be the reason for so many women to have IVF these days? And most women have more than one IVF…Actually, my husband and I had done some online research about Dr. Ganguly before we consulted him. We wanted to be careful about whom we chose this time. I was so fed up. But once I met him, I knew he was a good person. He had assured me that I will have a baby. He was the first doctor I'd met who was very encouraging and supportive. He behaved more like a friend and less like a doctor. He scolded me whenever I did something wrong but I knew he was scolding me for my own benefit. Except for his short temper, everything else about him impressed me very much. I instantly liked him. He didn't make me feel dirty. I was so fed up with being constantly touched and probed by my earlier doctors! I can't explain how miserable I used to feel. After some time, I started thinking that these men only became gynaecologists to touch women. I was tired of removing my underwear in front of strangers and being touched by them. Nobody would say anything or give me any information and they would start doing something. I didn't want to listen to them anymore. I told my husband also, that enough, I cannot handle such doctors anymore. So, it was such a relief when Dr. Ganguly treated me with respect and didn't treat me like a child. He informed me about the treatment at every step. It's a different thing that I didn't understand lot of things he said *chuckled* I am just so happy that ultimately everything was fine…I'm the proud mother[118] of a beautiful son and it's all thanks to Dr. Ganguly[119]."

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[118] See chapter three for a discussion on how being a "proud mother" indicates the woman's achievement of reproductive success in the form of her prolonged perseverance for which she was finally rewarded.

[119] Like the other women, Neeta attributed the birth of her son to the infertility specialist. Other actors (other practitioners) and actants (conceptive technologies) did not make an appearance in her narrative of reproductive success and it was the infertility specialist who appeared as the protagonist in her journey of her becoming a

My findings resonate with those of Bharadwaj (2016, p. 221) wherein he claims that although couples were opposed to medical mismanagement, they nevertheless persisted in their hope to search and find the right expert who would assist them in achieving reproductive success. Bharadwaj referred to this approach as the "trial and error" approach or the "resist and persist" approach to medical treatment and conception (ibid.). Within the patient as consumer discourse, Lupton (1997a, p. 373) argues that it is, indeed, common amongst childless couples to "shop around" for suitable doctors by actively evaluating the doctors' services and finding another doctor if the previous doctors' performance was deemed unsatisfactory. In enacting the role of the "consumerist" patient, Lupton argues that the patient is also a "reflexive" actor (ibid., p. 374) utilising her active and strategic agency by not only deciding that she needs *to* submit herself to the medical demands of the doctors and technologies if she wishes to have a child but by also deciding which doctor should treat her. As we can see in Neeta's statements above, her agency was revealed in her deciding to stop feeling "dirty" and refusing to "handle" the doctors before Dr. Ganguly. As she said, she was frustrated with the doctors infantilising her, having to take off her underwear, and with their constant probing of her body without providing any prior information. Her apparent non-compliance as a patient emerged more from how she was treated and regarded by those doctors and less from how she regarded the medical regimen(s). It would be prudent here to note that Neeta attributed the birth of her son to Dr. Ganguly. Other actors (other medical personnel) and actants (conceptive technologies) did not make an appearance in her narrative of reproductive success and it was the infertility specialist who appeared as the protagonist in her journey of her becoming a "proud mother of a beautiful son". Such examples reaffirm the point made at the beginning of this chapter wherein the centre-stage was usually accorded to the infertility specialist.

Neeta's criticism of her previous doctors and her scepticism before meeting Dr. Ganguly was not an exceptional case and there were several other female interlocutors in this study who voiced similar concerns while seeking infertility treatments. For instance, a professor, Sushma Pal, remarked that it was natural and understandable for any educated person to be doubtful

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"proud mother of a beautiful son". Such examples are a call back to the centre-stage accorded to the infertility specialist, as discussed at the beginning of this chapter.

before meeting their doctor for the first time given the news reports in India about poor, illiterate, and lower-class people being occasionally duped by doctors:

> “If you follow the daily news, you will come across news reports about doctors cheating their patients to make more money. So, for any educated person in our society, it is natural to be doubtful about meeting any doctor for the first time. For people like us, we are hoping that a doctor will give us a baby, that he will fill that large vacuum in the lives of childless women like me. We obviously want to trust the doctor but a little scepticism is of course understandable considering the situation in India. Actually, I personally think that trusting the doctor is good but it should not be blind trust. People should be careful and ask the doctor if they have any doubts. It’s very easy to get confused as patients when doctors speak to you using their medical vocabulary, but I think if as patients we don’t understand something, we have the right to ask. Sadly, most people in India who belong to a lower class and are illiterate don’t do so because they worship the doctor. It’s as if whatever comes out of the doctor’s mouth is the ultimate word! We forget that ultimately the doctors are doing their job, we pay them for a service they are providing for us, and they are accountable if there is a mistake on their part. Also, as patients, we have the right to decide which doctor we want to be with. There’s no reason for us to continue with any doctor if he or she is mistreating us or trying to cheat us. Ultimately, it’s a give and take relationship. People should not forget that they would not be making this much money if we didn’t avail their services!”

Malin et al.’s (2001) research in Finland has shown that in becoming an assertive consumer in the reproductive technology market can be empowering for involuntarily childless women who attempt to resist the objectification and alienation of their body under the clinical gaze. Moreover, Becker (2000, p. 129) notes that questioning the ‘providers’ (doctors) who supply the ‘services’ (treatments) within the patient as consumer discourse not only reflects the agency of consumer-patients but also imbues them with moral authority. I additionally suggest that it is also the middle-class positionality of the interlocutors in my study that imbues them with certain agentic capacities, utilising which they decide and articulate how they want to be treated by doctors. For Sushma, while trusting one’s doctor was understandable, she pointed out that “a little scepticism” was also understandable given the situation in India. Distinguishing herself from lower-class, illiterate people who worship doctors and get duped by them, Sushma enacted herself as an educated consumer-patient and stated that “people like her” should remember that doctors are being paid for a service they are providing and that they are accountable for any mistake they may have committed. Referring to the doctor-patient relationship as a “give and take relationship”, Sushma also said that it is the patients’ prerogative to decide which doctor they should be treated by and if any patient is being mistreated or cheated by a doctor, then he/she has the right to stop pursuing treatment under that particular doctor’s supervision. Her remarks can be understood as her viewing of patients, specifically the educated patients[120] as herself, as agentic and reflexive actors who can (and should) make the required treatment-seeking decisions based on their (prior) experiences with a doctor[121]. As such, the act of deciding which doctor is the right expert who will help the couples in achieving reproductive success and the understanding that doctors make money because their services are availed by the consumer-patients gives couples a sense of control and power in their otherwise distressed and constrained circumstances caused by reproductive disruptions. Such decisions can, thus, be seen as a means to exert power in a situation which is otherwise largely controlled by the practitioners.

In addition to enacting the role of reflexive consumer-patients, many of the female interlocutors (and their husbands) also exercised forms of strategic agency which, for instance, manifested in active decisions which they made during ongoing infertility treatments. Let me illustrate this point with 37-year-old Baani's example who during one appointment, informed the infertility specialist, Dr. Chatterjee, that her father-in-law had been diagnosed with terminal cancer and his doctors had said that he would not survive for long. Baani then said that she wanted to stop the treatment as she wanted to stay at home and look after her father in-law. Dr. Chatterjee asked her why the treatment had to be stopped if her father-in-law was ill. Baani said that since her in-laws lived in Purulia[122], it would be impossible for her to travel to the clinic frequently. She also told Dr. Chatterjee that she would resume the treatment when she was in a better mental state and would also have more time on her hands. She also mentioned that her husband was not in a mental state either to participate in and support the treatment at this difficult time in his life. On hearing all of this, Dr. Chatterjee said,

> "I understand the situation and that all this is hard for you. But you also need to understand what stopping the treatment means. In your case, you are nearing 40. At this age, the longer you wait, the lesser your chances of pregnancy are and the chances of miscarriage with IVF are much higher at your age. I have told you this before that you don't have a lot of eggs. Please don't cry to me later if you have to use donor eggs. I am going to say some harsh things to you Baani, but it's for your own benefit and it's my job to make you understand. I have nothing to gain by saying all this because if you go, another patient will come. See, people are going to die, your father-in-law is old *she asked his age and Baani said he was 77* so see, he will eventually die, either today or tomorrow. We all will die, right? Nobody knows how long we will live. And you don't know whether he will live for another month or for a year. But we need to think of the future and do what's good for your future, right? You need to think of your future. Your husband will think of his sick father now but he also needs to think about

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[120] I found it interesting that Sushma referred to herself as a patient throughout our conversation, even though she and her husband had opted for surrogacy and as such, she was not undergoing any treatment.

[121] Of course, this is no way implies that people from disenfranchised backgrounds are devoid of agency!

[122] It is a district in West Bengal which is nearly 300 kms away from Kolkata.

> his future family. Isn't it? Am I right or not, tell me? *Baani nodded* Tell your husband to come in the next two or three days or as soon as possible and give his semen sample. Without his sample, we can't go ahead. There's no point in me doing your scan today. First, we need your husband's sample, we'll store it while we collect your eggs, and only then we can do the fertilisation for the embryo transfer. Think about what I am telling you. If there's no imminent mishap, then please ask your husband to come and give his sample. Do you understand what I'm saying? People die every day. That's how the world works. But we need to do what's important. So, talk to your husband and explain this to him. And if he doesn't understand, then make him call me, I will explain the situation to him. He also needs to understand that this is just as important as looking after his father. So please talk to him and then let me know when we he will be able to come here. Tell him there is a lot of money involved here. If you stop now, you will not be refunded with the money you have already paid. Everything you have done so far will be a waste of both your time and mine. Do you understand what I'm saying?"
>
> Bani responded by saying:
>
> "Dr. Chatterjee, I understand. But my in-laws and my husband need me right now. I can start the treatment again but my father-in-law will be gone any day. The doctors have said he only has a few more months. I lost my father at a young age, and he has always treated me like his own daughter. Also, my husband is not in a mental state to come to the clinic and give his sample. Of course, we want a baby but neither of us wish to continue the treatment now."

The conversation ended with Dr. Chatterjee asking Baani to nevertheless discuss the issue with her husband and to give her an update accordingly as soon as possible.

Around two weeks later, when I was chatting with Dr. Chatterjee, I asked her whether Baani had decided to continue or forego the treatment, to which she said,

> "Actually, she had called me a couple of days earlier. She has decided to stop the treatment. She said the same thing she said that day – she wants to be with her family. She said something about her mother-in-law also being sick. See all that is fine, I get that family issues are important and that she also lives quite far away so it's difficult for her to travel. But you see, the problem is that they will come to me eventually and say, Dr. Chatterjee, I want a baby. It's not magic! I don't have a baby factory here which produces ready-made babies! This patient is nearing forty and now she has decided to stop the treatment. You saw that I tried to explain the situation to her. It's fine with me. She will come when she wishes! It's her life, she needs a baby, I don't! I can't force any patient to do something."

Based on exploring early-stage treatment consultations in infertility clinics, Shaw (2016, p. 138) has shown how women insert their agency into the treatment process in subtle ways while permitting ample space for the experts in the infertility clinic to utilise their expertise. She suggests that such instances show how the notion of the infertility specialist as the "expert" who has centralised power is disrupted. As we can see from the dialogue above, in the capacity of a medical expert, Dr. Chatterjee explained to Baani that since her older age and low number of eggs were detrimental factors in achieving conception, she should prioritise the IVF treatment over taking care of her terminally ill father-in-law. Nevertheless, Baani remained resolute and told Dr. Chatterjee that she (and her husband) had jointly decided to stop the treatment. In going against the doctor's medical advice, Baani was neither a passive nor a compliant patient and neither did she blindly follow the doctor's advice. Instead, by displaying her reluctance to comply to the doctor's agenda, Baani utilised her strategic agency by deciding and choosing what she deemed was a priority for her at that point in her life course. Indeed, there were many such instances during my study wherein the female interlocutors exercised their agency through their non-compliance with doctors' suggestions on whether and how to proceed with a treatment. I present an interaction below between Dr. Sen at clinic B and a couple, Hema and Ravi Ganguly, both professors, to demonstrate my point. The couple had experienced two miscarriages earlier after Hema had conceived without any medical intervention and were insistent on pursuing IVF.

Having examined Hema's TVS, blood tests, previous medical reports and Ravi's sperm analysis reports, Dr. Sen told the couple that they would have to try IVF using donor egg as well as donor sperm. According to Dr. Sen, the couple's chances of having a child were only by using donor embryo as Hema was pre-menopausal since her "ovarian reserve" was reportedly "exhausted" and Ravi on the other hand, had "poor sperm quantity" and "very low sperm motility". In addition, Dr. Sen informed the couple that since Hema suffered from rheumatoid arthritis, it would make a nine-month gestation period as well as raising a child difficult for her in the long run. Dr. Sen recommended the couple to try adoption or to not be bothered by the hassles of adoption and instead, advised them to enjoy their conjugal lives with each other. The following conversation ensued among Dr. Sen and the couple:

> Ravi: Sir, we want to try with IVF as we think that's the best and fastest route. We have read about your success rates online and we will see if by God's grace we can also get good results like your other patients. Otherwise, we will not have a child. We have no desire to adopt. Having our own child is important to us and to our family. So we wish to try before we lose all hope. Since we don't have any problems financially, we can try with IVF more than once.
>
> Dr. Sen: I have seen your reports and it's not good news. It's unfortunate, but that is the bitter truth and I don't want to sugar-coat it. I'll be honest with you so that you don't have any false hopes. I'm not like other doctors who will say everything is fine, then take a lot of money from you, and not give you a baby. See, the chances of you having a baby with your wife's egg and your sperm are almost nil. And as I have already told you, I suggest you try adopting. If you really want a child, then there's no harm in adoption. I recommend it to some of my patients who have cases like yours where their chances of conceiving with treatment are almost nil. But please remember, having a child is not the only route to having a happy and fulfilling life! At the end of the day, it's your life and you both should have the final right to choose what you want to do.

> Ravi: True sir, but we have no intentions of adopting. If we can't have a baby of our own, then we will never adopt. We don't have that kind of mentality. My family will also not be comfortable with it. Actually, frankly speaking, Hema has mentioned it once or twice, but I am absolutely not comfortable with the idea of adoption. Who knows whose baby we will end up getting? How would that child react if it ever finds out that it is not our own? The child will not have our genes, it will never look like either one of us, people will ask all kinds of questions. Even if we don't tell people, they will know that the child is not ours. And sir, it might also affect the child's psyche later. Sir, we really want to try with IVF with your help.
>
> Dr. Sen (looked at Hema): What do you want? Do you agree with him?
>
> Hema: (smiled at Dr. Sen, at her husband, and then at me): Yes, I am okay with his decision. I have also thought about it. Adoption is not easy sir as that would also take a lot of time.
>
> Dr. Sen: You don't have to decide right here and right now. Go outside, have some lunch, there's a wonderful shopping mall close by, do some shopping, talk to each other in detail and then tell me what you both have decided. These decisions have to be discussed between the husband and wife in a calm way. Otherwise your marriage will not be a happy one later. Do you understand what I'm saying to both of you?
>
> Ravi: Sir, we both have talked about this at length before coming to you. It is our joint decision. We want to start IVF as soon as you think it's the right time.
>
> Dr. Sen finally agreed to accept Hema as a patient.

Although Dr. Sen recommended the couple to look into adoption or live a childfree life[123], the couple, especially the husband, was adamant on trying to have a biological child with IVF as adopting a child who did not share their genes was reportedly not an option for him and his family. Indeed, I had often observed that women and men utilised their agency in actively persuading the doctor to proceed with a certain route of treatment, even when the doctor expressed his/her disinclination based on medical reasons. I present one final example in this regard before concluding this section.

49-year-old Tanuja Ghatak was a government school principal who had spent more than a decade trying to have a child. In pursuing various treatments with three infertility specialists, Tanuja had undergone 4 IUI and 6 IVF cycles but she had never conceived. In her first consultation with Dr. Sen, he spent the first few minutes reading her medical history which

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[123] The reader might find it contradictory that the doctor was suggesting adoption or even a childfree life, given that earlier in this chapter I discussed how patients were encouraged to have a genetically related child and the involvement of donor gametes was discouraged. I want to point out that Dr. Sen's suggestion of adoption or a childfree free was a rarest of rare case. Moreover, in cases where a couple's own gametes were not 'viable' as the doctor would infer from tests and reports, there was no option but to opt for donor gametes, while adoption was still considered to be the last resort, if at all.

mentioned her as being obese and having been previously diagnosed as diabetic and also with hyperthyroidism, and high blood pressure. One of the reports also mentioned an absence of eggs in her ovaries due to menopause. After putting down the file on his table, Dr. Sen put both his hands on his head, sighed heavily, looked intermittently between the medical reports and then at Tanuja's face. She and her husband looked at each other while smiling nervously. After a minute of silence, Dr. Sen said to her:

> "What should I say? I am speechless. You are a well-educated woman. Why have you done this to your body? I can clearly see that you love eating and I think I know what kind of food you like to eat. I'm guessing fried food is a must every evening! *Tanuja chuckled nervously* With so many hormonal problems, how will any doctor give you a baby? *Dr. Sen looked at her husband* Why have you allowed her to do this to herself? I'm guessing she doesn't listen to anything you say! She's been a school principal after all. She's used to commanding students and teachers! *addressed Tanuja again* See, in my experience, till date, no woman who is almost 50 has been able to conceive using her own eggs because she doesn't have any left. Most women by this age will have menopause. And any menopausal woman who wishes to have a child will have to use donor eggs. So, you would need donor eggs right away. But more importantly, because of your weight and very high sugar levels, I will not accept your case at the moment. The chances of pregnancy are very low, and, I can tell you right now that if you don't lose weight, then you will not conceive. Even if you miraculously conceive, it will end in a miscarriage if your weight stays the same. And if not a miscarriage, then the baby is likely to be abnormal. I know you have a lot of money, but even if you give me one crore rupees, I won't take your case right now. That's just how this clinic works. I don't accept all patients. In your case, before I agree to take your case, you first have to meet a diabetologist and get your sugar levels in control. You will also have to reduce your weight by at least 20 kilos before I start any treatment. I think it's best if you start looking into adoption. That would be better for you in my opinion. Why do you want to spend so much time and money doing IVF? I can recommend you some places where you can apply for adoption. I think –"
>
> Before Dr. Sen could finish, he was interrupted by Tanuja who said,
>
> "No sir, we do not wish to adopt. We don't want to think about all that. If we had to adopt, we would have done that by now. Sir, please don't send us back. We have come to you with very high hopes. Please don't say no to us. We really want a child of our own. We have been trying for so long. We will do what you ask us to do. I promise I will lose weight. No other doctor explained it to us like this before this. But please don't send us back. I'm sure with God's grace and your help, we will have a baby."

Dr. Sen continued telling Tanuja and her husband that given her health condition, her chances of pregnancy were very low, even with donor eggs, and that adoption would be the best option for them but the couple kept trying to convince Dr. Sen to accept their case. Accepting her own carelessness towards her health, Tanuja told Dr. Sen as she wept,

> "You are right sir. It's all because of my own carelessness and bad food habits. But please, don't send us away. I will do everything you say. I promise you sir. I will join a gym. I will control my diet. Whatever you say sir, I will do everything. But you are our last hope. We have already spent a lot of money. My entire married life I have heard all kinds of taunts from my relatives. I really need a child. I can't handle people's taunts anymore."

Dr. Sen finally agreed to take the couple on-board as patients but his condition was that Tanuja would have to lose weight. He told her,

> "Fine, I am only taking your case because you both seem like good people. But Tanuja, you have to promise me that you will lose weight. I am giving you 3 months' time. Consult with a nutritionist. The junk food has to immediately stop! I want to see how much effort you can put in. Come back to me after 3 months and if I am satisfied with your progress, only then I will start the treatment. Otherwise, please don't request me again. I can only work with patients who listen to me and follow my instructions. If you don't put the necessary effort, then why should I? Understood?"

The couple thanked Dr. Sen repeatedly before leaving the room and on the way out, Tanuja promised that she would work hard and show Dr. Sen that she is a "*bhālo* (good) patient".

Despite Dr. Sen using his position as the expert and recommending Tanuja and her husband to consider adoption, the couple convinced Dr. Sen to accept their case. For scholars such as Morgan (1998) and Pappas (1990) the couples' acts of convincing the doctor to undergo IVF even though the doctor was reluctant could be interpreted as resistance in the form of action against the doctor's authority and power. However, I take inspiration from Shaw (2016, p. 150) who does not understand such acts by couples as a form of defiance or resistance as they do not wish to defy the doctor's authority or resist the expertise offered by the doctors. Instead, I agree with Shaw who notes that such acts should be understood as the couple's desire to actively partake in the decision-making process regarding treatments and to let their voices be heard instead of simply playing the role of passive bystanders. As such, Tanuja's utilisation of her agency to convince Dr. Sen to initiate treatment or previously when Hema and Ravi's insisted on their desire to have a child with IVF instead of adopting – such cases suggest the couples' need for the doctor and not their resistance against the doctor. As we can see then, the power was not only lying with the doctor in his position as the medical expert but also with the women and/or couples who utilised their power and agentic capabilities in convincing the doctor to accept them as patients. It was by making their voices heard during the meeting with Dr. Sen that the two couples demonstrated their ability to act strategically and to assert the limited power of control they had within the medical spaces (see also Greil, 2002, p. 113; Shaw, 2016, p. 150). Indeed, as Shaw (2016, p. 150) has rightly argued following Foucault (1982, 2010[1984]), instead of simply critiquing the exercise of power by certain elites and institutions, it is important to analyse "how power is utilised, the techniques and forms power takes, and how it is enacted in relationships".

Lazarus (1988, p. 34) explains that there have been broadly two approaches to examining doctor-patient interactions and relationships. The first is the explanatory model which is primarily cognitive and focuses on how individuals understand sickness and health and how they consequently act in specific ways regarding the treatment (see also Kleinman, 1988). The second approach is the critical medical anthropology which informs the present chapter as well as the discussion in chapter three. This approach emphasises the conflict(s) inherent in social relations and it analyses the relationships not as an isolated dyad but as part of a larger medical system which is embedded in a historically constructed social framework (Lazarus, 1998, p. 35). The strength of the critical medical anthropology approach, according to Lazarus, lies in its examination of the workings of the asymmetrical social relations within medical institutions (ibid., p. 46). He further notes that while explanatory models, such as famously described by Kleinman offer insights into physicians' explanation of illness, their analytical focus has largely remained on patients' illness experience (ibid., p. 48). It would be more expedient then if the analytical focus was on the social relationship between the doctor and the patient and on the power and control exercised by these actors in expressing what they expect from the treatment (ibid.).

The asymmetrical power relationships between the doctors and the patients and/or couples within the infertility clinics is precisely what I have tried to highlight in this part of the present chapter. As I have shown so far with various examples, although it seemed like it was the doctors who had a virtual monopoly on whether and how the course of a treatment would proceed, the women and/or couples utilised various forms of constrained but strategic agency to ultimately attempt and push the treatment plan in the direction they wished for in order to achieve their desired or imagined version of reproductive success. Within such a "patient choice" discourse, Dent (2006, p. 471) notes that the clinical gaze identified by Foucault is to a certain extent, turned on its head. It is the doctor who becomes the "object" of the "patient's gaze" insofar as the patient *needs* the doctor to achieve reproductive success (ibid.). Therefore, both the patients and the doctors along with the other actors and actants utilised their agency in playing an active (or passive) role by creating a collaborative relationship in order to facilitate successful treatment (see also Shaw, 2016, p. 146).

Next, I show that several female interlocutors exercised strategic actions not only in order to seek treatment from the right expert but also to seek therapeutic intimacy with their doctor or with other practitioners in cases where the doctor was deemed unapproachable.

4.4. The Seeking and Offering of Therapeutic Intimacy

In the present section, I show that while some practitioners exclusively performed the role of the medical expert who manages and controls the treatment process, there were others who juggled the extended role(s) of a medical expert, counsellor, friend, and confidante for the couples, in particular for the female patients. I also show that when a doctor exclusively enacted the role of an expert who was unable to offer the desired human touch and emotional solace, the women actively sought other available and approachable practitioners in order to find a cathartic space and manage their emotions. My argument in this section is that for the practitioners, enacting extended roles as friends or counsellors was not merely for the benefit of the patients, but also a professional requirement for ensuring that the patients did not leave them and opt for another clinic, where they could find the desired therapeutic intimacy.

4.4.1. The Doctor: Friend, Counsellor, and Well-wisher

Hema and Prateek (see previous section), both college professors in Kolkata, have been married for fifteen years. The couple had suffered multiple experiences of reproductive loss within the first few years of their marriage. After two first-trimester miscarriages, Hema told me that she and Prateek had decided to take a gap from trying to have a child. When they started trying again after two years, Hema said that she was unable to conceive despite trying for almost a year. She further mentioned that she had started noticing a severe irregularity in her menstrual cycle and recurrent episodes of intense pain in her bones and joints which resulted in her reluctance to engage in frequent sexual intercourse. Of the three doctors (two gynaecologists and one general physician) the couple had initially consulted, the couple had been unanimously recommended to consult with an infertility specialist “before it was too late”. The couple decided to consult with Dr. Sen based on their online research.

As I described in the previous section, Dr. Sen advised the couple to opt for adoption instead of Hema undergoing treatment. Nevertheless, the couple convinced him that they wanted to try IVF as adoption was not an option for them. Although Dr. Sen finally agreed to accepting their case, he put forth the following condition for Hema before commencing treatment:

> “See, we avoid any infertility treatments for people who aren’t physically fit. So, before any treatment, I have one condition. You have to get yourself checked properly for rheumatoid arthritis. It won’t make sense to do an IVF and have a baby if your arthritis is rapidly progressing. So until and unless I get a green signal from the rheumatologist, I won’t proceed with IVF. How will you raise a child if you aren’t healthy? If you are constantly in pain and can’t move around properly, then how will you run around after your baby? Once you meet the arthritis doctor and get a green signal, then I would like to give you hormone therapy so that your uterus doesn’t shrink and also so that there are lesser chances of osteoporosis developing as that would increase your risks of having a fracture easily. You have to understand that the body takes an immense toll during pregnancy, especially for an IVF pregnancy, and it will be difficult for you to carry a pregnancy to full term if you are constantly in pain and unable to take care of yourself first.”
>
> The couple agreed with Dr. Sen and on their way out of the room, Hema, teary-eyed, asked Dr. Sen if she had a “good chance”. Smiling, Dr. Sen said,
>
> “Look, what’s my final target? My final goal is to ensure that my patient goes home with a healthy baby. Just making you pregnant is not my final target. If you conceive, but that ends in a miscarriage then what’s the point? You have already been through two sad incidents. I need to work in such a way that you are able to become pregnant, have a healthy delivery, and also be in a condition to raise that baby. So your health is very important. If you follow what I’m saying word by word, only then we can go ahead. Your health is my priority. A baby comes only after your own health, isn’t it? *Hema nodded* So take care of yourself, enjoy your lives and we will see what I can do here to fulfil your dream. Please don’t get depressed. I will fight for you. It won’t work if you are dejected so soon. You have to promise me that you will not be dejected and upset anymore! We will first make you fit! You have to be strong to fight this battle! Just like Netaji[124] said, you give me blood, I will give you freedom. Now, I am telling you, you give me good health and I will give you a baby! *laughed* I am your friend from now, not only your doctor. You have to trust me as a friend, okay? And I am promising you that as your friend and well-wisher, we will get through this challenging time together! You have any problem, you come and talk to me. Understood? Now wipe your tears and come shake my hands.”

As Dr. Sen put forward his hand to shake Hema’s hands, she came forward and instead of shaking hands with him, she took his hand and placed it on her head, asking him to bless her with all his heart. He smiled, blessed her, and then asked the couple to schedule their next appointment after they had consulted with the rheumatologist.

According to Franklin (1997, p. 162), infertility doctors often enact themselves as “comrade[s] in struggle” whom women seeking treatments have to trust. IVF pronatalism, explains Franklin, is often “narrated as an aggressive pursuit of an elusive goal, in which women are warriors, with battle scars attesting to their bravery on an epic quest for a child of their own” (ibid.). As Dr. Sen said, he needed Hema’s trust in order to “fight this battle” – the battle of improving her health, of undergoing infertility treatments, and of ultimately, achieving

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[124] Subhas Chandra Bose, who was popularly known as Netaji, was one of the most prominent freedom fighters during India’s independence struggle and also the founder of the Indian National Army. “You give me blood, I will give you freedom” was one of his most famous slogans.

reproductive success. The metaphor of a battle and Hema as a warrior was reinforced when Dr. Sen cited the slogan of the Indian freedom fighter, Subhas Chandra Bose. Furthermore, as a private healthcare professional[125], Dr. Sen participated in offering what Franklin (1997, p. 162) terms as a "customer-satisfaction orientated service". Such a service entailed Dr. Sen reassuring Hema that he would do everything in his capacity for her well-being and in order to do so, he represented himself not only as a medical professional but also an approachable friend-figure. Like other patients and/or couples I had interacted with at clinic B, Hema was also satisfied with the 'service' she was receiving which was reflected in her relief of Dr. Sen having prioritised her health instead of pushing her to become pregnant. During our interview a few weeks following the above cited consultation, Hema said:

> "I can't tell you what a relief it was! Dr. Sen is the first doctor who did not treat me like my previous doctors. The others were only concerned about my increasing age and that I should have a child soon. It was not only my doctors but also people around me – my in-laws, my relatives, my own parents, my close friends – everybody had only one question. So, when do we get the good news? Dr. Sen is the first person ever who has shown so much concern about my health! I met my arthritis doctor recently and I am already having physiotherapy twice a week. In our last consultation, he was very happy to hear that I am undergoing physiotherapy and he said that I should continue for another two months. No other doctor recommended me this before. I am happy that for a change the focus is on my own health and not just on becoming pregnant. I feel so fortunate and I thank God that I met someone like Dr. Sen! Talking to him really feels like I'm with a friend!"

Acknowledgement and receiving care, support, and personal attention from the medical practitioners where their role was not confined to being a paternalistic medical expert, was, indeed, received positively and appreciated by the women and/or couples in my study. As another female interlocutor, Maya, who was also Dr. Sen's patient, said:

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[125] In order to understand doctor-patient relationships and their social interactions in a medical environment, Lazarus (1988, p. 49) suggests that for a nuanced understanding of why people act in certain ways and how much power the physician sustains, it is important to consider the institutional setting where the interaction is being performed instead of viewing it merely as a backdrop. In this regard, Fisher and Todd (1983 in Lazarus, 1988, p. 50) have illustrated how physicians manifest power differently in private and public clinics. While physicians practicing in public clinics/hospitals share their authority significantly with other medical staff, the physicians in private clinics tend to hold the larger share of power, both over other medical staff as well as over the patients and/or couples (ibid.). In the private infertility clinics in my study, such 'customer service' was offered to the couples not only during the consultations and treatments, but even before the couple met the doctor, for instance, in the way the couple would be greeted at the clinic's reception by the courteous receptionist. The receptionist at clinic B would often be scolded by Dr. Sen if he noticed that she was not dressed 'formally' or if she was not greeting the new couples 'properly'. On one such occasion, Dr. Sen said to her, "You are the first person a couple meets in my clinic. We have to make the patients feel welcome here." I suggest the customer service offered at these private clinics could be viewed as resembling a hospitality industry which aims to take care of the patients and/or couples instead of merely a medical institution which offers treatments.

> “My husband and I are very happy with everyone at the clinic, especially Dr. Sen. It feels good to have him giving so much attention to us. We are actually extremely happy with how Dr. Sen takes care of us. He is like my best friend who understands me and doesn’t judge me. I can talk to him without any hesitation. He had told me that I can call him whenever I want. It feels good to have a doctor and a team of people who cares about me and doesn’t treat me only like a patient. Actually, I must say, that all the people at clinic B are very nice to me *smiled*.”

Moreover, the one common theme which emerged in my conversations with the female interlocutors was that they were delighted and satisfied when the doctors and staff treated them less like a patient and more like a friend (see also Franklin, 1997, p. 163). As Dr. Sen mentioned, one of the main reasons why he was admired, showered with affection, and trusted by his patients was because he made the effort to develop an empathetic and personal relationship with them. Speaking of his role as “a friend, counsellor, and well-wisher”, he said,

> “Since I’ve been trained abroad, I’ve been taught to see each patient individually and empathetically. Every patient’s case is different. It’s not like medical schools in India where basic manners are not taught to doctors. If making money was my goal, then I would have given the same kind of diagnosis to everyone and just made them wait and wait. But that has never been my goal. I treat my patients the way I would want to be treated by other doctors. Sometimes patients just need a friend, counsellor, and well-wisher. They just want someone to listen. People already feel extremely stressed when they come here and these treatments tend to stress them even more. They aren’t looking for a motivational speech at that time. They need friendly advice and comfort. It’s important to make them feel comfortable. My patients know that this is a safe space where they will not be judged and where they can vent and share their secrets. I know many doctors who only see the patient as a patient, as somebody they need to give a child. And when the doctors are unable to do so, then patients leave them and find other doctors. But you have seen, I have so many patients with me for years. They trust me immensely and they will not go to any other doctor. I believe in making bonds and personal relationships with my patients. All the affection showered on me is because of the good relations I have with them. My focus is on quality of care with fewer patients than giving substandard care with many patients. I could be the best doctor but if I am not a good person to my patients and if I don’t treat them kindly, then patients would also understand that and they would leave me to find someone else. Everyone understands when there is genuine affection and care and when they are being fooled.”

The patients and/or couples in my study who had experienced reproductive loss and were subsequently experiencing the ordeal of undergoing assisted conception, effectively sought a human touch (see Bharadwaj, 2016, p. 224) from the practitioners who would perform the diverse roles of a friend, counsellor, guide and not only that of a medical expert. By being cognisant of the couples’ wider sociocultural context, social pressure, and personal stress, Dr. Sen offered them “genuine affection and care”, as he mentioned in his excerpt above[126]. With

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[126] Bharadwaj (2016, p. 224) has observed that the IVF clinics in India do not provide any psychological therapeutic interventions which are designed to help patients manage their anxiety that accompanies patients who undergo infertility treatments. In my study, only infertility clinic A had a professional psychologist but I learnt

his long-term patients, Dr. Sen frequently engaged in informal chats about their daily lives, counselled them about issues unrelated to treatments, and often cracked jokes to lighten the mood of an otherwise tense situation. Moreover, as Dr. Sen mentioned, if he did not treat his patients kindly and offer them a safe and cathartic space, they would leave him to find someone who did give offer the same emotional refuge.

In the next two sub-sections, I discuss the extended roles performed by the head nurse at clinic A and embryologist at clinic C, given that the infertility specialists at both these clinics were considered to be rather unapproachable by the patients and/or the couples.

4.4.2. The Nurse: Giving Patients a Shoulder to Cry on

At clinic A, where the infertility specialist, Dr. Ganguly, was known among his female patients and clinic staff for his short temper and his hectic schedule, many of his female patients had developed an intimate relationship with head Nurse Shanti. As I learnt during my conversations with the clinic's former and current female patients, Nurse Shanti was their confidante with whom they shared their personal life stories regarding marriage, sex lives, and the social pressures they faced to have a child. When I spoke to Nurse Shanti about this, she told me that the women related to her so much probably because they could relate to her experiences of having suffered three miscarriages herself. She also mentioned that it was easier for women to open up to her as she was a woman herself. Considering herself as a good friend of her female patients, Nurse Shanti said,

> "Patients connect with me a lot. They feel that I understand their pain and sadness. Most of them feel more comfortable with me than with Dr. Ganguly. He is strict so they are unable to open up with him. He is perpetually busy and he doesn't have the time and patience to listen to people's life stories. Moreover, he is a man so women might feel hesitant in speaking to him about certain things. Usually when I meet a patient, she often makes me sit longer with her and then shares her problems with me. Sometimes, these women simply need a person they can speak to, a person who will not judge them. Many patients speak to me about their in-laws pressuring them for a child - the mother-in law or the sister-in law seem to be the common villains! *laughed* Some of them tell me about their husbands not being nice to them. There are some who tell me about their practically non-existent sex lives. I mostly listen and sometimes I give advice. I try to be their good friend because I understand they need a friend in such a difficult time in their lives *interrupted by a phone call* See, this woman who called,

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from her that she had received only a handful of patients in her one-year professional period. Moreover, when seeking assisted conception, couples not only brought their medical problems to the doctors but also the social context and the cultural topography within which these problems were embedded (Bharadwaj, 2016, 2006). Bharadwaj (2016, p. 214) also notes that infertility clinics in India "revolve around the very epicentre of moral, social and medical dilemmas as well as the ensuing conflicts". Thus, quite often, wider cultural issues are addressed within the doctor-patient interactions (ibid., p. 215).

> she is a patient who is undergoing IVF and she had her first embryo transfer day before yesterday. I have to constantly assure such patients that everything will be fine. The same things have been told to them by Dr. Ganguly but they want to hear everything from me again. They want that reassurance. You have seen yourself – I get several such calls in a day either from the patient or from the husband. I am happy to help as much as I can manage in my capacity because I understand the stress they must be feeling."

Indeed, for the female patients and couples of clinic A, Nurse Shanti was their go-to person. Following her around the clinic, I observed that women or their husbands would call her at any time of the day to discuss any problem they were experiencing, whether or not it was treatment related. One of the female interlocutors, Shikha, who had experienced a miscarriage, had to say the following about the post-miscarriage emotional support she had received from Nurse Shanti:

> "Shanti *dī* supported me tremendously, even before the miscarriage happened. All the painful injections, they were given to me by her. After the mishap, I remember her coming to my house and spending time with me, comforting me, saying nice things. Whenever I was feeling depressed, I would call her. I felt better after speaking to her. She is such a positive person. She would always tell me that she's praying for me. She would often call to ask how I was feeling. There was no need for her to do any of this but I am so grateful that she took such good care of me."

The experiences of reproductive loss, the stress, and challenges of undergoing assisted conception, and the overall pressure of achieving conception evoked powerful emotions among the couples, which was particularly expressed by my female interlocutors. To manage their emotions while avoiding any kind of judgement from people in their social networks, most of the female interlocutors often looked for emotional support from their doctors. Unlike in the previous section where Dr. Sen performed the roles of friend and counsellor, in clinic A it was Nurse Shanti who was approached whenever women wanted to "actively manage" (Allan, 2001) their emotions whether that was by sharing their stories or by venting and grieving about their loss(es). As such, Nurse Shanti was not only an integral cog in the smooth functioning of clinic A, but she was also the most accessible practitioner on whom female patients relied significantly for emotional support. During stressful and vulnerable moments, she was available to the women in the clinic (and outside, at their homes or via the telephone), to console the women. In this context, Shaw (2016, p. 144) has remarked that nurses have the ability and time to relate to the women on a personal and emotional level, thus, developing a relationship which is different than the doctor-patient relationship.

Most of clinic A’s female patients shared a “therapeutic relationship” or a “connected relationship” with Nurse Shanti as opposed to a “clinical relationship” with a practitioner (Morse, 1991; see also Kadner, 1994; Williams, 2001). In a “clinical relationship”, a nurse is involved with the patient superficially, the interaction is usually perfunctory, and there is an absence of a personal relationship with any emotional involvement (Morse, 1991, p. 458). On the other hand, in a “therapeutic nurse-patient relationship”, a nurse views the patient not only in the role of a patient but also as a person with a life beyond being a patient and thereby, the nurse tends to the patients’ issues which are not solely medical (ibid.). However, women who had been patients for an extended period of time had developed a “connected relationship” with a nurse that had evolved beyond a clinical or a therapeutic relationship (ibid.). Nurse Shanti’s relationship with her patients is a good example of such a connected relationship and of the emotional labour she performs involving offering extra care to patients and becoming emotionally involved with their life stories. However, as medical practitioners, nurses have to maintain a certain degree of emotional distance from the patients’ lives in order to be able to perform their jobs regularly. As Nurse Shanti said in this context:

> “In the beginning, I would get emotionally involved with my patients’ stories. It’s natural to feel this way when you hear someone crying and sharing their sad stories with you. But with time and experience, I have learnt to detach myself. I realised that doing the kind of job I do, it would become difficult if I kept getting attached to my patients. It takes time to learn how to be detached but gradually we all learn. This profession is like this. We deal with people’s personal stories and feelings but somehow we have to learn how to maintain distance. Ultimately, we are here as medical staff, not as their family members. We need to remember that. But of course, I am always here to listen to them and to give them a shoulder to cry on.”

According to Allan (2001, p. 20), clinic staff often get emotionally affected when they witness or engage with patients’ experiences and this could potentially threaten the smooth running of the unit. Thus, one of the ways in which nurses handled such a scenario was to care without getting too attached. As Nurse Shanti remarked, in order to perform her professional duties effectively and efficiently, detachment from the patients was warranted which, however, did not imply that she was not available for her patients’ to “give them a shoulder to cry on”.

4.4.3. The Embryologist: Going the Extra Mile for Patients

In the several months that I had spent conducting fieldwork at clinic C, I had observed that the infertility specialist, Dr. Chatterjee, steered clear from engaging in any interaction with the patients which did not pertain to treatments. Even during a medical procedure, if a patient displayed any signs of discomfort or uneasiness, she would not offer any words of solace and would instead scold that patient for now allowing her to do her job efficiently. Moreover, as I have shown earlier in this chapter (section 4.3.1), she would become agitated when couples asked her too many questions or when couples reiterated their desperate need for a child. During consultations, if a woman (or her husband) interrupted Dr. Chatterjee to say or ask something, she would get annoyed and say, for instance, "Let me finish first or "Do you know everything already?" As such, the only interaction which she engaged in with her patients and/or couples was limited to treatment-related matters. Even if a patient did initiate a personal (medically unrelated) topic, she would immediately ask her to stop, saying that she did not have time or she would curtly respond to the patient in a way which hindered the patient from indulging in a longer conversation. In one of our conversations after a patient left the room in tears[127], Dr. Banerjee said to me:

> "I understand that there is a lot of family pressure, but what can I do? I am a doctor, not a therapist. That's not why patients are paying me. If these same people who pay me and don't get the result, then they will go to some other doctor. So, I always try to be focused on my work. If I start listening to people's sob stories, then that's it, I'll spend all my day sitting in this room! If they want to share their stories, I'm sure they'll find other people with whom the can speak. My medical training is not for listening to patients. That's the job of a psychologist. And, a psychologist will not give them a baby, right? We all have our specialisations and my job is to make sure a couple goes home with a child. I don't have the time or energy for listening to patient's personal problems. I barely get any time for my own son so how can I spend whatever little time I get listening to other people's sad stories? And as doctors, we are trained to not get involved with our patients' personal lives. How will I do my job then? As doctors we are trained to maintain distance from our patients. Look, I can sympathise with this patient's situation, but that's all. I can't really do anything about it."

As we can see from the quote, Dr. Chatterjee clearly states her role as that of a doctor, not a therapist, and her main job is to send couples home with a baby. She also mentioned how she did not have the time or energy to entertain patients' "sob stories". Given her disposition, which her long-term patients had also presumably picked up on, I noticed that those patients actively refrained from disclosing their personal stories or expressing their emotions to Dr. Chatterjee. Nevertheless desiring emotional solace, the distressed patients sought another practitioner in the clinic with whom they could establish an intimate relationship which was not confined to treatment-related discussions. As such, Dr. Bose, the embryologist, who was

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[127] This patient had been unable to conceive after trying for five years and this was her first appointment with Dr. Chatterjee. She had barely started speaking about the pressure from her family when Dr. Chatterjee told her to not speak further about it as other patients were waiting outside and that she did not have the time.

also a physician and the person responsible for managing the clinic, became the practitioner whom patients and/or couples would frequently approach. Her sociable and jovial disposition made it easier for the patients to approach her and she, in turn, performed the extended roles of a friend and a counsellor for them. I had often observed Dr. Bose spending time with a female patient whenever the latter wanted to talk about something personal. I saw her listening intently to such patients, at times while holding their hands or softly rubbing their back or arm as they cried, offering them a glass of water. Unlike any other practitioner in my study, I had often seen Dr. Bose giving hugs to women who could not stop crying or to those women who were devastated after experiencing reproductive loss. I was not surprised when during my conversations with the female patients at clinic C, they had the nicest things to say about her and of her behaviour towards them. For instance, the following excerpt is from my interview with Ritika Roy, for whom Dr. Bose was her "angel" who helped her cope with a troubled marriage, multiple events of reproductive loss, and post-partum depression:

> "Pooja *di* is like family to me. Actually, she's more than my family. She is the angel who came into my life at the right time. You have no idea how much she supported me mentally and financially when my marriage was completely falling apart. Even my own parents didn't support me this much. If it wasn't for her, then I don't know what dangerous step I would have taken during the dark times in my life. My husband is a horrible man who has no respect for women. I had an arranged marriage but if I had known this about him, I would have never made the mistake of marrying him. It was definitely the biggest mistake of my life. But somehow I had accepted it as my fate. It was only after I met Pooja *di* that she explained to me that this was not my fate and I should not accept this. She made me understand that I didn't deserve this and I don't have to stay with him just because I'm scared of what people will say. I'm currently separated from my husband and the only reason I haven't filed a divorce is because of my son. Pooja *di* has spent several hours just listening to me even though as you have seen, she is very busy at the clinic. She was there for me when I had two miscarriages before my son was born. My husband paid no attention to me and, a few months later, I found out that he was having an affair. I had no one I could speak to about the miscarriages or what I was going through emotionally. When I became pregnant the third time with IVF, Pooja *di* helped me get through my pregnancy...When my son was born last year, I didn't want to look at him. I don't know why, but I had thoughts of killing him. I was not able to trust myself with him alone in a room. I have had many thoughts where I wanted to put a pillow over his face *cried* it was the worst time of my life. I told Pooja *di* everything and she is the one who sent me to one of the best psychiatrists in Kolkata. The psychiatrist said I have severe post-partum depression and it could be because I was not getting any support to raise the child from my husband or any family member, or it could be because I had two miscarriages which had affected me. I had been on medication till last month. He told me to stop after that because he saw my progress. I feel better and happier now with my son. Playing with him is the best time of my day *smiled* I don't know what a disaster would have happened if Pooja *di* hadn't given me the right advice at the right time. I think without her, I wouldn't be standing here today, speaking to you. I owe so much to her, you can't imagine how she helped me during the worst times. She is everything for me – you can give it any label – my guardian, well-wisher, best friend, advisor, teacher, doctor – doesn't matter. What matters is that she helped me give new meaning to my life and she stood by me when I had nobody else next to me. I am eternally indebted to her."

Ritika expressed a great amount of adulation, respect, and affection which she feels for Dr. Bose who offered her support and guidance in her distressed life when she did not have any social support. She talked about how Dr. Bose is “everything” for her whether it is as a guardian, well-wisher, best friend, advisor, teacher or doctor. Indeed, Dr. Bose not only performed the role of the embryologist and medical expert during Ritika’s IVF but also gave her the emotional support she needed as a friend and advisor. On speaking to Dr. Bose about how everyone in the clinic had only praises for her because of the way she interacted with them, she smiled and said,

> “Oh, come on! They are all just being too nice. They don’t tell you about times when I scold them for not listening to me properly! *laughed* See, I had grown up seeing my father interacting with his patients in a very informal and friendly way. So for me, when I became a doctor, I behaved in the same way with my patients as I had seen my father. You learn what you see, isn’t it? And particularly in infertility medicine, I think patients come to us with expectations of not just getting a baby but also of just listening to them. If we don’t listen to them as doctors, then they would be upset and leave to find another doctor who actually listens to them. Unfortunately, we live in a society which is very harsh and judgemental so patients don’t have people in their family with whom they can speak to without being stigmatised. So, I feel that when they come to us, we should take out time to listen to them. We don’t have to always give them advice. Sometimes just giving them a hug makes a huge difference! They feel better instantly, I have seen it. That’s what I try and do here. I honestly think that if we as practitioners don’t go the extra mile for our patients considering that they put all their faith in us, then it’s not fair to the patients.”

Considering the protracted experiences of reproductive loss, grief, social pressure, a marital relationship fraught with tension (see chapter six), and lack of professional counselling and social support groups for the childless and bereaved couples in India, the patients’ trust in the medical practitioners can be seen as a “leap of faith” (see Skirbekk et al., 2011, p. 1182) as well as an attempt to seek emotional refuge. This “leap of faith” was acknowledged by (some) practitioners in my study who were empathetic to their patients’ emotional needs. As Dr. Bose mentioned, as practitioners a part of their job is to go “the extra mile” for their patients given that the latter places all their faith in them (see Morse, 1991, p. 458). As I have shown so far, in clinic A and C where the infertility specialists enacted themselves exclusively as medical experts or who were deemed unapproachable by (most of their) patients, other practitioners, such as the nurse and embryologist, offered a cathartic and safe space for the women by enacting the extended roles of a counsellor, friend, and advisor. As these practitioners pointed out, if they did not offer the emotional support the patients were looking for, they would find another practitioner at another clinic who did offer that therapeutic intimacy. Thus, I suggest that the practitioners’ enactment of extended roles was not only for the benefit of the patients but also based on what an individual practitioner deemed as the most appropriate form of practitioner-patient relationship to ensure that the patients did not opt for another clinic.

4.5. Conclusion

In the present study about reproductive disruptions, it has been important to examine and understand what medical practitioners have to say and how they interact with their patients because the practitioners were indispensable actors in across all the female interlocutor's and/or couple's narratives. As I have firstly argued in this chapter, in the couples' attempts to achieve reproductive success through practitioner-mediated conception (and not only technology-mediated conception), the medical practitioners performed an indispensable role in controlling, influencing, manipulating, managing, and shaping the women's behaviour as patients, their reproductive experiences as well as the meanings the women and men attached to concepts of relatedness, family, and gender roles. I have also argued that various forms of negotiations and collaborations are made between the practitioners and the agential female patients and/or couples where all the actors ultimately desire(ed) to achieve reproductive success.

I have shown firstly that doctors encouraged and convinced women and/or couples to achieve conception with their own gametes instead of relying on donor gametes. In doing so, the doctors reproduced, reinforced, and naturalised the need for genetic ties in defining relatedness (which they associated with physical resemblance and similar behavioural traits) for the making of a 'normal' i.e. socially legitimate family. I have also shown that the doctors essentialised dominant gender roles wherein motherhood was identified as synonymous to 'womanhood' and 'manhood' was defined through emotional stoicism and performing a caretaker's role for the apparently emotionally fragile wives (see chapter seven).

In the second section, I have shown that through different disciplinary mechanisms, the doctors enacted the women and/or couples as 'good patients' i.e. those who were submissive, compliant, and who displayed complete trust and confidence in the doctor's medical advice. For instance, a common disciplinary mechanism was doctors reprimanding the women and/or couples for asking too many questions, for being disobedient and/or for questioning their medical advice. Positive reinforcement as a disciplinary mechanism was also employed by the practitioners by praising the women and/or couples when they behaved how the doctor expected them to behave. I propose that these mechanisms were performed by the doctors to maintain their authority, power, and control over the medical encounters as well as to ensure that the power dynamics in the clinical setting were not disturbed.

However, taking cue from Shaw (2016), I have shown that the decision-making processes in the clinics was not monopolised by the doctors and neither did power reside solely with the doctors. Instead I have shown that power was distributed, although disparately and asymmetrically, among the various actors in the clinics. As such, the women and/or couples were not simply passive actors who blindly conformed to the doctor’s instructions. Instead, I have argued that the women and/or couples utilised forms of strategic agency which were often co-constituted or defined by their constraints, for instance, by accepting the disciplining by the doctors and enacting themselves as ‘good patients’ as it was by doing so that they would get closer to achieving reproductive success. I have also presented other examples where the middle-class couples utilised their agentic capabilities, for instance, by enacting themselves as reflexive consumer-patients to find the doctor who would be the right fit for them to achieve conception but also someone who treated them with respect and by persuading doctors to accept them as patients. Such utilisation of forms of strategic agency by the patients and/or couples can, indeed, be understood as what Thompson (2005, p. 198) argues is “a (controlled) means to a desired end”.

Finally, I have shown that individual practitioners performed extended roles in order to offer the women and/or couples the desired therapeutic intimacy but to also ensure that the latter did not leave them to go to another clinic. While some practitioners juggled the extended roles of a friend, counsellor, and advisor, there were others who chose to limit their role to that of a medical expert whose primary job was to send couples home with a baby and not to offer them therapy. Either way, the practitioners decided which role(s) they wanted to enact depending on their preferred route to achieve reproductive success.

However, as I noticed in the clinics and learnt from my conversations with the female interlocutors, the emotional refuge or emotional attention which many of them were searching for after experiencing reproductive loss, was frequently not offered to them by the medical practitioners as well as by the other actors, particularly in cases of early gestational loss(es). As such, in the following chapter, I focus on the bereaved women’s experiences of unrecognised reproductive loss, disenfranchised grief, and the utilisation of forms of constrained but strategic agency to process their grief and cope with their loss.

Chapter 5. Reproductive Loss as a Non-Event: Women's Disenfranchised Grief and Coping Strategies

5.1. Introduction

As I was standing behind the infertility specialist, Dr. Chatterjee, and the embryologist, Dr. Bose, inside the ultrasound room at infertility clinic C, the female patients came in one at a time for their TVS. One of these women, Gayatri Dhar, came in with a file, exchanged a cursory greeting with the doctors and handed over her file to Dr. Bose. As the doctors reviewed Gayatri's prior medical records in the file and discussed her case history, Gayatri removed her underwear and lay on the bed with her legs raised and bent, arms over her head, and sari pulled up to her knees. Evidently, this was not her first time experiencing this scan. Unlike the new patients, Gayatri had not shown any hesitation and neither did she wait for the doctor to give her any instructions (see chapter three). Meanwhile, I picked up on the brief conversation between the doctors and learnt that Gayatri was going to start her third IVF cycle.

While conducting the scan, Dr. Chatterjee informed me that Gayatri's previous IVF cycles had not resulted in conception and before that she had also experienced perinatal death. After the scan, as Gayatri was putting her underwear back on and adjusting her clothes, she was told by Dr. Chatterjee to undergo the P4 blood test (see Appendix 2) which would confirm her ovulation. As Gayatri was leaving the room, Dr. Chatterjee introduced me to her. Gayatri and I went outside the room and exchanged initial pleasantries. After I briefed her about my research, I asked her if she would like to be interviewed anonymously. A brief moment of hesitation later, she agreed. I asked her to accompany me to the room in the clinic which had been allotted to me for conducting interviews.

33-year-old Gayatri had been married to Prannoy, a lawyer, for five years. Having completed her postgraduate degree in Computer Sciences, she worked as an instructor at a computer training institute. She informed me that they had started trying a year after their marriage and when that did not result in a pregnancy, the couple decided to consult an infertility specialist – the one before Dr. Chatterjee. Initial test reports had revealed that Gayatri had uterine fibroids, endometriosis, and PCOS (see Appendix 2). The infertility specialist had suggested the usual treatment protocol starting with Timed Intercourse, commonly referred to as TI in the clinics (see chapter six) followed by IUI. The three months of TI and two IUI cycles unfortunately did not help Gayatri to conceive. She told me that in December 2011, she had conceived for the first time without medical intervention. Entirely unanticipated, she and her husband, as she said, “were uncontrollably happy”. However, unable to feel the baby’s movements in the 30th week of the pregnancy, Gayatri had woken up Prannoy in the middle of the night. When he called the consulting gynaecologist, she told him to tell Gayatri that since it is not easy for “*shādhāraṇa manush*” (laymen) to detect such movements, especially in the last stages of the pregnancy, they should not worry unnecessarily.

Less than 48 hours later, following some unprecedented vaginal bleeding and what Gayatri described as excruciating abdominal pain, she was immediately taken to the hospital in an ambulance. Based on an ultrasound scan, the emergency doctor had informed the couple that the baby had died in-utero. Eventually, the couple wanted to know the cause for this incident but reportedly neither their infertility specialist, the consulting gynaecologist nor the two gynaecologists they consulted subsequently were able to give them a coherent reason. Gayatri then told me that she was told by all these doctors that “such accidents” could happen at any stage in a pregnancy and it could not have been anticipated by anyone. The doctors had reportedly also told her that although such an incident was extremely unfortunate, she should think ahead and try to conceive again instead of being upset about the past. At this point in our interview, Gayatri had an emotional breakdown and she said that if her gynaecologist had taken her seriously on the night when she had been unable to feel her baby’s movements, then perhaps the mishap could have been avoided. She added that she even though she was not a doctor, she was a mother, and she had sensed that something was wrong with her baby.[128] Recalling that incident, she said the following:

> “Actually, the mishap happened just three days before my *shādha* [129]. All my relatives and my best friends had been invited. My husband had bought a new saree for me to wear that day. But the One

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[128] Researchers have explained that medical practitioners as experts and the visualising technology of ultrasound claim to have more insight and knowledge about the pregnancy and the foetus than the embodied experience of the pregnant woman based on the ‘scientific’ and ‘objective’ qualities of the former unlike the woman’s intuition which is not scientifically verifiable (see Roberts, 2012; Zechmeister, 2001).

[129] It is common among pregnant women in the Bengali community to have a pre-birth celebration known as *shādha* (literally meaning taste and also desire) in their late second or early third trimester. This Hindu ritual is equivalent to ritual of the baby shower in many western countries. It involves the pregnant woman being fed her favourite food by her mother or mother-in-law and sometimes gifts are also given to the woman. Close female relatives and female friends are invited to be a part of this occasion as well. The ritual, performed similarly, among non-Bengalis in Kolkata and in parts of northern India is known as *gōdabharāī,* literally meaning to fill the lap or womb*,* with an abundance of gifts, nutritious food, and blessings for both mother and child.

> up there had other plans for me. Besides, you know how people say, whatever is written in your fate, that will happen and nobody can stop that…I had given birth to a son. My husband told me a few days after the incident happened, as I was insistent to know whether I had a son or a daughter. I later found out that my husband and mother in-law had seen him and my husband told me that our son was very beautiful. He had a head full of black hair and was light skinned, just like my husband's side of the family. I wanted to see my son after the delivery. Every mother wants to see her child after the birth, isn't it? Because he hadn't survived, nobody even asked me if I wanted to see my son whom I had carried in my womb for eight months…The nurse and doctor kept telling me to rest and sleep. At that time, I didn't say anything. My mind was so muddled and I remembering feeling exhausted. It was a normal delivery. Can you imagine my fate? I gave birth to a dead baby. I only remember crying for a long time after I woke up and I don't remember when I slept again. After waking up, I asked the nurse if I could see my son just once. She said that why would I want to do that and cause myself more pain. I told my husband as well – let me see my baby just once, at least from a distance. But he also refused and said that I should rest. He said that if I saw my baby like that then I would be hurt more… I have never stopped thinking of how my son must have looked. If only I could see him once. Everybody keeps telling me to forget what happened and pray for a healthy baby instead. My parents and in-laws started telling me soon after the incident that I should start trying again. They said that having a child would make me forget my past pain. The doctors also said that one such accident shouldn't stop me from trying again. But how can I ever forget that [incident]? I remember everything became dark in front of my eyes the moment the doctor gave me the news…It has been four years and I know that my son wasn't born alive, but for me, that was his birthday. On that day, each year, I go to the temple near my home and offer my prayers with sweets and flowers…I named him Sisir [dream]. But I decided not to tell anybody about any of this because I think people might judge me. Only my husband knows about this but he never speaks about it. He only told a couple of times to stop this and focus on the treatment instead. When my mother-in-law asks me why I am going to the temple, I tell her because I wish to. Actually, my parents and my in-laws would be angry that I am doing these things…But they don't understand that everyone takes their own time to heal. There are certain things in life which one can't simply forget. Some incidents in life leave a scar on your heart and only time can heal that scar."
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> I asked Gayatri if she knew what had been done to her son afterwards to which she said:
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> "My husband and father in-law buried him, that's all I know. I don't know when and where they did it because nobody told me. I have asked my husband a few times, but he does not tell me anything. I know my mother-in-law also knows about this, but she doesn't tell me anything either. Whenever I ask, they tell me that I should be thinking of the future and not of the past. My husband knows that if he told me the location, I would inevitably go there. They say they want to protect me from more pain but it's a pain that nobody can understand or protect me from. Only a mother can feel that pain. That pain resides in my heart and it was a turning point in my life. I was a mother who didn't have it in her fate to play with her first child. Is there anything more painful than this? "

After her son's death, Gayatri had quit her job and become a homemaker. She told me that since that incident, she had no interest in continuing her job because she felt depressed and unmotivated. On everyone's insistence and because she knew that the pressure to become pregnant would not seize anytime soon, she had started with the IVF treatment at infertility clinic C around six months after the incident.

Reproductive loss after conception tends to be a unique traumatic experience for the intended parents because unlike a person's death after a terminal illness or the death of an ageing adult, the death of a wished-for child (at any stage in the pregnancy) is generally unanticipated (see Brier, 2008; Gray and Lassance, 2003; Kersting and Wagner, 2012). According to Leon (2008, p. 6), the process of grieving for a person who has died involves "recollecting the sights, sounds, smells and touch of the beloved". Thus, what makes coping with reproductive loss an even more unique process is that the "raw materials" which are required to grieve for a deceased person are absent and there are very limited sensory memories or interactions with the baby and often, not even a body to be seen or touched when the loss occurs in the early stages of pregnancy (see Leon, 2008). The process of mourning and coping becomes all the more emotionally challenging for the intended parents when the loss remains socially unacknowledged, their grief is marginalised, and few, if any, formalised grief rituals exist for them (see Layne, 2003; Trepal, Semivan and Caley-Bruce, 2005). Although, in several western countries, as discussed in chapter one, the emergence of organisations, chaplaincies, and support groups since the late 21st century have facilitated the grieving process for bereaved couples by allowing them to engage in certain rituals (see chapter one).

As I have also mentioned in chapter one, hardly any empirical research has concerned itself with the topic of reproductive loss in relation to grief, bereavement, death rituals, and coping mechanisms in the urban Indian context (for exception, see Mammen, 1995). The present chapter is my novel endeavour to address and engage with these underexplored themes among the middle-class milieu in urban Kolkata. The chapter is primarily concerned with the middle-class women's poignant accounts of disenfranchised grief following incidents of reproductive loss which occurred at different stages in their pregnancies. Here, I draw on Doka's (1989, p. 4) definition of disenfranchised grief as "grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported". Additionally drawing on Scheper-Hughes and Lock (1987, p. 28-29), I suggest that it is important to engage with the emotions experienced by the grieving female interlocutors given that an anthropological study of the gendered body experiencing reproductive disruptions, specifically the death of a desired baby, is remiss without examining the associated emotions – emotions entailing feelings, cognitive orientations, public morality, and cultural ideology. As rightly pointed out by Scheper-Hughes and Lock (1987, p. 28), "emotions affect the way in which the body, illness, and pain are experienced".

Gayatri's experiences regarding the non-recognition of loss and disenfranchised grief resonates with the experiences of several female interlocutors in my study. In order to unpack these experiences and engage in an analytical discussion, I have divided the chapter into three sections. In the first section, I demonstrate that various social actors curtailed the women's agency to grieve for their loss by not allowing them to have any visual or tactile contact with the deceased child, even when a few women expressed such a desire. Women's agency to grieve was further denied by these actors by excluding the former from the process of decision-making and performance of rituals, if any, regarding the disposal of the deceased baby's body. In the second section, I show another context of constrained female agency wherein the women's loss was disregarded as a significant event and they were advised by other actors to focus on the future, i.e. to try and conceive again, instead of spending their present time crying about the bygone. Herein, I show that the very doctors who had encouraged bonding during ultrasound scanning (see chapter three), ignored that same bonding after the loss had occurred. Instead, all these external actors pushed the women into undergoing another treatment cycle with renewed hope and determination. Nevertheless, most women did not agree to conceiving right away and instead, took time to deliberate over their decision about pursuing further treatment. In the third section, I continue to highlight women's utilisation of agentic capacities through their performance of creative, and usually private, grieving practices, rituals of memorialisation, and coping strategies which allowed them to process their grief and to also give meaning to their loss. I argue that it is through such practices, rituals, and strategies that the female interlocutors enacted themselves as mothers who had, indeed, experienced the loss of a real baby, which further legitimised their loss as a meaningful and traumatic experience – a social recognition and validation of their loss which they had not been accorded otherwise. Finally, in the last section, based on the case of a male interlocutor's experience of loss, I address the gendered expression of grief and coping strategies and how men face a "double disenfranchisement" (Doka, 1994) wherein not only are they not supposed to grieve openly through overt expressions of emotions as part of enacting their normative masculinity (see chapter seven) but they also feel helpless regarding how to grieve for their unborn child which is not even socially acknowledged by the society.

5.2. Women's Exclusion from Grieving Practices and Rituals

Most of the couples and the medical practitioners in my study were largely unaware that there was not one but three Hindu burial grounds in Kolkata where deceased babies can be/are buried. In fact, I had gained this information only during my pilot study in 2015 (wherein I was briefly accompanied by one of my former professors as he has been conducting research on perinatal death). When I mentioned this newfound information during my subsequent conversations with some interlocutors, most of them expressed their surprise on hearing that Hindus buried their deceased as the norm is cremation[130]. The only couples who were not surprised and were already aware of the existence of such burial grounds were the ones who had experienced reproductive loss in the form of perinatal death, stillbirth or neonatal death. They told me that they had gained this information from an older member of the family and that was usually the female interlocutors' mother-in-law. The following ethnographic vignette pertains to my visit to one particular Hindu burial ground in order to discover more about this largely unknown and silenced aspect around baby death in the public discourse in India.

In February 2018, I visited the Muraripukur Hindu *Kabarasthāna* or burial ground (see Fig. 19) which was located outside a decrepit biscuit factory in North Kolkata. Established in the nineteenth century, this burial ground is the smallest in area at around three acres and is managed by the Kolkata Municipal Corporation. The high and faded red walls of the ground was surrounded by some residential buildings, a couple of tea stalls, and small breakfast places, characteristic of the older parts of the city. I was accompanied by my aunt as I had been told by several people (including the staff at infertility clinic A from whom I learnt about this place) that since it was an "unsafe" area for a woman, I should avoid going alone. I was also recommended by a couple of people that it would be better if a male friend could conduct the interview on my behalf or at least accompany me to the burial ground. The gendered aspect of death and funerals had been brought to my notice, even though I was only going to the burial ground in the capacity of a researcher. As soon as my aunt and I stepped out of our auto-rickshaw, I noticed, albeit not to my surprise, that it was a male-dominated public space, akin to most public spaces in India. I also realised that the puzzled looks which my aunt and I were receiving probably had to do with the oddity of two women entering a burial ground,

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[130] Dalits have traditionally been burying their deceased as "a way of resisting the crushing authority of Brahmanical Hinduism" (Acharya and Sanyal, 2018). Arnold (2016) also notes that while burning the bodies of the dead has been an ancient rite and practice in India, especially among the upper-caste Hindus, members of the lower-castes, unless exceptionally wealthy, buried their dead. Arnold argues that cremation is not a universal practice among Hindus as it was often presumed to be (ibid., p. 401; see also Parry, 1994). However, Arnold proceeds to explain that since the 1890s, this distinction between how castes disposed their dead was being eroded as more Hindus, regardless of caste, chose to follow the "prestigious rite of open-air cremation or aspired to it as part of their social reform agenda" (ibid.).

unaccompanied by a male figure, both visibly unmarried (as neither of us were wearing any quintessential symbols of Hindu married women such as the *sindoor*). As we stepped inside the premises of the burial ground, we encountered an old man (who I later learnt was also the oldest gravedigger) standing at the iron gate and he asked us our purpose for visiting. On telling him that I was a PhD student and that I wanted to look around and conduct interviews for my research, he asked us to wait as the person who would answer my queries was having lunch. On asking whom I would be interviewing, I was told that it would be the medical examiner who was also the person in-charge of that burial ground.

Fig. 19. Muraripukur Hindu Burial Ground, Kolkata (Photo credit: Ms. Royina Saha)

As I waited and looked around, I could not see any burial sites. Rather, it looked like a large garden, quiet, unkempt, with some intermittent dry patches of land. I saw a young boy sauntering around with a goat which stopped every few seconds to feed on dry grass. Nothing about that place would let an onlooker know immediately that it was a burial ground. As my aunt and I waited around the entrance area, two young men approached us, who as I discovered during our conversation were gravediggers. One of them asked me if I worked for a company or the government and whether I had a permission letter to conduct an official interview. On learning about my student status and my research topic, the men looked convinced and did not probe me with any further questions. As they were lighting a *biṛi* (local Indian cigarette), I asked them about the protocol for burying deceased babies and who brought them here. One of them said,

> "Yes, we do have some people who come here. Usually the father or some other male member of the family like the grandfather or uncle comes with the dead baby. They first have to meet the medical examiner and do some official paperwork. Then one of us digs the grave. Digging graves for babies

> doesn’t take much time as it is smaller compared to the ones for adults. Once the baby is buried, the accompanying person usually lights an incense stick, puts some flowers or a small garland on the grave. I remember one person, he put the photo of some God, I don’t remember which one-
>
> The other man interrupted and said,
>
> Yes, but that is rare…Very few people come every year on the same date that their baby was buried. Most people just put some flowers. I have also seen a few people sprinkle some water from the [river] Ganga on the grave the first time.”

I asked the men whether they could show me around the burial ground while I was waiting to interview the medical examiner. They readily agreed and as we started walking, one of the men expressed his curiosity about my reasons for conducting research on such a “sad” topic. As we were talking and had walked a few hundred metres, one of the men pointed out to me that this was the point from which the burials started. I noticed that unlike the Christian cemeteries I had visited in India and in Europe, these burial grounds had no gravestones or any other markings. I asked the men that in the absence of any prominent markers, how did people recognise and remember where their family member was buried. To this, one of the men informed me that the burial spots were usually allocated with a number and that people usually remembered the burial location. In case somebody did not remember, then one of the caretakers or gravedigger would locate it for them. I asked them if there was any particular space allotted for the burials of babies and I was told that it depended on the availability of empty space. On further asking if a baby had been buried recently, they took me a few steps ahead, pointed towards a spot with some withered flowers on top, and informed me that a stillborn had been buried there some days ago. I was told that it was a boy and that he belonged to a Marwari family. When I asked who brought the baby, I was informed that it was the father and another male who looked a lot like the father’s older brother. The men then said that we should start walking back as the medical examiner would have finished his lunch.

We walked towards a small room which I had noticed earlier near the entrance. My aunt and I were greeted by the medical examiner and he invited us inside the sparsely furnished room. We were given two chairs to sit on and the medical examiner sat across us. There were three other men in the room, including the two men who had spoken to me earlier, and the old man who had met us at the entrance. After briefing the medical examiner about my research, he told me that he had been working at this burial ground for twelve years and that he was responsible for recording the official medical information when someone came with their deceased family member. I asked him for some more details about his job to which he said:

> “I am the first person the family members meet when they come here. I firstly ask them for the death certificate signed by a doctor before we agree to bury. I note down all the relevant information. Details such as the age and sex of the baby, place of birth, hospital’s name, and the cause of death are mentioned on that certificate. Most of the time the cause is stillbirth, miscarriage, or because the baby died inside the mother’s womb. I have a register where all these details need to be recorded for governmental purposes. This information is used to maintain statistical data of each year. The children buried here are as young as six or seven months old before birth and up to the age of ten. After ten, children are cremated. Once I have completed the paper work, one of these men you see here, take the family member with the body. We ask that person if he has any preference of location for the burial. People usually choose some spot under a big tree where there is shade. *smiled* I never understand how it matters to the dead whether there is sun or shade, but I never ask as it’s a personal choice. It’s a matter of sentiments, after all. If the people don’t have any preference regarding the location, then we bury the child depending on where we have free space. Yes, that’s all that happens.”

I asked him the reason for not burying children below the age of ten and he replied saying that children who die before the age of ten do not require *shuddhi* (purification) by fire as according to Hinduism, those children are considered to be “without sin”. He also mentioned that in the case of stillborn babies or babies who died in the late stages of a pregnancy, it would be traumatic for the family to see their child being burnt which is why cremation is recommended in Hindu religious texts for children only above the age of ten. The same explanation was given to me by the Hindu priest I had an informal chat with during a religious ceremony in Kolkata. I was told that babies and young pre-pubertal children dying before the *Upanayama* stage i.e. before the age of ten, are buried and not cremated (see also Parry, 1994, p. 220). The priest also said that “a newborn baby has never lived a life so there is no possibility for it to have committed any sin”. Regarding formalised rituals, the priest informed me that the dead baby has a religious thread tied on to the wrist and after giving the baby a bath, a male family member takes the body, wrapped in a fresh white cloth, to the burial ground or to the holy Ganges river. A similar account of death rituals has been described by Gatrad, Ray and Sheikh (2004, p. 1096) who write that according to Hindu (Brahmanical) religious texts and scriptures, once a baby dies, it is believed that it leaves the “earthly” realm into an “intermediate” zone followed by an entry into the “Divine” realm. A thread with religious significance may be tied on the wrist or the neck of the dead baby (ibid.). Stillborn babies are given the same religious “service” as an adult who has died (ibid.). A *Tulsi* (holy basil) leaf is placed in the baby’s mouth, sometimes along with a gold coin. After a ritual wash, the baby has new clothes put on which is then wrapped by a white shroud. In some cases, the body of the baby is taken from the hospital straight to the burial ground while in other cases, it is taken to its respective home where holy water from the river Ganges is sprinkled on to the body before it is buried.

When I asked the medical examiner about any rituals that were conducted during the burial, I was told that deceased babies were usually brought in a white cloth (as also mentioned by the priest) and he was not aware of any rituals performed prior to that. He added:

> "No specific rituals are performed by the family member(s) during or after the baby had been buried. At least nothing is done here, I obviously cannot tell you if they do anything at home or at a temple. Here, they do what they feel like doing, whether that is offering a prayer, lighting an incense stick , putting some flowers or nothing at all."

I subsequently enquired whether only men come with the deceased babies, as I had been informed by the gravediggers earlier, to which the medical examiner said:

> "Yes that's true. I have never seen any women come here with their babies. I don't think women would be able to see their baby being buried. The death of a child is a sad thing and for the woman who carried the baby, it is the worst thing which she could have suffered. So, it's always the father with some other male family member, usually the paternal or maternal uncle, who brings the body."

When I asked him if I could get an estimate of how many babies were buried annually, he refused saying that just as I could not reveal the names of the infertility clinics where I was conducting research, similarly he could not divulge any statistics due to reasons of confidentiality and also because it was official state information. Finally, when I asked him whether he could tell me whether there were more female or male babies who had been buried, he refused to answer on the same grounds of confidentiality and anonymity.

In his rich ethnographic account of death in Banaras in northern India, Parry (1994) has observed that not all Hindu corpses are cremated (see also Arnold 2016). The bodies of small children, most kinds of ascetics, members of various sectarian groups, those who died from certain diseases, people who cannot afford the cost of cremation, and those who died from any kind of "bad death"[131] – these are the exceptions to the rule of cremation in Hinduism and these bodies are either buried or immersed in the holy Ganges river, explains Parry (ibid., p. 68). As had also been explained to me by the medical examiner and the priest, Parry similarly

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[131] By "bad death", Parry (1994, p. 162) refers to an untimely death which indicates that the person died as a result of a violent incident, an unanticipated accident, or leprosy. As opposed to a "good death", a bad death is an "uncontrolled and involuntary evacuation of the body" (ibid.). A good death, explains Parry, occurs at the right time and at the right place after the person has ideally lived a long, health, and good life (ibid., p. 160-161).

notes that a baby is not cremated because it is not regarded to be polluting (or with the ability to pollute). According to Parry, a baby acquires the polluting aspect only when it is gradually incorporated into the social world where it then becomes closely related to other people (ibid., p. 68). Moreover, a baby is also considered to be ineligible for cremation because it has no teeth for mastication (Kane, 1973, p. 4, 227 in Parry, 1994, p. 185).

In many parts of India, death rituals for children are either absent or much simpler than those of adults, note Alex and Polit (2016, p. 10). The few rituals that are performed, such as placing flowers on the grave, lighting incense sticks, and sprinkling holy water, are exclusively performed by the male members of the family – a point which had also been reiterated by the interlocutors in my study. As Parry (1994, p. 152) has also written about the gendered aspect of death rituals in general, it is the men who perform these rituals and women are distanced as they are considered to be too "faint hearted" to accompany the corpse to the cremation (see also Gatrad, Ray and Sheikh, 2004, p. 1096). As such, the present section is concerned with the distancing and exclusion of the female interlocutors in my study from participating in any form of death rituals and grieving practices after the episodes of foetal/baby death. Based on the illustrations in this section, I show that women's agency to grieve for their loss by wanting to participate in such rituals and practices was denied by other actors – a denial which was based on gendered stereotypes according to which women were characterised as hyperemotional or emotionally fragile persons who *had* to be protected from being traumatised further. As one practitioner said, the "very emotional women" do not know what is best for them in such vulnerable situations.

Consider the following accounts of two female interlocutors in order to highlight their exclusion from the decisions and rituals related to the disposal of the deceased baby.

5.2.1. Discarded Feelings and Being Kept in the Dark

Jaya's narrative began with her recounting the sudden and intense onset of abdominal pain in her eighth month of pregnancy. On contacting her gynaecologist, she was recommended an emergency caesarean delivery. Jaya mentioned that she and her husband, Govinda, were concerned about the baby's survival as the pregnancy had not yet reached full term but the gynaecologist did not want to delay any longer. Barely two hours after the baby had been delivered, the paediatrician had declared the baby dead. As Jaya wept while narrating this incident, she told me that at first she and Govinda were overjoyed to hear that she had given birth to a girl. However, when the doctor informed the couple that their baby had not survived, Jaya said that she could not feel the ground beneath her feet (*“pāyēr tolāẏa māṭi chilō nā”*). She described feeling numb and not being able to believe the doctor’s words. When she asked the doctor for the cause, she was only told that this was a “rare incident” and it could not have been prevented. Jaya then told me that her husband was informed by the doctor that their daughter had physical deformities, she had become bluish soon after being born, and that in such cases, a baby’s survival is nearly impossible. Jaya regretfully said that the doctor had given the reasons for their baby’s death to her husband but not to her despite having asked. When she had mentioned this to Govinda, he consoled her by saying that the doctor was only trying to be considerate of her feelings and avoid causing her further pain. As she sniffled, Jaya told me that the baby had also been shown only to Govinda and his parents:

> “It was a caesarean, so I did not feel much physical pain. But it was the emotional pain/suffering (*koshto*) which was unbearable. I had never been in that much agony. Life had many ups and downs before as well, but none of those compared to that day. The day which every mother waits for, when she will see her baby for the first time, the baby she has carried for months, and I gave birth to a baby whom I couldn’t even see. I cried for hours saying that please let me see my daughter once, but nobody let me see her. I begged my husband that I want to see her and hold her only once but he said that the doctor would not allow it as it would cause me lifelong trauma. I didn’t know what to do at that time…If I hadn’t gone through a caesarean, I would have probably stood up myself and gone to see where they had kept my baby. My mother-in-law who was present at the hospital said that seeing my baby in that condition would give me sleepless nights and that for a woman, there was nothing worse in the world than the sight of her dead child. Everyone kept saying there’s no point in seeing my baby because I would only be more hurt and that I would never be able to forget that image. I wanted to tell these people that if God has given me the strength as a woman to carry my baby, then I had enough strength to see her in whichever condition it was...But at that moment, I was feeling very helpless and I could only cry. I wasn’t able to understand what had happened in my life.”
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> When I asked Jaya about what had been done with her baby after the incident, she said,
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> “Initially, when I asked my husband and the nurse about what would be done with my daughter , nobody told me anything. Everyone kept saying don’t worry, we will take care of your baby. I was so angry at everyone, I wanted to scream. I felt that even though I was the mother, my feelings had been discarded on the side. I was so frustrated, I felt like throwing and breaking everything and shouting. Nobody understood my pain. I only found out several weeks later that my husband and my father-in-law had buried her. They didn’t tell me the location. I kept asking because I wanted to go there, put some flowers, and offer a prayer. I have asked many times since then but I still don’t know. Now I don’t ask anymore.”

Since the early 1980s, medical practitioners in several Euro-American countries encouraged bereaved couples to physically spend some time with their deceased child in order to grieve and cope with the loss (see chapter one). And in order to facilitate the grieving process, couples are further advised by medical practitioners and social workers to memorialise their loss by participating in rituals such as naming the baby and taking photographs of/with it (see chapter one). In contrast, the practitioners in my study informed me that the protocol in Indian hospitals was to immediately remove the deceased baby out of a woman's sight in order to avoid her from having any visual contact with the baby. The rationale offered by the practitioners for this practice was twofold – firstly, they wanted to ensure that a woman did not suffer from shock after seeing the body of her dead child and secondly, they wanted to discourage any attachment between the woman and the child. As we can see from Jaya's case, even when she wished to see her baby, it was never shown to her with the well-meaning intention that the image of her dead baby would cause her lifelong trauma. As Nurse Shanti at infertility clinic A said in this regard:

> "Actually, women are too emotional which is why we usually show the baby's body only to the husband. But husbands also don't want to see it sometimes. Look, no woman wants to see that she has given birth to a dead baby. So, there's no positive side of the woman seeing the dead baby. The woman is already heartbroken and then showing her the body will make her much more upset and might even cause her to go into trauma. A few women ask to see their baby, but we advise them against it. We don't want the woman to have any attachment with the baby because what would be the benefit of that? At the time of this incident, the women are very emotional, they do not know what's best for them. We have to make certain decisions for them even if they don't like it..If it's a late-term loss, then we ask the husband or some other family member whether they would like to see the baby and take it. Otherwise we take care of it ourselves. And if the baby is malformed, then we don't show it to anyone from the family."
>
> When I asked Nurse Shanti about what she meant by "take care of it ourselves", she said:
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> "Many times the sweeper at our clinic takes care of this. He is usually given a small amount of money by the family. Actually, if it's a first trimester baby, then we throw it away as medical waste. Usually, the late-term babies get immersed in river Ganga, that's what I have heard from a few husbands. There were also some cases where the husbands took the babies to the burial ground. Actually, I was quite surprised to hear this the first time. I wasn't even aware that Hindu babies get buried. But yes, some people do that. So yes, it all depends on how far the pregnancy has progressed. And as far as I know, the sweeper doesn't bother taking the babies for burial. He wouldn't put in so much effort for such a small amount of money! He either throws them in the [river] Ganga or dumps them in some dustbin somewhere. But I can't say with certainty as I have never asked him about this."

I was met with similar responses to my queries on how deceased babies or late-term foetuses are "taken care of" from the other practitioners in my study. When I shared the grieving practices performed in many western countries with some of the practitioners and asked their thoughts on it, I was met with a general expression of surprise and they told me that they had never heard about such things before. I was unanimously told that such practices would not bode well in India and that most people might not be able to accept such things like taking photographs of/with their dead baby. When I asked them why they felt that way, the common response seemed to be that Indians, especially women, are more emotional and sentimental as compared to people in the western countries who were characterised as emotionally stronger and more resilient. Speaking of the "different kind of mentality" which Indians have, the ultrasound clinician of infertility clinic A said:

> "See what you are saying, all this works in the foreign countries. They have a different system and it works because people there are not so emotional about everything. Indian women are far more emotional and sentimental. The lives of women in our country revolves around having a child so if that child dies, then naturally, they are devasted. Women in foreign countries are not like this. They are emotionally stronger, much more resilient, and that's why all these photos of the babies and everything you mentioned works for them. It's best that women here are kept away from the dead baby and anything to do with it. We can't expect the foreign system to work in India because as I said, as Indians we have a different kind of mentality."

What struck me after hearing the practitioners' responses and views on this matter was that none of them had considered that seeing or holding the baby in cases of late term pregnancy loss might have facilitated a woman's process of grieving and coping (or perhaps even for both parents). Herein, I must point out that my intention is not to comment on whether the protocols regarding grieving practices followed in the western countries are better (or worse) than those adhered to in the Indian medical institutions. I believe that making any such affirmation would necessitate conducting a comparative and longitudinal study where women's (and men's) grief responses can be studied over a longer period of time. Instead, my intention is to offer empirical accounts which demonstrate the gendered aspects within and even beyond medical spaces that circumscribe and shape women's experiences of reproductive loss, grief, and bereavement. As we can see from Jaya's and Gayatri's narrative (discussed in the introduction), they had been excluded from making any decisions and as Jaya said, she felt that her feelings had been discarded. It was the husbands of both women and other family members who were asked about whether they wished to see the baby and it was these other actors who decided about disposal of the baby's body. Both women were enacted by the medical and non-medical actors as emotionally fragile and who needed to be shielded from the pain of knowing the reasons for their baby's death, of seeing their deceased child, or of knowing where their baby had been buried. Bereaved women were also infantilised (see chapter three), as we can see from Nurse Shanti's excerpt, wherein she states that as highly emotional women, they do not know what is best for them and as such, certain decisions *have* to be taken on their behalf by others.

Before proceeding to further discussion, let me introduce the reader to Neha's case in order to show, once again, how women are excluded from decision-making about the deceased baby's disposal. A patient and an employee at infertility clinic A, Neha was advised by the infertility specialist to terminate her pregnancy as her baby had been diagnosed with a medical condition called Gastroschisis[132]. The doctor had informed Neha that by doing so she would avoid giving birth to an 'abnormal' baby whose life expectancy would not be more than a few hours. Describing the episode in her life when she underwent a vaginal delivery in the 16th week of her pregnancy, Neha said[133],

> "I didn't know what else to do. I thought that okay, it's better to take this decision now than to go ahead with this pregnancy…The operation happened at the clinic [A] itself because Dr. Ganguly said it was not a major operation. I had a normal delivery because the doctor said that it could not be sucked out with D&C[134]. The normal delivery was enormously painful. I would not wish that sort of pain even on my enemy! I was being given injections to induce labour and for 36 hours I was lying on the bed. That feeling of knowing that I was doing all this after which a dead baby would come out of my body – I think that's the worst feeling for any mother *wiped a few tears off her cheek* When I gained consciousness after the delivery, all I wanted to know was what had been done to my baby. I kept asking my husband but he never told me. I knew that at 4 months, it would have been small, like a big mango maybe *indicated the size with her hands* So, I kept wondering what had been done. I knew that at this stage the babies are usually given to the sweeper. But I realised it feels different when it's your own baby. Suddenly it feels like an insensitive thing to just give it to the sweeper. I really wanted to know what would be done with my baby but nobody told me anything. Everyone had kept me in the dark…Yes, it's true that my baby didn't survive, but it's also true that I had carried it in my womb for four months. It was much later when on my constant insistence, my husband told me that he had immersed the baby in the [river] Ganga. He told me that during the time I was unconscious, he had gone to the sweet shop nearby, got an empty box which he then filled with sweets, flowers, and brought it back to the nurse. The nurse put our baby on top and then my husband covered it with more flowers. He said he had gone alone to immerse the box. I later found out that my mother in-law was actually furious when she heard that her son had done something like this without consulting her. She said that the fish would feed on the body and that wasn't a good thing. I don't know from where my husband had this idea…I was just angry when I found out that my husband had told my mother-in-law about this before he told me. I was so angry! It was my baby and I was the last one to find out about this! Whenever I would ask what had been done with my baby, both of them would always say that since I am a woman, I would be become too emotional if I knew the details and wouldn't know

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[132] Gastroschisis is the condition in which the abdominal wall of the foetus remains underdeveloped which results in the intestines hanging outside the abdomen.

[133] This interview was conducted jointly by Prof. Harish Naraindas and myself during my pilot study in 2015.

[134] D&C or Dilation and Curettage is a method of surgical abortion that can be performed safely up to 14 weeks.

> how to handle the details. Even today, I wish my husband would have involved me in his decision – at least for my mental peace."

Neha's account of how her husband had decided to immerse their baby in a sweet box in the Ganges river was undoubtedly one of the most unique narratives in my study. Speaking of her embodied loss, she mentioned that she wished she could have participated in her husband's decision, if only, for her "mental peace". However, similar to Jaya's and Gayatri's case, Neha was excluded by her husband from decisions of her deceased baby's disposal. Her husband and mother in-law also did not tell her about how the baby was disposed because according to them, she would have become overtly emotional and would not have been able to grapple with the details.

Anthropological research has shown that emotions are culturally circumscribed and are enacted as social processes, thereby, problematizing the essentialist idea in traditional psychological research that there is a universal and basic set of emotions (Geertz, 1973, Lutz, 1998, Rosaldo, 1980 in Lock, 2011, p. 187; see also Scheper-Hughes, 1992). Studies have also shown that meanings of certain emotions and the importance of the terms used to express certain emotions change over time (for e.g., see Edwards, 1999; Gergen, 1995; Harré, 1983 in Locke, 2011, p. 187). Moreover, it has been argued by some researchers that the traditional gendered stereotypes of the 'emotional woman' and the 'non-emotional' man are culturally evident and endorsed (Lupton, 1998; Lutz, 1990 in Locke, 2011, p. 188; see also Fischer, 1993). As such, in this chapter, as well as intermittently in this study, I have shown and argued that the expression of gendered emotions, or the lack thereof, by the female and male interlocutors in my study who have experienced reproductive loss, are culturally ascribed, reiterated, and continually enacted by the other actors and by the interlocutors themselves in various contexts. Drawing on Butler's (1990) argument of gender as a performative act, emotions and how they are expressed, are, indeed, a part of this performance. As Fischer (1993, p. 312) has also argued, the "claim that women are more emotional than men tells us more about our cultural stereotypes than about actual sex differences in emotions". Thus, "any discourse on emotion is also, at least implicitly, a discourse on gender" (Lutz, 1990, p. 151 in Locke, 2011, p. 192).

As we have seen in the examples discussed so far, the female interlocutors were continually enacted by other actors as being overtly emotional and as emotionally tenuous[135]. This ostensibly natural 'feminine' quality of hyperemotionality and emotional fragility was invoked as a reason by the other actors to deny the women from gaining visual access to the baby and for being excluded from partaking in decisions and rituals regarding the disposal of the deceased baby. The men, on the other hand, as the emotionally restrained individuals, were made responsible (or assumed responsibility) for performing the burial and death rituals. By enacting the bereaved women as overtly emotional and fragile and men as emotionally stoic, I argue that within the larger narratives and experiences of reproductive loss and grief, gendered stereotypes are reproduced, sustained, and, therefore, normalised.

An interesting irony I seek to address briefly in the next section is that while the female interlocutors were considered by the other actors, including the mothers-in-law, as hyperemotional or fragile to participate in the decision-making process about their child's disposal, it was the mother-in-law, a woman herself, who was primarily responsible for making the decisions. My reason for allotting a separate section to this topic is because in my interactions with women, I learnt that the mother-in-law played a vital role not only in taking decisions regarding the deceased baby's disposal but also in affecting the women's reproductive experiences and decisions after they had experienced reproductive loss.

5.2.2. The Mother-in-Law as the Decision-Maker: Highlighting the Discrepancy

For many to-be parents, the death of their baby is a novel experience, perhaps even their first experience with death at all (Rajan and Oakley, 1993, p. 75). As an unfamiliar and unique event, the bereaved women and men in my study informed me that following the incidents, they were uncertain about how they should have handled such an unanticipated situation.

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[135] This prevailing notion that women are overtly emotional compared to men is not limited to the Indian context. Rather, as Shields (2002) has pointed out, this is one of the strongest gendered stereotypes held in western societies as well. In the context of the United States, Shields (2005, p. 9) explains that there are normatively two "emotional styles" that are linked to gender – "extravagant expressiveness" characterises women and men are characterised by "manly emotion" (ibid.). Shields further explains that while "feminine-identified emotional standards, as expressed in extravagant expressiveness, foster many socially desired behaviours, such as tenderness and selflessness, they are culturally tainted because of their association with emotion that is out of control or threatening to become so" (ibid., p. 10).

Under such circumstances and given the lack of medical protocol as well as the absence of formalised rituals, it was understandable that the couples sought help from an older family member. It was usually the woman's mother-in-law who gave (her son) instructions on how to dispose the baby's body. Even the medical staff deemed it appropriate to show the deceased baby to the mother-in-law (often the father-in-law as well) along with the intended father. I take this opportunity to briefly examine the role of the mother-in-law who despite her female gender is a crucial actor in the narratives of reproductive disruptions and performs a decisive role concerning the disposal of the deceased (grand)child.

During my interviews with my female interlocutors, a common trope which emerged repeatedly was the strained relationship they shared with their mothers-in-law. One of the ways in which this also came to my notice was that some women would invite me to their home for interviews or informal conversations only when their mothers-in-law were not around. In their absence, the women were more comfortable and shared intimate issues such as their marital distress without any hesitation whereas in the presence of the mothers-in-law, the women were visibly more alert and careful about what they shared during the interviews. For instance, when I visited Kanika at her home for the first interview, her mother-in-law repeatedly interrupted the conversation and did not let Kanika speak for herself. If I asked Kanika a question, it was the mother-in-law who would frequently answer on her behalf. When I was leaving, Kanika whispered to me saying that she would invite me again when her mother-in-law was not at home. A few weeks later, I received a WhatsApp message from Kanika saying that I should visit her on a particular Sunday when her in-laws would be at a relatives' home. When we met again, Kanika apologised for her mother-in-law's interruptions during the previous interview and said:

> "My mother-in-law has the habit of poking her nose into everything! She thinks she knows about everything. Please don't mind her, okay? Actually, there are no decisions in my house which are taken without consulting her…You know, when I started the [infertility] treatments, my husband and I hadn't told anybody else in our families about it. But my in-laws knew of course, as we live in the same house. My mother-in-law always wanted to know where was I going, why, when I would be back. My own mother has never been this strict! If ever I would be late in the evenings, immediately she would complain to her son that instead of focusing on my treatments, I was wasting time. This would mostly result in arguments between me and my husband. What was I supposed to do? Just because I was having treatments, am I supposed to sit inside the house and stare at her face? When the treatments had started, she had told me to keep her updated about my periods. And each time, she would hear that I have my periods, she would react as if someone had died. She wouldn't speak to me for a few days. She made me feel like it's all my fault, that I had intentionally made my periods start. She had really made my life hell during those years!"

Eventually, as we began discussing Kanika’s experience of perinatal death, she told me about her exclusion from any decision regarding the disposal of her dead baby and that it was her mother-in-law who made the decisions and instructed Kanika’s husband on burying the body.

Researchers have found that for many married couples in India, they are not the sole decision-makers when it comes to matters of fertility such as contraceptive use and family planning (see Char, Savaala and Kulmala, 2010; Jejeebhoy and Sathar, 2001). This is all the more visible in South Asian societies where it is common for married women to live with the husband’s family following the practice of patrilineality and patrilocal residence (see Allendorf, 2006; Deshmukh-Ranadive, 2005; Donner, 2008; Jejeebhoy and Sathar, 2001). With the birth of children, especially sons, and with the subsequent entry of the daughter(s)-in-law, the residing woman in a South Asian household tends to move to the top of the generational hierarchy while her position in the household becomes more deeply embedded (see Allendorf, 2006; Lamb, 2000; Polit, 2016). In her ethnography of aging, gender, and body in West Bengal, Lamb (2000, p. 240) notes that in important ways, women do gain more power and freedom as they age and become mothers-in-law, thus enjoying considerable authority and autonomy as the female head of the household. Her research also shows that older women in the household often tend to ensure the compliance of their daughters-in-law (or granddaughters) in order to ensure their own honor, “and that of the family that they have come to be invested in, to care about, to be a part of” (ibid.; see chapter six for a discussion on the importance of women upholding honor in the middle-class Indian setting).

Similarly, other scholars have also observed that within the Indian household, the hierarchy of authority is governed by age and sex, with the older over the younger and men over women (see Malhotra, Vanneman and Kishor, 1995; Sharma, 1980). As such, in Indian households, the mother-in-law wields the main authority over domestic affairs and as such, all married (younger) women in a household are subject to the mother-in-law’s authority (see Bloom, Wypij and Das Gupta, 2001; see also Lamb, 2000, p. 7). In contrast, it has been observed that women who live without older female affines, particularly the mother-in-law, tend to have more interpersonal control over resources and information in order to determine events in their own lives, as they are obligated to fewer older individuals (Bloom, Wypij and Das Gupta, 2001, p. 68; see also Char, Savaala and Kulmala, 2010; Jejeebhoy and Sathar, 2001; Vera-Sanso, 2004). It is with the birth and growth of children, argues Vatuk (1987, p. 35), that the extent to which mothers-in-law exert authority over the ‘mature’ married woman gradually diminishes. With the presence of children, the married woman becomes less subservient to the mother-in-law and gradually, the mother-in-law withdraws voluntarily from her central role as a manager of the household, or is forced out of this dominant role by the daughter-in-law (Vatuk, 1987, p. 35). As such, we can see that societal hierarchies itself posits individuals into roles in a way that women themselves become the practitioners or enforcers of certain decisions, rules, and customs which ultimately highlights the importance of considering consider specific local contexts in which certain relations and interactions unfold.

Given that my study engages with narratives of involuntary childlessness and reproductive loss, the female interlocutors without children did not have a particular stronghold in the family if one were to follow Vatuk’s (1987) line of argument. As the conversations with most of the female interlocutors in my study revealed, it was the mothers-in-law who not only pressurised the former to procreate but they also wielded the power to make decisions about the death rituals following the incidence(s) of reproductive loss. My intention here, however, is neither to essentialise the image of the Indian mother-in law as the proverbial villain or archnemesis (as is often portrayed in popular culture) who suppresses, controls, and tortures the daughter-in law nor to portray the daughter-in-law as the oppressed victim (see Lamb, 2000, p. 7). Instead, I wanted to highlight a discrepancy that on the one hand, while the bereaved female interlocutors on account of their gender were regarded as emotionally fragile and incapable of taking certain rational and pragmatic decisions, the mothers-in-law, also women, were not considered in the same light. The issue here then is not that *all* women are enacted as overtly emotional or fragile. Rather, it is the younger, inexperienced, usually childless woman who is enacted by others as being inept at handling her emotions and thus, needs to be protected from the trauma of seeing her deceased baby, as opposed to the mature mother-in-law, the matriarch, who has more life experiences and relatedly, more power and authority in the familial structure to make certain decisions.

5.3. Forget It and Try Again: The Absence of Social Support for Bereaved Women

In this section, I address how the female interlocutors’ experiences of reproductive loss was treated as a non-event or a medical(ised) event by various actors (see also Layne, 2003, p. 16; Rajan and Oakley, 1993, p. 75). Particularly in cases of early-term miscarriages where a baby was ‘unborn’ or never born, i.e. in the absence of a tangible body, the various actors around the bereaved women viewed the loss as immaterial which need not be acknowledged.

5.3.1. What will people say: Disenfranchisement of Grief by Husbands and Mothers-in-law

Madhu had spent more than half of her conjugal life in trying bear a child. After three first-trimester miscarriages, she pursued infertility treatments. Subsequently, she conceived for the fourth time after an IUI treatment cycle. Less than a month before her scheduled delivery, Madhu’s baby died in-utero due to medical complications. Not long after the incident, Madhu’s mother-in-law insisted that she should try for a baby again as she was getting older and because “people had started asking questions”. Regarding this pressure, Madhu said,

> “It had hardly been six months since the incident when my mother in-law started convincing me to try again. She would tell the same to my husband when he returned from work and he would start coercing me at night. He and I got into many arguments because of this. I kept refusing for a long time but both mother and son didn’t stop. Of course, I want a baby, but I wanted to wait for some time before trying again. I wanted things between my husband and me to get normal before we started trying again. I was still suffering emotional but he didn’t try and understand. I was hurt that he wasn’t able to understand that I needed to become normal again before thinking of having another child…My mother-in-law suggested we consult with my infertility doctor again when she saw that I was not pregnant after a few months of her telling us to try. Her only concern is with what people will say. I spoke to my own mother about the situation and she said that I should do what my mother-in-law was saying before any tensions arose with my in-laws. I had no support – not even my own mother understood my mental condition. By then, people had also started asking questions. Some of my neighbours and relatives would constantly ask me why I didn’t have a child after so many years of marriage. When they heard about the incident, they would ask me to forget about it, and convince me to try again. It seemed like everyone was showing me fake sympathy. I didn’t have the energy to handle any more pressure and arguments with my husband. I finally agreed to returning to the [infertility] doctor. Since my husband wanted a baby soon, the doctor said we shouldn’t waste time and start IVF immediately. I had understood by then that all the arguments and the tension would end once I had a baby. Having a baby – that’s the only solution to all this. How I feel, that’s not anybody’s concern.”

A similar trope was reflected in Neha’s case wherein following the medical termination of her pregnancy as discussed earlier in this chapter (see section 5.2.1), she had also not been given any time and space by either her husband or her mother-in-law to grieve for her loss. However, despite being pushed to undergo infertility treatments, Neha refused, as she wanted more time to process her baby’s death and also because she was uncertain about staying in the marriage with her husband due to increasing marital conflicts (see chapter six). In this regard, she said the following:

> “My mother-in-law said to my husband, why does she have to worry? She can try again. It’s we who lost our heir. I was in the adjacent room and I remember hearing that and feeling very hurt. I was the

> one who was carrying the baby. What about my feelings? My pain? My loss wasn't seen as my loss! My in-laws think they are highly educated. They're actually worse than the people from the slums! You won't believe the kind of pressure my mother-in-law put on me to start treatments after I lost my baby. She only wanted a grandchild and what I was going through didn't matter to her or to anyone. She had started collecting a fund where my husband and I would have to put in a part of our salary. Initially, she told me it was for some religious event. When I overheard her speaking to my husband and mentioning that she was keeping money aside for my treatments, I stopped giving her my money. Can you believe what a cunning woman she is! She was furious that I went against her decision. I could often hear her complaining about me to my father-in-law and husband. She wouldn't speak to me about any other topic, as if this was the only reason why she had gotten me married to their son. I would come back from work after a long day, feeling exhausted, and still upset from what the mishap in my life, but nobody spoke to me normally. I would mostly have dinner alone at the dining table even though I knew that my in-laws were awake. I could hear them watching some silly television show in their room. The worst part is that my husband never said anything to them and he never supported me. He would actually argue with me based on what his mother would tell him. Whenever I told him that I was upset, he would ignore me and tell me to find some distraction. He would say, go to the beauty parlour or watch a movie. I should have realised that he's not a good person right then. I don't know why it took me this long to understand what kind of a person I had been married to. During that time, I thought why should I go through these treatments to have a baby with a man who is not a good human! I knew from my job that these treatments were physically exhausting and painful. So, I finally decided to say no. As if I didn't have to face enough mental torture from my husband and mother-in-law, and on top of that, treatments?! Absolutely not! I was done being treated like a puppet!"

Research in western countries shows that social support from family and friends plays a crucial role in how bereaved persons adjust and cope with their loss and such support tends to have a buffering effect (for e.g., see Gray and Lassance, 2003; Layne, 2003; Smith, 2013). On the other hand, poor social support tends to result in complicated and prolonged grief (see Laakso and Paunonen-Ilmonen, 2002; Lasker and Toedter, 1994; Layne, 2003). Moreover, many bereaved women and/or couples not only have to cope with their own grief, but also the reactions of people around them (Rajan and Oakley, 1993; see also Van Praagh, 2001). Mammen's (1995) study, even though it included a small sample of only nine middle-class women in Bangalore, suggests that family members in India, particularly the husband's family, are largely unsupportive towards women who have experienced perinatal death and it is the women are usually held accountable for having failed the family. In their study in Australia, Rowlands and Lee (2010, p. 283) have shown that the lack of emotional support from family members and friends meant that women were often unable to grieve in their own way. Researchers have also identified that for bereaved women, an important part of their coping experience is the formal acknowledgment or the public recognition of the loss and of receiving validation from other people that a child - whether real or potential – has been lost (for e.g., see Bansen and Stevens, 1992; Corbet-Owen and Kruger, 2001; Leppert and Pahlka, 1994).

Nonetheless, women who have suffered incidences of reproductive loss are eventually made to realise by the people around them that their grief is not a noteworthy emotional experience and the social expectation is that while it is a sad affair, the best way to resolve it is with the conceiving again (Rajan and Oakley, 1993, p. 75-76). Consequently, the bereaved women experience the loss of their baby in a silent environment in which they feel socially and internally pressured to move on and to end their grieving even if they do not feel ready.

Writing about the "forgotten grief" of pregnancy loss more than five decades ago, Cain and Cain (1964 in Kirkley-Best and Keller, 1982, p. 423) explained that in western countries, women were frequently encouraged to become pregnant again to forget their previous loss. Labelling it as the "replacement-child syndrome", Cain and Cain argued that the rationale used was that women would heal from their earlier loss by becoming busy with their new baby. While in many western countries this rationale has largely been rejected since the 1980s due to the presence of various social support groups and hospital protocols which help women and/or couples grieve for their deceased baby in a timely manner (see chapter one), it certainly seems to be a valid and common way of grappling with the occurrence of reproductive loss in India as illustrated by my research findings. As we can see from both Madhu and Neha's case at the beginning of this section, shortly after their baby's death, there was a sense of urgency and a hurried time frame within which the women were pushed by everyone around them to have a 'replacement baby' which would (apparently) make them forget about their previous loss. Similar accounts were narrated by all the bereaved female interlocutors in my study who had experienced reproductive loss at any stage in their pregnancy. By pushing Madhu, Neha, and the other women to have a replacement baby and by asking them to get over it or to forget it, their experiences of loss and grief were, indeed, marginalised by their husbands, mothers-in-law, and sometimes as we have seen in Madhu's case, by her own parents. Such social expectation(s) for these women to move on emerges from the idea that the expression of mourning must be appropriately condensed in response to the "short life", or lack thereof, of the deceased child (Martel, 2014, p. 328).

However, even within these constrained situations where women were denied the agency to grieve in their own way and time, it would be unfair to view them merely as passive victims. For instance, Madhu eventually made an active decision to undergo IVF because as she said, she had realised that bringing a baby in her home was the only solution for putting an end to the tensions in her conjugal life. In Neha's case, not only did she refuse to contribute money to the fund for infertility treatment created by her mother-in-law but she also consciously decided to refrain from undergoing any treatments at all. Although both women took control of their lives in different ways, their deliberative and decisive acts certainly indicate the utilisation of forms of constrained but strategic agency.

Based on two doctor-patient interactions, I show next that instead of offering bereaved women the "emotional attention"[136] (see Gray and Lassance, 2003, p. 21) they were searching for and acknowledging the personal meanings they attributed to their loss, the medical practitioners marginalised the women's experience of loss and denied them the agency to grieve on their own accord.

5.3.2. "Crying is not the solution": Disenfranchisement of Grief by Medical Practitioners

Married for 13 years, Lakshmi's first two pregnancies had resulted in first-trimester miscarriages. Eventually, she had undergone treatments at infertility clinic B and after three failed IUIs, Lakshmi conceived on her first IVF cycle. Unfortunately, Lakshmi experienced a perinatal death at 29 weeks. The following interaction happened between the infertility specialist, Dr. Sen, and Lakshmi when she visited him a few days after the incident:

> Lakshmi (L): *sobbing* Sir, please help me. I am not able to understand why this happened again. This is the third time I am going through this pain. I think God does not want me to be happy. He is punishing me for some grave error I must have committed in my past life. Sir, I must be the most unfortunate woman in this world. I cannot do this anymore. I feel like my life is over. I have nothing else to live for.
>
> Dr. Sen (Dr.): Please calm down first. And why are you talking like this? Please control yourself. Crying will not help. I am trying my best to give you a baby, isn't it? You have to be strong. We will try again. It won't help if you break down like this.
>
> L: Sir, how can I explain? *sobbing* I was a mother after trying for so many years. I was in anticipation and then suddenly this mishap happened. There is no worse feeling than this for any mother. I don't understand why my body is not supporting me. What did I do wrong? How will I recover from this pain and sadness?
>
> Dr.: See, I understand, feeling upset is normal. It is, indeed, a very sad situation. I understand that but you can't spend all your time crying. Will crying solve your problem? If you say so, then I can prescribe you to cry all the time. We have a problem in front of us. And we need a solution. You have to be mentally strong to get through this hard time in your life. Sitting at home or sitting in front of me and crying for hours won't help you. So, I suggest that you first stop crying, mentally prepare yourself, and

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[136] In regard to "emotional attention", Gray and Lassance (2003, p. 21) note, that "a clinician first and foremost must be a "keen observer" and respond to what the clients'/patients' manifested behaviour indicates what those needs are". The authors make this observation specifically in the Euro-American context, but it would not be far-fetched to claim that the same phrase can be applied to the present discussion.

> then we can try for IVF once again. I have many patients like you but you cannot give up hope yet. There are many women like you who have a baby after many such sad incidents. It's their never-die spirit which takes them forward. You were pregnant, you can become pregnant again. It is not impossible. We just have to try. You take a holiday somewhere. Alright? Tell your husband to take leave from his office and to take you to some nice place.
>
> L: But sir, I do not have the mental energy to do this again anytime soon. What if I try and this mishap happens again? I will not be able to survive another mishap. I can't, I just can't. Maybe I should stop now and accept that this is what is written in my destiny.
>
> Dr.: If you don't take a chance, then how will you get the result? You can't sit and home and think of winning the lottery without buying the lottery ticket! And look, you are almost 40. The older you get, the more the chances of miscarriage and we don't want to take that risk, right? So, waiting at this stage only means wasting precious time. If you wait now, then you might regret wasting this time later. I think it's best we start your second IVF cycle as soon as possible.
>
> L: But sir, do you think a mishap like this can happen again? Please promise me sir that nothing like this will happen again.
>
> Dr.: I think that the chances of you becoming pregnant again are quite good. And look, I can't guarantee you that such an incident won't happen again. How can I say that in advance? Can you guarantee me that you'll buy a car and an accident won't happen? So, I can't assure anyone that such an incident won't repeat itself. Just have a steady, positive mind, and keep moving ahead! You have to promise me that you will give your best! Without your faith and cooperation, we will never succeed! We will give it our best but of course, the final decision is in the hands of the One sitting up there. Creating a life is the most difficult job which only God can do. I am here to try and help you in the best way possible."
>
> L: Okay sir, if you think this is the best decision, I will think about it. I will speak to my husband and decide what we should do. I will then inform you.

This was not the first time I had witnessed such a conversation during my fieldwork. Consider another comparable dialogue at infertility clinic C after Soumya had experienced her fifth miscarriage despite being a 'good patient' (see chapter four). As Soumya kept looking down and softly weeping, Dr. Chatterjee initiated the conversation:

> Dr. Chatterjee(Dr.): I am sorry for what happened. I don't know what else to say. It's just bad luck. Women go home from here with a baby after one IVF but for some reason, luck is not favouring you.
>
> Soumya (S): *weeping and sniffling* I don't understand why me. Why does this keep happening to me, Dr. Chatterjee? I followed all the instructions but still this happened again. I don't know what to do now. I don't know why this is happening to me repeatedly.
>
> Dr.: Look, sometimes these things happen and they are beyond anyone's control. Crying is not the solution. You crying like this will not give us a solution. We are all giving it our best each time. But the truth is that we can all do our best but finally, there's someone above us all who takes the final decision. You please don't lose hope. You have come this far. I will pray to God that you are successful in your next IVF. It will happen, don't give up hope.

> S: I don't know if can do this again. I am exhausted, my body is exhausted. I can't go through all the injections and medicines again. This is what I have been doing for more than two years. What if I do another IVF and have a miscarriage again? I don't know if I have the energy to handle another mishap.
>
> Dr.: Finally, it's your decision but don't regret later that you didn't give this your 100%. I am here to give you a child. You came to me asking for a child, isn't it? So, I don't think you should be giving up yet. It's not like you could not conceive at all like some of my other patients. You conceived five times and your last pregnancy reached the second trimester. So, there is a high chance that your next IVF will show results. But if you don't put in the hard work, then how will you get the results? I know you are trying but you have to be a little more patient.
>
> S: Yes Dr., I do want a child. But I need some time before I can do another IVF. I'm not in a mental state to start another IVF right away. And there is a lot of money involved as well so i, I'd like to speak to my husband because this would be my/our last IVF attempt. And if it doesn't happen this time, I want to convince my husband to adopt because I can't keep doing this .
>
> Dr.: Yes, that's fine, take your time. But if you want to do another IVF, then I suggest you don't delay much. You are already 36, so the more you wait, the riskier the pregnancy will become. Understood? *Soumya nodded * Good, now go home, talk to your husband, and let me know what you decide.

Taussig (1980) argues that both science and medicine can only explain the "how" of a disease, but not the "why". He writes that science can

> …point to chains of physical cause and effect, but as to why I am struck down now rather than at some other time, or as to why is it me rather than someone else, medical science can only respond with some variety of probability theory which is unsatisfactory to the mind searching for certainty and for significance (Taussig, 1980, p. 4).

Bharadwaj (2006, p. 456) has observed that "leaving things" to God emerged as a routine clinical practice in infertility clinics as couples were repeatedly told by their clinicians after the most sophisticated interventions to bypass their (in)fertility that their case now rested with a higher court of appeal which would determine the eventual outcome of the clinical efforts. The suspension of "scientific rationality", Bharadwaj claims, is at its most prominent when clinicians have to explain the unpredictability of assisted conception by resorting to metaphysical rationalisations (ibid.). He also notes that the success or failure of techniques is partly acknowledged by the clinicians as a scientific and technical intervention, "beyond which lies the unexplored realm of the unknown that is best understood by resorting to explanations more spiritual and cosmological in nature" (ibid.). Bharadwaj argues that such a way of making sense not only indigenises biomedicine but it also produces, "clinical theodicies that resolve the *why* questions posed by intractable infertility" (ibid., p. 463). Such an indigenization of biomedicine in India, according to him, demonstrates that the "clinical-bio-medical modalities are far more open to uncertainty and amenable to pluralistic understandings than the technocratic imperative which permeate the clinical applications of science” in the Euro-American contexts (ibid.).

As we can see above in Lakshmi’s and Soumya’s dialogues, while the doctors had previously claimed to treat their childlessness with science and medicine, those same elements do not provide them with concrete answers for *why* a certain treatment did not have the desired outcome or for the occurrence of reproductive loss. Thus, in scenarios of unwanted treatment outcomes and following episodes of reproductive loss, the doctors inevitably relied on “spiritual causality” (Bharadwaj, 2016, p. 456) to explain to the grieving patients that the decision of whether a couple would have a child, predominantly lies in the hand of God. When Lakshmi and Soumya wanted to know of the reasons for their loss, both the doctors referred to metaphysical explanations and invoked the will of Divine intervention as culturally acceptable ways of making sense of the reasons for the unwanted outcomes instead of resorting to the seemingly empirical and objective clinical facts. Doctors making statements about the final decision being in the “hands of the One sitting up there” was, indeed, a common way in which practitioners in my study explained to their patients that achieving reproductive success was not solely in the hands of medical science and the practitioners themselves. And as Dr. Sen also said, he was not trying to do God’s job of creating life but only trying to help his patients in his own capacity as a doctor (see also Roberts, 2005, p. 525-526).

While alluding to Divine will and/or some metaphysical rationalisation for explaining why incidents of reproductive loss occurred, the doctors simultaneously pushed the female patients to undergo a subsequent treatment cycle. In doing so, they failed to provide the emotional attention which Lakshmi and Soumya desired and in the process, marginalised their embodied experiences of loss and grief. In the aforementioned examples, both women expressed their anxieties, concerns, and grief to the doctors along with expressing how their bodies and destiny had failed them. The two women were evidently seeking answers from their respective doctors about how they could cope with their loss and for assurance that such a loss would not repeat itself if they did decide to undergo another round of IVF. While Lakshmi posed questions such as, “What did I do wrong?”, “How will I recover from this pain and sadness?”, and “Sir, do you think a mishap like this can happen again?”, for Soumya, her question, “Why does this keep happening to me?” implied her frustration at not being able to achieve reproductive success in spite of having followed all the instructions as a good patient.

However, in both cases, the doctors failed to (or perhaps chose not to?) recognise that the women had suffered a significant loss and that they needed time to process their grief and reconcile with the failure of not having achieved motherhood, which as Franklin (1997, p. 154) writes is “undeniably the most emotionally demanding aspect of IVF”. Instead, they kept telling the women to stop crying, and tried pushing them to start another treatment cycle. It seems that while Lakshmi’s and Soumya’s loss was regarded as a sad and misfortunate incident by their respective doctors, it was nevertheless regarded as something which the women should leave behind, move on, and try to conceive once again. My findings echo with the limited research on pregnancy loss in India which has also shown that in interacting with grieving women, doctors and nurses unceremoniously instruct the women to stop crying, not make a big deal, and get on with life (see Iyer, 2015; Mammen, 1995; Mehta and Verma, 1990; Rajan and Oakley, 1993).

According to Cosgrove (2004), the biomedical discourse’s vocabulary fails to capture the lived experiences of grieving women in the aftermath of pregnancy loss. She argues that the terminologies used by the medical professionals indicates not only their assumptions about the female body and reproduction, but also about how such grieving women should be managed. The medical model in many western countries, for instance, sees miscarriage as a “minor emergency” that can be treated in a routine way and the physical management of miscarriage has become an accepted and standardised protocol (ibid., p. 109). However, Cosgrove convincingly explains that health care professionals’ vocabularies are not simply neutral acts of description that produce a seemingly objective response to women who have experienced pregnancy loss (ibid., p. 111). Instead, she suggests that it is important for medical professionals “to create a space where women have the opportunity to identify and “own” the ways in which they have survived their loss and have created meaning out of it” (ibid., p. 118). An integral part of the therapeutic process, therefore, should be to honor women’s sense-making, appreciate both traditional and non-traditional coping strategies as well as to explore their resilience (ibid.).

Taking cue from Cosgrove (2004), I have shown that the interactions of both Lakshmi and Soumya with their respective doctors highlights how the vocabulary used by the latter suggested trying again with IVF as a way of apparently solving and managing the issue of loss and grief. In both cases, the doctors dismissed and marginalised the women’s experiences of loss and denied them the agency to grieve instead of respecting the women's embodied reproductive experiences and acknowledging that they were seeking emotional attention which included being empathetic and letting the women take as much time as they needed to mourn. Instead, both the doctors reminded the women of their increasing age and that it was not a good idea for them to delay the next treatment cycle as it would mean losing out on precious time. The onus of not having a riskier pregnancy, of regretting the decision to not having done whatever it takes, and of regretting that they did not put in a hundred percent hard work for having a child was, thus, placed on both women.

Moreover, when Lakshmi and Soumya expressed their apprehensions about undergoing another IVF cycle, both the doctors offered them the assurance that since they had at least conceived previously, they had relatively better chances on the next treatment cycle. The doctors construed the occurrence of reproductive loss as an impetus to proceed with subsequent IVF cycles with a greater degree of hope for achieving reproductive success. As Franklin (1997, p. 156) notes, some IVF cycles are not considered to have failed simply because they did not proceed far enough and rather, even if a treatment fails, it is sometimes considered a success in relative terms. Regardless of Lakshmi and Soumya telling their doctors that they both were emotionally and physically exhausted and that they were uncertain of undergoing IVF again, their doctors constantly reminded them that they should not give up hope and that they needed to be more patient and have the "never-die spirit". This mechanism of resolving the failure of one treatment cycle by undergoing subsequent treatment cycles, argues Franklin, is part of the "treadmill effect" i.e. a "cycle of dependency on subsequent treatments to resolve failed ones and an increasing determination to succeed in the face of serial failures" (ibid., p. 157). Similarly, Throsby (2002, p. 16) claims that the IVF experience is like "being on a treadmill from which there is no easily apparent exit point, and the cyclical nature of IVF presents a persistent maybe-next-time promise" (see also Baker, 2004; De Lacey, 2002).

Furthermore, Dr. Sen told Lakshmi, "If you don't take a chance, then how will you get the result? You can't sit and home and think of winning the lottery without buying the lottery ticket!" Researchers have observed that the metaphor of IVF as a lottery, gamble, or roulette as rhetorical devices are commonly and purposefully deployed in the discourse of infertility treatments, wherein doctors tell their patients that it is only by taking a chance, will they move closer to achieving reproductive success (for e.g., see Baker, 2004; Bergart, 2000; De Lacey, 2002; Franklin, 1997). Such metaphors as employed by doctors, remains a pivotal ingredient in the “recipe for success”, writes De Lacey (2002, p. 46). These metaphors further emphasise that by taking the chance of undergoing repeated IVF cycles, the endurance, perseverance, and determination of the patient will ultimately be rewarded. The doctors in my study, thus, used the tropes of hope and willpower to convince Lakshmi and Soumya to try again as it was only by trying again, that their desire of having a child and a normal family life could be fulfilled (see also Baker, 2004, p. 51). I follow Shaw (2016) to argue that it was not only the pull of the conceptive technologies which embodied hope and desire that compelled women to undergo subsequent treatment cycles (see chapter three) but it was also the push of the medical practitioners which convinced women that they will be rewarded only when they keep trying instead of mourning over their previous loss.

Having said that, my additional argument is that it is within these constrained circumstances of being pulled and pushed to conceive again that the bereaved women manifested and/or utilised multiple forms of strategic agency by reflecting, deliberating, and negotiating about undergoing IVF again. In her study on infertility, Shaw (2016, p. 261) illustrates that for most women, they exercised agency by “reflecting upon their treatment experience and desire for a child, and renegotiating the available options”, which permitted them to manoeuvre around their given constraints. Similar to Shaw’s observations, we can see from Lakshmi’s and Soumya’s interactions with their doctors that they exercised their agentic capacity through reflective statements which highlighted their apprehension and anxiety in regard to the doctors’ advice of starting another IVF cycle. Statements by the female interlocutors such as “I will think about it” and “I’m not in a mental state to start another IVF right away” indicate an enactment of their agential selves instead of solely enacting themselves as compliant and disciplined female patient-bodies. As I continue to demonstrate in the next section, it was, indeed, somewhere between the “pull of the technologies” and the “push of the society” (Shaw 2016, p. 42-43) that the bereaved female interlocutors utilised creative forms of strategic agency in order to give meaning to their disruptive reproductive experiences.

5.4. Grieving for No‘Body’: Women’s Coping Strategies and Rituals of Memorialisation

Within the sparse body of research on reproductive loss and grief in Asia[137], an important ethnographic study on pregnancy loss and mourning rituals by Smith (2013) explores how Japanese women experienced the death of a life that is (or was) precious to them and how their sociocultural environment shaped their mourning practices following the loss of a baby or foetus. Smith observed that there was a longing among the women to incorporate the “lost presence” of their babies into their life in one form or another as a part of the mourning process (ibid., p. xi). This recently formalised Japanese practice of memorial services for the loss of a child since the 1950s is known as *Mizuko Kuyo* where *Mizuko* can be translated as “dead”, “lost”, or the “unseen” child and *Kuyo* roughly refers to memorial rites (ibid., p. 7-8). This practice offers a formal, public, and ritualised way to acknowledge the existence of a child and that even though the child has died, it nevertheless remains a child to its parents.

In his study, Smith (2013, p. 251) notes that “grief not encountered is a grief denied and one thereby retains the “frenzied longing” in one guise or another”. Researchers have similarly observed that there is a vast silence regarding the topics of reproductive loss and the ensuing grief within the feminist lexicon (Keane, 2009; Layne, 2003; Smith, 2013). In an anthropological account of pregnancy loss in North America, Layne (2003, p. 239-240) claims that the silence among feminist scholars in engaging with these topics is related to their fear of acknowledging the embryonic and foetal personhood located within the abortion debate. As such, feminists have been reluctant to concede that embryos and foetuses are equivalent to babies and children (Keane, 2009, p. 154). However, this is not the case unless one accepts the anti-abortion view of personhood in the first place, argues Layne (2003, p. 240). If one were to instead accept an anthropologically informed view of personhood, according to which personhood is enacted as a process which varies across cultures and over time, then one can see that the process of enacting personhood may be undertaken with some embryos or foetuses and not others (ibid.). It needs to be acknowledged that during the course of

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[137] In China, the death of a baby is considered to be a “bad death”, as it is an untimely death, writes Väisänen (1999, p. 27), and it is not socially acceptable to discuss such a death (see also Parry, 1994, p. 68). Another example in Asia is that of the Celebes Island in Indonesia where a baby’s dead body is taken away by the shaman without conducting any rituals, while in Sumatra the location of a dead baby’s grave depends on whether the baby had already developed teeth or not (Väisänen, 1999, p. 28). Stillbirths in Indonesia are considered to belong to the category of the “dreadful deceased” and, consequently, in the event of a stillbirth exceptional rituals are used to shield surrounding people from the supernatural powers of the stillborn baby (ibid.).

pregnancy or even before conception occurs, individuals may begin to establish an imagined future and a social relationship with the wished-for child. Consequently, a loss of this anticipated child may result in intense grief, as I show in this study. To that end, Layne offers a number of suggestions, such as creating religious and nonreligious rituals, spreading more awareness, and advocating new forms of medical management, for how feminists could respond and help in creating a women-centred discourse of pregnancy loss wherein the frequency and impact of such events on women's lives are recognised (Layne, 2003, p. 239).

For ethnographic elaboration, I present the cases of three female interlocutors who shared their ways of processing and channelising their grief and their understanding of how they are mothers who suffered the loss of their baby, notwithstanding the stage of pregnancy in which they had experienced the loss. Given that the women in my study were denied their agency to grieve as I have shown so far in this chapter, I further show that they utilised their agentic capacities to process their emotions and channelise it in their own unique and often, private, ways. The importance of such mechanisms and rituals, notes Leon (2008), lies in letting women distinguish, remember, and honor the loss as well as to create meaning and make sense of the loss because the baby's identity until then is vague, ephemeral, and lacking social validation. Such strategies and rituals also help women to heal from the pain of their loss by acknowledging the traumatic event and to gradually move on (Brin, 2004). Furthermore, taking cue from Allison's (2010, p. 229) study on pregnancy loss in Ireland, I show that the women's grieving and coping mechanisms made room for "alternative forms of maternal legitimacy even in the absence of wider social recognition of loss". As such, in the process of grieving and legitimising the loss of their baby as a real person, most of the female interlocutors in my study identified themselves as mothers who had experienced an embodied pregnancy, for however short a period, along with the embodied pain of childbirth – a recognition of their identity as mothers and their baby's social personhood which had otherwise been socially denied.

5.4.1. Musical Expression of Grief and Ultrasound Images as Keepsake 'Baby Photos'

I started this dissertation with a self-composed song by a female interlocutor, Maya Chatterjee wherein the lyrics depict her melancholy after the first miscarriage. When she experienced three successive miscarriages in the next two years, she kept returning to music and singing which enabled her to express her grief. Speaking about how music helped her survive, with a wistful smile on her face, Maya said,

> "My music is the only thing that has helped me survive this tough time in my life. When the first miscarriage happened, I was extremely dejected. I didn't have anybody with whom I could talk and express my pain and of how much I was hurting. I could only speak to my younger sister, but she lives far away so I didn't want to disturb her as she has a family of her own. At that time, I used to try to speak to my husband, but he would usually avoid it. He has never blamed me for anything, but he never likes to talk about it. He just said that these things happen and it's sad, but we should try again. It's a sad thing but nobody understands the pain a woman goes through when she has these mishaps. My husband probably doesn't understand my pain because he wasn't the one was pregnant four times. So, it's natural that I feel the sadness and the pain the most…I was completely heartbroken when the same mishap happened three more times. I had lost all hope and I was feeling very lonely during those days. But I kept going back to my music as my way of surviving these mishaps. If I didn't have my music, I think I would have been severely depressed. I might have even ended my life. You see me sitting here in front of you, smiling, only because of my music. Music is my best friend. Music understands my sadness and my pain. When I had nobody else to share my pain with, I turned to music. I don't know how to else to explain this but without music I would have lost my sanity… I sing when I am happy, I sing when I am sad, I sing when I want to cry. I sing whenever I feel like it and without singing, I don't think I would have survived."

Researchers have documented that creative interventions such as music, dance, writing, arts, and crafts are adaptive strategies used by individuals to process grief and cope with loss (Buser, Buser and Gladding, 2008; Trepal, Semivan and Caley-Bruce, 2005). Through such interventions, bereaved individuals can connect with their loss and express their emotions by giving voice to difficult feelings which are associated with the loss, and thereby, create meaning in the loss (Buser, Buser and Gladding, 2008). Particularly in the case of music, MacDonald, Kreutz and Mitchell (2012, p. 4) note that in recent years there have been an increasing number of studies which have investigated the relationship between music, wellbeing, and health. According to Miranda et al. (2012, p. 515-516), music can involve "emotional regulation" i.e. processes by which positive and negative emotions are regulated in either adaptive (e.g. self-reflection) or maladaptive (e.g. rumination) ways and well as provide ways to cope with grief. When Maya was not receiving any social support and empathy from people around her, including her husband, she used music and singing as a creative form of expression and as a coping strategy to process and channelise her grief. In order to avoid getting depressed and as she said, as "a way of surviving these mishaps", she used music therapeutically as an emotional regulation and coping strategy.

Furthermore, Maya mentioned that she secretly spoke to the ultrasound scan of her babies when she felt lonely, upset and knew that nobody else could understand her pain which she felt as the mother:

> "Actually, my husband also doesn't know this but there is a secret space in my bedroom where I have a file of all my babies' ultrasound scans. Sometimes when I feel very lonely or upset or when I feel that nobody in the world understands my pain, then I talk to these scans. I think they understand me. Please don't think I'm crazy *I said, not at all* I am only sharing this with you because I feel you will be able to understand and you won't judge me *I assured her that I am not judging her at all* I can't explain this to anyone, but I get a strange sense of satisfaction when I do this. I ask them why did they leave me. Was I not giving them a comfortable home to stay in? Maybe God will listen to me and understand the pain I have been going through. I might not have given birth to a baby who is here with me today but I did carry four babies. So what if the world doesn't consider me as a mother? I felt the pain that only a mother can feel when she loses her child…Actually, this is the first time in my life that I am sharing all these details with someone. My heart feels light after sharing this."

Although early pregnancy losses are associated with disappointment and a sense of failure, it is much more devastating for a couple to experience the loss of their child in the later stages of pregnancy, note Mehta and Verma (1990, p. 607), as in the latter case, the couple goes through the various phases of a normal pregnancy, feels the baby's movements, and is prepared for its birth. Consequently, the authors argue that the death of the baby in the later stages of gestation leaves the couple with an acute sense of loss and shock. However, some researchers have noted that the conflation of augmented distress and grief depending on the gestational period lacks empirical evidence (for e.g., see Cosgrove, 2004, p. 110; see also Slade, 1994; Thapar and Thapar, 1992). According to Cosgrove (2004, p. 110), the assumption that a woman's grief will be heightened if the loss occurs in the later stages of her pregnancy is sustained by the biomedical discourse which supports the erroneous belief that the mother becomes increasingly attached to the child as the period of gestation increases. For Cosgrove, "it is the *meaning* that women give to their pregnancies and their individual histories that are crucial in shaping their experience of perinatal [or any form of] loss" (ibid.). Likewise, Moulder (1994, p. 66) has argued that the aftermath of any pregnancy loss is a complex experience and the amount of distress should not be conflated with the gestation stage as women experiencing loss at the same gestational stage can have varied definitions of and reactions to their experiences. For instance, Leppert and Pahlka (1984) found that women having an early miscarriage experienced the same intensity of grief as women who had a stillbirth.

Even though Maya had three miscarriages within the first trimester and one in the second trimester, for her, it was the loss of her babies and not foetuses. The ultrasound images became a cathartic tool for her to preserve the memories of the babies who were never born. Looking at those images periodically was a source of comfort for her as it made her feel connected to the babies whom she had gestated (see also Van and Meleis, 2003, p. 34). It is, however, not surprising that Maya feels this connection between the images and her babies. As I have discussed elaborately in chapter three, the visualising technology of ultrasound scanning facilitates the enactment of foetal personhood by the medical practitioners and the practitioners in turn, encourage pregnant women to participate in the process of enacting personhood. These technologies that contributed to Maya's expectations of a baby and produced ultrasound images, those same images were used by her as keepsakes to remember her babies. She mentioned how she felt a strange sense of inexplicable satisfaction whenever she would speak to her first baby, whom she enacted as a wished-for daughter. Indeed, as Murphy (2012a, p. 119) argues, for many bereaved parents, the "technologies of expectations" move to being the "technologies of comfort" after the occurrence of loss. As such, the ultrasound scans acted as a tangible reminder of the babies that had lived in her womb, h however short lived. I also argue that the scans seemingly provided Maya with the recognition she needed to enact herself as a woman who had become a mother.

5.4.2. Finding Solace in Religion and an Undeterred Faith in God

During the nine years in which Kanika had undergone multiple infertility treatments, she had conceived once after IVF treatment. However, that pregnancy had ended in a perinatal death in the eighth month of gestation. Her journey of assisted conception had ultimately and successfully ended with her giving birth to twins after another attempt at IVF. For Kanika, she considered herself to be a mother of three children of which two had survived[138]:

> "You know, my husband would never agree with me. If he knew I feel this way, he would think it's rubbish! This is why I have never told him about this. But the thing is, I had become a mother even before these two gems came into my life *she caressed the two babies who were lying on the bed between us* just like these two were inside me, that baby was too, right? I didn't know initially because nobody told me, but days later I found out that I had given birth to a boy. If I didn't have such a fate, then these two could have had an older brother today…I never saw my first son. But I had felt him kick inside me. I read to him, I sang for him. He was a part of me and for me he will always be my

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[138] This was quite unlike Van Hollen's (2003, p. 217) Tamil female interlocutors who only highlighted the children who had lived rather than those who had not (see chapter one).

> first-born On his birthday, I make sure I take time out to go to the temple and pray for his well-being. I don't tell anyone about it…I wish that he is happy wherever he is - that is all a mother can wish for…I am fortunate I have my babies today but yes, there are times when I miss my first baby…but it's all destined, isn't it?

Feelings of grief about a previous loss despite having become pregnant again or even after having given birth are not uncommon (Garrod and Pascal, 2018). Even though Kanika finally gave birth to twins, she expressed having become a mother when she was pregnant the first time even though the baby did not survive. She enacted herself as a mother who had embodied experiences of being pregnant which included interacting with her baby through reading, singing, and when it kicked inside her womb. As part of remembering her first-born, Kanika ensures that she discreetly prays for his well-being each year on the day he was 'born'. She further mentioned that whenever she would become upset and wanted an outlet for her feelings, people (including her doctors, husband, family members, and friends) would ask her to forget about the "accident" and focus on becoming pregnant again. It was during this time when feelings of dejection and helplessness turned her towards finding comfort in religion. Participating in *satsaṅgas* and *jāgrans* (loosely translated as prayer meetings or religious gatherings) and visiting temples were her ways of processing the grief and managing the stress which had consumed her life – an illustration once again of women utilising forms of constrained agency to make sense of their lives. As she explains below, even though she was not raised in a particularly religious family, it was her faith in God which gave her the strength to undergo the infertility treatments again and her hope to have a child was renewed and ultimately, fulfilled:

> "To be honest, I had never been a very religious person. As a child I went to temples only when my parents took me. I did not grow up in a very religious family. But during that difficult time in my life, I had nobody I could depend on. Whether I spoke to my husband, my doctor or anybody in my family, they all repeated the same nonsense – forget about it Kanika, what's gone is gone, don't waste time thinking about it. My mother-in-law would say that it was an unfortunate accident and that I should not spend my time in thinking about it. I cannot tell you how I felt that time. I couldn't understand how people were able to say these things to me so easily. How were they forgetting that I was a mother who carried her baby for eight months?! I was absolutely dejected and helpless at that time. I did not know what to do. I often thought of jumping into the lake close to our home. That seemed to be the only solution to end all this emotional torture. But you know how people say that when there's nobody, there's God? I don't know from where I gained this sudden courage but I decided to go to temples regularly. I had started speaking to God when I had nobody else to speak to. I started going to *satsaṅgas* and *jāgrans* frequently and this was something I had never done before in my life. I found my time at those places to be very peaceful. I got the opportunity to ask God, why me? I asked him why I had to suffer for such a long time. Had I done something wrong in my previous life? Had I hurt somebody? Praying at these religious events made me quite calm and gave me the strength and the

> faith I needed to continue. I might have lost all hope if I had not found my strength in God. Maybe because I didn't give up, God blessed me with my two gems *smiled*"

Bhattacharya (2006) argues that, indirectly or not, religion continues to influence the perspectives of people within the clinical setting and patients' worldviews, wherein religious and cultural beliefs are tightly interwoven with their attitudes towards health and medical care. When struggling with life and death issues, both patients and clinicians alike find it difficult, if not impossible, to discuss their situations without referring to religious beliefs (ibid., p. 14; see section 5.3.2). As such, grieving people often rationalised treatment failures and their reproductive failure(s) by resorting to metaphysical explanations as culturally acceptable coping strategies (see Bharadwaj, 2006, p. 463). My findings reveal that during the interviews nearly all the women and/or couples expressed their belief in God's will and that God had something good planned for them, that God was testing them by making them endure such a loss or that God was punishing them for a mistake they had committed in their past lives (see also Van der Sijpt, 2018). Even in cases where a woman had multiple episodes of reproductive loss, her belief in God's will was not deterred. As Kanika said, finally giving birth to her "two gems" after all the hardships was probably God's blessing for her because she did not lose hope. Indeed, the trope of being blessed or rewarded if the woman persists, has faith (in the reproductive technologies, ability of the medical practitioners, and in Divine will), and keeps undergoing treatments, as I have discussed earlier in this chapter as well as in chapter three, had emerged once again.

Specifically concerning the loss of a wished-for-child, research in the Euro-American settings has shown that bereaved women often relied on their religious and spiritual beliefs and values as a common coping strategy (Van and Meleis, 2003; Wortmann and Park, 2008). Developing, renewing, or maintaining a relationship with God was paramount for them and they spoke of having utmost faith in God as the benevolent protector who could fix anything and did everything for a reason (Van and Meleis, 2003, p. 33; Wortmann and Park, 2008, p. 17). Moreover, for individuals who face a lack of support from one's partner, increased religious participation has been related to a significantly increased perception of social support which contributes to lesser grief-related distress (Kersting and Wagner, 2012, p. 189). Indeed, like Kanika, several female interlocutors in my study had narrated similar accounts that in the absence of support from their husbands and other actors, it was by praying to God and by going to temples regularly that bestowed them with the courage, hope, and emotional strength they needed to cope with their loss, to continue with the infertility treatments, and to deal with their distressed (conjugal) lives.

5.4.3. Healing through Empathy Shared Experiences

When a couple experienced reproductive loss at infertility clinic B, they were asked by the infertility specialist, Dr. Sen, to speak to Aparna whose official designation is that of Patient Relations Manager. With an educational background in political science and sociology followed by a few years of working in an advertising firm, 39-year-old Aparna had started working at the clinic a year after its establishment. As Patient Relations Manager, Aparna was primarily responsible for maintaining a record of the patients, their medical and reproductive histories, the ongoing treatments, and the list of medicines patients had been advised. She was the go-to person for any patient who had any query at any time of the day. Since Dr. Sen could not allot more than a limited amount of time to each patient and/or couple, it was Aparna who communicated with them at length. Especially in cases where a couple had experienced reproductive loss, Aparna, who was often referred to by Dr. Sen as the "in-house counsellor", spent a significant amount of time to listen to and counsel the bereaved couple. All the patients I interacted with at clinic B had high praises for Aparna and they mentioned feeling better after having shared their loss and grief with her. Indeed, Aparna was one of the medical practitioners in my study who extended her professional role from a clinic staff member to becoming a friend and counsellor in order to offer patients and/or couples the therapeutic intimacy they frequently desired in their journey to achieve reproductive success (see chapter four).

During our interview, Aparna admitted that she was self-taught about the various aspects of infertility and the related treatments only after she had started working at the clinic. Her experience of having hosted television shows with medical experts for several years previously reportedly helped her in grasping the various facets of infertility treatments. Alongside the job at the clinic, Aparna also managed a local NGO. She told me that she wanted to be a voice for the voiceless such as stray animals who are sick. At this point in the interview, she pensively smiled and said, "I know how it feels to be without a voice."

Aparna then offered a retrospective account of her first encounter with the clinic’s infertility specialist, Dr. Sen, when she was one of his initial patients. After not being able to conceive for two years of trying, she started pursuing assisted conception. Following two second-trimester miscarriages, Aparna said that she had started questioning her own existence. At that time in her life, she mentioned not having received any support from her family members. Instead of giving her the time and support she needed to recover from the miscarriages, Aparna said that her family members, especially her mother-in-law, were constantly pushing her to have another child. Visibly emotional at this point in the interview, Aparna requested that I change the topic of conversation since it was still very painful and difficult for her to speak of “those days”. She said that she preferred to refrain from “digging up old, painful memories.” I told her that she was free to speak about anything she deemed comfortable. Speaking of her job at the clinic, Aparna explained that she felt that her proclivity to counsel people could be attributed to her strong sense of empathy and of having been in the “same boat” as many of the patients:

> “I strongly believe that to become a good counsellor, one needs to be very empathetic. Who is more suitable to counsel the patients at such a clinic than somebody who knows what the pain of not having a child feels like? You might think that it’s ironical that a woman without children of her own is counselling infertile couples. See, I have experienced that side, I know what it means to go through loss, to suffer, to hear other people taunting you repeatedly, to have constant arguments with your husband, to feel like the world is coming to an end, to question my very existence – I know all these feelings all too well. So it’s easy for me to put myself in the patients’ shoes. One may also think that how can I be counselling patients without a proper degree in psychology? Yes, it is true that I don’t have a degree in psychology. But you know, I want to tell you that having the right degree is not everything. I could have a lot of degrees that are required for this job but I still could have been a bad counsellor. See, I actually know and understand what a woman is going through when she sits across me and sheds tears, day after day. I think I was meant to do this job. I thank the universe every single day that I found the strength to cope with this situation in a much better way than I could have ever imagined. The patients who come here, they respect me and they take my word seriously. Many of the patients whom I have known for a long time, know that I myself don’t have any children. But they never question my advice. In fact, they take my advice more seriously because they know that I understand their feelings from my own personal experience. I share my story with the patients who seem to have given up all hope and are completely miserable. I tell them that yes, I don’t have children but I do understand what it means to be a mother who gave birth to a dead child, not once but twice…But I should also tell you that I wasn’t always this mentally strong. At the beginning, I felt emotionally attached to each woman who came to me and shared her story. When they cried, I cried. I couldn’t help myself as not much time had passed since my own mishap. But after almost four years of sitting on this chair, I feel that I can now handle the patients and their stories in a more detached way. There are times when I certainly become emotional but I try to keep that aside and focus on my job...I think this job came as my saviour during the lowest point in my life. Truly, this job is the reason for my rebirth. I will remain eternally grateful and indebted to Dr. Sen because he gave me this job when I needed it the most. I wasn’t prepared for it but he showed complete faith in my potential to do this job well. He saw me drowning and he helped me breathe again. I poured my heart and soul

> into this work from the day I started. I knew that this was my only way to heal myself. I honestly don't know what I would have done if I didn't have this in my life…I feel good that I am able to use the story of my life to help the patients, even if in a small way. This is what keeps me going – that I am doing something useful, something which is helping people cope with a difficult time in their lives. See, people find different ways of coping with their sadness and depression. I found this. When those mishaps happened five years ago, I had never thought that I would recover from that shock. I didn't think that my life had any meaning anymore. I thought, this is the worst that could have happened in my life. There is no worse feeling for a mother. But I guess everyone has a certain destiny planned for them. You know, how people say that if life has given you sadness and pain, then life will also show you the way to handle that pain. I suffered a lot and now, each day, I try to help people in a way so that they don't have to suffer as much as I did. The patients who come to me probably don't realise this but actually, even after all these years, they help me deal with my own pain as much as I help them deal with theirs *smiled*."

Unlike most other bereaved female interlocutors in my study who processed their grief and coped wither loss(es) in a private way, Aparna utilised her job in the professional arena to heal herself while healing others. We can see from Aparna's excerpt that it was her job at the clinic which had given her a sense of rebirth after the miscarriages. Counselling childless patients who have/had also experienced reproductive loss was her way of giving meaning to her own losses and coping with it. In doing so, she said she felt content about doing something good for couples who have/had similar life stories of loss, pain, and sufferings. She was also of the opinion that it is not merely an educational degree in psychology which makes for a good counsellor, but rather, the quality of empathy and the sharing of mutual experiences and vulnerabilities which allowed her to develop an intimate connection with the grieving patients. She also identified herself as a woman who was a mother who gave birth to a dead child, not once but twice, which according to her, allowed her to empathise strongly with the women who came to her to vent and share their grief. The sharing of vulnerabilities, as Aparna said, also helped her to heal from her own pain, even though the mishaps happened five years ago. As she said at the end, it was not only that she helped the patients cope with their pain but they also helped her in healing from and processing her own pain and loss.

All the women whom I have mentioned in this section and throughout this chapter as well shared similar experiences of marginalised loss, disenfranchised grief, inadequate social support, being pushed into trying again to conceive, and utilizing forms of constrained agency to grieve for their loss. While Maya found her comfort in music, Kanika turned to religion and God, and for Aparna, her own healing happened as she helped other people heal from their grief of reproductive loss. Moreover, the act(s) of memory-making was performed by some of the women, for instance, by Maya who kept ultrasound images as baby photos and by Kanika who visited the temple on her son's 'birthday'. Such acts of memorialising are unique ways in which the women incorporate the "lost presence" of their child into their lives, in one form or another, as Smith (2013, p. xi) has observed in his study among Japanese women and child death. Evidently, the stage of gestation at which the incidence of loss occurred or the form of loss did not determine if the women grieved more or less. Similar findings have been demonstrated by Van der Sijpt (2018) where she writes that the Romanian women in her study did not distinguish between the medically defined terms of miscarriage, stillbirth, and post-partum death. Instead, the bereaved women reported that any instance of loss "entails the transformation of a (potential) child into an innocent little angel (*îngeraş*), no matter its (gestational) age" (Van der Sijpt, 2018, p. 181).

In addition, since the bereaved women in my study had not been socially recognised as mothers who had suffered a significant loss, they enacted themselves as mothers who had experiences of embodied pregnancy and who did, indeed, suffer the loss of a person whom they would never forget, regardless of the stage of gestation at which the loss occurred. Similar observations have been made by Allison (2010) in Ireland where she suggests that women *need* to lay claim on motherhood as an identity in the absence of children and for infertile women, grief serves as a means of making sense of their reproductive experiences. Allison argues that for the female participants in her study, the process of grieving "seeks to materialize loss, rendering tangible and legitimate an otherwise invisible motherhood identity" (ibid., p. 220). And as has been explained by Butler (2004, p. 3) in writing about the performative aspects of gender identities, subjectivities are about performing and about doing, or that "doing is being". As such, I argue it was the enactment of the motherhood identity that enabled the female interlocutors in my study to define themselves as women who had become mothers and not simply potential mothers which further allowed them to, at least temporarily, not remain in the liminal[139] state which is associated with childlessness,

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[139] My understanding of the liminal state is based on the influential work of Victor Turner (1991 [1969]) who builds on the work of Van Gennep (1909) and defines liminality by the phrase "betwixt and between" in order to analyse rites of passage. According to Van Gennep, all rites of passage or "transitions" are marked by three phases: separation, margin (threshold) and aggregation. For the analytical purposes in this section, I limit myself to the second phase of transition which is the threshold or the "liminal period" (ibid., p. 94). Turner writes that a person is characterised by ambiguity during the liminal phase as "[s]he passes through a cultural realm that has few or none of the attributes of the past or the present" (ibid.). According to Turner, "the attributes of liminality

infertility, and pregnancy. I deliberately use the term temporarily because their state of liminality was re-introduced when they resumed the infertility treatments wherein once again, they were between the state of desiring a child and achieving pregnancy[140]. Nevertheless, I suggest that in order to give meaning to and effectively cope with their loss, the female interlocutors, as I have shown in this section, performed creative strategies to enact the completion of their transition from pregnancy i.e. 'what is' into motherhood i.e. 'what can or will be'. Finally, the act(s) of memory-making as part of the coping strategies also allowed the women to overcome the uncertainty or liminality regarding the status of their deceased child by enacting them as deceased 'persons' they wished to remember.

Next, I briefly discuss men's experiences of loss in order to shed light on the gendered contrast in how the female and male interlocutors expressed their grief and bereavement.

5.5. Men Don't Cry: 'Masculine' Expressions of Grief and (Gendered) Coping Strategies

In June 2018, I visited the Stillbirth and Neonatal Death Charity (SANDS) in London.[141] In my interview with Ross Jones who was one of the senior bereavement care coordinators at SANDS, I learnt about instances where one man held his dead baby in his arms while watching a game of football on his phone and how another man drank a can of beer while holding his deceased baby. Ross informed me that these were some of the rituals as part of creating memories with their child before it was taken away from them. Watching football with the child or drinking beer together when the child was older were some of the things which these men had envisioned as part of being fathers in their imagined future. I was also told by Ross that unlike the women who inevitably cried as part of expressing their grief, British men would restrain themselves from displaying any overt signs of emotions. After I shared my experiences

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or of liminal *personae* ("threshold people") are necessarily ambiguous, since this condition and these persons elude or slip through the network of classifications that normally locates states and positions in cultural space. Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention and ceremonial" (ibid., p. 95).

[140] See Becker (2000), Franklin (1997), Greil (1991), and Throsby (2002) for a discussion on the liminality of pregnancy and childbirth.

[141] Although this was not an official part of my fieldwork, I was curious to know about SANDS given that it is perhaps the most popular bereavement support organisation worldwide. Since I was going to attend a conference on Reproductive Politics at Cambridge that month, I combined it with my trip to SANDS. I am grateful to Ross Jones for giving me the opportunity to visit SANDS and for the interview on experiences of reproductive loss among couples in the United Kingdom.

from my fieldwork in Kolkata, Ross and I talked about the strikingly similar responses of most men, either in England or in India, in regard to supressing their emotions and presenting themselves as stoic in the face of unexpected occurrence(s) of reproductive loss.

In this section I discuss a short yet telling excerpt from my interview with 40-year-old Akash Datta to show how he, like most other bereaved male interlocutors in my study, processed his grief and coped with his loss in an emotionally restrained manner. I draw attention to the "double enfranchisement" (Doka, 1989) which such men experience as not only are they surrounded by normative gendered prescriptions which do not allow men to grieve openly but also the absence of grieving practices for something i.e. their unborn child, that is not socially recognised or acknowledged by the society (see also Thompson, 1997, p. 78).

Akash and his wife Tanu had experienced a stillbirth followed by a neonatal death and like the other bereaved male interlocutors who reportedly coped with events of loss by spending more time at their workplace, Akash also gave a similar response:

> "I felt like everything had been taken away from me. Nothing mattered, there was no meaning in anything. My money, my life, nothing mattered anymore. I only remember seeing their faces, their eyes shut, lying down peacefully, as if they were sleeping. I remember Tanu crying night after night. Sometimes loudly, and sometimes I heard her crying softly in the middle of the night because she didn't want to wake me up. I didn't know what I could do to show or tell her to make her feel better…Of course, I was very upset. It's true that Tanu carried them inside her, but I was looking forward to becoming their father. So of course, those were the worst days of my life. But see, my boss wouldn't let me sit at home because of this. I did take a few days off after both incidents but that was mainly because I knew I had to stay with Tanu. She had broken down emotionally and I knew that she needed me. But after that, I had to go and do my work. I didn't have the time to stay at home and cry. If I didn't work, how would my wife and I survive? I think my coping with these mishaps involved me spending longer hours at my office. I immersed myself in work. That's all. I deliberately didn't give myself free time because I knew if I did, I would start thinking about what had happened. There was no point in constantly thinking about what had happened. If I wasn't mentally strong, I wouldn't have been able to support Tanu."

Following an episode of reproductive loss, the reactions of men and women can be traced to gender-specific cultural norms (Stinson et al., 1992, p. 219). It has been suggested that men do not express their emotional needs, partially because "the processing and sharing of emotions may be more socially acceptable for women than men" (Jordan and Revenson, 1999, p. 353). As such, men and women tend to express their grief in adherence to stereotypical gender roles wherein women are vocal about their sadness and feel the need to verbalise their experiences and feelings about the loss at length while men usually avoid overt emotions and enact a stoic demeanour (Jaffe and Diamond, 2010). Scholars like Parry (1994) and Das (1986) who have studied mourning and Hindu death rituals in the Indian context have also noted that the legitimate expression of grief is circumscribed by normative gender roles. Parry (1994, p. 152, 155) writes that while men perform the cremation, women's role is limited to grieving. Ironically, as I have demonstrated throughout this chapter, in the case of reproductive loss and the loss of the unborn child, women were not even accorded the time and space to grieve. Nonetheless, the display of hyperemotionality by bereaved women is considered by other actors to be a legitimate and appropriate expression of their grief (Parry, 1994, p. 152; see also Shields, 2005, p. 7). This so-called feminine characteristic of hyperemotionality is posited in contrast to men's expression of grief which is supposed to be marked by emotional stoicism.

Such a gendered contrast in grief expressions was also starkly visible during the interviews I conducted where the female interlocutors cried and articulated their feelings in a more verbose manner when speaking about the loss of their wished-for child as opposed to the men who were mostly curt and never displayed any stark emotions. As Parry (1994, p. 155) has explained, while it is acceptable for women to weep, for men, however deep their personal anguish, they are supposed to or socially expected show emotional restraint. Research has further shown that most men process their grief by attempting to return to normal and by not making a big deal of the issue, especially in front of their wives – an aspect I discuss in chapter seven (see Abboud and Liamputtong, 2005; Martin and Doka, 2000). As a coping strategy, some men convinced themselves that the event was in the past and nothing could be done to change the situation (Abboud and Liamputtong, 2005, p. 14). While women were more likely to seek external support and vent their feelings as a grieving and coping mechanism, men were inclined to controlling their affective expression, intellectualising their grief, and using more problem-focused strategies as part of coping (Martin and Doka, 2000, p. 102).

However, studies in western contexts also suggest that although men may display less immediate expressions of "active grief" (i.e. conscious forms of grieving) following reproductive loss as compared to women, that should not necessarily imply that they are any less vulnerable to feelings of despair. Instead, they might have considerable difficulty in coping with the loss and often, a man may feel ignored or overlooked as he grieves the loss (see; Cumming et al., 2007; Douglas and Fox, 2009; Staudacher, 1991; Puddifoot and Johnson, 1999). For instance, McCreight's (2004) study of Irish men following events of pregnancy loss indicates that while men may conceal feelings of grief and anger, they do report experiencing self-blame, loss of identity, and the pressure to appear strong. In cultures which instruct men to be inexpressive, (potential) fathers who experience loss may be subject to a "masculine-must-be-strong" ethic (Stinson et al., 1992, p. 219). Consequently, bereaved men tend to enact themselves and are also enacted as the protector who is responsible for the well-being of the female spouse, while denying their own needs (see chapter four and seven).

On the one hand, acutely affected by the death of both his children, as indicated by the statement, “Nothing mattered, there was no meaning in anything”, Akash’s helplessness in being unable to express his grief or to comfort his wife was revealed when he said, “I didn’t know what I could do to show or tell her to make her feel better”. According to the discursively acceptable norms of how to be a man (see chapter seven), Akash knew that after his short break at home, he had to resume work to financially support himself and his wife as his role as the husband was to take care of his wife. As he mentioned, he did not have the time to sit and cry at home and instead, he coped with his grief by being busy with his work. Similar to my research findings, the study by Beutel et al. (1996) amongst German couples who had a miscarriage also demonstrated that men coped with their loss by trying to distract themselves and they mostly did so by immersing themselves in their work. Parry (1994, p. 157-158) rightly argues that instead of interpreting the differences in gendered roles of expressing grief as “two universally problematic reactions to death”, these expressions and roles should be understood as “part of a process by which hierarchical relations between the sexes are reasserted and their legitimacy ‘proved’”. Such contrasting gendered reactions to death and loss are, therefore, hierarchised, “such that their association with the two sexes reinforces an ideology of gender hierarchy” (ibid., p. 158). As such, it is not simply the case that men are unable to or unwilling to express grief openly. Instead, there is a need for understanding the rigid patriarchal conceptions of masculinity which hinder men from expressing their grief and from restricting their emotional displays to culturally prescribed masculine ways. The themes of enacting masculinity(-ies), displaying emotional restraint, and men’s (internalized) need to be the strong partners for their wives has been extensively discussed in chapter seven.

5.6. Conclusion

Even though reproductive loss is universally experienced, it should be acknowledged that each experience is contextually unique in how bereaved women (and men) ascribe meaning to that experience and how they process their grief and cope with the loss. However, as I have illustrated in this chapter, while having a child is considered to be one of the most important life-cycle rituals in the making of social and gendered personhood in the pronatalist Indian context, ironically, the loss of the imagined but unborn child remains unrecognised and the ensuing grief experienced, particularly by women, is largely disenfranchised by other actors. The personhood, which was attributed to the unborn child becomes conditional, i.e. only as long as the woman is pregnant, and is withdrawn by the other actors, more so when the couple experiences loss in the early stages of the pregnancy.

Along with pull of the technologies (see chapter three), I have demonstrated in the chapter's first half that it is also the push of the society which compels women to continue their pursuit of assisted reproduction until they have/had achieved reproductive success. I have shown that after experiencing reproductive loss, women were not allowed by the medical practitioners, their husband, and mother-in-law to have any contact with their deceased child, in spite of the women's insistence in some cases. Women were also excluded from the decision-making process of how their baby's body was to be disposed and they were further excluded from performing any kind of grieving practices or death rituals. It was the women's husbands, (an)other male family member(s), and the mothers-in-law who were involved in such decisions, practices, and rituals. Such exclusion of the bereaved women as I have shown was rationalised on the basis of gendered stereotypes which characterised women as emotionally fragile and incapacitated in the aftermath of the loss, thus seemingly requiring them to be protected by the other actors from further trauma and pain. Further, I have shown that the external actors treated the loss as a non-event and soon after the loss, pushed the women to stop crying, forget such accidents, move on, and focus instead on trying to conceive again.

In the second half of the chapter, I have demonstrated that it is in their being constrained and muted by the other actors which led many female interlocutors to performing agential acts of coping which further helped them in giving meaning to their loss and channelising their grief through different avenues. For instance, they performed unique coping strategies, such as using music as a means of expression and as an adaptive strategy or by finding solace in God, and/or by memorialising their babies (by naming them or by having ultrasound images as keepsakes). It was in performing such strategies that the women enacted and legitimised themselves as mothers who had suffered a substantial loss – the loss of an actual and not merely a potential wished-for child. While it was challenging for the women to grieve given the absence of social support and other constraints, the social expectations of being a man made it hard(er) for the male interlocutors in my study to express the anguish of the loss of their unborn child actively and publicly, as I have shown with one example. Thus, episodes of reproductive loss were not only emotionally challenging but also highly gendered experiences for the female and male interlocutors in my study.

However, it needs to be pointed out that the middle-class female interlocutors did not identify or enact themselves exclusively as grieving or bereaved mothers. As I will show in the following chapter, within the disrupted site of marital and sexual relationships following reproductive loss, women's agency while constrained was actively channelised into reflecting on, transgressing, and/or challenging the gender scripts which dictate the enactment of ideal middle-class Indian women essentially as 'good mothers' and 'good wives'. The next chapter's focus, then, is on the female interlocutors seeking to make sense of and cope with the loss of normalcy within their conjugal sites and to restore a semblance of that normalcy.

Chapter 6. Loss of 'Normalcy': Disrupted Marital and Sexual Relationships

6.1. Introduction

While Kanika was in the final year of pursuing her postgraduate degree, her parents chose 'a suitable boy' for her from a matrimonial advertisement[142] and she had an arranged marriage soon thereafter. Kanika and her husband tried having a child in the first year of their marriage but when they were unable to do so, they resorted to assisted conception. Over the next few years, the couple consulted two gynaecologists and five infertility specialists, across Kolkata, New Delhi, and Mumbai. During their reproductive journey, following several treatment failures when Kanika was unable to conceive, the couple experienced a perinatal death when Kanika was 26 weeks pregnant after having conceived with IVF. After experiencing multiple occurrences of reproductive loss and undergoing assisted conception for almost a decade, the couple finally achieved reproductive success when Kanika gave birth to twins having undergone her fourth IVF cycle at infertility clinic B.

While Kanika had been diagnosed with uterine fibroids, her husband had been diagnosed with a low sperm count and low sperm motility. Despite both partners having medical(ised) issues which contributed to their obstacles of having a child, Kanika recounted that she was always at the receiving end of the constant pressure and taunts from family members, relatives, and friends. She said that she never told anyone about her husband's diagnosis because she did not want people to make fun of him[143]. Becoming emotional at this point in the interview, Kanika mentioned that while she was protecting her husband, she was hurt the most when he constantly blamed and taunted her for being unable to conceive even after undergoing multiple treatment cycles, but mainly because she had been unable to sustain her one pregnancy for the complete term. She added that her husband's behaviour towards her and their regular arguments had started affecting her much more than not being able to have a child. The lack of emotional support from the people around her, the stress of undergoing treatments, and especially her distressed marital relationship had pushed Kanika to

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[142] Matrimonial advertisements in India, either in newspapers or online, are one of the most popular avenues that provide matchmaking services for families to find a prospective groom or bride for their daughter or son.

[143] It appears that women usually assumed primary responsibility for infertility (Carmeli and Birenbaum-Carmeli, 1994, p. 664). In chapter seven, I briefly discuss about how men often do not disclose their diagnosis of male-factor infertility while their female partners engage in "patriarchal bargain" (Kandijyoti, 1988) to shoulder the blame of infertility and childlessness in order to keep their husbands' 'fragile' masculinity intact.

contemplate committing suicide on more than one occasion. As she said, I had completely broken down (*"maiṅ pūrī taraha sē ṭūṭ chuki thī*"). Eventually, while speaking of her distraught marriage, Kanika began speaking at length about how her sex life had been affected during these events in their lives which exacerbated her stress:

> "I missed having a normal life. My life had only become about going to the clinic and back home and then back to the clinic. My body used to hurt all the time from the many injections and the constant probing by the doctors. The thought of going to a clinic had become a nightmare. For nine years, my life only consisted of such things. And it becomes a hundred times more difficult when your husband doesn't support you in this tough time. It's not like he's a bad man. The reason I agreed to marry him was because I thought he was a good and honest man and that he would keep me happy. But when we were having a difficult time and I was going through all those treatments, I felt like he didn't love me anymore. I was not getting any support. We would fight all the time. I had started asking myself if the only reason he had married me was because he wanted to take his family name forward. I had started thinking – was my worth as a woman only related to having a child? I had such thoughts when I would be by myself. See, a marriage should not be only about having children. The husband and wife's personal relation, whether they have children or not, is the most important part of a marriage. But he didn't understand this. We were barely talking to each other.. Actually, let me share this very personal thing with you. My husband would usually get irritated if I wanted to have sex with him. To avoid having any kind of physical relation, he would often sleep on our bedroom floor. You can't imagine how a wife feels when her husband doesn't want to sleep on the same bed as her. When I insisted on him sleeping on the bed, he told me if I wasn't able to give him a baby, what other purpose did I have as a woman? I had never felt so depressed in my entire life. I was just praying to God all the time that please give us a baby soon so that this torture stops. I mean, our sex life- people in our country think that women do not have any desires. It was a very hard time for me. I was trying everything to attract my husband but he hardly showed any interest. I remember going with my best friend to buy sexy nightwear but nothing seemed to be working on him. I suggested to him several times that we should go for a vacation where we can have some time alone. You can imagine that in a joint family like mine, having any time alone or being romantic is impossible[144]. We hardly have any privacy in this house! But he kept refusing and one day, when he was very angry, he shouted at me saying that how could I think of such things when we were already so stressed? He said that if I was so eager to be romantic, then I should find another man who would be interested in me. I cried a lot that night. I was very upset and embarrassed. I am sure my in-laws in the adjacent room had heard everything. But finally, thanks to Dr. Ganguly and to God, things are all fine between us now *smiled*. We are very happy and things have become normal between us. Ever since we have had our children, my husband has become a different person! No more sleeping separately! *winked*"

During my fieldwork, I observed that the prolonged period of treatments[145] would usually commence with the infertility specialist charting out an initial treatment plan based on the reports of blood tests, diagnostic tests such as TVS and HSG (see chapter three) for the woman, and semen analysis for the man (see chapter seven). The first stage of this plan entailed the

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[144] See Puri (1999, p. 130) for a discussion on middle-class Indian women's narratives about the loss of freedom after marriage and the constraints of living in conjugal families.

[145] For a childless couple in India, the average duration of years spent pursuing infertility treatments is more than seven years (Bharadwaj, 2016, p. 85).

couple being told by the doctor to undergo Timed Intercourse (TI)[146] for a minimum of three months and up to six months at the latest. The months of TI required the woman to monitor her menstrual cycle, take oral medicines, and subject herself to several timed hormonal injections. Each month, the couple would be required to engage in sexual intercourse during the 'best time' of the woman's menstrual cycle (i.e. days before and during ovulation) and when her body had the 'correct' temperature (i.e. the basal body temperature during ovulation). However, as many of the female interlocutors in my study informed me, engaging in sex during these months felt more like a chore than an act of pleasure as it was entirely dependent on a timetable dictated by their menstrual cycle. As Asha pointed out,

> "We had to follow a strict timetable to have sex! It was not fun anymore and felt more like a routine we had to follow. No romance, no chemistry, nothing at all. We had sex during those months only because we *had* to, not because we wanted to. There were times when neither of us were in the mood but we had to force ourselves."

Oher studies have also suggested that the pressure from the doctors, wider kin, and internalised pressure of the couples themselves to perform resulted in them viewing sex as a test or as an obligation, which ultimately resulted in a decline in the frequency of intercourse (for e.g., see Baker, 2004, p. 44; Inhorn, 2003a, p. 238; Onat and Beji, 2012, p. 47; Thompson, 2005, p. 61).

If TI did not result in conception, then the infertility specialist proceeded to the advanced treatments such as IUI and eventually IVF, in case IUI did not result in conception either. In case multiple IVF cycles also did not result in the desired outcome of reproductive success, then the last option recommended by the infertility specialist would be surrogacy. Adoption was proposed as the final resort in exceptional cases but it almost always received resistance from the couples (see chapter four and seven). Given the copious amount of physical, emotional, psychological, financial, and time investment in the pursuit of a child during the usually extended period of treatments, the couples, understandably, experienced a relentless amount of pressure to make every treatment cycle count. As we can see from Kanika's case above, she offered a retrospective and comparative account of missing the 'normal' time in her marriage and sex life during the period of reproductive disruptions. Her marital relationship finally became 'normal' only after she had achieved reproductive success and as

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[146] Although this plan would vary from couple to couple, TI was the first step if the tests showed that the man had a 'normal' semen analysis report and the woman did not have any 'abnormality' in her reproductive organs.

she implied with a wink, her sex life had also become ‘normal’ as she and her husband were no longer sleeping separately.

The tropes in Kanika’s narrative including an introspective reflection about her marriage and her role as a woman along with the desire to resume the ‘normal’ time in her life were echoed by several female interlocutors. As I will demonstrate throughout this chapter, at the core of the female narratives regarding marital disruptions lies the notion of what constitutes normalcy for them. Although the interlocutors did not explicitly mention what they understood as ‘normal’, I infer based on their narratives that for them a ‘normal’ conjugal life is one that does not revolve around the social pressure to procreate, to put up with constant medical intervention, is not inundated with regular marital conflicts and instead entails ‘normal’ daily activities and a sexual relationship where the men wish to be intimate and express their sexual desire.

To that end, I firstly argue that the marriages and the sex lives of the middle-class couples in my study were profoundly affected by the occurrences of reproductive loss and “treatment intrusiveness” (Benazon, Wright and Sabourin, 1992, p. 274) to which they were subjected to until they achieved reproductive success. Examining such experiences of distraught marital and sexual relationships is, indeed, important as they constituted a pivotal part of the female interlocutors’ narratives of how reproductive loss and childlessness had disrupted their lives. The importance of presenting such narratives and experiences also contributes to the anthropological scholarship on the impact of reproductive loss and involuntary childlessness on the conjugal lives of middle-class couples in India which is otherwise largely missing. However, I am not concerned solely with how women felt constrained in their distressed conjugal lives, for instance, by being reduced to the role of a procreative body by their husbands. As Polit (2006, p. 339) has pointed out, “we should not assume that women in India or any other country to be mute and powerless just because they have a different way of expressing themselves than men”. As such, continuing with my objective to illustrate the diverse forms of agency in my study, my second argument in this chapter is that the female interlocutors were not merely helpless victims in their conjugal partnerships. Instead, I show how they exercised their agency by actively transgressing the discursive gendered scripts in regard to Indian middle-class ‘femininity’.

In order to explicate my arguments, let me begin with reviewing relevant literature, primarily drawing on Henrike Donner's influential research on conjugalities and maternities in middle-class Kolkata, insofar as I shall outline the norms which underline the making or the enactment of middle-class Indian women as 'good wives' and 'good mothers'.

6.2. The 'Good Wife' and 'Good Mother': Enactment of the 'Indian Middle-Class Woman'

In June 2018, Netflix released an anthology of Hindi short films called *Lust Stories* which explored the entangled themes of lust, love, relationships, marriage, desire, and sexuality in urban India. The following conversation is an extract from the fourth story of this anthology. The conversation ensues at the dinner table between the protagonist who is a newly married woman and her mother-in-law. Other family members are also seated at this table. When the mother-in-law starts the conversation by saying, "it's a woman's issue", her two sons promptly leave the dinner table to smoke, on the pretext of getting some fresh air.

> Mother-in-law (MIL): (to her daughter-in-law) "Listen to me. Look at my other daughter-in-law. She is so happy. She had two kids, one after the other. She spends the whole day looking after them. She doesn't need to break a sweat anymore.
>
> Daughter-in-law (DIL): *looking confounded* "Break a sweat?"
>
> MIL: "Yes, what else? See, your mother-in-law squawks all day and the bed squeaks at night. This will end once you have kids. When desires are fulfilled, the drudgery [of having sex] will also come to an end."
>
> DIL: "And what if desires are not fulfilled?"
>
> MIL: "How is that possible? Tell me, does a woman desire anything more than a child?"
>
> (I have used the English translation as it was in the Netflix subtitles and made some minor alterations.)

The mother-in-law looks for approval at the two other women at the table – the older daughter-in-law and the mother of the newly married woman – and gets a reaffirming nod from both of them. The scene ends with the protagonist smiling uncomfortably and averting her gaze from everyone else at the table. She does not tell her mother-in-law that having a child is not a priority for her as she had established earlier in the film. By this point in the storyline, the audience has been shown that the young bride is sexually unfulfilled by her husband due to him prematurely ejaculating whenever they engaged in sexual intercourse. The story proceeds to the daughter-in-law trying to furtively masturbate having acquired a sex toy from the 'other' older, unmarried woman in the film who was portrayed as lascivious and devoid of any morals. However, the protagonist is accidentally caught in the act by her husband and mother-in-law in a comic turn of events. Interestingly, to highlight the 'non-traditional' and 'immoral' aspect of female sexual desire and female masturbation, the scene of the woman orgasming is juxtaposed with the 'traditional' background music from a famous Bollywood movie. Appalled and furious at the daughter-in-law's 'indecent' behaviour, the mother-in-law informs the former's mother that the marriage needs to be dissolved. When the bride's mother implores her not to take such a decision given the kind of negative social impact a divorce would have on her daughter, the mother-in-law says that she would tell everyone that the marriage had to be called off because the bride suffered from epileptic fits.

Although the scenes in this short film are a tad exaggerated for cinematic effect, it is nonetheless, an illustration of popular culture depicting a rather telling account of the heteronormative and pronatalist discourse in India where a woman is pushed to procreate while her sexual desire or sexual satisfaction remains unacknowledged. In addition, female sexual expression which transgresses the culturally prescribed *Lakshman Rekha*[147] for a middle-class Indian woman, a moral boundary which is confined to procreative sex, is condemned. As discussed in chapter one, the normative social biography for an Indian woman mandates marriage and sexual activity for the purposes of childbearing regardless of her class, caste, religion, and ethnicity. The question of whether a woman *wants* to have a child is usually not asked by others. For instance, in the dialogue cited above, the mother-in-law does not ask whether her daughter-in-law wants children. It is assumed that this is what she must want. That becoming a mother is what every woman naturally desires. As the mother-in-law implies, the daughter-in-law is a married woman in her 'prime reproductive years' which makes having a child the priority, irrespective of whether her sexual desires are fulfilled.

It is well-documented by several scholars that class along with caste are inextricably intertwined in defining and constituting gendered and sexual identities in the Indian context (for e.g., see Abraham, 2001; Chakravarti, 2003; Chowdhry, 2007, 2001; Donner, 2008; Gilbertson, 2018; John and Nair, 1998; Kapadia, 1995; Lamb, 2000; Puri, 1999; Radhakrishnan,

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[147] Abraham (2001, p. 136) writes that "Ramayana, one of the two great Hindu epics, continues to have a powerful hold over the imagination of all Indians, male and female. In a pivotal scene in the epic, Lakshman, the brother of Ram, draws a line (*Lakshman Rekha*) on the earth with his arrow - the line is intended to protect Sita [Ram's wife] from the dangers of the forest." For Indians, this line "symbolises the limits of Sita's confinement and also the idealised confinement of the chaste Indian woman, who must cast herself in the Sita mould" (ibid.).

2011, 2009; Uberoi, 2006, 2005, 1998; Vishwanath and Palakonda, 2011)[148]. Drawing on this existing body of literature, I seek to outline the making or the enactment of the 'ideal' middle-class, upper caste Indian woman through the two crucial rites of passage i.e. marriage and motherhood, along with spelling out the morals which circumscribe women belonging to this class-caste group, such as sexual propriety, chaste heterosexuality, and the characterisation of their bodies as repositories of honor.

Donner (2008, p. 66-67) notes that marriage is an important site to gain an understanding of the larger project of the Indian middle-class and it is as much about "making social persons" as much as it is about "doing class". According to Donner, the lives of middle-class Indian women are dominated by the roles of being a 'good wife' and a 'good mother'. For the middle-class, upper caste ideal of the chaste Hindu wife in India, the virtue of being *pativratā*[149] (a wife who is devoted and faithful to her husband) and fulfilling her *dharma* (duty) of being subordinate to her husband as well as to bear children (preferably sons) have been historically established as the primary aspects of her life (Donner, 2008, p. 43-44). Donner explains that since the nineteenth century, as women's roles in the homes as homemakers and mothers started to be politicised within the discourse of Indian nationalism, motherhood emerged as the positive symbol of Indian womanhood and a positive signifier of nationalist modernity (ibid., p. 48). Thus, within this nationalist discourse of new patriarchy characteristic of reformist ideas, becoming a mother was socially and politically construed as the main purpose of the lives of middle-class Indian women who were supposed to lead an exclusively domestic life and sacrifice their personal interests for the interests of the greater good of their conjugal families and the larger community (ibid., p. 48-49). This discursive framework which mandated motherhood as the ultimate role for a woman was a precondition for her to be granted full personhood and it continued well into the twentieth century, irrespective of the rise in the women's age of marriage and educational reforms for women, notes Donner. The ideal middle-class Indian woman continued to be absorbed into the husband's lineage after

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[148] As Ortner (2006, p. 26) has also argued in the context of the United States, "class discourse is submerged within, and spoken through sexual discourse". It is not as if class is hiding within other social discourses and instead as Ortner notes, "the language of sexuality is also the language of class" (ibid., p. 72).

[149] The notion that the Indian wife has to be *pativrata* have existed time immemorial in the ancient Hindu texts such as the *Puranas* and *Smritis*. According to these texts, the wife must be obedient to her husband and she should worship her husband as God. Other Hindu texts such as the Ramayana stated that the wife can have a high and noble status only by service to her husband (see Singh and Nath, 2010).

marriage and her individualism was denied in favour of the interests of the kin group (ibid., p. 46, 91). Donner further argues that a middle-class woman's life in India is dominated by her roles as a wife and a mother and it is her perceived success as a mother which forms the common denominator of her identity (ibid., p. 32), even in the era of globalisation which imbues her with the modernised identity of the 'global Indian woman', as I explain below.

The emergence of the economic reforms and liberalisation policies since the 1990s (see chapter one) also saw the emergence of the "urban, employed, middle-class 'new Indian woman'" (Sen, Biswas and Dhawan, 2011, p. 8). This new middle-class, usually upper caste, global Indian woman was portrayed in public discourse as a modern subject, a consumer, with a career like her male counterpart, and (apparently) free from gender discrimination (ibid., p. 8). This was a so-called shift from the portrayal of the traditional middle-class Indian woman who was occupied by her roles as an ideal wife and mother. However, Radhakrishnan (2009, p. 197) notes that the global middle-class Indian woman was caught between the dichotomy of being sufficiently modern, while remaining essentially Indian. This 'Indianness' of the middle-class woman was fundamentally related to notions of appropriate or respectable femininity and sexual propriety which indicated clear limitations surrounding her sexuality (see Gilbertson, 2014; Khanna and Price, 1994; Radhakrishnan, 2009).

With capitalism and globalisation resulting in the infiltration of western media images and westernised ideas in the popular discourse regarding women's freedom in the public sphere, the "Indian ideologies of domesticity, family order and control of women's sexuality" were being gradually challenged which resulted in a considerable unease prevailing around the increasing modernisation of the new middle-class Indian woman (Sen, Biswas and Dhawan, 2011, p. 10). Thus, according to Sen, Biswas and Dhawan, while there was a social acceptance of the new Indian middle-class woman embarking on her career, there was far less acceptance by society when her modernity was threatening the patriarchal and familial threshold of heterosexual marriage and female sexuality (ibid., p. 10). As the bearer of the burden of Indian culture and tradition, the new Indian middle-class woman was held responsible for "reproducing cultural capital – gendered ideologies, beliefs and stereotypes associated with legitimate forms of family and sexual practices - a marker of middle-classes" (ibid., p. 11). Regulating female sexuality was, therefore, concerned less with the women themselves, many of whom displayed resistance to being controlled and being portrayed as victims in social discourses, and had more to do with maintaining the tradition, culture, and morals of being a middle-class, upper caste Indian woman. The compulsion and social expectations of maintaining systems of prestige and notions of sexual propriety among the middle classes and upper caste groups in order to be Indian, therefore, inevitably fell/falls on women, argues Gilbertson (2014, p. 122). As John and Nair (1998, p. 8) have also contended, the new middle-class Indian woman was the ground on which "questions of modernity and tradition were framed, she was the embodiment of boundaries between licit and illicit forms of sexuality, as well as the guardian of the nation's morality".

While the sexuality of middle-class women in India has culturally been regulated and framed as passive and compromising according to the dominant norms of "gender asymmetric heterosexuality", male sexuality has been framed as aggressive, writes Abraham (2001, p. 134), in her study of sexuality in urban India. Within the traditional cultural ethos, male sexuality in India is not defined by or restricted to the social institution of marriage and monogamy and is in posited in contrast to female sexuality that is confined to marriage and is "subordinated to the male (husband's) sexuality through rigid norms that insist on the maintenance of virginity before marriage and chastity after marriage (ibid., p. 135)"[150]. Likewise, Puri (1991, p. 2) explains that with the onset of menstruation, comes the implication of chaste heterosexuality and it is widely believed that Indian middle-class women should express their sexualities only within the realms of heterosexual marriage. One of the most influential thinkers on Indian sexuality, Sudhir Kakar (1990) has also argued that social norms seek to channel women's sexualities into the institutions of heterosexual marriage and ultimately, motherhood. Abraham (2001, p. 135) does, however, offer a caveat to such a control of female sexuality by stating that the norms differ in the context of tribal communities and lower caste groups in India. Kapadia's (1995) study in Tamil Nadu is a prime example which shows that the sexuality of women from the lower caste and class groups is not as closely

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[150] The ambivalence regarding female sexuality in India is reflected in that on the one hand, it is restricted and bound to marriage and husbands. On the other hand, in myths and popular culture, the Indian woman is seen as "both 'goddess' as well as possessing dangerous power, both pure and impure in her embodiment" (Abraham 2001, p. 135; see also Kapadia, 1995). As such, there seems to be an imperative need for this potentially dangerous and destructive female sexuality to be controlled and regulated by societal sanctions. Abraham (2001, p. 135) explains that the control of female sexuality lies at the core of patriarchal and caste relations (ibid.). It is through the regulation of marriage and sexual relations that caste boundaries are primarily maintained. As such, in India, "family, marriage, and kinship structures form the primary institutions through which female sexuality gets defined and controlled", argues Abraham (ibid.).

controlled as women from higher castes and middle- and upper classes. She observed, for instance, that pre-marital pregnancy was not seen as a catastrophe among the untouchable Pallar women of Tamil Nadu as it was among the higher caste groups.

As such, middle-class women in the Indian society are discursively distinguished from two broad categories of women – an elite group comprising of upper class, higher caste groups and the lower class, lower caste groups (of course, this is a generalisation for the purposes of this discussion). Even though the elite groups are seen as "overtly Westernised and lacking in proper Indian family values and concern for propriety", they are nevertheless emulated to some extent as their lifestyles are seen as "prestigious and fashionably luxurious", explains Gilbertson (2014, p. 130). The status of the middle-class Indian woman can thus be maintained through her consumption and display of western consumer goods while maintaining a deft balance between adhering to 'Indian morality', 'Indian traditional values', and 'Indian culture' (ibid.). On the other hand, women who do not fit within the middle-class moral paradigm are characterised in popular discourse as "the Other" woman who is 'sexually dangerous' (see Chowdhry, 2001, p. 24; John and Nair, 1998, p. 8). In stark contrast to the chaste, monogamous, sexually passive, middle-class, and upper caste Indian woman is the lower caste-class woman who is characterised by limited education, lack of exposure to the world beyond home and family, early marriage, and deviant and 'unfeminine' sexuality (Gilbertson, 2014, p. 29, 132). This group of "the Other" largely comprises of women as the 'lustful lover' who engages in lascivious conduct and may even engage in 'inappropriate' behaviour with men of other castes (Chowdhry, 2001). This group also consists of the woman as a prostitute who is "irresponsibly promiscuous" and the archetypal "non-mother" (John and Nair, 1998, p. 8). As I show shortly in this chapter, the transgression of the socially prescribed patriarchal boundaries of middle-class moralities by some of the childless women in my study is met with anger from their husbands for having become "the Other" woman – the immoral woman who could not produce a child but still wishes to engage in sexual activity.

In the following section I present the cases of female interlocutors who speak about the distressed relationships with their husbands and loss of normalcy in their conjugal lives as a result of the reproductive disruptions. I show that within the given set of constraints in their conjugal families, the women adapted to, negotiated, and navigated through these constraints by asserting forms of agentic capacities.

6.3. Before Reproductive Loss (BRL) and After Reproductive Loss (ARL)

After half a year of trying Timed Intercourse, Soumya underwent four IUI cycles and three IVF cycles in the next five years. She had conceived five times in those years but each conception ended in a miscarriage. When I interviewed Soumya for the first time, she was starting her fourth IVF cycle. Speaking of the physical and mental exhaustion of undergoing the treatments, she said:

> "I feel exhausted all the time from having to come to the clinic frequently and of having to take so many injections and medicines. It's been going on for six years! have not had a normal life since I started these treatments which take up all my time and energy. If I am to be honest with you, I wanted to give up many times. But I am still doing this because I know how much my husband wants a child and how much my in-laws want a grandchild. And I know that if I don't have a child then I will have to spend my entire life hearing people's nonsense and in our society, it will always be my fault since I am a woman. Also, I have this little fear inside me that if I don't have a child soon, then my marriage will suffer. I know of a couple who had a divorce because they couldn't have a child…Actually, the last few years have already been very hard on our marriage, with the regular arguments and pointless fighting...I didn't want to make the situation worse by telling my husband that I would rather not have a child this way where I don't feel like my body belongs to me anymore."

At this point in the conversation, Soumya began crying and reiterated how she felt physically and mentally exhausted. She apologised for her emotional breakdown and mentioned that since this was the first time she was speaking about these things so openly, she was not able to control herself.[151] As I tried comforting her, telling her not to apologise, and that we need not continue with the interview if she wanted a break, she had a glass of water, wiped her tears, and said that she was fine and wanted to continue:

> "At the beginning when the treatments had started, things were not this bad. But in the last two-three years, my husband and I have barely had a normal life. We can't seem to behave normally around each other. We have mostly stopped going out for any social gatherings. Most of the time our only topic of conversation is regarding my treatments and arguments between us have become a regular thing. Small issues like me not taking one of my medicines on time leads to arguments about how I am not taking this seriously and how much money he is spending for all this. He doesn't realise that I spend most of the day doing chores in the house and I also have to look after his parents. So, sometimes it can happen that I miss the exact time for my medicines. Instead of understanding this, he comes home from work and starts shouting at me. As if I miss my medicine intentionally! Obviously I understand that he is also stressed. My mother-in-law keeps asking him why there is no positive result yet and he

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[151] This was a common occurrence during my interviews with the female interlocutors which is one of the reasons why this research project has been an emotional roller-coaster ride along with being an intellectual exercise. Whenever the women started crying, I would tell them that we can stop the interview and if they wish, we can resume it later. However, these emotionally strong and resilient women continued sharing their life stories which reaffirmed for me that they were certainly not the emotionally fragile persons as they were being portrayed or enacted repeatedly by the other actors.

> is also feeling the pressure regarding the amount of money we have spent on these treatments. Since I have quit my job, the financial pressure falls entirely on him. But he forgets that I have a life beyond this. I also want a baby but I don't want to spend my entire time only thinking about this one thing! I need to stay distracted and try to stay normal otherwise I will go mad! So, this is how things have been between us for some time now...One day while we were arguing about this same issue, I angrily asked him if he had just married me so that I could serve his parents and give them a grandchild? That made the argument even worse. Just the other day, I said that I wanted to go watch a movie - just the two of us because it had been so long since the two of us did anything nice together. But he angrily said that he was not in the mood. That's it, we ended up arguing. It was hardly an issue but we fought all evening. He had never spoken to me like this before. Earlier, he was happy to take me here and there. We used to meet friends quite often and have dinner together. But since this time in our life has come, he always makes me feel like we are investing *his* money and still I'm not taking this seriously. Somehow he always finds a reason to blame me for our situation. When I had my job, these things were not such a major problem because I had a distraction. But since I have quit and after the miscarriages- *started crying again* He is my husband, he is the only one who has seen me suffer after not one but five miscarriages. I am still trying to recover from those mishaps. Just because I don't show my pain all day long, does that mean I am not hurting? I want to try and stay normal but fighting about the same things all the time makes me even more frustrated and upset. If my husband doesn't understand my mental state, how can I expect anyone else to understand? To be honest, I just want to have a baby soon so that everything is normal between us again. I don't want our marriage to suffer like this anymore. It has been so long since he and I have been like any other normal couple."

Soumya finally told me that this was most likely her last attempt at IVF and if this did not "work", then she would try to convince her husband to adopt a girl child, as she had always wanted a daughter[152]. As it happened, I chanced upon meeting Soumya again during the second phase of my fieldwork at infertility clinic C. Her final IVF had resulted in a reproductive success story – she had given birth to a baby girl and they were at the clinic to meet the infertility specialist.

A couple's decision to seek medical intervention and pursue infertility treatments is not simply about fulfilling the so-called natural desire of having a child. Franklin (2013, p. 749) notes that childless couples seek treatments for various reasons, including wanting to be certain that they have tried the available options, satisfying the demands of the in-laws, and not wanting to be seen by others as complacent in the face of adversity. For some other couples, continuing to pursue the infertility treatments is a means of strengthening their conjugal relations (see Humphrey, 1975; Franklin, 1997; Lorber, 1989; Sandelowski, 1991, 1993). Whereas for some women, the fear of future marital instability in the absence of a child was an important motivation to seek these treatments, as Whittaker (2014, p. 17) observed in her

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[152] There were some other female interlocutors who expressed their desire to adopt if it were not for the severe objection from their husbands and in-laws (see chapter seven).

study of infertility in Thailand. As we can see from Soumya's narrative, her reasons for spending six years of her life in pursuing infertility treatments, in spite of the mental and physical exhaustion, had less to do with her innate drive to reproduce (see chapter three) and more to do with other external factors, such as fulfilling her in-laws' desire for a grandchild. Moreover, Soumya did not want her marriage to suffer further or to eventually fall apart lest she was unable to produce a child. I suggest that the stakes for Soumya and women in similar circumstances to save their marriages is much higher than men in similar situations given the social stigma for childless women and especially, childless, divorced women among the middle-classes in India – a topic I discuss later in this chapter. Not only did Soumya decide to continue the treatments but she also decided to stop after a final attempt at IVF. Indeed, as Shaw (2016, p. 42-43) points out, it was somewhere between the "pull" of the technologies and the "push" of the society that Soumya utilised forms of constrained agency to reflect on the reasons for investing her time and energy in undergoing the repeated treatment cycles. As she mentioned, she knew that the sooner she had a child, the sooner her marriage and life would become 'normal' once again, and then she would no longer have to put her body and mind through the onerous regime of infertility treatments.

Soumya's feeling that her body does not belong to her anymore – this sense of alienation from one's body, constant medical surveillance, treatment intrusiveness, and the social pressure to have a child – similar themes emerged repeatedly in my dialogues with the other female interlocutors in my study. These themes have also appeared in women's responses across sociocultural contexts as has been documented widely (for e.g., see Baker, 2004; Bergart, 2000; Carmeli and Birenbaum-Carmeli, 1994; Clarke, 2006; Cussins, 1998; Franklin, 1997; Gupta and Richters, 2008; Greil, 1991; Malin et al., 2001; Thompson, 2005). Furthermore, Soumya's narrative about the loss of normalcy in her marriage indicated by the increasing frequency of arguments with her spouse, the absence of any 'normal' or 'nice' activities (such as attending social events), not being able to behave 'normally' around each other, and the lack of emotional support and empathy was also not an isolated case and most of my female interlocutors expressed similar sentiments. As such, a common trope which emerged prominently during my research was the distinction women made between their husband's demeanour towards them 'before reproductive loss (BRL)' i.e. the normal conjugal period and 'after reproductive loss' (ARL) i.e. the period involving a loss of normalcy.

Consider the following excerpt from my interview with another female interlocutor, Gayatri, who expressed her frustration about being treated like a patient at home by her husband:

> "Ever since these treatments have started, we have not had any nice time with each other. It was not like this when we got married. We have not gone to a nice restaurant for dinner or gone shopping for many months. Earlier, we used to have short weekend trips whenever we got time but we haven't done anything fun in a long time. He keeps saying he wants me to focus only on the treatment. I know that my husband really loves me but it's frustrating now because he has become extremely obsessive! He is stressed all the time. Actually, I think he is more stressed and desperate than I am. As long as he is awake, this is the only thought running in his mind and I don't think this is a healthy person's behaviour. He can't focus on his work, doesn't do anything else, and is always bothered about what I am doing, what I eat, where I go,, when I sleep. He doesn't trust me if I say I have taken the medicine. Most times, he gives me the medicine and sees me take it with his own eyes.. He just wants to be around me all the time and see what I am doing. He is always saying you should eat this, don't eat that. How can I eat what he says all the time? I also feel like eating something which I like but he doesn't let me do that. He doesn't let me do anything at home. He doesn't let me move as I wish! He has kept so many servants at home so that I don't have to do anything. When he is not at home, he tells my mother-in-law to ensure that I don't do any chores. He loves me, I know that, but he needs to understand that I need my freedom. He forgets that I am an adult and I don't need full-time supervision. He wants a child so desperately that he has forgotten that I am his wife and not just someone who will give him a child. Do a woman and man get married only to have children? Aren't there couples in the world who are happy without children? If he knew I was thinking such things, he would get annoyed which is why I don't share all this with him. Since I'm usually quite frustrated and he is stressed, naturally, we end up arguing a lot. He can't see that by doing all of this he is affecting our relationship. I have told him several times that if God wants and if it is destined, then we will have a child, nothing can change that, but he wants to control everything. I understand I am a patient here [at the clinic], but it is really frustrating that my husband treats me like a patient at home as well."

Our interview was interrupted twice by Gayatri's husband calling her to ask when she would be home as her lunch time was getting delayed. Both times she told her husband that she was stuck in traffic. She told me that if her husband knew about this interview, he would ask her a hundred questions about it and probably not be so happy that she gave this interview.

Bali, Dhingra and Baru's (2010) quantitative study in north India about marital adjustment among infertile couples suggests that the majority of the male and female respondents had a positive attitude towards their spouses before the unexpected and disruptive experience of childlessness. However, the authors show that after the diagnosis of female infertility, only sixty percent of the husbands had a positive attitude towards their wives, while the rest of the husbands had a negative attitude, were extremely frustrated, and would blame their wives for the childlessness. The childless couples in that study also faced other marital problems, such as a shortage or lack of recreational time spent with each other and lack of intimacy (ibid., p. 75). My research findings point in a similar direction as we can see from Soumya and

Gayatri's accounts who expressed that their husbands' attitudes towards them had changed since the reproductive disruptions and the stress of undergoing assisted conception had overwhelmed their daily lives. Gayatri's husband, as she explained, obsessed over her daily activities and tried to control all aspects of her life including her diet. This obsession of her husband, she said, is what frustrated her which resulted in arguments. She distinguished between the periods of BRL and ARL by saying that that since the treatments had started, she and her husband had not done anything 'nice', such as taking weekend trips, going for dinner, or shopping – activities which they reportedly did earlier as part of their normal conjugal life. Like Soumya, Gayatri also pondered about her role as a wife and reflected on whether a couple's happiness was entirely conditional on having a child. Such reflections, indeed, indicate women's constrained agentive capacities through which they make sense of their gendered identity and their role as wives in their distressed marriages where they are under constant pressure to bear a child.

However, it was not only the stress of undergoing infertility treatments and failed treatment cycles which strained the marriages in my study. The occurrence of reproductive loss after natural conception without any medical intervention also caused significant marital stress. Speaking about the loss of normalcy in regard to romance and intimacy, Maya, who had suffered four miscarriages, said the following:

> "Look, arguments are normal between any married couple. But it's not normal if a couple fights every single day about the same topic! Our daily conversations are no longer about normal things. Earlier, my husband made me laugh so much! His sense of humour was one of the reasons I fell in love with him! But since the mishaps, he seems to have become a different person – always serious and grumpy. We talk, argue, talk, argue, that's it! And it's always about this one thing. Child! Child! Child! That's all we talk about! As if my only job in this world is to give my husband a child! I know we have had a very sad time in our lives. Who would know that better than me? But does that mean I should stop smiling and stop living my life?.. Whenever I go out with my husband nowadays, he walks *pointed her finger to a distance* that far away from me. It wasn't like this before because he was actually more romantic than me at times! I am a big romantic but now if I want to hold his hand in public or be close to him, he deliberately walks afar from me. How can I be happy like this? *started weeping* I am his wife so why can't I hold his hand or touch him in public? Is that a mistake? He tells me that I embarrass him in public. But I don't care! I still try to hold his hand and walk closer to him *looked at a young couple next to us kissing* I think if I did this with my husband now in public then he would give me a divorce! I just miss the laughter and romance. Everyone has bad times in their lives but that doesn't mean that people stop living their lives."

Like Soumya and Gayatri, Maya also expressed her feelings of missing the normal relationship she shared with her husband in the time BRL. Their arguments revolved only around having a child and while Maya thought that it was normal for married couples to argue, arguing about the same thing repeatedly was not normal for her. Citing examples of her conjugal life BRL and ARL, such as how her husband had a sense of humour earlier and how he had become serious later on, or how he would insist on her singing earlier but now her singing embarrassed him, Maya explained how her marital relationship was affected since the miscarriages. As a self-proclaimed romantic, Maya mentioned missing being affectionate towards her husband and that it upset her that he did not understand that to stay 'normal', despite the mishaps, she needed to engage in 'normal' activities and 'normal' behaviour. She further mentioned that as the mother, she knew the feelings of grief and loss too well (see chapter five), but, as she said, "…does that mean I should stop smiling and stop living my life?"

As we have seen in this section, the three female interlocutors – Soumya, Gayatri, and Maya – distinguished between the periods in their marriage BRL and ARL and expressed comparable sentiments regarding how reproductive disruptions had resulted in the loss of normalcy in their marriages. They reflected on how they had been reduced to the role of being passive wives whose only task was to focus on producing a child. It could be extrapolated from the women's narratives that while they wished to have conjugal relationships that did not strictly revolve around reproduction or were so severely affected by the absence of a child, their spouses enacted them as disciplined procreative bodies and 'good wives' who ought to be focused on the goal of procreation instead of being distracted. As I show next, the enactment of middle-class Indian women as 'good wives' in the light of reproductive loss and childlessness became even more evident when the women's roles as sexually desiring persons was deemed as unacceptable and morally offensive by the husbands.

6.4. Loss of Sexual Intimacy and the Transgression of Patriarchal Norms

The perpetuation and normalisation of normative expectations regarding the conduct of middle-class Indian women as 'proper' wives and daughters-in-law can most commonly be observed in the matrimonial advertisements in any Indian newspaper[153] or on online

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[153] With urbanisation and the decline of the role of the physical matchmaker, there has been a rise in newspaper advertisements for matchmaking among the post-colonial urban middle classes of Kolkata, observes Majumdar (2009 in Kaur and Palriwala, 2014, p. 14). Majumdar's study shows that this 'modernised' mode of matchmaking was accompanied by the emergence of a new domesticated model for Bengali women, a demand for dowry, and

matrimonial websites which search for particular kind of women with a number of 'desirable' qualities. As Sharma (2018, p. 2) points out, Indian families use matrimonial advertisements in order to "demand and exhibit particular kinds of brides without much variation, revealing the discourses of commodification, narcissism, femininity, and heteronormativity". In their study of such websites, Jha and Adelman (2009, p. 66) claim that there is an explicit gendered ideology which functions behind the production of such advertisements. With the sole purpose of securing marriage in countries like India where pre-marital relationships are still relatively uncommon (but certainly on the rise), these matrimonial ads also perpetuate sociocultural discourses which reinforce normative heterosexuality and gender scripts by defining 'appropriate' behaviours for women and men (see Ramasubramaniam and Jain, 2009; Sharma, 2018). These ads essentially showcase the 'desirable' qualities which make for a 'good Indian wife' within an arranged marriage setting. The trope of the 'good Indian wife' often means sharing the same caste as the man's family, having a light(er) skin tone[154], thin, educated (but not too highly qualified and preferably lesser than the man), and 'homely'. Unlike the English word 'homely' which means cosy or comfortable, this word in the context of matrimonial ads characterizes women (this word is *never* used for men) who are introverted (indicated by qualities of not being outgoing, loud, or loquacious) but instead are compliant and who can manage household chores without much fuss (cooking, for instance, is a crucial requirement).

Although middle-class families in recent years have started looking for daughters-in-law who have careers, they nevertheless prefer professions with fixed working hours, stable incomes (preferably not more than their sons), and which allow enough time for the women to maintain a balance between work and home (Mukhopadhyay, 2011, p. 137; Radhakrishnan, 2011, p. 149). As such, what is not explicitly mentioned in these matrimonial ads but is rather heavily implied, particularly in the use of the word 'homely' (or 'presentable' or 'cultured') is that the 'good, middle-class Indian woman' should be modest, well-behaved, be able to take

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a decline in women's status. According to Majumdar, these newspaper ads reproduce(d) the normative distinctions in the roles and attributes of women and men.

[154] The presence of the caste system, which is an integral aspect of matrimonial advertisements in India, promotes the "hierarchy of skin colour" as lighter skin is more likely to be seen in higher caste members while darker skin is viewed as being of a lower caste (Jha and Adelman, 2009, p. 68). Often, descriptive words used to signify the prospective bride's beauty such as 'beautiful', 'pretty', 'lovely', and 'gorgeous' are not so subtle codes for lighter skin tones (ibid., p. 73).

good care of the family, and not engage in any ‘westernised’ activities such as drinking, smoking or other ‘inappropriate’ behaviour such as wearing ‘western, provocative’ clothes[155] or staying out late at night, even if it is for the sake of her career. Of course, and very importantly so, implicit within all these desired qualities is her fertility and her biological ability to produce a child (or two) and carry her husband’s lineage forward. As Donner (2008, p. 32) has argued that among the middle-class in India, women’s education, their marriages, and professional careers are ultimately arranged and represented in relation to the making of a ‘good’ Indian wife and eventually, a ‘good mother’.

Based on the conversations with my female interlocutors, I suggest that the virtue of modesty and propriety culturally ascribed to the middle-class Indian woman is not limited to her conduct in the patrilocal residence but is also extended to the private and intimate space of the married couple’s bedroom. This is, in my understanding, also valid in cases for a couple who had a love marriage wherein the process of partner-selection by the respective families had been circumvented (see section 6.6). The middle-class Indian wife’s expression of sexual assertiveness and sexual desire to engage in sex or certain other sexual acts (i.e. acts which are not limited to sexual intercourse and specifically for the purpose of procreation) becomes particularly unacceptable and offensive for the husband, especially when the woman has *failed* in her foremost duty as a married woman i.e. childbearing. For ethnographic elaboration, let me present Maya’s case once again (see previous section) who shared how she missed having a normal sex life and that any attempts by her to initiate sexual activity, especially if it was ‘deviant’, was met with her husband’s annoyance and disapproval.

6.4.1. The ‘Immorality’ of Desiring Sex as a (Childless) Middle-Class Indian Wife

A classical singer and a former school teacher, 34-year-old Maya resides in a posh neighbourhood in south Kolkata with her husband, Sushant, who is a software engineer. Since their marriage in 2012, the couple had not been living with Sushant’s parents. The reason for this, Maya told me, was that her in-laws had refused to accept her as she was not from a financially affluent and Brahmin family unlike her husband:

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[155] How women, especially middle-class women dress, has been one of the most evident sites where gender politics unfolds. It seems to be a societal consensus that a woman who wears jeans and T-shirt is significantly influenced by ‘western’ culture and hence, has ‘loose morals’ while also being devoid of ‘traditional value’s that an ‘Indian’ woman ought to have (see Dutta, 2011).

> "I told Sushant that if your parents can't accept me, then I don't want to stay in the same house as them. Sushant visits his parents almost regularly but they never ask about how I am doing. I never stop him from meeting them but I also don't visit them. Earlier, I used to ask how they were doing. My mother always told me to be nice to them. But when my mother-in-law didn't ask about me even once after my miscarriages, not one single time, that's when I decided to never have any relation with them. If somebody lacks basic humanity, then I don't want anything to do with them. Everyone has a patience level, you see. For me, I couldn't handle any more of their behaviour. What had I done? Their son loved me and I loved him. Is that such a big crime that they can't even ask about me after I had so many miscarriages? I have made the decision that once I have a child, they will not get to see my child either. Sushant and I get into many fights because of this issue but I have taken this decision because if they can't show me any concern, then they have nothing to do with my child. So when they have an heir, then they are suddenly interested but they refuse to show any care for me? I have no wish of keeping such people in my life or my child's life. If they can make decisions, I too can make strong decisions."

For Maya, her decision to not have a relationship with her in-laws stemmed from her anger and disappointment due to several reasons such as not being accepted by them because she belonged to a 'lower' caste group and because her family was not as financially affluent. However, the tipping point for Maya was when her in-laws did not show any concern for her when she suffered four miscarriages. Her narrative was interspersed with instances of "patriarchal bargains" (Kandijyoti, 1988)[156] wherein she exercised her agency within certain constraints. For instance, Maya's decision to be in a relationship with a man despite the opposition from her mother as well as her in-laws, her subsequent choice to have an inter-caste marriage despite the prevalence of caste-endogamous marriages in India, her decision to not reside in patrilocal residence (as is the norm for most Indian marriages, Donner, 2008, p. 73), and her admittedly "strong decision" to not have any contact with her in-laws even after she gives birth – all these decisions demonstrated forms of strategic agency drawing on which Maya negotiated with patriarchal boundaries.

After the last miscarriage in 2017, Maya had quit her job as a school teacher as she had started her first IVF treatment cycle in 2018. She told me that her husband had asked her to quit her job as she had to focus on the treatment and avoid travelling to her workplace which was more than an hour away. As someone who reportedly enjoyed being a teacher and interacting with young students, Maya mentioned that sitting idle at home all day made her unhappy. While sharing how she was completely bored at home, she spoke about how her marital

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[156] Kandijyoti (1988, p. 275) has defined "patriarchal bargains" as women strategizing within their given set of constraints and this exhibition of strategies tends to vary according to class, caste and ethnicity. Such bargains, according to Kandijyoti, shape women's subjectivities and also "influence both the potential for and specific forms of women's active or passive resistance in the face of their oppression" (ibid).

relationship had not been ‘normal’ since the miscarriages (as described in the previous section) and eventually, she spoke about how her sex life had been affected as well. Sounding disappointed, she expressed how her husband had lost any interest in being “physical”:

> “When Sushant returns home from work, he doesn’t want to talk to me or spend time with me because he says he is exhausted. I usually don’t disturb him but sometimes I also have a certain *icchā* (desire). I feel like going out with him, having a nice evening but he refuses. He isn’t even interested in having fun at home! You know what I mean? *I asked her what she meant* Okay, I’m going to be completely honest with you – please don’t judge me! Actually, we have hardly had any physical relations in the last two years. Ever since the last miscarriage happened and my treatment has started, we have not had sex properly. Please don’t mind, but you are the first person I am saying all this to because I didn’t have anybody else I could share this with *I said I did not mind at all and she could share anything she wanted to* I just wish he understood that as a woman I have certain desires in life. I love him and I know he loves me too, but love is not always enough…Actually, if I say these things to anyone else, they might think I am a crazy, desperate woman who only thinks about sex. Sushant also thinks so, I guess, because like the rest of our conservative society he also thinks that a woman cannot have any interest in sex. But to be honest, I am a woman who really likes and enjoys having sex and Sushant doesn’t understand that. I have tried telling him this in many ways. I have tried looking sexy for him. A few times I wore sexy clothes before he returned from work. You know, I even bought sexy lingerie – like women wear abroad? The lacy kind with satin and all the fancy stuff. But he became angry, shouted at me, and said that I am behaving like a *bājē* (bad) and desperate woman. Tell me, does any woman like hearing such horrible things from her own husband? When we were having TI [Timed Intercourse] earlier, the doctor said we were supposed to have sex at a certain time. But then I told Sushant so many times that the doctor never said anything about not having sex at any other time! I told him that there is so much more than just having sex for having a baby. I told him that I am happy to just please him, he wouldn’t have to do anything for me. I even told him that *whispered* I like giving blow jobs [sic] so if he doesn’t want to do anything, then I can give him pleasure. But he says no to that too. I always thought that a man would like this, but Sushant doesn’t say yes to this either! In fact, when I say this, he just tells me to stop all this nonsense or just quickly has sex with me and then falls asleep...He hasn’t touched me in so long. We have had sex only three or four times in the last one year and that too, he was least interested. As a woman, you get to know when a man is truly interested and when he is doing it just to get done with it. How long can I continue like this? *became teary eyed* I feel embarrassed and ashamed sometimes but then I think that he’s my husband, so I have to try and tell him how I feel. I couldn’t talk about these things to anyone else. Once I even suggested watching blue films[157] together. We saw such films earlier, even after getting married, but now when I suggest it, he gets furious! The sex we did have in the last year, it was also quite boring. We haven’t done anything exciting ever since this time has come in our lives…You know, I really believe that everything in life has an artistic side to it. I believe in this very strongly. Even as a child, I would try and find art in everything around me. So, I really feel that sex should also have an artistic side to it. It should not be only about having a baby and it is something that should be enjoyed by two people. But for Sushant, lately, it is just about wanting to finish it somehow, if I insist, and then he goes to sleep...Since I have shared so much with you, let me share one more secret. I told him that he doesn’t need to penetrate and that he can *whispered* ejaculate anywhere he wants. I was hoping this would excite him because we had seen something like this in a blue film earlier. But the moment I said this, he started shouting at me saying that how could I say such *noṅṛā* (dirty) things? That day he said that women from decent families don’t behave like this *wept softly* I was very hurt that day. Can only a men express their sexual feelings and desires? Don’t I have the right as a woman to express my physical needs? Is having

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[157] The term “blue films” is colloquially used in India to refer to pornographic videos.

> a child the only important thing in a marriage? Can a husband and wife not have a life without a child? I am hurt because of his behaviour. Our marriage has become all about having a child. *wiped her tears and asked me to change the topic to something happy so that she could be distracted*."

The limited body of literature on sex and sexuality in India, according to Puri (1999, p. 116), paints a dismal painting of women's sexuality and sexual desire, thereby reinforcing the notion that women lack (sexual) agency and that they are merely reluctant and/or passive participants in sex. For instance, Dhruvarajan's (1989 in Puri, 1999, p. 116) study in a south Indian village suggests that Hindu women perceive sex as a woman's duty and for the man's pleasure, that men have stronger sex urges, and that it is unwomanly to be interested in sex while still accommodating men and bearing their children. In her study of women in Punjab, Das (1976 in Puri, 1999, p. 116) claims that women are expected to be sexually accessible to husband's desires, to extend their lineage, and "to absorb the pollution of sexual intercourse, including its attendant sin and danger". Contrary to these existing studies, Puri's (1999) own study on female sexuality in the postcolonial Indian setting indicates that middle-class women's narratives do not reflect their simple availability to their husbands and neither do the women describe sex primarily as an avenue to motherhood. Instead, the middle-class women in her study represented themselves as sexual persons and viewed sexuality as a central aspect of forging and maintaining marital bonds (Puri, 1999, p. 116). Within a heteronormative framework, the female interlocutors in Puri's study closely associated marital sexual activity with concepts of romantic love and intimacy where "the quality of one determines the quality of the other" (ibid.).

As I also discovered in my own study, many of the female interlocutors' narratives about their marriage and sex lives were replete with their understandings about what constitutes a normal conjugal relationship in relation to love, romance, (hetero)sexual desires, and sexual intimacy. Narratives of Maya and other female interlocutors were, indeed, illustrative of their agentic capacities within their systemic and ideologically constrained circumstances in which their lives and bodies were controlled and they were pushed to have a child, either by the medical practitioners in the clinical settings or by their husbands and/or mothers-in-law at home, as I have illustrated thus far in this dissertation. Through their accounts about sex and sexual desire, I aim to show how some female interlocutors contested and transgressed the discursive notions of female sexual passivity, sexual respectability, and appropriate femininity ascribed to middle-class Indian women. I unpack such contestations and transgressions in the women's enactment of themselves as sexual agents who displayed sexual desire while also wishing to be desired by their husbands as part of their attempt(s) to resume a semblance of normalcy in their disrupted marriages but to also express their femininity which was not limited to being a 'good wife' and a (potentially) 'good mother'.

As we can see from Maya's lengthy quote, she spoke elaborately about the disruptions in her sex life and explained how sex had become a rare aspect in her conjugal life due to her husband's diminished interest in any sexual intimacy since the miscarriages. She mentioned that I was the first person she was sharing such things with because according to her, if she had shared it with anybody else, then people in the "conservative" Indian society would think of her as a "crazy, desperate woman" who only thought about sex. Maya explained that as a woman who enjoys having sex, she had tried telling her husband on several occasions that she desired sexual intimacy. Regardless, he did not show any interest in participating actively in any sexual activities and would mostly decline any proposition made by her. Wearing seductive clothes or lingerie "like women wear abroad"[158] and suggestions to engage in non-penetrative sex in the form or oral sex were met with responses of anger and disapproval from the husband who called her "*bājē*", (bad), desperate, and "*noṅṛā*" (dirty). Maya's sexual assertiveness and suggestions for her husband to participate in such 'deviant' sexual acts (see Khanna and Price, 1994, p. 29) and relatedly, her self-representation as an 'inappropriately' feminine woman, more so as a middle-class, childless[159] Indian woman, was not well received by her husband. As has been argued by Valentine (1993), the norm of heterosexuality within the site of marriage is "'naturalised' through the definition of 'monogamous procreative sex' (involving penetration by penis) as the quintessential sex act, a performance that links masculinity to activity and femininity to passivity" (Hubbard, 2000, p. 197)[160].

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[158] The notion that women in western countries wear sexy lingerie suggests that Maya understands women in western countries as having different or more 'open' standards of sexual propriety and femininity than Indian middle-class women (see Gilbertson, 2014).

[159] I would assume that even after having a child, it would be deemed morally unacceptable for some Indian men to view the mother of their child as suggesting any 'deviant' sexual acts given the (Divine) glorification of Indian mothers in the larger society. Ultimately, whether a woman is childless or a mother, particularly in the middle-class milieu, the idea that women can be sexually assertive is not a very widely acceptable proposition.

[160] See McPhilips, Braun and Gavey (2001) for a discussion on the "coital imperative" or penile-vaginal intercourse as quintessential in defining [hetero]sex) as noted in the western context. The authors discuss how intercourse is prioritised over other sexual practices as "real sex" even though alternative discursive spaces for sexual acts which do not involve intercourse in the understanding of sex certainly exist.

Rubin (1989 in Hubbard, 2000, p. 197) argues that the imagining of certain sexual acts as morally acceptable or unacceptable is crucial in defining “heteronormality”. Relations which involve women’s sexual gratification independent of procreation are constructed as the worst forms of sexuality, argues Rubin. As such, “while ‘good’ sex acts are imbued with emotional complexity and reciprocity, sex acts on the ‘bad’ side of the line are considered utterly repulsive and devoid of all emotional nuances” (ibid., p. 197). In the context of reproductive loss, research conducted in the Euro-American context suggests that for many bereaved parents, reproductive loss may result in a breakdown or decline in sexual relationships (for e.g., see Black, 1992b; Pepper and Knapp, 1980; Martin and Doka, 2000). While grief, depression, and lack of energy or interest in sexual intimacy among the couples in such research were cited as some of the common outcomes in the aftermath of loss, for many, the very act of sexual intercourse was problematic – it meant “inappropriate pleasure, evoked memories of the deceased child, or created anxiety over the prospect of a new child” (Martin and Doka, 2000, p. 102; see also Black, 1992b, p. 20). Yet, in other cases, sexual intimacy and sexual expression was welcomed for the emotional comfort it offered and for the creation of a new child (Black, 1992b, p. 28). It has also been shown that in some western countries, marital stress and a decline in either partner’s sexual responsiveness is a common consequence of infertility, childlessness, and the related biomedical interventions (see Benazon, Wright and Sabourin, 1992, p. 274; Black, 1992b, p. 20). While some studies have shown that such forms of stress can bring couples closer together (for e.g., see Humphrey, 1975; Franklin, 1997), there are others which indicate that the stress pushes couples further apart and can potentially result in separation or divorce (for e.g., see Andrews, Abbey and Halman, 1991; Fledderjohann, 2012; Greil, 1997; Onat and Beji, 2012; Schmidt et al., 2005). In Maya’s case, the use of words such as bad, dirty, and desperate by her husband to express his disapproval implied that her sexual ‘deviancy’ and her ‘immoral’ desire to engage in these acts had made her ‘dishonorable’. Moreover, Maya’s enactment of herself as the sexually desiring person was deemed all the more unacceptable and offensive by her husband in the light of the miscarriages which pointed towards her failed reproductive abilities. The hurtful reactions from her husband and his disinterest in sexual intimacy made Maya eventually introspect and reflexively pose questions about whether a woman was not allowed to express her sexual desires – a further illustration of her constrained and passive but yet real agency indeed.

The following excerpt from another female interlocutor, Gayatri, helps me in strengthening the discussion so far:

> "We haven't had sex for almost a year. I can't begin to explain how frustrated I am! Whenever I want to be romantic with my husband, he says that I shouldn't waste time because he is not interested. He always says that once we have a baby then we can do all this. I have told him so many times that maybe we will feel better if we have sex just for fun but his usual response is that he is not in the right mood. I can't actually remember the last time we had sex like a normal couple. We have had many arguments because of this. I keep telling him that we can be romantic sometimes and forget about everything else but he doesn't seem to understand. If I sometimes insist on having sex or at least doing anything else physically, then he gets angry and says things like, why are you desperate or that women from good families don't behave like this. One day I suggested we watch porn together but he became very angry and said to me that if I wanted to do such *oshlīl* (filthy or obscene) things, I should do it alone and not bother him. That day he said that I was behaving like a *choritrohīn* (characterless) woman. We fought a lot and I asked him if women become characterless by wanting to see porn with their husbands? I am his wife, I don't understand why he treats me like a *satī savitrī* [161]*.* I was obviously extremely hurt when he said those things…I miss having sex, honestly speaking. Everything in life has become about having a child. I wish I could understand why he has been behaving like this."

Butler (1990, p. 72) has argued that within the confines of a heterosexual marriage, the masculine is desiring of the feminine and a disruption in the performance of these culturally prescribed gender roles can potentially lead to ostracization, or in the case of the women in this section, humiliation, of the disruptor. Like Maya, Gayatri's agential attempts to initiate any kind of sexual intimacy by disrupting her position as the modest middle-class Indian woman was not responded to positively by her spouse. For instance, suggestions by Gayatri (and even by Maya) to watch pornography as a stimulant for their waning sex lives was seen by the husband(s) as a dirty gesture, which led to Gayatri's husband calling her *choritrohīn* (characterless). The notion that a middle-class Indian woman could desire not just sex but propose watching porn resulted in her character and relatedly her morality being questioned, given that they are not supposed to be enjoying such form of sexual stimulation (see also Puri 1999, p. 124). The usage of word such as characterless also refer to a woman with apparently loose morals and hints at a woman who is easily available (i.e. promiscuous) as opposed to a

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[161] The term "*satī savitrī*" is used in popular discourse to refer to a woman who is prudish, a virgin, or who is a 'dedicated' wife. The term originates from the name of Savitri who was a Hindu mythical female character, considered to be the "embodiment of wifely devotion" (Sangari and Vaid, 1981, p. 1287). Partha Chatterjee (1989, p. 248-249 in Mody, 2008, p. 55) has described the "*Sita-Sati-Savitri*" construct as having emerged from a middle-class culture in the era of Indian nationalism. Mody notes that according to Chatterjee, "by characterizing women as goddesses [*Sita*], the nationalists liberated women from their sexuality and facilitated their safe movement into the outside world" (ibid). However, in disagreement with Chatterjee's argument, Mody writes that Chatterjee does not acknowledge that even (supposedly) chaste and pious women who emerged in the public sphere risked the consequences of hurt male honor and pride.

woman with integrity, a strong character, and essentially an ideal middle-class married Indian woman who does not *ask* for sex. Indeed, the social expectations of "sexual respectability" for a middle-class Indian woman are sustained both before and after marriage as I have discussed earlier in this chapter (see also Puri, 1999). Puri defines "sexual respectability" as that which

> encodes expectations of what is socially and sexually appropriate for middle-class women. As a standard of acceptable social conduct, notions of sexual respectability prevail mainly in two dimensions: the threat of male sexual harm to women's bodies, and the threat of women transgressing the lines of acceptable sexual behaviour (Puri, 1999, p. 77).

As Gayatri's husband said, "women from good families don't behave like this". Thus, according to the husband, middle-class Indian women from "good families" are not sexually assertive, sexually improper, or licentious and should rather embody respectable femininity and sexual passivity. Radhakrishnan (2009, p. 11,45) explains that in the Indian context, "good family backgrounds are composed of heterosexual families in which middle-class women make appropriate decisions for their husbands and children" which is posited in contrast to women from "bad families" who are characterised by their inappropriate sexuality or inappropriate femininity. Although sexual pleasure was expected and included in 'normal' marital relationships, it was ideally supposed to remain secondary to the fulfilment of the woman's duty of bearing children and of being subordinate to the husband (see Netting, 2010, p. 709).

As we can see from the examples in this section, the female interlocutors shared similar concerns – the marked decline in sexual responsiveness from their husbands and a lack of sexual intimacy since the experiences of reproductive loss and childlessness. I argue that these women performed transgressive acts by desiring sex and through that desire (again?) finding (sexual) agency that had been otherwise denied to them through the conformist patriarchal and heterosexual demands of marriage. As such, by repudiating the culturally mandated *Lakshman Rekha* for middle-class Indian women, these women enacted themselves as sexual agents who wished to be seen by their spouses as more than mere procreative bodies. As we have seen in their excerpts, they were, indeed, disappointed and upset about their husbands seeing them only as modest wives (implied, for instance, by Gayatri saying that she does not wish her husband to treat her like a *satī savitri*) who should be sexually passive and ought to be focusing on reproduction. Although the women enacted themselves as sexual agents, their husbands responded by using hurtful and derogatory words and questioned their 'character' which ultimately suggested that their middle-class Indian wives were not maintaining the sanctity of a middle-class woman's expected sexual purity (see Radhakrishnan, 2009) or that they were not conforming to the deeply ingrained and pervasive moral codes of conduct in relation to sexual propriety and sexual respectability for married, middle-class women in India.

In the next section, I show that the strained marital relationships as described thus far in the chapter often resulted in some female interlocutors contemplating divorce but ultimately, deciding to stay in their marriages by adapting to and negotiating with their constraints, in both active and passive ways.

6.5. Considering and Dismissing Divorce: Women's Reflections and Negotiations within Conjugal Constraints

In a patriarchal familial setting in India, a woman's inability to contribute heirs is punished by the real threat of abandonment regardless of which partner is infertile (Bharadwaj, 2016, p. 71). Jefferey et al.'s (1989, p. 87 in Bharadwaj, 2016, p. 71) study has shown that it is not uncommon in rural North India, for instance, that if a woman fails to produce a child or does not have any living children then it is calamitous for the woman as she is returned to her natal family (see also Naraindas, 2009, p. 99-100). It has also been suggested by Madan (1976 in Bharadwaj, 2016, p. 71) that childless Hindu women are not only fearful of being rejected by their husbands but they also fear the impending threat of divorce. Interestingly, during my fieldwork, none of the male interlocutors I interviewed mentioned or even hinted at having thought about divorce or remarriage[162]. However, there were a handful of female interlocutors who in their retrospective accounts shared the moments in their marriage when they had deliberated about getting divorced as is evident from the two excerpts below:

> "I was just so fed up. My husband and I were barely speaking to each other. We would end up fighting all the time and usually he would blame me for everything. It felt as if we were just looking for a reason to fight. I didn't see any reason for us to be together anymore. Actually, I told him a few times that we should file for a divorce. But he never took me seriously. It didn't feel like a marriage at all. It felt like two people were forcefully living under the same roof just so that we could pretend that we were fine…During those years of treatments, the stress and pressure on me from my in-laws' family was so much that I often thought that it would have been much better if I were to get a divorce. But I also knew that it is not easy to live in our society where people judge women all the time, especially divorced women. I knew that a divorce would upset our families and also give the society a chance to point fingers at me. People would say that it is my fault that the divorce happened. So, I had decided

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[162] It is possible that there were some male interlocutors who might have wanted to separate from or divorce their wives in order to remarry but did not mention that to me in the interviews given that most of them did not share any personal details about their marriage and/or it could have been a passing thought at some point in their marriage which they did not deem worthy of mentioning during the interviews.

> to just shut my eyes, close my ears, and go through with everything. I used to tell myself that I have to start ignoring what people say if I want to keep this marriage together and if I want to keep myself from going crazy. I am glad that finally everything turned out to be fine."
> (Kanika Gupta)

> "I was ready to give up after five years of trying. I told Kunal that he could divorce me if he wanted to marry someone else who could give him a child because I was done going for check-ups. I was tired of taking off clothes in front of strangers and being touched by them. I told Kunal several times that he should divorce me or if he didn't want to do it, then I said I would file for it. I was unable to handle the stress anymore! It was terrible because during that time, Kunal had started drinking a lot. That made things worse between us. We would end up having horrible arguments after he would get drunk. The years of running to clinics, meeting so many doctors, and not having a child for this long really tested our marriage…Actually, I know of couples who got divorced after they couldn't have a child. When I heard this for the first time from a friend of mine, I thought it was strange. I thought to myself, why would a couple get divorced if they couldn't have a child? But I understand now when the same happened to me. So, I wouldn't have been surprised if our marriage had ended. You see, after some time, it becomes impossible to stay with each other without fighting about the most trivial of things. But one day I finally decided to stay and fight this battle. I had spent so long fighting, my body had been through so much, I didn't want to run away. I realised that I have to start answering people whenever they taunted me in any way. I had suffered enough. Why should I? That's what I told myself...I know that if I had decided on divorcing my husband, everyone would have immediately blamed and taunted me . Without thinking what I have been going through, people would say things like she couldn't give him a child, and on top of that, instead of trying, she quit. People pretend to be modern and educated but when it comes to such things, they don't hesitate from pointing fingers at the woman…Even if in my frustration and anger I spoke about divorce, I knew that as a woman without a child and a husband in our society even in today's time is very difficult. And I didn't know if I was mentally strong enough to cope with that. Also, it was about mine and Kunal's family. It wasn't their fault in any way. I knew people would not hesitate from saying things to our family members either and I didn't want them to suffer because of my decision."
> (Neeta Saha)

Bharadwaj (2016, p. 85) suggests that the pursuit of assisted reproduction "becomes a sieve through which only the *strongest conjugal partnerships* can pass given their *unwavering commitment* to each other" (emphasis mine). I am, however, not completely convinced with Bharadwaj as this unwavering commitment could either be a positive reflection on a couple's quality of marital relationship as he seems to imply or arguably the commitment could be a performative gesture or a façade maintained by a couple in order to avoid disclosing their marital problems to other people and perhaps, to also buy time for trying to save the marriage from falling apart. Based on the Kanika's and Neeta's excerpts as aforementioned, we can see that there are reasons other than a couple's unwavering commitment based on which the women decided to continue their marriages despite having contemplated about divorce – reasons which were not particularly related to strong partnerships and shared commitment. For both women, their reasons to consider divorce at a certain moment in their distressed lives was related to the social pressure from the in-laws as well as to their intensely strained marital relationship as a result of the reproductive disruptions. Nevertheless, both women ultimately adapted to and negotiated with their social, familial, and marital constraints in active and passive ways and decided not to proceed with the divorce - an illustration of their processual agentive capacities with which they re-created their world. On the one hand, Kanika decided to "shut her eyes, close her ears" and go through with whatever came her way, ignoring what people said in order to save her marriage and to maintain her sanity. Neeta, on the other hand, utilised a different and more active strategy to adapt with her constraints by deciding that she was not going to tolerate any more taunts from people and start answering back as she had decidedly suffered enough. Neeta further made the decision that she did not want to leave the "battle" mid-way – a battle in which she had invested her time and energy for a considerably long time and one in which she had been through a physical ordeal. Moreover, both women referred to the societal stigma and blame that women in the Indian society would have to endure if they were divorced and childless.[163] They did not wish to be blamed for not having tried enough to have a child.[164] As I have mentioned earlier in this chapter , one of the reasons for women deciding to continue infertility treatments was to not be blamed for being complacent in the face of adversity (see Franklin, 2013, p. 749).

Besides, Neeta's explanation for not ultimately going through with divorce was also related to her concern about the repercussions that her husband's family and her natal family would have to face socially. It is interesting to note here that while the same middle-class female interlocutors who had represented themselves as modern subjects in regard to their decisions about selecting their own marriage partner (see section 6.6) or in the consumption of high-tech biomedical treatments and reproductive technologies (see chapter three), when it came to the issue of divorce, the so-called traditional values of honor and family's reputation were accorded significance. This particular observation can be understood by following Liechty's (2003, p. 37-38) reasoning that

> "…members of an emerging middle-class meld preexisting local cultural narratives (such as notions of propriety, orthodoxy, and honor) with "modern" logics of value and truth (achievement, progress,

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[163] Herein, I agree with Bharadwaj (2016, p. 84) when he asks while a man can choose to walk out of a barren marriage with his dignity intact, what about the great majority of women for whom this option is unavailable?

[164] See Inhorn (2002) for a discussion on how women are blamed for reproductive failings and expected to seek treatment even when it is the husbands who are diagnosed as infertile.

> development) in their efforts to construct a new sociocultural space and claim legitimacy for their own class values."

The notion that the honor of a middle-class, upper caste traditional family is tied to the women in that family has been discussed extensively in literature (for e.g., see Chowdhry, 2007, 2005, 2001; Derné, 1994; Guzder and Krishna, 1991; John and Nair, 1998; Mody, 2008; Uberoi, 1998; Vishwanath and Palakonda, 2011). It has also been noted that the meaning of divorce or separation varies from one caste (and class) to another. For instance, among the non-elite, lower caste groups, and tribal communities in India, studies have shown that divorce and remarriage are socially accepted and practised (see Palriwala and Kaur, 2014, p. 9; see also Aura, 2006; Chakravarti, 2003; Holden, 2008; Kapadia, 1995; Unisa, 1999). However, among the higher castes (and middle classes), divorce or separation is considered shameful and there is a risk of being socially stigmatised (Aura, 2006, p. 172). As Devi's (1998, p. 76 in Aura, 2006, p. 197) study shows, nearly half of her divorced female respondents were persuaded by their family members and relatives not to opt for divorce by arguing that such an act would bring shame upon the entire family. While actions 'appropriate' to tradition and duty maintain the family's honor and purity, 'inappropriate' actions (such as divorce), defiles it (Chakravarti, 2003, p. 148-149; see also Uberoi, 1998, p. 306). The cultural ideology of honor, a highly gendered notion in India, ascribes the woman, and especially her body and procreative capacity, as the repository of family honor (Vishwanath and Palakonda, 2011, p. 387; see also Chowdhry, 2007, p. 16-17; John and Nair, 1998, p. 8). As such, given that honor is perhaps the most cherished value in middle-class Indian families, that cherished honor is lost through the 'improper' behaviour of that family's women write Vishwanath and Palakonda (2011, p. 386). As Donner (2008, p. 60-61) has also noted, for the reputation of Indian middle-class families is an important aspect of their lives which they need to preserve as opposed to the poor who reportedly "have nothing to lose". Indeed, a divorced, middle-class woman in India challenges the dominant discourses and patriarchal codes in a society which defines a woman's honor according to her relation to men: fathers, husbands, or sons (Aura, 2006, p. 171-172). As such, I suggest that Neeta's decision to ultimately not separate from her husband was partially grounded in reasons of her own as well as her husband's family's honor being at stake as both she and the families would reportedly have to face questions from others about the divorce.

It is important to mention here that I do not understand Kanika and Neeta's final decision of not divorcing their husbands, continuing to undergo infertility treatments in their quest for a child, and adapting to or negotiating with their various constraints as acts of submission. Instead, I take cue from Polit (2006) and Shaw (2016) to see both women as agents who engaged in conscious and strategic acts which would enable them to not only achieve reproductive success and resume normalcy in their marital and social relationships but would also allow them to be seen by other actors as women who did not quit in the face of hardships. As Polit (2006, p. 339) has aptly argued, "…instead of interpreting a woman's behaviour as submission to domination, this woman can simply be seen as acting in a way that she knows will make people think she is a 'good woman'". As other scholars have also noted, instead of viewing apparent acts of submission and silence by women as one-sided understanding of male domination and power, they can be read as "conscious strategies of self-representation, deployed when it is expedient to do so before particular audiences and in particular contexts" (Raheja and Gold, 1994 and Trawick, 1990 in Polit, 2006, p. 339).

I now discuss the case of the only female interlocutor in my study who divorced her husband after regular marital conflicts and other events triggered by the occurrence of reproductive loss. I show how in the process of making this decision, she transgressed the patriarchal boundaries which define the 'traditional middle-class good wife' while still being embedded in the existing social discourses regarding how divorced women are perceived in the Indian middle-class context.

6.5.1. Divorce better than Distressed Marriage: The Exception

Neha's pregnancy was medically terminated in the 16th week of gestation as her baby had been diagnosed with a genetic anomaly (see chapter five). When I met Neha during my pilot study in 2015, she mentioned that she was legally separated from her husband and was living with her widowed mother. During the second interview a year later, she shared details about how her marriage had taken an emotional toll on her since her baby's death and that the ensuing events had confirmed her decision to file for a divorce. I was curious to know the ground(s) on which Neha filed for the divorce because according to Indian law, infertility is not a valid reason although impotence entailing the physical inability to consummate the marriage or the refusal of one spouse to do so can be a legally valid reason (see Chaudhari, 2012). Moreover, infertility is also not considered as a legal ground for divorce because, "first, marriage serves more social purposes than merely the biological purpose of procreation of children, and second, there are several alternatives to infertility such as medical treatment or adoption which are available irrespective of one’s caste and class in society” (Dutta, 2011, p. 186). When I asked Neha about the grounds for divorce, she told me in detail about the adultery and emotional abuse she had experienced since the death of her child:

> “The problems in my marriage mainly started after my pregnancy was terminated. My husband had stopped paying any attention to me and we had started fighting almost every day. He behaved with me as if it was my fault that our baby had died. Any fight we had, he would not fail to point fingers at me. He would drag my distant uncle into the argument and say that our baby had a genetic problem because that uncle of mine was abnormal. He had started verbally abusing me and he would say horrible things to me during our arguments. I was scared of him because he had a very bad temper. Tell me, is it my fault? What could I have done? But he always said that it was my bad karma that affected our child. Can any mother ever hurt her own child? *became teary-eyed* He would often say that what kind of a woman are you who can’t carry a child? This was his weapon - to hurt me where it hurts the most. Like a fool, I would listen to all this and keep crying. I had also started blaming myself for the death of my baby. So yes, these things kept happening for more than a year.. The atmosphere at home was very bitter. We were a married couple only as a joke, that’s it. Only married for the outside world! He had no interest in talking to me. We had become like two strangers in the same house who spoke to each other only when required. He was only concerned with his job and would spend most of his time travelling abroad for work. It was after a few months of his travelling that I sensed something was not right. I had a gut feeling that his travelling for work was an excuse for staying away from me. Whenever he came home or even when I tried talking to him when he was away, I suspected that he was having an affair, or maybe even multiple affairs, who knows! I mean, he never told me this obviously, but one day I saw that he had written single in his job contract when asked for his marital status! Such a bad man! Why would anyone write single when he is married if he did not have any bad intentions? I wish I had known about his character before, then I would have never married someone like him. I actually started suspecting him when he showed absolutely no interest in the bedroom when he would be at home for a few weeks between his projects abroad. Before these incidents happened in our marriage, he had always been very keen about physical relations. But during that time, he used to show no interest. I tried many times to initiate something hoping that he would behave nicely with me but he always rejected me and gave some excuse. Forget physical relations, he would barely touch me! It was as if I was an untouchable! Naturally, things between us became worse with time. I was constantly frustrated because on the one hand my mother-in-law kept pressuring me – have a child, have a child – that was like a hymn for her – and on the other hand, my husband had no interest in behaving normally…Anyway, one day I decided to go through his phone as I didn’t know what else to do. I knew that if I asked him directly about the affair, he would refuse. Will any thief tell you he was stealing if you ask him? So I checked his phone to confirm my suspicions. That’s when I saw photos of him with another woman. They both were standing close to each other, smiling. In one photo she was kissing him on the cheek. The woman didn’t look Indian. I was devastated. I blamed myself at first thinking that maybe my husband was right. Maybe, if our child hadn’t died, then he would not have gone to someone else. But I came to my senses soon after speaking to my best friend. I realised that none of this was my fault and that it was his fault and that he was a bad person. I am glad that I am no longer married to that horrible man. I now live with my mother. I could not remain married to a man who has no sense of what is right and wrong. I now focus on my work and my relationship with my mother and my friends. Obviously at my age I can’t marry again, not in our society, which doesn’t see divorced women in a good light. But I am happy I took this decision before I ended up in a mental hospital because of my husband and his mother! I decided that I’d rather stay single than be in an awful marriage. See, the problem in India is that people think that as women our one and only task is to produce children. Are we a factory which can produce a baby every time? And God forbid, if something goes wrong, then of course, it’s the woman’s fault! Even the most educated

> people you meet, they also think the same way. I am tired of this constant drama - have a baby, have a baby! But I am done with all this. I simply don't care anymore what society thinks and says...Naturally, I feel sad whenever I think about the mishap with my child but I know in my heart, it was not my fault. It was a rare case and as Dr. Ganguly also said, it happens to one in a million. Maybe it was just my bad luck or God's wish, I don't know. Whatever it is, I am happier now. I feel more calm. I no longer feel like I am in a prison *smiled* Maybe God knew that bringing a child into this world with that man as a father and that woman as a grandmother would be horrible for the child. Maybe that's why my life took this turn. This is why people say, that sometimes when something bad happens, it's only later when we realise that it happened for a reason."

Let me point out right away that after reading Neha's excerpt, the reader could potentially claim that Neha filing for a divorce was an exception in the sense that it was not only a case of marital conflict following reproductive loss but also that her husband had allegedly committed adultery. It could also be speculated by the reader that Neha's marriage eventually ended not because of the event of reproductive loss in itself but rather because of the husband's deceit and adultery. However, my focus here is not specifically on why the marriage ended. Instead, while accepting that this was certainly an exception in my study, I am concerned here with Neha's subjective experiences which suggest that it is the incidence of reproductive loss and her presumed reproductive failure which triggered a domino-effect for her wherein it was the marital conflict after the loss which led to adultery and subsequently, separation and divorce. Of course, it could be said that Neha's husband might have had an extra-marital affair irrespective of whether they had a child together or not. However, my observations and analysis are based solely on Neha's narrative in order to show how reproductive disruptions can unsettle certain marital relationships and how she exercised forms of strategic agency within the existing discursive frameworks which had bounded her in certain ways. Indeed, I suggest that if one were to view the entirety of Neha's experiences and lived realities following reproductive loss, then it is important to be cognizant of the above-mentioned events which she narrated regarding how she exercised her constrained agency and took control of her life in whichever way she deemed best.

While divorced women in India are often perceived as passive, suffering victims (Aura, 2006, p. 192), Neha decided to continue her life without subscribing to the societal standards for an ideal middle-class Indian woman. Her decision to not tolerate her husband's emotional abuse and ultimately divorce him shows how she transgressed the middle-class morals which prescribes the wife's subordination to her husband and considers divorce as a taboo. Her strategic agency lies not only in making those decisions but also in giving newfound meaning to her life irrespective of whether she has a husband or a child. Even though Neha felt that remarriage is not an option for her given that divorced women in the Indian society are not seen positively, she explained how she found meaning in her life through her relationship with her mother, her friends, and at work. Further, although she did not adhere to the dominant cultural ideology which grants social personhood to a middle-class Indian woman by becoming a wife and a mother, she did accept that re-marriage for her was not an option due to the societal constraints in regard to the remarriage of divorced women who are not seen in "a good light" (see Holden, 2008). Indeed, Neha's case is a good illustration to prove Butler's argument according to which an actor's agency is determined by the underlying constraints of the existing discursive framework and it is also within this framework that acts of disobedience and transgression occur (Polit, 2006, p. 22).

In addition, Neha's rationalisation regarding the loss of her baby is a further testament to her agentic capabilities. At first, Neha said that she had felt that the chain of events starting from the regular arguments with her husband and ultimately, his extra-marital affair, would probably have not transpired if she had given birth. Eventually though Neha had accepted that it was not her inability to give a child to her husband which had led to his affair but rather because he was, as she said, "a bad man". She proceeded to rationalise the episode of reproductive loss in her life either due to God's wish or her own luck or because raising a child with her husband and mother-in-law would have been "horrible" for the child. Finally, Neha's agentic capacity was also indicated by her introspections regarding the social pressure on women to give birth. She pointed out that the problem in India was that a woman's only task was considered to be procreation. She went on to state that women were not a factory that could produce a baby every time, unfailingly. Referring to the constant drama and societal insistence on a woman to procreate, Neha said that she was happy to be no longer dealing with it. Whether it was Neha's resistance to undergo IVF as discussed earlier in this dissertation (see chapter five), her decision of divorce, her introspective reflection on her life's purpose (which she no longer wanted to achieve through marriage and motherhood), her rationalisation regarding the occurrence of reproductive loss, and her decision to not partake in society's drama regarding procreation – all of these are illustrative of the processual forms of constrained but strategic agency which Neha utilised at different moments in her life. Indeed, instead of situating herself outside cultural configurations, Neha, recreated her life and found alternative ways to give meaning to her life within the existing social discourses.

6.6. Conclusion

I had noticed that of the diverse roles performed by some of the medical practitioners at the infertility clinics in Kolkata (see chapter four), the role of a (quasi)counsellor was rather crucial. The counselling offered largely pertained to the couples' marital distress that was triggered by the occurrence of reproductive loss(es) and which worsened over time the escalating social as well as internalized pressure to achieve reproductive success. As clinic B's infertility specialist, Dr. Sen said to me during an informal conversation, "I have saved many marriages. At times I feel like a marriage counsellor more than an infertility specialist!" In regard to this, infertility clinic A's counsellor pointed out:

> "In my one year of being a counsellor at the clinic, I have received only five or six couples. The couples who did visit spoke less about the treatments or the family's pressure to have a child and much more about their unstable marriages. The wives wanted advice on how they could strengthen their relationship. They cried and vented whereas the husbands hardly spoke. The women usually spoke about having regular arguments and how they were being pressurised into conceiving again. A common complaint from women was that their husbands had no interest in sex. When I encouraged the husbands to speak up and share their thoughts, they only said a few words. I even tried speaking to the husband and wife separately, but the situation did not change. I was not surprised though because Indian men are uncomfortable speaking about personal matters with a female doctor and also in front of their wives. Also, whenever I asked a couple to visit me after their first session, they never returned. See, it's the stigma we have in our society about therapy. People will happily go to the doctors repeatedly for a simple cold or fever. People in India are willing to spend money and go through all kinds of surgeries to have a child but nobody wants to see a psychologist for their mental well-being. At times I think I should have become an infertility specialist. I would have definitely made a lot more money! *laughed*"

As I have described throughout this chapter, marital relationships of the female interlocutors in my study were profoundly disrupted as a result of reproductive disruptions and prolonged treatment intrusiveness – a theme which had emerged prominently and recurrently during the interviews with most of my female interlocutors. I have shown that within the discursive constraints which prescribe the gendered performance of an ideal middle-class, married Indian woman as modest, chaste, submissive, and sexually passive and the conjugal constraints where their role was reduced to that of a procreative body, the female interlocutors utilised several forms of constrained but strategic agency. They did that by not enacting themselves exclusively as women whose gendered identities were defined exclusively by marriage and motherhood and neither did they represent themselves as passive, repressed, and helpless victims of their circumstances. Instead, it was through their transgressive gendered practices that they made room for the utilisation of forms of strategic agency. For instance, while some female interlocutors enacted themselves as sexual agents who desired sex, there were others who exercised their passive agency by reflecting on their roles as women within their marriages.

After discussing the making of the middle-class Indian woman based on relevant literature in the second section, in the third and fourth sections I have shown that the women compared the dynamics of their marriage before and after the reproductive disruptions. According to them, there was a loss of normalcy in regard to romance and sexual intimacy in the light of reproductive loss followed by the stress of pursuing assisted conception. In order to restore a semblance of normalcy, the women proposed everyday activities with their husbands such as dining out. The women also attempted to initiate sexually intimate acts as the husbands had been displaying a lack of interest in having sexual relations. However, as I have shown, the transgressive attempts of the women representing themselves as sexually assertive persons who desired sexual intimacy for pleasure, and not procreation, was met with disapproval, anger, and irritation from the husbands. Words such as bad, cheap, dirty, and desperate were used by the husbands to indicate that middle-class Indian women from ‘good’ and ‘decent’ families were not meant to behave in such ‘immoral’ and ‘dishonorable’ ways, especially since they had been unable to or had *failed* to fulfil their sacred ‘duty’ of procreation. In the fifth section, I have elaborated on women’s utilisation of their constrained agency by showing that some female interlocutors reflected on how divorce might have been a better option for them than suffering in their distressed marriages. Nonetheless, they eventually decided not to end their marriages - with the exception of one woman - because they wanted to avoid the stigma that divorced and childless middle-class women would have to face in India and the blame that would be placed on them by other people for not having tried hard enough to have a child. Their decision to not divorce their husbands was also related to their concern about not putting their own honor and the honor of their families at stake.

So far in this dissertation, my primary focus has been on the subjective experiences and lived realities of the female interlocutors. Although the male interlocutors’ were not subjected to the same level of medical scrutiny and surveillance as the female interlocutors, they did nevertheless suffer from the anxieties regarding certain (embodied) experiences which I address. As such, the next chapter is concerned with men’s reproductive motivations and practices within the broader context of reproductive loss, involuntary childlessness, and wanting to achieve reproductive success as well as the enactment of multiple masculinities.

Chapter 7. Men's Reproductive Aspirations, Practices, and Experiences: The Enactment of Multiple Masculinities

7.1. Introduction

Given that reproduction is not an exclusively female or woman-led experience, this present study warrants that I pay attention to men's reproductive experiences as well, especially given that the husbands played an important role in the ways in which the female interlocutors experienced reproductive disruptions. As I have mentioned in chapter one, there is a paucity of anthropological research on men's reproductive practices and embodied experiences, particularly in South Asia. As Osella and Osella (2006) have pointed out in regard to the absence of men as the "explicit object of study" in South Asian ethnography,

> When we look at south Asian ethnography with the intention of searching for an understanding of men, masculinities and masculine hierarchies, we encounter an ambivalent situation: men are certainly present—even too much present—in the ethnographic record, but they are generally not the explicit object of study, nor is much attention paid to analysing the gendering of their behaviour and their relationships with others. Men as a specific focus mostly appear in two particular and bounded sets of literature: that on the putative south Asian 'culture-bound syndrome' of semen-loss anxiety[165]; and in historical analyses of masculinities under colonialism (Osella and Osella, 2006, p. 4).

In order to address this gap in anthropological research, especially in the middle-class urban Indian setting, I depart from the centrality I have allocated to women's experiences so far in this study and deliberately shift my focus to presenting the male interlocutor's aspirations, motivations, and experiences in relation to their desire for biogenetic fatherhood (or the absence of it in select cases), their role in reproductive-decision making, their understandings of conception, their experience(s) of childlessness resulting from reproductive loss, their treatment-seeking practices, and the ways in which they made sense of their loss.

By delving into these above-mentioned themes, I highlight the multiple ways in which masculinities were narrated and enacted by the male partners in my study. I use the term masculinities here to imply multiplicity (and not plurality, see Mol, 2002 in chapter two) since the male interlocutors did not enact a singular masculinity in the sense of a fixed, coherent, and homogeneous category that is not amenable to change in varying relational contexts and

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[165] In studying masculinity in India, scholars have paid attention to the 'culture-bound' syndrome of the "*dhat* syndrome" in order to explore the ideas attached to the importance of preserving the semen (for e.g., see Alter, 1997; Paris, 1992) The word *dhat* is derived from the Sanskrit word *dhatu* which means vital essence and it is considered to be "the most concentrated, perfect, and powerful bodily substance" (Paris, 1992, p. 109).

over time (see Connell, 2005; Dudgeon and Inhorn, 2009). My overall argument in this chapter is that examining men's lived realities, (embodied) experiences, anxieties, vulnerabilities, and the multiplicity of enacting masculinities allows us to understand that men's reproductive aspirations, motivations, and practices are far more complex and nuanced than the concept of hegemonic masculinity allows. To that end, I show that the male interlocutors enacted different ways of *being* men, at times within the same narrative, and in the process, agentially challenged and countered the normative forms of manhood. Subsequently, I also show how some male interlocutors were compelled (by other actors, such as medical practitioners and ARTs) to enact certain forms of normative masculinities within the biomedical sites of infertility clinics. Throughout the chapter, I will show that the multiple masculinities enacted by the men were largely shaped by and embedded in the discursive norms of kinship, biogenetic relatedness, pronatalism, and the gendered notions of procreation that prevail in the South Asian context. I draw on Butler (1993) to show that the performance of these gender roles within the existing discourse(s) involves a repetition of gender norms that occurs under conditions of cultural constraint(s) which while compelling some appearances of masculinity, prohibit others (see Brickell, 2005, p. 26). As such, the necessity for repeated and continuing performance(s) by the men in their enactment of masculinities is exemplified throughout the chapter, while also accounting for the exceptions which demonstrate variety and novelty in how diverse masculinities are enacted.

In order to present my ethnographic findings, I have divided this chapter into five sections. Having introduced the chapter's concerns in this first section, in the second section I offer an overview of the relevant literature related to the normative understandings of masculinities, focusing on the concept of hegemonic masculinity that informs the analytical discussions. In the third section, I engage with the interview excerpts of the male interlocutors who expressed their natural desire to become fathers as well as their anticipation and enthusiasm to partake in their child's upbringing. I suggest that on the one hand, this articulation of a desire for fatherhood was discursively shaped by norms of pronatalism and parenthood as inevitable, natural, and thus, normal rites of passage of adult life in patriarchal societies (see Inhorn, 2003a). On the other hand, I claim that the eagerness to be involved in raising the wished-for child is partially related to the middle-class background of these men who desire one or two children, thus, indicating newer forms of fatherhood in contemporary India which reflects a form of "caring masculinities" (Elliott, 2015). I then introduce contrasting examples to show that a few male interlocutors challenged this apparently natural desire for fatherhood by articulating their lack of an inherent yearning for children. I argue that their ideological ‘deviation’ from the norm that prescribes fatherhood as a prime way of *becoming* men and yet agreeing to have to a child to fulfil their wives’ (‘natural’) reproductive desire is an illustration of “emergent masculinities” (Inhorn, 2012).

In the fourth section, I present the narrative of one male interlocutor who responded to the episode of reproductive loss by being compassionate towards his wife while simultaneously adhering to the norms of hegemonic masculinity insofar as he engaged in “restrictive emotionality” (Jansz, 2000). I show that this interlocutor did not question his manhood in relation the occurrence of loss, since as he pointed out, the “problem” did not lie with him. In the next section, I introduce the case of another interlocutor whose inability to impregnate his wife resulted in him emasculating himself. This particular narrative, however, is not simply about his subjective experiences of his perceived loss of manhood. Instead, as part of enacting what I refer to as “vulnerable masculinities”, he expressed his emotional distress during the interview by crying while however stating that as the husband he had no option but to remain strong in his wife’s presence. This example, like the others in this chapter, helps me in corroborating my argument that masculinities are enacted as multiple and relational.

Finally, in the fifth section, I describe the male interlocutors’ views on semen collection, donor insemination, and adoption - the trifecta which, I suggest, poses a threat to the enactment of being ‘real men’. I address the conflation of masculinity, (hetero)sexuality, and virility by examining men’s narratives and their lived realities regarding semen collection, donor sperm-induced conception, undergoing Testicular Sperm Epidydimal Aspiration (TESA) to achieve “authentic fatherhood” (Goldberg, 2009, p. 206), as well as their views and attitudes towards adoption. I look at how the availability and access to ARTs, such as TESA and Intracytoplasmic Sperm Injection (ICSI), enables infertile men to have a child conceived with their own sperm. I argue that the prospect of the middle-class male interlocutors to have a biogenetically related child by using these reproductive technologies compelled them to enact normative masculinities by reinforcing the need for genetic ties to establish paternity. Finally, I unpack the invisible but dominant hierarchy which exists in the inclusion and acceptance of a third party input at infertility clinics where I show that adoption was the least preferred option in having a child and that men would rather prefer donor sperm-induced conception.

7.2. Normative Masculinities: An Overview of Literature

According to Connell and Messerschmidt, masculinity can be understood as

> “the pattern of practice, i.e. things done, not just a set of role expectations or an identity” or as a configuration of practice which “represents not a certain type of man but, rather, a way that men position themselves through discursive practices” (Connell and Messerschmidt, 2005, p. 832, 841).

Likewise, in regard to the praxis of masculinity, Dudgeon and Inhorn have argued that men

> “do not simply fill static roles and identities; rather, they must perform masculinity as an ongoing process drawing on existing sets of behaviours and ideas while allowing for innovation and change over time” (Dudgeon and Inhorn, 2009, p. 80).

While masculinity is produced socially, it is embodied by men in different ways in the process of *being* male. The enactment of manliness, explains Srivastava (2010, p. 1), is manifested in different ways such as manners of speech, behaviour, gestures, social interaction, and a division of tasks deemed proper for men and women. Srivastava further explains that the representation of masculinity is done in a manner that it stands in contrast to (actual or imagined) femininity. Moreover, it has also been suggested by scholars such as Gilmore (1990) and Inhorn (2003a) that masculine identities and roles need to be performed more vigorously than feminine identities because of two reasons. Firstly, because masculine identities are more tenuous and secondly, while women can demonstrate their ‘femaleness’ through pregnancy and childbirth, men cannot demonstrate such a physical embodiment or concrete realisation of their gender. However, dominant masculinity is posited not just in opposition to femininity, but “also to those ways of being male that are seen to deviate from the ideal” (Srivastava, 2010, p. 1). In writing about the “hegemonic masculine identity”, Srivastava notes,

> masculinity possesses both external (relating to women) as well as an internal (relating to ‘other’ men) characteristics. Both these contexts assist in bolstering what scholars have referred to as ‘hegemonic’ masculine identity . So, the heterosexual, white-collar married male who is the ‘breadwinner’ is a useful (if somewhat caricatured) type to think about hegemonic masculinity. For, embedded in this representation is an entire inventory of the behaviours and roles that have been historically valorised as becoming of ideal masculinity. Hence, the dominant modes of being men could be said to be manufactured out of discourses on sexual orientation (heteronormativity), class, race, conjugality, the ‘protective’ function of males and women as recipients of protection, and the place of emotions in the lives of men and women (Srivastava, 2010, p. 1).

Based on Gramsci’s concept of hegemony, Connell (2005) defines “hegemonic masculinity” as the strategy for being a man or a pattern of normative practices enacted by men which legitimises patriarchy and allows for a hierarchical and gendered social dominance over women (and other men who do not comply to such norms) to prevail. My concern in this chapter, however, is not with men's dominance but rather, with the discursive framework of hegemonic masculinity which provides me with the backdrop against which my findings are situated. Even though hegemonic masculinities vary across cultures, they often share certain traits (Inhorn and Wentzell, 2011, p. 802). Indeed, several scholars have conceptualised "hegemonic masculinity" as the kind of ideal masculinity or the dominant mode of being a man which can be characterised by four prominent attributes – autonomy (not admitting his dependence on others), achievement (the breadwinner), aggression (tough) and emotional stoicism (avoidance of grieving openly or sharing feelings of pain) (see Connell, 2005; Cousineau & Domar, 2007; Culley et al., 2013; Donaldson, 1993; Dudgeon and Inhorn, 2009; Fahami et al., 2010; Herrera 2013; Hinton & Miller, 2013; Inhorn, 2007; Inhorn and Wentzell, 2011; Jansz, 2000; Srivastava, 2010; Webb & Daniluk, 1999; Wischmann & Thorn, 2013). As such, wealth, attractiveness, virility, physical strength, heterosexuality, sexual prowess, and emotional detachment are commonly seen as the qualities which characterise hegemonic masculinities and are deemed necessary for the enactment of conventional gendered scripts of how to be a man. Conversely, "subaltern masculinities" (also referred to as "subordinate, "alternative", or "non-hegemonic" masculinities) embody the opposite of these so-called ideal attributes, characterised for instance, by the inability of men to perform sexually, a performance which is manifested through the ability to have erections, ejaculate through masturbation, and impregnate a woman (Dudgeon and Inhorn, 2009, p. 4-5,81). Although hegemonic masculinity is not enacted by all men universally, it is the normative kind of masculinity that embodies the "most honored way of being a man" and it tends to subsume other kinds of subaltern or subordinate masculinities, argue Connell and Messerschmidt (2005, p. 832,846). In a cross-cultural study of masculinities, Gilmore (1990, p. 4) has further observed that hegemonic masculinity as "the manhood ideal" is a culturally imposed ideal which men must conform to whether or not it is a reflection of their individual psychological make-up. Thus, in sociocultural contexts where models of hegemonic masculinities, or ideal masculine behaviour and identity are the norm, the inability to achieve and successfully enact these ideals causes distress for many men (Dudgeon and Inhorn, 2009, p. 81).

Of the various norms which define the socio-culturally approved way of being an adult male in the pronatalist Indian or broadly South Asian setting, the present chapter is concerned with norms which significantly inform and shape the enactment of masculinities by middle-class men in urban Kolkata in relation to fatherhood, (non)reproduction, and assisted conception. As such, the norms I refer to most notably are heterosexuality, male virility, the importance attached to semen and sperm as the "life-giving" substance[166] for enacting kinship and relatedness, and emotional restraint. As I have discussed in chapter one, the achievement of biogenetic fatherhood is undeniably a crucial life stage in the enactment of normative masculinities in pronatalist societies as well as for achieving social and gendered personhood for an adult male. Throughout this chapter, I draw on the existing body of literature which has established that in such pronatalist societies, whether that is in the 'Global North' or the 'Global South', biological fatherhood is the normative expectation for adult males and is associated with hegemonic concepts of masculinity (for e.g., see Barnes, 2014; Chowdhry, 2005; Dolan et al., 2017; Dolan and Coe, 2011; Dudgeon and Inhorn, 2009; Hadley and Hanley, 2011; Inhorn, 2009, 2003a, 2003b; Morell and Richter, 2006; Osella and Osella, 2006; Pujari and Unisa, 2014; Rutstein and Shah, 2004; Throsby and Gill, 2004; Tjørnhøj-Thomsen, 2009). For instance, Herrera (2013, p. 1063) notes in his study of masculinity and reproduction in South America that "paternity is a fundamental step in the path of an adult man since procreation proves his heterosexuality and masculinity". The limited body of research which exists on fatherhood in South Asia (see chapter one), has also shown that becoming a father is intrinsically associated with the enactment of masculinity and maleness. Given that the desire for biogenetic fatherhood and the achievement of it thereof is the site through which heterosexuality and male fertility becomes established, the question which arises and that frames this chapter, is that how is a man's enactment of maleness affected if he is diagnosed as infertile and is unable to father a child and/or when his female partner is unable to conceive (or has experienced reproductive loss in some other form)?

Studies have shown that unlike in the cases of female fertility, societal norms and values associate fatherhood and male fertility with virility, sexual competency, and potency (see Gilmore, 1990; Humphrey, 1969; Inhorn et al., 2009). According to Humphrey,

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[166] Scholars have discussed how in most textual and oral traditions in India, there has been a strong emphasis on the father's contribution to procreation (Pande, 2009, p. 383). As Dube (1986 in Pande, 2009, p. 383) has discussed, the patrilineal focus can be seen in the ubiquitous notions of seed and earth wherein seed symbolises the father's contribution whereas earth or the field represents the role of the mother. Notions of procreation, or "coming into being" are, indeed, inherently gendered, placing more value on men, who are seen as created in the image of God, as genitors, and as divinely embodied in the life giving "seed" in the form of sperm (Inhorn, 2009, p. 4).

> Whilst a sense of failure may be common to both sexes, it is only the proud male who regards it [infertility] as an affront to his sexual capacity. For him procreation has always served as a means of demonstrating his virility, whereas it is well known that a woman's fertility gives no indication of her sexual responsiveness. And no matter how bravely he has accepted the discovery at a conscious level, unconsciously the equation with impotence is likely to remain (Humphrey, 1969, p. 52 in Lloyd, 1996, p. 434).

Following Humphrey's argument, Llyod (1996, p. 2) coined the term "fertility-virility linkage", essentially denoting the association between fertility and virility or potency. He claims that this linkage is a key component of hegemonic masculinity and it renders infertility as a potential threat for men. Llyod further suggests that on the one hand while men are disappointed by infertility, on the other hand they may find it seriously threatening due to the fertility-virility linkage, which makes it a sensitive topic for them. As I will show later in the chapter, the diagnosis of infertility renders a man's masculinity at stake – a masculinity which is constitutive of his gender identity and sexuality. As Inhorn (2002, p. 344) notes, male infertility is not only a medical condition which casts doubts upon a man's ability to impregnate his partner through heterosexual, penetrative sex but it is also a sexual condition which implicates and deeply challenges normative male sexuality, masculinity, and paternity, which becomes deeply distressing for men in societies where "to be a man" means to be a virile patriarch who begets children, particularly sons. Indeed, as cross-cultural studies have indicated, the failure to procreate at the desired life juncture due to infertility often constitutes a major life crisis and a crisis of masculinity for prospective fathers (for e.g., see Chowdhry, 2007; Khan et al., 2008; Mikkelsen et al., 2013; Throsby and Gill, 2004). For instance, Inhorn's (2003a, p. 240) study in the Middle East shows that male infertility as a "reproductive impairment" is "profoundly emasculating and thus, a delicate and invisible subject". Fahami et al.'s (2010) study in Iran suggests that the stress created by male infertility can be equated to similar levels of trauma experienced by the death of a child or a spouse. It could be extrapolated from such studies that male infertility, then, is the form in which reproductive loss is experienced by men.

Furthermore, Van Balen and Inhorn (2002) argue that involuntary childlessness caused by infertility has profoundly gendered social consequences for both women and men which are graver in non-western social settings where the pronatalist social norms are stronger as compared to their western counterparts. For instance, a handful of studies in India have shown that there are considerable social disadvantages, such as the loss of self-esteem, which a man has to bear for being unable to produce a genetically related child (see chapter one). Studies in other parts of the world have also shown that the loss of social status and societal power, lowered self-image and self-esteem, identity loss, compromised manhood, feeling ashamed, emasculated, disabled or stigmatised, a self-perception of being losers, and/or heightened insecurities were some of the prominent effects observed among infertile men (for e.g., see Gannon, Glover and Abel, 2004; Humphrey, 1977; Inhorn, 2002; Nachtigall et al., 1992). Indeed, as I also show in this chapter, the desire for biogenetic fatherhood and the achievement of it thereof, is the site through which heterosexuality and male fertility become visibly established and also through which normative masculinities are enacted.

7.3. "What is there to think?": The Naturalness of Desiring Biogenetic Fatherhood

At the time I met Raj and Khushi, she was in the second trimester of her pregnancy after having suffered a miscarriage in her first pregnancy (see chapter three). On asking Raj his reasons for wanting children, he looked at me, discernibly surprised, and said:

> "That is a strange question! Having a child is the most normal thing after marriage. It's how nature works. It's how life moves on. Whether it is humans or animals – it is the most natural thing in the world! This is how generations move on, right? *I nodded* Who wouldn't want that to happen? And having a child is nature's rule, it is as natural as eating, drinking, and sleeping! If you think about it, this is how God has created us. I mean, our bodies are designed in a way that a woman can become a mother and a man can become a father. Both Khushi and I really love kids. We both knew we wanted kids as soon as possible. That was actually one of the first things we talked about when we met for the first time. I want to raise a child. I want to see it (he used the gender neutral pronoun in Hindi, *usko*) walk, talk, fall, everything. I want to be there for everything. I always tell Khushi that I am waiting to see our child who would look like us and behave like us…We started trying soon after getting married. We didn't think much about it. What was there to think? It happens for everyone, why wouldn't it happen for us? I don't know whether it was our bad luck or it was written in our fate, but this one accident [miscarriage] happened with us. It was obviously a difficult time for both of us. But now, with God's blessing, Khushi is pregnant again and the doctor said that everything is fine so far. Actually, we do not know or even care if it is a boy or girl, but we both want a boy as our first baby. My wife wants to call him Vivaan, that's her favourite name. We don't know if we will actually have a boy, but whenever we address the baby now, we call him Vivaan. We say, for example, Vivaan, how are you? Vivaan, what are you doing now? We talk to our baby like this. Maybe he can hear us. We think that if we talk like this, he will know the voices of his parents. Actually, my father said this one thing to me when I was growing up - becoming a father and raising a child is the best feeling for any man and that it is only after becoming a father that a man learns about many of life's important lessons and what unconditional love truly means. At that time, I did not understand what he was saying. But now, I do. I already feel such love for this child who is still not here! I am eagerly waiting for that special day when my child will come to this world *smiled*."

In order to problematise and unpack the concept of 'natural desire' for parenthood, one of the first questions that I had asked the male (and female) interlocutors was their motivation(s) and reason(s) to procreate. On most occasions, I was met with a look of surprise as to why I would ask such a question because as Raj said, wanting to have a child is "as natural as eating, drinking and sleeping". Moreover, in describing the apparent naturalness of procreation, Raj stated that female and male bodies were designed by God in a way that enables them to become mothers and fathers. Of the seventeen men I had interviewed, fourteen of them had said that they wanted children and that this desire for fatherhood was absolutely natural. In the men's responses, the common themes which appeared were the innate desire to become a father, the naturalness of fatherhood, and the emphasis to have one's own child. Bartholomaeus and Riggs (2017, p. 1) note that the desire to have children requires little explanation or reasoning compared to the decisions of not wanting to have children. The feeling that having a child is something innate or inherent, especially at a certain stage in the life trajectory, partially explains the difficulty in articulating why one wants a child (ibid., p. 8). Pronatalist statements about the so-called natural desire to procreate is axiomatic which positions this desire and drive to have children as unquestioned (ibid.). As Raj said, "We didn't think about it. What is there to think?"

Moreover, for Raj and most of the other male interlocutors, wanting to see their own features being reflected in their children was pivotal (see chapter three for a discussion on the importance attached to relatedness and shared resemblance) – a longing rarely articulated by any of the female interlocutors. As another male interlocutor mentioned, he wanted to see a "mini version" of himself and his wife. I gathered by the end of my research that for the female interlocutors, their desire for motherhood was (mostly) framed as wanting a child but preferably as soon as possible because they were physically and mentally fatigued and did not want to put their body through the treatments any longer, they wanted their conjugal lives to become normal again, they wanted to save their marriage from falling apart, and because they did not want to face any more social pressure, taunts, and blame for the absence of a child. Indeed, how the interlocutors in my study framed their desire for a child was profoundly gendered and shaped by different factors. But returning to the men's desire for shared physical and behavioural resemblance with their child – such reiterations were, indeed, important tropes in how most of the male interlocutors enacted their masculinities.

However, wanting to achieve biogenetic fatherhood was not the only trope through which Raj and the other interlocutors enacted their masculinities given that masculinity is not a homogenous concept and there are different masculinities and correspondingly different ways of being a man. To that end, let me point out the longing expressed by men to pass on their knowledge to their child and to see the child grow. As Raj mentioned, he wanted to experience the joy of teaching his child. Such statements by the men indicate the involvement they intend to have in their child's life as proactive caregivers and not merely as providers or breadwinners. Raj's narrative, akin to many other male interlocutors, suggests that their enactment of masculinities not only adhered to the dominant norms which conflate virility and manhood in the role as the genitor but also reflected their enactment of "caring masculinities" (Elliott, 2015). Developed in many parts of the western world since the 2000s as a strong ally against hegemonic masculinity, the concept of caring masculinities combines contributions from critical studies on men, masculinities, and feminist care theory in order to highlight the reshaping in male identities and practices for gender equality improvements (Cunha et al., 2018, p. 304-305). According to Elliott (2015, p. 13), at the core of the framework of caring masculinities is men's rejection of the dominant norms of masculinities and its associated traits while embracing values derived from the realm of care such as affect, positive emotion, interdependence, and relationality. I suggest that newer forms of fatherhood points towards the enactment of caring masculinities wherein men like Raj "care for" for their child and express their desire to be hands-on fathers. This was voiced through their enthusiasm about their role in raising that child, implied for instance, in Raj's statement: "I want to see it walk, talk, fall, everything. I want to be there for everything". By participating in care work with the wives and being more emotionally invested in the child's growth and future, these 'modern-day' men in a sense, reconstruct normative masculinities to include aspects of 'traditional feminine' characteristics (see Cunha et al., 2018; Elliott, 2015; see chapter one).

Finally, and relatedly, I argue that such an emotional investment in raising the wished-for child is also related to the male interlocutors' middle-class backgrounds. As I have discussed in chapter one, there is a perceptible rise of single-child families in middle-class India in the 21st century where couples are more emotionally and financially invested in raising one or at the most two children which accentuates the intended parents' desire and attachment to that child. Raj spoke about how excited he was for the child even before it had been born. Such excitement, anticipation, and eagerness to be the caring, involved father – all of these emotions demonstrate an intense form of emotional attached to the wished-for child. Moreover, I suggest, that the emotions take on a heightened meaning because in Raj's case, his wife's reproductive trajectory had not followed a normal, i.e., linear progression, given that his wife had previously suffered a miscarriage. As such, the events of non-normative reproduction and the occurrence of reproductive loss had intensified Raj's desire and hope of having his own child and of becoming a father.

Unlike most of my male interlocutors who had expressed their desire for fatherhood as natural and procreation as a normal life progression which fit squarely with the normative understanding of what heterosexual adulthood entails, I now shift my attention to the few male interlocutors who expressed the absence of an inherent desire to have a child.

7.3.1. Questioning the 'Natural' Desire for Fatherhood

There were only three male interlocutors in my study who did not express a desire to attain fatherhood. I argue that given that the enactment of normative masculinities is conflated with becoming a biological father, these three men utilised their agency within the existing discursive framework by reflecting on and questioning the apparently innate desire for fatherhood and it is in this respect that they deviated from and/or transgressed the normative modalities of how to be a man. Even though these men were ideologically opposed to having a children, they nevertheless agreed to it because they loved their wives and wanted to fulfil the latters' reproductive desires which they deemed as 'natural' on account of them being women. Let me present my first example before I delve further into an analytical discussion.

Pratim and his wife, Arunima, are in their early forties and they got married in their late thirties due to their hectic professional schedules (Pratim is a bureaucrat and Arunima is a dentist who manages her own private clinic). During my interview with Arunima, she told me that although she wanted a child, she knew that because of her age and (an earlier diagnosis of) PCOS, conception would not be a smooth journey for her. Although Arunima had conceived once early on in her marriage, she said that it was an accidental pregnancy which had resulted in an early miscarriage. She further informed that she had no intentions of seeking any infertility treatments – one of the only three female interlocutors in my study who made such a decision. In this regard, she said that although the financial investment for such treatments was not a matter of concern for the couple, she was not willing to put her body and mind through the "prolonged trauma of undergoing treatments". Instead, Arunima wanted to adopt. However, her husband was against having children. In my interview with Pratim, he said,

> "I was very clear about this to my wife from the very beginning. I told her that I don't love kids and I don't see any reason why we should have one. But she always wanted a child and was desperate to have one. Actually, I don't even understand why she needs a child. I mean, having a child is a constant headache! School, college, marriage, it's just one responsibility after another and honestly, I have enough going on in my life and I don't need more responsibilities! But Arunima doesn't seem to get this. Anyway, I agreed on the adoption only because I love her and I know that she desperately wants a child…But frankly speaking, I often wonder how I would love something which I never wanted in the first place! Arunima keeps trying to convince me that I will gradually become fond of the child but I highly doubt it! I am just not that kind of a person but somehow, she thinks that there will be some kind of magic which will make me love the child! I mean, it is not even going to be our own child. I asked Arunima, what if the adopted child has some genetic problem that we discover later on? Who is going to be responsible for that? At least if it was our own child, we could have been assured about all this. But with some adopted child from an orphanage, who knows? I don't know, let's see what happens. I am not very convinced right now about how much I will be able to accept and love this child. Who knows, maybe some miracle will happen!"

I eventually asked Pratim if he had faced any pressure from family members or friends to have a child. I also asked him if having a child, or not, affected him in any way as a man in the Indian society. His response to these questions were as follows:

> "Yes, of course I have faced pressure from friends and family. I always knew that was going to happen. In our country, people think it's their birth-right to bother other people with such questions! But I never bothered. I know it is not the same for Arunima because she's a woman. I know that she has to suffer much more than me as more people ask her more questions. I know all of this but I am not going to change my mind because of what people say. People just talk. Will they raise my child? No, right? Then what is their concern if I have a child or not. I have told Arunima also that when people say anything about this matter, just ignore them or tell them that if they love children so much, then should have one! And in response to your second question, absolutely not! All these things about how a person is incomplete without children, all this is utter rubbish! Most people still have these strange, traditional views which they cannot move away from. They do not realise that times are changing and in today's modern time, having a child is not everyone's priority. I don't need to have children to feel like a man. I can drink enough whiskey to show how much of a man I am! *laughed* So yes, in my head I have no such thoughts. It's not easy in India to get away from such pressure but I think that a couple should have a child only if they want to, not because society is telling them to."

Contrary to the male interlocutors in the preceding section, Pratim's responses did not suggest any naturalised proclivity towards fatherhood. While he acknowledged the increased social pressure that women in India face to bear a child as compared to men, he mentioned that this notion of being incomplete without a child is "utter rubbish". Further, he said that he did not need to have children to "feel" like a man and that in "today's modern time", having a child is not everyone's priority. He proceeded to crack a joke in which he equated his capacity of drinking whiskey as a testament to his manhood. Pratim's statement about whiskey is actually germane to the understanding of the enactment of normative masculinity, not through desiring biogenetic paternity but rather through a certain aspect of his lifestyle. As Sehgal's (n.d.) essay on hyper masculinity and print alcohol ads in India suggests, while on the one hand there is an implicit disclosure for a politics of gendered consumption of alcohol (women are usually portrayed as sexualised objects who do not consume alcohol), on the other hand, these ads establish and passively propagate consumption-based masculine identity where certain liquor types and brands are seen as essential for creating a particular kind of masculine lifestyle. In particular, most whiskey ads in India (with whiskey names such as Royal Stag) are evocative of hyper masculine traits such as aggression, competitiveness, toughness, stoicism, a sense of adventure and thrill-seeking, lust, and muscular physicality – ideals of hegemonic masculinity (ibid.)[167]. As I have noticed in popular culture and the public discourse in India, whiskey is referred to as a "hard drink", usually consumed by men, as opposed to "soft drinks" such as wine and non-alcoholic beverages catered to women. There is also a definitive class angle to whiskey given that its consumption is part of the enactment of middleclassness by Indian men. While expensive premium alcohols such as whiskey, rum, and beer are increasingly consumed by middle-class professional men, *dēsī ṭharrā* or local liquor is most notably associated with the lower and working class Indian men.

For further ethnographic elaboration, consider the excerpts of the two other male interlocutors who also did not express the innate desire to become a father:

> "I know that Indian people want a son so that they can pass on their property or give them a proper funeral for the soul's peace. But I honestly think that these are outdated ideas. I don't feel this desperate need to become a father or have an heir who would carry forward my name. I don't agree with all this. We anyway have such a massive population in this country. Bringing more children is only going to make the situation worse. But I know that while I am happy without children, my wife is extremely unhappy. So, I cannot say any of this to my wife, you see. She's already under huge societal pressure. I love her, she's my life partner, so I cannot hurt her. She is already hurting a lot. I see how she stays quiet and deals with all the pressure from relatives and friends on a daily basis. I feel bad saying this but my own mother has said very hurtful things to her. I have told her to stop but the older generation is unable to understand how these things affect a person psychologically. And I don't want to add to her sadness and pain by saying that I don't want a child and that we should stop spending so much time and money on these treatments. I understand that for her it is absolutely natural to want to become a mother. She is a woman after all. But I think it's not like this for men. I am happy if we have a child but it's not as I *need* a child. Since I am her husband, I will do whatever I can in my capacity to ensure that we get a child because I know her happiness lies in a child. I am willing to go to as far as surrogacy. I hope I can be a good father because I know Jaya is going to be an amazing mother. She keeps telling me that I will be a good father as I also a good husband *smiled* Let's see what the one sitting there has in store for us *pointed upwards*"
> (Govinda Mridha, couple suffered a neonatal death, wife Jaya was undergoing second IUI cycle)

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[167] The consumption of premium whiskey has been associated with the ideals of normative masculinities among middle-class men in white-collar jobs in the United States as well (Holt and Cameron, 2010, p. 49).

> "You know, I'll be frank, I just don't understand why people need a child. Really, why does anyone need a child? I mean, there's no guarantee that a child will look after us when we become old: There's no guarantee of this nowadays considering children go abroad for study of jobs once they grow older. And once they leave, most of them do not return. See, people like you and me, we have a modern outlook so we don't have such thoughts that we should have children because they will look after us when we grow old. But unfortunately, most people in India are orthodox and they think like this even now. I told Akansha many times that it's better that while we are alive, I look after Akansha and she looks after me. That's all! Who needs anybody else to look after us? We have enough money to get the nurses we need even when get old. And to be honest, I really enjoy my time partying and traveling. I am a very social person. I have a huge friend circle and it's true that most of them have children. But what's the point of having those children because I have seen that those kids are usually raised by the *āyā* [nanny or caretaker]. I asked Akansha, who is going to go to PTA meetings and buy school books and make the child do homework and think about the future? It's too much for me. I don't think I am mentally or even physically prepared to do all this! Look at me! *laughed* (pointed towards his body which was reportedly overweight and unfit). But ultimately, I agreed to this IVF only by looking at Akansha's face and I know how desperately she wants a child. I have never said no to her for anything. I love her too much, she also knows that very well! I can't see her sitting and home and crying because of this. So if a child is what makes her happy, then I will support her. Finally, I know the child will go to the *āyā* because Akansha is also not going to have so much energy to run after the child all day long. She has a job, a very active social life so when will she have the time to sit and home and look after the child all day long? But yes, just to make Akansha happy, I have decided to go ahead with this. I hope that I am able to be a good father and live up to Akansha's expectations. So far, I have no expectations of myself! *laughed out loud*"
> (Sameer Agarwal, wife Akansha was going to start first IVF cycle)

As we can see from Govinda's excerpt at first, he did not believe in "outdated ideas" that prescribe the need to bear a male child for reasons of property and cremation. Also, he did not feel the need to have an heir who would carry forward his lineage. Govinda's views diverged from the gendered norms of the Hindu patriarchal order which dictates that a son is required for the lineage to be carried forward, for the man's "perpetuation of the self" as well as for the man's salvation after he has died (Bharadwaj, 2003, p. 1870; see also Naraindas, 2009). In Sameer's case, his statements about not wanting children is reflective of his deviation from another norm concerning filial obligations in India. Scholars have observed that central to the old-age support system in India is the norm that sons should provide financial and practical support for their elderly parents (see Chopra, 2008, p. 188; Chopra, 2006, p. 3; Vera-Sanso, 2004, p. 77). In his self-representation as a modern man, Sameer felt that people should not have children as guardians for the parents in their old age. By questioning the need to have children, the three male interlocutors in this section deviated from the discursive norms of South Asian masculinity which dictates that men ought to become fathers to enact their manhood. Instead, they enacted their masculinities through other aspects such as their lifestyle by representing themselves as modern men who do not harbour orthodox values and also as men who had not internalised the desire of becoming a father, simply because it was socially and normatively expected in the pronatalist Indian context.

Although none of these men desired fatherhood, they did agree to having a child and in doing so, I take cue from Inhorn and Wentzell (2011) to suggest that they enacted forms of "emergent masculinities". According to Inhorn and Wentzell (2011, p. 801) while existing anthropological research on masculinities reveals that men's enactment and understandings of their own manliness and actions are powerfully mediated by types of local masculinities, the focus of such research tends to be on whether men embody or reject locally hegemonic forms of manhood. Building on this existing scholarship of hegemonic and alternative masculinities, Inhorn has developed the concept of "emergent masculinities" which accounts for "the ongoing, context-specific, and embodied changes within men's enactment of masculinities as they encounter emerging health technologies" (ibid., p. 802)[168]. According to Inhorn and Wentzell, the intentionally plural term of emergent masculinities,

> …embraces social history, globalizing geographies, masculine embodiment, new masculine dynamics, and social movements in a way that hegemonic masculinity cannot. Whereas hegemony emphasizes the dominant and hierarchical, emergence highlights the novel and transformative. When applied to manhood, emergence encapsulates change over the male life course as men age, change over the generations as male youth grow to adulthood, and changes in social history that involve men in transformative social processes. Finally, emergent masculinities highlights new forms of everyday masculine practice that accompany these social trends (Inhorn and Wentzell, 2011, p. 803).

In her scholarship on the new Arab man in the Middle East, Inhorn (2012) applies the concept of emergent masculinities to show how Middle Eastern men are defying gender stereotypes in their engagement with "morally questionable" reproductive technologies and in the process, "changing their personal lives, interjecting new notions of manhood, gender relations, and intimate subjectivities into their ways of being" (ibid., p. 317). She suggests that in contemporary Middle East, emergent masculinities

> "entail love, tenderness, and affection, as well as untold sacrifice and suffering, all elements of contemporary manhood that go unnoticed and unappreciated, particularly when set against the tropes

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[168] Inhorn and Wentzell (2011, p. 803) developed the concept of "emergent masculinities" by drawing on Raymond William's work on the process of "emergence" in a cultural system where despite the dominant social order or practices, "new meanings and values, new practices, new relationships and kinds of relationship are continually being created". As such, Williams calls this process "emergence" to signify that which is "novel rather than strictly alternative or oppositional to the dominant culture" (Inhorn and Wentzell 2011, p. 803).

> of violent hypermasculinity that characterise ongoing Western Orientalist discourses" (Inhorn, 2012, p. 317).

Drawing on Inhorn's research, I apply this concept of emergent masculinities to show how the three men presented in this section prioritised their marital relationships over desiring fatherhood and were willing to, even if with a note of uncertainty, to become fathers and satisfy their wife's reproductive desires. Men's feelings of sympathy and sacrifice observed by Inhorn (2012, p. 300-301) in her own study – the "doing all this for her" sentiment – is evident in my interlocutors' excerpts as well where the commonly cited reason to have a child was that they loved their wives, they did not wish to hurt them further as the latter were already hurting from prior experiences of reproductive loss along with facing the social pressure to bear a child, and because as women it was natural for them to want a child. Interestingly, in their enactment of masculinities, the men co-opted the articulation of women's gendered performances vis-à-vis reproduction, especially their so-called natural desire to have children.

I now introduce the case study of another male interlocutor who desired fatherhood, enacted emergent masculinities along with specific aspects of hegemonic masculinity. In describing his case, I continue exploring the nuances in the enactment of masculinities, which I argue, is not captured adequately solely through the conceptual lens of normative masculinities.

7.4. The Shoulder for the Wife to Cry on: Reacting to Reproductive Loss with Compassion

Tarun lives with his wife Shikha in a joint family that includes his parents, his younger brother, and his brother's wife. After getting married in 2012, Tarun and Shikha started trying to have a child soon afterwards. When Shikha was unable to conceive after more than a year of trying, the couple consulted with Dr. Ganguly at infertility clinic A. Initial medical tests reportedly showed that Tarun had a 'normal' semen report while Shikha was diagnosed as 'infertile' due to the presence of uterine fibroids. A year into the treatments, Shikha suffered a miscarriage in the 17th week of her first IVF pregnancy. In my interview with Tarun several months after the incident, he said the following:

> "The miscarriage happened in June last year. Naturally, it was a very upsetting incident. Both Shikha and I were very upset. But my focus during that time was on making Shikha feel better. I didn't have the time to drown in my own sadness. I had to remain calm, so that I could keep her calm and happy. That was the most important thing for me. She was extremely upset in the following months. She had stopped eating or sleeping properly, she refused to meet other people, and would usually spend the entire day crying. My only priority as that time was to ensure that she becomes normal again. Our first baby dying – I will never forget that day when we got the news. I initially didn't know how to react.

> When the doctor told us, I remember Shikha started crying immediately but I didn't know what to say or do. Neither of us was prepared for anything like this. Is anybody prepared for an incident like this? So yes, that's what happened. And honestly speaking, as men we don't know how to cry immediately. If husbands start crying, then who is going to look after the official hospital matters and also take care of the wife? I had to be strong for Shikha. I think I recovered faster than her - maybe I had to. After all, I am the husband. How will it work if the man sits at home and cries? I have to be there for her when she needs a shoulder to cry on. If I start crying or become depressed or you know, have a break down, then who will take care of her? Actually Shikha doesn't know this, but the first time that I saw her crying and screaming at the top of her lungs, that was the only day I couldn't control myself. I went to the bathroom and cried myself. But I didn't let her see me. Otherwise, she would have become weaker. If two people break down at the same time, then how will things proceed further? One of the two has to be rational. And I think in such cases, it's the husband's duty to stand by his wife and think rationally for the both of them together about what can be done next…We will try again once she tells me that she is mentally and physically ready. I don't want to pressure her in any way. I have told my parents also to not pressure her. She needs time to recover from that mishap before we can think of trying again. Her happiness and health is the most important for me."

> Subsequently, Tarun mentioned the two things that he told himself and Shikha before they decided to commence another treatment cycle:

> "See, bad things happen in life. That is life. The bad and the good coexist. In every person's life, the good and the bad follow each other. So, I knew that we must move on from what has happened. And so, I have told two important things to Shikha and also to myself. I have told her many times not to blame herself, as it was in no way her fault. She would often say that during her pregnancy, she must have done something wrong or that she had not looked after the baby properly. But I kept telling her not to worry as it was not her fault at all. I never blamed her and why would I? It wasn't her fault at all. That's the first thing and the second thing I have told Shikha is that do not think about the money which I spent. She often mentioned about how much money we have spent at the clinic and that money was wasted when this mishap happened. But I think, one should not think in this way that the money is useless as the result is zero. No one should think like this, that what we invested is absolutely in vain. I have told her this many times. When there is a purpose, nothing is useless. At least at that moment it was useful. So how can it be useless and a waste of money? After some time, if she wants to try again, then I will spend the required money for this. I will encourage her to think of it as new beginning and to not feel so dejected."

Tarun proceeded to share how amidst all the sorrow he and Shikha had been experiencing, he was quite frustrated as he was unable to find the exact reason for the miscarriage. He continued talking about how after the mishap, he was curious to know why it happened so a similar incident could be avoided during the next pregnancy:

> "After the incident happened, I had done research before going to the doctor to ask about why this happened. I saw online that miscarriages are quite common in IVF pregnancies in the first trimester. The main thing is that in our case it happened after quite a few months. Generally, it doesn't happen after the pregnancy has reached this stage. But what matters is the reason why the IVF didn't work out. I know that mishaps can happen anytime, even after the pregnancy has reached full term...I understand that fibroids are very common so it was complicated in Shikha's case. As the pregnancy was increasing the size of the fibroid was also increasing. That did not favour her pregnancy. But I actually do not know why the miscarriage finally happened. Were the fibroids the only problem? I

really wanted to know. I asked the doctor and nurse a why this mishap happened? Actually, even they were confused. See, actually there is some hidden aspect which one cannot explain…You may have studied about diseases. Sometimes the reason is idiopathic. It means that the reason has been unexplored, but there is a definite cause you can't explore and that is the limitation. At least if we knew the reason, then we can try and avoid such an incident when we try again. That's what bothers me. Actually, as a scientist by profession, it's my job to know how and why things happen. So, it was important for me to find out why this had happened, and more importantly, I needed to know whether there was a chance that such a mishap would happen again. And see, as a matter of fact, after such an incident, no woman has the time to think about all this. A woman's state of mind is not such at that time. But as the husband , I can try to think about why this happened and ensure that such a mishap does not repeat itself. Unfortunately, the doctors could not tell me any specific cause. I did some more online research later but, I mean, this is not my field of specialisation, so I was unable to understand a lot of medical details. Let's see what happens next time. I want to clarify everything with the doctor before proceeding with any treatment."

When I asked Tarun about whether he faced any social pressure from people around him to have a child soon after the miscarriage and whether that had affected him as a man, he said:

"I do feel a little bad when I go out, especially when I meet my friends. All my friends have one or two children. Most of them had children within the first two to three years of their marriage. They often ask me when we will give them the good news. But Shikha and I do not wish to share our personal lives with everyone. Only one or two very close friends know about our situation. I have realised that people can be quite insensitive about this issue. Let me tell you about one such small incident. We were on vacation in Darjeeling a couple of months ago. Actually, Shikha didn't want to go because she doesn't like socialising a lot since the mishap. But I insisted that we should go because I thought it would be good for her to meet our friends and have a good time. I always encouraged her to get out of the house. I finally convinced her. Anyway, so we were four couples. One evening, my friend and I were sitting after dinner, just chatting, and having drinks, while Shikha and the other women were sitting and chatting in the other room. Suddenly, this topic of marriage and children came up and soon my friends started asking me why we were delaying having a child. One of my male friends laughed and said, 'Oh, Tarun must be shooting blanks otherwise Shikha *boudi*[169] would have definitely given us some good news by now!' Everyone in the room laughed because the friend who said it was a little drunk. I remember I laughed too and I didn't respond to it, but, of course, it bothered me. Nobody knew what Shikha and I have been going through. I told Shikha about this later, maybe I shouldn't have, because it made her very upset. I consoled her saying that people only talk rubbish, nobody knows how much we have suffered. I was naturally upset too with my friend's comment, but I didn't show it in front of everyone. My friend who made that comment obviously didn't know that there was nothing wrong with me but I didn't want to say anything. Nobody needs to know that Shikha has a problem because then she will just get fake sympathy from people. So, yes, once in a while I have to hear such things but what can I say or do? I quietly hear and ignore these things. People in India don't think much before saying such things. I hope this time passes by soon. And I know that getting angry will not help. How many people will I get angry at? Does it affect me as a man? No, not at all. Why would I feel bad as a man? There is no problem with me. If the doctor had said that the problem was with me and that it was because of me that we were not able to have a baby, then it might have affected me. Actually, I don't know, I have not thought about it in this way to be honest…If we are able to have a baby next time, assuming that Shikha is doing well, then that's good. Otherwise, even if we

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[169] *Boudi* is the Bengali term used by younger brothers to address their elder's brother's wife. In this context however, it is a common and respectful term for Bengali men in general to address the wives of other men.

> cannot have a child, I would be fine with it. I know Shikha would be unhappy but for me, her physical and mental health is much more important than being able to have a baby.”

Writing about the culture of toxic masculinity in India, Bhargava (2019, n.p.) explains that along with the other core features of the “model of manhood” such as aggression, ambition, and ruthlessness, it is also “uncharacteristic of men to adopt the point of view of others, show empathy and understanding, gentleness and compassion”. However, Tarun’s case is a suitable illustration to show that there are diverse ways of being a man which cannot be merely accounted for by the norms of toxic masculinity as explained by Bhargava. For instance, unlike in the case of other couples in my study where the wives talked about their husbands being insensitive towards their feelings of grief (see chapter five and six), Tarun displayed ample concern towards his wife’s emotional wellbeing. In chapter five, I discussed how bereaved women did not receive social support and were instead pushed by the people around them, including their husbands, to try and have a child soon after the incidence of loss. In contrast, Tarun mentioned that not only did he not pressure Shikha to undergo a treatment cycle immediately after the loss but he had also told his own parents to refrain from doing the same because she needed to recover from the mishap. As a concerned and supportive husband, Tarun also mentioned that they would commence another treatment cycle only when Shikha felt mentally and physically ready which is also when he said he would encourage her to see this as a new start instead of thinking about the past. In chapter six, I also mentioned that women spoke about being blamed by their husbands for the loss and for not being able to produce a child but Tarun had been convincing Shikha that the miscarriage was not her fault even though she had found reasons to blame herself.

Moreover, Tarun mentioned that while his friends joked about him “shooting blanks” and flippantly held him responsible for the couple’s lack of a child, he did not want to let his friends know that the problem was not with him but his wife. He spoke about not wanting to be angry at people when they said “insensitive” things regarding their situation because that would be futile given that people, according to Tarun, would show fake sympathy. Evidently, it was not just women who shouldered the blame for their partner’s infertility (as described in the next section) but also some men who “bargained” or negotiated with patriarchal norms in order to protect their wife from social hecklings. Finally, Tarun said, that while he had not given it a proper thought, the absence of a child did not particularly affect him as a man since it was not him who had been diagnosed with any problem. As he mentioned, having a child was not more important for him than his wife's physical and mental health. Being a man for Tarun is seemingly not tied to his ability to become a father or to have a child at all, but rather with being a concerned husband. Such an enactment of a form of emergent masculinities resonates with the responses of the male interlocutors in the previous section who also prioritised their marriage and their wives' desires for a child over their own desire to not become fathers.

However, there was one particular aspect in which Tarun's statements reflected the dominant masculine norm of emotional restraint, not in the sense of apathy towards the loss or his wife's grief, but more as something that he had to do as the husband in order to take care of his wife. Tarun mentioned that as a man, he could not sit at home and cry as he had to recover faster in order to be emotionally available for his bereaved wife. His emotional restraint was also tied to his need to be composed and rational so that he could try to find out the reason behind the miscarriage. As Stroebe and Schut (2010, p. 282) have suggested in their research on bereavement and coping after the incidence of child loss (or the loss of a parent), men tend to actively engage with problems and practical issues associated with the loss as compared to women who are more expressive about the loss itself. As part of the gendered process of grieving and coping with loss, men usually rewrite the reproductive story in order to restore meaning and hope for the future whereas women grieve for the loss and make meaning of it in their own way, claim Jaffe and Diamond (2010, p. 101; see chapter five).

Although Tarun regarded the miscarriage as a very upsetting incident, his main focus was on keeping his wife calm and happy while also handling certain logistics. His wife's state of mind after the mishap reportedly did not allow her to make decisions or to think rationally which is why he had no choice but to take the responsibility of being the spouse who took rational decisions. Tarun had seemingly compartmentalised the event of reproductive loss into what had happened and what needed to be done thereon to avoid such a mishap from reoccurring (see Cudmore, 2005, p. 303). Indeed, "restrictive emotionality" (Jansz, 2000; see also Levant, 1995) as a common trope in the enactment of masculinities had repeatedly emerged in the interviews with nearly all the male interlocutors in my study who had experienced the loss of a desired child. Like Tarun, other male interlocutors presented in this chapter emphasised their need to be emotionally sturdy in order to handle the logistics immediately after the loss but more importantly, to perform the role of the wives' caretaker as they felt that it was their responsibility and priority as men to ensure that their wives were feeling better (see Robson, 2002, p. 187-188). (I specifically state presented in *this* chapter because the same support and care was not offered by all the men to their grieving wives following the event of reproductive loss, as I have shown in chapter five and six.)

The display of restrictive emotionality, according to Jansz (2000, p. 167), is a manifestation of the norm of male stoicism which prescribes strict control over emotions of pain and grief. Research conducted in Euro-American countries suggests that stoicism as a response by men is part of a traditional or prescribed masculine norm that reiterates notions of hegemonic masculinity (see Connell, 2005; Throsby and Gill, 2004; Webb and Daniluk, 1999; Wischmann and Thorn, 2013). Studies conducted in these countries has also shown that after the female partners experienced miscarriages or other forms of reproductive loss, the male partners were caught in a "double bind" where on the one hand, they felt the need to avoid showing any emotions so that they could be supportive and on the other hand, they experienced feelings of loss and grief akin to their female partners (Dudgeon and Inhorn, 2009, p. 91; see also Reimann, 2016). As Tarun mentioned, even when he did cry, it was inside the bathroom and not in his wife's presence since he did not want to appear emotionally vulnerable in front of her. Even though men can potentially experience similar levels of emotional distress as women (or perhaps even more in some cases?), they did perceive that they needed to be the strong ones in their relationships and that they should not share their pain and loss with others (see Peronace, Bovin, and Schmidt, 2007; Webb and Daniluk, 1999). As Throsby and Gill (2004) have observed, men assumed the role of "the sturdy oak" or "emotional rock" following occurrences of reproductive loss. In Tarun's case, he was the shoulder for his wife to cry on.

The emotionally restrained demeanour of most of the male interlocutors in my study was also evident during our interviews, where unlike the women who expressed their emotions through tears and profound poignancy, the men refrained from expressing any such visible signs of emotional vulnerability which corresponds to the discursive notion that compared to women, male non-verbal behaviour is less expressive or that men hardly ever cry (Jansz 2000, p. 172). However, the generalised idea or the gendered stereotype which assumes that men speak less about personal matters and especially that men diagnosed with infertility will keep their emotional distress to themselves given the sensitive nature of the topic, creates challenges to research on experiences of male infertility (Hanna and Gough, 2015, p. 5). While I too faced a similar challenge while conducting interviews with men who had experienced reproductive loss as a result of male-factor infertility and did not wish to speak about it openly (see chapter two), I did encounter one exception as I discuss in the next section which shows that restrictive emotionality is not necessarily a given among men but is rather situational.

7.5. “It feels shameful”: Erectile Dysfunction and ‘Failed Manhood’

I met Bapin and his wife Tina for the first time during their second consultation with the infertility specialist, Dr. Chatterjee, at infertility clinic C. I was informed by the doctor before the couple entered the room that Bapin had been unable to masturbate for the semen analysis test despite trying on three separate occasions. When the couple entered, following some niceties, Dr. Chatterjee asked Bapin whether there was any problem which he had not disclosed to her. After a couple of minutes of silence, as he looked down and avoided any eye contact with anyone in the room, fidgeting with the file in his hand, he was lightly nudged by his wife. Almost in a whisper, Bapin told Dr. Chatterjee that he was unable to maintain an erection for longer than a few seconds. She then asked if this was the first time such an incident had happened to which Bapin said that he had never had an erection properly in his entire adult life. Barely concealing her surprise, Dr. Chatterjee exclaimed loudly,

> “Oh my God! Why didn’t you tell me this in our first consultation? Oh no, we have been unnecessarily wasting time with you both. If we knew this from day one, then we would have proceeded accordingly. *Looked at me* See, this is the problem. Patients don’t want to tell us everything and then they complain when they don’t get results. *Faced the couple* Anyway, see it’s not a surprise that you both haven’t had a child so far. It looks like Bapin has ED. It means erectile dysfunction, which I had suspected after the first two times he couldn’t give his sample in the clinic. Do you know what this means? *the couple indicated a no with their heads* This means that Bapin can’t have an erection properly and without an erection, how can you have sex properly? *Dr. Chatterjee lightly smacked her hand on her forehead[170]* Oh god, this means you both wasted all this time without having proper penetration! Anyway, now we know the problem so we can take a decision accordingly. We have some options in front of us. You both decide and tell me what you want to do.*started writing on her notepad* The best option would be to opt for donor sperm. Otherwise we can try giving you some medicines and see if you have an erection. But these medicines do not work well in my experience. And if you do not wish to choose donor sperm, then I can do a small operation called TESA[171] where I will extract sperm from Bapin’s testes and then do IVF. Understood? *the couple nodded indicating yes* So, let me know next week what you both decide. I think TESA is your best option here before choosing donor sperm. You should try with your own sperm first. But you both can think about what you want and let me know.”

In my interview with Bapin a few days later, he told me that the first time he and Tina had consulted Dr. Chatterjee was when his wife was unable to conceive despite trying for a year.

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[170] In India, the physical gesture of slapping one’s own forehead is commonly used to display frustration or disappointment at the ineptness or idiocy of another person and/or of a situation.

[171] Dr. Chatterjee did not explain TESA or even mention the full form to the couple (see section 7.6.3).

Recounting his experience, Bapin told me that he was unable to masturbate for the first two times in the infertility clinic. He did not use the word masturbate and instead said “I couldn’t do it”. The first time, he was alone in the room, and the second time, the nurse has asked his wife to accompany him inside the room. Bapin then told me that after those two attempts, the nurse had advised him to masturbate at home when he felt relaxed. He was told to bring back his “sample” to the clinic within an hour of ejaculation in order to keep it “fresh”. Bapin told me that he was unable to masturbate even when he was at home. He also said that on Dr. Chatterjee’s recommendation, he had decided that he would try medicines (for erectile dysfunction) and if that did not work, he would opt for TESA. When I asked Bapin whether he was willing to use donor sperm instead of undergoing TESA, he said, “Taking a donor is out of the question for both me and my family!” I asked Bapin his thoughts on the ED diagnosis by the doctor and the upcoming days of treatment and potential surgery, to which he said,

> “*Smiled feebly while he looked down at the table between us* What should I say? I have never talked about this to anybody before so I don’t know where to start. I haven’t been able to focus on anything – my family, my friends, my job, nothing – because for the last few years my entire life has been about this one thing. These days when I look at myself in the mirror, I ask myself if I am truly a man. What kind of a man am I that I can’t even get a proper erection? *started tearing up* I can’t make my wife pregnant. That hurts me a lot. It feels shameful. I feel helpless. I have never said these things to anybody, not even to my wife…Actually the thing is, I have never been with a woman before I got married, I have never had a girlfriend. I never loved someone in that way. Actually, to be frank with you, I was a virgin until I got married. I hadn’t even kissed anyone till then. You must be thinking I’m a strange man because such things nowadays are unheard of *I said not at all* I come from a very strict and orthodox family and my parents had always told me that it was their job to find a woman for me. It never occurred to me that such a problem could happen with me. I feel – how should I say – I feel very small inside…I don’t know what else to say. I feel very lucky that my wife loves me despite this and is still with me. She really loves me *started crying softly* But I feel like a failure. The one thing a man is supposed to be able to do easily and I cannot do it…I don’t know what else to say to you.”

Bapin’s narration was interspersed with several pauses, shifting glances, absence of eye contact, and by the end, he was in tears. I offered him a glass of water and he asked me if we could reschedule the interview for another time. I immediately stopped and asked him to contact me if and when he felt like talking to me again. Nearly a month later, Bapin and I met at his home after he had called and informed me that he was ready to be interviewed again.

On the day of the interview, I reached Bapin’s home around noon. It was a Sunday, and as we sat in the living room, he informed me that his wife was cooking lunch. He called out loudly and asked her to bring us tea. A few minutes after a general chat, I asked him if there was anything he would have liked to continue from our last interview. At first, he gave me an update regarding his treatment. He informed me that since the medicines for ED were not showing any positive results, Dr. Chatterjee would be performing TESA. He then said that he would prefer it if I asked him direct questions instead of waiting for him to say something on his own. I proceeded to ask Bapin his thoughts about why he had trouble masturbating and if and how this affected him:

> “Okay, I will tell you something I didn’t tell you the other day and I have also never told this to anybody else…Sorry, please give me some time. Since I have never spoken about this to anybody else, it might take me some time to talk about it openly. *I asked him to take all the time he needed*…Actually, when I was ten or eleven years old- Okay, so you first need to know that I grew up in a joint family. And as you know, it is normal to grow up with many cousins. You grow up with them, so you don’t see them as cousins, they become like your own brothers and sisters. I had two cousin brothers who were elder to me, five-six years older, and one day I told them about my problem of night falls[172]. You know what I am talking about, right? *I nod affirmatively* Yes, so, I told them that this was happening and they told me that this was a very bad thing. At that age, I didn’t know whom else to discuss this with. I thought they must be right. They told me that people will laugh if I tell them about it. They also told me that time that I should never masturbate as it is a very bad thing. They said I should only let my sperm out of my body when I get married. Actually, I remember one of them telling me that I should only ever sleep with the woman I marry and if I have sex with any woman before marriage then I would lose my semen. They also said that the more I lose it, the weaker I would become. I never questioned them and even though there were times when I wanted to masturbate, I rarely did it because I believed my cousins. By the time I went to college and realised that everything they had said was just to make fun of me and to tease me, I wasn’t able to have a proper erection anymore. I mean it would happen, but only for a few seconds. My male friends in college were always talking about which woman they liked and which woman they wanted to sleep with. I used to joke along with them otherwise they would think that I am abnormal or I am gay. But I have never had a girlfriend. I didn’t have fun with any girl in college because I was too embarrassed about my condition. Finally, when I was 28, I said yes to marriage because I couldn’t resist my parents’ pressure anymore. They had started pressuring me for marriage when I was 24-25. So, it is because of all these things, I was unable to masturbate at the clinic. You might say that it is a psychological block. I would have told Dr. Chatterjee but I didn’t know how to say all this in front of my wife…All this trouble wouldn’t have happened today if my cousins hadn’t told me all kinds of false information. I will never forgive them for what they did to me. I hardly have any contact with them since I got married. They made me think I was abnormal because of my night falls. If only I hadn’t taken them seriously, then I wouldn’t have had this problem today. But how would I know that my own cousins would make a fool out of me? My wife and I are suffering today because of them *started weeping softly* I hope my wife can’t hear me..*wiped his tears* I will never understand how they could play with my head like this. How could they do this to their own family member? Today, both of them have children. I found out from a relative recently that one of their sons is going abroad to study. But look at me. I am not even able to make my wife pregnant and she is also suffering because of me. They ruined my life. I don’t think I will be able to forgive them.”

Bapin excused himself at this point saying he needed to go to the toilet. When we resumed the interview, he mentioned providing emotional support for his wife:

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[172] “Night falls” is the colloquial term used for nocturnal emission which is an involuntary ejaculation of semen during the sleep cycle.

> "Even though the problem is with me, everyone else thinks it is Tina's fault that we do not have a baby until now. Most people don't know that I have the problem. So, people taunt her, they say insensitive things to her. She doesn't tell people that I am the one with the problem. She knows that people will make fun of me. I feel very angry and hurt that people constantly taunt her and repeatedly ask her about why she isn't getting pregnant. As if it's her fault! She is bearing all the taunts so that she can protect me. I understand that it is much more difficult for a woman in our society to be in such a situation. The only thing I can do as her husband is to support her and be there for her when she is feeling upset. I am the man in this relationship so I need to behave like one, isn't it? I can't cry in front of her. I *have* to support her otherwise what kind of a husband will I be? She is already suffering enough because of me."

> After concluding the interview, as I was on my way out, Bapin thanked me for listening to him,

> "It was very nice speaking to you. Really, I felt very good. Thank you for speaking to me *I thanked him for taking out time to speak to me* No really, I should thank you for listening to me and not ridiculing me. You know how it is in the Indian society? Men never share such personal things with anyone, and that too with a woman. I had never thought I would say these things about my life out loud. I am glad I could share with you. I feel like years of burden on my heart has suddenly become lighter. Please pray that everything goes well for us."

I thanked Bapin for giving me his time and for opening up to me. I told him that I was immensely grateful that he shared such intimate details about his life with me and I was hopeful that he and Tina would be able to have a child soon.

Given that paternity is seen as an achievement and a major source of masculine identity in societies where hegemonic concepts of masculinity prevail, as discussed earlier in this chapter, male infertility can be a debilitating and often, shameful diagnosis for men (Cudmore, 2005, p. 303; Dudgeon and Inhorn, 2009, p. 89). Studies have shown that it is common for men to hide their feelings about infertility and that in such cases, the wives protected the men by covering up for them (for e.g., see Cudmore, 2005; Inhorn, 2003a, 2003b). For instance, in her study in Egypt, Inhorn (2003a, p. 249) has observed that male infertility can be so stigmatising to the prevailing norms of hegemonic masculinity that most men would "rather live a lie – enforcing or tacitly accepting a cover-up on the part of their wives and families – than risk exposure of their emasculated "defect" to their male peers". Living this lie, writes Inhorn (ibid., p. 249), makes men pay the heavy price of diminished self-esteem and profound psychological suffering. She further argues that the burden, however, is greater for the men's wives who feel compelled to shoulder the blame so as to ensure that their husband's infertility remains invisible and thus, hegemonic masculinities remain intact. This means that as a "patriarchal bargain" (Kandijyoti, 1988), the wives of infertile men endure the social ostracism of being childless along with bearing the physical, emotional, and psychological toll of undergoing medical treatment for a condition located outside their own bodies (ibid., p. 249). Similar to Inhorn's findings, I found in my study that for the male interlocutors who had been diagnosed as infertile, including Bapin (even though erectile dysfunction (ED) implied that he was impotent and not necessarily infertile), the information had not been disclosed to anybody in his social circle. Even though Bapin was aware that it was his wife who was bearing the taunts in order to protect him, neither he nor his wife disclosed to anyone that the 'problem' was not with his wife but rather with him, thus, keeping his 'manhood' intact.

Indeed, various studies have shown that for men, the ability to father a child is viewed as a crucial signifier of manhood and consequently, the inability to do so is perceived by men as a failure of their masculinity. Studies show that for many men, male infertility results in them feeling inadequate about their manliness, as traditionally, manliness has been related more to the ability of impregnating a woman than in undertaking the role of the father. For instance, in their study of men's involvement with IVF in the United Kingdom, Throsby and Gill (2004, p. 336) write that "in finding themselves unable to make their partner pregnant (for whichever reason), men felt that their sense of themselves as men was called into question". Male infertility may further be compounded by ED or impotence wherein 'failed' sexual performance on the male's part prevents intercourse from being completed or undertaken, notes Inhorn (2003a, p. 237). As such for men diagnosed with ED, their inability to have an erection and engage in 'normal' penetrative sex to impregnate their partners can be perceived by them as a threat to masculinity which is closely related to the stigmatisation and the personal silence that enshrouds male infertility in general (see Dudgeon and Inhorn, 2009; Inhorn, 2003a, 2003b; Moore, 2009; Tjørnhøj-Thomsen, 2009). In South Asia, Khan et al.'s (2008, p. 42) study has shown that an erect penis for men represents the "ultimate prestige of manliness" which indicates "manly power" beyond the sexual domain. The failure to get an erection for sexual penetration and not being able to maintain that erection for a long(er) period of time were considered by Khan's male interlocutors as types of "erection crises" (ibid., p. 42). Khan et al. argue that men who experienced such crises internalised the shame and fear associated with failure in achieving erections and consequently, as a failure of their manhood. Moreover, Bharadwaj (2016, p. 81) in his study of infertility in India discusses an example of male impotence to suggest that the sensitivity of men towards their "sexual disability" aggravates the anxiety of social disapproval given that the husband's "failed manhood” is implicated in his wife’s inability to become visibly pregnant. As we can also see from Bapin’s excerpts previously, he reflexively posed questions about the kind of man he was if he was unable to have “a proper erection” and impregnate his wife. He spoke about feeling ashamed, helpless, inferior, and as less of a man. Bapin’s diagnosis of ED and male infertility made him feel emasculated and he also felt that his life was “ruined”. Thus for Bapin, his inability to have an erection and to impregnate his wife ‘normally’, which as he said was the “one thing a man is able to do easily”, was perceived by him as his failure to enact his sexual and masculine self, both of which are strongly intertwined in cases of male infertility.

However, I want to point out that Bapin’s narrative was not exclusively about him enacting his ‘failed’ masculinity as a reiteration of the dominant ideals of hegemonic masculinity wherein he conflated his masculine identity with his ability to sexually perform. Instead, as part of enacting multiple masculinities, his narrative was also an illustration of what I refer to as “vulnerable masculinities”. Taking inspiration from the recently developed work on shifting masculine identities by scholars such as Elliott (2015) and Inhorn and Wentzell (2011), I have coined the term “vulnerable masculinities” that allows me to question the essentialised notion of hegemonic masculinity characterised by the inability of men to display their emotional vulnerabilities and to portray themselves as tough and macho. With the ethnographic illustration above, I have shown that following the diagnosis of ED and male infertility, Bapin confronted his vulnerability in a way that was incongruous with dominant ideals which valorise emotional restraint as an index of manhood (see Smith and Inhorn, 2016, p. 448). As we can see from his excerpts, after overcoming his initial hesitation, Bapin shared his intimate life stories, whether that was about his virginity before marriage or about his experience of “night falls”. These stories, as he mentioned, were shared with me for the first time which helped him in feeling lighter. In an Indian society, as Bapin mentioned, men do not talk about such personal things, and so given that he had “exposed” parts of his masculine self (perhaps intensifying his experience as he expressed it to a female researcher?) shows the enactment of a form of vulnerable masculinities. The moments during the interview when Bapin became emotional and expressed his vulnerability through his tears and body language, indeed, reflect a different or alternative way of embodying his masculinity – a man, who I suggest, had (at least temporarily) transgressed the masculine norms of stoicism and emotional restraint. Even though Bapin’s narrative of enacting vulnerable masculinities was an exception, I suggest that an illustration like this helps me in corroborating the larger argument in the present chapter which is that masculinities are enacted in diverse, complex, and nuanced ways which cannot always be understood by locating men’s experiences within the conceptual framework of hegemonic masculinities.

Even though Bapin allowed himself to be vulnerable during the interview, he said that he had to resume his strong, masculine self in his marital relationship where he understood that toughness as part of being the husband. He oscillated between his enactment of feeling like a ‘failed’, vulnerable man, and then finally as a man who had to be emotionally strong and restrained in front of his wife. As he said, “I am the man in this relationship so I need to behave like one”. Studies, for example that of Johansson, Hellstrom, and Berg (2011) among Swedish infertile men, has shown that men often subsumed their own emotions and accorded their own emotional needs a lesser priority than their female partner’s emotional well-being. A certain type of chivalry emerged among the men based on being strengthened by assuming responsibility of taking care of their spouses which further reinforced the men’s sense of self (ibid.). Other studies have similarly shown that men’s emotional response to infertility has demonstrated some common patterns which indicate that men stated their need to be strong for their female partner, even if that meant suppressing their own emotions (for e.g., see Culley et al., 2013; Malik and Coulson, 2008; Throsby and Gill, 2004; see also section 7.4).

As we can see from Bapin’s case, it is essential to acknowledge the interplay between the enactment of masculinities, sexuality, and virility when examining the reproductive experiences of men who have been diagnosed as impotent and/or infertile. In the next section, I explore this interplay further by focusing on men’s reproductive experiences and treatment-seeking practices within the biomedical sites of infertility clinics.

7.6. Semen Collection, Donor Sperm, and Adoption: Challenges to the Enactment of Normative Masculinities

In this section, I examine the practices of semen collection, donor insemination, and Testicular Epidydimal Sperm Aspiration (TESA) that is a procedure involving the extraction of sperm from the testicles. I address the topic of adoption at the end of the section to address the invisible but obvious hierarchy within clinical spaces in regard to the involvement of “reproductive others” (Freeman, 2014) or "third party" input in the couple’s dyadic unit (Bharadwaj, 2016). Based on ethnographic data, I firstly argue that the inability to perform during the process of semen collection i.e. ejaculate through masturbation, the practice of donor sperm-induced conception, and adoption challenge and/or threaten the enactment of normative masculinities. My second argument relatedly is that the availability of ARTs directed towards treating male infertility, particularly TESA and Intracytoplasmic Sperm Injection (ICSI), compelled men to enact normative masculinities, most prominently through the achievement of biogenetic paternity. Following Inhorn’s (2003a, 2007) research on male infertility, I show that in the process of enacting normative masculinities by attempting and hoping to achieve biogenetic paternity, the men suffered from forms of “embodied agony” (Inhorn, 2007, p. 49), for instance, while undergoing the often mentally distressing process of semen collection or during the painful medical procedure of TESA. This section about men’s reproductive practices and embodied experiences ascertains Inhorn’s (2007, p. 38) observation that in the era of assisted reproduction, infertile men’s bodies are, indeed, no longer unscathed as had been suggested previously by feminist researchers.

7.6.1. ‘Performance Pressure’ during Semen Collection

Before a man was given an appointment for giving his semen sample for it to be tested at any of the three infertility clinics in my study, he was instructed by the doctor or the nurse to undergo a period of abstinence for at least three to four days before the appointment. In a sense, the bodily preparation of the man for the impending test had begun. The process of semen collection in the ‘men’s room’ was followed by a sperm analysis test by the clinic’s andrologist or lab technician. The test involves sperm washing (see Fig. 20) in order to separate the sperm from the semen followed by checking for the markers of sperm health, indicated primarily by the sperm quantity, morphology, and (progressive or non-progressive) motility under the microscope. The infertility clinics, as I was informed by the practitioners, followed the WHO guidelines for assessing normal sperm health. I was wondering if these clinic guidelines were fixed because the parameters and references for what can be considered as normal sperm health has been updated several times by the WHO and several limitations of these arbitrary guidelines has been pointed out by researchers. For instance, Cooper et al. (2010, p. 232) show that the data to decide what is normal sperm health was derived from imprecisely defined reference male populations and obtained from laboratories with unknown comparability. My focus, however, is not on how the normal parameters for assessing sperm health are manufactured under the microscope – a technological device without which looking at the sperm and the production of a certain kind of knowledge regarding sperms would not have been rendered possible. Rather, given that the production of semen is the only act that men have to perform as a "reproductive person (Inhorn, 2003a), I show that the process of semen collection puts pressure on some men to perform, and thus, they (are pushed to?) enact normative masculinities in a discursive context where the linkage between virility, biological paternity, and heterosexuality is accorded much significance. Also, it is not only the actual performance on-demand, but as Inhorn (2007) points out, even the thought of fulfilling these so-called normal parameters of sperm health can cause added anxiety for some men, as I demonstrate with the case below.

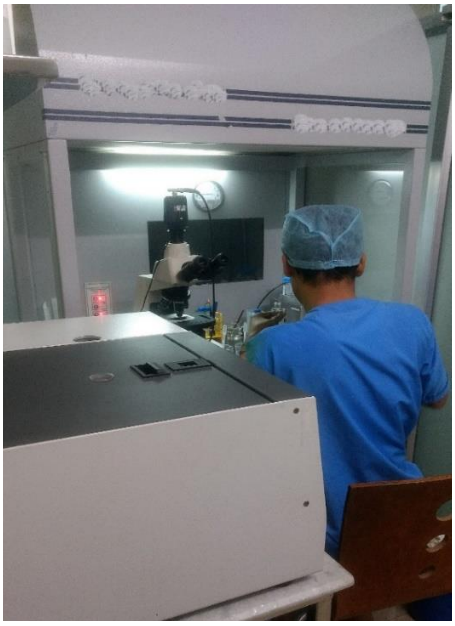

Fig. 20. Lab technician engaged in sperm washing, Infertility clinic B

My first encounter with 33-year-old Sisir Ray and his wife, Reba, was at infertility clinic C during their consultation with Dr. Chatterjee. I learned that the couple had been married for four years and not having conceived after a year of trying, they had decided to visit the clinic. As per the protocol, Sisir was asked by Dr. Chatterjee to “give his sample” and Reba was asked to go to the ultrasound room for her TVS. Sisir told the doctor that since he had a busy schedule at his office that entire week, he would come to the clinic when he had a less hectic week. A few days later, as I was sitting in clinic C’s waiting area and making my fieldwork notes, I saw Sisir entering the clinic. I approached Sisir and started a conversation with him after a brief introduction. A few minutes into our conversation, he informed me that he was at the clinic that day for his semen test. I asked him if his wife had also come to the clinic, to which he said no, and he then asked me if we could talk some other time. I readily agreed and returned to making my notes. A few minutes later, the andrologist walked into the waiting room, announced Sisir's name loudly, and asked him to follow her. When both of them were outside my sight, I (and presumably the others in the waiting room) could only hear the andrologist's voice. Such public conversations of private topics were rather common in these clinics (see chapter two). I noticed that in the conversation between the andrologist and Sisir, the latter's voice was hardly audible. This was not entirely surprising since most men usually responded in nods and soft, neutral hmmms. As I had observed this process earlier at this clinic, as well as at the other clinics, I knew how these conversations generally played out. It involved the andrologist (or sometimes a nurse) instructing the man to masturbate in a plastic cup without spilling any of it outside. This was followed by asking the man if he knew how to masturbate, and finally, the man would be told to relax, and do the needful.

The following morning, I was having tea as usual with the clinic's female staff before the day's proceedings commenced. At some point during the conversations, the andrologist who had instructed Sisir regarding the sperm collection shared with everyone that he had been unable to "deposit" his sample. She described how when he came outside the room after more than three hours, he was sweating profusely and he had asked if he could go home and try again another day. This anecdote resulted in banter among the women, when one of the nurses said that it's strange that men "cannot do this one small thing" while women have to undergo so many procedures. One doctor laughed and said, "Oh you know what I think? These men deliberately spend more time in that room because their wives would never allow them at home!" Her statement made everyone laugh.

In my conversation with the andrologist a couple of weeks later, I discovered that Sisir had was "successful" only on his fourth attempt:

> "Thank god! He was finally able to do it! But you know, it is actually not that uncommon. I have been in this job for nearly two years now. I have often seen that men are not able to do this on their first or second attempt. Some men come out of the room looking like they were fighting a battle! They are sweating and they look very stressed! Only very few men come out in 15-20 minutes. So, it varies from man to man. I think for some men, they put too much pressure on themselves. I don't know but maybe it is because they think that if they cannot do this one thing properly, then it is embarrassing for them. I always tell the men before going into the room to relax and not be stressed. But for some men, that advice never works."

Based on the semen analysis test done by the andrologist, I was informed that Sisir had a bad test report because the sperm count was “very low” and the few available sperms, according to her, had “poor morphology”.

While women can have embodied experiences of reproductive failure at various stages during an infertility treatment cycle (see chapter three), Inhorn (2003a, p. 246) notes that as long as men are the least bit spermatogenic, they cannot ‘fail’ reproductively. She explains that “men cannot be blamed for failures of procreation, unless because of impotence or premature ejaculation, they are unable to pass their worm-enveloped children into women’s wombs” (ibid.). Nevertheless, even though semen collection is the only routine test which men had to undergo as part of the infertility treatment workup, this test tends to cause both somatic and psychological suffering among men, according to Inhorn (2007, p. 38). She points out that infertility researchers, including feminist scholars, have downplayed men’s embodiment in infertility treatment-seeking by privileging women’s bodily experiences and in doing so, they have regarded men’s role in the process as “relatively minor, even perfunctory” (ibid., p. 38). Inhorn also argues that this under-privileging of men’s bodily role in the infertility treatment process is mistaken because while it is ideologically driven to make an important feminist point, it also ignores the lived subjectivities of many men’s lives. Indeed, the seemingly physically easy routine of masturbation does cause some (or perhaps most) men a significant amount of anxiety, awkwardness, and embarrassment because as Inhorn explains, such reproductive experiences of men involve “profound forms of gendered embodiment, involving self-touching through time-sensitive, masturbatory ejaculation of semen into a plastic cup…” (ibid., p. 38).

Previously in this chapter, I have shown that the inability to ejaculate through masturbation on repeated occasions caused Bapin to feel intensely distressed and express feeling “like less of man” (see section 7.5). As we can also see from Sisir’s case in this section, he had been unable to masturbate on three attempts, a phenomenon reportedly not uncommon inside the infertility clinics. The andrologist later explained to me that barring a few men who came out of the room in a short period of time, most men were unable to masturbate on the first or even second attempt and took a much longer time. The men’s struggle to ejaculate in the plastic cup was described by the andrologist through phrases describing their physical appearance when they came out of the men’s room, such as profuse sweating and looking stressed, as if they had been fighting a battle. Of course, it would not be erroneous to claim that in comparison to women's embodied experiences of undergoing infertility treatments which include invasive and (sometimes) painful diagnostic tests and medical procedures (see chapter three), male masturbation as part of a diagnostic test is not a physically demanding process. This relative ease of performing this process is also the reason which led the nurse in the vignette above to state that it is strange that men "cannot do this one small thing" followed by a doctor's repartee about men deliberately taking more time in the room because their wives do not allow them to masturbate at home. Notwithstanding the relative ease of the semen collection process, I take cue from Inhorn (2003a, 2007) to argue that certain aspects of this process – the pressure to perform by ejaculating while ensuring that nothing is spilled out of the cup, knowing that people outside the room are waiting for them to finish, the stress of thinking about whether they can produce the required quality (indicated by sperm motility and sperm morphology) and quantity (indicated by the sperm count), and ultimately wanting to assert their manliness through this process, transforms this rather easy routine test into a psychologically distressing experience for some (or perhaps many) men.

Along with the pressure to display such an "appropriate gender performance" (Mohr, 2018, p. 53), the location of where this performance unfolds is also an additional factor which contributes to making semen collection into an anxiety-laden process for many men. Unlike the Middle Eastern infertility clinics where the hospital toilet is perhaps the most common site of semen collection (Inhorn, 2007), it is mandatory as per the ICMR guidelines to have a semen collection room in every infertility clinic in India. According to the ICMR guidelines, the minimum requirements of such a room is described as follows[173]:

> This must be a well-appointed room with privacy and an appropriate environment; it should be located in a secluded area close to the laboratory. Such a facility must be available in-house rather than having the patient collect the sample and bring it to the laboratory for analysis as, in the latter case, semen quality and identity is likely to be compromised. Procedures for collection of semen as described in the WHO Semen Analysis Manual must be followed with special reference to the type of container used; these containers must be sterile, maintained at body temperature and nontoxic. This room must have a washbasin with availability of soap and clean towels. The room must also have a toilet and must not be used for any other purpose.

Labelled as "men's rooms" in the clinics in my study, these rooms were designed slightly differently than the prescribed guidelines. Each room was air-conditioned, included a single

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[173] https://www.icmr.nic.in/guidelines?field_select_disease_tid=90

bed, a small flat-screen TV installed on the wall, a dustbin, and a small table with a bottle of water and tissue paper roll placed on it (see Fig. 21). However, there was an absence of a washbasin or soap inside the rooms as recommended by the guidelines and neither were there any attached toilets. Instead, in each of the clinics, one found a common toilet which was accessed by everyone. Moreover, these rooms were not located in a secluded area given that the clinics were not big-scale hospitals and had limited space, which therefore, made privacy an additional issue. For instance, in clinic C, the men's room is located right next to the doctor's consultation room while in clinic A and B it is adjacent to the waiting area. Moreover, the guidelines specify that in order to not compromise the "semen quality and identity", the collection process must happen in-house. Nevertheless, I often observed that in certain cases when some men were unable to successfully give their sample, they were sent home where they could hopefully be more relaxed, and then bring the sample back to the clinic within an hour of ejaculation.

Fig. 21. Men's room, Infertility clinic C

Interestingly, while the television in these rooms were connected to a power source, there were no functioning channels. Unlike the semen collection rooms (also known as sample collection rooms or production rooms) in western countries where pornographic magazines and/or videos are provided to assist the men for sexual stimulation (see Murphy, 2016)[174], no

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[174] See Inhorn (2007) for a discussion on the availability of pornography in certain infertility clinics in Egypt and Lebanon where pornography is illegal.

such material had been provided at the infertility clinics in my study. When I asked the Dr. Chatterjee about this, she said:

> "Actually, I think that at least some magazines should be provided because it will help the men. But I think in India, this would come across as a cultural shock. In foreign countries, it's fine. These things are open there. But in India, people don't have that kind of mentality that we can keep porn out in the open. We don't want to hurt anyone's sensibilities".

The "sensibilities" of Indian people that the doctor referred to, or the so-called Indian sense of morality in relation to pornography, is a topic I will refrain from delving into given the limited scope of this section and chapter.

In general, male masturbation has had a long history of being regarded as "a personal vice, a corruptive practice that turns the masturbating male individual into a weakling by emasculating him", writes Mohr (2018, p. 73). The socially taboo and ostensibly sinful act of masturbation is supposed to be engaged in complete privacy and behind closed doors (see Alter, 1997; Meerabeau, 1999; Mohr, 2018)[175]. However, as I have described in this section, this morally questionable and private act was rendered rather public at infertility clinic C (and also at the other two clinics) when men were loudly asked by a practitioner to give their sample. It was evident to everyone in the waiting area that the man whose name was announced was about to masturbate. As Meerabeau (1999, p. 1511) points out, men's presence in infertility clinics and their role as producers of semen is not confined to a medical act given its strong sexual connotations. Thus, regardless of the provision of a separate room, my observations resonated with Inhorn's (2007, p. 46) findings who writes that "the public nature of this most intimate act was deeply threatening, and performance anxiety problems, where men were unable to provide a semen sample, occurred from time to time". As such, the enactment of male sexuality through successful ejaculation of a 'good sample' is an intrinsic performative aspect of their reproductive and gendered role within the clinics. And the inability to produce this required sample challenges the enactment of that same gendered role, as is also indicated by the following quote of the junior doctor at clinic B where she

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[175] Along with the dominant discourses of masturbation as a social taboo and as sinful, there have also been historically alternative interpretations of masturbation as positive and fundamentally important in the enactment of masculinity and male development (Mohr, 2018, p. 74). As such, masturbation in some sociocultural contexts was/is also seen as an important step towards the becoming of 'real men'.

mentioned how men perceive their inability to produce the semen sample or the absence of sperm in their semen as if “their manhood has been harmed/stained”:

> “Most men are not willing to accept that there might be an issue with their sperm quality. I remember this recent case where the husband had a low sperm count in the first semen analysis report. He looked at it and said, ‘The report must be wrong’. I have often seen men getting angry when I ask questions about their medical history. The idea that something could be wrong with them seems unlikely to them. Some men simply assume that the problem must be with their wives. Actually, I have observed this repeatedly that many men with azoospermia [absence of sperm] or those with a low sperm count are not at all open about it. They are very hesitant to talk about it. They don’t realise that it’s a medical problem for which there can be alternative solutions. I have also noticed that such men relate their absence of sperm to impotence or a low libido. If I had to say it in simple Hindi words, *unakī mardānagī pe āñch ā jāti hai* (their manhood has been harmed/stained)!

Dr. Sen at infertility clinic B additionally informed me that some men would show disbelief if they were told that they had not produced a good sample according to their semen analysis reports. I also observed this during several consultations that when the doctor would give them the results of their report, some men would express disbelief if the results did not meet their expectations (by statements such as “Are you sure?” or “Can I look at it myself?”). The men who were informed by the doctor that they had no viable sperm or that there was a complete absence of sperm were the most visibly distraught. Dr. Sen explained to me that their incredulousness and distress resulted from them not knowing the difference between semen and sperm. He further said that for a man who had produced a large volume of semen, the assumption was that there would sufficient sperm. But the discrepancy on the reports between the volume of semen and lack of good quality sperm reportedly the men to be in disbelief. To assure such husbands who were troubled by this discrepancy, Dr. Sen would ask the andrologist to show the semen sample to the husband under the microscope. He told me that this was the best way to maintain transparency between doctor and patient. But, “what” the husband had to look for, was guided by the practitioner himself. As I have discussed in chapter three, the act of seeing – whether that is embryos or foetuses on the ultrasound monitor or sperms under the microscope – is not a natural or neutral activity and instead, is a learned and practiced skill where certain scientific facts are interpreted as objective.

Returning to the present discussion, men’s understandings of their manhood and gendered performativity in relation to the production of a good sample was also shaped by the articulations of the other actors in the clinics, primarily the medical practitioners – articulations which I suggest play a role in reinforcing and normalising the notion that the production of a good sample is related to the enactment of being a real man. For instance, after taking a look at the semen report, Dr. Chatterjee looked at a man with a grin and said,

> “Oh wow, what have you done! This is a record! Congratulations! *laughed* *the husband blushed and smiled sheepishly* This is fantastic! This is a really large sample! I have rarely seen such a large volume of semen produced by a man! And I see here that everything is absolutely normal with your sperm. Wow! Look at this! *she asked me to look at the report* The sperm motility is also excellent! Great job done! I’m very happy to see this!”

In her study of male infertility in the Israeli-Jewish context, Goldberg (2009, p. 205) notes that men were largely missing in the infertility clinics and all that left of them was their sperm. The sperm, in Goldberg’s words, was an “iconic signifier” of men’s presence in such clinics. In addition, Carmeli and Birenbaum-Carmeli (1994, p. 673) have explained that due to the general lack of emphasis on male infertility research, and the relative lack of treatment of sperm production, the “medical manipulation” is directed towards the physiological product i.e. the sperm, and not on the male body itself – although, I will shortly show that men’s bodies in the new era of assisted conception are also medically manipulated. The sperm sample which is medically evaluated primarily based on sperm quantity, concentration, and motility is constructed by the medical practitioners in terms of “results” (Carmeli and Birenbaum-Carmeli 1994, p. 673). And the success or failure to produce a good sample or a good result was applied by the practitioners directly to a man’s very potency and virility (ibid., p. 673). As such, “good results” were praised by the practitioners as an accomplishment, while “poor results” were seen by the men as personal failures. As we can also see from Dr. Chatterjee’s comments above, she congratulated a man for producing a “large sample”, expressing her happiness at the “fantastic” and “great job” he had done, and also because everything was “absolutely normal” with the sperm. Such comments, I suggest, play an important role in describing the manliness of a man by his performance, almost as if it is a hard-earned achievement.

Given the importance placed on being able to produce the imperative good quality semen sample as a way of being a real man, I argue that the inability to do the same threatens the enactment of normative masculinities which associates being a man with virility and potency. The men who were unable to produce the desired sperm and were diagnosed as infertile, the infertility specialist would offer them alternative treatment options, such as donor insemination (DI), testicular aspiration (i.e. TESA), and/or ICSI in combination with IVF (ICSI is the process where a single viable sperm is directly injected with a hollow needle into an egg for purposes of fertilisation). However, for men diagnosed with azoospermia i.e. without any sperm in the ejaculate, donor sperm-induced conception was commonly suggested by the doctors. As I show in the following section, the option of not having a genetically related child was regarded with much hesitancy and trepidation by most of the male interlocutors.

7.6.2. Donor Insemination: The Question of "Authentic Fatherhood"

As one of reproductive biomedicine's most long-standing endeavours and as a low-tech solution for involuntary childlessness, the practice of sperm donation, i.e. the collection of semen in a container through masturbation for the purposes of artificial insemination, has existed for more than two centuries (Mohr, 2018, p. 1). The process of Donor Insemination (DI) involves the sperm of a donor, i.e. a man other than the husband (or male partner) being artificially injected into the woman's cervix. Before the invention of the ICSI technology in the mid-1990s which enabled men, who have, as Dr. Sen said, "just one good runner", to establish biogenetic paternity, DI was and remains as one of the oldest, most widespread, and most successful ways to treat male infertility (Wu, 2011, p. 97). Despite DI in humans dating back to the late nineteenth century, men's experiences as users of this technology and the "masculine culture" of DI have very recently become a focus of scholarly attention (Mohr, 2018, p. 96-97).

In this section, I show how male interlocutors in my study perceived the inclusion of the third party (i.e. the donor sperm) as a threat to their enactment of normative masculinities given that they would no longer perform the role of the genitor. In addition to not being able to impregnate their wives, the notion of another man's sperm being used to induce conception was bothersome to them as is evident from the interview excerpts below:

> "Using donor sperm is out of the question! If my family ever finds out, they will never accept my child. I know that my wife is alright with it but I will never be able to accept it. My child has to be a combination of me and my wife. That is the how God intended it. Our child should look like us, behave like us, talk like us. My wife doesn't understand that she will get to carry the child in her womb but what about me? Donor sperm is not an option for me at all."
> (Bapin Dey, diagnosed with infertility due to erectile dysfunction and 'low sperm count', was scheduled to undergo TESA and then wife Tina would undergo ICSI-IVF)

> "Look, I will say this directly but I don't want to a child conceived with donor sperm. In fact, I would rather not have any children if my own sperm can't be used. I think that there can only be a real connection with children who are your own or at least from your own family. Let me give you an example. So, whenever I travel somewhere, I always try to bring back some souvenirs for the children

> in my family like my nieces and nephews and then for my wife's nieces. And that is very natural for me to first think of my sister's kids and then my wife's nieces. You know what I mean? People always think of their own people first. Also, what is the guarantee that the donor will not come in the future and lay claim on my child? Can anyone give me this guarantee? I can't take such risk. Dr. Sen has said he will give me some medicines. In case Akansha cannot have a child from IVF, then Dr. Sen has said that we will try again with ICSI. If we can have our own child, great. If not, then perhaps this is what our destiny had in store for us."
> (Sameer Agarwal, diagnosed with infertility due to 'poor sperm motility', wife Akansha was scheduled to undergo IVF and if it did not 'succeed', then IVF-ICSI)

> "Actually, I will be frank with you. I am not that modern and liberal. I cannot live with the fact that my child is born from some other man's sperm. My wife will become pregnant so nobody will ask her anything. But if the child doesn't even look like me, won't people raise questions? See I am being honest with you. If I cannot have my own child, then I will wait and we will try again. That child will never look like. Everyone will talk about this and I cannot handle such things. I think it is better to not have children than have one with some other man's sperm. And why should I go for donor sperm when the doctor said that my own sperm can be used after TESA? Arushi and I are just hoping that the next treatment works and we are able go home with a healthy baby."
> (Sudip Nandi, diagnosed with infertility, had undergone TESA and wife Arushi was scheduled to start ICSI-IVF)

In chapter three, I discussed how with the advent of ARTs, anthropologists and sociologists have noted that the understanding of kinship has been reconceptualised. Reproductive technologies have, indeed, complicated the picture of what has been deemed as 'natural' i.e. kinship, which was earlier regarded by social scientists as "a social fact modelled after nature" (Mohr, 2018, p. 101). Such technologies configure kinship in both traditional and non-traditional ways and people, accordingly, define who is kin, who is not, and what kinds of kinship count and what kinds do not (Carsten, 2004, p. 180 in Mohr, 2018, p. 101). For instance, Franklin (2013, p. 751) explains that along with assisted reproduction, particularly with donor gametes, the practice of remaking or re-crafting kinship has created non-traditional modern or achieved families. In this regard, she further writes:

> The last three decades have seen a globalization of this pattern of social legitimation, accompanied by the increasing expansion of assisted reproduction services. Increasing use of technologically assisted conception services has been accompanied by the rise of 'new kinships', such as those achieved through transnational adoption and same-sex parenthood, and by the increasing prominence of mixed and blended families. Increasingly, these new forms of kinship and parenthood, enabled by biomedical assistance and supported by changing social conventions, are in turn reshaping institutions such as family and marriage (Franklin, 2013, p. 751).

As I have also mentioned in chapter three, the enactment of kinship in South Asia, or as Carsten (2000) uses the term relatedness, has not always been associated with the exclusive exchange of bodily substances and social relatedness between the parent(s) and child(ren) has traditionally existed. However, as we can see from the aforementioned male interlocutors' accounts, they voiced their concern about not having a real connection with the desired child who would not be their own, thereby, implying that their only connection with the child would have been enacted through their sperm while the woman would have a connection irrespective of whose gamete is used since she would be the one gestating. Moreover, the men displayed a concern about the familial and social acceptance of their child due to the absence of shared physical resemblance. Such views expressed by the male interlocutors reproduce and reiterate a narrow definition of biology to circumscribe what kinship entails (see Lambert, 2000, p. 74). In other words, their statements essentialise the enactment of relatedness as genetically grounded (see chapter three). Although, none of them specifically used the term genes/genetics in their statements, recurrent implications were made to the sperm as a biogenetic substance which transfers inheritable traits (i.e. physical looks and behaviour) from the father as the genitor (see Shaw, 2018, p. 284). As such, I argue that such an understanding of relatedness as biogenetically enacted significantly shaped the male interlocutors' articulations regarding their desire towards fatherhood (wanting to have one's own child), the process of reproductive decision-making (deciding to reject donor sperm), and within these articulations, their enactment of normative masculinities is also implicated.

On a similar note, Wischmann and Thorn (2013, p. 240) explain that biological parenthood takes on more significance for men because the bonding between the father and the child is dependent on the sharing of genetic ties. The inability of a man to fulfil his role in conception leads to "a failure to create a commodity that will carry on his name and genetic line" (Hardy and Makuch, 2002, p. 22). For infertile men who are given the option of donor sperm-induced conception, they might perceive the donor as the genitor or as the real or "authentic" father (Hardy and Makuch, 2002; see also Goldberg, 2009, p. 226). In contrast, research has shown that women in general are relatively more receptive to the use of donor egg or sperm in inducing conception and that they engaged in agential acts of meaning-making to define their relatedness with the child in the absence of the transference of genetic substances from the intended parent(s) (for e.g., see Roberts, 2008, 2006; Shaw, 2018)[176]. This observation was

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[176] The process of actors adjusting their notions about relatedness in cases of third-party reproduction has been termed by Thompson (2005, p. 145) as "strategic naturalisation". Based on cases of surrogacy and egg donation, Thompson shows how different actors in infertility clinics establish and disambiguate kin relations in order to

corroborated by my study as most of the female interlocutors undergoing infertility treatments had not displayed or suggested any qualms about bearing a child who was conceived with donor sperm. In order to highlight this gendered contrast in responses towards DI, here's an excerpt from one of my female interlocutors, Kanika, who gave birth to twins after undergoing ICSI-IVF:

> "I really did not care! How does it matter? I had told my husband that we could use his brother's sperm. I wouldn't have wanted that to be honest, but I thought it would make my husband happy to know that it is all within the family. But he had not agreed to that either. Instead he had become furious with me for even having made that suggestion. He calmed down when I told him that it was actually his own mother and sister's suggestion! And because he wouldn't have said anything to them, he just told me to ignore these bad ideas. See, whoever gave the sperm, what ultimately mattered is that we had a healthy baby. I knew that once a baby comes home, all other problems would end, and that is exactly what happened *smiled*".

As we can see from Kanika's excerpt, she was not averse to the idea of conceiving with her brother-in-law's sperm to keep it "within the family" – a concern she acknowledged was to keep her husband happy. Akin to other female interlocutors, Kanika's main concern was to have a healthy baby and/or raising the child well. Another excerpt by Kajol Bose who was undergoing ICSI-IVF and whose husband, Prashant, had undergone TESA, said:

> "Prashant is actually quite progressive. That's actually one of the reasons I fell in love with him. But when it comes to this issue, he behaves like a stone-age man! We used to have so many arguments about this. I told him once, why do you unnecessarily want to put yourself through TESA when we can easily go for donor sperm? But no, he was absolutely insistent. In one of our big arguments, he shouted once at me saying why don't you sleep with another man if you are so keen on having a child with donor sperm? I was so angry! I told him to stop speaking like an illiterate ass! How can you call yourself an educated person if you have such ridiculous ideas?! I couldn't imagine those words coming out from the mouth of my husband. I honestly don't understand this obsession. I mean, I understand that this mainly about male ego and masculinity, but I would have never thought that Prashant had such orthodox views. Ultimately, what matters is that the child is healthy and how we raise it. Unfortunately, Prashant doesn't seem to understand this one small thing. This male ego – my child, my child – I find this obsession ridiculous. Actually, I have told Prashant very clearly that if this IVF does not work out, then I am not going through anymore treatments. We can try adoption and if he keeps behaving like this, then I'd rather not have a child. But I am not going to keep trying and spending my life undergoing these treatments. Don't I have anything better to do in my life? I honestly might not have done this IVF either but he and his parents were really keen that I at least try once. Of course, I also want a child but not like this. I would happily adopt a girl child if this IVF does not work out".

Kajol mentioned that she would not mind adopting but if her husband kept obsessing over having a child with his own sperm, then she would not have a child at all. She sounded slightly

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foreground and recraft certain kin differentiations while minimising others in order to make the intended parents "come out through legitimate and intact chains of descent as real parents".

disappointed when she talked about her otherwise progressive husband harboring such "orthodox views". She mentioned how they had several arguments about her husband's insistence on using his own sperm for conception and that she had told him that undergoing TESA was unnecessary when they could easily opt for donor sperm. To this, her husband had equated her being impregnated with donor sperm to having sexual intercourse with another man. In this regard, Inhorn (2006, p. 432-433) has noted in her research among the Sunni Islamic communities that the use of donor gametes was tantamount to adultery. Even though none of the interlocutors in my study were Muslims, the same tropes were repeated by Kajol and also by another female interlocutor, Tina, who said,

> "He [husband] would get angry whenever I tried convincing him for donor sperm. Once he said, if you are so interested in having a child with another man's sperm, why don't you just have sex with him?"

Both women's statements indicated that for their respective husbands, adultery was implicated in the use of donor sperm. As Inhorn (2006, p. 440) has argued, the very fact that another man's sperm "enter[s] a place where they do not belong", makes the act of using of donor sperm wrong for many men and threatening to the sacred dyadic unit of the couple.

Writing about the sacred institution of Hindu marriage being threatened by the inclusion of the donor sperm as the "third party", Bharadwaj (2003) draws attention to the concept of the "immutable triad". He writes that as in many cultures across the world, in Hindu cosmology too, there lies an intimate connection between the body and the progeny (ibid., p. 1870). This intimate, corporeal connection between the (married) bodies and their offspring is both biological and social. It is this connection, explains Bharadwaj, that binds the mother (womb), father (semen) and child (foetus) in an immutable triad (ibid., p. 1870). The destabilisation of this triad is caused by the occurrence of involuntary childlessness which then becomes a socially stigmatised condition (ibid., p. 1871). As such, Bharadwaj argues that when infertile couples seek assisted conception, they "do so in the hope of restoring the (visible) "social triad" and to create an illusion of culturally "unproblematic visuality" of fertility (ibid.). Based on such a conceptualisation of the social triad, he further argues that it is the inclusion of a third party which "fractures culturally conceptualised boundaries of a family as inextricably tied to the conjugal bond" (ibid., p. 1868). Furthermore, according to Bharadwaj, infertile couples who seek assisted conception face the possibility of breaching the normative values of Hindu marriage and family in two ways (ibid., p. 1871). Firstly, there is the fear of the "alien input or the third party" which threatens the invisible biological tripartite base on which the normative image of the family is located. Secondly, even in cases where the couple's own biological material is used to induce pregnancy, the otherwise private act of sexual intercourse is replaced by the clinician's i.e. a third party's expertise. Bharadwaj then claims that this makes the most intimate part of a marriage, i.e. reproduction, visible, and public while also putting the sacrosanct institution of marriage at stake with its boundaries being violated publicly by the inclusion of a third party (Bharadwaj, 2003, p. 1871).

Based on the interviews with the male interlocutors in my study and by drawing on scholars like Inhorn and Bharadwaj, I argue that the inclusion of donor sperm as the third party not only posed a threat to the immutable social triad but also the men's heterosexuality and enactment of their manhood and manliness vis-à-vis establishing paternity. Indeed, in order to preserve the immutable triad, enact the role of the "authentic father", and to also relatedly prove their manhood, a few male interlocutors had decided to undergo testicular aspiration (TESA), as I illustrate next. Based on this particular case study, I show how male infertility results in a crisis of masculinity and how the male body has also been brought under the clinical gaze in the world of assisted conception.

7.6.3. Testicular Aspiration: Desiring Biogenetic Paternity and Establishing Manhood

Prashant and his wife Kajol had started visiting infertility clinic C when she was unable to conceive. During their initial consultation, Dr. Chatterjee checked the reports of the couple's preliminary tests (TVS, HSG, semen collection, and blood tests) and informed the couple that while Kajol had an "okay-ish" egg quantity, Prashant's sperm motility was in an "extremely bad condition". Looking at Kajol, Dr. Chatterjee said,

> "Look, you have already come here quite late. You don't want to be running after your kid when you are in your sixties, isn't it? I honestly don't understand why educated people like you wait for so long to get this treatment. Don't you know that as your age increases, the number of eggs reduces? Anyway, better late than never. Now you are here and instead of wasting any more time, I suggest you start with IVF as soon as possible. With your age, there's anyway no guarantee of whether the first time will be a success, so we may have to try again. I recommend that you be mentally prepared that we might have to try more than once. Miscarriage might also be a possibility in your case but of course, we will hope for the best in the first cycle. I will give you some medicines and injections first and monitor how you're your ovaries are responding to them. Understood? Any questions?"

While Kajol indicated a non-verbal yes by nodding her head and started asking some questions about her diet, Prashant intervened to ask Dr. Chatterjee what she was planning to do regarding his *obosthā* (condition) and the following conversation ensued between them:

> Dr. Chatterjee (Dr.): See, you have two options. You can either choose donor sperm or undergo this procedure called TESA in which I will extract the sperm from your testicle.
>
> P: Dr. Chatterjee, I don't want to use a donor. I'm not comfortable with that. Is TESA painful?
>
> Dr.: It's just a little uncomfortable. Don't worry, you will be under general anaesthesia. You might have some swelling but that's normal and won't stay for more than a day or two. But see, my concern is that TESA might not work because as you can see from the report [semen analysis], you hardly have any good sperm. The few sperms which are present have very low motility. Even within that, progressive motility is very poor. I can try once but donor sperm would be the best option for your wife and you-
>
> P: Dr. Chatterjee, I understand but if you could please try TESA before deciding to choose donor sperm.

Dr. Chatterjee agreed to performing TESA and called in the nurse to enquire the earliest for when the Operation Theatre (OT) would be available. The consultation ended with her telling Kajol to come to the clinic from her next menstrual cycle and Prashant was given a date a month later for the procedure.

On the day of the procedure, I was having an informal chat with Prashant in the patient ward before the doctors arrived. As we were talking, the nurse came into the room and instructed him to change into a green robe and to use the toilet before he was taken to the OT. A few minutes later when I entered the OT, I noticed that the embryologist, Dr. Bose, and her assistant, were already in the embryology lab. Prashant was accompanied to the OT by a male nurse who told him to lie down on the surgical bed. This was followed by the male nurse covering Prashant's body with a green sheet. Meanwhile, the infertility specialist, Dr. Chatterjee, walked into the room while adjusting her surgical gloves. She was followed by the male anaesthesiologist whom I had seen for the first time at this clinic[177]. Without saying anything to Prashant, the anaesthesiologist attached the monitoring device on his finger and chest to observe his vital signs. Prashant was then sedated under general anaesthesia and was asked by the anaesthesiologist to count in reverse from ten to one. In a few seconds, Prashant became unconscious and the male nurse removed the green sheet from his body. The male and female nurse worked together to swiftly remove Prashant's robe following which they

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[177] I had observed that at all three infertility clinics, it was common to bring in anaesthesiologists on a freelance-basis. Furthermore, since I knew that clinic C had an all-female staff, I was curious to see two male practitioners inside the OT. I had asked Dr. Chatterjee about this anomaly later to which she said that they had at least one or two men in the room when any male patient underwent this procedure. She told me that seeing all women around could be embarrassing or humiliating for the male patient and the presence of other men in the room would make the patient more comfortable.

placed each of his legs on the stirrups, strapped them with Velcro, and covered each leg with a green cloth. The male nurse then placed another green sheet on top of Prashant but this sheet had a big hole which exposed Prashant's testicles. As Dr. Chatterjee sat on the stool, she told the male nurse to bring Prashant further down on the bed. In order to reposition Prashant's body, the nurse dragged Prashant's unconscious and limp body, pushing and pulling it from one side to another, until Dr. Chatterjee said it was fine. The procedure started with Dr. Chatterjee rubbing Prashant's testicles with an antiseptic liquid. She then wore glasses with smaller microscopic glasses attached to them. The female nurse handed over a finely aspirated, thin-gauged needle to Dr. Chatterjee which she took with her right hand and simultaneously used her left hand to hold one of the testicles. The female nurse positioned herself next to Dr. Chatterjee while holding a petri-dish. Over the next twenty minutes or so, Dr. Chatterjee removed a few sperms from one testicle at a time and placed them delicately inside the petri-dish. Halfway into the procedure, I saw one of Prashant's toes wiggle slightly and he had started groaning softly. I noticed the anaesthesiologist did not push in more sedative. When I had asked Dr. Chatterjee after the procedure as to why the Prashant was not given a stronger sedative, she said that it was not a very painful procedure like egg retrieval in women. She added, "Women endure much more pain during [their] surgeries! He is a man, he should be able to endure this much pain!"

Once the procedure was over, Dr. Chatterjee removed her surgical gloves and left the room along with the anaesthesiologist while the female nurse handed over the petri-dish to the embryologist. The male nurse removed the green sheet from Prashant's body and replaced it with the previous green sheet which covered his entire body. By this time, even though Prashant was still unconscious, the volume of his groaning had increased and he had started moving his fingers and toes lightly. I was informed by the male nurse that Prashant would gain complete consciousness in a couple of hours and he would be allowed to go home that evening. He also mentioned that Dr. Chatterjee would recommend medicines for Prashant to treat the post-operative fatigue, residual pain, and potential swelling of his testicles.

When a childless couple seeks assisted conception through IUI and IVF, the role of the man in impregnating the woman through sexual intercourse gets suspended. Instead, the ARTs and the medical practitioners take on the primary roles in making the woman pregnant. As such, the only physical contribution of the man in the act of conception is to ejaculate through masturbation and produce a good semen sample (see section 7.6.1). However, if the man is diagnosed as infertile (or impotent) and is unable to provide the sperm, the use of donor sperm to induce conception invalidates the man's presence, both physically and genetically. Thus, as has also been shown by other researchers (for e.g., see Chowdhry, 2007, Khan et al., 2008), the diagnosis of male infertility results in a crisis of masculinity and the use of donor sperm exacerbates this crisis. As we saw in Prashant's case, he insisted on undergoing TESA even though Dr. Chatterjee had expressed her apprehension considering his sperm motility and had given him the option to circumvent the procedure by choosing donor insemination. Inhorn (2007, p. 49-50) has rightly argued that "the earlier feminist credo that only women's bodies are violated in IVF – while men's bodies go 'untouched' – is no longer legitimate in the new era of assisted conception at the turn of the century". Like Prashant, there were other male interlocutors in my study who after having been diagnosed as impotent or infertile voluntarily decided to undergo the uncomfortable medical procedure of TESA instead of opting for donor sperm-induced conception. This is a telling aspect of men's reproductive practices because they chose to suffer the "embodied agony" of this medical procedure which includes "testicular needlework", a process accompanied by pain and discomfort (Inhorn 2007, p. 49) – pain which in Prashant's case was overlooked by the doctor on account of him being a man. With reproductive technologies such as TESA and ICSI, men with low sperm count or poor quality sperm have the option to use their own sperm for conception and, thus, be able to maintain genetic ties with the intended offspring. The availability of these technologies aimed at treating male infertility reinforces the notion of biogenetic relatedness while simultaneously creating an opportunity for infertile men where if they undergo an operation, they can (potentially) become the father of their own child, and in the process, maintain their manhood. As such, I argue that the availability of and access to such technologies compel men to enact normative masculinities in relation to establishing their heterosexuality and virility.

However, not all the male interlocutors in my study were insistent about achieving biogenetic paternity. I would now like to present the case of Rahul who questioned societal norms regarding masculinity and was the only male interlocutor who had not expressed any major concerns or anxieties about having a child conceived with donor sperm.

7.6.4. Questioning Normative Masculinities and Biogenetic Paternity: The Exception

My first encounter with Rahul and his wife Vaishali happened at infertility clinic C when they had come for Vaishali's TVS. During the interview subsequently, Rahul informed me that they had been trying for a child for over a year and had finally decided to consult Dr. Chatterjee. With a smile, Rahul said:

> "Vaishali and I both love children. In fact, I would love to have two children – a boy and girl. Also, I am the only son of my parents. I have no siblings. So, my parents have this expectation from me and Vaishali that we will give them a grandchild soon. They want a grandchild who will take forward the family name and we both also wanted children. So, Vaishali and I decided to not wait for long after getting married. Since we were already trying for more than year one year and nothing had happened, we decided to consult a doctor."

He then told me that his semen analysis report had shown that he had azoospermia (i.e. no sperm in the semen). Dr. Chatterjee had reportedly suggested the couple that their only option was to use donor sperm with which they would first try IUI and then IVF, if necessary. I asked Rahul his views about using donor sperm, to which he said:

> "I have no problem with this. What problem will I have? It does not matter where the sperm comes from, at least for me and Vaishali. We are both fine with this. I know that the baby will grow inside my wife so I would already consider it as my own. Also, for me, it doesn't really matter where the sperm or even egg comes from, because it is the environment that finally matters. I mean, the environment the child is raised in, matters the most to me. How the child will grow up depends on how Vaishali and I raise it. What if we have a child who looks like us and then turns out to be a bad human being? I want to have a healthy child, that's all, and raise a good human being and for that, it doesn't matter where the sperm comes from. And just because I couldn't make Vaishali pregnant due to my own problem doesn't mean that she shouldn't have a child. Her happiness is the most important thing for me and I know that a child will give her that happiness."

Compared to the other male interlocutors who had been diagnosed as infertile and had expressed their averseness to the idea of donor sperm-induced conception, Rahul was the first and only male interlocutor across the three infertility clinics with a different perspective. He was not only critical of the norms attached to masculinity in the Indian society but also questioned the very notion of biogenetic paternity. When I asked Rahul about his thoughts on donor sperm and whether it affected his *mardānagī* (manhood), he said:

> "Actually, if I tell you honestly what I really think, then I think that the society has very twisted ideas about what it means to be a real man. Who I am is not defined by my ability to produce sperm. I should be judged on how I am as a person, what kind of a son I am, what kind of a husband I am, what kind of a father I will be. Frankly speaking, when the doctor told me I have azoospermia, I was very concerned. I thought it's my fault..*asked if he could share something personal and I told him that he could speak about anything he wanted to* Okay, thank you. I think I can be open with you without you judging me. You're a researcher so you will not think like other people. Actually, I have been

> masturbating regularly since I was nine or ten years old. It was a very normal thing for me to do. There wasn't a single day when I didn't masturbate. Even after I started dating Vaishali, I would masturbate once a day at least. I told Vaishali about this too. She would sometimes joke about my heightened *ṭharak* (lust) *smiled embarrassedly* but she never had an actual problem with this. I would encourage her to masturbate as well. She would feel very shy in the beginning but then she started enjoying it. I felt my day would be incomplete if I hadn't masturbated at least once. I would start feeling strange and anxious if I didn't do it once a day. But when I found out that I had azoospermia, I actually thought that it's because I was masturbating so regularly that I didn't have any sperm left. I didn't know how to speak to the doctor about this. For a couple of days, I was quite disturbed because I kept thinking that I did this to myself. It was only after researching online about azoospermia that I realised that my masturbation was not the reason. After that I felt much better and I realised that it's now time to stop thinking about all this and focus on having a child *smiled*."

Even though Rahul spoke about not being worried about the source of the sperm, he nevertheless wanted to ensure that nobody had access to this information owing to his "very conservative and very traditional" family members:

> "I don't want my family to know that we are using donor sperm. I told Dr. Chatterjee to ensure that the donor has some similarity with how I look, like my height and my skin colour. See, both Vaishali and I as well as our families, all of us are tall. So, if our child was short, then there might be questions and we don't want to face such things. People might not ask me anything but they may bother Vaishali. My family does not think like us. They are very conservative. They are actually very traditional so it's best that they never find out. Actually, I have also told Dr. Chatterjee that I will pay the money for the donor separately so that it doesn't show on the actual bill. I have told Vaishali also to never tell this to anyone. Why invite trouble? I believe that some things can stay between the married couple. And, it is possible that if my father finds out that our child is born from some other man's sperm, then he will not include my child in the will [property]. So, the best thing is that nobody ever finds out about this."

Rahul's association between his diagnosis of azoospermia and infertility with his daily practice of masturbation since he was a young boy draws a parallel to Inhorn's (2007, p. 43) research where she notes that infertile Muslim men in Egypt and Lebanon also expressed their sexual guilt and lamented about their youthful practices of excessive masturbation in their pre-marital days as the plausible cause of their infertility. Rahul was one of the handful of men in my study (other than the male interlocutors whose views I described earlier in this chapter in section 7.3.1) who took a critical stance towards Indian society's "twisted" ideas about what it means to be a man. Based on his acceptance of donor sperm-induced conception, I show that Rahul transgressed the dominant norms of hegemonic masculinity which conflates manhood, virility, and biogenetic paternity. Instead of enacting his masculinity in relation to his ability to produce sperm ("it doesn't matter where the sperm comes from"), Rahul enacted his masculinity through the relational identities in his life, such as being a good son, a good husband, and a good father in the future. Moreover, he enacted his relatedness with his desired child not through the sharing of his genetic substance but rather by the fact that the child would grow in his wife’s body. He further emphasised on him and his wife providing a good environment for the child’s socialisation. Emphasising on nurture over nature, what was evidently more important for Rahul was not that the child shared physical resemblance with himself or his wife, but rather that it is healthy and someone who is raised to be a good human being – the same marker by which he expected himself to be understood by the society as well. Finally, Rahul also mentioned that if he could not impregnate his wife due to his own ‘problem’, that did not mean that his wife should not have a child. Prioritising his wife’s happiness, he displayed a sense of care and concern which is conventionally not accounted for by forms of normative masculinities. As such, I suggest that Rahul’s enactment of how to be a man is an illustration of “emergent masculinities” (Inhorn, 2012) wherein he enacts a new form of manhood which is not exclusively defined by a man’s ability to establish relatedness between himself and child through genetic ties (see section 7.3.1).

Even though Rahul suggested that he and his wife were comfortable with their decision to have a child through donor insemination, he mentioned wanting to keep this a secret from their families. According to Wischmann and Thorn (2013, p. 240), DI has been shrouded in secrecy for many decades and for men, the secrecy is warranted based on two fears. Firstly, in heterosexual couples, DI reveals the male partner’s infertility in contrast to adopting a child where the secret of which partner is infertile can be kept hidden from other people. Secondly, the donor’s contribution results in a non-normative family composition where many men (and other people, if they found out about the donor sperm) might consider the donor as the genitor. Primarily based on the second reason, Rahul expressed his apprehension about hassles in the future regarding the child’s paternity, his wife being bothered by others, and their child being left out from inheritance of property if people were to find out the child’s ‘origin’. As such, in order to ensure that the child resembled Rahul so as to avoid any potential questions from his family in the future, he had asked the doctor to select a donor who had similar physical characteristics as him, such as height and skin colour. His narrative, therefore, indicates the enactment of forms of emergent masculinities through his transgressive act (i.e. of rejecting biogenetic paternity and biogenetic relatedness), albeit within the existing discursive framework where he acts strategically within the constraints of patrilineal kinship and power relations within his own family. As Butler (1995) has argued, subjects are constituted by and through the very discourses they are located in and it is within those discursive frameworks that they establish and sustain their agency (see chapter two).

Finally, I engage with some of the male interlocutor's responses regarding adoption wherein I show that along with donor insemination, child adoption also posed a significant threat, perhaps even more than donor insemination, to their enactment of normative masculinities.

7.6.5. The 'No-Man's Land' of Adoption

Social science research on child adoption in South Asia, and especially in the context of infertility and involuntary childlessness has largely been neglected (for exception, see Bharat, 1993; Lamichhane, 2022). According to Bharadwaj (2003, p. 1868), the societal stigma attached to adoption is an underdeveloped field of qualitative study in the Indian context and there is only hearsay evidence on how infertile couples, who are already stigmatised for their inability to reproduce, are stigmatised further if they seek adoption. Although child adoption has been practiced in India for thousands of years and Hindu epics such as the Mahabharata and Ramayana also bear references to adoption, it was always the adoption of a male child as the potential lawful heir who would receive the father's inheritance and also perform the last rites in the event of the father's death (Bhaskar et al., 2012, p. 3-4). Legal domestic adoption in India gained momentum only as late as the 1980s (ibid., p. 2). Kalra (2018) points out that the Indian government's Central Adoption Resource Authority (CARA) statistics show that the numbers of adoption in India have been dropping in the past few years. According to CARA, in 2010 there were 5,593 adoptions in India which reduced to 3,276 in 2017-2018. As of 2018, there are approximately 20,000 couples in line waiting to adopt as compared to the 27.5 million infertile couples in India who are pursuing assisted conception according to the Indian Society of Assisted Reproduction (Kalra, 2018).

Before the advent of ARTs in India or broadly in South Asia, infertile couples turned to adoption as their only means of forming a family (see Bharadwaj, 2003, p. 1868). As Lamicchane (2022, p. 230) writes in his study of involuntary childlessness and masculinity in Nepal, adoption (and foster care) is not a novel practice for family formation in (Hindu) South Asia. It should be noted though that the preferred format of adoption included a consideration of certain features of "lineal masculinity" (Lamicchane, 2022, p. 236) such as maintenance of caste purity, shared physical resemblance, preference for a young infant in order to mimic biological reproduction, and a high demand for male children. However, with the easy availability of ARTs, and especially easy access for the economically affluent middle-class couples, adoption had either become the last resort if all other options have failed or no resort at all for the male interlocutors in my study. In contemporary times, Bharadwaj (2003, p. 1868) points out that adoption is usually seen as an option for less affluent couples who due to financial hardships are not able to afford the infertility treatments for an extended period. As I also observed in my own research, the couples from economically disenfranchised backgrounds were usually able to afford only one IVF cycle, and that too by taking loans and/or having mortgaged their homes. This was in stark contrast to the middle-class couples in my study who could afford multiple treatment cycles as long as they could have a (preferably genetically related) child.

My concern in this section, however, is not with why involuntarily childless couples who have experienced reproductive loss do not adopt. Instead, I briefly examine how the discursive norms of conception, biogenetic relatedness, and normative masculinities moulds men's attitudes and views regarding adoption and influences their decisions of not wanting to adopt. While none of the female interlocutors expressed any reservations in adopting a child, the male interlocutors expressed significant apprehension and reluctance. The following quotes are from four male interlocutors when I asked them whether they would adopt a child if the infertility treatments did not result in reproductive success:

> "I have never thought about adoption because I don't think I have such a mentality. Actually, I think most people in India still don't have that mentality. I don't think it's easy to raise an adopted child. I can't treat someone else's child as my own especially when it comes to punishing that child. Loving is not the difficult part because you can love any child. But if I want to punish or scold or hit a child to teach him that he or she has done something wrong, then I can't do that with someone else's child. You know how there is a saying, *pēṭēr ār piṭhēr kokhonō ēka hoyē nā* (literally means that the one from the stomach and the one from the back are never the same - a common Bengali metaphor which means that the child born from the womb can never be the same as the one who is not from the womb). Ultimately, your own child is your own..Besides, we live in a society which is very judgemental. People can say all kinds of unpleasant things and I don't want a child to be psychologically affected because of what people might say later. You never know when a person might tell the child that it is adopted, even if it is done accidentally, and how that would affect the child."
> (Tanmoy Mondol, wife Meha has had undergone two IVF cycles, 2 miscarriages)

> "Who is going to get into the hassle of adopting a child? It's such a long process! Actually, I will say this because you asked me about adoption. I think I would rather go for a donor. At least that way, my child would grow inside my wife's body. It will not come from some absolute strangers whom I will know nothing about. And frankly, I know that this is something that almost everyone thinks about but most people wouldn't admit it because it sounds mean or impolite. Just imagine, there is a random kid in front of you, who is covered in dirt or who has a runny nose and is crying – would you want to pick that up? *I smiled* No, right? But if it was your own child, you wouldn't have any hesitation. Even if your child is covered in shit, you would happily pick it up and clean it. But you would never feel the same way for another child! This is a fact and people might think I am being mean by saying this but I know that this is exactly how most people would think in their mind. And see, I have a lot of property and money to

> my name and I don’t want any random child to have it. Who knows who all will claim it after I die or when I am very old to do anything about it? If I can’t have a child of my own then I’d rather make sure that my brother and sister’s children get shares and also, I’d like to leave some for Akansha’s nieces. It’s simple – I have worked hard for this and for me, it’s important that all this remains within the family.”
> (Sameer Agarwal, wife Akansha was starting her first IVF cycle during this interview)

> “Wanting to have one’s own child is normal. That’s what we think. We don’t have financial problems so we can afford these treatments. It’s expensive but we both really want this. This is our last try with IVF and if this also doesn’t work, then we will go for surrogacy. We have discussed this. Money is not a problem. We just want our own child. We have already spoken to Dr. Bose and she has said she will tell her agent to start looking for a surrogate. Somebody else’s child, I don’t know. I don’t understand how people can be comfortable with knowing that they are raising someone else’s child. It feels almost abnormal to me. It’s always going to be at the back of my mind that this is not my child. I will never be able to see Sumita or myself in that child. Other people will also immediately know the child is not ours. It’s nice that others can adopt but I am very uncomfortable.”
> (Anand Roy, wife Sumita has undergone 5 IVF cycles, had 3 miscarriages, and was undergoing the 6th IVF cycle during this interview)

> “To be honest, I don’t know how attached I would feel to an adopted baby. People keep saying that an adopted child will never be the same as your own child. I also have the same feelings. And if we can afford to have our own baby through surrogacy, then why should we adopt someone else’s baby? Sushma might have been okay with it finally but I don’t think I would have been happy with that decision. With an adopted child, you never know about the biological parents’ background. We could end up with a child who has some serious physical or mental problem which we might not find out for years. Then, what do we do? Also, we don’t know under what circumstances the child was born. There is no guarantee we will ever find out about the actual parents’ history. So, we don’t want to take such a risk.
> (Pradeep Banerjee, wife Sushma Pal, surrogate was 6 months pregnant during this interview)

In these aforementioned excerpts, two tropes emerged prominently and repeatedly – first, the ubiquitous insistence by the men on desiring and having one’s own child and, second, the distinction they drew between the normalcy of desiring and raising one’s own child as opposed to the abnormality of raising someone else’s child. The common reasons cited by the men in expressing their reluctance towards adoption centred around being unable to share genetic ties with the child. They further stated that they would be unable to treat an adopted child in the same way as a biological child. For instance, Tanmoy pointed out that while it is easy to show affection to an adopted child, punishing that child who is not his own would be a challenge. He also pointed out that raising a child in a society which is judgemental could be psychologically harmful to the child because of what other people might say. He used the Bengali metaphor - *pēṭēr ār piṭhēr kokhonō ēka hoyē nā* i.e. the child born from the womb can never be the same as the one who is not from the womb – in order to express his reservations about adoption. The second interlocutor, Sameer said that he did not want his property to be passed on to an adopted child and that he wanted to keep his property within the family. By emphasising the need for a genetically related child, he enacted his masculinity which was coated with the desire of perpetuating relationships based on the transference of property. For Anand, he regarded it as abnormal to raise a child which was not his own and for Pradeep, not knowing the background of the adopted child's parents was a problem since the child might have some physical and mental problem that he would not know about beforehand, thus, making the adopted child a liability. In this regard, Bharadwaj (2003, p. 1876) has pointed out that it is interesting "how the invisibility of a child's origin marks him/her as socially deficient". Furthermore, it is the quality of the invisible background of a child he argues, that becomes a concern for people and that concern is manifested in their questions about the "genetic credentials" of the adopted child (ibid., p. 1877). "Such a concern is in consonance with apprehensions surrounding the invisible bloodline, clan and caste origins of an adoptee", states Bharadwaj (ibid.).

Based on their studies in Egypt and India respectively, both Inhorn and Bharadwaj (2003) have suggested that most men would rather resort to ARTs as their only viable option for having a child instead of opting for social fatherhood through adoption. Bharadwaj (2003) explains,

> …when reproduction goes awry, couples would rather secretly resort to accepting donated sperm than choose the option of adoption, an option that evokes widespread fears of making infertility permanently "visible" and irreparably upsetting the sacred social and biological triad of mother (womb), father (semen) and child (foetus) (Bharadwaj, 2003, p. 1879).

My research findings resonates with studies as I have shown so far in this section. As Sameer mentioned, he would rather have a child with donor sperm because at least it would grow inside his wife's body as compared to an adopted child from "absolute strangers". Accordingly, I suggest there is a certain invisible but evidently dominant and influential hierarchy in the domain of assisted conception when it comes to which form of third party input a childless couple is willing to include and accept in their pursuit of a child. My findings show that the acceptance of a donor gamete to have a child was relatively more than the acceptance of adoption. Even within the realm of donor gametes, conception with donor egg was accepted relatively easily than conception with donor sperm. If donor gametes were not an option, then financially affluent couples opted for surrogacy, preferably using their own gametes. Given that in the case of adoption, the female partner is not visibly pregnant, for some men adoption poses more of a threat to the enactment of masculinities than conception induced with donor sperm as it is the visibility of the pregnant female body which becomes a testament to the male partner's virility, heterosexuality, and as a corollary, of his successful manhood (Bharadwaj, 2003, p. 1870). Moreover, I suggest that the availability of the ARTs along with the role played by the medical practitioners in essentialising the role of genetic ties in creating a normal family (see chapter three) pushes the option of adoption at the bottom of the hierarchy. Instead, within the biomedical spaces of the infertility clinics, the notion that both relatedness and masculinity are ideally enacted through the achievement of biogenetic paternity, is reproduced, reinforced, and normalised on a daily basis.

7.7. Conclusion

While conceptions of femininity(-ies) are widely deliberated amongst scholars on reproductive health, masculinity(-ies) has been largely sidelined. As such, the primary concern of this chapter has been to examine the middle-class male interlocutors' lived realities, embodied experiences, concerns, and anxieties in relation to conception, reproduction, fatherhood, and reproductive loss. In my ethnographic engagements with men's diverse subjectivities, I have demonstrated that they enacted multiple forms of masculinities which challenged and countered the normative forms of masculinities. I have presented several cases which illustrate that even within the same narrative, there is not a singular and fixed, but rather, multiple and relational ways of being a man. In addition, I have also argued that the men's reproductive aspirations, motivations, and treatment-seeking practices were more diverse, complex, and nuanced than the concept of hegemonic masculinity allows us to understand. Throughout the chapter, I have shown that the enactment of these multiple forms of masculinities were shaped by the culturally specific norms of kinship, biogenetic relatedness, pronatalism, and the gendered notions of procreation while being embedded in the contemporary, middle-class, urban Indian setting.

I started the chapter by offering an insight into the concept of hegemonic masculinity and male infertility in order to offer a contextual backdrop against which the remaining chapter is situated. In the first section, I discussed men's aspirations to become a father and in the process, I highlighted how the desire for fatherhood was deemed as natural and a normal life progression for an adult male. Emphasis was placed by men on the need to have a child who resembles them, thereby, reinforcing the enactment of relatedness through the sharing of genetic substances. I suggested that on the one hand, the men's responses were reflective of the pervasive pronatalist ideology in the South Asian context and the dominant ideals of normative masculinities which mandates the achievement of biogenetic paternity in the enactment of a ‘real man’. On the other hand, these narratives were also reflective of newer forms of fatherhood through which these interlocutors enacted forms of “caring masculinities” (Elliott, 2015), for instance, by expressing their excitement, eagerness, and longing to be an active caregiver and be emotionally involved in their wished-for child’s life and upbringing. In the second half of this section, I offered contrasting examples of men who displayed no such apparent innate desire to become a father and instead enacted their masculinities by expressing their modern views (in contrast to ‘traditional’ and ‘orthodox’ mindsets which deem procreation as natural and necessary for reasons such as having an heir, particularly a son, for property transference, fulfilling filial obligations, and for performing funeral rituals). Nevertheless, these interlocutors agreed to have a child because of the love they harbored for their respective wives whom they also had sympathy for given the social pressure the latter had to face for bearing a child. In prioritising their marriage, expressing their love and affection for their wives, and agreeing to have a child to satisfy their wives’ reproductive desires, I suggest that they enacted forms of “emergent masculinities” (Inhorn, 2012) by defying gender stereotypes of how to be a man.

In the fourth section, I discussed the case where a male interlocutor and his wife experienced reproductive loss in the form of a miscarriage to show that this interlocutor’s enactment of masculinities rejected the cultural ideology of toxic masculinity which assumes that men are aggressive and incapable of being considerate and sympathetic. However, in order to ensure that he could be emotionally available for his wife, this interlocutor performed the masculine norm of emotional restraint and accordingly, refrained from expressing any visible signs of grief in front of her. Instead, as he said, became the shoulder for her to cry on. Next, I looked at the narrative of another male interlocutor who enacted forms of what I refer to as “vulnerable masculinities” which I suggest challenged and transgressed the norms of toxic masculinity according to which men must never expose their vulnerabilities. While this interlocutor expressed his emotions through tears during his narration about erectile dysfunction and the loss of his manhood since he had been unable to impregnate his wife through normal (penetrative) sex, he did however mention that as the husband, he would need to be emotionally strong for his wife, thus adhering partially to the norm of stoicism.

Finally, in the last section, I engaged with men’s reproductive experiences and treatment-seeking practices in order to examine the interplay of heterosexuality, virility, and masculinities within the biomedical spaces of infertility clinics. I started this section by discussing that as reproductive persons, men are only required to provide the sperm for conception and, thus, the social and internalised pressure to produce a ‘good sample’ of semen with ‘normal’ sperm quantity and quality created a significant amount of distress both somatically and psychologically. This further resulted in them not being able to ejaculate on the first couple of attempts and I have argued that the inability to ‘perform’ threatened their enactment of normative masculinities. Further, I have shown that infertile men whose semen analysis reports showed that they had some viable sperm preferred undergoing the uncomfortable medical procedure and the embodied agony of testicular aspiration than opt for donor sperm-induced conception in order to have a genetically related child and thus, establish authentic fatherhood. I did, however, discuss an exception to the rule of biogenetic paternity in which one male interlocutor agreed to have a child conceived of donor sperm, emphasised on the importance of nurture over nature, questioned the societal ideas of associating manhood with being able to produce sperm and father a child, and in the process, transgressed dominant ideals of normative masculinities. Such a dissenting voice makes it possible for me to explicate that the discourse on masculinities is, indeed, not homogenous. I ended the last section by briefly exploring that for the men in my study, adoption was not an option at all in their pursuit of a child based on reasons of not being able to establish a “real connection” with a child and being uncertain about the origins of that child and its parents. Throughout this last section on men’s reproductive practices, views, and experiences, the common strand which tied them all was my argument that the availability of ARTs, particularly TESA and ICSI, created the desire among men to try and establish biogenetic paternity (instead of opting for a donor sperm or adoption) and in the process, compelled them to enact forms of normative masculinities in a more accentuated manner.

I now proceed to the final chapter wherein I present a summary of the intricately entangled ethnographic findings I have engaged with so far followed by a few comments on the implications of this study and the scope for future research.

Chapter 8. Conclusion

> “The IVF circus has spread like wildfire nowadays! It seems you can find an infertility clinic every few kilometres! I’m sure you have noticed the numerous advertisements on hoardings. But back then, things were different. See, I was married when I was 21, a few months after I finished my under-graduation. It was an arranged marriage – my husband’s family and my uncle’s family knew each other so that’s how our families got in touch. After a year of our marriage, everyone started asking us for the good news. I didn’t know what to say, so I would usually smile and remain quiet. We tried but I wasn’t able to conceive. Our close family members and friends who found out about this, started giving us all kinds of advice and suggestions. We went to three doctors who asked me to get some blood tests done. I remember having ultrasound scans and then I was given lots of pills and some injections but nothing was working. When five years had gone by and we still didn’t have a child, our relatives were saying all kinds of things and everything was aimed at me. Initially, I would become very upset and spend hours crying. If we had more treatment options back then, we would have tried them, mainly because I was so tired and angry of people asking me and blaming me all the time."

The excerpt above is from my interview with 53-year-old Ruma, a retired primary school teacher. I had chanced upon meeting her at the diagnostic centre where Infertility Clinic A was located (see chapter two) and where she had come for her annual health check-up. Getting to know about my research topic seemed to have evidently moved her as without me having asked her any questions, without any hesitation, and with much poignancy, Ruma’s life story tumbled out of her. I realised that our conversation would be a long one – she had a lot to share and I wanted to listen. We moved to a nearby café after she had finished her tests. Over coffee and sandwiches, Ruma went on to say:

> “One day I decided that I have had enough. I told my husband that I can’t do this anymore. I was fed up with people saying rubbish. They would show him sympathy and taunt me. My sister-in-law once said, ‘Oh such a pity, my brother loves children so much but he couldn’t get one”. I snapped and told her to mind her own business. Since then she has not said a word about this. My husband and I finally decided to tell people that we never wanted children. But after this, we heard people say that we are selfish, that life without a child is meaningless, and that we must be hiding something. People are never happy! Everyone in India is interested to know what is happening in someone else’s life. It’s unbearable! Over time, people gradually stopped poking their nose into our personal lives. They must have become tired *chuckled* I decided to get a diploma in teaching and I became a kindergarten teacher and then a primary school teacher. I have been a teacher for almost 20 years. I have never felt the need to have a child who came from my womb when there are so many children in the school whom I could love immensely. People need to understand that children are children, whether you give birth to them or not. This obsession about having *my own* child – I really do not understand this. Having one’s own child isn’t the only purpose of life.”

A couple of hours later, both Ruma and I realised that it was late and we both had to get back home. Before leaving, she hugged me and said,

> “You know, I would have never thought when leaving my home today that I would have met someone with whom I would share things about my life I haven’t shared with anyone else. Really, I am so glad that I have been able to talk about this with you. I have to say that your research is very important

> because people in our society need to know about the kind of pressure that women and even men feel to have a child and that nobody should be pressured like this .It's really sad that women are made to feel like failures because they didn't want to or choose to become mothers. Look at me. I don't see myself as a failure at all. I live a very fulfilling life with my husband. I have had a wonderful career. My husband and I have been taking singing lessons. We frequently travel with our friends. We are healthy people. We have a wonderful social life. What's there to miss? Not having a child hasn't ended our lives…Yes it's true and I won't deny that I wanted a child when I was young because I thought that's what people do. That it is natural. But today, I have no regrets at all *smiled*."

Facing familial and societal pressure to reproduce soon after marriage, being singularly taunted and blamed for the absence of a child in the marital relationship, and the clinical gaze on the female body – not only do these experiences form the detritus of Ruma's long journey from being an aspiring mother to a contented individual, but also resonates with the experiences of other female interlocutors in my study. What was also similar across these life stories was the women's utilisation of multifaceted forms of agency within their constrained circumstances – agency not only as act(s) of resistance, choice or free will at specific moments in time but as their processual capacity to give meaning to their lived realities, to counter the diverse constraints, and to participate in the (re)creation of their own world. Like the other female interlocutors, Ruma engaged in the process of meaning-making by actively deciding how *she* wanted to define her life. Contrary to the pronatalist injunction of motherhood and reproduction, she gave meaning to her life through her career and a vibrant social life. However, unlike the other female interlocutors and/or couples who relentlessly pursued assisted conception to have a child (preferably genetically related), Ruma utilised her agency by deciding to transform her involuntarily childless life into living a voluntarily childfree life[178]. She found joy in being with children in her school and spoke about maternal love as not contingent on biological ties. Although her younger days had been about wanting a child because she thought of it as the natural and normal thing to do as a married woman, in hindsight, she is decidedly sanguine that she has had a fulfilling life and there was nothing that she missed or regretted. It does merit mentioning that her smile came as a welcome epilogue to her narration, and the realisation it emerged from. In another important aspect, Ruma's

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[178] See Riessman (2000) for a discussion of how in the face of social constraints and stigma, involuntarily childless women in south India exercised their agency by transforming their lives; See also Butler (2003 in Magnus, 2006, p. 100) who has argued that the transformative potential of individuals within the constraints of existing social discourses indicates individual agency.

narrative is unique compared to the other female interlocutors, and addressing that next, helps me in driving home my first argument in this study.

Ruma mentioned that when she and her husband were trying to have a child during the late 1980s and early 1990s, neither had the “IVF circus” spread like wildfire and nor was there a prominent presence of such infertility treatments in the public discourse in India. As I have mentioned in chapter one, it was since the early 2000s that the biomedical fertility industry started thriving as part of the private health care sector in India and only in the last two decades has there been a rapid escalation in the number of such clinics in the urban Indian landscape. It was also roughly around the same time that (bio)medicalised reproductive practices, such as hospitalised births and elective caesarean sections, were becoming the norm for the modern middle classes in urban Indian cities . As such, my first argument in this study has been that the sociocultural and socioeconomic context of 21st century, globalising, middle-class, urban India where reproduction is increasingly biomedicalised and where couples increasingly want to emotionally and financially invest in raising one or two ‘normal’ children *creates* a historically *specific version* of reproductive loss and grief. As I have demonstrated across this dissertation, this particular discursive context creates a *heightened* sense of loss and (maternal) grief for the married couples in Kolkata. It further prescribes a particular way, i.e. biomedical interventions, in which to ‘resolve’ the ‘problem’ of involuntary childlessness and achieve reproductive success – experiences and conceptualisations of loss and success which would not have been conceivable in the same way before this period.

This brings me to the second argument of my study that it is not only the above-mentioned discursive context which produces and shapes intense forms of loss and grief. Instead, the couples’ experiences of reproductive disruptions and their ensuing attempts to achieve reproductive success were also *shaped* by multiple ‘enactments’ (Mol, 2002) of gendered identities and roles of the involved actors (particularly the married women and men), of the nature of certain entities (such as foetuses and embryos), of gendered emotions (such as hyperemotionality and emotional restraint), and of certain normative concepts (such as relatedness). Based on numerous ethnographic accounts, I have demonstrated that these identities, roles, entities, emotions, and normative concepts which shaped the profoundly gendered reproductive experiences of the couples were not pre-ordained or fixed. Rather, I have shown that they were recurrently done or enacted in relation to each other and it was the coming together of these multiple enactments which ultimately shaped the couples' experiences of reproductive loss and of the various disruptions in the aftermath of loss. Furthermore, in each chapter, I have shown that as part of these multiple enactments, the agency of the interlocutors, particularly of the women, was repeatedly constrained by other human actors and non-human actants (Latour, 2005), such as the medical practitioners and reproductive technologies. In describing these enactments, I have paid attention to the way in which the agentic capacities of the female interlocutors were curtailed by systemic constraints in the biomedical spaces (such as the medico-technological demands) and by ideological constraints within the site of heterosexual marriage (such as the middle-class morals for married women in India).

This study, however, has not only been about portraying the various constraints on the couples', and especially, the women's agentic movements and capacities. Drawing on Shaw's (2016) research on embodied agency and assisted reproduction in Colombia, I have presented several instances of the utilisation of diverse forms of constrained agency by the female interlocutors – agency not merely as acts of choice, free will or resistance, but also as processual, as both active and passive, as their capacity to engage in acts of meaning-making, and in acts of creating and recreating their world through reflection, negotiation, submission, and collaboration within their constrained or coercive circumstances. In understanding agency and constraints as intertwined and co-constituted, I have shown that women exercised diverse forms of strategic agency throughout their disrupted reproductive journeys as well as within their distressed conjugal lives. Indeed, as Shaw (2016, p. 42-43,62) has astutely pointed out, it was somewhere between the "push of the society" and the "pull of the technologies" that women's constrained but strategic agency was visible, not only at a singular moment or as a single act, but rather as a process which unfolds and co-evolves with the constraints. My third argument in this study, therefore, is that as actors-enacted (Law and Mol, 2008), the female (and male) interlocutors utilised multiple forms of agentic capacities, movements, and maneuverings in relation to other actors and actants while also being acted upon or enacted in one way or another.

My research findings in relation to the experiences of reproductive loss, involuntary childlessness, the increased consumption of biomedical services, techniques, and conceptive technologies, and the gendered grieving practices for the loss of the wished-for child are not radically different from what has been observed in other parts of the world. Even though my ethnographic material comes from Kolkata in eastern India, it speaks to similar reproductive experiences, treatment-seeking practices, and grieving practices of childless and/or bereaved women and men who live elsewhere but similarly belong to and/or identify themselves as belonging to the global middle-class. For instance, for heterosexual, (usually) married couples around the world who have experienced any form of reproductive loss, the pursuit of biomedical treatments is reported to be strongly related to their desire for a biogenetically related child and this is a desire and practice certainly not confined to middle-class India (see Franklin, 1993, 1997; Handwerker, 2002; Roberts, 2008, 2006; Shaw, 2016). In the 'Global South' as well as the 'Global North', the increasing normalisation of seeking biomedical interventions to have a one's own child, indeed, reinforces and essentialises the "genetic idiom" for parenthood (Cussins, 1998, p. 166).

As I have discussed in chapter three, relatedness in the Indian context has been traditionally established in different ways, including social parenthood, non-genetic ties, sharing of bodily substances, food, and locality. However, I have shown that within the infertility clinics in my study, the doctors reproduced, reinforced, and essentialised the enactment of biogenetic relatedness in the making of a 'normal' family and emphasis was placed by them on the manifestation of this relatedness through shared physical and behavioural resemblances. It was not only the medical practitioners, but also most of the male interlocutors who stressed the importance of having a child conceived with their own sperm and thus, establishing biogenetic paternity, as I have illustrated in chapter seven. I have argued that the availability and access to ARTs compelled infertile men to undergo the painful and uncomfortable medical procedures of TESA in order to have their own child and thereby enact themselves in accordance with normative forms of masculinities which conflate heterosexuality, virility, and procreation. As such, even though ARTs have been partially successful in establishing non-traditional forms of families where genetic ties have been severed, they still, for the most part, provide the occasion for reproducing and naturalising the understanding of relatedness as biogenetically enacted (see Chavkin, 2010, p. 9; Franklin, 1993, p. 30).

In chapter three, I have also discussed that the middle-class couples in Kolkata participated in a sacralising (Naraindas, 2015) of biomedical reproductive technologies (see also Handwerker, 2002; Roberts, 2008, 2006). For most of the couples, these latest, modern technologies and treatments were reportedly the most logical choice to have a child in the light of reproductive loss. Even when these conceptive technologies did not result in reproductive success, most women and/or couples continued displaying their faith in them. I have argued that such a display of faith in these technologies and high-tech infertility treatments is shaped by their understanding of biomedical treatments as the best and most rational choice *because* it is modern and scientific. As I have mentioned, all the married couples had reportedly not pursued any 'alternative' or traditional treatment options, or as one female interlocutor mentioned, "other non-reliable" treatments, in their pursuit of a child (see chapter three). Indeed, I suggest that the couples' exclusive pursuit of biomedical services, techniques, and treatments is significantly related to the enactment and reiteration of their middle-class positionality. In addition, I have further demonstrated that the interlocutors' pursuit of and faith in such biomedical interventions was not solely related to their middle-class ethos of modernity and consumerism. For instance, I have pointed out in chapter three that the hyped advertisements in public discourse featuring inflated success rates and take-home baby rates of the infertility clinics contributes to the myth of biomedical treatments as the only hope for childless couples even though the actual chances of having a baby in the best case scenario are not more than thirty to forty percent. Moreover, following Franklin (1997), I have also discussed in the same chapter that it was only by maintaining faith in these technologies and treatments, that the women and/or couples could sustain their hope of having their (own) child, the possibility of socially acceptable parenthood, and a 'normal' family.

However, it is not only the hope embodied in the reproductive technologies which compelled the female interlocutors to have faith in them and continue undergoing repeated treatment cycles, at times, despite multiple treatment failures. Rather, the women's persistent attempts at the treatments are related to their desire and hope to have a child – desire and hope which are responded to but also created by the reproductive technologies (Franklin, 2013, p. 749). The rationale is that by pursuing these technologies, by taking a gamble, and by putting in their best efforts, the women and/or couples will eventually be rewarded with a child as well as with a parenthood identity. Moreover, it is also the "pull" of these technologies which gave women the "impetus to repeat and persist" in their pursuit of the treatments despite experiencing multiple losses and treatment failures (Sandelowski, 1991, p. 36). In the case of IVF, a reproductive technology which consists of several progressive stages, each stage has the potential to fail which means that every time a stage fails, the entire treatment would have to be started again from square one. However, as Sandelowski (1991) explains, the accomplishment in any one stage compels women to move to the next stage and in the case of a stage having failed, they are compelled to start anew as they feel that they have never been *that* close to conceiving before (see also Becker, 2000, p. 119; Franklin, 1997, p. 152). As such, the "never-enough" quality of such technologies is derived not only from cultural imperatives, such as pronatalist values and patriarchal agendas, but it also results from the nature of the technologies themselves and the manner in which they operate (Sandelowski, 1991, p. 39).

Ironically, as I have illustrated in chapter three, the very reproductive technologies which the female interlocutors placed their faith in and regarded as instrumental in their quest to achieve reproductive success were conspicuously absent in their narratives of reproductive loss and reproductive failure. The female interlocutors pursuing infertility treatments never questioned the efficacy of the technologies or held them accountable. I have argued that in doing so, they invisibilised the agentic capacity of the technologies in having played a significant intermediary role in the (unwanted) treatment outcome(s). Instead, as part of making sense of their loss, they attributed agency to other non-human actants such as Divine will, karma, and destiny in having played a role in them not having had a child so far.

However, it is not only the pull of the technologies, but also the "push" of the society, including actors such as the medical practitioners, the husbands and family members, which compelled the female interlocutors to pursue repeated treatment cycles, as I have shown in chapter five. Most women were consistently pushed and coerced by the other actors into undergoing subsequent treatments soon after the incidence of loss. In general, the social expectation seemed to be that given their educational background, financial affluence, and ease of access to private healthcare, middle-class childless couples as modern subjects *will* and *must* seek the required biomedical attention in order to have a child. I would go one step further and claim that given the prevalence of private hospitals and infertility clinics in urban Kolkata that claim to offer world-class facilities, *not* availing biomedical intervention would intensify the stigma which childless couples, and especially women, have to endure in a larger pronatalist Indian context where procreation is the *sine qua non* of heterosexual marriage. While the decision to consult with a gynaecologist or an infertility specialist following the occurrence of reproductive loss can be framed as a matter of choice and serves as an illustration of agency, it is also constituted within a specific discourse. Indeed, it is the increasingly biomedicalised landscape in contemporary India and the socially expected response that when a couple cannot procreate, they *should* seek medical attention, which determines and normalises what appears to be a childless couple's choice.

The normative discourses which push or compel childless couples to seek biomedical interventions in the pursuit of a child, however, do not anticipate the possibility of reproductive loss being *produced* or the sense of loss and grief being *heightened* within such a context where the biomedical myth suggests the possibility of conquering death (see Van Hollen, 2003, p. 217) and medical technologies and practitioners supposedly offer complete control over the process of reproduction. As I have shown in chapter three, specific technological practices, such as the attribution of foetal and embryonic personhood enabled by the visualising technology of ultrasound and doctors encouraging pregnant women to participate in the visual and aural interaction with their 'baby', complicated and augmented the experiences of reproductive loss for the female interlocutors. While the medical practitioners at the infertility clinics viewed such practices as important for stimulating maternal bonding and assuring women that their baby is 'normal', I have shown that the enactment of foetal and embryonic personhood was, in fact, conditional insofar that it only occurred in the context of ultrasound scanning. Consequently, the infertility specialists disregarded the same bonding and foetal or embryonic personhood, which they had encouraged during the ultrasound scans, after an episode of reproductive loss had occurred (see chapter five). I have also shown that the doctors failed to recognise the female interlocutors' grief or to offer them the emotional attention they desired after the loss and instead pushed them to undergo another treatment cycle (see chapter five). Furthermore, I have shown that the reliance on 'objectivity' and on the apparent infallibility of science and technology is suspended by the doctors during the post-loss consultations and instead, they resort to metaphysical and cosmological explanations to explain the loss and unwanted treatment outcomes to the female interlocutors and/or couples (see chapter three and five).

Regardless of the medical practitioners and other actors marginalising the female interlocutors experiences of loss, especially after early-stage pregnancy losses, I have shown that the female interlocutors who had suffered a loss after conception experienced profound grief, irrespective of the gestational stage at which the loss occurred. It was the meaning of ‘what’ the women had lost – the wished-for child, an imagined future of raising that child, a motherhood identity, a sense of control over their bodies, a sense of normalcy in their lives – which rendered their experiences of reproductive disruptions as deeply distressing. Indeed, as I have shown in the preceding ethnographic chapters, incidences of reproductive loss disrupted the women’s and also the men’s life trajectories in more ways than one. For instance, in chapter three and seven I have discussed that both female and male interlocutors expressed that their normal bodily functions and biological processes as well as their normative gender roles and identities had been disrupted and challenged following the death of their wished-for child and/or in the light of their inability to procreate.

This research has not only been about women’s reproductive experiences of loss and grief. I have dedicated chapter seven (and a section in chapter five) to bring the focus on men by highlighting the nuances and complexities in their reproductive aspirations, practices, and experiences in order to show how vital their role is for gaining an understanding of the gendered experiences of reproductive loss and childlessness among the middle-class couples in this study. I have discussed examples which shed light on men’s ideas about the naturalness of their desire to attain fatherhood, their eagerness to be involved in the upbringing of their desired child, their acts of transgression (for instance, by questioning biogenetic paternity), and their embodied experiences within infertility clinics. Through these diverse examples, I have shown how the male interlocutors enacted multiple masculinities, such as forms of caring masculinities (Elliot, 2015), emergent masculinities (Inhorn 2012), and vulnerable masculinities – multiplicities of *being* a man which co-constitute but also counter forms of normative masculinities.

It was almost impossible to undertake a project about reproductive loss and involuntary childlessness without acknowledging the gendered aspect of these themes. As such, a prominent finding of my research was that the male and female interlocutors were consistently enacted by the other actors according to dominant gender norms in the South Asian context. I have followed Butler’s (1988, 1990, 1996) theorisation of gender performativity in order to show that a gendered subject is enacted by the other actors through repetitive and performative speech acts and practices. The gendered body, in this sense, is performed and (re)produced in an ongoing process wherein gender categories such as female/male and woman/man are brought into being performatively. For instance, I have shown that the gender stereotype of women as hyperemotional and relatedly, irrational, was reproduced by the medical practitioners and their husbands in their enactment of the bereaved female interlocutors as emotionally incapacitated to take certain decisions – whether that was regarding the disposal of their dead baby's body (see chapter five) or about the subsequent plan of action following the occurrence of loss (see chapter five and seven). Another instance I discussed was the enactment of women by medical practitioners as having an innate maternal instinct and procreative drive (see chapter three). On the other hand, men were enacted by the practitioners as emotionally stoic persons who did not have an inherent reproductive desire and whose prime responsibilities were limited to taking care of their emotionally weaker wives. As such, it was not only normative gender roles and stereotypes which were enacted as part of the couples' experiences of reproductive loss, but also the very emotions they were supposed to feel. Such a discursive enactment of emotions was an important part of how gender roles and identities were enacted throughout the couples' disrupted reproductive journeys, wherein an overt display of emotionality was culturally coded as 'feminine' while restrictive emotionality was seen as 'masculine'.

The gendered enactments of the female interlocutors by the other actors and the corresponding constraints on their agency has, indeed, been a recurring motif across all the ethnographic chapters. For instance, in chapter three and four, I have highlighted that women's agency to make decisions about their bodies, regarding the medical treatments, and/or questioning the given instructions or decisions was severely constrained by the doctors. In both these chapters, I have shown the various ways in which the doctors enacted 'good patients' characterised by compliance, submissiveness, and a display of complete trust and faith in the doctor's medical advice and abilities. Controlling the women's epistemic capital, (for example, by black-boxing the reproductive technologies or by providing piecemeal information about a treatment), performing forms of what I refer to as pre-obstetric violence, infantilising them when they expressed any signs of pain while undergoing medical procedures, reprimanding them for asking too many questions and/or for failing to display faith in the doctor's decisions – these were some of the prominent ways in which the agentic capacities of the female interlocutors was constrained during medical encounters.

Subsequently, in chapter five, I have shown that women's agency to grieve and mourn for the loss of their wished-for child and to have the time and space to cope with their loss was also constrained. I have focused on the experiences of the female interlocutors who had experienced late-term reproductive loss (in the form of stillbirth or neonatal death) to describe accounts of them being restricted from having visual contact with their babies in the hospitals, even when they expressed their desire for it. They were enacted as emotionally fragile by the medical practitioners as well as by their husbands and mothers-in-law who reasoned that women would not be able to bear the sight of their dead baby. Based on such gendered stereotypes and the well-meaning intention that women *need* to be protected from further trauma and grief, the female interlocutors were also excluded from the decision-making process of where and how the baby's body was to be disposed. Such decisions were taken by the bereaved women's mothers-in-law and the rituals of disposal (for instance, by burial in Hindu burial grounds) were performed by the women's husbands and an accompanying male family member. Based on such illustrations in chapter five, I have argued that the female interlocutors experienced their loss in a socio-culturally silent environment which was characterised by a non-recognition of their loss, disenfranchised grief, an absence of formalised mourning rituals, and an absence of social support systems, both within medical and familial networks.

Moreover, it was not only the encounters inside the medical settings where women's agency was constrained and where they were enacted according to discursive gender roles. As I have described in chapter six, several female interlocutors spoke about the loss of sexual intimacy in their marriage and their husbands' loss of sexual interest ever since the stress of reproductive loss and undergoing assisted conception had disrupted their normal life progression. Within the disrupted site of marriage, women utilised their sexual agency and often initiated sexual acts in an effort to regain a semblance of normalcy in their conjugal lives. However, according to the women's narratives, such initiations were met with the husbands humiliating them for having transgressed the morally-bound, value-oriented boundaries of the 'Indian middle-class woman' who is discursively framed as the sexually passive, chaste, and modest 'good wife'. Words such as dirty, desperate, and characterless were used by the husbands and wives were reminded that women from 'decent' or 'good' families do not participate in such 'dishonorable' acts. Taking cue from Butler (1990, p. 72), I have suggested that a disruption in the normative gender scripts resulted in the humiliation of the disruptor, i.e. the middle-class, married Indian women who desired sex without having fulfilled the duty of childbearing. The women's enactment of themselves as sexually desiring persons became particularly unacceptable for the husbands in light of their ongoing disruptive life events of reproductive loss and childlessness. Since the act of monogamous procreative sex had not resulted in a progeny along with the added distress of undergoing infertility treatments and the prolonged wait for a child, I have argued that the self-representation of the wives' as sexual persons and their desire for recreative sex despite their 'failed' procreative abilities, was deemed improper and morally offensive by the husbands.

Butler (1995 in Webster, 2008, p. 8) has argued that it is within the existing social discursive framework and underlying constraints of these discourses within which individuals exercise their agency and also perform acts of subversion or transgression. As such, this study has not only been about depicting the various constraints on the agency of the female (and male) interlocutors but also significantly about how they utilised diverse forms of strategic agency to negotiate, navigate, and adapt within their constraints, both actively and passively. For instance, in chapter three and four, I have shown that even though the female interlocutors were enacted by the medical practitioners as 'good patients' who ought to be passive and obedient, the female interlocutors also enacted themselves as 'good patients' by agreeing to submit their bodies to continuous medical surveillance as well as by willingly participating in the medical procedures. I have argued that the interlocutors objectified themselves (see Thompson, 2005) in order move closer to achieving reproductive success, to avoid a risky pregnancy and/or another occurrence of reproductive loss, to ensure that their baby is normal, and to gain a sense of control over their pregnancy. The agential decision-making process of the female (and male) interlocutors was also visible, as discussed in these two chapters, during the ongoing treatment process. For instance, the women and men actively decided about whether they wanted to proceed with a certain treatment schedule, they convinced doctors to accept their case even when doctors were reluctant, and/or they suggested which treatment plan was best for them to try and have a genetically related child. Such encounters of the couples with doctors have helped me in demonstrating that the women and/or couples were not merely docile and compliant patients/patient parties but instead, they demonstrated their ability to act strategically and judiciously by intercalating their needs and concerns to achieve reproductive success (see Shaw, 2016, p. 138). Other illustrations of women's medicalised agency was, for instance, when several female interlocutors actively made the decision to pursue subsequent treatments cycles despite multiple treatment failures while others decided to stop after one final attempt and accept it as their destiny (see chapter three). There were others who mentioned that their main reason to keep pursuing treatments, in spite of the mental and physical exhaustion, was related to their desire of keeping their distressed marriages from falling apart (see chapter six). All these instances, I have argued, reflected the female (and male) interlocutors' utilisation of forms of constrained but strategic agency.

Furthermore, in chapter four, I have shown that within the "patient as consumer discourse" (Lupton, 1997a, p. 373), the patients and/or couples not only agreed to submit themselves to medical demands, but they also actively decided which doctor is the best fit for them to fulfil their reproductive desire. Such a decision-making process involves the patient and/or couple to "shop around" (Lupton, 1997a, p. 373) and to participate in the "trial and error" approach (Bharadwaj, 2016, p. 221) before deciding to be treated by the right expert. In addition, the agentic movements of the women were evident in their search for a medical practitioner in whom they could find emotional refuge (see chapter four). Given the stressful demands of undergoing infertility treatments as illustrated throughout the study, the resulting conflicts in their marital relationships (see chapter six), and the sociocultural silence around this issue (see chapter five), women in my study did not have any options for spaces where they could engage in emotional catharsis. In this regard, I have shown that when an infertility specialist exclusively performed the role of the medical expert, women actively sought other practitioners (such as the nurse and embryologist) with whom they could share their distress (see chapter four). This was, as I have argued, another example of women utilising a form of strategic agency to cope with and manage their emotions. I have also argued in this regard that the enactment of diverse roles by the practitioners was not only related to offering a safe and non-judgmental space for the benefit of the patients and/or couples but also a professional requirement in order to ensure that the latter did not leave them and opt for another clinic where they could find the desired therapeutic intimacy.

It was, however, not only the active decision-making processes which demonstrated the female interlocutors' agentic capacities. As I have shown through several examples, the female interlocutors strategically shifted between utilising forms of both active and passive agency during their interactions with other actors. For instance, in chapter three, I have shown that some women's acts of deliberately not wanting to acquire more information about a specific medical procedure, or what Shaw (2016, p. 155) refers to as "conscious inaction" and "desired ignorance", can also be seen as examples of the manifestation of constrained agency through adaptive tactics in order to manage their emotions while undergoing treatments. In addition, women's non-actions or ostensibly passive stances during clinical encounters, where they let the doctor make medical decisions for them, can also be seen as a form of "hidden agency" which helped the women to reduce their anxiety about having to make decisions (Shaw, 2016, p. 158-159). Another form of passive agency is when women endured pain during medical procedures because they knew that it is by undergoing these procedures, they will be able to move closer to their desired outcome of reproductive success (see chapter three). Indeed, both chapter three and four are illustrative of not only the medical practitioners enacting 'good patients', but also of the women drawing on forms of constrained but strategic agency in enacting themselves as 'good patients'. Such examples of the agentic capacities exercised by the women (and men) in my study have helped me to argue that even though *prima facie* the doctors have an ostensibly established position of authority and dominance in the clinical spaces in regard to medical decisions, it is the constant negotiations and collaborations between various actors which finally results in the desired reproductive success (see also Shaw 2016).

As further illustrations of the female interlocutors utilising forms of constrained but strategic agency, I have discussed the (gendered) coping mechanisms and grieving practices in chapter five. As mentioned earlier in this chapter and at length in chapter five, women's agency to grieve for their loss and to participate in the mourning rituals was restricted by the external actors and they were hurriedly pushed by these actors into trying to conceive again. Within such a coercive environment where their loss and grief were marginalised, some bereaved women exercised their strategic agency by performing creative, and often private, coping strategies and rituals. These strategies enabled them to not only grieve for their loss, but it also allowed them to memorialise their loss, to give meaning to the loss of a real baby – a social recognition of the women's loss and the baby's personhood which had not been accorded otherwise. Creative forms of expression such as music, finding comfort through religious activities, and sharing vulnerabilities through personal life stories – these are the vignettes I have described to illustrate some women's adaptive and coping strategies. Moreover, discretely naming the child, visiting a temple on the 'birth' date of the deceased baby, and keeping ultrasound images were some ways in which the women memorialised the loss of their baby whom they wished to remember – practices which, I suggest, help(ed) them in making sense of their disruptive reproductive experiences. Following Butler (2004, p. 3) who has argued that subjectivities are about performing, or that “doing is being”, I suggest that the grieving practices as well as the memorialisation rituals allowed the female interlocutors to enact their identities tangibly and legitimately as mothers who had experienced the pain of childbirth as an unforgettable embodied loss and who need(ed) the time and space before they could conceive again. Such an enactment, I suggest, also allowed women as mothers to not be in a liminal state i.e. being trapped in between the stages of conception, pregnancy, and yet having to become a mother. This, however, was temporary, as the women’s state of liminality was re-introduced when they resumed their pursuit of assisted conception, where, once again, they were between the states of waiting to conceive and yet to give birth.

As part of the diverse agential roles enacted by the women in my study, along with their enactments of themselves as ‘good patients’, consumer-patients, bereaved women, and grieving mothers, in chapter six I have shed light on their enactment of themselves as sexual agents. I have elaborated on the disrupted marital relationships which entailed the occurrence of regularly increasing conflicts between the couples as a result of the reproductive disruptions. In an attempt to regain a semblance of normalcy in their marriage, women initiated acts of sexual intimacy with their husbands, for instance, by suggesting to watch pornographic films together, wearing seductive lingerie, and proposing sexual acts not confined to sexual intercourse. Such accounts of female sexual agency are in contrast with an array of existing, albeit limited, studies on female sexuality in the middle-class Indian context, that tend to portray women as reluctant and passive participants in their sex lives (Puri, 1999, p. 116). I have shown that even though many women in my study wanted to enact themselves as more than procreative bodies whose lives were not circumscribed by their reproductive biology, the husbands enacted their wives’ femininity by reiterating the dominant gendered norms that characterise middle-class Indian women as embodying the moral virtues of modesty, sexual passivity, and sexual propriety. Despite such reactions from the husbands, instead of representing themselves as helpless victims in their marriage, the female interlocutors exercised their agentic capacities by reflecting on their roles as wives and on whether their identity and worth as women meant being confined to their reproductive function. Some women reported that the intense marital distress had pushed them towards contemplating about and eventually talking to their husbands about getting a divorce. In the case of one woman, I have shown that the occurrence of reproductive loss triggered certain events in her conjugal life, almost like a domino-effect, that ultimately resulted in her seeking separation and then a divorce. However, for the other women, their reasons to continue their marriages, as I have argued, had less to do with the “unwavering commitment” which couples reportedly display during infertility treatments, as Bharadwaj (2016, p. 85) suggests, and more to do with the societal stigma attached to childless, (relatively) older, divorced women and the loss of their families’ honor within the Indian middle-class setting. Women’s utilisation of their forms of strategic agency was certainly visible in the ways in which they adapted to and negotiated with the constraints of their distressed conjugal lives. It was not only women but also the men who utilised forms of constrained agency, for instance, by negotiating with the patriarchal ideals of kinship ties and power relations within Indian households. In this regard, I discussed the case of a male interlocutor in chapter seven who decided not to disclose to his family that he and his wife were having a child conceived from donor sperm in order to ensure that the paternity of the child does not become a point of contention in the future.

To summarise, this study has been an ethnographic documentation of the profoundly disrupted life trajectories of middle-class married couples in urban Kolkata as a result of the events of reproductive loss. It has simultaneously dealt with the couples’ persistent struggles to have a (biogenetically related) child by seeking assisted conception. My aim across the ethnographic chapters has been to foreground the voices of the married women and men, their stories of reproductive loss and grief but also of their resilience and indomitable spirit in the face of that loss and in their pursuit of reproductive success. In the process, I wanted to establish three intricately entangled arguments. Firstly, I have argued that the heightened meaning which couples ascribed to their experiences of reproductive loss and the ensuing emotions of grief for the wished-for baby that died or was never conceived are produced in and reflective of the specific sociocultural and socioeconomic context of 21st century, globalising, middle-class India wherein conception, pregnancy, childbirth, and involuntary childlessness are increasingly biomedicalised and this biomedicalisation is normalised as part of middle-class reproductive practices. Furthermore, I have argued that the women’s and men’s experiences of loss and grief were constituted by multiple enactments of gender roles, emotions, entities, and normative concepts both within and beyond medical encounters, in the process of which the agency of the couples, primarily the women, was constrained by external actors. Finally, I have argued that within the systemic and ideological constraints and the restrictive ways of being enacted, the women (and men) were not merely muted or oppressed victims. Instead, they engaged in diverse forms of strategic agency within their constraints by enacting themselves (and others) in certain ways to give meaning to and make sense of their loss(es) and to move closer to achieving reproductive success which, they hoped, would ultimately enable them to resume normalcy in their disrupted lives.

8.1. Implications and Future Directions

> "Reproduction, it is safe to say, has become transbiological, transtemporal and transnational in hitherto unimagined ways while introducing possibilities of selection at each step (Wahlberg and Gammeltoft, 2018, p. 7)".

During my ethnographic engagements with the married couples and the medical practitioners, one of the themes which emerged was the *kind* of child these actors desired. Words such as 'normal', 'perfect', 'healthy', and 'beautiful' were routinely used to describe this wished-for child (and at times, even the foetus and the transferred embryos). There were also instances when a particular *kind* of gamete was desired by the couples who had agreed to having a child through donor gamete-induced conception. Such couples were usually assured by their infertility specialist that the "best quality" or "high quality" egg and/or sperm would be used. What are the political implications and ethical considerations which emerge from the desire of a baby conceived with certain kinds of gametes? More specifically, what meaning does such a desire for a biogenetically related 'beautiful', 'perfect' and 'normal' child take on in 21st century India with the rise of Hindu nationalism, its related biopolitics[179] and eugenic logic[180] promoted by the right-wing ideological groups? In addition, what ethical ramifications would "selective reproduction" have in the contemporary Indian context and (how) does/would it complicate individuals' experiences of reproductive loss and grief?

According to Wahlberg and Gammeltoft (2018, p. 1-2), the term "selective reproduction" refers to "practices that aim to promote the birth of particular kinds of children" and this practice is taking place globally on a historically unprecedented scale. The development of biomedical technologies since the mid-twentieth century has allowed for selective reproductive practices to become more targeted wherein the entire reproductive process has

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[179] Subramaniam (2019, p. 10) examines how Hindu nationalist ideas and ideologies are "scientized" through biopolitical claims about gender, race, caste, and sexuality (ibid.).

[180] Promoting the reproduction of some groups while curtailing the reproduction of others is the basis of '"eugenics logic" and the focus is on producing "a superior society by regulating reproductive landscapes" (Subramaniam, 2019, p. 98).

been “parcelled out and fragmented using ever more specialised techniques related to insemination, fertilization, implantation, gestation, and birth” (ibid., p. 7). Selective Reproductive Technologies (SRTs) include prenatal and antenatal screening techniques, such as the more conventional and routinised techniques of ultrasound and amniocentesis and the more recently developed techniques such as pre-implantation genetic diagnosis (PGD)[181] and pre-implantation genetic screening (PGS)[182]. While ARTs are availed by involuntary childless couples, SRTs allow couples to select the *kind* of child(ren) they desire not just in regard to the sex but also in relation to the child’s characteristics. Moreover, technologies such as PGD are used to facilitate ‘family balancing’ or ‘lifestyle sex selection’ for couples who decide which embryos they want to be implanted after the embryos have been biopsied and genetic tests have been conducted in order to actualise their imagined future family lives and the kind of child they desire in that future (see Bhatia, 2018). In regard to PGD, Franklin and Roberts (2006, p. 161 in Wahlberg and Gammeltoft, 2018, p. 5) argue that while both ARTs and SRTs involve IVF, “the goal of IVF is a child, whereas the goal of PGD is, in a sense, the reverse, in that it is aimed at preventing some kinds of children being born”. SRTs, therefore, are oriented towards “the future living of families” i.e. the kinds of lives which families might want to *avoid* (e.g. living only with girls) or *achieve* (e.g. living with healthy children) (Wahlberg and Gammeltoft, 2018, p. 5).

The present study has addressed the topic of enactment of embryonic and foetal personhood facilitated by the technology of ultrasound scanning and the couples’ as well as the practitioners’ reiterated desire for a ‘normal’ child (see chapter three). However, ultrasound scanning does not provide any knowledge about the “genetic make-up of the foetus which is hidden away in its DNA” (Wahlberg and Gammeltoft, 2018, p. 9). This is where antenatal reproductive genetic techniques like PGD and PGS enter the arena of conception and pregnancy which happened in India in late 1990s and early 2000s. As such, my study opens up possibilities and invites further empirical research into selective reproduction, ‘new’ eugenics,

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[181] PGD entails the genetic testing of the embryos prior to the transfer and implantation stage as part of IVF. This technique was developed “to help families with a known hereditary disease to avoid commencing an affected pregnancy, thereby hopefully alleviating them of the difficult decision of whether or not to terminate a pregnancy” (Wahlberg and Gammeltoft, 2018, p. 8). It is also used as means to “secure the birth of a histologically compatible child (a so-called saviour sibling) who can provide blood and tissue samples for therapeutic use in a sick sibling suffering from, for example, sickle cell anaemia or ß-thalassaemia” (ibid., p. 9).

[182] PGS is the technique to screen embryos in order to ensure the presence of 23 pairs of chromosomes to avoid the chances of transferring ‘abnormal’ embryos during IVF (based on conversations with Dr. Sen at clinic B).

and ‘new genetic essentialism’ i.e. the return of the/an “it’s all in your genes” mentality (Franklin, 1993, p. 33) in urban India where infertility clinics are mushrooming at a rapid rate.

The Bulletin of the Indian Medical Council of Research (2007, 37(1-3)) states that currently, the PGD has rapidly become an essential tool for improving the success rate of ARTs “and offering couples a *normal* baby, thus avoiding the need for a *therapeutic abortion* of *abnormal* foetuses” (emphasis mine). As I had observed at infertility clinic B, female patients in their late forties and above were told by Dr. Sen to undergo IVF inclusive of PGS in order to ensure that the chances of having an ‘abnormal’ baby are diminished. Moreover, recent social media posts by Dr. Sen and the junior doctor at his clinic displayed photos of them conducting seminars proposing the *need* for the PGD technology. It can only be anticipated that such SRTs will eventually become routinised and normalised as a part of the reproductive journeys of middle-class women and men in India in their pursuit of the ‘perfect’ baby. The discourse of selective reproduction in urban India has, indeed, gained traction in the last decade or so, and such a biomedicalised discursive framework significantly shapes the ways in which ‘normal’ and ‘abnormal’ foetuses are defined in public and political discourse.

In her study on Hindu nationalism, biopolitics, and eugenics, Subramaniam (2019, p. 11) notes that “the liveliness of biology is important to the vitality of politics and social movements”. As such, what makes these genetic screening techniques for creating the ‘perfect’ child even more interesting and thought-provoking are their political ramifications. For instance, the national governments of some Asian countries are employing SRTs as political tools for the purposes of selective reproduction in efforts to enhance population quality (Wahlberg and Gammeltoft, 2018, p. 14)[183]. The Chinese and Vietnamese governments are particularly active in encouraging pregnant women to make use of prenatal screening testing techniques in order to prevent the birth of disabled children (ibid). As potential citizens of the State, these governments appear to have a vested interest in ensuring that the ‘right’ kind of children are born who will ensure national stability and welfare (ibid). Indeed, the desire for “improved-

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[183] This is in contrast to the Euro-American countries where selective reproduction decisions are framed by the government authorities more as matters of personal preference and choice rather than as a matter of national interest and demographics (Wahlberg and Gammeltoft, 2018, p. 14). However, in social settings where official health care guidelines emphasise “balanced information and individual choice” which are, in fact, produced in a certain context and actually push people into making certain decisions, such selective reproductive decisions in the 21st century have been characterised by some scholars as a “laissez-faire”, “back-door”, “neo”, or “flexible” eugenics (see Duster, 2003, Taussig et al., 2003, Lock, 2007 in ibid., p. 15).

quality births” among intended parents and nation states has been observed in countries such as China (see Handwerker, 2002) and a similar politically-driven desire to create “customised” and “genius babies” is gradually and ominously unfolding in contemporary India as well.

The Arogya Bharati, the health wing of the Hindu nationalist grassroots organisation, Rashtriya Swamsevak Sangh (RSS) has allegedly been operating the “customised baby project” since 2010 (Gowen, 2017; Malhotra, 2017; Nanu, 2017). Known as the *Garbh Vigyan Sanskar* project (loosely translated as Science and Culture of the Womb), it aimed to create ‘perfect babies’ through a process which involves three-months of ‘purification’ of the intended parents to prevent the transference of genetic defects, sexual intercourse as decided by planetary configurations, and complete abstinence after conception (Malhotra, 2017). The process also includes procedural and dietary regulations to increase the child’s IQ such as by an intake of calcium in the third month of gestation when the bones of the foetus develop, *ghee* (clarified butter) in the fifth month when the brain develops, and Vitamin A in the sixth to seventh month when the eyes develop (ibid.). In addition, the intended mother must chant Sanskrit verses as repetitive chants help in the baby’s mental growth as also to avoid labour pain (ibid.). Within such a moral prescription, it is usually the women’s bodies which become sites of “biopolitical control”, argues Subramaniam (2019, p. 184).

Although this project has no official sanction from the Indian government, it claims to have delivered as many as 450 ‘custom babies’ and targeted thousands by 2020, as reported by the project convenor (Malhotra, 2017). (A cursory online search, however, does not indicate any completion of such a target as of January 2023.) The rationale behind this project’s development according to its founders is to create a “strong India” which essentially translates into not having “weak Hindus”. According to the RSS ideologues, this project aims at making India “great again” by creating intelligent, tall, and strong bespoke Hindu babies with fair skin, even if the parents are dark skinned, short, have a poor educational background, and low IQ (Gowen, 2017). While some RSS officials claim that the project was birthed in Germany and emerges straight out of the Nazi playbooks, others claim that the idea and science behind this project was derived from the Mahabharata from which Germans had learnt about “baby customisation” (Gowen, 2017; Nanu, 2017). But as is the case in China, where the search for the “perfect” baby translates into the search for the “perfect” boy (Handwerker, 2002, p. 310), in India too where son preference is not a thing of the past, it may be speculated that the same situation could potentially arise. As described earlier in this section, selective reproduction essentially means that certain embryos and foetuses with certain ‘undesirable’ traits can be barred from being born. In this scenario, who makes these decisions of which *kind* of child *deserves* to be born and which factors shape such decisions? Moreover, how does this biomedical practice impact the disability discourse in the Indian society where persons, especially women, with physical and mental disabilities are largely stigmatised and disenfranchised? (see Hiranandani and Sonpal, 2010; Mehrotra, 2012)

On the one hand, given the rapid pace of development in reproductive biomedicine, embryology, and genetic technologies, reproduction can now be *achieved* and particular *types* of reproduction can be deliberately chosen to a degree never witnessed before (Franklin and Roberts, 2006, p. xvi). On the other hand, creating ‘designer babies’ inevitably raises ethical questions, concerns, and anxieties about what kind of society we are moving towards if an increasing number of prospective parents have the choice to select ‘desirable’ traits in their wished-for child (Wahlberg and Gammeltoft, 2018, p. 17). Almost two decades ago, Franklin and Roberts (2006) remarked that such a brave new world of perfectly designed babies still seems far away. However, the first tottering steps towards that world have been seemingly taken when we look at the alleged customised baby project in India, the recent suspected birth of the ‘designer twins’ in China (Picard, 2018), and the growing use of SRTs worldwide.

The rise of selective reproduction and SRTs in the ‘Global South’ since the beginning of the 21st century has not been met with an adequate anthropological response and research has largely remained limited to the ‘Global North’. It would, indeed, be intriguing to conduct empirical research in the rapidly developing field of assisted and selective reproduction and its related sociocultural, ethical, biomedical(ised), and legal aspects. Particularly, in the current Indian political landscape, the new form of anthropological question concerns itself with the *kind* of babies that technoscientific innovations regarding selective reproduction holds. This question can further be connected to addressing questions regarding how individual reproductive experiences, normative notions of parenthood, conception, and pregnancy are understood – not only among heterosexual women and men but also among those individuals who do not fit within such a heteronormative canvas. Such questions can both be empirically determined as well as conceptually redefined to provide possible answers to our political future which, while resting upon imagined utopias, is wrested by lived realities.

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Appendix 1: An Overview of the Forms of Reproductive Loss[184]

1. Biochemical or Chemical Pregnancy

A biochemical pregnancy (BCP) i.e. an initial positive pregnancy which does not necessarily progress into a clinical pregnancy, or to the point of ultrasound confirmation wherein the gestational sac is visible (Annan et al., 2013, p. 270). This kind of reproductive loss occurs at less than 13 weeks of gestation because of which most BCPs go completely unrecognized as it occurs at such an initial stage of the pregnancy. Also referred to as a chemical pregnancy or pre-clinical embryo loss, BCP is often considered to be a "false positive pregnancy test". The exact aetiology of BCP is unknown and the situation is treated in such a manner as if there was never a positive pregnancy test to begin with (Annan et al., 2013, p. 271). This particular situation ends up becoming a conundrum for the "supposedly pregnant" woman who on the one hand gets a positive β-hCG test result, but on the other hand, she is told by her medical practitioners that she was not pregnant at all. In actuality, BCP is indeed a conception and it is in fact, a very early miscarriage.

Annan et al. (2013, p. 271) state that, "as many as 25% of pregnancies fail even before the woman has any subjective indication that she is pregnant i.e. before she misses her menstrual period or has symptoms of pregnancy". As such, the most difficult aspect of a BCP is the initial false hope that it brings (ibid., p. 272). The most common questions that women usually have after experiencing a BCP is – how can I be a "little bit pregnant"? Why did this happen? Did I do something to harm the embryo? Does this mean I'm never destined to have a baby? Does this mean my uterus is defective and is rejecting the baby? (ibid.). However, it is evident that at least one embryo reached the advanced pre-implantation phase of development (i.e. the blastocyst stage), went on to "hatch" and attempted implant. As such, BCP is the "dark cloud that has a silver lining" since it offers the hope of a successful clinical pregnancy in the future (ibid.).

2. Ectopic Pregnancy

One of the most common ways of experiencing pregnancy loss is in the form of an ectopic pregnancy which refers to the implantation of the fertilized ovum outside the uterine cavity. In a 'normal' pregnancy, the ovary releases an egg which travels down the fallopian tube on the way to the womb. During this time, the egg is fertilised by the sperm to create an embryo which finally reaches the womb and gets implanted resulting in a successful conception. However, if the embryo gets implanted in the fallopian tube, ovary or cervix instead of the womb, then that results in an ectopic pregnancy. The most common sites of such an implantation are the fallopian tubes according to the National Health Portal, India[185]. In such a pregnancy, as the pregnancy continues, it can cause the fallopian tube to rupture with internal bleeding. The common signs and symptoms on an ectopic pregnancy include vaginal bleeding, abdominal pain, pelvic pain, tender cervix and the rarer signs are nausea, vomiting and diarrhoea[186]. Consequently, ectopic pregnancy can prove to be fatal for the pregnant woman herself and usually, gets treated as a medical emergency. In India, ectopic pregnancy accounts for 3.5-7.1% of maternal deaths[187].

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[184] Parts of the descriptions which do not have citations are based on my conversations with the medical practitioners at the infertility clinics in my study.

[185] https://www.nhp.gov.in/disease/gynaecology-and-obstetrics/ectopic-pregnancy

[186] https://www.omicsonline.org/india/ectopic-pregnancy-peer-reviewed-pdf-ppt-articles/

[187] https://www.nhp.gov.in/disease/gynaecology-and-obstetrics/ectopic-pregnancy

3. Miscarriage

Commonly characterised by the pattern of bleeding, cramps and pain, a miscarriage results in the loss of either an embryo, foetus or baby, depending on the duration of the pregnancy. Broadly divided into the categories of early and late miscarriage, the former is any loss before sixteen weeks of gestation and the latter is any loss that occurs after sixteen weeks (Moulder, 1990). According to the National Health Portal of India, a miscarriage is also referred to as a Spontaneous Abortion or early pregnancy loss which entails "non-induced embryonic or fetal death or passage of products of conception before 20 weeks gestation"[188]. The WHO defines miscarriage as "an expulsion or extraction of an embryo or foetus weighing 500 grams or less". Roughly half the miscarriages are caused when an embryo has the wrong number of chromosomes which is more often than not, accidental, and not genetic. Each person has 23 pairs of chromosomes and in total, the embryo has 46 pairs of chromosomes from both parents.[189] An 'abnormal' number of chromosomes can lead to miscarriage most commonly in the form of blighted ovum. Also known as 'anembryonic pregnancy' in medical parlance, the fertilized egg attaches itself to the uterine wall, but no embryo develops (Chaudhry and Siccardi, 2019). A woman with a blighted ovum will possibly have dark brown vaginal bleeding early on in the pregnancy, resulting in an early miscarriage. In such a case, it is possible for a woman to feel all the 'normal' pregnancy symptoms (such as breast tenderness) until the hormone levels responsible for these bodily symptoms gradually fade. Molar pregnancy can also be a form of miscarriage due to an 'abnormal' number of chromosomes. This form of pregnancy entails the implantation of an 'abnormal' fertilized egg in the uterus and the cells which were supposed to develop as the placenta, grow rapidly, thus taking over the space where the embryo would normally develop.

3. Medical Termination of Pregnancy

According to Kersting and Wagner (2012), contrary to the other forms of reproductive losses, the medical termination of a pregnancy, also known as selective abortion or therapeutic abortion, is not an unexpected event. Once the medical practitioner has diagnosed the foetus with an abnormality, then the intended parents are asked to make the decision of whether they want to terminate the pregnancy immediately or whether they would like to continue the pregnancy. Usually, the factors which contribute in the decision to terminate the ongoing pregnancy are the child's prognosis and future well-being as well as how an *abnormal* child would affect the couple's marital relationship.

4. Perinatal death

Perinatal death or perinatal mortality refers to the death of an infant in the first week of life or fetal death in-utero in the form of stillbirths (see World Health Organization 2006). According to the American Academy of Paediatrics, while perinatal death is not considered to be a reportable vital event, it is documented for statistical purposes (Barfield, 2011, p. 178). The Academy defines perinatal death as "fetal deaths and live births with only brief survival (days or weeks)" (ibid.). This definition of perinatal death is further categorised into three categories – Definition I includes infant deaths that occur at less than 7 days after being born and fetal deaths with a gestation of 28 weeks or more; Definition II includes infant deaths that occur at less than 28 days of age and fetal deaths with a gestation of 20 weeks or more; and lastly, Definition III includes infant deaths that occur at less than 7 days of age and fetal deaths with a gestation of 20 weeks or more (ibid.).

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[188] https://www.nhp.gov.in/disease/gynaecology-and-obstetrics/early-pregnancy-loss

[189] https://www.marchofdimes.org/complications/miscarriage.aspx

5. Stillbirth

The death of a foetus after twenty weeks of gestation with a weight of over 500 grams is referred to as a stillbirth. While in many countries the threshold for a stillbirth is considered to be twenty weeks, in some other countries, the threshold might be 22 or 24 weeks. In cases of stillbirth, the foetus dies just before or during labour, often quite unexpectedly due to some unforeseen complications. If the foetus does die before the delivery, then the pregnant woman has to undergo induced labour to give 'birth'. Broadly, there can be two types of stillbirth, write Kirkley-Best and Keller (1982, p. 420). The first is when the foetus dies inside the woman's womb, i.e. fetal death in-utero, and this is not a very common type of stillbirth. And the second type of stillbirth, which is the more common type, entails the death of the baby being diagnosed during the labour or delivery. In this case, the woman or even the practitioner has no prior knowledge of such an event. According to Kirkley-best and Keller (1982, p. 420-421), although it is important to recognize the differences between these two kinds of stillbirth, "the grieving processes set in motion are the same; both result from the simultaneous birth and death of the child".

6. Neonatal death

The neonatal period, i.e. the first 28 days of an infant's life, is considered to be the most vulnerable time for its survival. The highest risk of dying is faced by children during this period and as per global average, there are 18 deaths per 1,000 live births in 2017.[190] According to the World Health Organization (2006:iii), the death of a baby within four weeks of it being born is referred to as neonatal death and it is an early neonatal death if the baby's demise occurs in the first week of being born. Two-thirds of the world's total number of neonatal deaths occurs in ten countries, all of which are located in Asia (Jehan, 2009, p. 130). In absolute numbers, the largest numbers of death happen in South Asian countries, and in particular, India alone contributes to 27% of the global neonatal deaths (Lawn, Cousens and Zupan, 2005, p. 892). The common reasons for the majority of the neonatal deaths worldwide are severe infections such as sepsis and pneumonia, tetanus and diarrhoea, preterm birth and birth asphyxia. A small percentage of the deaths are related to congenital abnormalities, and other problems during the pregnancy such as problems with the placenta or umbilical cord of in cases of preeclampsia wherein the woman has high blood pressure and signs that some of her organs such as liver or kidneys might not be functioning properly (see Jehan, 2009, p. 130, Lawn, Cousens and Zupan, 200, p. :896).

7. Recurrent Pregnancy Loss

Recurrent Pregnancy Loss (RPL) is defined as the loss of two or more pregnancies. There can be broadly, two kinds of RPL – primary and secondary recurrent pregnancy loss. The former kind of RPL entails a pregnancy loss without a previous ongoing viable pregnancy beyond 24 weeks of gestation. Whereas secondary RPL is when a pregnancy loss occurs after one or more previous pregnancies having progressed beyond 24 weeks of gestation. However, if two or more pregnancy losses occur before 10 weeks of gestation, then it is referred to as Recurrent Early Pregnancy Loss (REPL). While pregnancy loss, or reproductive loss, in itself is a significant traumatic life event, the repetitive occurrence of RPL intensifies the grief experienced (see ESHRE 2017).

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[190] https://data.unicef.org/topic/child-survival/neonatal-mortality/

Appendix 2: Glossary of Medical Terminologies[191]

ß-HcG test: the Beta Human Chorionic Gonadotropin blood test is used to detect whether a woman has become pregnant. In conceptions via 'normal' penetrative sexual intercourse, this test can be done 10 days after the first missed menstrual cycle. In conceptions induced by infertility treatments, the test is supposed to be done two weeks after the process of IUI or the embryo transfer (IVF).

Amniocentesis: a prenatal test performed during the second-trimester of pregnancy to check for chromosomal 'abnormalities' (most commonly Down's Syndrome), neural tube 'defects' (most commonly spina bifida), and genetic 'defects' in the foetus. The test involves inserting a thin needle into the pregnant woman's abdomen using ultrasound scanning to procure a small amount of amniotic fluid (around 25-30 ml) from the gestational sac.

Azoospermia: one of the primary causes of male infertility, this is the medical condition in which the semen analysis test indicates the absence of 'viable' sperm in a man's semen.

Donor Insemination (DI): an anonymous donor's sperm is used in this procedure to inseminate a woman (either during IUI or IVF) when the husband's sperm cannot be used.

Embryo Grading: this process involves the embryologist rating the embryos based on their development. The embryos are graded from I to IV where Grades I and II are considered to be "high-quality". A blastocyst embryo (Grade I or II) is considered by embryologists to be the best kind as it has developed more than other embryos.

Embryo Transfer (ET): this procedure involves the transfer of "high-quality" embryos into a woman's uterus in order to maximise the chances of conception. The embryos are placed in a woman's endometrial cavity using a soft catheter and the procedure is performed under ultrasound guidance.

Endometriosis: it is defined as the presence and proliferation of endometrial like tissue outside the uterus, for instance on the ovaries. It is considered to be one of the primary causes for female infertility. It was commonly referred to as "chocolate cyst" by the infertility specialists in my study.

Uterine Fibroids: considered to be the most common kind of uterine tumour in women. It affects 20-50% of women in their 'reproductive age' group. Such fibroids may have a negative impact on female fertility and early implantation of the embryo.

Folliculometry: a test performed on women to monitor ovarian induction i.e. the process of follicles (eggs) growing inside the ovaries after she has been given the necessary hormonal injections. This surveillance of follicular development is done via TVS and usually the woman is scanned at least four times between two menstrual cycles. Usually, the first scan ('Baseline Scan') is on day 2 of the menstrual cycle, then on day 9 or 10, then on day 11 or 14 and finally on day 14 or 15 ('Ovulation Scan'). Depending on the follicular development, the woman is told to continue the same set of injections or to change to a new injection. In few cases, the overdose of these hormonal injections results in ovarian hyperstimulation (OHSS) and in such a case, the injections are stopped or reduced

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[191] This glossary is largely based on the conversations with the medical practitioners at infertility clinic A, B and C; I have also taken some descriptions from these sources: Bhattacharya and Hamilton (2014), Palermo et al. (2009), and Purohit and Vigneswaran (2016).

immediately as the hyperstimulation could be risky for the woman's health. Based on TVS reports, the infertility specialist decides when the eggs are "mature enough" or when they are "ready" for ovulation. Accordingly, a date is set for performing IUI or the oocyte retrieval procedure for IVF.

Foetal Reduction: a surgical procedure, also known as selective reduction, is performed in the first trimester on a woman who has multiple pregnancies. The doctor ascertains which of the foetuses is 'not viable' and that particular foetus is removed.

Hysterosalpingogram or Hysterosalpingography (HSG): a routine medical procedure which is used a diagnostic test to determine whether a woman has any blockage in her fallopian tubes or uterine cavity in the form of tumour masses, adhesions, uterine fibroids or any other malformations. The procedure involves the manual insertion of a radiopaque dye (which is visible under X-ray) into the woman's cervix and then uterus followed by X-ray scanning.

Hysteroscopy: a diagnostic procedure where a device called the hysteroscope is used to look inside the uterine cavity. It involves inserting a small telescope through the vagina and cervix into the uterus and is done under general anaesthesia. It is often used to remove polyps (an overgrowth in the uterine lining) which may have been a factor causing infertility.

Intracytoplasmic Sperm Injection (ICSI): an ART technique, (used in combination with IVF) adopted from animal husbandry this procedure involves the use of a micromanipulation machine and a high-powered microscope to inject a single spermatozoid with a pipette into an ovum to achieve fertilisation. It is considered to the "gold standard treatment" for male infertility as by using this technique, an oocyte can be fertilized irrespective of the morphology or motility of the single sperm which is injected.

Intratubal Gamete Transfer (GIFT): an assisted reproductive treatment which involves the manual mixing of the ova and semen and immediately placing them in one of the fallopian tubes using a catheter. Unlike IVF, in this procedure the eggs are not fertilised inside the laboratory but rather, inside the fallopian tube.

Intrauterine Insemination: an infertility treatment which involves the manual injection or artificial insemination of a concentrated volume of sperm (husband's or anonymous donor's) into a woman's uterus to facilitate fertilisation.

In Vitro Fertilisation (IVF): an assisted reproductive treatment which involves the manual mixing of the ova and semen in a petri dish in a laboratory to achieve ex-vivo fertilisation. The resulting embryos are "graded" (see Embryo Grading) and the 'viable' embryos are transferred to a woman's uterus. The extra embryos are frozen for further use if implantation of the embryo does not successfully occur or if the woman has to undergo another IVF cycle.

Laparoscopy: a surgical procedure which allows seeing inside the uterus, fallopian tubes, and ovaries, to detect endometriosis, pelvic infection, uterine fibroids, or build-up of scar tissue.

Oocyte Retrieval (OOR): this procedure used in IVF involves the retrieval of a certain number of oocytes (eggs) from a woman's ovaries which will enable ex vivo fertilisation.

Ovarian Hyperstimulation Syndrome (OHSS): a medical condition which is a side effect of ovulation induction (see Folliculometry). The symptoms can range from mild to severe abdominal pain, nausea, diarrhoea, respiratory distress, and severe thrombosis which can be fatal.

P4 test: a blood test to check for a woman's progesterone (sex hormone involved in a woman's menstrual cycle and pregnancy) level. This test is performed on Day 21 of the menstrual cycle to confirm whether a woman is ovulating, which is indicated by a level of <1. This further indicates that a woman's body is 'ready' for an IUI cycle or for the process of oocyte retrieval as part of IVF.

Polycystic Ovarian Syndrome (PCOS): it is a medical(ised) condition in women characterized by polycystic-appearing ovaries (i.e. more than the 'normal' number of 12 ovarian follicles), irregular periods (amenorrhoea), hirsutism (excessive hair growth, especially on the face), acne, and weight gain around the abdomen. It is considered to be a primary cause for female infertility.

Semen Analysis Test: a standard examination of the male semen to evaluate certain characteristics of the sperm such as quality, quantity, and morphology. The exam requires the male to masturbate and ejaculate in a cup and it is then analysed by an andrologist or a lab technician under the microscope.

Sperm Washing: a process which involves the removal of the sperm from the semen in a centrifuge. Any chemicals which might affect the uterus adversely are washed before the process of IUI and IVF.

Testicular Sperm Aspiration (TESA): a surgical procedure which involves the extraction of tissue from the male testes to check if there are any 'viable' sperm which can be used for IVF-ICSI. This procedure is usually advised when the semen analysis test shows 'poor quality' or 'poor quantity' of sperm.

Timed Intercourse (TI): it is the first step advised by the infertility specialist to monitor the woman's ovarian cycle via transvaginal ultrasound. It involves the couple having sexual intercourse depending on the basal body temperature (i.e. lowest body temperature attained during a period of rest) and when the woman ovulates. This part of the infertility treatment can last from anywhere between three months to a year (as observed in my fieldwork).

Transvaginal Scan (TVS): a diagnostic ultrasound examination of a woman's reproductive organs (uterine cavity and ovaries) for instance, to determine the number of eggs in the ovaries and whether the endometrium is 'viable' for implantation of the embryo. This test involves the use of a probe which is inserted vaginally to also monitor ovarian stimulation during Folliculometry and to detect as well as to monitor "high-risk" pregnancies.

Vaginismus: it is a medical condition where a woman's body has an involuntary reaction in the form of pelvic muscle spasms to any kind of vaginal penetration.