Introduction

This paper is based on interviews, observation, and informal interactions completed by the author during 16 months of qualitative ethnographic research conducted in Lucknow, India, primarily from 2005 to 2007, on the social and cultural contexts of infertility. Lucknow is the capital of Uttar Pradesh, the most populous state in India and home to nearly 200 million people. Results show that assisted reproductive technologies allow women to challenge power relations within their marital families and to pursue stigmatized forms of reproduction. However, they also offer new ways for families to continue an old pattern of exerting control over women's reproductive potential.

Women who sought infertility treatment in government facilities during my research period in Lucknow came from a variety of backgrounds that influenced their particular experiences of treatment. These women overwhelmingly asserted that biomedical treatment as carried out by infertility specialists was their best hope for conceiving children; however, many of them also visited a variety of holy places or people at different points in their search for children. Few women totally discounted these sites as possibly efficacious, although they often expressed skepticism about the power of these places, people, and the substances obtained from them to bring the birth of a child. I attribute this skepticism partly to the increasing influence of biomedicine and science in general in urban South Asia, as well as to the biases of women utilizing biomedical treatment in the hopes of overcoming infertility problems.

Methods

This paper draws on data gathered through semi-structured interviews with over fifty women from a variety of religious, class, and caste backgrounds suffering from infertility. Interviews took place in government infertility clinics and outside of clinical spaces and participants were recruited opportunistically, rather than through a purposeful structured sample. Members of several local non-governmental organizations assisted with recruiting participants outside of clinics. In addition, I observed the work of 15 doctors specializing in gynecology and women's health, as well as the work of other medical staff members, with whom I conducted structured interviews and more informal interactions during clinic hours. Interviews took place in the Hindi and Urdu vernacular language common to Uttar Pradesh, and occasionally in English, according to the preferences of participants. I am fluent in spoken Hindi and Urdu and I have become familiar with local colloquial language through years of residence in Uttar Pradesh and neighboring Bihar state, so I did not work with a translator for any of the interviews.

Results

From women I interviewed in infertility clinics, I heard both stories of harassment and of support from in-laws. What I did not hear, in most cases, were completely overwrought, unrelenting narratives of despair. Mixtures of hope (ummid or asha) and realism emerged in women’s narratives of their paths to this clinic and their evaluations of future possibilities. Despite the difficulties of undergoing treatment in a biomedical facility, trading surveillance by
their in-laws for even more intimate surveillance by physicians and the compulsion to discipline their patterns of interaction with their husbands (intercourse was usually termed as milna or milna-julna, "to meet," and prescribed according to a schedule established by the doctor), for many women in the clinic, treatment seemed to be a victory, proof of their worth in the marital household, a place where women's health often comes last.

Rama, a woman who had been trying to have a child for four years, had been coming to the clinic for three months after previously abandoning treatment. In her evaluation, "if it's in [my] destiny, then we'll get it [a child]... everybody wants children. Everyone's fond of them." While leaving responsibility for the ultimate outcome of treatment to fate, she did not reference the whims of destiny as a reason to abandon all action. She also said that coming to the clinic itself increased their hopes of success in getting a child, as well as their desire to be successful. Like many other women I met in the clinic, Rama had in-laws who supported her frequent trips to the clinic by taking care of the household chores in her absence. The sentiment that coming to the clinic increased one's hopes, but also increased desire, sometimes to the point of desperation, was also often expressed by women in the English fertility clinics studied by Sarah Franklin in the late 1980s and early 1990s (Franklin 1997: 183). Franklin describes IVF as a "hope technology" (Franklin 1997: 202-3) that demands much balance, saying, "IVF presents contradictory demands: to hope enough but not too much; to try your best but realize it is a gamble; to make sense of the unexplained; to believe in miracles" (Franklin 1997: 191).

Hindi/Urdu offers a plethora of ways for expressing uncertainty and the limited control of actors on the outcome of their efforts, from the subjunctive mood that grammatically indicates possible futures, to constructions such as inshallah or bhagvan kare (god-willing) that often bracket statements about the future in everyday speech. These constructions do not indicate complete fatalism, nor do they provide complete comfort about the ability to bring about a particular outcome.

Oscillations between sadness and hope, frustration and desires for the future, were evident in women's stories of their treatment. I met Shivani in the ninth month of treatment, when she was about to undergo IUI (intrauterine insemination) for the sixth time at the government clinic, after she had abandoned treatment at a private hospital because of the excessive expense involved. She had never been pregnant in nearly three years of marriage, and said that along with going to the clinic, she took comfort from her mother-in-law, had consulted a pandit (Brahmin religious specialist), and was fasting every Monday in honor of the god Shiva. Her words were both mournful and hopeful. She started out saying, "I've become distressed... it hurts.... It's a very bad experience. Let it not be so with anyone [use of subjunctive/conditional verb]." As our conversation continued, she said that lots of people asked about her children, without thinking whether or not they should ask. She said that she thought about adopting a child, preferably an unknown outsider, with no attachment to any other extended family members. Her husband, she said, would prefer to have their "own" child, and encouraged her by saying that they hadn't been going for treatment for very long; it was still possible that they would get a child this way. If it's not possible, she said, then they would adopt, but not just yet—"When I/we get exhausted. Right now I/we still have courage (himmat)."

Women in infertility clinics often recited to me the various places they had visited in the hopes of conceiving a child, including the offices of gynecologists and other biomedical clinics, as well as non-biomedical healing sites. From both Hindus and Muslims, I learned of local sites, including Hindu and Muslim shrines, where women would make offerings. For example, at the
grave of a Muslim holy person (a *mazaar*), women offer cotton or silk bedsheets embroidered with metallic thread (*chaadar*), flowers, cardamom pods, and sweets (especially *revri*). At some sites, women would tie a thread (*dagha bandhna*) to a tree or other sacred object and make their wish or vow, promising to return to untie the thread and make a special offering if their wish was fulfilled. Famous sites such as Ajmer Sharif, the shrine or dargah of the medieval Sufi master Hazrat Moinuddin Hasan Chishti in Rajasthan, western India, and sites at Agra/Fatehpur Sikri, Uttar Pradesh, associated with the Mughal ruler Akbar also appeared in women’s lists of places one might go in search of the blessings needed to obtain a child.

Other women mentioned Hindu holy men (*tantriks, babas, or pandits*) from whom they might take advice or medicine, or whose advice had been sought by other members of their family on their behalf. One Hindu woman said that her mother-in-law had brought her medicine from a *tantrik*, but she refused to take it, and that she had never visited that sort of holy person herself because she did not believe in them. Another Hindu woman said that her mother-in-law got a *taaviz*, a protective amulet filled with a small piece of paper inscribed with verses from the Qur’an, made for her. She said that she wore the *taaviz*, although she did not herself believe in its power. This woman did not, however, state any discomfort about the idea of being given an amulet containing Qur’anic verses. She framed her rejection of its efficacy not as a rejection of Islam, but as an affirmation of her belief in the power of biomedicine, and an affirmation that while wearing such a ritual object could not, in any case, harm her prospects for becoming pregnant, it would please her mother-in-law.

Muslim women I interviewed often said that they would not consult an expert in religious law about their appropriate course of treatment because they considered this to be a doctor’s area of expertise. However, many clearly expressed the general social concern that babies should be conceived only with the husband’s sperm because the paternity of the resulting child should not be questioned. Both inside and outside of clinics, women from different religious backgrounds consistently argued that the experience of infertility trumps religious allegiances. I heard again and again that women facing the prospect of childlessness had common experiences of exploitation and family strife, and that while they might do so quietly, women disregarded religious boundaries in their quests for children, even as they might well respect and uphold them in other areas of daily life. However, economic and religious factors limited the options that women could hope to pursue in their search for children, especially if they attempted to legally adopt a child.

Women volunteered information about multiple strategies for overcoming infertility when I asked them about what else people might do in cases of infertility other than come to an infertility clinic, and/or what else they had done, if anything, but this was not the first information they volunteered about their fertility journeys. In clinics, these non-biomedical strategies generally only entered conversation after women completed their narrations of the different gynecologists and infertility clinics they visited in their villages, nearby towns, and/or cities in Uttar Pradesh. Physicians and other medical staff generally discounted and even ridiculed such multiple strategies by women as a waste of money, as superstition, and as markers of their failure to embrace "modern" life. Physicians might recognize amulets or other jewelry worn by women as indications that they had visited holy people and comment upon it. Few women I met in infertility clinics objected to these strategies; some disavowed their own faith in them while accepting them from other family members. If these strategies did not succeed in bringing a child into their lives, at least they might bind family members closer together.
Women in clinics who got strong support from husbands or other family members exuded confidence, even though they were regularly subjected to procedures that violated their regular norms of modesty and bodily comfort. Despite long litanies of treatment failures, high expenditures of resources, and the prolonged inconvenience of travel for treatment, most women still expressed measured hope for the success of their efforts. Overwhelmingly, women expressed the hope that they find success in the clinic and would not have to resort to adoption, to taking someone else's child to raise as their own, in order to attain their goal of becoming mothers. However, most of them were realistic enough about their chances to know that, in the end, they might well not get children through infertility clinics. Only then would most of these women, who, because of their relative privilege and success in managing family relationships, had been able to pursue their quests for children in biomedical infertility clinics, consider other options for creating families. In the process of pursuing biomedical infertility treatment they gained unique opportunities to build their relationships with their husbands and to position themselves as highly valued family members because of their access to biomedical methods for resolving infertility, while hiding the details of their family-making excursions.