Beliefs and Attitudes towards Infertility and Assisted Reproductive Technologies in Bangladesh: An Anthropological Study

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Academic Session 2015-16
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Thesis submitted for the Degree of Doctor of Philosophy

Department of Anthropology
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Declaration

This dissertation has been documented and submitted to the Department of Anthropology, University of Dhaka, Bangladesh in fulfilling the degree of Doctoral of Philosophy (PhD) Program. Here, I declare that all data and documents presented here are original and has not been submitted in any other academic program. It is to mention that I have partly revised this thesis as response to the letter from office of the controller of examinations.

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Certificate

This is our pleasure to state that Sumaiya Habib has completed her dissertation entitled "Beliefs and Attitudes towards Infertility and Assisted Reproductive Technologies in Bangladesh: An Anthropological Study" for the award of PhD degree in the Department of Anthropology, University of Dhaka, Bangladesh.

This dissertation is submitted in the fulfilling of the requirement for the degree of doctoral of philosophy (PhD) in Anthropology from the Department of Anthropology, University of Dhaka, Bangladesh, during the session 2015-16.

This is the revised version of the thesis as suggested by the office of the controller of examinations.

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Abstract

With the rapid increase of global infertility, we observe vast development of assisted reproductive technologies. However, this western technological medication has formed and shaped into a "localization" (Inhorn and Balen 2012) process, that it has been accepted according to the cultural practices and belief system of the existing society. In countries like Bangladesh, where society is actively pronatal and infertility is often regarded as curse, not as a biological constrain; the recognition of the specific cause of infertility and its solution through assisted technological intervention faces socio-cultural, economic and psychological challenges. This study has observed the penetration of assisted reproductive technologies like, IVF, ICSI etc. in the context of Bangladeshi patient's culture, belief system, knowledge and relationship to their society. Here, children are not only the related to love and affiliation, they are valuable as considered as the socio-economic security for the old parents. Moreover, religiously people belief that raising children, mothering and parenting are the most important duties of social life. The socio-psychological consequences of infertility in Bangladesh includes, family disruption, extra-marital relations, stress, suicidal attempts, vulnerable socio-economic status etc. Customarily, women suffer the most, as traditionally in the patriarchal practice, women are blamed for any reproductive failure. Thus, the notion of infertility is stigmatized and so it's treatments are. In 2001 Bangladesh experienced first successful birth of IVF triplets. After that, the assisted reproductive treatments had been introduced in many private clinics. This study has explained how infertility and these western treatments are experienced by the infertile people.

This thesis is written based on the field experience between the years 2016-2017. The research followed semi-structured questionnaire and separate checklists for the in-depth interviews with various categories of respondents (in total 70). Meticulously, the reflexive position of the researcher has intervened the data

collection and analysis as a whole. Though, women are the core subject to reproduction, who experience the treatments and agonies more directly, they became the first choice of interrogation. However, the research has also indicated the situation of men with an infertile conjugality in the patriarchal society, Bangladesh. However, their kin relations, doctors and other naturally conceived people were also became the research respondents to understand the holistic attitude towards infertility and assisted reproductive technologies.

The thesis demonstrates the way in which Bangladeshi infertile couples are represented and culturally defined. The subjective experiences of the infertile female, male, doctors and others indicates that the class, gender and belief system work as a encompassing force that shapes their living and understanding of infertility and it's biomedical treatment. Though, urbanization and globalization has delayed the age of mothering (mostly in urban settings), still motherhood is a normative behaviour in the context of Bangladesh. Thus, the anomalies to the reproductive order make worried not only the woman but also her family (natal and in-law). However, it is the infertile women who becomes the most vulnerable in this situation. But, they does not act as passive victim of the situation. Most of the IVF seeking women showed their agency by choosing and changing medication and even imposing husbands and family to support them either directly or strategically. Many of them maintain close relations with co-hearts who can share similar problems and ask for advice to resolve different social taunts and hinders. However, still the limited knowledge of reproductive health and the uneven power relation between doctor-patients play role in the medication for infertility. But, it was interesting to notice that women are more optimistic to the assisted reproductive treatments than that of their husbands. The responses of the husbands towards infertility and assisted reproductive technologies are more passive, though they suffer psychologically no lesser than their wives. These emotional breakdowns constrains the conjugal bond and

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hampers their socialization, family tie, income and even occupational success. Moreover, the cycle of IVF and other options cost not only money but also relationships in many cases.

The procedure of assisted reproductive treatment has challenged the traditional practice of pregnancy, thus it is stigmatized and kept hidden. As few forms of treatments are prohibited among the Muslims, the treatments became more stigmatized and questionable. Though, many of the infertile people are desperate to have children (with any option fit for them), shaping their mind that mothering is the precious opportunity of life. And, most of the IVF seeker do not consult religious expert to understand the ethical issues of it, though IVF experts and doctors are conscious about it. Depending on biological problem and affordability people travel for better treatment of infertility. Thus, medical tourism has offered new avenue for the patients who cannot seek their treatment in the cultural settings here in Bangladesh.

However, the high expenses of these western treatments obstructs the solution to the fertility problem of the poor people, though they suffer the most. It is observed that though fertility is a human right, but the government and non-government agents have not subsidized the expenses of infertility treatments. For that reason, mostly all the infertility centers are capital city based. Thus, women with no financial support face socio-psychological and economic vulnerability with infertility. However, class is not only the only obstacle to this biomedical treatment. Many are not interest because of fear of wrong treatment or mingling wrong semen and egg. And still, many lack the information that there are biomedical treatments for infertility. Even, the successful IVF parents do not want to tell naturally conceived people about their experiences or disclose their identity, because of the cultural understanding of infertility and its biomedical solutions.

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This research will contribute in the anthropological studies on reproduction, health, gender and culture and technology studies. The overall findings provide insights on the subjective experiences of infertile male and female and their struggle with assisted reproductive technologies. And concludes that with a stigmatized notion they search for a solution from infertility; show agency and strategic way out in the medical system, where infertile people have little and no access.

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Chapter 1
Introduction

Life on earth have survived through its great ability to reproduce. As a social being humans reproduce and pass their culture and genetic features to their offspring, through which they form and maintain kinship and lineages. Reproduction thus play an important role in family and society. However, with the advancement of science and technology reproduction has been controlled and modified, though in most cases people depend on supernatural power to have child(ren) in time. Thus, for many reproducing and parenting is a gift. Going through parenthood is an expected natural process in human life. Almost all the human bodies in earth would like to be mature from childhood, celebrate youth and embrace his or her fatherhood/motherhood. Accordingly, mothering and child birth has been given priority in all most every society. People around the world possess certain cultural customs and rituals dealing with child birth and motherhood. Any unwilling violation to this natural progress in life may arouse discomfort and anxiety within the social unit and culture. Motherhood is always a desired bio-social status. However, in many cases the natural response to reproductive health turns unsuccessful. Thus, a number of people remain infertile. Though infertility is a problem from both biological and socio-cultural context, is neglected in the third world. The right to give birth thus, kept wrapped under the pressure of the country's over population agenda. However, reproduction at a certain age is a lawful right and society like ours is pronatalist

in nature. There is an urge for having children in the wider family to newly wedded couples in the context of Bangladesh. Here, motherhood and parenting is normative and expected. Although, motherhood and parenting is cherished and glorified rigorously in the society; but, there is a sharp dearth on not only the number of social researchers, but also attempting to nourish the infertile womb. In Bangladesh most of the research works on reproductive health has given emphasis on maternal health, secured natal birth, gender and sexuality, fertility, family planning or controlling fertility (Aziz, Maloney and Sarker1981, Aziz and Maloney 1985, Blanchet 1984,Ahmad 1991,Khandaker and Latif 1996, Ubaidur 2004, Kaosar 2005). Unlike, West there are few anthropological works dealing with infertility in Israel, India, Africa, Egypt and Bangladesh (Martha 2000; Abdallah and Zara 2002; Widge 2001,2005; Osato 2002; Inhorn 2003a, 2003b; Pashigian 2009; Nahar 2010 etc). Still, there is dearth of study on infertility and assisted reproductive technologies in South-Asian countries like, Bangladesh. It happened because Bangladesh is recognized by population problem and poverty. Consequently, the National policy and NGOs do not work for the infertile population of the country. Still, there is no epidemiological study from national level. World Fertility Survey and others has assessed South Asian infertility rate, where they confirmed 4% people in Bangladesh living with infertility. Another study dealing with primary and secondary infertility among the women who are at the end of their reproductive life (45 to 49 aged) in South Asia indicates 15 % infertility in Bangladesh, which is, in fact, the highest in South Asia (Vaessen

1984; Farely 1988, cited in Nahar 2012). This rate may rise, because the reasons of infertility identified are increasing in Bangladesh.

1.1 Rationale of the Study

In many non-western developing country child is incredibly essential. Children are acknowledged as a source of socio-economic security in Bangladesh. Infertility is considered as a curse in the broader ideology of South Asian countries, as it is in Bangladesh. Unwanted childlessness is such a situation which may reason several socio-economic and physical disorders. Any hampered natural growth is an annoyance in social and biological health, indeed. In societies like Bangladesh fertility is a blessing, a common habitual prayer for the newly married couple is, '*shoto putrer ma hou'* (May you be the mother of hundred sons). This prayer indicates the desire of having many children, especially sons. Thus, fertility meant status and social security to the parents, especially to the mother. Though Bangladesh is an over populated country people here crave for many children for a number of socio-economic and religious reasons. Aziz, Maloney and Sarker (1981) have observed rituals to promote fertility among the Hindu and Muslim community of Bangladesh. A mother is always considered respected than a barren woman. A childless woman is blamed for any misfortunes of a family. Infertility, although could be a reproductive health problem of either male or female or both; but unfortunately, is always considered as a biological error of female body. Thus, fertility is always allied with the women. Infertile women face social discrimination inside and

outside of the family. Nationally, they are marginalized in terms of health issues. Maternal health is always the prime concern of the national and global policy makers. And, certainly, it should be. But, undermining the health condition of the infertile men or women has threatened the psycho-physical health of these susceptible people.

Infertile couples often feel frustrated and ignored. Not only the dishearten couple but also the whole family of them turns distressed. It is obvious that parents feelings, socio-psychological stipulation cannot be compared with any other, but the broader family has certain aspiration to be connected with the unborn ties. In Bangladesh, kinship plays a significant role in its social structure. Here, marriages are usually arranged by the kin herd and performed with the presence of all kinsmen. After marriage having children is a common expectation of the relatives to the newly married couple. Even just on the day of wedding many mother-in-laws (usually mother of the groom) wishes to be grandmother soon. Hence, the larger families of the infertile couples also go through socio-psychological trauma. The whole family countenances lack of inheritance of their lineages. Thus, an infertile couple challenges the loss of their lineage inheritance.

Western technology has given us a number of ways to find possible solutions for infertile families. The treatments depend on the causes of infertility. Most of the treatment methods are quite expensive considering third world economy. Before the invention of these western treatments and technologies, the local people used

to have indigenous medication for fertility. Assisted reproductive technologies (ART) made living easier and happier for many infertile lives. ART include a number of methods to rescue human reproductive system, in vitro fertilization is one of them. The history of in vitro fertilization is not too old, but its successful results made its journey fast around the world. Now-a-days many third world countries are also applying in vitro fertilization method for child birth. Usually these methods are found in specialized clinics or in private hospitals as they are expensive. And as mentioned before, the government policy of third world countries including Bangladesh does not regard infertility as a vital problem, though the velocity of infertility is increasing day by day with nominal scope of advanced reproductive treatments, which are available in private medical sectors. The policy makers are reluctant to improve or introduce new reproductive technologies in Bangladesh because over population is still a burden for Bangladesh. Therefore, the infertile status of many people remains constant problem in their every today life.

1.2 Purpose of the Study

The scarcity of infertility study in Bangladesh is recognized through the other reproductive health researches and fertility decline researches of the past years. The concept of infertility in Bangladesh was understood in its fertility seeking strategy, as the previous studies have investigated. This study will address various issues concerning with infertile couple. **The principal objective of the study is to find out the differential subjective experiences of infertile couples**

and their intervention to encounter infertility through assisted reproductive technologies. The aim of this study is gathered bellow:

(1) The study will search the belief and attitudes to infertility and assisted reproductive technologies among the married males and female of different socio-economic class having difficulty with reproduction,

(2) It will explore, whether and why childless couples are interested in modern medication. The research will also investigate the relationship between in vitro fertilization and given belief, attitude and personal emotion.

(3) The research will explore how male and female encounter and experience infertility, assisted reproductive technology and medical experts of it.

(4) It will also find out how their relatives reacting towards modern treatments for infertility and relate the IVF baby as a part of living. The research will examine what plays role in decision making for in vitro fertilization and how they accommodate to the new phase of life.

1.3 Analysis of Related Literatures

After the remarkable ethnographic work of Briggitte Jordan (1978), academicians put more interest on studying birth and reproduction analyzing from different socio-cultural aspects instead of the demographic scholarship. Hence then, anthropologists, sociologists, psychologists and other humanitarians had worked on human reproduction from a wider range, which helped me to

categorize the researches dealt with infertility and assisted reproductive technologies. Arguments of the scholars vary in their methodological and theoretical understanding. Thus, research works can be classified according to its relatedness with infertility and assisted reproductive technologies. Some of the literatures dealt with the fertility-infertility debate, whereas, many focused on the religious beliefs to understand infertility and assisted reproduction. Many studies on new reproductive technologies have shown new direction in studying kinship. Some researchers focused on traditional healing and health seeking attitudes in their studies on infertility, on the other hand, some paid attention on the psychological issues of infertility and its new reproductive technologies. Except a few works (Inhorn 2012) most of the social researches on infertility and assisted reproductive technologies have given their keen attention toward females, and estimated infertility and assisted reproduction a gendered issue, because it is the women who suffer the most while she is childless. The infertility and ART scholarship could raise wide range of social debates according to the arguments of various researchers. Different issues and concerns have been focused and rigorously attended by scholars, which has been reviewed to enrich the theoretical ground of the current work. In the context of Bangladesh, this study also required fine observation on gender issues which is very much related and obvious with this study of infertility and ART.

Fertility-Infertility Debate

Negligence towards infertility as a problem in the oriental society is embedded in the high reproductive people of this region. The tropical climate has enhanced

puberty at early age which enables them to have more children with a long reproductive age. High productivity and high infant mortality rate used to be the demographic features of many societies in the East. Thus, the infertile people's voice, perspective and dilemma were not the central interest for researchers and agencies. There is dearth of anthropological research on infertility of Bangladesh. We can understand the problem of infertility, when reproduction is in jeopardy for certain people. The early fertility behavior studies in Bangladesh can help us to understand the obscurity of infertility. Aziz, Maloney and Sarker (1981) and Aziz and Maloney (1985) minutely observed the notion of fertility in Bangladesh, where they addressed that the problem of infertility is recognized and thought to be a female problem without any medical investigation. They also explored the medical systems chosen by the rural people of Bangladesh for their reproductive health and how those folk/ traditional sectors of medical systems launched by the existing religious beliefs. People's attitude towards professional sectors of medication regarding sexuality and fertility were highly controlled by religious belief and patriarchy. In their research, Maloney et.al have mentioned the importance of having and bearing children in the religious ideologies of the people of Bangladesh. Here, in Bangladesh all couples enter into conjugal life, expecting to have children, who will carry the name of their lineage generation after generation (Maloney: 100). Hence, it is duty of each married women to conceive just after marriage and reproduce as more children as she could. There are socio-economic interests of having more children, especially male children, in the context of Bangladesh as the researcher stated. Children not only secure

family lineage but also can be of great man power as labour and play vital role in factional village politics. Any lineage having more male youth is of high command and acquire privilege in village authority .Many of the other anthropological studies on rural Bangladesh have identified this phenomenon (Bertocci 1970, Islam 1973, 1974, Zaman 1977, Khan 1977, Choudhury 1978, Aziz 1979). The belief system in Bangladesh has its long flame influence to fertility by giving mother a virtual honorary place. As a consequence, infertility brings misery to the married women without children.

Theoretically, the studies on infertility and the new reproductive technologies vary in their arguments. Some argues to find out the reasons of negligence, stress the social stigma considering infertility and its treatment. Many scholars viewed the situation from feminist lens. Feminist ideology, postmodern view and the exercise of knowledge-power ideology were the area of interest to understand infertility and new reproductive technologies for many. Some of the social scholars observe that the new reproductive technologies have brought new direction in kinship, religion, race and ethnicity study. Infertility and new reproductive technologies has also been studied from psychoanalytical perspective.

Kinship, Infertility and ARTs

Strathern's *Reproducing the Future: Anthropology, Kinship, and the New Reproductive Technologies* (1992) was a fundamental ethnographic research on new dimension in kinship study. The author addressed that the effects of assisted

reproduction to the relationship pattern and relatedness. The Euro-American kinship is widely studied by Strathern, thus she asked how the new reproductive system engages with the existing kinship pattern, which is rooted in biological reproduction. In this age of ART, whether anthropologists need to redefine kinship; as it is constructed; and motherhood and fatherhood can be of various articulations. Strathern's research shows how the Euro-Americans face the trouble to conceptualize relatedness with ART. If kinship is understood biologically then kinship itself may be questioned by the new reproductive systems (ie. third party reproduction). This thought enhances critical questions to ART and kinship through the distinction between biological and social parenting (Inhorn and Carmeli 2008). Therefore, Euro- American societies and other nonwestern societies, where kinship is the base of their social organization should be minutely observed to comprehend the conceptualization of assisted reproductive technologies.

Susan Kahn's (2000) exigent study among the Jews women of Israel point out some new challenges in assisted reproduction and indicate a rigorous cultural shift in Israel. The study of Kahn interrogated the political and historical roots of Israeli Jews pronatal interest, which enables them to embrace reproductive technologies. Both married and unmarried Jewish women may go through assisted reproduction in Israeli Jewish culture. Though having child without marriage or husband is not socially encouraged but it is accepted, moreover the government initiated state policies, which recognize and support single parents, as a consequence the unmarried mothers are well accepted in the secular Jewish

communities in Israel. The children born via artificial insemination to the unmarried/single women inherit the same cultural, religious and social identity as those born to married women, Kahn investigated. Marriage is controlled by the religious authorities in Israel, and many of the traditional rabbis, especially the religious women oppose the single motherhood through new reproductive technologies; though it is not incorporated in the religious law of Israel. As the pronatalist state are supportive and taking legislative actions to encourage Jews reproduction by all means. Kahn beautifully examined various cultural discourses that come to bear on the social use of the new reproductive technologies in Israel. The assisted reproductive technologies has created new question to understand the notion of kinship of Israeli Jews, which focuses on rabbinic perception of symbolic meaning of relatedness that is endorsed to bodily substance, "paternity can have variety of coordinates" (2000:110). The new notion of kinship, that is paternity, maternity and origins of Jewishness is introduces with the advancement of new reproductive technologies. In reality, the social consequences of assisted reproduction depend on the religious –legal authority and social actors who initiate the symbolic meanings of Jewish kinship in Israel, according to Kahn. The required bodily substance for assisted reproduction, either Jewish or non-Jewish, opens a "kinship puzzle", but both situations incorporates reproductive tourism in order to reproduce Jews. Susan Kahn has also investigated the social meaning of the fragmented identity of maternity in new surrogacy law. Regarding surrogacy and contradictory beliefs about contemporary assisted maternity of Israel, Kahn argued "…Jewish babies

are only born from Jewish wombs. The rabbinic idea of gestation and parturition determine Jewish identity is thus codified, and thereby entrenched, in secular legislation" (2000:173). In observing the cultural recognitions of assisted reproduction Kahn compared the Jewish conception of kinship as opposed to Euro- American kinship, from where the technology was introduced. Today the uses of these technological advancement in Israel has created a series of complex social dilemmas, observed by the researcher. Kahn mentioned that the urge for new reproductive technologies among the married infertile and single women in Israel has roused conflicting and contradictory kinship cosmologies.

Melissa Pashigian (2009) did her field research at Vietnam, which goes beyond the psychoanalytical issues of mother- child or father-child bond in IVF, moreover Pashigian's article argues how the Vietnamese kinship and society encountered IVF. It discovers the importance of womb as an organizing principle for relatedness in Vietnamese society. The author traces the womb as a site for determining maternal relatedness in contemporary assisted reproduction policy through cultural beliefs about gestation, popular legend, and contemporary and historical forms of polygamy and surrogacy, drawing attention to the continuities between past and current practices surrounding infertility and indigenous solutions to the challenges infertility poses in forming kin-relatedness. Infertility was not a reproductive disruption; it was considered as an outcome of prior deeds, choices or fate for the Vietnamese women, it makes the barren women marginal in the society as Pashigian stated. The researcher pointed out the social value of mothers with wombs in this society. Pashigian noticed that the meaning

to mother has changed as the assisted reproductive technologies entered the country. Now the culture and the legal system of the country give importance to the womb with gestation, not identifying genetics. Thus, the woman who carries the fetus obtains a greater value of a mother in Vietnam. The kin relation is much associated with the womb with fetus. Therefore, surrogacy is culturally ban in Vietnam. In assisted reproduction gestation is viewed with the infertile mother, thus motherhood is identified and the fetus- mother relation is well maintained according to their existing culture. Pashigian addressed the kinship system which has faced challenge confronting new reproductive technologies. Though polygamy is not legal in Vietnam, but still people practice polygyny for the sake of children, and sometimes the second wife became the surrogate mother. Polygyny is practiced to have children, but according to the cultural understanding of Vietnamese motherhood, the child is always associated to the birthing mother. However, if the infertility is caused by the male then having second wife will not bring solution. In these complicated matter of reproductive disorder in Vietnam, the culture and state has given importance to the maternal ties, thus women are empowered through their womb, according to Pashigian. The researcher investigated the authority of the state in controlling the IVF and surrogacy. The state judges women bodies to observe who is qualified to go through IVF. It is interesting to see that instead promoting the patriline, the state enhances a matri-focal process. Thus, the state limits the choices of reproduction and motherhood is identified is its own cultural understanding, which may resist technological progress for infertile couples as the researcher apprehended in

Vietnam. However, here women are more associated with their ability and disability to reproduce. Thus, they correlates motherhood and womanhood as complementary. Many of the Asian cultures dignifies womanhood with their ability of mothering and caring.

Social-psychology of Infertility and ARTs

Some other studies on in vitro fertilization focus on its psychological standpoint and kinship status through technologies. These studies address the nature and role of family relationship and bond in the families where in vitro fertilization took place. In a research Balen (1995) claimed that the mothers who has gone through new reproductive technologies are comparatively more care giver than the naturally conceived mothers. IVF mothers showed more warmth to the children and are more emotionally attached. Even IVF mothers and non-IVF infertile mothers stated that they could be better mother and could maintain baby in a more easy way. The parents used IVF are positive to their children and find less burden of parenthood, Balen found. These IVF mother and non IVF infertile mother group reported that they are more capable to handle children than what fertile mother group did. IVF children get more attention and privilege. In many cases mothers overestimated their IVF children as Balen stated. However, psychological development research does not significantly prove that IVF children are additionally developed (Morin et. al.1989). Golombok et.al. (1995) reported that the adopted and conceived children's psychology and emotion does not differ from the IVF children. All these especial children behave to their parents as conceived children do. On the other hand, in a pilot study Golombok

and others identify that the incidence of behavioural and emotional problem are higher though they made normal development progress (Wang:1996). In addition to this negative impact of IVF, researcher found the overprotected attitude of the IVF parents toward their children. Over protection and overindulgence could be an obstacle for the children's independency, responsibility and can go ahead to insecurity and dependency (Weaver et. al. 1993, in Wang:1996). These researches are pointed to the cognitive interpretation of parent- child relation through IVF.

Health Policies and Cultural Practices

Pamela Feldman-Savelsberg (1995) recognized the lack of attention to infertility as surprising in Africa; because demographers have identified 'infertility belt' in central Africa from the sample survey and census data of the post-world war II. In fact, these areas are surviving with limited resources and fighting against different reproductive health problems (i.e. HIV/AIDS, infertility etc) is their procedure of survival. Johanne Sundby (2002) addressed infertility and health care in developing countries with less resource. State policy differs on its fertility issues, for example, fertility is regulated by the authoritarian reproductive polices of China; whereas Norway government policies encourage fertility through series of incentives for child bearing. According to Sundby (1997) and Gerrits (1997) infertility presents a paradox, because its psychological consequences in high-fertility settings may often be worse than in countries where women have more flexible models of expressing femininity and fulfilling social roles.

Sundby mentioned that like Gambia and Zimbabwe many Africans countries are fighting against reproductive health diseases which costs their fertility. Gambia posses a low contraceptive prevalence rate, the contraceptive prevalence study (WB/MOH/UNFPA, 1993) investigated that among the women with the end of their reproductive period, up to 3 to4 percent had no children, the study suggested further diagnosis of infertility for these childless women. There is no such data available for infertility frequency rate of many developing countries. Comparatively, developing countries are going through secondary infertility as mention before; the developed faces primary infertility in most cases. However, these Sub-Saharan African countries women recognize secondary infertility as a result of their first pelvic infection (WHO, 1991). In her famous work *Local Babies, Global Science: Gender, Religion and In Vitro Fertilization in Egypt* (2003), Inhorn acknowledged that the secondary infertility which occurs due to infections are high in the Third World- for example, 40 percent in Latin America, 23 percent in Asia and 16 percent in North Africa, including Egypt. The women with these reproductive problems lack control of medical care, reasons are bilateral, according to Sundby. The childless women and the women with chronic reproductive health disease of central Africa visit doctor but very few overcome their infertility. The biomedical health services are of limited quality and scope. Many people even visit traditional health care agencies, which are popular alternative among different ethnic group. The traditional healers offer remedies and advices for possible ways to cure. Herbalist healer and faith healers are also working as ‘shaman’, who communicates with ancestral sprits. In many

cases these faith healers declares that infertility is caused by the dissatisfied sprit of the ancestor. Sundby claimed that the health centers and village hospitals offer limited treatments. Reproductive health problems like, abortion, maternal morbidity and mortality, complicated deliveries, HIV/AIDS in pregnancy are urgent in priority list; whereas infertility ranks at bottom. Yet, the affluent infertile clients of Gambia and Zimbabwe visit private clinics where they can understand the problem of infertility and investigated the possible reasons of infertility, but many of these clinics could not offer any advanced assisted reproductive technology. However, some recent studies stated that many African countries including Nigeria, Ghana, Cameroon, Zimbabwe, Togo have number of assisted reproductive technologies including in vitro fertilization (Ola:2012). Usually, assisted reproductive technologies are available at private sectors in Africa, and it's only accessible to the middle and upper classes. Moreover, the centers and experts of assisted reproductive health care are often located in the large cities, thus it is fairly inaccessible for the couples from more remote place. In addition, it is not affordable because it is an expensive procedure.

Religion, Infertility and ARTs in the Global World

Anthropological research works on assisted reproduction flourished by the scholarly works of Marcia C. Inhorn, who made ethnographic research work in Egypt and Arabian nations. In her works, she mainly focused on the infertility situation of the common people and the way of having in vitro fertilization as a solution to this problem (Inhorn: 1994, 1996, 2003b). Moreover, she stressed how economy, local belief and knowledge system deal with new productive

technologies in Muslim nations where patriarchy is dominating the social practices. Before 1960s Egypt was well known for overpopulation problem and family planning was the prime goal for the then government; infertility was never been included as a pollution problem, it was entertained as a public health concern and sufferings of Egyptians, especially women (Inhorn 2002:3). After the International Conference on Population and Development in 1994, Egyptian Fertility Care Society published that 12 percent of the Egyptian married couples are living with infertility. The societies of Middle East comprise pronatalist view. Thus, child is of great value for families of different socio-economic strata. Recent researches show that infertile muslim couples of Middle East –both male and female are interested in assisted reproduction to pursue their parenthood (Inhorn and Tremayne, 2012). Adoption is not the suitable path to social parenthood in many Middle Eastern society, thus they considered ART to progress biological parenthood. Moreover, Islamic authorizes of these region permitted and accepted ART as 'marriage savior' (Inhorn and Gurtin 2012). Therefore, both male and female infertile married people of different background are heading towards new reproductive technologies, though third party reproductive assistance is not appreciated in many cultures. In a research Inhorn and Gurtin (2012) mentioned that the Sunni Islamic people have their *fatwa* for assisted reproduction. According to their outline they prohibit third party donation in the process of ART, Shia Islamic people agree with most of Sunni fatwa but some progressive Shia people also permit the third party assisted

reproduction. The Shia dominant Iran as well as Lebanon, thus, practices all forms of ART.

Consequently, Iran and Lebanon have become the recipients of ‘reproductive tourism’ from neighboring Sunni majority countries (Inhorn 2011). Thus, Marcia Inhorn argued that infertility and the practice of ART faces the class, race and gender inequality. Non Western poor countries face the lack of IVF treatments, thus the societies where children are of greater social value go through childlessness. As far as our concern infertility in most cases is considered as a female problem. Thus, the male is observed as second sex in terms of infertility, Inhorn explained.

In her work *The New Arab Man* (2012), Inhorn identified the changing nature of patriarchy, patrilineality, patrilocality and polygyny in Middle East through the study of male reproductive health issues and globalization. Here, Inhorn pointed out the stigma of infertility is higher to the muslim male of Middle East. The muslim males of her study blamed the psychological stress due to war as the major reason of male infertility rather observing the genetic disorder due to generations of cousin marriage ,which is widely practiced in many Muslim communities in the world. Inhorn artfully delivered her anthropological message on the gender studies and reproductive health issues; perpetuating the global technological effects on the local religious morals and stereotype representation of gender while introducing a emergent masculinity in Middle East Muslim.

Reproductive Technology and Political Economy

In their study on infertility and assisted reproduction, Abdallah S. Daar and Zara Merali (2002) pointed out the crisis of fertility in the developing nations; those who are addressed for their over populated features are suffering from infertility problem and at a high risk like the developed nations. They mention both on primary and secondary infertility and rectify that sub-Sahara Africa and Latin America possess high chances of secondary infertility, whereas Asia and other developed nations have chances of primary infertility. Daar and Merali categorized the harms and sufferings of infertility and focused on the differential sufferings of infertile people from developing and developed nations. They successfully observed the pain and sorrow of the infertile people and found that the scale of suffering is intense for the developing nations; especially the women of the developing nations undergo the most for not having child. Physical violence and suicide are the extreme consequences of infertility. The overpopulated discourse and lack of resources prolonged the infertility treatment in many developing countries. Daar and Merali's have replied to the argument of overpopulation and low resource, which appears as obstacles towards the establishment of ART in many developing countries. Like Ginsburgh and Rapp (1995), Daar and Merali also observe that the women's bodies are the locus for socio-economic and political exercise take place and the mechanism of fertility and reproduction is what Foucault observes as 'bio-power' exercise. Thus, the overpopulated discourse and agencies aliened the existence of infertile population and terminated them from new reproductive technologies in many

developing countries. Overpopulation discourse should not resist the infertile population from ART , as it is the right of all human beings to reproduce "if, when and as often as they wish" as it was stated in the definition of reproductive health adopted by the United Nation's 1994 International Conference on Population and Development. Thus, Infertility should be prioritized and ART should be introduced with the public-private partnership in these low resource developing countries as Daar and Merali explained. The disparities of infertility treatment between the developing and developed country thus creates 'stratified reproduction', as addressed by Rapp. The concept of 'stratified reproduction' was developed by Colen. Rapp and Ginsburg's work, *Conceiving the New World Order: The Global politics of Reproduction*, discuss on several societies that limited women's choice on reproduction and childcare due to socioeconomic factors. They conclude that the global political order and local socioeconomic relations that form the context for stratified reproduction, whereby some categories of people, who are well-off, are empowered to nurture and reproduce, while others are disempowered. They observe that the technology is gathered only for those who can afford it by their economic and cultural ideologies and state policies reinforce the stratified reproduction according to the socioeconomic factors of the state.

Social Milieu of Infertility and Stigma

Many people of our neighboring country India are suffering from infertility with rare scope of modern medication. The ideology of motherhood is related with the identity of womanhood in most of South-East Asian countries. The socio-

cultural context of infertility and the application of assisted reproductive technologies in India are minutely observed by Anjali Widge (2001, 2005). Feminine identity is defined by the ideology of motherhood, being fertile is important and infertile is huge problem, Widge argued. Widge assessed the significance of child, especially son in the patriarchal India, where polygyny takes place in case of infertility. Adoption within the consanguine family is accepted as blood tie is essential for the inheritor. Thus, fertility has socio-economic and political attention in Indian context, Widge noticed. In India childlessness is a matter of social exclusion from the society. Infertility is a stigma and the couples suffering from it undergo enormous social and religious pressure, particularly the women. Women in India face the blame of infertility and go through the social and economic consequences, such as, personal guilt, grief, marital violence, economic deprivation from family, physical assault, remarriage of the husband, divorce etc. Anjali Widge examined the subjective experience and struggles of the Indian women who observe infertility, which indeed a unique attempt to uncover the social aspects of infertility in Indian context. The social order makes these women defenseless. Even few of those who are financially capable to have IVF endure uncomfortable experiences, Widge stated. Though IVF is a relief for the dishearten infertile women but the expense of IVF make it difficult for the poor people. Widge artfully investigate that some of the couples prefer son while having IVF in India. Though it is illegal to identify sex during gestation in India, for its high expectation of son, general people are still fond of having son as their successor. Widge found it the

disturbance of IVF in Indian context. Many studies focus on the interest in IVF in India and less priority for adoption (Mulgaonkar 2001 in D. Barani Ganth et al 2013). In India where female fetus abortion takes place, there the process of IVF requires high monitoring and legal observation. Women reproductive issues in India should be studies in its general context of poverty, class, gender inequality and unequal access to resources Widge suggested.

Paapreen Nahar's (2010) work is a significant anthropological study regarding infertility in Bangladesh. Nahar investigated the socio-cultural trauma of infertility among the rural and urban middle class women of Bangladesh. She investigated the consequences of childlessness among the rural and urban women of Bangladesh. The childless women are the victimized in many ways, they blame themselves as they are guilty for not giving birth of a child. They face social insecurity as family disruption is an effect of infertility in Bangladesh. These victimized women live with stigma and horror of isolation. The rural infertile women sometimes are divorced and abandoned by the husbands, whereas urban women have less tendency of being divorced, observed by Nahar. The situation of rural and urban sector differs, because of the consciousness of the urban people and treatment opportunities. Nahar stated that the urban women have more access to biomedical tests which make them 'deviant' if their infertility is proved, whereas rural women with no such test maintain hope till menopause. Nahar and Geest (2014) also explored that the resilience of childless women, how they confront the stigma of childlessness. She made clear distinction in the adoption strategies of urban and rural Bangladeshi infertile

women. The rural women secretly try to find out the solution of their physical problem of infertility, as they confront risk of divorce and abandonment they maintain the strategy of being more submissive and tolerate all the socio-psychological, if they fail in doing so, the result will be more severe for the infertile women. One interesting resilience behavior of rural infertile women is to increase their socialization, whereas the urban women avoid social gathering. The urban infertile women search for medication and go through different sorts of therapy, they believe in medical pluralism. These women undertake alternative works in order to get busy, thus they will be confident and empower in family and society (Nahar and Geest 2014). The researchers have shown that the Bangladeshi infertile women show agency, resistance and resilience, building on their inner strength and social inventiveness. However, in conclusion they poisoned that with different resistance and resilience infertile women still remain burdened with stigmatization and cultural blame.

Gender, Health and Reproductive Concerns

Gender construction influence the overall reproductive health system including its meaning and understanding to individuals. Thus, women became the locus of human reproduction; though their counter-part also play important role not only biologically, but also socially. The biological problem of sterility may rest in either male, or female or both; but, women are blamed for infertility in patrilineal societies (Gerrits 2002). In rural Bangladesh, womanhood is specifically connected with fertility. Thus, infertility is exclusively considered as the disease of woman (Islam 1985). Blanchet’s study (1981) on birth rituals of rural

Bangladesh addressed that both Muslim and Hindu societies share the concept of universal maternity. It is expected that the sign of pregnancy within a year of marriage. Unless and until, the woman give a ‘good news’ to her in-laws she could be blamed with the suspicions of barrenness. Failure to conceive is always attributed to the women (Kotalova 1996, Reynolds 1983). Moreover, the people of rural Bangladesh consider that it is auspicious to deliver a son as the first child, thus the woman after getting married has to accomplish the expectation of desired children in order to express her womanhood. “…pregnancy grants her full body promising increase, and surviving son affirms her aspirations to domestic power and gives a security against the calamity of widowhood.” (Kotalova 1996:202). Thus, motherhood has become the prime status for the women of Bangladesh.

Though delivering offspring and raising them is considered the primary task of women, but any failure to conceive is not considered as a disease in rural Bangladesh. In general, rural women of Bangladesh lack health care (Islam 1985). The health seeking attitudes thus depends on the gender construction and symbolic capital of the body, Begum (2015) interrogated. She noticed that the women with upper cultural and economic capital connect reproductive illness with biomedical concepts, about those they were informed at schools or other public health care programs., whereas, other women with lower symbolic capitals consider reproductive problems as ‘*dushi*’ or ‘*jadu*’ rather than ‘*osukh*’ (Begum 2015:141). Thus, the gender construction and understanding of health and reproduction are influenced by the symbolic capital of individuals.

Masculinity and Infertility Treatment

In most societies, motherhood has been prioritized; still that does not fade any significance of fatherhood; as men are more likely to associate fatherhood with masculinity. The domination of patriarchy glorified the active existence of fatherhood as one of the partner in reproduction. Yet, human reproduction and fertility behavior is observed among the women in an exclusive way that the fertility-infertility debate and concerns passively discourage men to involve into the wonders and worries of it. As a result, most of the males feel discomfort not only on discussing on reproductive health issues, but also in the treatment procedure of infertility, if required. The masculine ego hinders the investigation of the location of biological anomalies. Mason (1993) claimed that traditionally “manliness” is observed and experienced more to the ability to make a woman pregnant than to undertaking the role of father. Thus, it agrees that infertility is a threat to male sexuality and masculinity. Accordingly, many researchers have been stated that fathering of children is related with masculinity. Thus, for, many infertile men, having children is their gender identity (Nachtigall et al. 1992). What so ever, male infertility is kept as a secret from the wider society in rural Bangladesh and women are blamed and turns more vulnerable in the society as Kotalova(1996) and Maloney (1981) has presented. However, there is still dearth of research on male infertility cause the potency and fertility confrontation has made the issue a social stigma and taboo to be discussed, as Bents (1985) has argued. Similarly, Kotalova (1996) has shown that Bangladeshi man who fail to get married are indicted and dodged of not having ‘sex organ’ and go through

ridicule by others. Thus, it is more about the cultural understanding of potency and fertility problem than to its medical definition (Humphrey 1969, Bents 1985, Gannon et al 2004). Dudgeon and Inhorn (2003) has put more insights on the culture influences on individuals and society. They stated that culture influences not only how individuals are treated for their reproductive health problems within given systems of medicine, but also how individuals living within local communities define and experience their reproductive health. As a matter of fact, infertile men face mockery cruel pranks, interrogated in different societies. Thus, secrecy and blaming women becomes the way to rid for many men. (Mason 1993, Imeson and McMurray 1996 in Thorsby and Gill 2004)). In their article, Dudgeon and Inhorn concluded with an urge to study on the changing notion of gender and masculinity which influence the understanding reproductive health according to the it's cultural construction. Later in 2015, Inhon published her work on Middle-Eastern manhood and infertility, where she elaborated the contemporary notion of middle eastern manhood focusing on their views to new reproductive technologies. Inhorn feels that the idea of 'hegemonic masculinity' need to be applied in the studies of non-western gender studies as manhood is not static or constant fact, it changes. She challenged the Western myth on the patriarchal men of the Middle-Eastern Muslim men.

Apart from the infertility, it's treatment and masculinity questions, some researchers have been focused on how wives and husbands show disparity on the parenting, financial costs and solutions to their problem of couple infertility (Epstein and Rosenberg 1997).

Body Politics, Authoritative Power and Medicalization

Paula Saukka and Lori Reed (2010) in their edited book *Governing Female Body* have chosen Foucault's three dimensional theory of "governance" and power and focused on the connections between gender, power and body. The female body has been introduced under governance of various categories of power and knowledge metaphors, which enables women's body work within the framework of authoritative power. Saukka and Reed's work has gathered various aspects of female body in relation to power and governance, where Karen Throsby's article has applied Foucault's bio-power concept in addressing the IVF strugglers who failed to succeed in terms of normality and naturalness. In relation to bodily governance and health practices new form of identity is produced in their own norms and responsibilities. Thus, the unsuccessful IVF couples pose to their own meaning of "selfishness", "everything possible", "IVF-junkie", "designer baby", or "miracle baby". Apart from these metaphoric identifications, Throsby addressed most devastating situation is the women's regardless self-blaming tendencies. Not matter from where the infertility is situated (male or female body) it is the women who guilt their own body, not the technology for the failure of IVF cycles. thus, the intervention of the assisted reproductive technologies like, IVF provokes many women stuck in the vulnerable position.

Consequently, Margarete Sandelowski and Sheryl de Lacy (2002) disclosed the notion of infertility as a by-product of the invention of new reproductive

technologies. Sandelowski and Lacy's interpretation of infertility has been considered in this to understand the attitudes toward infertility and ART.

As mentioned before that the theoretical understanding of researchers vary, which is cleared in the above discussion. The goals to identify particular research issue possess its own philosophical understanding. This research will focus on the couples of Bangladesh who struggled with infertility and IVF, thus it will cover both male and female identities and their associates that go through the struggle of infertility and it's treatments. Thus, contemporary Bangladeshi masculinity could be addressed in this study. Though, the latest work of Inhorn is concerned with masculinity and infertility, many other infertility researches lack the male's voice to understand their view on infertility and its treatment. While comparing the treatment facilities of urban and rural sectors, Nahar mentioned that the unlike rural women, urban women experience the 'hopeless' situation of infertility earlier, as they recognize their problem through biomedical checkup. Thus, living with the identified trouble can make their life more vulnerable, which will be my research curiosity. Understanding the relatedness with new reproductive technologies will focus not only the infertile couple but also their relations with others, as we know Bangladesh is a kin-based country, so it is very necessary to recognize the kin's perception and emotion and their relatedness. This research will uncover how the people of urban Dhaka, who have different socio-economic and religious background confront infertility and the new reproductive technologies.

1.4 Theoretical Framework

The study connotes Margarete Sandelowski and Sheryl de Lacy's notion of infertility as a by-product of assisted reproductive technological invention (Sandelowski and Lacy 2002). They have explored the misrepresentations of infertile. Sandellowski and Lacy argues that the representation of infertile as patients is arguable. Though barrenness or sterility appears out of bodily dysfunction, it is not considered as other diseases like, cancer, heart disease, blood pressure or diabetes, it is compared with not having or fulfilling the desire of having children; like the desire of having sharp nose or firmed body. Thus, infertility is addressed more socially, psychologically and emotionally rather than medically. It is the inability to achieve a desired social role of motherhood/fatherhood/parenthood. As they mentioned that the social role of motherhood/fatherhood/parenthood is a socially desired factor, I can relate this social desire with the belief system and social expectation of the Bangladeshi people. Moreover, they have stated that sterility is an absolute identity, whereas infertility indicated a liminal state in which infertile persons hover between reproductive capacity and incapacity (Greil1991). The hover between these phases sort the affected people act accordingly, perform stressed and imbalanced behaviour and decide to jump over the solutions and switch from one place to another. Except a few evidences of infertile couple's resistance to the psychological model to infertile position, majority seek attention to counselling, both formal and informal as they viewed. Moreover, when the society labeled some as infertile couple then,

they are viewed as socially handicapped and in need of socio-psychological support. Accordingly, infertile people are judged in harsh way for all of their dealings and doings, as Sandelowski and Lacy have pointed out that these infertile people are the targeted consumers as many of them comprise with dual income with no kids. Furthermore, those who attain medical supports and IVF are not less interrogated by the stereotype society. However, Sandelowski and Lacy profoundly express their views on the invention and representation of infertile by the stereotype society, medical participants and social researchers. Thus, assisted reproductive technology constructed the liminal state of infertility, though it appeared to challenge the absolute physical condition of sterility. This study considered infertility as the way infertile defines themselves and focus on how infertile people represent themselves and are represented and treated through belief and attitudes in the social context of Bangladesh. The subjective experiences of the infertile male, female, doctors and their social intimates indicates that gender, class and belief system work as a encompassing force that shapes their living and understanding. Thus, I have reflected Sandelowski and Lacy's conceptions on the understanding of infertile people and their psycho-physical positioning inside the Bangladeshi society. The socio-cultural construction of 'infertile' has been viewed through the views of Sandelowski and Lacy's interpretation.

The experiences of western technological varied in various ways. In Bangladesh people show inconsistency and a dualistic response to the

assisted reproductive technologies. The achievements of assisted reproductive technologies have engaged the disparity in global reproduction and class and social-cultural boundaries play role to determine the affordability in Asian countries where society is pro-natalist. In this regard, I consider Colen's (1986) stratified reproduction, where he described how reproduction is structured across social and cultural boundaries, empowering privileged women and disempowering less privileged women. However, the women who are the subject of the assisted reproductive technologies have their own meaning of understanding and dealing the procedure of IVF treatments where their body and soul run into constant dilemmas and pain, which they recover by their own means. Arthur L. Greil (2002) has argued that infertile women do not respond passively to medical definitions of them but react actively and strategically. They work in the system and try to push medical treatment in the direction they want it to go. Infertile women are neither passive victims of bio-medicine or uncritical consumers, wanting to take advantages of all available medical technologies. Rather, they are problem solvers; operating creatively within a system they do not control (Greil 2002). In the introduction of *Situating Fertility: Anthropology and Demographic Inquiry*, Susan Greenhalgh (1995) demonstrated how gender shapes reproduction in different time and places. Citing examples from diverse cultural boundaries, she described the gendered character of the networks through which migrant/ less privileged women sought their reproductive aids (Fuch and Moch 1990) and show active or passive agency.

She pointed out that the subordination of women (third world women) have hindered women's active role in health issues as well. Many of the scholarly writings have illustrated them as victims of patriarchal institutions, where women had no choice to control their reproductive health (Caldwell 1978; Cain et al. 1979 in Greenhalgh 1995). Carter (1995) argued that those writings have portrayed women as too passive model in patriarchal society. Women have more strategic way out for their pain relief. Societies like North India where women are subject to subordination of patriarchal institutions, defy husband and in laws and form secret agency in order to ask reproductive aids that includes, abortions, birth-control, menstrual disorder and other childbearing health problems (Jeffrey and others 1988 in Carter 1995). Parsian women as Fuch and Moch (1990) explained, also have information sharing and mutual support that helped them to solve critical reproductive problems. Theses invisible secret networks are strategic resources in a world that offer limited scopes for sensitive reproductive problems which are considered stigmatized. In the case of approaching assisted reproductive technologies American middle class women's strategic agency to explore the treatment has been dogged by Greil (2002), similarly this research will show how the women here in Bangladesh act in choosing their treatments and operate agency in the given patriarchal institutions, like hospital and family. In the context of Bangladesh, most of the institutions are patriarchal in nature. Thus, both the hospitals and family as institution framed in the favour of patriarchic decisions. However, as Greil identified American women

strategically act to explore infertile body, infertility treatments and interact with hospital services from their American understanding of health and illness.

The philosophical understanding of the present research will focus on the thoughtful works of Marcia Inhorn. Inhorn (1994, 1996, 2003a, 2003b, 2011, 2012) has explored versatile agendas on infertility and IVF among the Middle Eastern societies. She argues that infertility and reproductive bodies are shaped according to the cultural understanding of the specific locality and the virtue of new reproductive technologies has embraced the joy of parenthood to the solvent infertile couples, but created a 'stratified reproduction'; at the same time Inhorn stated how ICSI succeeded people experienced the artificial biological parenthood which were the only choice for many infertile male of Egyptian Muslims. However, when reproductive technologies for infertile people challenge the exiting religious and cultural meaning of kinship in the Muslim world of Egypt, many travel to neighbouring countries where they could avail other options to have IVF child(ren). Thus, many tend to come out with their individual perception of belief on the Western treatments. As a result, 'reproductive tourism' becomes an optimal goal to save many matrimonial bonds, but questioned the biological identity of the IVF children and threatened the sunni Muslim reproductive regulations. 'Reproductive tourism' has been defined as the search for assisted reproductive technologies (ARTs) and human gametes (eggs, sperm, embryos) across national and international borders (Inhorn

2011:87). Further studies of Blyth and Farrand (2005), Deech (2003) and Pennings (2002) have identified several causes of reproductive tourism, such as, ethical constraints, affordability, efficiency, privacy etc.; the causes and situations of Bangladeshi infertile couples who travel for treatments have been examined accordingly. In other works, Inhorn (1996, 2012) and Dudgeon and Inhorn (2003a) argue that male infertility is not less stigmatized than female infertility. But, through the emergence to new reproductive technologies the new male identity is rising in the patriarchal Muslim Arab world as Inhorn (2012) noticed. Inhorn (2012) excavated that the concept of masculinity among the present Arab male has been shifted from their traditional nature. The Arab male of 21st century are more considerable and committed to their spouse and encourage IVF treatments without third party donation. The interrogation among the pro-natalist Muslim Egyptian culture of Inhorn has elaborately discussed the notion and manner of a western technology becoming culture-free and universal to the commoners and explained how these treatments are experienced subject to the gender, race, class and religion. Being a patriarchal Muslim pro-natal non-Western society, infertile people of Bangladesh also experience the assisted reproductive technologies by their own terms. Thus, Inhorn's understanding on the ups and downs of the Western treatment among the patriacrchal women, its efficacy, gendered embodiment and modification with local belief system were considered to understand how infertile couple here in Bangladesh interact and experience these Western technologies.

This particular study will be held in a society where patriarchal sprit of kinship is the basis of social structure. And most of its population are Muslims (sunni muslim dominating) though a strong connection of Bengali culture and tradition can be found in the lifestyle of its population. So, this research will examine whether Inhorn’s experience is similar with the assisted reproductive cases of here in Bangladesh.

Chapter 2

The Methodology

This thesis is an outcome of qualitative research. A field research has been conducted between the time February, 2016 and June, 2017. Methodologically, I was much enhanced by the ethnography of Marcia C. Inhorn (2003b) and Sadelowsk's(2000) methodological position. Sandelowski defines qualitative descriptive studies as offering: "a comprehensive summary of an event in everyday terms of those events. Researchers conducting such studies seek descriptive validity, or an accurate accounting of events that most people (including researchers and participants) observing the same event would agree is accurate, and interpretive validity, or an accurate accounting of the meanings participants attributed to those events that those participants would agree is accurate" (2000: 336). The things, I see are considered my observation on 'certain issues', which has a reflexive impact. Researcher's view and consideration are not value free, thus certainly the subjective experiences of my respondents has shown their colours following the lens of an anthropologist. Moreover, Inhorn's(2003a, 2003b) study on the Egyptian infertile people and IVF patients profoundly explored the experiences of Muslim infertile male and female IVF experts, common Egyptians; viewed the psychosocial and economic battle of the IVF patients. Similarly, this research have considered that different categories of respondents are necessary to understand the experiences of infertile people with IVF.

However, this research is liberated from the boundaries of clinical settings. More or less, searching the subjective experiences of patient's or sufferer's following interviews in a formal place (clinic and hospital) face terrific obstacles. Sometimes it hampers the clinical decorum; sometimes it turns difficult to talk on fertility and infertility issues at a public place, because child birth, fertility and infertility are considered private topic of discussion and people here are not familiar to talk certain issues with unknown people, like a researcher. Thus, my entrance to the field was not hospitable at hospitals and clinics. This chapter explores the research methodology, the stages of doing research, the obstacles and the methodological strategies used to overcome the unfriendliness of different stakeholders of assisted reproductive technologies.

2.1 Reflexive Position

The ambiguous anthropological methodology experienced modification after the diaries of Malinowski published in the second half of the twentieth century. Malinowski's personal interpretations opened the concerns of value and ethics in anthropological scholarship. Hence, reflexivity was born in anthropological methodology. The critics on Malinowski's ethnographic method, let reflexivity a central concern in anthropological research and soon it became widely popular. Reflexivity entered anthropological discourse in 1970s through films and artistic productions. In anthropology it must be observed how the ethnographer's presence and attitude changes the subject of the study as well as the changing view of the ethnographer to the response of native or subject or situation under study. The observations, interviews with categories of informants with those who

were aware of my socio-economic status have certain impact on the subjectivity of the respondents of the research. Moreover, the power relation of interviewer and interviewee exits in many ways. Thus, Leach (1989) wisely said, "The only ego that I know at first hand is my own. When Malinowski writes about Trobriand Islanders he is writing about himself; when Evans-Pritchard writes about the Nuer he is writing about himself. Ethnographers as authors are not primarily concerned with factual truth, they convince by the way they write." (1989:139). The urge of my data, being a cultural participant of the same community of the research respondents, sometimes made the people considering me as known to their understanding, which was not true by all means. My urban birth, cultural learning and understanding of Bangladeshi culture, reading ethnographies has limited my scope of generalizing people of Bangladesh. Many times, people were uncomfortable to talk on issues (like child preferences, conjugal life, cultural norms, beliefs, doctor's attitude etc.), considered me as the part of Bangladeshi culture (as if I know each and every traditional meaning of mutual relationship) and when I asked more in detail, they laughed at my ignorance. For them, though I was a member of their cultural entity; but, my education, urban raising, economic capability and naturally conceived position with a son has narrower my inspection of understanding their view to world. Rooted in the critics of colonial researches, reflexivity has appeared in feminist and anti-colonial writings as well. Thus, researcher's socio-political position has necessarily become the influential factor to analyze the subjective experiences of the respondents. In addition, both respondents and ethnographer's position

changes due to the situation of the study area, for example, clinical or non-clinical or residential. Exploring the IVF experts, doctors, nurses and infertile couples in different power infra-structure has reshaped the data representation. Thus, I clarify my reflexive position as studying Bangladeshi people as being urban educated middle class professional progressive Muslim Bangladeshi married woman, with one son. While working in the field I was considered a highly educated progressive Muslim woman to my respondents and informants. In conversing with the population where I belong make things confusing as the respondents presume that we share common understanding of culture and society. Therefore, I deliberately repeated my research purpose to my respondents, which assisted me in many ways. The reflexivity challenged the distinction between the objectivity and subjectivity of writing style. The writing of the reflexive ethnography is more personal than conceptual, as Nazaruk observed "objectivity is imbued in a subjective stance" (2011:76).

2.2 Access to the Field

The data was collected from clinical and non-clinical settings, thus the research was conducted not only in clinic, hospital, shops beside the clinics, but also in the residential of the infertile and IVF treated couples. However, getting access to field work in hospitals and clinics was methodologically challenged as there were a number of restrictions to do research in a clinical settings, where the patients could not express their view for their vulnerable physical and social status as being patients to the knowledgeable medical associates. Thus, the non-clinical setting helped the research go much smoother and spontaneous rather

inside the hospital lobby. But, many of the infertile couples visit these specialized medical zones to cure themselves from infertility. However, as the hospitals which provide infertility care and specialized infertility clinics vary according to its popularity and luxury, the doctor-patients relation varies. The majority of infertility clinics are situated in Mohammadpur and Dhanmondi region of Dhaka city. There are also infertility care centers in private clinics like Square, Apollo, and Anwar Khan Modern Hospital etc. Before staring the formal field work, I visited a number of hospitals and clinics where gynecology department also offer treatments for infertility, where many of the infertile couples come. It was not easy to get access to the doctors and IVF experts of specialized hospitals; unless, they are convinced with the research proposal. However, there were also some voluntary respondents of various categories, who encourage this research. I was blessed to have doctor friend whose colleague got intimate family tie with one of the famous female IVF experts of the country, who accepted my request and grant me to conduct field without hampering their patients and following rules and restrictions of the infertility clinic, otherwise, having appointment with IVF experts in Bangladesh terrifying.

As the research issue was sensitive, it was not always easy to reach patient’s inner feelings. But, when I was at the waiting zone, in front of the doctor’s chamber many recognized me as a patient like them and started sharing their experiences. When they came to know my intention of being there, many of they stopped talking with me. Some women avoided me in front of their husbands. The research was conducted with those patients who did not stop talking with

me after knowing that their personal information will be unknown to the world as the research will follow pseudo identity. However, there were also few respondents who do not ask whether their name will be recognized or not. But, I used pseudo name and identity and place name, considering the sensitivity of the research issue.

Though it was a fortune that I had a social network to explore one of the IVF experts of the country, I had harsh experience to communicate with other experts. Here, I will depict two of my experiences to address entrance to my field. Dr. Enam, who gave me access to the field, was not accessible at time as I mentioned on the pervious paragraph. The first meeting was settled by my doctor friend who was not much optimistic. The time of meeting was fixed at 6pm. I was so excited that I reached the clinic almost one hour before the scheduled timing. The entrance and outer architectural attraction provoked me to guess that the interior of the infertility clinic would be as luxurious as the other private hospitals and clinics of Dhaka city. But, I was disheartened by the untidy interior with less light and poor ventilation. There were few patients waiting and number increases by the time, but the doctor didn’t arrive. I informed the receptionist about my intention of visiting her with an appointment. It was 4 hours I was waiting observing patients complaining about the IVF expert’s time sense. Many women came from distance places to visit her, and it would be difficult for many to return home. Sometimes they have to wait around 2pm to meet the doctor, one woman said who is under her supervision for the last 4 years. However, she was informed about my presence thus she called me up sending a man from the reception. I

entered at Dr. Enam's chamber crossing a small room, where patient's history and reports are taken. She welcomed me as I was introduced by a close kin of her. She agreed that my issue of research is an essential demand for the society, and she asked a short form of my research proposal to understand the specific objectives of my research, besides she was worried whether the patients will be comfortable with my questions. She was made comfortable by ensuring none will be forced to talk on certain private issues and the research paper will use pseudo name identity of patients and her medical institution. She also ensured that my presence should not hinder doctor and medical associates while they are serving the patients. Having access to this infertility clinic was a big challenge to this sensitive research; it was only possible as I was introduced by her dear one.

The data was also generated from the infertile and fertile couples to whom I was introduced by those clinic patients and my own friends and family while the research was generated. While visiting other gynecologists I have also gathered data and met prospective informants, which helped me to draw a wider scope for collecting data. For example, the specialized infertility clinic resembles a narrow, underrated and clumsy environment compare to other private hospitals that also have specialized infertility center. However, the private hospitals with infertility centers are crowed by the upper middle class and rich people, whereas the specialized infertility clinic serves the middle class and lower middle class too. One of the reasons was Dr. Enam is also working at a government hospital , thus patients from different class come to her private clinic. But, the IVF experts and

other gynecologists of private hospital only consult there, thus introduced by less, who can afford the private charges.

Though Dr. Enam agreed to give interview and support my data collection, not all the cases with IVF expert and gynecologists were pleasant. Dr. Murad, an eminent IVF expert of the city didn't get time for long interview. I waited for 6 hours at his waiting lobby and but he was unwilling to talk and avoided to provide any support giving excuses that he is too busy with his work. He also discouraged me to do such research as he thinks that only less experienced gynecologist may help me, thus a fruitful result may not appear at this study. However, my friend's social network helped me to reach one of the pioneer IVF experts of Bangladesh. But, none of the experiences go in vain. While waiting at the lobby of Dr. Murad I have observed many infertile couples and IUI conceived patients. Like Dr. Enam, Dr. Murad also had patients from all over the country. Though Dr. Murad only practices at private hospitals, he is active in social media compare to other experts of Bangladesh. Thus patients all around the country are coming to him for infertility solutions. I have seen patients with short travel bags, who will go to his work station or home after consulting him. Dr. Murad advised 43 patients on that day, all were fighting against infertility. Among 43 patients only 5 were carrying fetus after having IUI/IVF. There were three young women who were assisting the doctor to deal patients. It was interesting to notice that three of them had three different clothing styles. The first one was wearing *salwar-kamiz* and *orna* on her shoulder, who was taking the serials of the patients and guiding them to sit properly at the waiting lobby. The second woman was

standing in front of the doctor's consulting room managing and calling patients according to the serial, she was wearing *saree*. This woman had *sindur* on her forehead and *sakha-pala* over her hand, which symbolizes a married Hindu woman. The third woman usually stays inside the doctor's consulting room and comes out when patients leave, she simplifies the advices doctor made for the patients and provide guideline for the best of the patients. This third woman was wearing *burkha-hijab*, just unveiled her mouth to speak properly with the patients. Though I didn't continue my data collection in this private hospital, the appearance of these three young woman exhibit that the authority is much concern to make it's patients comfortable and communicate with them by the their approaches with whom they can relate psycho-physically and ethically. The appearance of multi-religious and cultural veil would make all infertility care seeker, accept the procedure of treatment. The presence of three assistances and one junior doctor with Dr. Murad is an exceptional example to me as I have visited more than six doctors (gynecologist and IVF experts) and none of them were assisted like him. Dr. Enam also had junior doctor who follow the case history, two nurses (uniformed) who helps patients if needed and one receptionist to maintain and call the serials. But the assistances of Dr. Murad represent a viable approach to the treatment of infertility for diversified group of people. Dr.Murad's rigid approach of not to provide any interview and allowing to visit his consulting zone disappointed me; but opened an avenue to understand how professional people loom when a social researcher is unknown. I assume that there is a dearth of sharing knowledge between medical professionals and

medical anthropologists in Bangladesh. Building rapport with commoners, the fluid people is much easier than highly educated professionals unless the researcher follow the proper channel. Moreover, inside the hospitals and clinics the doctors and medical associates play the powerful role, where others are recognized as medical subjects or health service seekers. As a result, access in a research field like clinic or hospital requires a systematic procedure to deal with the authority. And it could be easier if the researcher find networking rapport working at the hospital. However, as I mentioned earlier in this chapter that the hospitals which provide infertility care and specialized infertility clinics vary according to its popularity and luxury, accordingly the doctor-patients relation varies, thus some gynecologists and IVF experts allowed me to seat and talk to the patients without any clarification, if patients want to disclose their experiences.

2.3 Field in Clinical and Non-clinical Ambiance

After situating myself in the infertility clinic, it took considerable time to understand the infrastructure of the clinic. I have passed my two weeks watching the patients, nurses, medical associates and cleaners. None was cooperative enough until, Dr. Jui who is assistant professor of that clinic, introduced me to the head-nurse of the clinic. In Bangladesh people are friendly in the informal settings of everyday life, but when it comes with institutional-formal medical surrounding, many of the authorized people fear to talk with unauthorized people, like a social researcher. But, it does not take much time for those authorized people to be informal, if they are introduced by common known

middle man. After meeting Dr. Jui and the head nurse, it was easier to communicate. Gradually, I started my interviews with those who gave me access. The infertility clinic was situated in Mohammadpur. It was multi-stored building with a modern out-look, though in side of the clinic was not well-ventilated and decorated. However, the infertility zone of the luxurious hospital of Dhanmondi was more modernized and garlanded. In doing the research, I have talked with four gynecologists and two IVF experts from Dhaka city. They were chosen according to their availability. My field in the infertility clinic and infertility zone of a luxurious hospital has a ceremonial form of behavior and architecture. As most of my informants were infertile men and women I was also floating with them in the waiting lobby of the clinic and beside doctor's room. Except Dr. Jui, assistant professor at infertility clinic none of the doctors gave me interview twice. She and Dr. Enam also introduced me with infertile couples admitting assisted infertility treatment from their clinic. Though all the doctors and medical associates were busy at their workplace, Dr. Jui helped me to figure out a considerable way to conduct my research. In clinics and hospitals most of the doctors seem to be very busy. They consider their patients first. Most of the time, I waited 3 to 4 hours to meet the doctors. The clinics and hospitals has its own settings and infrastructure, which enables the receptionist to control all the people visiting doctor including patients, nurses, peon of the institution, medical representative and me. Thus, the formal position of the doctors put them in a distinct setting to consider them as superior and separate from the commoners. Moreover, the close circuit cameras all over the medical zone inspire its

surroundings to feel under surveillances. As a result, doing research in a clinic sometimes hampers the fluency of data generating process both for the interviewer and interviewee. It is already mentioned that this research has been liberated from the obstacles of clinical research by roaming around the shops nears by, such as the *chotpotiwala*'s shop, the road-side folk-healer etc; moreover, I originated rapport to visit the residences of the patients and gradually I understood that infertile women do got communication with one another, thus the purposive-snowball sampling was chosen as a right choice to accumulate data. I have also visited nearby guesthouses for the patients who came from other districts of Bangladesh.

I had separate check-list and semi-structured questionnaire for different sorts of informants, doctors, infertile couple, their relatives, naturally conceived people. It was complicate to ask questions directly on certain sensitive and personal issues. Thus, all of my conversation could not be formulated as cases. I have observed and talked with many infertile couples, whose case are not incorporated in the thesis, but helped me to understand their experiences and re-construct my questionnaire. Meeting and conversing with more infertile couples and medical associates decreased the hurdles of interviews. The infertile clinic and the infertile zone of the hospital allowed me to be in the waiting zone, patient's personal room (if they permit), post ET room and front of the delivery room or OT. In non-clinical settings I have interviewed in the patient's guest-house and residences of the infertile couples.

Though the IVF expert, Dr. Enam permitted to do the field at her clinic at times I failed to meet her as she is tremendously busy with her job, meetings and other academic workshops. Many time medical associates, such as receptionists, nurses, cleaners etc did not give me appropriate time for their busy schedule. It was cheering and refreshing for the younger nurses to have tea or *chotpoti* with me on the roadside of the clinic on their ways to home. The *chotpotiwala* became an informant for my research, who helped me building rapport with folk-medicine seller, cleaners, nurses and regular patients of the clinic. This man ferry *chotpoti-fuska*, chips, noodles and bottled water. It was my husband who started building a friendly relation with the *chotpotiwala* sharing his knowledge of the *chotpotiwala*'s home district. In Bangladesh people are homesick and their relation to home district is expressed with the bodily substance dipped in the soil of their natal home. Thus, I tried to connect people addressing and sharing knowledge of home districts.

Though many of the infertile and IVF patients were unknown to me, they became familiar with me after knowing me personally. With whom I was related previously, kinsmen were less prompt in sharing their experiences. Thus, my relation to them didn't help me, but these people gave me plenty of time and introduced with other infertile couple who were friend to them. The shortest time of interview was 15 munities, whereas the longest were about 3 hours (180 munities), considering short-break (going toilet, checking serial numbers, having snacks).I have spent days with infertile couples and IVF parents, experienced their emotions and understanding of life and living. I meet and interviewed their

relatives, who were with them during my visit. Among them I consider the naturally conceived people to understand their thought about IVF.

2.4 Stories of Cases and Informants

The study required different categories of informants. Thus, the infertile men and women as couples, their relatives, doctors, medical associates, religious expert and naturally conceived people were considered as respondents. The informants and respondents were selected purposively, according to the requirement of the research purpose. Moreover, oral consent of the respondents was considered. When I started my fieldwork at the hospital, I was wondering how could I get my informants informally talk and share their living with infertility and assisted reproductive technologies, like IVF. At times I was frustrated. It was all about time and luck to initiate fieldwork on issues which are addressed as "sensitive issues" in Bangladesh. Inside the infertility hospital and centers many patients start talking on different issues including infertility problem and other sensitive issues, but when they are informed about research most of them hesitate to talk. As I mentioned some of the doctors and medical associates helped me to communicate with their patients. Besides, my social network and professional identity facilitated me to build rapport often. Steadily, I progressed with my field and felt amused with friendly informants, who not only shared their stories with me, but also offered me tea at their house. In the period of my field work I have met more than 40 infertile couples (under treatment and achieved IVF baby); but experienced 23 cases for my study, most of them were fighting against infertility. Among the 23 cases, 23 women and 10 men (who were the husbands of 10

women respondants) were my respondents who were interviewed about their experiences of infertility and it’s technological treatment. In order to understand the view and attitude of the male as husbands I tried to communicate husbands of all respondents. Only 10 of them gave consent for my interview. This research also interviewed relatives from 11 cases, who were available during my study. Apart from Dr. Enam another I have also communicated with another IVF expert. Other gynecologists, nurses and medical associates were also considered as key informant. Many times I was in conversation with the ferryman around the hospital who helped me to communicate with the patients and medical associates. The basic information of my infertility struggling respondents is pointed at the chart below.

Table 1: The list of infertile cases with specified problems

	Name	**G**	**Age**	**present marital status**	**Education**	**occupation**	**Socio-economic status**	**Present Residence**	**medical problem as informant describe**	**Present status**
1*	Asma	F	28	Married	BA	House wife	Urban-Affluent	Dhaka	Body is not fit for assisted reproduction.	Unsuccessful IVF, waiting for next cycle
	Dulal	M	36		MBA	Banker			Low motility, no quality sperm . He had gone through surgery.	
2	Rupmoti	F	31	Separated	Primary school	Temporary maid	Rural-Poor	Dhaka	Tubal blockage	No Treatment
3*	Hira	F	28	Married	High school	House wife	Rural-Affluent	Mymensing	Minor pelvic infection	IVF Twin Conceived after two attempts
	Akhter	M	34		Higher Secondary	Remittance Earner			Poor moving and low number of sperm	
4	Kumo	F	34	Married	Higher secondary	Housewife	Rural-Affluent	Pabna	PCOS and diabetis	One son with homeo-treatment
	Raja	M	40		Higher secondary	Remittance Earner			No problem identified	

	Name	G	Age	present marital status	Education	occupation	Socio-economic status	Present Residence	medical problem as informant describe	Present status
5	Honufa	F	34	Married	MBBS	Left job	Urban-Upper-Middle	Jhalkanthi	Her husband's problem, though her body took several cycles of IVF	Conceived and delivered IVF son
6*	Saira	F	30	Married	BSC	Housewife	Urban-Middle class	Dhaka	No problem identified	Undecided
	Mashuk	M	35		BA	Private employee			Poor moving and low number of sperm	
7*	Khaibar	M	40	Married	MSS	Industrialist	Urban-Affluent	Dhaka	Low sperm with abnormalities in shape	Successful IVF girl
	Shapla	F	33		BA	Left job			No problem identified	
8	Jinaat	F	34	Married	MSC	MNC	Urban-Upper-middle	Dhaka	Secondary infertility. Mother of one son and a daughter.	No treatment plan.
9	Nipa	F	34	Divorced	BBA	MNC	Urban-middle	Dhaka	Abnormally in Uterus. Failed IVF.	No treatment plan.
10*	Ikbal	M	42	Married	MSS	University Teacher	Urban-upper-middle	Dhaka	No problem indentified	Failed IVF twice
	Rehana	F	38		MSS	Left job			Spontaneous miscarriage	
11*	Saimum	M	38	Married	MBA	MNC	Urban-upper-middle	Dhaka	No problem indentified.	Undecided
	Jara	F	35		MSS	Government employee			Ovulation problem identified	
12*	Kusum	F	34	Married	MSS	Government employee	Urban-middle	Comilla	Husband's problem	Failed IUI
13*	Ismat	F	36	Married	Higher Secondary	Housewife	Urban-middle	Tongi	Unexplained problem	Failed IUI and IVF several times
14*	Lamia	F	33	Married	MSS	Housewife	Urban-Upper-middle	Dhaka	PCOS and hormonal disorder	Successful IVF
	Sohan	M	39		MSS	Business man			No problem identified	
15	Tina	F	34	Separated	BA	Housewife	Urban-middle	Netrokona	Progesterone disorder	Faied IUI and IVF
16	Shopon	M	45	Married	MBA	Banker	Urban-upper-middle	Dhaka	No problem identified	Failed IVF
	Lira	F	42		MBA	Tele-com employee			Hormonal disorder, but unexplained infertility	
17	Maimuna	F	34	Married	BSC	Left job	Urban-upper-middle	Dhaka	Husband's azoopermia	Successful IVF

	Name	G	Age	present marital status	Education	occupation	Socio-economic status	Present Residence	medical problem as informant describe	Present status
18	Lipi	F	32	Married	Higher secondary	Housewife	Urban-lower-middle	Dhaka	Abnormally in uterus	No treatment plan
19	Khukumoni	F	54	Married	BA	Left job	Urban-upper-middle	Dhaka	Delayed diagnosis. Both have problems. Unfit to have treatment.	Adopted relative's son
20	Marina	F	42	Married	BSC	Housewife	Urban-affluent	Dhaka	Untold female infertility	Never plan for treatment
21*	Sakira	F	36	Married	BBA	Private employee	Urban-middle	Dhaka	Cervical female infertility	Failed IVF
22	Rabeya	F	38	Married	BA	Housewife	Urban-affluent	Dhaka	Secondary infertility, mother of one son.	Planning to have IVF
23	Sheba	F	38	Married	MBBS	Doctor	Urban-affluent	Dhaka	Unexplained infertility	Failed IVF several times, adopted
	Hasan	M	40		MBA	Bank				

Note: '*'indicates the cases were introduced from hospital and clinics.

Source: field work 2016-17

The above table indicates the 23 cases I interviewed. The gender, age, profession, socio-economic class of 33 fertility challenged people (23 women and 10 men) dealing with infertile status along with their bio-medical problems and solutions they are planning is exhibited in this table. The average age of 33 infertile respondents is 36.34 (The average age of female respondents is 35.30 and male is 38.9). Among the 23 cases 6 couples reside other districts of Bangladesh, who visits Dhaka only for treatment. The table also indicates that the percentage of affluent class and upper-middle class are high and more prominent to avail bio-medical treatment, whereas the percentage of middle class respondents is low and the lower middle class and poor class do not appear in the infertile clinics for their treatments.

The class is determined by their income, assets and living standards as they informed. The urban affluent class earns more than two lacs taka per month. They also inherit or possess others properties like land, house, established business etc. Those who earn less than two lacs but more than one lac belong to the urban upper middle class. Few of them inherit residence at city. The urban middle class usually do not own urban property; they earn less than one lac but more than fifty thousand per month. Many of them depend on their rural crop production (from their inherited land) for living. In urban sector, the bottom group as I determined, is the urban lower middle class, who earn less than fifty thousand per month and manage their living accordingly. Along with more than six *bigha* (approximate) of land, the rural affluent class possesses little business property in the local town. The respondents who belong to the urban/rural poor class do not have any land property; they earn about eight to fifteen thousand taka per month, and temporarily living at Dhaka. The class determination of naturally conceived people also accessed similarly.

In order to comprehend the people's perception, belief and attitude about infertility and it's bio-medical solutions, I have also interviewed 12 naturally conceived married people to understand their view about infertility and its bio-medical treatment, which is IVF. This category of respondent belongs to various class and gender of Dhaka city. The details of the naturally conceived married people are listed below.

Table 2: The list of naturally conceived people

	Name	G	Age	Education	Occupation	Socio-economic status	Numbers of children
1	Anu	F	40	Primary	Housemaid	Poor	5
2	Belal	M	42	Primary	Rickshaw-puller	Poor	4
3	Rani	F	32	Secondary	Tailor-assistant	Poor	3
4	Nurjahan	F	34	Degree	Housewife	Middle	3
5	Nargis	F	44	BBA	Banker	Middle	2
6	Abdul	M	46	Diploma	Engineer	Upper-middle	2
7	Malek	M	27	MSS	Private job	Middle	1
8	Titu	M	31	MSS	MNC	Upper-middle	1
9	Muna	F	34	MSS	Private job	Middle	2
10	Champa	F	34	Honors'	MNC	Upper-middle	2
11	Summona	F	32	MSC	Housewife	Affluent	2
12	Sinthiya	F	37	MSS	University Teacher	Affluent	2

Source: Fieldwork 2016-2017

The socio-economic status of all respondents was evaluated according to their perception of class and status. Monthly income, expenditure, education, occupational status and social-global exposure play important role in socio-economic status. Among these naturally gifted respondents, there were 4 male and 8 female from various socio-economic status group. Among the 12 respondents 3 were from poor class, 4 were from middle class, 3 were from upper-middle class and the rest 2 were from affluent class. Only 2 women were housewives, others earn living. The average age of the respondents is 33.25 and average number of children is 2.33.

As mentioned earlier categories of respondents were interviewed, in order to investigate the relationship between infertility, in vitro fertilization and given belief, attitude and personal emotion among people of different socio-economic

class and gender. The total number and categories of the respondents are sorted in the table below.

Table 3: Total number and categories of the respondents

Category	**Male**	**Female**
Infertile people	10	23
Naturally conceived people	4	8
IVF expert	1	1
Gynecologist	1	3
Nurses and medical associates	2	3
Religious Expert	1	0
Alternative Medicine Expert	2	0
Relatives of Infertile couple	0	11
Total (70)	21	49

Source: Fieldwork 2016-2017

Apart from these 70 interviewees I have conversed with many infertile and naturally conceived people and eventually gone through further investigation to accumulate data and build rapport. After doing interviews and visiting my respondents 4 months in a row, I understood stories follow some common nature of entity though hindered by individual socio-economic status and social-global exposure. Meanwhile, the gathered data were ready to code and do analysis. The research generated coding and generating data in the last 4 months of fieldwork, which helped the research to find out what where the lacking and gap of information collected. This helped me to go back to my respondents again for 3 months with specific queries.

2.5 <u>Analysis and Representation</u>

After conversing with infertile women, my informants those who become informal to me asked whether I am also going through the same problem of infertility, but when they knew I have one son, they started encourage me to have more. As I answered them that currently I am busy with my study and job, few were disappointed. Many times they tried to convince me to have a daughter and raise my son properly instead career. Some also thought me as a medical associate and asked me for suggestions for their problems. I tried to convince them by disclosing my intentions to being in the clinic. Everyday after returning from my interview experiences I struggled with personality conflict and got emotional with my data I recorded. It was hard to control emotions after knowing women's heartrending personal stories fighting with infertility and IVF, writing up field notes and reading those again and again. At times, the analysis was halt for the emotional stress, which was recovered with kind help of friends, family and research supervisors.

Rigorous data collection and analysis could not be separated, being reflexive. A reflexive representation requires researcher's interpretation and observation of each situation from the field. My observation about the surroundings of field and sharing knowledge with many of non-interviewed patients, medical associates, small tradesmen and infertile friends and relatives were recorded in pen and paper. The interviews were conducted by me in the native language *Bangla*, as it is my mother tongue I offered them convenient translation through paraphrasing. However, many times the responses the interviewee made were

not always according to what I was asking for, because of their little understanding of anthropological study, medical terms and reproductive health. Still, the researcher's perception does not claim any epistemological superiority; nevertheless the choice of emphasizing depends on the researcher's choice. Correspondingly, Becker (2000:23) also argues that, ″Ultimately the ethnographer must choose what to emphasize, and in doing so he/she shapes the nature of the ethnography." Whereas Sandelowski (2000:335) explains further that "…all inquiry entails description, all description entails interpretation…. Descriptions always depend on the perception, inclinations, sensitivities, and sensibilities of the describer." Thus, I also agree that the description is partial to some extent, depends on in the process of featuring certain aspects of the field situation and affected by number of experiences and events surrounded.

In addition to these, the representation of data interrogated three challenges to be solved. Firstly, how to categorize varieties of data from various respondents? Each case of infertility carries its own way of pain and possibilities. Different cases hold different stage of fertility and social problem. I comprehended as much as data could be introduced to shape the multi-faced experiences of the respondents of different class and gender. Throughout my thesis I have mentioned the word 'infertile', to demonstrate people those who did not give birth to child without technological support. Secondly, how to distinguish various techniques of assisted reproductive technology? With the advancement of modern technology new reproductive technologies are improving every day.

Yet, there are many techniques to be introduced in Bangladesh. Still, all of the available techniques are not officially disclosed for ethical ground. Moreover, considering the affordability, sensitivity last but not the least present population pressure of Bangladesh, assisted technologies is not spread throughout the country. The problem of distinguishing the available technologies is addressed according to the technology seeker's attitude about it. Thirdly, how to discuss research finding? The way of writing completely deliberated through the reflexive understanding. The text itself explicit the findings, though throughout the exhibition of data I implicitly gone through various scholarships and materials and cross checked, by doing comparisons and explaining the context I observed.

2.6 Ethics and Boundaries

The ethics of the research is maintained, considering the significance of personal information and social status of the respondents. While doing fieldwork at the hospital many of the patients were sharing their experiences with me and other surrounding, but when they were informed about my purpose of research most of them avoided me. In doing my field work I have been encountered by many infertile couple, their relatives and naturally conceived people, about the prospects of my research. Some were convinced with my intention, but most of them were hazy and did not seem to talk with me further. Those who did not want to take part in my research claimed that these researches will not bring change in the society to accept infertile people or the assisted bio-technological method easily. According to them personal experiences should not be shared

with anyone unknown. And as a researcher I was unknown to them. The research was conducted with those who agreed to give information. Before staring any of the interviews they were addressed by my research purpose and promised not to use any name and identity in practice, thus pseudo name and identity has been used. Moreover, the respondents were allowed to keep silent on the research question if they are not comfortable to answer. Consent form was given to the respondents, but only few have gone through the consent form, as the interviews were spontaneous than structured. Thus, the oral consent worked in this case. There were some respondents who orally consented to my interview and after that contacted with me not to use her information for any research purpose. I have tried to convince and succeeded in certain cases. However, most of the interviews run smoothly and lively. Though few accepted me taking pictures, none of them allowed using their frontal pictures published in anywhere. Among the 70 respondents only 2 wanted to read my note on their part, which was done, by not hampering others information. The rest 68 respondents agreed to share their personal experiences without exposing their name and identity. Thus, using pseudo name and identity was strictly maintained. Though few of them captured photos with me for their personal collection, most of them did not allow me to use their photographs in documentation. Only a few said that their face should not clearly appear in the pictures if I use for research. However, their unwillingness prevented to use any of their photographs in my thesis. During the fieldwork no harm happened to any living being, none were forced to talk or financially suffered.

Chapter 3
Understanding Infertile People: Bangladesh Perspective

Fertility is a natural aptitude to have offspring. Human societies have institutionalized this basic need and created different socio-religious and cultural practices to deal with human fertility. Diversified cultural context of human beings urge divergent meaning of fertility. Most of the couples in Bangladesh get married with a dream to be parent of their own children. Fertility is cherished from the early beginning of the marriage. In traditional Bangladeshi culture the brides are welcomed with paddy and grass which not only relates her to the agrarian production but also wishes her reproduction/fertility. Here, having children is not an option but a compulsory duty of the married Bangladeshi women. The primary task of the married couples is to beget and rear child as a moral task in order to pass the lineage and clan's name. The elders wish that the next generation will take care of the parental property and esteem their name and fame by good deed, in this way they will find peace and happiness (Maloney 1981). The traditional cultural practice does not give women space to rethink of this obligatory task. However, with the massive spread of 'population control project' people are much aware of contraceptives, thus; nowadays few of the married women decide her right time to reproduce. As, Arens (2013) has stated that rural women of Bangladesh take responsibility to use contraceptives in order to plan their family. In rural Bangladesh Family planning projects usually assist women to grab control over her reproductive timing. However, these women are

much exercised by the patriarchal notion of male virility (Arens 2013) .With expand of family planning projects, a number of newly married couple has shaped their reproductive lifespan; but almost none want to be childless, especially the poor, rural people and women. It must be taken under consideration that family planning does not lead to population control. Feminists have argued that family planning is initiated to give women's right over her reproductive body and population control projects an authoritative power which assists how many children should a couple produce. However, Bangladesh government is working for both family planning and population control. Thus, in one way family planning is giving control over women's willingness to have children on the contrary population control asks for one child per couple.

The urge of having more children has challenged the government's policy of population control and family planning projects. People of bottom and upper economic class of Bangladesh desire to have more children. Poor people want to have more economic sources via their offspring. Though child labour is legally unappreciated but, the socio-economic need push the poor to send their children work and earn for them. These children will be the shelter of poor parents at their old age, in the context of Bangladesh. The people of upper strata also need more children to control and take care of the inherited property, which is land or industry.

The instinct of motherhood is not natural but learned through the gender role application of the society; it is embedded in the playtime with mamma dolls of

the toddler girls. The dream to be mother started when the girls try to feed, dress, and brush and clean their dolls at their early age. However, Ann Oakley put her figure on these social agents to manipulate women's self-esteem and considered motherhood as myth. Oakley believed that women do not want to be mothers if they are not socialized to become mother; '…women are socially and culturally conditioned to be mothers' (Oakley 1974:187,199).Shulamith Firestone (1970) goes further rigid than Oakley on reproduction, she considered adults have been socialized to be biological parents, to reproduce in order to immortalized man's name, property, class and ethnic identification and to rationalize woman's existence in her homebound. Though in *The Dialectic of Sex,* Firestone (1970) predicted that with the development of new reproductive technologies, women will no longer want to bear children in pain and travail or rear children endlessly and self-sacrificially, I argue that biological reproduction is the socio-political strength of woman, which helps her to negotiate power in family and society, thus woman would consider child bearing pain and sacrifice to bargain her contribution as mother in the context of Bangladesh. Most importantly, the way De Beauvoir perceived that reproduction would be under control of woman's choice not a patriarchal learning. Unlike Firestone Beauvoir understood the positive willingness of motherhood, thus she stated that the relationship between parent and offspring, like between husband and wife, ought to be freely willed (Beauvoir 1953). I concur with Tong (1989) that from woman's standpoint, bearing a pregnancy could be both power giving and pleasure giving. All the difficulties and pains of pregnancy demolishes after the successful

accomplishment of maternal responsibilities. Thus, the life of infertile couple turns miserable in the context of Bangladesh. And the infertile women face the extreme pain and stigma dealing with their social, conjugal and professional life.

In the context of Bangladesh, the situation and articulation of 'infertile' people is embedded in the glory of fertile life. This chapter will focus on the concept of 'infertility' in the social life of Bangladeshi couples those who suffer from involuntary childlessness. In this chapter I will put light on different understanding of infertility periodically. As I have investigated the conception of infertility changes throughout the time of conjugal life. In bio-medicine, the researchers and doctors want to say 'sub-infertility' for those who have a hope to reproduce through medication. But, people have their own meaning of infertility which corresponds with their culture and living. The cultural definition of infertility is examined. This chapter will also unveil the life of women and men who are facing infertility. The experience of infertility differs not only according to its bio-medical reason but also the socio-economic class status of the infertile couple cause differential experiences. But the successful stories lighten the beam of hope for many those who are struggling through western bio-medical solutions, such as assisted reproductive technologies.

3.1 Cultural Context of Infertile Life

Couple of years ago, when I was planning my research idea; I had a get-together program to attain. It was the day of *pohela falgun* (the first day of spring). There I found a school friend of mine, Zinat. She is from a well-educated solvent family

of Dhaka. Her parents have higher degree from abroad. She has completed her Master's and now having a family with husband and two kids; one daughter and a son. She is working for an overseas company. We meet at Fuller Road residential area's playground, sitting on the bench there; sharing experiences about our post-marital life. I was talking about my restless time with my two years old son. My impatience with one child made my friend annoyed, '*why are you so paranoid with "only one child"?*' she asked. Though Zinat knew that I am not willing to have further issue, she insisted me by telling her own journey of reproduction. She has six members in her family of orientation. Her parents grew four children. Her memory of having four siblings under the same roof made her obsessed to have more children. Unfortunately, she has gone through a misdeed of a gynecologist when delivering her first child at the best clinic of Chittagong. She said that the gynecologist was the best (as people said to her) in the town, but that doctor used forceps while delivering (the first issue required C-section as informed by some other gynecologist later, but that consultant was late to understand, thus used forceps) in a ill way, which injured her cervical canal that troubled my friend's second issue. The second child was essential as the first child was daughter (as she stated) and Allah blessed her second pregnancy with a son, my highly educated, self-dependent friend stated. In the context of Bangladesh, having a son is necessary. Here, a son symbolizes the capital of socio-economic and religious for the parents. Zinat's second pregnancy was very close to involuntary abortion, this time she was more conscious and aware. Doctors delivered her son at 7 month of pregnancy; the infant was in the

incubator for one and half month. Despite all the uneven occurrences of second issue, Zinat's willingness made her get pregnant for the third time, but it failed with a spontaneous abortion. This time her medical consultant scolds her and suggested not to have further issue. Zinat wept, "I feel incomplete when I understand… I will not be able to deliver baby again. I am infertile…that doctor made me infertile! I will never get a house full of kids, love and laughter which I dreamed for." I had no words for her but sympathy for her pain of addressing herself 'infertile' with two children; one daughter and one son. The pleasant breeze of spring got heavier with Zinat's weeping. In medical term, it is defined as secondary infertility, which was caused by internal cervical damage. Bio-medically, infertility could be categorized into some types, whereas the cultural definition corresponds with the individual's socio-cultural factors.

The bio medical definition of infertility differs from the cultural definition. The cultural understanding of infertility ignores the concept of primary infertility, secondary infertility, male or female infertility. The aim of the bio-medical typologies of infertility is related with the physical connotation whereas the cultural definition of infertility rarely calls for typology; moreover it is associated with the existing cultural system. Inhorn (2002) articulated cultural definition of infertility as shaped and maintained through the existing social practices of reproduction. It is social norms and cultural living that assist and reason the fertility behavoiur of certain society. The case of Zinat portrays that beyond her achievements of having one son and one daughter, her inability of pursuing another issue depress her and evaporates her dream of having many children.

The craving for children appears into women's mind not only for her natural motherly instinct, but also for the wider social expectation to proof herself as authentic woman as many consider motherhood and womanhood are complementary; no matter where(male or female) the biological insufficiency exists. Moreover, ability to give birth enhance pride and satisfaction to women like Zinat as discussed above.

Apart from secondary infertility, another biological cause of infertility is the male infertility, which is much ignored in Bangladeshi cultural context. The urge and duty to conceive has been tagged with women, while men's active participation is a must to have children. But, any anomaly of having children will be addressed as a womanly weakness and the participation of men would be doomed under accusing women. Women are thought to be the cause of sex determination and successful birth of a baby. In the West, infertility is typically treated as a problem in reproductive partnership (Sandelowski and Lacy 2002). Unlike West, the Bangladeshi people generally show less priority on male's reproductive improbability. As a result, many women suffering from infertility visit doctors without husbands and feel 'half' and incomplete in front of the doctor. Thus, one patient waiting for her serial at the infertility clinic retorted,

"In rural Bangladesh the common thinking is the gender of the baby depend on the mother so do the first aggression comes to the women if she fails to give birth or conceive. Thus biological clarification comes at second for some who visits

doctors; otherwise infertility is a female disease…though I have came … with my husband's problem". (Fieldwork 2015-16)

She disclosed her anger at the lobby of the clinic, where she was waiting for husband to join doctor's appointment. She took leave from her office to visit doctor but her husband didn't. Her socio-economic and educational status helps her to state like this, but majority of the infertile women keep silent about biological clarification of infertility. The embodied inferiority of women defines that the problem of fertility is must be with women's body in Bangladesh. The reproductive biological reality has put woman associated with reproduction in such a way that women are compared with soil. If the soil is fertile then crops will produce; if not then no hope of crop. The contribution of bad seed comes next. So, biologically determined male infertility does not appear as the prominent cause of social infertility. Thus, the blame of infertility goes with women. Usually, the loss of semen (*dhatu bhanga*) is thought to be leading cause of male infertility the rural people think in Bangladesh. But, if a male is socially recognized infertile by others he is called '*durbol*'(weak/impotent) which is a threat for his masculinity (Maloney 1981). Though, the cause of infertility is concerned much with female, but both male and female are desperate to get a child. The desperateness to be a father appears clear in our society as male gets remarried to have his heir. In Bangladeshi patriarchal society inheritance is given much priority, thus infertile women usually grant the second marriage of husband. Many women complacent their motherhood desire by loving and mothering other's children; usually brother's or sister's children.

Inhorn (2002) identified social construction of infertility varies culture to culture. The pro-natal society of Bangladesh stands for more children; people love to see family with a son and a daughter as an ideal; but if a couple have more than two and can manage their being, then this pro-natal patriarchal society admire that. In rural Bangladesh, still there are families with more than three kids, though government emphasis not to have more than two kids and one is preferred best choice. But, this study did not find any correlation between one male child and social infertility in Bangladesh. However, parents having only daughters or only one child of any sex are socially bothered by the society and worried about their old age security and forthcoming aloneness. These couples with only daughter or single baby are not publicly blamed or tagged ‘infertile’; but, serve a topic of babble among other naturally conceived people. Though, medically many of the parents with one child are living with secondary infertility, which is kept as a secret to others and most of them do not consult doctors for any assisted technology. Bangladeshi society encourages new couples to have one son and one daughter. All of my natural fertile couple respondents admitted that one son is must, but daughters are also essential. According to them son is the capital for living and daughter is for rearing and caring if needed. The infertile patients who were under IVF treatment wish and pray to have at least one son, but they remain pleased with what Allah decides. However, the woman with normal pregnancy faces more social pressure to deliver a son than an infertile woman in Bangladesh. One gynecologist experienced the anger of a new father of having daughter at the second time. That angry father already had a daughter who is

three years old. He expected that the second child would be son. "It happened when I was posted as the district surgeon. The new father was not informed earlier about the ultrasound sex determination. His wife and in laws knew about it. They family hide it even after the birth of the child. They hide it to resist violence and divorce. That man works as a clerk of post office. The relatives did not let the father to take the new baby properly in arms. When he understood it's a girl after two days of delivery. He became furious and run towards my office to beat me. Other officials help me out. I was saved…." This gynecologist doesn't know what happened to that little baby girls or their mother. But the incident clears the position of the rural women with two daughters. Though, the mother of daughter is not called barren but faced almost the same social status of barren woman. She could be left and divorced by her husband. Even according to my highly educated solvent urban friend, life with only one child is barren. Thus, the cultural construction of infertile people poses with fluidity and fallacies.

3.2 Women's life with Infertility

Life of a mother is cherished in different socio-cultural practices of Bangladesh. Mothers are given high value and respect in religion and wider society. Poets have written poems on loving mothers and different organizations have rewarded mothers who successfully completed motherhood. The "*ratna gorva ma* award" is given by Azad products of Bangladesh from 2003. This award of Azad products is circulated among the mothers who have produced highly qualified, socially and financially established sons and daughters. This is given in order to

recognize mother's contribution in rearing children properly. There is also "supermom contest" of Meril industrial company, where mothers write expected dreams for their children and judge decide who will achieve the contest prize to support the young mother's dream. These awards acknowledge the contribution of good mothering and disclose the supremacy of motherhood. Women's life is thus not only biologically formed to be mother but also the socio-cultural institutions shape her psychology to be a successful mother. Thus, the pro-natal circumstances put the life of infertile women in a harsh reality. It is not unlike to think, these infertile women feel excluded from these mainstream mothers' world. Infertile women are socially excluded in different ways, thus, they aspire to keep away from social and public gathering, turns individualistic and sensitive. The social context of women's infertile life can be drawn into three phases.

At the first phase woman recognized her inability to conceive after mating without contraceptives. It puts her anxious. Each cycle of period turns painful, not physically but psychologically. "Each unsuccessful pregnancy test killed me. I cried days after days…. But, I could not visit a doctor out of fear." Honufa told while talking about her days of infertility. The fear of knowing the infertile condition kept Honufa away from doctors. Thus, bio-medical checkup makes people hopeless and distressed with verified medical documents. Similarly, while comparing urban and rural infertility, Nahar has explained that women who have interrogated with bio-medical checkup go through hopelessness compare to their counter parts who do not visit doctors. It requires sufficient time

to overcome this fear, come out of hopeless condition and start for bio-medical treatment. The case of Honufa can be addressed in this context. Though, she was a doctor it took more than 4 years for her to start consulting gynecologists. When I met Honufa, she was carrying an eight month IVF baby inside womb. Honufa used to work at a hospital. She left her job for the treatment. But, the experience of the poor maid Rupmoti or Hira, the rural housewife was different. They never had pregnancy test by their own. They did not know that pregnancy test can be done at home. Rupmoti did not go through such weeping for negative results of pregnancy. But, she cried for her husband who left her behind after accusing her infertile. Thus, the social and cultural capital can put impact on the realization of women's fertility trouble. It is more difficult for the educated working infertile women, which is the case with Honufa and others like her. The availability of home test pregnancy make theses educated women psychologically distressed and impatient. Series of negative pregnancy results cause anxiety, depression and other psychological problems too. Some of the urban women who are housewives stop going parties and social gathering, whereas some engage themselves with small social works where no relatives are involved, where they could find new avenue of hope and happiness. These women are actually afraid of relatives, answering unsolvable questions. They exclude themselves from the society they belong, after recognizing their infertile status. However, the biological identification of infertility put them under much trauma and make them alien in the context of Bangladesh, where fertility is associated with womanhood.

Every woman has the chance of decaying number of egg production at a certain age. The amount of egg woman produce is decided when she is in her mother's womb. Thus, in most cases so other social factors work to reduce the amount of egg production. However, alcohol, smoking, anxiety, over loaded work and sleeplessness may hamper egg and sperm quality and quantity. Bio-medically diagnosed infertile women and women with infertile husband go through same agony. Both are identified childless. At the second stage, women struggle to diagnosis of the problem and the biological identification put the couple and their close kins in an exposed socio-psychological condition. Identifying the locus of infertility create further social interferences like, separation, divorce and remarriage. Though, I have seen that many male infertility diagnosed couple discovered infertility in both when started IVF. It happens, because most of them take a long time to settle their decision of IVF and goes through socio-psychological pressure which enables hormones and body mechanism produce low egg quantity. Women who have own problem or husband's inability cannot distinguish the sufferings unless she goes through a serious hard family talk. Thus, in most cases women do not blame their counterpart for infertility as long as their partners or family provoke them. Conversely, the social and cultural capital assist her to deal with diagnosed infertility problem. Women who have no or less urban affiliation usually confess their shortcomings and blame herself more than women with urban affiliation. Socio-cultural affiliation and economic capital interrupt the further treatment. Thus, at the third stage of experiencing infertility, women completely rely on husband's wish and any of the family's

support in different terms. Medication not only requires economic solvency but also the willingness of both of the couple. Doctors appreciate enthusiasm of infertile couple throughout IVF procedure. If infertile couple can afford the biomedical solution of their infertility, then the treatment comes not only with the physical pains, sufferings and side effects of drugs but also with affected social status, feeling of alienation; where social reasoning of treatment need to disclose among a number of relatives in the context of Bangladesh.

Women's life with secondary infertility has a distinct picture, where sometimes it a voluntary decision not to have more than one child; but they are reported as 'having complications with fertility' by others. Many of my respondents admitted that apart from cooking tricks and household troubles, the informal discussion among the women of Bangladesh have a greater interest to talk on love, sex life, pregnancy and child care. Thus it is always 'the others' who are relatives and neighbor, who think of assumed secondary infertility and keep on gossiping (though they are not correct in many cases). However, I have interviewed two secondary infertile couple one was planning for IVF, another one is still to decide. Their economic status helped them to do so. Attempting IVF for secondary infertility is exceptional in the context of Bangladesh. Usually, women with secondary infertility do not tag themselves as infertile. Many fear to talk about their secondary infertility. A mother of one son wants a daughter and daughter's mother wants a son of her own, but secondary infertility prohibits. Thus, the inner feelings of loss of fertility shake their social position in front of their in laws. Secondary infertility in Bangladesh is more secret, covert

and stealthy matter to disclose with family and friends. It is because, infertility itself is much stigmatized and secondary infertility could be hidden, kept secret compare to primary infertility.

But, the pain and agony of losing the control over fertility hamper the inner peace of women's mind and some show frustrations like Zinat, as discussed earlier. However, women's life with infertility varies according to its time-span stage, her socio-economic background, her settlement or locality and work environment. As, Nahar mentioned urban women challenge their infertility in a more pathetic way, than the rural women, this study locates that working women who are thought to be more empowered than homemakers face more devastating experience of infertility. The more people are aware of their medical short-coming, they become depressed, yet they are the probable group to initiate the bio-medical treatment faster than others. Still, they go through understanding their infertile condition in certain ways. Firstly, their education, social awareness and access to information help them to be conscious about arenas of solution of their involuntary childlessness. Secondly, they face the ill whisperings of not only relatives but also colleagues who are culturally recognized as fertile. At times, relatives and colleagues misunderstand infertile women and think that these women are more career oriented, thus are not proceeding any initiative to be mother. Thirdly, some of them face immoral proposal from office colleagues, which is also common for non-working infertile women. However, in most cases working educated women took the final decision for IVF and supported their husbands financially, unless it could be impossible for many. One infertile

husband said that they took the initiative as his wife had a good salaried job. She left her job for IVF and got a good amount of money from the company, which helped them in doing the treatment. His wife, Maimuna also told me that she had no other option but to leave the job. She is a promising architect. In her word, " I have changed at least 4 jobs in the last 6 years…just for the pinching and whispering of colleagues. I was shocked, how people could be so unsympathetic!…..(long sniffed) May be, its normal. May be I would do the same, if I was in their court…. I was planning to be a housewife or leave Bangladesh forever. Here, people are insensitive (she sobbed)". She also rectified some embracing situations mentioning the following conversations with her colleagues:

Colleague: will you go out for lunch today?

Maimuna: no…not today. I have to give money for insurance premium.

Colleague: what insurance? You have no children. Do you save money for your second honeymoon? (laughters)

Other colleague: you are very *kipta*.. Why don't you take us all to a treat? In some good restaurant! You have plenty of money. You have no school fees and demands of children to accomplish. Your bank account is always full.

A number studies (Chesler, 1988; Gibbs, 11989; Quindlen,1987 in Sandelowski and Lacy, 2002) have shown that infertile people are viewed as consumers and ultimate customers as they have dual income, no kids (DINK). Experiences of Maimuna with few of colleagues are similar to those studies. Maimuna's

colleagues are aware of her full bank account, but ignore the empty lap. She always felt left out in her groups of colleagues. They shop for their children, whereas Maimuna but for herself or her husband, which is also criticized, “you still belong to your romantic days!” Other day Maimuna was late at office for her father’s illness.

Colleague : hi! why so late! You don’t need to change diapers all over the night.

Other colleague: so lucky! (Secretly whispering)

Maimuna’s experiences at office were insensitive to her situation, though she admitted there were also many of her colleagues who suggested secret techniques to get pregnant quicker. Yet, the working environment sometimes gets harsher for many infertile women. They are blamed *kipta* for not giving treat in reputed restaurant. Sometimes their coworkers find them competitive as they can give more time at office than employees with children. Sakira is now a research coordinator at an international organization, thought she will forget her pain of infertility and engage herself to official tasks, which turned as a curse, like her one of her previous male bosses, asked her, whether she is unhappy with husband thus stay long at office. These sorts of behavior made her feel uncomfortable, thus like Maimuna she also changed her job twice. In another office a female senior mentioned her, “girls like you those who don’t have children, are solemn at work and career. You will shine one day.” But none of these infertile working women want to shine without being mother. Thus, the experience of these working infertile women seems pitiable. Two of my respondents left office and

one were forced to leave office because of infertility and its treatment. However, infertility put women in such a situation that working women sometimes want to leave job as they feel alien and housewives are asked to engage in productive works to forget the pains of infertility and not to feel excluded. Its like the bangla proverb " *jole kumir dangai bagh* " (there is crocodile in the water and tiger on land).

The experiences of housewives are not pleasant even. They are double blamed not to contribute in productivity and reproductively. The inability to give the heir of her husband's family, exclude women from family, peer group and society. The only peace she could find is her parental home, which is also forbidden for many like one respondent of Sylhet. She came with husband many times at Dhaka for a solution of their involuntary childlessness. Her mother does not allow her to visit natal home as it may harm her pregnant sister in law. Thus, she has stopped visiting natal home. Her sister-in law hates her for being barren, she blubbered. She feels unsuccessful as a woman for not being able to satisfy her in-laws and natal relations.

The infertile women shape their live and living in several ways. The response to undesired infertility varies according to the social, cultural and economic capital of the person. The 50 years old female respondent, who adopted a boy 10 years back, recalled her days with no child, where her withdrawn from household task appears as an agency to resist her infertile situation, which forced her husband to for investigation of reproductive inabilities. Actively or passively women hold

their position of being infertile with an arrangement of a few close kin or friend who also have common physical inability. It was interesting to notice that most of the infertile women have at least one friend/relative in connection that is also infertile. They communicate and share their experiences of sufferings, struggles and resistance against the broader pro-natal society.

3.3 Infertility and the Patriarchal Man

The patriarchal society of Bangladesh, engaged their women in child rearing and upbringing. Though fathers are not formally recognized as primary care giver of the children at family, they are given priority in socio-religious standpoint of Bangladeshi patriarchal culture. The infertile life in patriarchal society not only put women in adverse social situation, men also experience their barren life and try to solve in their own ways. The patriarchal knowledge of infertility has blamed the women as the primary cause of infertility, without any bio-medical investigation. Undoubtedly, women are more vulnerable in her barren life. But, men do masquerade their condition and play role. The importance and cherishment of motherhood had undermined the social aspects of fatherhood throughout the world. A very little appreciation is held for the invisible appearance of fathers. Feminists have critically spoken of conflated motherhood and womanhood, but didn't recognize the inevitable role of fathers. In Bangladesh fatherhood is one of the strong elements in the construction of male identity (Ball and Wahedi: 2010). The Bengali folk story of *Aatkure raja* demonstrates the social status of an involuntary childless king, where the clearner (*methore)* does not want to start his day seeing the face of *aatkure raja*.

Starting a day meeting an infertile person is judged unlucky; no matter he is a commoner or the king. Thus, the society destabilizes the socio-political position of a king for being childless. The loss of having an heir is a matter of losing own identity for Bangladeshi male.

Dudgeon and Inhorn refers infertility as humiliating and emasculating to men. Masculinity could be profoundly affected by infertility. Dudgeon and Inhorn also stated that infertility is more stigmatizing for men than it is for women. They argue that men can conflate infertility, virility and sexual potency, which can therefore lead to perceived personal inadequacy. I found similarity with the perception of Dudgeon and Inhorn. Sometimes personal inadequacy leads to misleading behaviour of men, which made the wives annoyed and astonished. Many women talked about their husband's dual personality regarding infertility. However, economic class or education or job status does not play any role in the experience of men in their infertile life. The physical weakness of man is a matter of dishonor. If any kind of physical disability of men is investigated the male ego hurts and turns either violent or exclude himself from his known social world at the primary phase of diagnosis. It takes considerable time for men to adjust with his physical disability. The cultural construction of male superiority constrains not only men but also their consanguine family to accept male infertility. In most cases, male infertility is more stigmatized than female infertility. And, there are women who try to hide their husband's problem in front of outsiders.

"…if my husband's problem is known to all, he will feel low. How could I put a man in that position? It's a matter of great shame for him….Specially in front of my relatives. I fear, I will lose him forever if I disclose." - said Saira, who was introduced by Dr. Jui and at the first visit she has hidden her husband's physical inability. The male ego could be hurt and leave his partner forever. In countries like Bangladesh girls are their parent's responsibility to get married, it is because that the girls need to spend their life in the shadow of a guardian according to unwritten law of society. As a result, women are possessive about their husbands and try to live with him in health and illness, following the custom. Saira wants to settle her life with her infertile husband and get treated, doing IVF, though her husband does not want to do so. After day long conversation with Saira, she called me over phone and wanted me to talk with her husband and make him agree for IVF; she felt that their marriage may come to end due to infertility trouble.

According to the IVF expert of Bangladesh, almost 45% infertility is caused for male factors; about 10% can be cured by oral medication. Among the rest 45% female infertility, 30 % could be solved through surgery and oral medication. Thus, male infertility is leads to the IVF treatments in most cases. The rest 10% reason of infertility is unknown. However, more than 50% of the infertility couple requires IVF as a solution of their infertile life as one of the IVF experts indicated. The infertility experts state that the treatment takes more time as the woman's reproductive age grows. And, in most cases male infertility addressed lately compare to female infertility, which makes the treatment not only

complicated and lengthy, but also, female egg production decreases in the decision making time. Thus, in most cases male infertility is kept in disguise, moreover the overall treatment procedure enable males out of any long term medication. It is the woman who is supposed to go through hormone therapy and ET because; she will be carrying the IVF baby. Husband's problems are concealed by wives and others of the family in many ways. Only a few men admit their own physical inability of being father in front of me, unless doctor or their wives disclosed that to me. The affiliation with urban and rural society and 'techno-social exposition' has impact on man's view of infertility and its bio-medical treatment. I will discuss more in the last chapter. The infertile couples those who were investigated with male infertility started their IVF treatment comparatively lately than female infertile patients. I have seen male infertile husbands talk less until they are gifted with IVF baby. The status of male infertility let husband feel impotent, though impotency and infertility are not alike. The feelings of social impotency cause personality disorder, thus many of them turns covert in nature. On a contrary, many turn vindictive, alcoholic and aggressive towards wife. Some starts lying to wife about going to doctors and taking medicines, in response to diagnosed male infertility. The number of males searching for ayurveda and folk medicine for male infertility is not less than women who also search for those with the help of others.

Conversely, unlike women they are in a better psycho-social condition in their work place. I investigated that men do not talk of their personal matter at office what women do. Thus, they are not affected by their fertility status much. While

asking, one male respondent answered, “it may happen that others are talking of my childlessness, but none will ask me about it. We are busier with office task. Moreover, we are more professional. But my wife faced tremendous trouble dealing with coworkers. She left her job, though she was in a good position. She was a chief executive of a telecom company.” The professional behavior and personality help infertile male from humiliation at office. But, the feelings of not having heir put him in graveyard of loneliness and sorrow. During my interviews with male respondents I see them started talking on their personal feeling on how they vary from their wives in dealing infertility. Male and female world view varies, which is caused by the inevitable gender role practice of the broader society. One of the male respondents said that he has never shared his private stories (sex life and infertility) with other, but his wife always have gossip with friends and family members about childlessness or “ physical issues.” The self-centered personality work as an agency to resist his pains of infertility in many ways. Unlike women, men play a covert role in his experience of infertility. But, many times the wives feel ignored to this covert response of their husbands in experiencing infertility. It was interesting to notice that the men are seldom asked about their infertility by their kinsmen, whereas, women face series of questions and reactions (as a response of their answer) by relatives, friends and colleagues; which indicates that whatever the biological clarification of infertility diagnosed it remains with female body, mind and identity in the patriarchal context of Bangladesh.

Yet, the experience of male infertility misrepresented when the assisted reproductive technological treatments interfere the female body in a rigorous way. Female body is the locus of the entire procedure of IVF, except the giving the husband's semen. Nonetheless, to identify the causes of infertile life, both male and female need to undergo tests, including semen analysis, which is avoided several times by the husbands. None of my respondents admitted that the husbands have done their test according to the doctor's prescription. The husbands are unlikely to response positively on semen analysis. Among the 23 infertility cases 21 husbands has under gone semen analysis after several doctors and wife bound them to do so. All the women have undergone their tests just after arranging the required money; none of the women took more than 2 months for the tests to be done. On an average, the husbands take more than 12 months to be convinced to perform the test of semen analysis, without which the specific treatment could not be started. Thus, Bangladeshi masculine ego hinders to accept any bodily insufficiency and continue to control female body in their own terms of understanding reproductive failure. Though, they are equally interested to have successor and increase the name and fame of patri-clan.

3.4 Class and Infertile Life

The class system in Bangladesh has an influential impact on the every today life of its people. In many ways the basic needs of the population is well maintained if they are economically capable to earn those. Being a developing third world country, the state cannot provide equal opportunity to food, health and education for all. The bread earners are the males of the family and older parents depend

on their offspring for their living, especially, the sons are responsible. Thus, the expectation of having son and more children is very common for the poor people of Bangladesh. Even the people presume that many children will give you '*jannat*' at afterlife. The more children you have the more '*duwa*' you get after death. Thus, infertile life is crucial for poor people and more crucial for poor women; who are poorer among the poor.

The case of Rupmoti provides the picture of poor infertile women, who cannot solve her physical barrenness through medication, thus her husband left her, and she goes through abundant socio-economic and sexual insecurity. Yet, Rupmoti possess self-esteem and courageous enough to deal with the harsh urban society, though her mother frequently call her at village and asks her to be treated by ethno-medicines that she practices. But, Nipa, who was university educated women of urban Dhaka divorced her husband due to the social pressure of in laws, for being infertile. Nipa has a number of problems dealing with infertility. Her problems were first diagnosed by the doctors of Melbourne, where they lived after marriage. Firstly, she was diagnosed with poor egg quality. Secondly, her doctors advised her to have surrogate mother, as she will not be able of carry the fetus throughout the complete gestation period. The second problem was much painful for both Nipa and her husband. When they came back to Dhaka, Nipa's in-laws family begs her to get divorced, so that their son can move forward with a new wife and have own children. Nipa agreed, because, she was not willing to have a surrogate mother for her child. Thus, upper middle class women also face the same problem as Rupmoti. Infertile life inflames divorce and force many

woman living a vulnerable, struggling life. Thus, many have to leave conjugal life as a cost of infertility. The middle class people fear the most to have a divorced infertile daughter back in the family. Nipa faced the problem of living with parents and unmarried sister after divorce. She and her parents think that her marital and fertility status is hampering the younger sister's matrimonial proposals. But, the story of Lipi has followed a different path way of her conjugality. She is having her second husband with her own infertility. Lipi with a small uterus will never be able to conceive by her own. When she was attended by the gynecologist, she had no idea of her infertile condition. Lipi is from a middle class family of Old Dhaka. Her first marriage didn't work out after the diagnosis of her physical inability to have baby. Her first husband wanted her to agree his second wife as Lipi cannot be a mother. Lipi's parent didn't want her to do so. So, they asked Lipi to divorce and leave that man. Lipi listened to her parents. Within a year round, her parents convinced a man to get married with Lipi again by giving him dowry. Lipi says, "May be dowry brought him to me. But, my father is capable to give money for her infertile daughter. It's better than to have a barren divorced daughter at home." This is how Lipi justify the dowry. However, the question remained unsolved that whether, dowry can compensate the desire of motherhood and fatherhood! In fact, no. it only saves the conjugal life to some extent and secures the daughter's social position of having husband in the context of middle class people of Bangladesh. The urge of having child remains the same for Lipi and her present husband. But, neither can they afford

the expense of IVF nor surrogacy is practiced in Bangladesh, due to religious prohibition.

The poor and middle class people suffer the most for their infertility most, compare to the upper class, educated women are less concerned about being infertile. Women from upper class are not economically insecure, thus their choice is open to have IVF home and abroad. A few upper class urban women remained infertile with their husband, ignoring their in-laws desire to become grandparents, for example, Marina-Bijoy's case. They embarrassed their infertile life without any medication, though they could afford it home and abroad. The poor and middle class women face more psycho-social problems compare to the upper class women, like alienation, separation, financial deprivation from husband and in-laws, divorce, pressure of dowry. So, I have seen that the infertile life is feebler, vulnerable and stigmatized for poor and middle class people of Bangladesh.

3.5 Searching Corridors: Efficacy of Bio-medicine

As the expectation of the society is to see a girl married at her puberty and becomes mother in the following year of marriage, relatives do not stay calm if no issue takes place soon after a girl is starts her conjugal life. In most cases childless people are guided by elderly relatives to have child. Thus, before searching the solution by their own; the relatives, neighbours or friends take initiative to suggest different folk, herbal and spiritual solution. Some also guide life style and mating timing and procedure. Bio-medical solution usually does

not come at first choice. None of the couple having fertility problem went to an IVF expert at their first consultation to have children. People have a stigmatized approach to visit infertility consultant, thus gynecologists became the first medical consultant for all infertile people.

Class or gender does not play any role in understanding the medical identification of infertility. Infertile people do not believe their biological short comings until it is proved by the doctors at least twice. Despite the class position, mostly all man and woman dealing with childlessness believe in medical pluralism in health care. Medical pluralism is a widely practiced phenomenon in complex societies, where people overlap different forms of health solutions (Kleiman 1980). However, there is a difference in searching and utilizing infertility treatment between the developed and developing country. Most of the infertile people of developing countries, such as South Africa and Zimbabwe choose traditional healers as the first step to their fertility problem (Dyer et al 2004). Even Yebei (2000) identified that women from Ghana who are now migrated to the developed countries like the Netherlands often search for alternative practitioners like, herbalist and spiritual healers. From her experience on the infertile people from the slum of Bangladesh Nahar (2000) stated that the women search herbalist and healer in order to find solution to their fertile problems and men consider ‘remarriage’ as treatment. Many of the infertile women I have interviewed had used folk medicine, homeopathy, biomedicine and followed religious practices simultaneously. It was interesting to notice floating ferryman selling verity of folk medicine, including infertility solutions

and secrets of romance to be parents of son in different narrow roads of the infertility clinic I visited. Though his business is not good he said. That ferryman, aged about 65, admitted secretly that giving son or child is in Allah's hand. His folk medicine can only bring confidence and hope to those unhappy hearts. Without the bio-medical test none admitted their reproductive short comings. However, education and social upbringing plays role in believing in bio-medicine. Social and cultural capital play role in considering assisted reproductive techniques as a positive solution to infertility.

The poor part-time home maid Rupmoti, who lived in the slum of Poribagh, advised to have tubal surgery to be a mother does not believe that she has tubal block. She trusts that she could be mother one day without any surgery. Her husband left her not to give money for surgery. He didn't want to live with a women having tubal infertility. He is poor to give twenty thousand taka for his wife's recovery. The abundant pain of infertility, poverty and separated life made young woman sex worker to fulfill wishes of many men surrounded her locality. Her mother calls her over phone. She wants her daughter back to village, so that they could cure her tubal infertility. Rupmoti's mother believes in folk medicine. But, Rupmoti does not. Though, Her secret lover, her cousin have a wife with children wants to cure Rupmoti and remarry. However, Rupmoti didn't give her consent, yet. She seems to be confused about her cousin's desire. Her mother wants to cure her following the village folk medicine practitioner; where as her cousin wants to cure her by all means. He will arrange money for surgery if Rupmoti agrees. But, Rupmoti takes decision by her own not to have surgery,

but to have child normally. She believes everything will be fine when almighty will desire. She talks about her village mates who gave birth naturally 15 years after marriage without any medication. These experiences made her believe that bio-medical solution is not much required for her case. She knows her husband got married again. She does not want to go back to him. Rupmoti's mother and her social and cultural capital resist her to think of bio-medical solution positively. Thus, they either rely on the wish of god and nature or rest upon folk medication.

The experience of infertile couple varies one to another as the reason and types of infertility are different and unique. Most of people, here go for medical pluralism. Homeopathy and other folk medicines are also recognized by many infertile couples I met. While waiting for the doctor patients meet at the clinic corridor, where they talk on their own experiences and share knowledge. Many of them also talk about *duwa* to conceive early. When the result of treatment is uncertain and time consuming, the sufferers tend to search for variety of medical options. The other reasons of plural practices of medications are found for financial reason and at times for belief system or other's positive feedback. Each successful story comes with a hope for others. Case of Raja and Kumo demonstrates a distinct view to bio-medicine. They started their conjugal life 14 years back, when Kumo was only 18 and Raja 24. Raja used to work abroad as a technician, he left his wife at village. Raja visited Bangladesh once a year, but they didn't conceive within that short time of visit. Meanwhile Kumo was investigated with high blood pressure and sugar, which prolonged their infertility

problems. However, Raja left his job and came back village 5 years back when his father died. They stared consulting doctor at Dhaka. They have relatives at Dhaka, which helped them to stay and consult the gynecologist quarterly in a year. Apart from the oral medicines given by the endocrinologist and gynecologist, they also visited local homeopathy doctor as suggested by Kumo's cousin, who had heard of positive feedback of homeo-medicine of infertility. Raja and Kumo is now parent of a two month old boy (born in the last week of December 2016), which they perceive the fruitful effort of homeopathy treatment, not the bio-medical solution. They said they have stopped taking medicines of gynecologist and continued homeopathy medicines. However, doctor said that it happens. Sometimes the reproductive hormones do not listen to the medicines at the same level. The level of treatment varies one person to another. 'Sometimes it is all about luck, especially the production of egg.' stated gynecologist Dr. Ameena.

I have seen a number of patients preparing themselves for IVF which really requires enough patience to bear pain and strong motivation. Observing the painful hormone therapy of one of my infertile woman respondent named Asma, I asked her if it is so painful then why she is trying again and again. She gave a dumbfounded cold look and answered "you will not understand as you are a mother of a son". It was her third attempt in the fertility clinic. I met her in fertility clinic while she was under hormone therapy. Though she was very weak and stressed both physically and mentally she did not refuse to talk with me. Asma got married after completing her BBA from a private university at Dhaka.

Her husband, Dulal works at Bank as AVP. Asma was young when she started her conjugal life, but didn't wish to be mother at that time. Both of them decided to settle abroad as many of the young couples do, as they stated. Asma informed that before marriage Dulal meets her twice where he said about his desire to go abroad. Asma herself was also charmed to go abroad rather than live with in-laws. Dulal and Asma were from upper middle class family of urban Dhaka. However, the sudden death of Dulal's father discouraged him to settle abroad. As the only son, he was supposed to take care of his widow mother and two university going younger sisters. After 3 years of marriage they started thinking of having baby. But, they could not get positive pregnancy result. Both became frustrated at that time, Asma says that 'if I knew what is happing next….. I would never wait….(sighed) I guess I should had baby at the first year of our marriage. I will tell all to have baby as early as possible.' In most cases, infertile couples understand their reproductive problem after 2 to 3 years of marriage and majority of them were using contraceptives before planning to be parent. As Mirza stands opposite to the predominant discourse of Bangladeshi motherhood as the only option and argues that at the begging of marriage people challenge motherhood in marriage for certain struggling period of career (2013). Mirza has lighten Burter's notion of performativity and argues that "motherhood is an ideal construct that is materialized through regulatory practices" (Mirza 2013:12). She also mentioned that though infertile people considered motherhood as the optimal choice as married, they themselves did not take initiative to be parents just after getting married. The example of Asma and Dulal indicates that gap of

planning child among the many other newly married couples as Mirza mentioned in her study. However, it is yet to medically clarify whether 'taking gap' is related with certain infertility causes. The causes of 'taking gap' are multidimensional which also indicates a form of globalization and westernization. Like Asma-Dulal, Hira-Akhter and Kumu-Raja also took a gap as the husbands were out of the country. Although 28 is not a late age for Asma and Hira to have complications to get pregnant.

Asma's doctor could not help her to go through IVF as the doctor said that the side effects of hormone therapy didn't allow Asma to go for an embryo transplant. Asma-Dulal was passing 7 years of marriage with no issue and Dulal is now detected with low quality sperm count. Asma grew angry while conversing, 'it is may be for the alcohol drinking habit he grew' Asma said with anger, she continued ' I am trying heart and soul just to be a mother. Dulal says he also want to be father. But he is weak… mentally thus cannot take all negative results of pregnancy and to forget pain started having alcohol with his friends. But does alcohol help him? He is ruining everything.' Asma failed to control treas. Dulal didn't agree about his addiction to alcohol. He said that he usually avoids alcohol cause he cannot get early in the morning for office. He ignored Asma's allegation of drinking. Dulal accused his bad luck and he also thinks that his father was not happy with his behavior.. ' may be it's a curse by *abba*…I don't know! I failed to make him happy. May be it's a punishment by *Allah'* . It is also very common for most of my respondents who think its all about their fate not to becoming parents naturally more specifically without the intervention

of technologies. (More will be in chapter 6) However, the well enough socio-economic status didn't hamper the IVF treatment for Asma and Dulal, but Asma's body was not ready to complete all the hormone therapy needed. Last time she got severely allergic, thus required to stop hormones. Each time Asma and Dulal came with a hope to complete the cycle and have a successful embryo transfer. Asma has gone through oral medication to make her body fit, but her allergy porn body didn't allow her to complete the IVF procedure. Despite knowing the fact of being allergic to those medicines Asma never think to stop her medication to get pregnant. She requested doctor a couple of time whether it is possible to continue with allergy, but doctors dishearten her and Dulal, too. They are now worried about the quality of egg and sperm as day by day they are getting old. The option of frozen embryo transfer will not be good here in Bangladesh as Asma was informed from another IVF patient. So, if this time it fails we will go to Bangkok or India for further treatment. It is easy for them to think this way, but the case of middle class and lower middle class patient is different. Dulal has inherited a five stored house as well as Asma's father also gifted a flat in Dhaka, so their solvency helped them in IVF treatment. I asked if they know frozen embryo will be good option for them then why Asma is waiting and having pain with less possibility of a positive result. If the best quality egg and sperm are not frozen earlier then chances of having embryo decreases. Asma looked at Dulal , who was standing far from us. Then she whispered 'his sisters do not allow us to go other country for treatment …may be they think differently. They will never understand our condition. It pains where cuts. Moreover, people

do know about IVF at all. May be your research may lighten others to know more'. Though Asma's education and socio-economic position allow her to decide and control her fertility but her sister in laws have interference and tries to establish their decision on where and how to treat infertility. May be their ignorance is responsible or something else. As the case Hira's husband assumed that his brother does not want him to be father. (more in chapter 5)

The infertile couples who urge to become parents have explained their unconditional desire to be mother and father in most of the cases. Their desire turns into struggle as different constrains appear to avail infertility treatments. Not all cases of infertile couple remain infertile rest of their life. Some of them succeed according to their desire others keep on freighting and struggling for a solution to their infertility. They fight; they fight till they are not convinced. The infertile fighters interact and struggle with different agencies of their social life; relatives, friends, colleagues and various types of physicians in order to negotiate their problems, pains and agonies. Though bio-medicine have provided much successful data of having baby through assisted reproductive technologies, the viability and affordability of such treatments are questioned in Bangladesh.

Different cases have their own nature and meaning of infertility, its treatment, journey to a solution, frustration, pains and pleasure and personalized significance of child. Apart from Asma's strong determined nature and Akhter's dogged wish to be parent, I also meet Marina ,middle aged urban lady from an affluent family who refused to take any treatment of her infertility and remained

childless with the support of her husband though her mother, in laws and friend and relatives didn't appreciate her. Ten years back she was forced to leave Bangladesh to avoid friends and family. She expresses "me and my husband Bijoy were haunted by all. We left Dhaka, shifted to Toronto. Now, I am at my forties …my father is ill so do my in-laws. We came back now." When I asked that they were enough rich to have Art then why didn't go for it; she said, "I wanted to be a mother naturally, I failed…we failed in fact. I didn't want the doctor's baby." However, Marina's mother-in-law informed me something else. She crossly said that "an impenitent and impatient woman like Marina cannot be a mother." The mother-in-law also explained that Marina was afraid of the painful treatment. Her friend did, so she knew a lot about the traumas and sore side effects. These treatments require patience. The case of Marina was quite similar with Khaibar's first wife, who sacrificed the matrimonial bond. However, Marina's husband Bijoy was considerable and more sympathetic for her, thus did not force to go for the painful, stressful treatment. Though Bijoy's mother is not happy for it, Marina was able to take step according to her will to be as it is. Thus, childless women pose agency and stand by their position. However, it was also easier deciding to escape form country and ignoring ill treatments from relatives as their economic solvency helped them to do so. Class and social potion of Marina and Bijoy facilitated them go beyond the dominating motherhood discourse and to do according to their desired living. Moreover, having a subservient husband was a blessing to her, which she admitted.

Rearing and raising children has given value in the socio-religious context of Bangladesh (Maloney 1981, Blanchet 1984, Kotalova 1993).The poor people raise child in an expectation to earn more. For many poor and lower-middle class people children are not only assets but also earning source. It is very common for the poor people of Bangladesh to accept child labour The social norms and economic realities forces a child to earn for his/her parents at an early age (UNICEF 2010).Thus, more children would secure the old age of parents. Life without children turns miserable for many, especially for the poor infertile people; as they cannot afford new reproductive technologies. The doctor notifies their treatments according to the class and social background of their patients. Thus, a chunk of poor infertile patients remains unattended considering the cost of assisted reproductive technologies. However, regardless of class, the urge of motherhood is similar and considered as normal as to every married couple; though the biomedical solutions of infertility charge the patients financially, physically and emotionally with some hope to have children.

Femininity and motherhood are judged as parallel in Bangladesh. The availability of contraceptives and forced abortion has assisted the timing, frequency and number of children; but the dominant normative discourse of idealized feminine mother is not challenged and deconstructed like the west. Voluntary childlessness may rise as an unrelated exceptional circumstance for specific individual in the cultural context of Bangladesh, where motherhood is a dominant discourse (Maloney 1981, Blanchet 1984, Kotalova1993, Nahar 2007). The couples those who are suffering from reproductive disorder cannot be taken

granted as voluntary childless couple, as it is not an option for them. Nonetheless, Mirza's work on motherhood challenged the normalization of motherhood and addressed the women who decide and control her reproduction with the means of time and their childlessness tend them to encounter constrains and cope unorthodox situations. I argue that, in Bangladesh motherhood is a regulatory ideal as womanhood and their identity is embedded in the notion of motherhood and motherly attitudes, at the same time, infertile, sterile life challenges woman's strength, though infertile women cope with her childlessness and show agency, do not act as the victim of situation. The pro-natal culture of Bangladesh has veiled the unit of family as a safe chamber of infant, which indicates family is fulfilled and best understood with children. Thus, infertility hampers the ideal picture of family in Bangladesh. The socio-cultural and economic demand of children have marginalized and excluded the infertile male and female from their family and professional life. Infertility hinders the natural conjugal life and makes the women socially vulnerable in Bangladesh. Though, both male and female suffer from social exclusion, socio-economic vulnerability, psychological imbalance and disorder in conjugal life as a result of social and biological infertility; they show agency, resilience and resistance through their stigmatized living (more in chapter 5, 6 and 7). The next chapter will rigorously address and explain the challenges of infertile lives who are attending biomedical solutions to their infertile life.

Chapter 4

Challenges of Childless Couple with Assisted Reproductive Technology (ART)

This chapter connotes how privileged (in class and status) and less privileged people challenge their involuntary childlessness in Bangladesh, focusing Colen's understanding of reproduction. In doing so, I would address Sandelowski and Lacy's(2002) representation of infertility as a by-product of technological intervention. They have viewed the (mis)representation of infertile people in the wider society of the West. Here, I would put light on the varied challenges of Bangladeshi infertile people and how they are observed, represented, analyzed and brought under the light of supervision of medical knowledge and wider society. The suffering of infertility quested childless couple economic hardship, social stigma, blame, alienation, isolation, fear, guilt, helplessness and some cases violence. The crucial problems of infertility are more experienced in developing countries, where society is pro-natal and the availability of ART as infertility treatment is not prioritized by the state, as state stands anti-natal position for scarce resource with overpopulation problem (Daar and Merali 2009). The social and economic costs of infertility arrest the middle class young couple into a callous reality for existence. The economic cost of infertility could be harsher in third world countries like Bangladesh.

Dr. Jui Shikder whom I met in the private infertility clinic, was a friendly young doctor said that if IVF is required then it should be done as early as possible. The

lesser the age the probability is high for women, cause it is easier for younger age group to get pregnant at first chance. But, many middle class young couple will not able to manage the IVF cost, which is not less than 3 *lac* taka. This amount is for the clinical expense only, additionally the treatment seekers need, not less than 2 *lac* for frequent expensive medicines and doctor's consultation charges. In practice, the cost increases according to the IVF seeker's socio-economic and physical location. Dr. Shikder objected that it is really an expensive treatment and turns impossible for any young married couple of Bangladesh. As a result, many infertile patients could not be treated as soon as their problem is diagnosed. The patients they (the clinic) have are mostly that wing from middle class family who got financial support from their parents. After paying house rent and other every day costs of a single family it is hard to manage doctor's visit for many couples as this young doctor viewed. Most of the middle class earning sons have a responsibility to send a portion of their income to their parent; only a few can ask for IVF treatment money from parents. Dr. Shikder herself is struggling with infertility. She and his husband will be having further infertility treatment at Bangkok as they are going to migrate there permanently.

The fight of infertile patients is of different arenas psycho-physiological, financial, familial, religious and ethical. The case of Asma shows the psycho-physiolocal strength she accumulates to be a mother; however they were financially capable to go for further treatment. But the case of many says different stories. There were many who cannot think for these technological costs

to bear. One of my respondents from lower middle class family requested me again and again to insist her husband to manage the cost anyhow. Hira's husband Akhter had sold two of his shops to have IVF. Akhter talked about his earning at Bahrain and his struggle over there. But he also thinks without a son it will all go in vain. He wants an inheritor for his property. Whereas, Rupmoti's husband escaped for his inability to give money for surgical treatment and Saira's financial insufficiency let her force husband to ask money from relatives came into light in my study. Thus, the opportunity of having treatment of infertility is not equal. This chapter will focus on the socio-economic and psychological challenges of infertile couples in searching for solution of their fertility problem. As it is an expensive treatment which is not available throughout the country it turns difficult for categories of people to utilize the best from it. Thus, the class position of infertile people indicated people's experiences variously while tending IVF. The process of negotiation with the doctor, gynecologists, IVF experts and medical associates is also discussed in this chapter. I have also verified how the conjugal life is challenged through a technological pregnancy of IVF.

4.1 Socio-economic Inequality and Reproduction

With the emergence of birth contraceptives human reproduction have experienced the control of western medication on fertility and demography. The indigenous birth control systems were widely popular in many third world countries before the birth contraceptives were made available. These

birth control mechanisms made affordable not only to empower women by controlling her fertility, but also have checked the population growth of the third world countries, where societies are pro-natal. Some of the women of third world are empowered by taking decision to get pregnant and plan family. However, as fertility needs to be free choice, when it hampers human productivity will be challenged. Thus, the innovations of new assisted reproductive technologies facilitated many involuntary childless people to be productive and reproduce. The opportunity of healing reproductive failure is one of the expensive treatments in Bangladesh, if IVF and ICSI is required. Colen (1986) coined the term stratified reproduction to describe how reproduction is structured across social and cultural boundaries; empowering privileged women and disempowering less privileged women. The history of using contraceptives has not only empowered women to control her fertility, but the mechanism to inspiring its application proves its function to control population in the third world countries like Bangladesh. Thus, fertility and reproduction is structured according to the hierarchy of class and gender, geo-political, racial and ethnic identity of the population. So, the government policies promote control over fertility and passively hinder the fertility services for the infertile people of Bangladesh. The fertility services and technological solutions of infertility are not provided with a wide range of population. Though, human fertility following a family is a basic human right. The fertility services should be an available choice for human beings

not an opportunity for a specific group of population based on race or class or religion.

Starting from the diagnosis of the treatment infertile people need to count big amount of money. The urban couples facing problems with fertility usually visits gynecologists at their first attempt. Primarily most of the couples are given number blood tests, ultra-sound x-rays and semen analysis which cost about 15000 to 20000 taka during my field work. Thus, a simple understanding of infertility problem requires at least 17000 taka along with the double visit of the doctors. In contrast, the rural infertile couples firstly seek support from elder relatives and the local healers. If it fails then, few of them starts visiting local doctors. Like, Nahar (2010b) I also agree that the social class and geographical location shapes the health seeking behaviour of childless women of Bangladesh. Thus, rarely a few are addressed assisted reproductive technologies. Though many of the rural women could be cured with simple bio-medical guideline, most of the rural women are not properly diagnosed.

The treatment of infertility can be guided according to the specific biological problem of the patient. Some gynecologists disagree with the urgency of assisted reproductive technologies in Bangladesh. Among the 4 gynecologists I have interviewed, 2 observe that in Bangladesh infertility can be reduced through oral medication if it is diagnosed and treated within the age of high productivity. One of the doctors said that in rural Bangladesh

most of the girls gets married earlier (before 18) and conceive without any consultancy of doctors, whereas nowadays most of the urban educated women are consulting at least once before getting pregnant. The doctor continues, " …yes. You can say these urban women are heath conscious, but I see they are also worried about their strength to be mother/father of baby. Now a days most women come with PCOS. Many of them get pregnant easily with some oral medicines. But, the fears of infertility haunt them." (Dr. Hafiz, one of the gynecologists explained)

Thus, many physicians think that assisted reproductive technology is mostly required for urban men and women who are wealthy enough to bear the expenses. In her study Nahar (2010b) addressed the health seeking behaviour of childless rural poor and urban middle class women in Bangladesh. According to her study the social class and the geographical location of the childless women determine their health seeking behaviour. The rural childless women profoundly depend on the Local healers in the informal sector. The reasons for the popularity of local healers includes low costs, the gender of the provider (with same-sex providers being preferred), having a shared explanatory model with the healers, and easy availability. Unlike their rural counterparts, urban childless women predominantly seek expensive assisted reproductive technologies (ART) treatment which is available only in the formal sector, in private services of Dhaka. However, "despite their affiliation with modern treatment, urban childless women still believe, like their rural counterparts, that the remedy for childlessness ultimately depends

on God. As a result, in addition to biomedical treatment, many return to or simultaneously pursue various traditional, spiritual or folk treatments" (Nahar 2010b:1780). Similarly, this study has found that most of the infertile couples of Bangladesh depend on bio-medical and traditional healing simultaneously according to their affordability and viability. Thus, I have argued that rural people also seek bio-medical treatments which are close to them. But, it is the medical practitioners who guide them what would be convenient for the rural less privileged couples.

Assisted technologies stayed at Dhaka, as "the rural and poor people do not need and afford them at all" according to the gynecologists. It was found in the study of Nahar (2010a) that in Bangladesh, where fertility control is the main focus of health policy, childless women are excluded from mainstream discussions on women's health. Consequently the childless women have to suffer in various ways as a result of their health seeking behaviour. Moreover, the stakeholder's attitude is anti-natal, because Bangladesh is well known for its over populated characteristics (However, Bangladesh has reduced its fertility rate in recent years.) As a result, government and NGO do not give an eye to the infertile people of the country, though fertility is a right and free choice for all living beings on earth. I have seen many are coming from village and district towns to Dhaka for their infertility problem. During my field work I have seen people of different socioeconomic strata are coming to gynecologist and IVF experts for their fertility problems. The poor people are not even informed about the assisted reproductive

technologies, I have investigated. If they are not satisfied with the gynecologist, they change consultant. Some said that, the previous gynecologist said that there is no hope for pregnancy. But the women never stop searching for medical solution, as they fear violence or their husband may get married again. None of the poor people whom I have meet and talked, know about test-tube baby or IVF at all. I asked the gynecologist Dr.Ameena to not why these infertile people are not informed about infertility or medicalization of infertility or IVF. She said that doctors try to understand the socio-economic condition of the people than give the suitable solution of their problem. As a result, the assisted reproductive technologies remain only for the couple who can afford it, whereas the poor consider children as assets for their socio-economic survivable more than the rich people in Bangladesh. Even most of the rural people ponder that the more children one have, the more probability of save old age is assured. Yet, these people are kept far from the biomedical choices because of the class determined treatment of assisted technologies. According to Dr.Ameena as the doctors understand the affordability level of the poor rural people will not help them to start IVF cycles, many doctors do not disclose this option in front of them. These poor rural infertile people are not only deprived from the modern treatments, but also are not informed about the expensive medical solutions of infertility they have. They keep searching local doctors and depend upon alternative medicine. Besides, there are still many pronatalist, patriarchal societies where infertility treatment are not available to those,

who requires children for their socio-economic and psycho-physical existence; though a number of Western countries have offered subsidy for IVF treatment. Even in the US private insurances and subsidy are not given for assisted reproductive treatments; and only the well-off infertile people can afford (Inhorn and Birenbaum-Carmeli 2008; Nachtigall 2006). Similarly, Ann V. Bell(2010) has interrogated the disparities of infertility medicalization in the context of United States. Bell focused on the low socioeconomic status women of United states who suffer from infertility, these women actively and creatively work hard to overcome their reproductive failure, though not all of them accept the dominant discourse of medicine and motherhood. However, Dillaway and Brubaker (2006) have claimed that none of the studies show whether there are disparities in choosing infertility treatments according to the class location, so, the poor infertile people are not only lose treatments but also are kept apart from the studies. Bell's study explores the dominant discourses of medicine and motherhood that intersect to frame the social context in which women of low socioeconomic status are excluded from infertility discourses, representations, and resolutions. The case of Rupmoti, the urban slum dweller relates the connotation made by Bell. The urban slum dweller Rupmoti refused to have any treatment of her tubal blockage, because; her husband left her for not bearing the cost of treatment. Her pain of losing husband made her to resist expensive treatment and live infertile for the rest of her life. She is surviving with a hope to be mother naturally; she told me

when we last met. As Bell stated that the low socioeconomic women who avoid medical solutions experience infertility within their own context, according to their own norms of motherhood. The hegemonic discourse cannot shape their way of living with infertility. Paradoxically, this attitudes of poor women prolong the class-based inequalities of medicine by excluding poor people from the assisted reproductive technologies in United States. However, in the context of Bangladesh, the poor and underprivileged people are still not aware of the medical solutions to their reproductive problems and Doctors avoid many poor people, not to make them disappointed and frustrated of life.

The conditions of lower middle class and middle class are pitiable. Many of them are aware of the treatment but know that it is expensive for them. But, the expectation of having at least one child made them craziest to go further beyond; asking financial support from others. Saira and Mashuk who were having a middle class living in Dhaka city cannot afford the treatment of IVF. Saira wants her husband to ask financial support from her father-in-law. But Mashuk ignored Saira several times. However, Saira requested me to talk with her husband, when I had conversation with him (he was not willing to meet me. He shouted over me and said not to provoke Saira for IVF. Mashuk is suffering from low sperm count. more in stigma chapter), I was informed that Mashuk and his father want Saira to adopt a son of their choice (Mashuk's brother's son) rather go for an expensive treatment like IVF. Thus, the challenges of middle class infertile men and women cannot be

judged in one dimension, sometimes its about finance and sometimes about the stigma of IVF or their knowledge and believe system that prohibits them to treat their shortcomings of living. The case of Ismat Ara who tried thrice, but failed to conceive has indebted a big amount of money to her brother and husband's friend. They are having the worst experience I have seen. Ismat Ara lives at Tongi with her husband. Her Husband is a diploma engineer, doing business. He is 44 years old. They got married 14 years back. I met her in the waiting lobby of the infertility clinic, where she came to visit the IVF expert. She had gone through IVF twice in Dhaka and once at Kolkata. After having repeated unsuccessful results from one IVF expert of Dhaka, she is now in another clinic with a hope. She said that this will be last attempt of IVF. She also told me that they financial condition fall due to this treatment. They have sold their natal land of village. The only earning member is her husband cannot give much time to business for the treatment because they are coming to Dhaka frequently for treatment. In his absence their business is facing loss. Moreover, the expensive treatment made them in debt. They never thought of owing money from relatives or friends, but Ismat and her husband could not help them but started trying cycle after cycle with a positive hope to have a child by their own. I was talking with Ismat Ara, while her husband was also sitting in a distance, reading a newspaper. He was not willing to talk with me. But, allowed her to talk with me. Ismat thinks that the cost of the treatment is not well adjusted. The IVF package price is cheaper at Kolkata, but accommodation, travelling cost and hazard do not

allow all to go abroad for treatment. “It is like a business package for the doctors, who are businessmen in disguise. For us..….(weeping she pronounced), it is matter of living …a baby is a meaning for living for me and my husband.” Ismat and her husband have 7 years experience of visiting gynecologists and IVF experts, but unfortunately none has recognized that the specific problem of their infertility. However, the economic insufficiency could not hold their hand to stop getting IVF thrice. She thinks her baby’s smile will make her richer, not the wealth they invested. The three cycles of IVF treatment has changed their social and financial condition.

Akhter from rural background posses a wealthy household in the context of rural Bangladesh. He invested his overseas earning to buy shops at *sadar* market. But, for this treatment he has sold out two shops he bought. His wife Hira is now pregnant with twin. When I first meet them, Hira was just gone through Embryo Transfer for the second time. They were living at Dhaka only for IVF for one year. Thus, the expense of IVF did not stop only paying the clinic chargers for IVF. They were also supposed to rent their living at Dhaka and buy all necessary goods to run a family. We had conversation for a couple of days, inside and outside the clinic. Akhter is a hard working man. He earned enough from Bahrain, now he wants his heir to take care of his property. Without a hire all of his earning will go to his brother, who he does not like. According to him IVF is an expensive treatment, but it is value worthy when the result is positive. and by positive result firstly he meant it need to be a son , then after knowing it’s a twin ; he said he will be happy if twins come as one son , one daughter. Though his

rural background and economic solvency do not object his strong ability in doing IVF, he managed it by his earning from Bahrain. Otherwise, the treatment would remain a dream for them.

For a few, the expense of IVF is given by the women's family to compensate their daughter's physical inability to reproduce. Tina whom I meet once had tendency of miscarriage a number of issues earlier. I meet her after embryo transfer. She was living with her sister for treatment. The house I meet her indicates the lower middle class socio-economic condition of its dwellers'. She came from Netrokona. Her husband left her and remarried. He is now having kids with his second wife. But, he didn't divorce Tina. Tina's parents are in good financial condition at Netrokona, thus giving money for the IVF treatment at Dhaka. Tina's painful pregnancy was unbearable. She couldn't move from bed during pregnancy, but never afford to complete the journey of 9 months. I have talked with Tina and her sister for over 40 minutes. While I noticed that she does not move her body, except head. Her determination and pains know no bounds. But, I have informed that she had a miscarriage just one week after I meet. Tina admitted that it is a matter of shame to have IVF treatment money from her father, but it is for her best. It was hard for her father to manage the expenses twice, but the Tina's old parents were worried and tried their best to bring her husband back; by offering offspring through IVF. Her husband cannot afford IVF. As, he is already having kids with new wife, he seldom communicates. He visited her during doctor visit at Dhaka and left. Tina knew that she can carry the fetus; she can secure her marriage for rest of her life. Moreover, she thought her

father will give money now, in his(Tina's father) absence (death) nobody will think of her treatment, so it will be better to have kid now through IVF, who may take care of Tina at old age. This is one of the common expectations of wider society of Bangladesh that children (specifically sons) will be taking care and support financially at the old age of their parents.

Thus, Tina wanted to get a child for her own with the financial help from her father, though her husband was not supportive at all. But, there are female infertility cases that are treated by the husbands in good hand, too. The cases of Sakira and Rehana show us the picture of husband taking care of wives with failures of IVF and didn't give up positivity; it is because both can afford it. IVF indicated different meaning to different class of people. Those who can afford the treatment fear the physical pain, shocks of failure and limitation of helping hands during pregnancy rather than the financial stress. But, they admit that the treatment is expensive for the middle class people of Bangladesh and the poor will not be able to think of having IVF in near future, if subsidy is not given for infertility treatment. The middle class infertile people feel that government should think of the pronatal society and evaluate infertility as a disease to cure not as a mechanism to control fertility. Because, reproduction is a human right.

Many young couple are going abroad to have IVF treatment, investigating all their saving with a hope to earn later in life, but to have baby earlier, before they lose all chances to reproduce. Though very few, but I meet one couple

who are planning to have IVF for their secondary infertility. They already have a son. But now, the woman is having infections which made her infertile for a being, thus want to have IVF baby as their second child. As they can afford the treatment easily, the eagerness to be parent let them go through the painful experience of IVF. I meet them at the medical agency company, where they were having counseling to go abroad for IVF. it was a short conversation of 30 minutes but Rabeya told me that she is ready to go through all the pains of motherhood again. Her son is now 8 years old. She wants a daughter now. She and her husband are planning to go India for her IVF. During her interview her 8 years son was playing with iphone6 plus. I observed that she and her son came in one car and her husband came from some other place in a different posh car. Their financial condition showed up that they can afford according to their will. Rabeya prays regularly as she says that, only Allah can bless her with a daughter, he has given them the ability to do IVF, so; they will try for it once. If not then, they will regret at old age for not having a 'complete family.'

In Bangladesh, the cost of IVF varies from clinic to another. It ranges between 3lac to 4 lac for one cycle. In case of failure, the clinic would offer their client 10% less amount for their second cycle. But, this package offers only some tests, charges of egg collection, semen collection and preserve and embryo transfer. The clients are supposed to buy the required hormonal injections, which are expensive and rare too. More or less the IVF patients need to have injection from the 1st day of period till the 12 weeks of pregnancy. Renting clinic's room, buying

and pushing injection charges are not included in the IVF package of these clinics. The patients those who are coming out of the town requires supplementary money. Some are asked to live near the clinic for the safety of the patient and the fetus, which requires additional funds. Again, if the 1st cycle fails the patients need to make living lengthy, thus extra capital goes for this expensive method. Many couples admitted that if anyone plan to start this treatment they must manage 6 to 10 lac taka, as it depends on luck (the more cycle the more money you need) and the physical fitness of the women. Thus, the cost of the treatment turns barrier for many infertile couple in Bangladesh. The emergence of assisted reproductive technology in Bangladesh, therefore initiated stratified reproduction as it many researchers have addressed in the other parts of the world (Colen 1986, Rapp and Ginsburg 1995, Collins 1996, King and Meyer 1997, Solinger 2005, Bell 2009, 2010).

Class position determines the overall fertility behavior. In traditional Bangladesh, the rural poor people desire to have as more children as they can reproduce. Now days, GO and a number of NGOs are working on family planning projects, which has brought a reduced population growth in Bangladesh. But, it is also alarming that many women got infectious after using norplant, which caused infections and leads to infertility. Thus, those who suffered from infertility due to attending temporary family planning program of local NGOs lack the opportunity to have a baby again. They also lack infertility treatment for their class position and geographical location. Having baby for

infertile couple costs money, career and time, thus it is not a free choice to reproduce, but a stratified opportunity to earn.

4.2 Negotiating with Experts

Many have experienced dissimilar views from gynecologist and IVF expert, which not only confuse them but also make them suspicious of the treatment. It is the gynecologist who first considers the infertile couple to wait until he/she is successful. For, many it turns damage for their quick recovery. Many gynecologists think that much of our infertility problem can be solved through oral medicines, thus IVF and ICSI is not required for a wide range of patients. Many infertile couple blamed the previous gynecologist for keeping them his/her patients for long period of time unnecessarily. It is very natural that once people face trouble in their expected pregnancy will visit gynecologist at their first experience. Some of the gynecologists take the chance of it and make them trust that, their problem could be solved through oral medication. The same gynecologist then wait 1 or 2 years then refer to any infertility expert. One of my respondents said that he had a very low sperm count and low motility, thus it was a bad report from a well reputed clinic, but the gynecologist said, "why you went to that expensive clinic for semen analysis? They do all test as negative. If they are right, then none will reproduce naturally in Bangladesh." then that gynecologist gave him oral medicines. He and his wife was on oral medicine one and a half year then the same doctor asked them to visit any infertility expert, as his semen quality was not improving. It was interesting to notice that the same

gynecologist suggested some other patient to do semen analysis from that expensive infertility clinic (which he said to avoid earlier) as they opposed to do analysis in his (doctor's) clinic as the surroundings are not well enough for them to ejaculate. For instance, Sue Fisher (1984) has uncovered the social and micro political relationship among the doctor and patient. In most cases, the patients are bound to accept that doctors know the best for them, Fisher observed. He stated that the doctor's medical knowledge and technical expertise provide them power, institutionally produced which is sustained. The patients lack that power and knowledge. "Patients have limited abilities to assess the competency of physicians or to evaluate the recommendation or the failure to recommend medical procedures. They must trust that their doctors know best" (Fisher 1984:25).

Moreover, many infertile experienced completely different approach from gynecologist and IVF expert in their counseling sessions. The infertile couples faced pessimistic approach more from gynecologist. The IVF experts never ask infertile couple to stop the cycle of IVF. Infertility experts ask to continue the IVF again and again. Each time of failure they justify the reason of failure and ask to do again for a better solution. However, the IVF experts are basically gynecologists of Bangladesh, those who have gone through training of assisted reproduction from abroad. In order to conduct the IVF or ICSI an embryologist is required. With some professional training a few gynecologists of Bangladesh are making/producing embryos, which is actually the task of embryologist. However, some of the clinics also appoint embryologist. The IVF experts in

Bangladesh have a very competitive professional situation; many have unveiled their hostile attitude towards one another. I have meet three IVF experts, though only one gave me kind response.

Most of the infertile couples visit IVF experts with frustration and hardship in marriage. Sometimes the husbands are not willing to visits doctors, whereas wives are optimistic in visiting doctors. Thus, negation starts from home to agree, to choose the favoured expert, to have appointment, to be on time, to do all the tests etc. Many couples admitted that they are confused to decide where to go and whether to agree with technological treatments. Expect a few; there are no poster and paper advertisements for infertility treatments. Infertile couples depend on friends, neighbor and relatives to know more about the positive results of IVF and the popular IVF experts; those would be sympathetic listener to their problem and less professional. One of the IVF experts said that after a couple of meeting we try to understand the solvency of the infertile couple than offer them various solutions according to their problem. He also admitted that if the infertile couple cannot afford IVF or ICSI or IUI then they go on for different oral medication, which may (" *jodi Allah-pak chan*" if almighty allows) or may not help them at all; but may boost their enthusiasm. Otherwise their living would be harder. He continues, "I am a doctor….a teacher of medical science, a gynecologist, an embryologist, a psychologist, a counselor and sometimes a loan giver to patients of mine." He seems to be one of the busiest IVF experts in the town now. I spend 8 hours in the lobby of his chamber and he could manage only 15 minutes for interview.

After taking the decision of the treatment, the patients and doctor communicate and negotiate on multiple issues while heading to start the steps of treatment. The total treatment follows a number of steps regarding particular problem of the specific patient. The negotiations vary according to those steps. Firstly, patients negotiate with the procedure of treatment. Except only a few (Hira and Akhter),the patients who decides to start IVF or ICSI try to collect information about the procedure of the treatment either from internet or from someone who have already gone through the same treatment and cross check with IVF experts. Patients feel comfortable and relaxed if the IVF experts make them understand the physical problems and locations to treat. Patients of infertility don't want to negotiate with their little knowledge about the treatment. One of the reasons is, they want to clarify whether the doctor will follow the religious barrier they belief. Secondly, the patients try to negotiate to have doctor's kind support and involvement in making embryo perfectly, so that the cycle runs positively. Though all think that the expense is high and hard to afford for almost all, but only a few want to negotiate on the costing of treatment. Though, the doctors know the best (Fisher 1984), infertile couple negotiate on risk, effectiveness, time accumulation and furthermore they actively and passively show agencies to deal with their treatment of infertility, as Greil discussed. (More in Chapter 5)

Khaibar and Shapla, who are now having a 2 and half years old girl belong to the upper class have requested IVF expert to give high chances of positive result in the first cycle. As Khaibar can afford, he offered more to the IVF

expert and arranged all required caring support a women need after the period of ET. Shapla is Khaibar's second wife. His first wife left him for his inability to be father. She didn't want to go through IVF for the side effect that may occur. His first wife was also from a affluent family of Dhaka. Shalpa was Khaibar's office employee previously. Shapla's lower middle class background and socio-economic dependency on her boss (now husband) manipulated her to get married to a divorced man. Thus, Khaibar was much cordial with Shapla, who took all the pains and side effects of IVF to give birth of his heir. However, he has negotiated with the doctor and got a successful IVF result in the very first cycle. In fact, they were enough conscious, Shapla was healthy and lucky thus having a positive result in her first attempt of IVF. According to doctors, none can talk on 100% success at the first attempt. Yet, many infertility clinic post about their success rate in online, but never talk about how many cycles that may take. In many ways, the politics of poetics of different online advertisement make the infertile women trust on certain clinics.

Thirdly, if the patients belong to media or well-known face for their skill, patients ask doctors not to disclose their identity with others. And the general infertile couples negotiate not to give name and contacts to anyone after the birth of IVF baby. Though the patients are requested to give picture of the baby, some hesitate in doing so. Those who give the pictures think that, the children changes their facial features, so none will identify who is an IVF baby after years.

Fourthly, some couples negotiate to have twins; others for single baby. It depends on their wish. Twins are preferred by the infertile couple as it may be one chance for many to do IVF as Inhorn(2002) discussed, but I have seen majority want a single issue from IVF, considering the afterward costing. IVF couples with twins and triplets keep themselves separated, stands with a more stigmatized nature to console themselves. However, it is also taken place according to fate, not by negotiation, though some couple wants to negotiate out of their little knowledge about IVF. The patients' body will decide how many fetuses will survive after embryo transfer; it is less about doctor's choice. Sometimes fetus is removed if the number of fetus is more than three. At this point, doctors and patient negotiate what to do. However, religiously terminating the fetus is considered unethical and illegal, thus the negotiations were kept in disguise by stakeholders. Thus, a number of negotiations took place with the experts of assisted reproductive technologies, which requires friendly support and patience hearing from the infertile. Consequently, the would-be kinsmen and friends of the infertile play important role to survive with infertility and its bio-medical treatments.

4.3 The would be Kinsmen

"Should I take it as my luck? My bad luck!.... Or should I proceed for…this treatment(!)? Whenever I had confusions… I asked my close friend or my sister. But this time, nobody can guide me. It is all about my decision. But, it is impossible to run the treatment alone." Zara was telling in the lobby of the infertility clinic. She was anxious and confused, so do her husband Saimum was.

They were confirmed from the IVF expert about Zara's unfortunate uterine fibroids caused tubal block and only laparoscopy would not help them out; IVF is their option to choose. While talking with me, Zara and Saimum were conversing about their relatives. They were anxious how to convince them to realize Zara's physical status of infertility. Infertility is judged as such a stigmatic physical condition that treating it faces a number of obstacles. Thus, infertile people not only face challenges to negotiate with doctor, but also with relatives and society.

Each married couple of Bangladesh are socially verbalized to their parents to reproduce and up bring the next generation with whom they will be tighten with blood . It is considered as a social responsibility for the couples to fulfill. Maloney's work is considerable in this regard, where she recorded reproduction as a social and religious duty of the married couple in Bangladesh. Thus, when any irregularities appear, it not only hurt the couple but also the wider family face tremendous trauma of losing inheritance. The cultural practice of Bangladesh shows that the would-be grandmothers should be informed about pregnancy as soon as possible. It is because that the would be grandmothers have a number of ritual (*saadh* event) and cultural responsibilities (making sweet-sour-hot pickle for pregnant woman and *kanth-balish* for the infant) to perform for the pregnant mother and fetus. The would-be grandparents take it as a responsibility. So, when they fail to do so, they feel ashamed in front of their kinsmen. Not only infertility but also its biomedical treatment is taken as a disability by the wider society of Bangladesh. The bio-medical treatment of

infertility is not that popular with the elderly people of Bangladesh, thus many face embarrassments to make them understand the problems and medical solutions of infertility. Whereas, the positive attitude of the other members of the family could help the couple to proceed to the treatment.

Afshani and others (2016) in their study has indicated that the stressful, critical treatment of infertility requires full family support. If a couple's family has full understanding and a great empathy with them, they can accept the reality with less difficulty. Therefore, being supported by family reduces the couple's negative thoughts and loneliness, consequently, their positive point of view makes them more willing to choose ART. Thus, the negative attitudes of the would-be kinsmen may bring up frustration and keep the infertile couple undecided to their biomedical solution of infertility. Both the cases of Mashuk and Saimum correspond to the study of Afshani and others.

As discussed earlier, Mashuk failed to agree with IVF, so do his father. Mashuk seems much dependent on his father’s words, so do Saimum is. Saimum is also very worried about his parents to accept IVF grandchildren positively. On the contrary, Ismat Ara and his husband is having forth time IVF cycle. Her in laws are unhappy with their decision. Many relatives hold a position that assisted reproductive technologies should not be an option for infertile couples. Only a few accepts it from the begging of the journey of IVF, when it was required. Many of them take time to start the treatment and meet the challenges. For example, Zara wanted to discuss with her friend and sister to take decision of

IVF. Support of relatives is very important for this treatment. The children coming on earth not only belong to parent but also belong to the kinsmen. Thus, the appreciation of kinsmen is important. Maimuna said that when she decided to go for IVF treatment her sister-in-law came and shouted over her not to start this treatment. She and her husband never asked any suggestion from any relatives about their treatments. But, when they informed others about their decision, her sister in law out busted with anger. Being a doctor she does not like assisted reproductive technologies as a treatment as it costs huge. She was also annoyed by Maimuna's decision to go abroad for treatment. However, Maimuna didn't follow her sister-in-laws guidance. After that all of her in law relatives including father-in law and mother-in law stopped calling her. She is now pregnant with twin babies but still none of her in laws asked her how she is. Her mother takes care of her. Maimuna said that though the problem is with "their son..their brother..they don't care at all." Maimuna spend her own money for treatment, her husband supported other expenses of the family. Thus, she didn't care what her sister in law thinks of IVF. It usually happens with the distrust of mixing semen. Though, relatives are not always welcomed to put their suggestion, many times they do so, like Maimuna's sister-in-law. In Bangladesh relatives feel responsible, as others may ask them questions about the fertility failure and treatment. Hira, the rural women also faced the same problem from brother in law and his wife. Her brother in law did not allow her mother in law to come and visit Hira during the treatment. Hira's *ja* told her that this treatment is *paap*. And they should accept their infertility for the rest of their life and

remain infertile. Hira's old mother was taking care of her. None of her in-laws was present. It is rare to find supportive husband's parents during the treatment, but more or less the wife's parents act in an encouraging way, no matter who causes the infertility. So, in the high sensitive periods of treatment it is the women and women's parents who take part in the decision making and controls the situation to some extent.

Ikbal's family is very supportive for the treatment of Rehana. Though they reside in nuclear setting, Ikbal's parents resided in the same building. They always take care of their daughter in law while having IVF, even after the unsuccessful IVF cycle they didn't stop caring for her. I interviewed Rehana at home after her fetus was removed through surgery. Rehana was ill and taken care by her mother in law. Rehana was in taken leave from job, she is a faculty of a private university at Dhaka. She lost both her parents in an accident, but had the same love from in laws. Her mother in law always monitors her by sending maid or others. The case of Shapla is also close to Rehana. Shalpa's sister-in-law is busy with her own family thus, she could not give Shapla time, but she has encouraged her in many ways during IVF treatment. Shalpa had her cousin living with her who helped her in the days of need. Shapla's father-in law is very old to talk and understand the IVF treatment.

Analyzing the would-be kinsmen's attitude towards infertility and assisted reproductive technology I investigated that 'availability' and 'geographical locations' of the in-law's influence the treatment and their attitude towards

IVF. Most of the women's mother or sister is the first hand to help in the time of IVF. Some lack help of mother if her brother's wife is not that much sympathetic. There are evidences of brother's wife's control over mother's love to her IVF patient daughter, which was rare in number. If the women have her mother it is she who takes most of the responsibility in helping daughter to get pregnant via assisted reproductive technology. The geographical location indicates the socio-cultural exposure of people, thus the parents who are educated, well-off and had a long term living in the urban culture profoundly support their daughter-in-law compare with the parents who have spend a significant time living in rural area. The social and cultural capital plays as an indicator to uphold and respect the decisions of daughter in law about IVF. As, I have seen that being doctors both Honufa and her husband failed to convince the would-be paternal grandfather and other paternal relatives about the treatment, but the maternal kins were convinced because of their distinct locality and occupational nature (more in chapter 5). However, some couples did not properly inform their rural relatives along with parents living at village about the treatment out of stigma and fear of misunderstanding (more in chapter 6). Even Kusum Rani's mother, who was with her during the ET, does not know about the treatment much. She just knew that has to take care of her daughter who is sick and getting treated to become mother, though the physical problem rested in the male body. As she saw her daughter is having failure in ET, it seems to her that the problem is with Kusum. Thus, Kusum is challenged by her mother's misconception of infertility and

treatment. As Inhorn and Bharadwaj (2007) have stated that the strong pro natal norms frequently blame women for reproductive failure. On a contrary, some rural mothers are progressive and enthusiastic; thus want to know about more for the sack of their children's betterment. For example, one rural ordinary woman told while taking care of her infertility treatment seeking daughter, *"* it does not matter what happens , I shall not give up my daughter in water*"* (*ja khushi houk, ami amar meye k pani te felte parbo na*). She feeds and cleans her after ET. Her daughter was supposed to take complete bed rest after the ET is done. Doctors suggest taking rest for 3 days. But, I have seen experienced many patients rest for at least 12 to 15 days, unless and until the blood test is done to confirm pregnancy. According to them, the chances of pregnancy are high for patients who got rest and support those days time. Most cases the mothers of the childless woman take this as a responsibility. No matters whose physical problem has been identified it is the women's mother who thinks that, having no children is a womanly problem. Thus, she jumps over to help her daughter out. The man's mothers also perceive it in this way, that infertility is a womanly problem. It is only her urban exposure and cultural capital which may or may not make her a friend of daughter in law. However, women herself also prefer their own mothers to take help if possible. Lira's mother in law always wanted to help her infertility solutions, but Lira ignored her in many ways. Lira finds it as humiliation, though her mother in law told me that she wants to help Lira by all means as she would serve her daughter. Thus, the stereotype relationship of mother in law- daughter in law exits in

some relationships, where as Rehana and Shapla have wonderful help from their in law relatives. Thus, I agree with Afshani and other's conclusion that making a decision and accepting ART can be influenced by couple's attitude, their family's attitude, and their awareness. Infertile couples with the most positive attitude are more willing to choose ART to become parents (Afshani and others 2016).

*4.4 **Conjugality and Technological Pregnancy***

Bringing life on earth is gifted to women, upon the certain mating relations taking place between man and woman. With the institutionalization of marriage the mating habit and reproduction placed in the frame of conjugal living of couples. Thus, the conjugal right has given prime priority in maintaining the socio-biological bond in the family. By conjugality, I mean the every today living and mating relations between husband and wife. Infertility hampers the conjugal relations and its bio-medical solutions question the existence of conjugality between husband and wife. The children are thought to be produced out of mating whereas the IVF babies are produced by the embryologists in the tube, where husband and wife works as a provider of egg and semen. The infertile couples face tremendous psychological disorder due to their inability to be parents. Many of them loses self esteem and fail to cohabit together. And after knowing the procedure of IVF, ICSI where embryo are made out by doctors, many infertile couples get confused and be unable to find interest in mating. Thus, conjugality faces challenged not only through infertility but also through technological birth.

Upon understanding the physical inability to be father or mother many stop having physical relations for a long period of time (3 months to 1 year). A number of male and female respondents admitted that conjugal romance and physical relations come to an end when couples understand that sex will not produce any baby anymore. Those who planned to have baby making mating; they became much anxious for not having their expected result. Thus, when these couples fail to become pregnant naturally then they loss hope and love for each other. Some feel alienated from sexual pleasure. Conversely, some women become worried to be separated from husbands. For example, Zara was worried about her condition, when a gynecologist advised her to remove one ovary, that day she have to rush to *Thakurgaon* for office, keeping husband at Dhaka. She said, she was worried what her husband would do knowing her problems to reproduce. Infertility brings doubt on the conjugal relations, too. The pleasure of mating reduces according to the length of conjugal life, but it turns painful when infertility is unveiled by the doctors.

Though assisted reproductive technologies brought chances to have children, it never satisfies the ways others' conceived. The pregnancy is flawlessly determined and monitored in the procedure of IVF, whereas the other's misses period and test for a positive result to confirm pregnancy. The procedure of IVF enables a number of people, for example, doctors, medical associates, nurses and some close relatives, to know the date of period and date of egg collection and others which are thought to be very private and belongs to conjugality, in Bangladesh. Thus, the privacy and charm to conjugality massacred by the

interference of IVF experts. Ismat Ara who has gone through IVF three times, still feel the same disgracefulness during her egg collection and embryo transfer. “everybody knows what is going inside …. I feel dying ..its not always about pain…but about self respect. My husband gives semen. I give egg…what the rubbish way ! no privacy at all. Doing several cycles could not make me easy to these process of treatment.” stated Ismat on her reactions about egg collection . Another respondent Maimuna said that, she didn’t know when the ET would take place. She went by the call of medical assistant, had ET unconsciously and when she eye she asked others “Am I pregnant now?” As it was her first attempt she was not aware of the total process and she consider it as a maze to perform the technological pregnancy, where the semen and egg play distinct role under the supervisions of medical associated.

Examples of extra marital affair, divorce, remarriage, separation comes with infertility. The conjugal relationship reaches its suffering and ends up for many. Thus the infertile male and female face challenges in their matrimonial relations in dealing infertility and assisted reproductive technologies in their life. Tina’s husband only visited her during medications, only to give semen in the clinic. He doesn’t have conjugal relation with Tina. He is staying with his second wife. Thus, Tina does not have any form of conjugal relationship with her husband but going through IVF in a hope to give birth of a baby without conjugality. Now, the question appears whether it would be a health solution for her and children’s future. She thinks her baby will be her strength of living, eyeball of old age, because at this age nobody will marry her with infertility problem. So, this is the

only option for her to avail. I don't know where Tina again will take chance in her next cycle. She went to her natal place after the miscarriage she had. Like Tina, Kusum Rani is also not having any contact with her husband but has gone through IVF by the semen of her husband. Kusum's husband is having extramarital affair as she said. But, in Kusum's case the problem lies with her husband's disability. Kusum didn't want to settle her life with him, but forced by her father and other relatives. Being an orthodox hindu, Kusum's father don't allow her to divorce. And she obeyed her father's decision. But, Kusum has lost hope to have a usual conjugal relation with her husband. Tina and Kusum are in a dilemma dealing with their conjugal life with unsuccessful cases of IVF. Nipa divorced her husband for having a weak ovary. Though she was forced to divorce by her in-laws, she also said that she lost her desire in having a healthy conjugal life without having a healthy ovary. Nipa remembered her days of depression and anxieties and with a broken heart, she accepted to live being singular.

Conversely, Khaibar was divorced for his infertility (low sperm motility), and as his first wife disagreed to have technological pregnancy. But, he didn't lose hope and interest in conjugal life, thus, remarried with his healthy, young unmarried office employee, Shapla. Shapla's socio-economic condition made her to agree with Khaibar's weakness and performing a happy conjugal life with one IVF daughter. Shapla may again plan for IVF, if they want, no matter what physical pain occurs to her. Though, Khaibar's and Kusum's case talk about male infertility, but none of the male loses sexual desire. They changed their partner instead. Tina's husband did the same for Tina's weakness. So, the male infertility

did not stop them from having a new partner, so is female infertility. But, some women, like Nipa interrogated with infertility shake to have new life partner, though Lipi with female infertility were set to her second marriage with dowry. Thus, interest in conjugal life and sexual desire do not depend on person's reproductive strength, but on their desire to be biological parents naturally. It is not uncommon that the partners show opposing decisions to choose the treatment procedure of their reproductive problem. Therefore, their distinct personality challenge conjugality and matrimonial bond. Planning for a baby naturally is the ultimate goal for Bangladeshi couples (though many urban couple 'take a gap' to get pregnant as Taslima mentioned in her study) and any biological problem with reproductive health may hinder the smooth conjugal relation. Thus, Infertility and technological pregnancy have threatened the existing conjugal living for many couples in Bangladesh. The technological intervention, therefore has profoundly indicated the problems and challenges of infertile people in such a way that the scholars, social researchers, medical consultants, psychologists and even general people interpret and represent infertile people as the constant victim of the whole situation.

4.5 Social Representation of the Infertile

The pursuits of infertile solution emerged and extensively spread throughout the world (after 1978) where pro-natalist patrilineal cultures glorifies motherhood; but the overpopulated states with limited resources hinder its promotions. Moreover, like many societies of the West, Bangladesh do not have any subsidy for this expensive treatment as it is comparatively a poor,

developing country to West. Thus, the social representation of infertile as Sandelowski and Lacy (2002) have articulated will partly address the situation of Bangladeshi infertile couple. Unlike West Bangladeshi people, including many women consider infertility as a female disease. Whereas, Western culture consider infertility as a couple problem. However, the '(mis)representations of the infertile' as Sandelowski and Lacy have explored will rectify how society itself challenge the infertile people by representing them with new status of infertility. After the introduction of assisted reproductive technologies in Bangladesh different group of people (more in chapter 7) developed various concerns and attitudes towards it with or without knowing the actual process of IVF treatment. But, commonly infertile people are represented and treated widely as patients, as emotionally distressed, as socially handicapped, as consumers, as cultural dupes and foils and as heroic sufferers, Sandelowski and Lacy stated. Infertile people those who have engaged themselves with assisted reproductive treatments are mostly represented as Sandelowski and Lacy's interpretation, by wide range of people. The growing attention to infertile people with assisted reproduction have engaged not only the IVF experts but also the behavioral, biological and social scientists; scholars from practice disciplines like ethicists, theologians, lawyers and legislators; social activists and cultural critics; and journalists and television commentators (Sandelowski and Lacy 2002:33). However, in the context of Bangladesh the technological intervention of assisted reproduction is spreading rapidly but in a silent mode

in a more stigmatized way. But, people's perception on the infertile is much related with the West, where they are treated as patients, but not deserving public support or any coverages and sick leaves as infertile. Though arguable and objectionable, these infertile people are assumed patients; as something is wrong with their reproductive health. As many of the respondents admitted that they feel others treat them patients when they start consulting with doctors for IVF. Though, they didn't consider themselves accordingly until they start attempting any sort of surgery for the treatment. In West, various categories of infertility counseling are organized, some for those who have started treatment, some who have failed number of trails, some who didn't start they journey to IVF. The significance of infertility counseling does not belong to the domain of medicine, but in Bangladesh few IVF experts keep on counseling their patients the fruitfulness of IVF treatments. Mostly the counseling is done by the other IVF patients who have already successfully completed the trials of IVF. Even after the accomplishment of the IVF journey experts requests and assists the new IVF baby parents to counsel other infertile people they know and send them to the expert they know. Boivin (1997) argued that the infertile people want others to be sympathetic to the difficulties of infertility, but they do not avail the psychological services offered to them. Here, in Bangladesh there is no such psychological counseling workshop like the West, but the campaign of different infertility centers goes on counseling in their own way, where they see active presence of the infertile people, both male and female in various districts of

Bangladesh. Moreover, the relatives of the IVF seekers (in most cases women's mother) keep on motivating daughters to overcome pains throughout the treatments. Thus, they get emotional support from close relatives. Indeed, the shabby days of the IVF treatment required a close monitoring of near and dear ones, unless they would feel alien and socially disable.

Sandelowski and Lacy have explained that infertile people are often viewed as socially handicapped because of their inactive role in the society. Like Nahar, I have also observed that infertile people withdraw themselves from social interactions and feel alien. Thus, others consider them as socially handicapped. According to Sandelowski and Lacy adoption can bring many back in social healthy living, when no other solution may work. However, adoption is questioned in Bangladesh for a number a reasons though it also works as a remedy for both infertile distressed couple and parentless children. In contrast to the views that infertile people are medically and socially disable or emotionally handicapped, they are also viewed as consumers. As discussed earlier (in chapter 3), Maimuna was strained by her colleagues for saving money, as they consider her enjoying dual income without kids. Even the doctors want to know whether both of them are working to understand their financial solvency for the IVF treatment as it is an expensive one. One of my respondents was annoyed by a doctor's approach to him, as he said, "you can afford the IVF treatment, both of you are earning enough. Do not wait for other oral medication. You can go for IVF." However, it is true that financial support

is necessary for the treatment, but, considering infertile dual income couples as customers or consumers indicates the capitalist approach of physicians. Conversely, in most of the capitalist, pronatalist, patriarchal society women are expected to avail all necessary infertility treatments they could afford. A number of people consider infertile women as anti-women and incomplete, thus, put them for instance, dupes and foils for cultural norms. The social expectations to a woman and technologies force women to reach their goal to assisted reproduction, unless they are trapped to be dupes and foils of the cultural practices they have.

As discussed earlier, infertile people do not consider themselves as patients, Sandelowski and Lacy discussed more clearly that they denied the privileges of not only patient status, but also often denied the privilege of naming their own experiences, they are accorded a privileged status as heroic sufferers when infertility is conceived as an illness. As living with infertility and responses to bodily, socially and culturally failure put woman to a risk of failure both physically and emotionally, their travails were best compared with the heroic sufferings. Thus, people around the IVF attempting women always keep on asking her condition in a more sensitive and kind way and consider her as brave and even daring for such uncertain, critical and courageous treatment (more in chapter 5,7).

In sum, the challenges of infertile couples with assisted reproductive technologies have multi-facet nature. Starting from social monitoring and

psychological trails, the complete procedure involves financial risk, unfriendly attitudes of kins and kiths, conjugal threats, losing job and hope for positive living etc. Among them many accept the reality and work hard to accept further challenges of the treatments, through strategies and agencies they learn while fighting against infertility. The infertile people and infertility experience disparities in terms of its socio-economic access and geographical availability. Thus, only a limited number of the infertile couples overcome the challenges and get the opportunity to come forward and take a risk to be parents of IVF babies. The next chapter will explore how infertile men and women peruse their challenges with limited knowledge and negotiate with doctors and relatives; and how authoritative knowledge and medicalization of infertility is objected by the strategies and agencies, women initiates during treatment.

Chapter 5

Knowledge, Authority and Agency of Reproduction

The nurses came and asked Honufa, 34 years old IVF would be mother to get ready; it is time to go to labour room. Her face turned pale. Her mother, husband, sister-in-law and brother was beside her. Looking at her mother she asked the nurses, “ will you give 2 minutes? I want to say my prayer.” Though it is not a usual praying time, she wanted to do a ‘*nofol namaz*’. The nurses allowed her. Soon, she gets up from the bed started saying prayer on the cabin’s chair. She was admitted for delivery at one of the expensive private hospitals of Dhaka city. The nurses waited for almost 3 munities, after the prayer she was injected an antibiotic. She gave a dry smile and said, “maybe its my last injection (of IVF treatment)…how many injection did I have?” her husband and she started counting. Then came to an end, “yes…..it’s about 200 injection in these 38 weeks (sighed)”. Her mother makes her easy, “no worries. Ever thing will be fine. You have suffered a lot.” Then she mumbled, “hope no side effect appear..may Almighty provide us a healthy baby…aahh! such a painful journey”. The experience and embodied knowledge of Honufa’s mother let her to react about the after-math of these lengthy bio-medical treatments. This chapter focuses the people’s knowledge on infertility and the bio-medical treatment of it. Here, I will also examine the embodiment of the treatment and how the embodied knowledge influence and at times manipulates the technological birth. How the class

position and access on resources help people to get access over knowledge and power is revealed in this chapter. In this chapter, I will discuss on people's perception on reproduction in Bangladesh and how doctor's regulate their expertise and maintain their hierarchy of knowledge and function authoritative knowledge, at the same time how the patient's deal with authoritative knowledge will be addressed. Medicalized infertile people pose and act to the system of medical knowledge, where they have limited access. This chapter will consider Greil's (2002) understanding of agency and medicalization in order to perpetuate patient's active and passive participation in the medical treatment (medical treatment is the locus of authoritative power) with assisted reproductive technologies in Bangladesh. Here, authoritative knowledge is defined as Jordan stated in his work. Jordan defines authoritative knowledge as it rules that carry more weight than others "either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority) and usually both" (Jordan 1993 [1978];152).

Considering medicalization of infertile body, this chapter argues how Bangladeshi infertile couples, especially women respond to the treatment. As, Greil (2002) has argued that American infertile women are conceptually medicalized and put them under the control of medical authority, then actively and strategically respond to the solution of the problem. Here, I see that Bangladeshi infertile women's embodied knowledge (embodied knowledge is a type of knowledge where the body knows how to act), passive

and active reactions and strategies to overcome uneven social, biological and emotional circumstances while planning and accomplishing their treatment through assisted reproductive technologies, IVF.

5.1 Hierarchical Knowledge on IVF

When Honufa's mother was mumbling about her unattended worries about the side-effects of the bio-medical treatments, other relatives (visitors) in the room looked very sympathetic to her sufferings of childlessness and a painful treatment of IVF. The carrier was ready there, they took her in the delivery room. Meanwhile her father-in-law and mother-in-law reached the clinic. Just before entering the delivery room, where entry is restricted, she waved hand and wanted to touch her husband's hand. Her husband ran after and holds her hand saying, "We are waiting exactly here."

The delivery room is restricted, so that only authorized people have access. None is allowed with their slippers except the doctors. Many relatives are waiting out-side the delivery room. Post-operative unit is also inside the delivery room; thus many are waiting to hear what is required for their patient.

Though the process of c-section does not take time, medical associates wait until a number of formalities are done before delivery, which includes some general observations of the patient. The delivery of my respondent was done after 1 hour (approximate) she taken inside. When the nurses came with the

clinical bed with the baby beside her, she was crying. All of her relatives surrounded the area with smile and they were asking, "what baby?" (ki baccha?) "…it's a boy.", said the nurse with her. After knowing it, her father-in-law stepped forward and stared reciting azan at the baby boy's ear. This father-in-law has stopped meeting her, when she decided to do IVF for her husband's infertility, though her in-laws always blamed her for not having baby. The old man looked at the baby boy, his grandson and said to the maternal grandmother of the baby, "See, the boy resembles us." As the affinal relatives of my respondent, Honufa, know less about the procedure of the treatment, they were not ready to accept IVF, but the facial representation of the new baby helped them to accept their blood. Otherwise, they were not in a good mood to accept the baby produced via IVF. The father of this IVF baby is a doctor himself, but could not comprehend his parents about the treatment easily. They have their own understanding of sickness and biomedical treatment of infertility. Honufa is also a doctor, manages her mother and other family members to have ethical trust on the available treatment. However, it must be considered that Honufa's family and her husband's family belongs to distinct social status group by their education, occupation and locality. It is not unfamiliar for many of the IVF seekers to avoid their own parents about the procedure of the treatments. Most of the parents of IVF seekers are told that this treatment is expensive and hardly positive results appear.

Occupational orientation, urban-rural settings, exposure to mass-media and networking reshapes our knowledge. People have their own viewpoint of gathering knowledge which is fashioned according to the authoritative structure they possess. Thus, saying prayer before going to the labour room is not only her religious learning but also her embodied knowledge that forces her to act accordingly. Asking permission for prayer to the nurses shows her obedience to the authoritative power of the hospital. Leaving all relatives outside of the delivery room make her eliminated from her own world, thus wanted the psychological support from her husband who also struggled these days for a baby. The expression of the paternal grandfather, while looking at his IVF grandson indicates his willingness to believe and accept him (IVF baby) as their new addition to the family. Thus, the affinal kins of Hunufa try to gather and incorporate their own knowledge of assisted reproductive technology about which they never aware. It was completely a new experience for them to accept and carry on.

This contradiction of knowledge happens in most of cases of biomedical treatments of infertility. Thus, many do not disclose what is happing actually. Even the seekers of the treatment do not have a clear knowledge about what and how the technological intervention tales place. However, the procedures of the treatment make the maternal body obedient to the drugs and doctors. Thus, Honufa's body and mind has shaped in away to take 300 injections and getting relaxed on the time of delivery, praying an end of the treatment. The technological intervention on women's health has made their body and mind

tamed and passive to the bio-medical machinery power. As Foucault addressed ‘docile’.

“The human body was entering a machinery of power that explores it, breaks it down and rearranges it.... It defined how one may have a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practiced bodies, "docile" bodies (Foucault 1977: 138).”

The provider and consumers of assisted reproductive technology has distinct knowledge, disciplinary power and authority over their needs and demands. Fertility itself is a personalized form of cultural behavior that regulates one of the important functioning principles of conjugal family. In cases where assisted technology is concerned than the given arrangement, demand disciplinary actions followed by the providers of the treatment; where fertility could not pose as a personalized bio-social condition. Thus, consuming ART, let the IVF experts hold over not only consumer’s reproductive body but also their social status of being fertile. Through the exclusive process of assisted fertility treatment women’s body turns docile to medications about which many were not informed. In many cases the doctors notice that it easier not to inform what is going to happen next to their patients. It is the patient’s social status, economic position, gender and education that shape doctor’s behavior. Thus, Hira, the rural woman had no

idea what is going with her. She only knew and believed that her husband will choose the best for her treatment to be a mother. And it was not easy to consider Akhter's eagerness for IVF treatment unless he discloses himself as a part-time cleaner in an IVF clinic aboard. His knowledge about the treatment was hosted from his life at a foreign Muslim country. As he himself has observed that many are having successful solution for their infertility problem he searched the same in his natal area. It was Akhter who informed me about the health campaign of the infertility clinic to increase the consciousness of the pregnant mothers, where many also consulted about their infertility problems. Akhter and Hira was one of them who came to that clinic after the doctors and 'clinic people' left their campaign. Though, Akhter does not belong to the wealthy educated urban class, his knowledge about the treatment and eagerness to have an heir helped him to accumulate all logistic support of IVF to his wife Hira, who was not informed much about the treatment. Hira has gone through the procedure twice. She was cared by her mother from the beginning of her treatment. Both do not have much knowledge about IVF treatment. Hira only talks about her painful experiences of injection. At times she asked the nurses about, what will happen next with her, but none of them could ever confirm her about the treatment of infertility. Moreover, she never knew that she had pelvic infections (she told about her painful experiences only and admitted her little knowledge about the specific medical problem), which was cured before her IVF treatment; it was Akhter's poor moving and low number of sperm that

lead her to have assisted technological pregnancy about which is unknown to Hira. The medication to meet up the IVF successfully, required body is not easy to get for most of the women, so does with Hira. But she and her mother perceive the first unsuccessful attempt as a big failure for Hira. Her mother is not only sympathetic for Hira's docile body due to several bio-medical interventions, but also worried for Akhter's expenses for this expensive treatment. However, she is happy for a son-in-law like Akhter who has given all his money for her daughter's treatment. Akhter, who had admitted his weakness to me, while conversing at roadside, remained indifferent when his mother-in-law praising him inside the room, accusing her daughter's weakness to be a mother. Hira's mother perception on reproductive knowledge think that fertility is vastly a womanly quality, thus failure is attached to her daughter. Though Akhter knew more assisted reproductive technology and his own weakness, he takes the chance supremacy of being normal and healthier than his wife and consciously operates his wife Hira to agree with all sorts of treatment he could afford. As in Bangladesh knowledge is provided, defining not only socio-economic class but also gender as a hierarchical position. Male with higher class are provided information vastly than others. Women are thought to be ignorant and do not deserve to know much. Accordingly, Bourdieu (1978) explains how higher capital provides higher opportunities in different arenas of society. In the context of Bangladesh, the patriarchal setting of the society

let the male uphold their position, thus male identity plays a role as their capital to exercise power and knowledge upon women.

*5.2 **Reproductive Knowledge***

In Bangladesh most of the people do not have any formal education on sex and reproduction. Any informal discussion on reproduction and sex is a matter of highly furtive topic. Thus, the knowledge of reproduction remains in the barrier of secret stories and experiences exposed in the ridicule relations, as like, co-hearts, friends and sister-in-laws. Most of people learn of their reproductive body by their own or elderly companions. Any discomfort of reproductive body is masked unless it turns severe. Compare to men, women feel shyer to talk about their sexual discomfort. However, Hira spoke of her problem to Akhter and he advised her talk with the senior woman of the house, his mother. But, as Hira didn't feel free to her, she asked her sister-in-law for a solution of her uneasiness sex and sting reproductive body. The sister-in-law (*ja*) scold her not have any treatment at Hira's natal home. Hira, being a newly married girl remained silent and didn't confront her *ja* by informing how she could know about sexual uneasiness before marriage. She (*ja*) also asked her not to say about pain to Akhter, though Akhter was informed earlier by Hira. This is how Hira's pelvic infection remained years after years for ignoring the discomfort of reproductive body, unless and until Akhter got serious about his fertility issues.

Human reproduction remained unquestioned as long it occurred without any obstruction. The more human unions voluntary or involuntary delayed and

dismissed their pregnancy the more cultural and ethical questions appeared, as a result involuntary childless couple search for knowledge of reproductions from suitable scopes according to their socio-economic position. Before the treatment of infertility, none of the couples have ever thought of their reproductive organs and the women's biological element of reproduction, that is egg of the womb. The cultural construction of fertility has given importance to woman's womb and man's sperm but not the egg, its function and its production. Those who had spontaneous pregnancy also didn't think of egg and ovulation. Though, it was observed that Bangladeshis are highly sensitive to weather, food type, environmental factor which control their sexuality (Aziz and Maloney: 187), they had a little of women's ovulation. Thus, fertility researchers of Bangladesh lack the conceptions of egg and ovulation of women. Inhorn also noticed that majority people of Egypt lack the knowledge of egg, while it plays as important role as sperm. Some other researchers shows male across the world have limited knowledge about reproduction and male infertility (Daumler and others 2016).

The educated urban involuntary childless couples tend to know about IVF treatment from a number of sources, for example internet, general text on reproduction, doctor friends and infertile relatives, IVF seekers and gynecologists. Thus, these people know about egg. Asma, from upper class of urban society who has completed bachelor degree, said that she never knew that woman also produce egg like other spices. *"I* did not know that human beings have eggs like other animals, maybe I was not a student of

science ; thus I don't know. My friend who studied in science knew about it. (*ami jantam na onno pranider moto manusher o deem hoi , hoytoba science pori naie tai jani na. amar science friend ra janto)"*. Asma is only 28 years old and looks beautiful and fashion conscious, but knew little about human procreation. Like Asma, Jara also had no idea of egg. Though she is a government employee, achieved higher degree from reputed institutions, she has inadequate knowledge about female body; she blames her non-science background at higher secondary level. However, Jara is suffering from ovulation problem. She could not produce enough quality eggs to get fertile. I meet Jara and Saimum at the infertility clinic where they for consultation. Both are educated and earning a handsome amount of money. They bought a flat at Dhaka. Jara is posted at *Thakurgaon,* where as Saimum lives at Dhaka. Saimum is only 38 and Jara 35, at this age buying a flat at a prime location of Dhaka indicates they solvency, but I saw Jara weeping for her eggs, about which she never knew.

In Bangladesh the knowledge of procreation is ignored in general discussion, the topic of reproductive health, child birth and fertility are considered as timorous and feminine. Though, recently government has introduced reproductive health education at school level, previously, there were less opportunity to gain understanding of own body, thus the educated and apparently health conscious women also have little knowledge about their ovulation, which is very important to conceive. Sometimes relatives and doctors suggest couples planning baby to have coitus from the 14th day of

menstruation till 21th, but a few talk of ovulation. Thus, rural or urban, educated or illiterate all remains under the same light of knowledge. When Jara came to know about her infertility problem she became very worried of lacking something feminine, though the idea of egg was completely absent in her mind before the gynecologist explained to her. Jara said that they have gone to at least 3 doctors (remembering and counting on fingers) before she came to the IVF expert, where we meet. None of the first two doctors informed them about egg. Jara hopelessly informing her ignorance about her reproductive body,

> "both of the doctors told me "you have problem. take medicine." I followed their advice. But, did not know what was the problem, in fact! I changed my gynecologist, with no hope from the earlier one. At last, this gynecologist explained me everything (importance of egg and how an embryo produced). She gave me time, drawn pictures and make me understand my ovulation problems. We know less about our inner body and the doctors keep rigid and silent in front of us, thus we fail to understand the actual condition of our body."

However, her ignorance of egg didn't give her the feeling of losing femininity, whereas; when she knew her specific physical weakness she became more traumatic. She was telling of the day when she came to know about her specific problem. The day they meet the doctor was Saturday and she had to catch the night bus, just after visiting the doctor. She was supposed

to be present at office the following morning. She thinks that the doctor was wise enough to make her understand the ovulation problem she has. But, the night was the worst night for her, sitting alone on the chair of the bus , keeping husband Dhaka. She confirmed that it was nothing to distrust her husband, but a fear of being unfamiliar to her world. However, Jara is trying to be confident to have ICSI or IVF, now. But Saimum wants her to wait for some time. He believes that Jara will be fine with oral medication. Saimum still need to know more about IVF treatment. He wants to talk with several IVF experts about the procedure of IVF as he came to know about different types of sources of IVF from internet. Thus, firstly Jara lacked knowledge of her reproductive illness, now Saimum is shaken for his distrust of mixed egg or sperms and poor knowledge of assisted technology. (more in chapter 6)

Jara's ignorance of the specific health problem relieved her from anxiety of unfemaleness, until she visited the last gynecologist, who explained her the process of ovulation and where she lacks. Like her, many infertile couples clam themselves not being consulting more doctors, as those doctors will rectify them as 'infertile'. There are many whom, I conversed, fear to face the reality heard by doctors and others. Modern technologies have scientifically proved where the problem of infertility rested, which many of the couples do not want to clarify. Thus, they avoid for a time being, but many changes their decision and step forward to locate problem and search for a solution of their infertile life in financially, psychologically and most importantly physically they can afford. In fact, the medical authority exercise

their knowledge as a power tool to bring patients again and again as they long suffer.

5.3 Authoritative Power

As a general rule, the hospital is a place where the authority plays the supreme role of power and pushes the health help seekers under a close observation and continuous monitoring. The interior of the office, banks, schools, universities, hospitals and now-days houses are accompanied with close-circuit cameras with the intention to inspect the happenings. The authoritative power has been enhanced with the wider exploration of modern scientific equipment, which kept people under surveillance. Foucault describes that the hospitals are having a clinical gaze, where besides consulting and teaching, doctors and other medical associates can do ward round and observe patients minutely and made them confess distinct psycho-physical discomfort by creating a vulnerable situation of having no relative beside. The 'restricted entrance' and architectural capacity made a clear distinction of authoritative power. On my first day at the infertility clinic I experienced the receptionist managing to clam the angry clients (the patients were angry as the doctor was almost 4 hours late) by saying that every attitude of the waiting patients are reordered in the CC camera and inside the chamber the doctor is watching "his misbehavoiurs." Thus, the technological involvement in the clinical zone has enhanced the authority to act more rigidly and exercise power to control them. The exercise of architecture power was also observed when I revealed that separate stairs and entrance are maintained for the administrative authority of the clinics.

However, most importantly I pointed that how the authority possess knowledge and share the realities with the patients not making them aware of severity of the problem.

While knowing that Jara was not informed by the two doctors she consulted although the tests she has undergone clearly indicated her shortage of quality eggs, I asked Dr. Jui why doctors don't explain. She smiled at my question. She was the friendly doctor I meet. She answered with a smile, "Yes, we should." She prolonged her conversation as telling that all patients are not same and there is immense lack of scientific knowledge in Bangladesh. People cannot take thinks easily. She also asked me what would happen if Jara's husband left her after knowing the exact disorder. Thus, she defended doctors by saying those two doctors were cultural sensitive and they have given priority to our patriarchy not informing how acute the problem was with the female reproductive body. However, two doctors have spoiled one year of her treatment and earned a good amount of money with no fruitful result as the patients comprehend. Some of the doctors think it's better if patients rely on the treatment without asking question, not attending the side effects of treatments and not knowing what actually happened to his/her. These doctors think that not asking about the side effects may boost patient's energy and trust upon the doctor. "It would be helpful for us to treat, if the patients trust us completely." told me one of the gynecologists. In reality, most patients complain about doctors not being friendly, homely, social and vocal. Some undergo with painful experiences and states that doctors are much proud about

their knowledge and power, thus they (doctors) think "they belong out of the world. They are not common people like us." B. Jordan (1993) views authoritative power as rules that carry more power than others, it is because of either efficacy or structural superiority or both. Authoritative power can be attached to a person who is in authority, otherwise it appears when decisions are made in a given situation, by a given group of people (Jordan: 1992).

By all means, doctors become the authority when the patients are admitted at hospitals or clinics. Under the medical technological surveillance the knowledge of general patients faded away as medical intelligence is not for all. The clinical procedure is not well informed in countries like Bangladesh. Though, the doctor talks about cultural tolerance, but the urban IVF seeker think that patients should have their lawful right to know how the doctor is going to operate medical knowledge over subject's body. The IVF seekers and patients waiting for doctor's visit portray the same picture of uncertainty. They talk with each other and share common frustration they face, but could not protest for not being in the authority. Most of the patients complain about doctor's behavior, communication problem, giving too many medicines and tests and not an attentive listener. But, none complain in front of doctors. They are afraid to be ill-treated. The authoritative position of doctors made them unaccountable to their patients. The IVF experts lack accountability of having failure cycles after cycle, because, fertility depends on several facts which are not in the hand of the experts. The female senior IVF expert demand that her clinic have more than 80% success rate, but does not confirm how many cycle

one couple may require. I have not seen any at that infertility clinic, who had a successful IVF at her first cycle, except Shapla and Khaibar, who were introduced by the expert herself.

Khaibar has male infertile problem and got divorced by his first wife, who was not willing to get IVF treatment. He belongs to an affluent urban educated family. It was not firm for him to get married with Shapla, his ex-employee and a young unmarried lower middle class lady. Shapla was ready to start for the treatment as soon as she knew about Khaibar's weakness. In their case both were concerned about their treatment. They have gone through studying literatures on the technological pregnancy over internet. Shapla got a complete rest as Khaibar appointed a number of people to out after her. Her cousin (student) was also living with them. Khaibar lost his mother and his old father lives with them, who is ill and usually does not communicate with others. Khaibar's socio-economic position and strong high contacts help him to meet the well-known IVF expert of Dhaka, who was requested to perform the treatment with exclusive care and sensitivity. Thus, Khaibar's economic and social capital made him powerful enough to have a second wife, convince her to do treatment and confirming an elite care at infertility clinic and palliative care at house for her wife while having treatment. As a result, Shapla got pregnant in the first chance of her IVF, they are now blessed with a two and half years old daughter. The case of Khaibar shows that the social and class position of patients may help to grab a authoritative power over doctors' decision. Khaibar seeks IVF expert's help cordially and made her understand

that a quick solution is essential as he already lost his first wife out of fear of IVF.

Among the 7 embryo 6 was transferred, Shapla was blessed enough to have one embryo surviving in her womb. According to the doctor Khaibar's luck, Shapla's sound reproductive health and accurate rest help them to have a positive result at the first attempt. Khaibar felt aloof after his divorce for infertility, it was a big shame for him. He is very grateful to Shapla who didn't think of the side effects of IVF like his previous wife. He tried at his level best to convince the doctors of infertility clinic. Still, they have good communication with the doctors over there. Khaibar brings gift for the IVF expert when he comes from abroad as Shpala mentioned smiling. The good friendly relation between the doctor and patients indicates that they feel sameness. It is not applicable for all ordinary cases I have observed. As the first day of my visit in the infertility clinic, I have observed the anger of waiting patients for not attending patients on time (more in chapter 2). Khaibar was desperate to have a positive solution at their first attempt for which he was ready to give more money. But the patients who also need child but don't have money and could barely arrange money for only one cycle as a result they failed to grow a good rapport with the IVF expert. Many of the middle class patients think doctors are fond of power and cash income rather than helping people by their medical knowledge. Though, the first ever Bangladeshi couple who had IVF baby at home was patronized by the doctors was not from a wealthy background. Khaibar's economic solvency and social status gained an

easy access to the IVF experts who exercise power of knowledge and authority simultaneously.

The knowledge of assisted reproductive technologies is revealed by the medical technicians, embryologist and IVF experts. All of them usually don't communicate with the IVF seekers. It is only the IVF experts (who are commonly gynecologist with an expertise of infertility treatments) who communicate and assist patients who have a little or no knowledge of technological pregnancy. Thus, the hierarchy of knowledge creates a positional distinction between the IVF seekers and IVF experts. The authoritative power of the IVF experts and other medical associates force the patients to be clam and absorb financial and socio-psychological stress for not only being in the authoritative position but also being present in the decision making area of egg and semen collection, preparing embryo, embryo transfer and so on.

The total structure of clinic is made to implement the authoritative power of the authorized persons. The architectures of the hospital, clinics and even schools are built in an institutional structure that surveillance turns an optimal choice for the authority to accumulate power and knowledge. "stones can make people docile and knowable," (Discipline and Punishment, 172). The doctor's chamber and the waiting zones of IVF care unit of each hospital are kept with high protection with more close-circuit cameras. The exclusive clinics and hospitals have more decorations at their IVF units, too. The

structure of the IVF unit can be defined as separated, elite decorated, most restricted, and confidential place of the clinic /hospital under surveillance of the top authority. The clinic/ hospitals basically can be distinguished into four structural part, (1) the waiting zone, there the patients wait with their relatives. This is the most formal and ornamental part of the IVF unit. There are some authorized people who control the serial of the treatment seekers and help people to assist the prescription given. They are also authorized to take care of the visiting payments made by the patients. (2) The chamber, where the experts are authorized to consult their patients. Inside the chamber the doctors listen to the patients and try to find a solution to the targeted problem of the patients. Usually, the experts ask the patients of their problem and they answer accordingly.it is also decorated as the doctor sit inside the chamber, it is a semi-formal place, as the patients can talk of their problems to the authorized doctor. (3) The operating room, where the deliveries take place. It is the most restricted zone, but the most informal place for the doctors and their assistances. The operating room/delivery room is less decorated, where mostly the equipments are gathered to execute the operations. Usually, it is more clean and big. Inside the operating room, the doctors and medical associates behave little informally among themselves. (4) The last part is the pathological room, where entrance is restricted as the operating room; but the here most of the pathological reports and equipment are maintained with high protection as these documents are much personal and essential for medication. Pathology rooms are usually not decorated. However, the excess decorations and

formalities of the waiting zone made the patients additional formal and they wait mostly in silence. The decorations and formalities put a psychological stress, so that the IVF seekers stay calm and systematic. The atmosphere of the chamber is also formal, until the doctor make patients easy to talk on their problem. The ambiance of the waiting zone turns the patients aloof from the outer world and it is the doctors who become the controller of the consultation session. In spite of having a huge number of patients with their relatives they lack agency as a result of decorative, formal and structural setting of the waiting zone and chamber. However, inside the operating room/delivery room the doctors, nurses and medical assistances play the role of supreme power and get informal among themselves. As none of the relatives of the patients is allowed inside that room, it is only the patient who enters there with a docile mind and body; it is the easiest place to mold and figure the patient according to the wish of the authority. The IVF seeker women feel much worried inside the delivery room. While they are very anxious about their babies to be delivered, the doctors and medical associates discuss about film-star's gossips, professional hazards and beautification among them. One of my respondents said, "ohh! Inside the delivery room…..it was horrible…its like 'Persona parlor'. All are girls and they shouting and gossiping of fairness cream and beautiful hair."

Thus, among the four zones of a hospital/clinic, the waiting zone, chamber and operation room influence the consumers in their own structural and formal way of representations. The patients behave according to the rules and

regulations given by the authorized people of the medical. The IVF seekers are the best to obey all the rules very carefully, unlike others patients of the hospitals. It is not only because of the formal structural form of the IVF unit, but also for the patient's complete ignorance of the treatment, make them dependable upon the authoritative power. But, the women as the compulsive treatment seeker keep on searching doors to know better about her body condition and scrutinize performances of the doctors and medical associates. Both rural and urban women of Bangladesh wait for a chance to ask doctors, medical associates, receptionist and the others (who are patients like them) if they are confused about the treatment. Thus, these women medicalized their body to cure but, never give up their awareness and show agency when they feel crucial.

5.4 Medicalized Infertility and Agency

Ann V. Bell(2010) has argued that medicalization of infertility, its pathological identification or treatment is more a social one than natural, which is dramatically increasing in the United States. All of the reproductive health sciences were developed to ensure the women to control their reproductive health; however as Greil (2002) claimed that to gain control over her own body women loss control by medicalizing herself. At the same time, women actively response to her bodily interventions by the medical associates Greil addressed. However, the assisted reproductive technologies belong to the experts and medical associates to do apply on women's body, according to the specific locus of the problem. In doing so, women and her accompanies built agency and argue

eventually to understand her own body. The process of infertility treatment varies according to the requirement of the specific bodily hitch. Though, to gain control women sometimes loss control over her body, but they are not the passive victim of assisted reproductive technologies Greil (2002), Letherby (2002), Parry (2005), Riessman (2000, 2002) and Todorova and Kotzeva (2003) have contended. In the context of Bangladesh, the women actively negotiate and show agency in various spaces, in both clinic and home.

The assisted reproductive technology is used in a personified shape to adjust with the docile body of woman. The first step for each requires case history (bodily experiences) of the infertile couple. In most cases, husbands hinder to visit infertility expert. The long listed pathological tests are given not only by the IVF experts, but also the gynecologists ask to do more than “10 tests” if the couple is facing fertility problem. Those who follow the prescription undergo the tests. While doing my field visits in different public and private hospital I asked both male and female whether they know about the tests given. They only can say “it’s a blood test or x-ray”, but do not know why these tests are given. Only few of the patients know detail of their tests though they have repeated these tests in different diagnostic centers, changed doctors frequently and tried to more by their own. The well-educated urban women are concerned about the side-effects and “doctor’s experiments” of infertility treatment, thus may avoid treatment, as Marina and Khaibar’s first wife didn’t proceed to have infertility treatment through assisted technologies. The fear of negative side-effects is high among the affluent well educated women of urban Dhaka. They

are much conscious about the reactions of different drugs and hormonal experiments. Most of the men want to avoid semen analysis and force their wives to do tests. Several men think that infertility is completely a female disease, thus male's body should not be interrogated, and the others apprehend their weakness to be revealed by semen analysis. However, women are always in a hurry to check their reproductive disorders very often than men. Most of the women check their signs of pregnancy, menstrual cycle and flow of blood during menstruation. Inhorn has described it as 'female scrutiny' as a part and parcel of female life in the context of Middle East. In addition she explored women are not only scrutinized by others for not having children, they also scrutiny themselves, their bodies and seeking patterns of menstruations cycles and searching symptoms of pregnancy. The women of Bangladesh also scrutinize their body and patterns of menstruation cycle. The respondents from poor and lower status group usually do not concerned of checking pregnancy frequently, whereas the urban and middle class educated women tend to search for pregnancy often. Thus, they feel more vulnerable and accuse themselves more than their counter women of rural, poor and lower status group.

In fact, the ICSI and IVF seeker women bear sorts of psycho-physical risk of their treatment from the begging of the infertile quests. These risks tend to have localized form of embodiment. The adverse reactions of the treatment both emotion and physical are same for both successful and unsuccessful patients. And the people of Bangladesh have embodied the nature of these treatments according to their cultural understanding. Among the 21 primary

infertility cases 7 were detected with male infertility problem. However, when couple fail to conceive the doctors provide tests for both male and female to identify the specific area of problem. As, I mentioned previously men usually do not have semen analysis until the wife's report healthy and fine. It is a matter of high disgrace to the male ego to have semen analysis in the cultural context of Bangladesh, where male ego perceives a notion of superiority in all ground. If man undergo his semen analysis firstly he keep it as a secret and hide the result even from his wife. And when the forces to know the result only then man informs her with a condition not to inform that he has done the tests. Semen analysis is a matter of lacking authority from the family and society as male ego perceive. Women basically face hormonal disorder, tubal or ovarian infertility problems. Many of these infertility problems could be solved with oral medication with hormonal injections and sometimes laparoscopic surgery. But, any over dose of these medications causes extreme damage to female reproductive health that could not be treated easily. However, all most all cases of male infertility require IUI or ICSI or IVF as a solution. Usually oral medication cannot give a fruitful result (in a limited time), whereas infertile patients reach doctor at the end of the reproductive age, so they run out of time. In these circumstances IVF becomes the only option for many.

Oral medication and injections usually do not make the couples worried as IUI, ICSI and IVF do. But, long term oral medication and injections increases women's body 'docile', thus they suffer from acute side effects about what they never knew. Compare to women men are afraid, toxic and stigmatized of

surgery and other assisted reproductive technologies to accomplish. The male infertility problems I have investigated are due to the poor quality and quantity of sperm, low motility etc. Doctors and wives usually think that the life style (smoking, alcohol consumption and ill eating) and over work (working in radiation and less rest) load is responsible for the increasing number of male infertility in Bangladesh. Whereas, female infertility are the result of late marriage, life style and some genetic problems as thought by the IVF seekers. The life cycle of an IVF/ICSI seeker turns traumatized; each and every step is thorny to spent, until a successful birth of baby. The stimulus given to increase the production of eggs makes women feel heavier lower abdomen, which is painful and uncomfortable to abide. Many feel bloating, vomiting, itching, gaining weight, pains in the injection areas etc. In the next stage, when egg is collected, so do the semen, couples wait for quality embryo. The weeks turn longer to cope. When ET has been done patients are told to rest for 3 day (varies according to the problem). But, in Bangladesh most of the women take complete bed rest for the 15 days unless they got a positive pregnancy blood report from the doctor. Most of women take bed rest in a fear to lose hope after embryo transfer. Thus, the assisted reproductive technologies come to it's seekers in a distinct nature to peruse their expectation in becoming mother.

The ultrasound was thought to be only test for the pregnant women, but the male organ need to go through ultrasound for testicular x-ray. Male infertility could be demonstrated via number tests which require the man to allow technical equipment over his body. Most of the man avoids those tests. As

gynecologist and IVF experts said that they rarely get male patients doing those tests at their first meeting. There are many those, who bring the male infertility tests one year after it was prescribed. Thus, the treatments are hindered due to male's ego and unwillingness to have tests. The embodiment of technologies to man's reproductive area defies the traditional male attitude of Bangladesh, where male never judged infertile often like female who are childless. The culture is embodied in the knowledge and people behave accordingly. The understanding of fertility, infertility and motherhood have embodied in the cognition of women according their socio-economic and psychological ambiance. The case of Maimuna can give gimps of her embodied knowledge and experience with other's embodiment of infertility treatment.

I met Maimuna at her home. She was carrying twin fetus by means of IVF. Maimuna welcomed me with a wide smile and explicated her journey of infertility and its treatment. She had to take leave from office to have this treatment. Her working environment was very challenging for her being infertile she explained. (See chapter 4). She had never taken her infertile condition seriously unless and until she invited relatives and friend on her second anniversary. She was an active, healthy, energetic and carrier oriented lady. Her life saddened when she understood her infertility. She always remembers the glorious student life of her. As a normal, active, healthy woman it was difficult to accept her failure to reproduce normally. She expressed her experience,

> "…when we had our second anniversary with no kid I understood its not normal anymore. Relatives of both side was asking various types of questions regarding child and our sex life. It was embracing. And it never stopped. I am having IVF, now still they are pinching me about how I feel….. They think IVF pregnancy is not like other normal pregnancy. People have some exotic understanding about IVF. Some think I don't have to take rest as it is a test tube baby...though it requires more safety and rest, which feels terrible at sometimes.… it was terrible to lay down on bed for 15 days; answering thousands of questions to relatives on overseas calls…."

Maimuna had her treatment at India. She said that many of her relatives usually don't communicate with her except eid day, but when they came to know about infertility treatment they started calling her on whatsup and viber frequently. Maimuna didn't attend those calls but her mother did. People poses their own understanding of infertility treatment, which are actually misconceptions, said Maimuna's mother. Maimuna's mother Laila Banu, who is 57years old was a headmistress of a school at Dhaka. She admitted that she knew about IVF treatment much before her daughter explained. It was easier to understand as some of her colleague's daughter also had IVF. Maimuna's mother said that she didn't like the treatment previously as many misconceptions are there regarding the treatment. She has an objection on the pictures shown in many clinics and even inside the doctor's chamber of coming babies out of a tube is recognized as IVF child. Laila Banu has to explain the total procedure of IVF to a number of her relative categorically.

The visual representation of IVF babies which are shown in infertility clinics make the little learners and general people confused about the treatment. The pictures put embedded cognition of the assisted reproduction, which creates disparities of knowledge on infertility treatment. Most of the people in Bangladesh have a common interest to know more about infertility treatment, more specifically about IVF. In doing the research I have faced a number of questions from my relative about the treatment. The people of Bangladesh urban or rural and educated or illiterate those who have heard of test-tube baby, encompass number of misconceptions embodied about assisted reproductive technologies. The list of queries IVF seeker face by the society is given bellow. Most of the IVF seekers find it as an awful experience of answering such question. Patients like Hira, who have no scientific knowledge about her treatment goes through added vulnerability attending atypical questions and faces cultural shock. Expect a few urban educated women; others (and their close ties) face questions from their relatives and neighbours. These people ask the treatment seekers in order to fulfill their exotic understanding of test-tube baby and pregnancy. Many of them are responsible for making the treatment stigmatized and striking to others, as urban educated IVF seekers presume. The infertile couples and their close kins are asked various questions from the relatives who know about the ongoing treatment, which are sometimes uncomfortable to answer. Many urban educated IVF seekers feel it as wired attitude.

Table 4: List of questions asked by the relatives for those who go through test-tube quest

Questions
Does it come from tube?
Does the pregnant mother feel vomiting and discomfort?
How many months of pregnancy are required? Is it like ours?
Is the pregnancy is occurred by husband's and wife's thing? How can you confirm 'no mixing'?
Will the test tube baby have the milk of mother?
Do these women can offer lactation?
Where is the scratched skin after delivery?
Why the husband is not with the wife? Is he not the real father?
Will the baby resemble father or mother or the doctor (!)?
Does religion permit test tube?
Isn't there high chance of having abnormal children?

Source: Fieldwork 2016-17

Many of my respondents admit that in Bangladesh women cannot prohibit themselves from asking questions about pregnancy and children, shortly after marriage. Bangladeshi women are habituated to show their knowledge and responsibility to share about pregnancy. Talking and gossiping on fertility, infertility, causes of infertility and the possible solutions are some feminine topics of discursions embodied in the cognition of married Bangladeshi women. Male and female react differently on knowing infertility and assisted

reproduction. Males ignore directly considering that it's a feminine topic to discuss, if he himself is not fighting with infertility. Females whisper on infertility treatments as the above negative attitudes are rooted about assisted reproduction (9 out of 10 women talk on fertility, sex and infertility once a week, whereas, 2 out of 10 men talk do so). Thus the phone calls appeared to Maimuna or her mother at the time of having infertility treatment, not to her husband, Tusher. Like other IVF seekers women, Maimuna also think that husbands are the most relaxed patient of IVF. Though the problem rest on a male body, the treatment in applied to the female body as, she is to carry the fetus. Thus, male's problem is never focused or clarified. Tusher, Maimuna's husband was never blamed for his infertility problem, nor was pinched by colleagues and forced to leave the job. Maimuna was sad and annoyed to say that it was like a vacation for him, coming to India, giving semen and going back to home. (more in chapter 6).

Both, the embodiment of drugs and sensitive words and attitudes put impact on the body of the IVF seeker women, but not much on men. It is the women who have to take drugs and go through pregnancy with in an assisted from, which hampers the total natural procedure of pregnancy for most of the women. the side effects of the IVF treatment traumatized a few women. As Khaibar's first wife didn't want to go through IVF for having baby. But she wanted to be mother, thus she left Khaibar, divorced and get remarried with a healthy man. As a matter of fact, her rigidity of not have IVF helped her to do so. According to Khaibar, she didn't want to lose her health as she came to know about some adverse effects

of the treatment and became afraid of such treatment. Khaibar's infertile condition made him socially weak to confront his position that the time of divorce. This is not usual for the middle class people here in Bangladesh. His first wife was from a highly educated, affluent family which let her to be much expressive than other middle class women of Bangladesh. On a contrary, Marina also from educated affluent background didn't want to go through ICSI/IVF out of fear, according to her mother in law, whereas she said that she didn't want to have drugs to have baby. Her husband Bijoy stayed clam with her knowing all psycho-physical lacking of Marina. Class and status play influential role to be medicalized infertile and take risk of the IVF/ICSI. Thus, Marina's infertility problem and avoidance to assisted reproductive technology didn't let Bijoy to stop their conjugal life. But, Khabar's wife didn't want to live a life without kid as she is in good health, thus divorced Khaibar, whereas Shapla, the lower middle class lady agreed to get pregnant through IVF for Khaibar's infertility. Both Marina and Khaibar wife are from well educated, affluent family thus didn't want to have any adverse effect of the medication of ICSI/IVF. Shapla's economic and social dependency let her follow husband's wish, the same goes for Hira, too. Hira's rural background and lack of knowledge about the infertility treatment helped her husband, Akhter to convince. The pains and traumas Hira have embodied are out her obedience to husband, not her willingness to be mother. As she said that if she knew that coitus is painful and so is the long treatment she would not think of baby now.

The knowledge of reproduction and assisted reproductive technology is highly stratified and gendered in Bangladesh. Both male and female are not aware of their reproductive health. Only a few are guided by the elderly relatives about their health and functions of bodily part. Many times they are misguided, too. Thus, sometimes it turns difficult for the doctors to make the general people understand the actual reproductive health problem. However, the superiority of the medical knowledge put doctors and experts in the top rank, thus they implement their knowledge, power and authority over the consumers of the infertility treatment.

*5.5 **Power and Body Politics***

Assisted reproductive technologies have increased male domination on female reproductive health. The problem rests in male body and treatment failure or success depends on female body. In reality, it could not be solved unless and until medical science experiences an artificial womb to conceive and carry the fetus. The natural procedure of carrying fetus and giving birth is still the womanly duty and thus, the male could pass his responsibility by only having a semen analysis and if required semen collection so that the embryologists could create the embryo combining the egg of the female. If any reproductive failure occurs it is the female body which requires going through a number of diagnoses. The common female tests are like serum hormonal analysis, pelvic ultrasound, genital x-rays, MRI, hystero-salpingogram, FNAC guides by CT scan and more. Among these HSG (hystero-salpingography) is the most painful experience; FNAC (for detecting any malignancy) is also painful, only

a few usually have FNAC. However, pelvic ultrasound and genital x-rays are the most common tests to understand the primary problems in a female body. All of the women I asked admit their timidity of having these tests for the first time. None had the idea of those tests before entering the ultra sound room. One of my respondents recollected her experience of having first pelvic tests and she expressed her experience like this,

> I entered the room (ultra-sound room at a private clinic of Dhaka), with a water full stomach…as I knew it was required …I had ultrasound test earlier…..But the assistant of that doctor (sonogarpher) told me to undress my panty! I was shocked for a while. "Why?" I screamed! She responded with a joking smile which humiliated me much, "sister, you are born as a female, you have to go through much more." (*apu, meye hoye jonmaichen..aro koto kisu korte hoibo).*

The physical weakness of being mother has put the women's personal body unveiled in such manner that many fear, scream, and feel humiliated and ashamed of being women. There are many patients those who come for reproductive health problem under go through the same tests, disclosed their humiliation in doing internal sonography. Some of the patients remain undiagnosed as they disagree to do the sonography. However, the IUI, ICSI and IVF require more intense observation and application on women's reproductive organ. Thus, it requires a mental preparation to uncover private bodily part of the women under the observation of medical authority.

The power of 'knowing' the body lies with the ability for expert reading of it, and achieved at the expense of those who are subject of the power of the gaze. Addressing skeletal body as 'anatomical atlas', Armstrong (1983:2) suggested that the development of this 'anatomical atlas' was vital in the construction of the 'political anatomy' or bio-politics of the body. The anatomical atlas directs attention to certain structures, certain similarities, certain systems and not others, in so doing forms a set of rules for reading the body, and for making it intelligible. In this sense, the reality of the body is only established by the observing eye that reads it. The atlas enables the anatomy student, when faced with the undifferentiated shapeless mass of the body, to see certain things and ignore others. In effect, what the student sees is not the atlas as a representation of the body, but the body as a representation of the atlas. The atlas is therefore a means of interpreting the body, of seeing its form and nature and establishing its reality. (Armstrong, 1983:2)

In the same way, the sonographer and the medical associates deal with the patients by reading the body and putting their knowledge as a bio-politics of human body, which shakes the womanly tenderness into fear with a withdrawal mind to medication. Thus, one either should surrender her private bodily parts or to stop any form of diagnosis. The medical language, the power of knowing the body anatomy and secrets of treatment increases the power of the medical bodies and made the patients more dependable to the medical associates. Therefore, the supremacy of the embryologists, IVF experts, gynecologists and medical associates control the bio politics of body and

create distinction between normal and assisted conception, though the conception and pregnancy more or less hold the same features.

However, under the control of patriarchal medical associates the locus infertile consumers, that is the women exercise their embodied knowledge and endeavor to grab the procedure of treatment. They seek for the advantage and disadvantages of each step by searching their contemporary IVF/ ICSI patients. They consult and argue with the medical assistants if anything bothers them. At times, I have seen female IVF positive patients yell outside the doctor's chamber and emotionally grab attention of doctor's assistant, so that she could visit the doctor without serial number. Many female patients pretend weak to get attention and keep them safe in the crowed lobby of the IVF experts. According to many female IVF seekers, the medical associates are not kind and compassionate, they do business with life and death; thus the "patient party" should be very careful and gather knowledge about their right to get proper attention. Moreover, these women act as self-defending body that struggle not only against their natural body (applying enormous drugs) but also conceal pain, emotion and resist patriarchal decisions in their own means. They strategically manage their husbands to do the tests (semen analysis etc) and visit infertility experts with them. Thus, both in private and public world women perform and rise their voice according. In most cases it was the women who decide doctor's appointment and changes doctor if they feel. Correspondingly, in the studies of Greil(1991a), Daniluk (2001), Webb and Daniluk(1999), Thorsby and Gill (2004) and Begum (2015) we find that wives

(with infertility problem) are more treatment oriented compare to their husbands. Nonetheless, it is the women who become much stressful at the same time. In his work Yebei (2000) viewed that Ghanaian women in The Netherlands found infertility treatment unpleasant and emotionally draining. Husbands, too, find treatment stressful (Schneider and Forthofer 2005), but men who perceive healthcare professionals as supportive report lower levels of stress and anxiety (Brucker and McKenry 2004). In order to decrease these anxiety and discomfort, many IVF seeker women have a network among them; they converse and solve their problems that hamper their conjugal life, social living and medical decisions. Even there are facebook groups where women converse and support infertile women by giving information of treatments and suitable doctors. Their self arranging strategic efforts help them to peruse the treatment as there is really lack of psychological counseling at the infertility centers of Bangladesh. In their study, Redshaw and others have (2007) investigated that patients consider themselves that they have little control over treatment and that they are being ill-treated, as if infertile people are not normal beings. Similarly, I have observed that patients of infertility also feel they have little control over treatment, but the keep searching for the best option they could afford, ask questions about their body and bargain for their desired solutions whenever they get favorable situation.

However, the social scenario and local belief system minimize the conscious active role and assist people to be strategic to overcome odds of ethical consideration of assisted reproductive technologies. The normalization of

motherhood has made infertile a stigma. The following chapter will elaborately discuss on the infertility stigma and IVF. Moreover, it has explained how western technology is subjugated, reformed and experienced in other cultures, like Bangladesh. The influence of local belief system and social sterility upon infertile and IVF seekers are also explained in the next chapter.

Chapter 6

Belief and Socio-ethical View on Assisted Reproductive Technology (ART)

> "The science-god sends people to the moon, inoculates people against disease, and transports images through vast spaces so that they can be seen in our living rooms. It is a mighty god and, like more ancient ones, gives people a measure of control over their lives. Some say the science-god gives more control and more power than any other god before it. But we know, and each day receives confirmation of it, that this is a false god. It is a god that speaks to us of power, not limits; speaks to us of ownership, not stewardship; speaks to us only of rights, not responsibilities; speaks to us of self aggrandizement, not humility." (Postman:1997)

As Postman view's technology and science as god or false god, he gradually states all innovations of humankind are not what god has given, thus god will not be responsible on any harm occurring to human being out of critical innovation. Though modern life is obsessed and controlled by technologies, people do not grant technology and science as their god. Belief upon god, the supreme thus took an upholding position in Asian societies like Bangladesh. But, still people appreciate and willingly wish to observe the scientific power to achieve miracles. Thus, in crucial situation the doctors become their security to live longer, a false god. However, people's perception is constituted by the exiting local knowledge, cultural ambiance, kinship system, moral thinking and belief system. Local knowledge and cultural ambiance has been assimilated with the religious view

of its inhabitants. Consequently, the pro-natal attitude of the society is not only the cultural constitution, but also the lawful religious *fatwa*, not to use contraception and keep faith on Allah, who will serve food and need for as many infant as he give. Thus, infertility is judged as a result of sin, as children are the precious gift of Allah. This chapter will focus on the stigmatized notion towards infertility and its modern technological treatments and how the religious context of the society is shaping the overall process, and; monitor and peruse infertile people to their living.

In Islam parents are given supreme position if they could raise children following Islam. Mothers are given more priority. In a contrary, the people who are not blessed by the children naturally are thought to be detested by the almighty (Maloney: 1981). In Bangladesh, it is unusual that couples remain voluntary childless. Being childless is a deviant, unwise and awful act to the society and religion in Bangladesh. And people consider it as a punishment or curse. Thus, people search the solution to their infertility by their own means of knowledge and perceptions. Infertility is considered as a social status. Though it might cause by any physical anomalies, most of the people blame social occurring, behavior and fate for infertility. Infertile man and women also blame themselves, feel guilty and accuse their bad luck (see chapter 3). Thus, infertility is judged in its own localized context of living. Societies with strong belief system view infertility in their own way of understanding. Like the west, the non-western societies cannot hide infertility in a polite way, as mentioned by Balen and Inhorn (2002, p9). Infertile social status is stigmatized, thus men and

women turns unresponsive and withdraws from normal living with family and peer group. Accordingly, infertile position cannot only be treated by gynecologists; the stigmatized attitudes towards infertile couples lead other psychological disorders, which also need to be taken under consideration. The experience of infertility and the response to assisted reproductive technologies varies according to its availability and belief system of certain society. Assisted reproductive technologies have encountered a number of ethical issues, as it contradicts the Islamic ethics and may appears as a risk to the existing kinship system we have. Thus, the Middle Eastern societies have formulated *fatwas* to have the Islamic use of assisted reproductive technologies. Accordingly, the infertility services in Bangladesh also do not approve any donor banks of eggs or sperm or ovary legally. As a result, any kind of third party donation is not executed under the supervision of any doctors, claimed the Dr. Omaira Enam, the IVF expert I interviewed. But, there are people who gossip about third party involvement and surrogacy. The tittle-tattle on infertility and assisted reproductive technologies indicates the stigmatized notion of thinking and acting. The belief system and social expectations on fertility and childbirth embedded in the cognition of the mass population of the society. Therefore, stigma of physical disability, fear of losing purity and running against the wind chase the life of infertile men and women.

As mentioned, this chapter will enable us to know how stigma is produced and perceived by the victims and to what extend people suffer for the stigmatized view of others. The Islamic use of assisted reproductive technology is narrated

in this chapter. The global Muslim world has shaped the biotechnological conception by *fatwa*. I will search the conception and experiences of orthodox Muslims and ordinary Muslims regarding infertility and its biomedical treatment of IVF/ICSI. How ordinary, practicing Muslims find a way out of their infertility problem by their own understanding and necessity is discuss in the following chapter. Adoption as a choice for infertile couples is unveiled and demonstrated here. Inhorn's (2003) experiences on the Egyptian infertile patients and the importance of their local moralities in shaping the application of new reproductive technologies will be compare with the Bangladeshi infertile people's experiences and their encounter with ART and local cultural belief system.

6.1 Stigma of Infertility and IVF

Being infertile is stigmatized in Bangladesh like many other societies around the world. But, unlike, west it is difficult to conceal women's infertility as close bond with relatives and informal texture of the relations let people ask on fertility issues. More or less marriage occurs at an early age and married couple usually do not wait too long to have child as, children are considered social assets. However, few urban working women tend to wait till some occupational achievements. In the context of Bangladesh, if any couple has their own family planning strategy, others stars thinking of their infertility, stars advising them to visit *huzur* or *fokir* or doctors, and let them feel stigmatized. Telling them that 'we are not planning to be pregnant' seems an offense in Bangladesh. As Maimuna never tried to get pregnant before their second anniversary, where the

invited guests (those who are her relatives) gave her feelings of childlessness; she felt stigmatized. In the wider society of Bangladesh it is more usual that relative and neighbor nudge every married couple to have children, if the couple delays people consider it as 'infertile' and make them feel stigmatized by categorizing them. Involuntary childlessness is the most terrible stigmatized situation for the married women in Bangladesh. The sense of not being in the right track pushes the infertile women immensely. The bodily anomalies are not taken easily in the case with childlessness. As Goffman's concept of stigma has been adopted in Sandelowski's ethnographic work, *With Child in Mind: Studies of Personal Encounter with Infertility* (1993), where she describes how infertility becomes a 'master status' for some men and women, where some pervade spoil their identity and the perceived judgments and misunderstanding from others which make them feel vulnerable and painful experiences as a result of other's insensitiveness. Infertile people feel alienated from their peer group and lack the normality of life. Sandelowski defines infertility as a social disease, where infertile people perceive 'otherness' and 'alone in a crowd.' Women those are housewives feels lonely and devastating at home without babies to cuddle as others of her age are busy with their babies. The days are long for them. The aged lady I met, named Khuku, who adopted a son remembered her days without any child. She had nothing to do at home after cooking. She used to visit other relative where the only topic raised was her childless misfortune and different exotic medicine to her solution. All these discussion made her psychologically disheartened that she stopped going to those place. Her own house was an empty

vessel as her womb. Many suggested her to join any office or do business, so that her mind remains busy. It may help her not feeling 'the other', working with many at office. However, she herself didn't join any office. But, I have investigated working infertile women' prickly experiences at their office (see chapter 4). The psycho-social challenges that women face regarding their empty womb put them into a black-hole of stigma, where they feel lost.

Though the tradition practices of excluding infertile women from different event (like, not allowing her to touch the would be bride, remain absent at *holud kota*, *gaye holud*, *bou-boron*, *saad/shat*, *atur ghor etc*) is not seen much at urban Dhaka, though few people whisper on such presence of infertile women. But, the rural societies still have the feelings to avoid infertile man and woman from auspicious occasions of other's life. In most cases the infertile people themselves avoid those occasions so that they are not blamed for anyone's misfortune. Kusum Rani's mother portrays the picture of traditional rural woman of Bangladesh. Thus, Kusum Rani's mother was telling her sister's infertile hardships in a low voice at the clinic bed with her daughter.

> "my sister have a big house, just beside the *pakka* road of the village. You will not understand (as she consider me as an urban settler) the importance of the position of that house. Such fresh cool wind will fly you at summer. But, she was infertile…thus; none come to her house from the *para*. Even they ask her to make a wall beside the road, as a distinction between house and road, so that others need not to see her face while going for any work or auspicious event. Infertility is such a pain. With the

> kindness of *Jagannath*, she had given birth of a baby after 17 years of her marriage. But, unfortunately, it was a daughter. Do you know daughter is of no work at village? You have to pay 1 *lac* as dowry for a salaried groom."

The patriarchal pronatal society has blamed their infertile women and mother of daughters (in many cases) for their bad luck and non-productive, barren living. In most cases it is the fertile women who constantly provoke the infertile women about their miserable psycho-social condition. The most devastating experience is when an infertile understand that many of her fertile female relatives and friends do not want their children to be close to infertile women, out of the fear of envy. Similarly, Inhorn opined that fear of envy exists in Egypt and IVF seekers couple have many other rationales to keep the stories of trails secret. Thus, the infertile status alienated the people from the social events, which directly and indirectly force them to consider themselves as defective and 'of no work'. Life turns burden for many. Some of them who are lucky to get treated do not want to remember her previous frustration, agony and stigmatized notion of living. As Hira's husband told me that Hira tried to commit suicide before coming for treatment at Dhaka, about which Hira never told me herself. According to her husband, she was terrified by her *ja*'s non-corporation, offensive and rude behavior. As a young married girl Hira was not much anxious about her childlessness, she was worried about her pain during coitus. But, it was her *ja* who made her felt guilty for not having baby. The existing stigma and blame make the life of infertile couple miserable. The notion of stigma is

culturally constructed and learned by the existing social practices. Hira, the rural woman and Maimuna, the urban educated woman, both were socially forced to feel stigmatized of not having baby. Both were not concern about their childless status much, but the social expectation of having baby after the successive year of marriage pressurize them to think accordingly. Having a child at that early stage of marriage was not much important for either Hira or Maimuna; there are others who also had the same feeling of social demand from the elderly people both kin and non-kin. Thus, the infertile position of a woman is imposed as her 'master status' by her social surroundings.

Apart from the stereotype 'master status' of infertility, I see Rupmoti, as not feeling stigmatized to her infertile problem. She never thought of other's understanding of her conjugal life or infertility. She believes that she may have some physical anomalies and if *Allah* wishes everything would be fine. Thus, she does not feel anxious or shy about her infertile status. She works her own living as non-resident home-maid and sends money to her parent every alternative month. The case of Lipi is more divergent in this chapter context. Lipi is not doomed for her infertility with small uterus. Her first husband wanted to have a second wife who will give birth to children; but he did not want to divorce her. (Divorce is also considered stigma in the urban middle class society.) It was Lipi who divorced that man following her father's advice. And she got married with another man by offering dowry. She has accepted her infertility, so do her new husband and his family. At times she feels sad for not having baby, but did not let it be her 'master status'. Here, dowry worked as an agency to protect the

weak woman's social position. As Arens (2014) have noted in her latest work that poor rural women find dowry as good for them, though it may cause financial crisis for their parents. However, educated middle class women face stigma of being childless more than others as far I experienced. On a contrary, Papreen Nahar draws some opposites to my observation. She has presented three women from educated urban sector those who do not experience that being infertile could make them stigmatized; they have introduced themselves as infertile, though actually they have chosen to be voluntary childless, in order to build their career. Still, these women do not represent the wider society of Bangladesh (Nahar: 2015). Though, Nahar argued that these three educated urban women think that their infertile identity will not make them feel stigmatize, but whether others (wider society) think in the same way about those three is yet to be unveiled by her. Moreover, most Bangladeshi consider voluntary childless as a deviant act, injustice to the nature and society. As a whole, childless situation for a couple after one and half years of married life through them in the gust of stigma and draft them in the periphery of the wider family and society; where they belong, I experience.

In my fieldwork I did not find any one who profoundly interested to give their identity and wanted to talk with me with a fear free mind. Many of my conversation started in a whispering mode. Each time I had to either convince them or meet them with some other's references. These references helped me to be trustworthy to them. Otherwise, the fieldwork would not be easy. Thus, I faced a stigmatized attitude towards IVF/ICSI among the provider and seekers

as a whole. Even the couples who are seeking these treatments confidently believe that others are having a stigmatized notion toward them. Thus, they don't want to talk on their infertility and its treatment. There are some who do not even inform close relatives about their treatment. A fear of acceptance of the IVF baby and treatment has been experienced in my study (more in chapter 7). In many ways women find that IVF conception may undermine her position as a 'mother', in her in-laws family and it makes her feel socially fragile and vulnerable.

Lamia and Sohan represented a compatible urban elite couple with whom I meet several times, at clinic and snack bar. They have helped me talking on their experience of hiding the 'test-tube baby stigma' to Lamia's in laws. Lamia is 33 years old from a middle class ordinary family. Coming from a *moffoshsal* town (sub-district town) of Bangladesh made her feeling underestimated by her in laws, thus, she never wanted them to know her failure in producing baby normally. Thus, she refused to go abroad and have treatment. She took help of her *mami,* who is her only relative living at Dhaka. Lamia's *mami* helped her in many ways hiding the actual way of her pregnancy. Lamia believes that if her in-laws came to know about the treatment they will be much angry and if they knew about her problem they will not let Sohan be with her. However, Sohan supported her in hiding everything, but he told me that Lamia is wrong about his relatives. He believes that his mother and sister would not do any harm to their relationship if they knew about Lamia's fertility problem. Sohan admits that his mother and sister have a "strong and moody" personality, which does not mean they will not accept her with problem. "its all Lamia's misconception. But, I

listen to her so that she will remain happy. I love her." Though I am doubtful about Sohan's promise that his relatives do not know about Lamia's fertility problem and IVF conception, because, they live with Sohan's mother. The drugs that Lamia takes may warn Sohan's mother, as I guess. Lamia confirmed that she was living with her *mami* during her operations and ET period, lying that she is going to visit her natal home, which is far from Dhaka. Thus, Lamia is afraid of her in-law's stigmatized attitude and avoided them strategically. Lamia's stigma of infertility, her weak self-esteem and inferiority complex made her to be strategic. Lamia and Sohan decided to have treatment at IVF clinic after they were confirmed Lamia ovarian problem by a gynecologist. They have conferred with their friends; one of them also treated her infertility problem, by the same doctor they are now consulting. Sohan was pleased and appreciated the treatment while talking with his friend. Sohan's friends help them to boost their mental strength as it was not that easy to start the treatment hiding relatives with whom you live. Moreover, Lamia's *mami* was much accommodating to take her home during painful days. This *mami* also thinks that Lamia's mother-in-law will not accept her with infertility.

The notion of fear and shame influence people to treat the assisted treatment in various ways. Lamia assumes that her in-law will think she is of not work if they know about her reproductive shortcomings. Lamia is also afraid of her in-law's perception on the treatment, but she has a relation of trust and love with her husband; whereas, I see Jara who does not know that her husband Saimum himself is not ready to start the treatment. Jara and Saimum was attending

infertility clinic with a hope to be parent. While talking with Saimum alone, he rectified his wiliness to wait for a normal conception rather than a technological one. He was trying to convince Jara by asking how they could manage their old parent those who have no idea of these treatments. Thus, Saimum hides his stigmatized notion towards IVF/ICSI in front of his wife, who was ready to face the treatment but worried about the finance, other family members and success of the treatment. As men have distinct challenges, compare the women (as discussed is chapter 3), their way of dealings and stigma varies. The common expression of the men is to denial the situation and blame himself frequently, though they usually do not protest any rude or unfavorable attitude to their counterpart. In fact, infertile men are excluding themselves from many social gathering, too. Furthermore, it is always the women who humiliate other infertile women and make sure that women are more glorious, happy and powerful with children. On a contrary, these fertile women show pity for the infertile men. Unlike infertile women, infertile men are given priority in different social gathering from in-laws, so that they do not feel humiliated for their short coming. It is very rare that women left their husband for infertility. Thus, I observe that stigma regarding stigma is much a woman oriented issue. And the patriarchal society is determined not to make it's male feel low, inferior and stigmatized.

In addition, I have seen that infertility is a stigma among the people of Bangladesh. And, socio-culturally diversified people deal with it differently. Firstly, people who are stigmatized (feeling of alienation), secondly, people think that others are stigmatized (fear of exclusion) and lastly, people those who hide

their own stigma (false identity). The first group of people has feeling of alienation. They think if they disclose their problem or they admit these treatments it may harm them in many ways, spiritual and social. Thus, they feel alien and dissimilar; possess a master status of infertility or IVF/ICSI seeker. The second group takes assisted reproductive technologies in a positive way but worried about the wider society to accept IVF infants. Thus, they have a fear of exclusion. This second group remains silent and performs a stigmatized role in front of others though they have appreciated the technology. The above two groups are the infertile people and IVF/ICSI seekers, who sometimes changes their value of thinking on assisted reproductive technologies in their time-span. The third group of people comprises dual personality, those who act that these treatments are usual and wise contribution of science and technology, but they are not ready to accept these treatments for their own or they will not suggest their close kins who are suffering from infertility. This personified stigma is rooted among the wider society of Bangladesh. Among, the 10 fertile couple (both men and women) I have interviewed most of them belong to the third group. People try to establish their positive attitude towards science, but their religious and cultural understanding and notions of reproduction put them in a dilemma to accept assisted reproductive technologies. Only 2 two fertile couple showed their negative statements towards these treatments. Whereas, the 8 couples think it's tolerable if someone need, but they would not try these treatment (if they required ART to have children) as it may harm religion, mother body's, infant's normal growth and last but not the least loss the financial

strength. They also think that test-tube babies will not have a normal life like others. They may come with defaults as Allah only can give healthy infant, not the doctors. They are worried of the high dose medicines and more rigidly mixing of egg or sperms. As a matter of fact, technological orientation of reproductive technologies is not as such known in Bangladesh. Correspondingly, Inhorn (2003) has explored that the common people in Egypt do not like the IVF treatments and show negative attitudes towards it's application; whereas inside the infertility clinic, the scenario is complete opposite, where number of infertile couples are eagerly waiting for a solution to their infertility through assisted reproductive technologies and confirms IVF as a key to their parenthood.

6.2 Technology and Culture

In Bangladesh people are not much familiar with technologies related with reproduction, expect the contraceptive (which had a long way of government and NGO campaign). Here, I want to categorize people into three different groups to deal with technologies. I consider the first group as 'reserve techno-group'. They are those, who have no willingness to know about new technology. They want to settle with the existing technology and customs. The first group usually cannot overcome their stigma of having anything new in their life. They are static and do not want any change in their life. They feel that they are the victim of any certain situation and technological solution will not suit them. To some extent, they are anti-development and close to nature and god. Second group wants to know the use of technology but will not use for themselves for various reasons (for example, stigma, financial solvency, shyness etc). The second group has

chances to change and defeat stigma, if miracles took place. This group of people changes their decision according to the demanding situation and after a long of calculations of the prospects and consequences of certain technologies. They belong to the traditions, but want to bring changes which will not charge their belief and ethics of living. They are smart to choose their decision, they are considered as 'smart techno-group'. The third group of people appreciates new technologies and wants to use if required. The third group is free from stigma; they are driven by their own will power. This group of people is less in number. They are mostly self-made hardworking people, who thinks they are enough responsible to take right decision. Those who became socially and financially successful by their own usually omit the broader cultural understanding of technological interventions. I regard them as 'ultra techno-group'. Acceptance of certain technology depends on people's perception of problem, sincerity to seek the solution, economical and religious choice and affordability.

Firat Alagoz, Martina Ziefle, Wiktoria Wikowska and Andre Calero Valdez (2011) have seen that cultural factors and knowledge gap affect the acceptance of medical technology. In their study in Germany, Poland and Turkey, the researchers have seen the acceptance of medical technology cross-culturally, where they have found significance of cultural factors on technology acceptance. Medical technology acceptance patterns vary according to age, gender and health status. Like Alagoz and others I have seen that women are profoundly accept medical technology than that of men. In most cases, it is the women who initiates the infertility treatment and convince others including husbands. As I have

already talked of Saira who was forcing her husband to agree for the treatment and requested me more than once to make her husband accept IVF. Sakira who failed twice IVF, still have hope for her treatment, but her husband is not willing to have IVF anymore. He thinks that IVF experts are doing business. Mashuk (Saira's husband) also thinks this way. At times Mashuk thought me as an agent of infertility treatment. However, I tried to make him realize my position of being a researcher. Thus, men have distinct notion regarding the technological intervention in reproduction. These technologies have nothing to do with a 'barren' body as Sakira's husband told to her. Sakira had hardship to make her husband agree for the treatment. Though, her husband helps her while taking her to clinics and tests hundreds of time. He was never happy with it. He wants Sakira to stop this treatment. But Sakira is attempting to have the next cycle. She told me that her husband will never agree unless she threat him divorce. Thus, the conjugal life faces ups and downs as cultural factors guide and put its hand in accepting medical technologies. Couples those who have gone through IVF/ICSI once have faced a number of barriers to cross. When I was talking with Sakira, her husband was outside having coconut water. He avoided me to talk on any issue of their treatment. He only brings her and takes part by giving sperm at laboratory; otherwise, he is much pessimistic about the treatment. Sakira thinks that, her husband loves her and will do the IVF again, though he does not believe in it.

Khaibar, Sohan and Akhter though belong to different socio-economic status accepted the technological intervention easily. Others rested long to accept

wife's decision. Akhter came to know about assisted reproductive technologies while he was working abroad as labour, which helped him to accept the treatment easily compare to other men of Bangladesh. Khaibar and Sohan both belong to educated wealthy families of Dhaka, who visit other countries frequently for business. Both have good social exposure and surroundings, thus they accepted these technologies for their fluidity to other cultures. But, others were more conservative in accepting technological intervention of the treatment. I have interrogated that in general women are more positive and teemed to medical technologies than men of Bangladesh. Social and global exposure play vital role to modify men's attitude towards medical technology like IVF/ICSI. While, women's social vulnerability for being infertile force them to accept these technologies.

6.3 Infertility, Adoption and Islam

Islam encourages marriage at an early age, which will enhance the opportunity of the couple to have more children. Thus, Islam posses a pro-natal attitude to its believers, as result infertility is considered as a sinful offence to the Muslim societies. According to Islam, mothers are given higher value/position in society and heaven as they go through painful pregnancy, delivery, child feeding and rearing. And it is a prime duty of the Muslims to raise children in a good religious manner, so that Islam will be cherished and more globalized generation after generation. There are infertile couples those who have failed or didn't approach ART, but adopted child from relative or orphanage. Adoption is not only a stress relief for the infertile couples, in many cases people adopt needy or orphan

children out of generosity in Bangladesh. Thus, adoption is considered as a good deed. Many of the infertile people's relatives admire adoption as a rise to motherhood instinct especially for the infertile women. Adoption is well- known is Bangladesh as psychological relief of the infertile couples, though; it does not let the society claim that the couple is no more infertile. Moreover, it turns as an issue of converse among the relatives of that infertile couple. Here, I will consider two cases of adoption. The first one I met was a 54 years old lady Khuku, about whom I discussed earlier in this chapter. She was suffering from infertility. She understood her problem almost 30 years back, but her husband denied visiting any doctor. At a point of her life she turned psychologically unstable for not having a child, she left her job from a school and even stopped cooking and doing other household chores. She lost all her interest in doing these. She was suffering from depression. At last, when her husband agreed to visit India for medical investigation they both were diagnosed with reproductive problems. But, it was too late to do treatment as Khuku was 40 years old, that time. Khuku was unstable and depressed after knowing that there is no hope left. Hence, they go for another solution of adopting a new born from Khuku's close relative. The case of Khuku also resembles a different picture of the biological parents of the baby boy, who sacrificed their parenthood for the sack of Khuku's peace and happiness. The biological mother of the boy has three children of her own. She decided to give Khuku this boy when she was 5 month pregnant. After delivery she didn't see her baby and given him to Khuku. Now, that adopted boy is 10 years old. Still, he does not know about his biological parents, though his

biological parents visit him once or twice a year. He is introduced with his own siblings as cousins. Khuku is having a normal life after adopting the baby boy; and she was always much caring of her adopted son compare to others according to her relatives. However, her in- laws did not appreciate Khuku and her husband decision of having an adopted son. Khuku assumes that they wanted her to be barren so that they (her in laws) could easily become the next heir. Still, now she worries, thus some of her property is already given her adopted son’s name as heir. Khuku’s husband loves and cares for the adopted son, too. Though adoption is a social practice, the law does not allow the adopted children to be the heir of property of family title. Thus, Khuku and her husband are worried of and planning to settle disputes with the other relatives. Though Khuku expressed her anger and disrespect for her brother in laws, she said that she behaves well to them, so that they will not do any harm. According to Khuku, her bother in laws are not that pious, but when it comes to property they say that no property will be given to the adopted kid as law and religion guides. They try to use their religion when it is in their favour, otherwise they forget to say prayer properly.

Islam encourages raising and taking care of the poor and orphan. But, on the issues like adoption is not cleared to the common believers. According to the *Quran*, one cannot become a person's real son merely by virtue of a declaration; Allah Says (what means): "...And He [i.e., Allah] has not made your claimed [i.e., adopted] sons your [true] sons. That is [merely] your saying by your mouths, but Allah says the truth, and He guides to the [right] way. Call them [i.e., the adopted children] by [the names of] their fathers; it is more just in the

sight of Allah. But if you do not know their fathers, they are your brothers in religion…" [*Quran* 33: 4-5] Thus, the declaration of adoption is claimed as unfair in *shariah* law. The natural parent-child relation has given higher value and it is expected to call children by their father's name. The biological parent's blood resembles the genetic characteristics and physical-mental establishment of the children. Islam also prohibits giving property to the adopted children by disappointing own blood.

Khuku and her husband both are pious. Khuku covers herself with *burkha*. And her husband kept a long beard after the *haj,* they done. I observed them saying prayers and doing other religious duties properly, but when it comes with their understanding of Islamic rightful application of adoption they remained silent. I asked Khuku about it, she was not willing to answer, but her husband said, "Islam is for peace. I am having a peaceful life now…we had to it, unless we could loss her. I lacked a family life before adopting my son". Indeed, people always do what is good or convenient for them, not what should be done as a believer. However, this adoption has caused uneven and untruthful relations among relatives, which Islam discourages.

The second case of adoption I experienced very closely. It was one of my landlords's cousin. I know the cousin's wife and her mother in law well. Mrs. Amerum, the mother in law never proudly introduced her daughter in law Sheba after knowing her infertile body. Sheba is a doctor herself and her husband is working at a bank. Sheba and her husband visited infertility clinics home and

abroad many times. But, unfortunately none of the treatment was successful. They stopped searching for treatment further and decided to adopt an orphan. It was very difficult to convince Mrs. Amerum and other members of the family. Sheba and her husband kept on trying for years. But, Mrs. Amerun and her husband wanted to have a grandson of their own blood, thus didn't agree with Sheba. Meanwhile, the second daughter-in-law of Mrs. Amerun delivered a baby boy, the expected heir, which helped Sheba and her husband to convince the family to adopt. Sheba was called 'mad' to adopt child from various relatives. But, their frequent IVF failure made them to decide for adoption. At last, in the May 2017 Sheba's husband adopt a girl of 8 months old. Every day new toys and necessary items were bought by the relatives. But, still Sheba understands her mother in law is not happy with the adopted girl. When Sheba goes to the hospital (where she works), her mother in law does not take care of the girl; thus either Sheba's parents (who lives on the other side of the road) or the chauffer carry the adopted girl. I meet Sheba on our way to go home and conversed many times. Sheba and her husband are happy with the girl. They are optimistic that Mrs. Amerun will accept their adopted girl soon. I occasionally see Mrs. Amerun. In a response about the adopted girl, she smiled and answered that the baby is cared by her mother and she is old to take care of this new baby girl. She was unwilling to answer my questions on the issue. However, Sheba and her husband consider Mrs. Amerun's feelings. They assume that like other members of the family Mrs. Amerun will also acknowledge the adopted girl when she would her "*dadumoni*". Sheba is trying to help the adopted girl to call *dadumoni*

before *ma*. Her incapability of being biological mother turns like a guilt. Though she admits that she lacks motherly instinct regarding caring of the adopted baby (as she lacks biological ties), she is happy to have this 8 months old baby girl. However, the next challenge appears on the issue of acceptance by the other members of the family Sheba confirms. Both Sheba and her husband understand that people will talk on the issue of adoption and their unsuccessful trails of infertility treatments, but gradually everything will be regularized with the space of time, they believe. On a conversation with Sheba's husband I asked him, what are things they considered before choosing a baby to adopt? He said that firstly, they wanted a girl so his siblings will not worry much, as girls would get less property. Secondly, they tried to find a baby of their skin complexion or hair texture to find a physical similarity. Thirdly, they wanted to adopt an orphan baby girl, so that no one could claim her later. They are happy they got according to their will, but still many legal works need to be done with the orphanage, which are stressful according to him. Sometimes he worries about the future of the adopted little one in his absence, then he boosts himself thinking that Sheba is doctor, a self-dependent woman, she will definitely raise their adopted daughter in the same manner to be financially and socially independent, so that nobody could mercy on her in their absence.

Adoption could be choice for many infertile couple, but it has its own problematic phases to accomplish. In most cases the husband's family could not appreciate an adoption. They deny giving any property share to the adopted child, who is not biologically related. Hence, Masuk's father want Saira and

Masuk to adopt a son of Masuk's brother (that is Masuk's nephew), but Saira wants her own child having treatment. Whereas, Masuk agrees with his father and remain silent about IVF. However, Islam allows to give certain portion of property to anyone you like, but one should not deprive his own blood kins to inherit their lawful portion as the religious expert ensures. Accordingly, it is right of any infertile people's nieces and nephews to have share of the property, if no lawful heir is established. In Bangladesh the Muslim inheritance law is established following the *Quran*, *sunnah* and *shariah*, supplemented by section 4 of Muslim family law audience 1961. Though Hindu law approves adoption, Muslim law does not. Among Muslims, Adoption is not legal in Bangladesh, but many adopt and raise children like their own, share property ignoring the patriarchal pressure. Thus, the patriarchal shareholders turn fade if anyone adopts children. Again, they consider adopting children of their choice from the common patriarchal lineage. The Muslim law of inheritance provides the patriarchal shareholders to resist adoption. Moreover, adoption does not provide a women complete motherhood as she does not go through pregnancy, delivery process and lactation. Sheba still misses experiences of pregnancy which she observed among the other women surrounding her. For her, pregnancy experiences is more charming and full of romanticism, which she lacked. She also feels sad as she didn't get any maternity leave, though the adopted child also needs motherly care from her. But, her husband feels more attached with the adopted girl and he confirms that day by day he is becoming the actual father of the girl. Islamic law and the pressure of the society could not resist many to adopt

children when it is a requirement for the happiness in conjugal life. Khuku could not have successful IVF for over age, whereas Sheba and her husband failed IUI and IVF several times, though both of them could afford the costing. For many, the expense of assisted technology resist them to have own biological offspring and pushes to remain either alone or adopting. However, Muslim law does not allow adopting, but appreciate treatment of it considering rules and regulations. Though the assisted reproductive technology is not affordable and viable for many, Islam approves treatment for any pain/disability if *shariah* and *sunnah* capacitate.

6.4 People, Islam and ART in Bangladesh

The wider society who have conceived children normally are more stigmatized on the issues of infertility and its bio-medical treatment. They differ according to their social exposure and interaction with other infertile couple. Though people have distinct stigmatize notion on infertility, they are fond of suggesting herbal, mythological and supernatural solutions of it. But, the biomedical solutions of infertility are often discouraged, for its stigmatized representation by the wider society. In general, any reproductive sickness and disease is kept as a stigmatized, secret issue in rural Bangladesh, as notices by Mamuda Islam (1985), Farhana Begum (2015). I found similarity with their studies, that is the rural childless women are not allowed much to go outside as they are sometimes blamed to be haunted by *jins* and ghosts. Thus, visiting doctors is difficult and stigmatized for a wide range of women, who remain untreated. Many times relatives resist going to doctors for the purpose of curing infertility, as they

consider it as will of supernatural powers, like *jin*. Most of the couples have undergone counseled by the religious expert from their known body to overcome infertility. It is true for the most of the infertile people of Bangladesh who remain at rural places, as the assisted reproductive technologies, which are the hope for many critical infertile couple is not available all over Bangladesh. Even those who can afford assisted reproductive technologies visit the IVF experts as their last choice of treatment. However, IVF experts have different opinion on this issue.

The very first day I meet Dr. Omaira Enam, IVF expert at her own clinic, she confidently asserts the wide acceptance of assisted reproductive technologies in Bangladesh. Her positivity towards the massive exploration of the treatment may encourage the infertile couples those who are still in dilemma of 'to do or not to do'. However, she could not help herself indicating fear from many those who are against the treatment. Being a Muslim Bangladeshi woman she said, " I am a Muslim. I don't do third party/donation here. But, I have clients who are willing to do so. If I do that for business, others will bomb me……those who have failed here, going to abroad and having third party donation. We don't do so." Moreover, this IVF expert also admitted that patients doing IVF usually do not communicate with more relatives during pregnancy, she observed. Thus, her thinking of not attending a stigmatized treatment by many relatives spins that the treatment is obviously a covert issue for many. And her fear about the 'others' who may bomb her clinic shows that there are many who are not ready to take all procedures of assisted reproductive technologies in Bangladesh. Inhorn

(2011) discuss how the Muslim world deal differently with various forms of assisted reproductive technologies. She explains that the sunni and shia circulate distinct fatwas for the use of donor gametes. At this point, I will discuss on the technological advancement of assisted reproductive technologies and Islamic view on it, this will clear Dr. Enam's fear of using third party donation in IVF/ICSI as treatment for many infertile couples of Bangladesh.

Assisted reproductive technology has developed vastly after the birth of Brown in 1978. The rapid medical globalization helped many infertile couples/man/woman to deliver baby. The popular techniques of assisted reproductive technologies are IVF and ICSI. These techniques have been supported by other new innovations like, using donor eggs or sperm, having a complete/ partial surrogate mother, multi-fetal pregnancy reduction to selectively abort multiple gestations IVF pregnancies. Women has the opportunity to hold her reproductive age clock by the new techniques like, ooplasm transfer where younger women's cytoplasm is transferred to the menopausal women to improve her egg quality and freezing eggs and using while she wants. Men and women can look for freeze unused eggs, sperm, embryos, oocytes and now ovarian tissue from the last decade. New technological advancement has given the embryologist opportunity to identify genetic defects of embryo created through IVF/ICSI before transferring it to the uterus. The other research innovations are human embryonic stem cell and human cloning. All of these innovative opportunities are not equally appreciated in religious and ethical ground. Thus, these expensive technological

opportunities are not viable and available throughout the world. Religious and ethical issues of confusing kinship have challenged the using of donor eggs-sperms, embryo, oocytes, surrogacy and last but not the least HESC (Human embryonic stem cell) and human cloning. Islamic bioethics reshapes the use of assisted reproductive technologies by formulating religious rules and orders so that the social institution of marriage and family does not challenged by unwanted incestuous reproduction via science and technology.

The learning of the *Quran* indicates the valuable role of family and marriage as social institution where men will be given women as wives, and it is the mercy and grace of Allah who will give men children from wives, as Hasan Chamsi Pasha and Mohammed Ali Akbar (2015) referred from the holy *Quran*. Marriage is one of the essentials for all capable Muslims and raising children is equally considered and cherished. From the *Quran*, we find scenarios of Prophet Abraham and his wife Sara's pursuit of infertility. After a long time of her barren life Allah gifted old Sara with a son. The stories of Prophet Abraham and Prophet Zakaria mention the urge of children and the sympathetic behavior of the husbands to their wives in a childless marriage. Both were cured by Allah and given a fruitful married life with son. Islamic scholarship emphasizes of being parents and raising them according to the rule of the *Quran* and *Shariah* (Pasha and Akbar: 2015). Thus, treatment of infertility is eventually encouraged by Muslims. Islam cherished the use of medical science and technology to cure the sufferings of human beings. And, the notion of Islam is "pronatalist", which encourages the growth of an Islamic "multitude" (Brockopp 2003, Brockopp and

Eich 2008 in Inhorn 2012, Inhorn 1994). Therefore, the biotechnological solutions in human reproduction have an embedded plead in the Muslim world. However, there are strict prohibition on any third party donation, surrogacy and having IVF without any medical ground. After providing the clear guideline on assisted reproductive technologies by the well reputed and widely excepted Islamic organizations Muslim world encouragingly accepted the Islamic use of these technologies. According to Islam, IVF/ICSI must be conducted using the husband's semen and wife's egg within the time-frame of their marriage contact. No more appropriate number of fertilized eggs should be transferred to the uterus. If frozen, then the fertilized ova should be given to the same couple, if their marriage contact remains the same. Frozen ova should not be transferred if the husband dies. Thus, no widow will be the mother of the baby from her departed husband. Surrogacy partial or complete both are discourages as Islam only give right to the birthing mother. According to the *Quran*, the biological mother is considered as mother not the lactating mother (*dudh ma*) or someone else. Sunni Islam allows embryo created by the husband's and wife's substance. In 1997 the ninth Islamic Law and Medicine conference held under the supervision of Kuwait based Islamic organization for medical sciences where the five point declaration recommended for the Sunni Muslims (who are 80-90% according to Inhorn) to attend assisted reproductive technologies, which included prohibition on human cloning and all third party gamete donation. Unlike Sunni Muslims, Shias were given distinct *fatwa* to use third party donation. It happened when the leader of Islamic republic of Iran Ayatollah

declared that third party donation could be used for Shai Muslims and allowed third party technology in those Shia majority countries, like Iran and Lebanon. This declaration provoked the scholars, moral religious leaders, policymakers and Muslims to face the new climate of moral beliefs. As a matter of fact, to accept biotechnological advancement Islamic manuscript need to be cross checked. Unless, the bioethics of assisted reproductive technologies and new *fatwas* will may contradict Islamic belief. As, in 2003 Iran's parliament noticed ban oven semen donation as it is equivalent to polyandry, which is not allowed in Islam. (Moosa 2003, Inhorn 2005, Inhorn and Tremayne eds. 2012)

Bangladesh is a sunni Muslim majority country. And the history of assisted reproduction is still a growing industry here, where most of the IVF experts pose great deal of privacy; as, Dr. Enam told that she never speaks about any patients with others as it is beyond their medical ethics. For her, patient's privacy is of supreme priority. Though, many hospitals clip photo of IVF baby on the notice board with the patient's permission (there was no notice board at Dr. Enam's clinic. But I have seen notice board with IVF babies' photo in other hospitals). IVF experts admit not only the privacy of their patients but also the sunni Islamic rule of the treatment as mentioned earlier. There is no such donor bank in the infertility clinics and doctors stated that they follow the Sunni Islamic notions of IVF/ICSI, I see no use of third party donation or surrogacy in practice. But, people sometimes whisper about donor use, though none confirmed about it. Majority of the infertile couples who seek IVF/ICSI treatment are not much concern about the religious *fatwa*. They are concerned on their biological

involvement to the fetus, the embryologist and IVF expert is producing. Thus, only few talk to religious expert if they are confused to their treatment. The confusion appears out of an alien feeling of having test-tube baby, not for religious quest. The sunni believers feel that Islam is a progressive religious, thus it appreciate science and technological solutions to human health and sufferings. The couples attending IVF experts affirmed that our state would not allow IVF/ICSI if it was against Islamic view (sunni), thus it must be okay. But, it's their personal choice to have or not this treatment. Mostly, the men are afraid of mixing semen and eggs by mistake, as in Bangladesh they have experienced wrong treatment of other diseases and giving wrong treatment to wrong patients. Women tend to believe in the IVF expert more than the men. Moreover, many women rely upon their husband to confirm the authenticity of their own egg and semen to use. The infertile couples tend to seek medical solutions and knock other services to reach a solution of their problem. All of my respondent's except the only Hindu respondent and Khaibar, have asked for *duwa*, *tabiz* or *pani pora* from *hujur* or *imam* in order to cure their infertility. But, none was comfortable in asking whether IVF/ICSI is justified as Muslim. But, they gossiped with friends and co-hearts about it and tried to convince themselves and justifying that Islam is pronatalist and this pronatatlist technology would not come to Bangladesh unless it is good for Muslims.

Those who cannot be cured by using their (husband-wife) own semen or egg or require surrogate mother goes through beyond trouble. Many think that surrogacy could be approved, if sister is carrying sister's ova. But, people's

perception is not Islamic view on it. It is incestuous, and may cause difficulty in kinship. Moreover, Islam only talks about the birthing mother; in that case the mother to whom the egg belongs would not be the mother according to Islam. I have heard of two surrogacy cases while visiting hospitals, but both refused to talk to me. And the doctor's denied of any surrogacy and third party donation, as I referred previously. Dr. Enam was also frightened of the orthodox Muslims and aggressive Muslims who may cause to her clinic. Thus, she could not do any publicity of the treatment, she said. But, finally when I asked if there is any stigma, she frowns at me, "no stigma on test-tube baby" she declared with confidence.

The local religious practitioners have little to say about assisted reproductive technologies. I have talked with many Imam of urban and rural Bangladesh. Only a few confirmed their knowledge about test-tube baby. According to the majority of religious practitioners, children are essential for a successful marriage. *Allah* and his *rasul* love children. It is the holy duty of each married couple to have children as many as they can take care, "as government has rule not to have three….however, there are many government issues which contradicts with Islamic ethics." They also said that if any couple is troubled with infertility they can consult doctors and even them for amulets and sacred spelled water. Only a very few know about assisted reproductive technologies, mostly who have completed studies at Madrasa. It was quite uncomfortable to interview the religious practitioners as being a Bangladeshi Muslim woman. However, I managed with the help of my relative. Several religious practitioners in

Bangladesh still have either no idea or wrong idea about test-tube conception. My interview with one Koumi Madrasa based religious practitioner, who is 42 years old male, indicates that using the husband's semen and wife's egg to reproduce artificially is allowed and no third party donor will be accepted as international Muslim leaders have declared. He also added that infertile women must visit a female gynecologist to do test-tube treatment and masturbation should be prohibited to collect semen. However, semen collection is required to have test in order to locate the infertility weakness and again it will be a requirement if the treatment proceeds. Using needle to collect semen is not a usual choice as I came to know from the nurse of the infertile clinic. About third party donation, the religious practitioner claimed that the doctors of Bangladesh will not do that and people are afraid to disobey *Allah*, thus none will go for it. According to him, Islam consider third party donation as *jena* (like having unethical physical bond). Most of the imams, who are considered as a guide to Islamic life ways, have a little knowledge about the procedures of the IVF treatment in Bangladesh. One of the local imam informed me that many come to him for advice or *duwa* or purified water in order to have children. Some also ask whether they should go for medical treatment. The imam answers them accordingly. He thinks that biomedical treatment must be good if it is affordable and if *duwa*, prayers, *daan-saadka* and having purified water or wearing amulets fail then infertile couples should visit doctors. He also considers that infertile should have faith in *Allah* and patience to overcome the situation and ask for help and forgiveness for their misfortune (that is infertility). However, Like other

Muslims he also think that the medical solutions of infertility came out of knowledge of human scientists as a blessing of *Allah*. Most of the Muslim IVF seekers of Bangladesh believe that knowledge is given by *Allah* and a Muslim doctor will be cautious about the 'sinful mixing'. Thus, they search for the best bio-medical solutions according to their affordability and adaptability in home and abroad.

6.5 Medical Tourism

With the advancement of globalization, the assisted reproductive technologies have spread in different regions of the world. Though the over-populated, poor countries lack these technologies, people who suffer from infertility may travel and get attended by IVF experts if they can afford. Thus, in one way the poor with minimum/less global exposure remains infertile and those who search for medical tourism may hunt IVF/ICSI at a cheaper price at other part of the world. However, medical tourism what Inhorn (2003a,2011,2012) said 'reproductive tourism' permit people's free choice of the technological pregnancy, as religious and cultural ethical boundaries hinder all varieties of assisted technologies to use in certain countries. Consequently, many people fly to their destiny to avail IVF/ICSI, eliminating their religious and ethical ground, some also cross border for a better treatment at a cheaper price. The bioethics of Islam has been studies by various Islamic scholars, where the sunni and shia community hold two different view to practice. This let sunni community to be more skeptical about the IVF/ICSI treatment. However, there are many those who have accepted the donor use and surrogacy being sunni Muslim, as they viewed children is more

important in their living. Thus, Inhorn and Tremayne (2012) indicate that after the donor prohibition at Iran, Lebanon becomes the reproductive tourism hub for the infertile couples who belong to the sunni Muslim countries of Middle East where donor technology is not permitted. Although Lebanon has opened their door for all form of donor amendment, there is still tension-anxiety about donor gamete uses among many of their political leaders as Clark demonstrates. Being a sunni Muslim oriented secular country Turkey do not permit donor technology for its population. Thus, many infertile Turkish sunni Muslim go to Cyprus, its neighbouring country for third-party donor solutions. In 2010, Turkish government constituted law against reproductive tourism of its people appealing third party reproduction from other countries. Turkey was the first Muslim country that banned reproductive tourism, though this law is more symbolic than encountered it shows us how the notion of Islam, secularism and culture is used in constituting not only sensitive Turkish identity but also international affiliation, as not only a 'democratic', 'secular', 'democratizing' but also as a Muslim country, Gurtin (2011) claimed.

While Dr. Enam claimed that her infertility clinic do not have donor technology, she assumed that those who are not attended by them with donor, they are travelling to neighbouring countries like, India, Thailand and Singapore. She revealed that India is the ultimate choice for the middle class people of Bangladesh, where there is no legal prohibition on third party donor and surrogacy. This doctor also declares that being a Muslim, she cannot do against the Islamic regulations of avoiding donor. She states that she still has at least

three patients, who are ready with donors (they have chosen), but she would not treat them, nor I was able to meet them, as their privacy was at certain by the doctor. However, many patients visit India and other countries for medical purposes. One of the reasons is also infertility. But, not all who are going to abroad for infertility need to be treated by third party donor or surrogate mother. There are many those who trust on the quality of treatment and fascinated by the experiences of couples those who got success there, after failure at Dhaka. I met Rabeya at a regional agency office of an Indian infertility clinic, who is planning to go India for her secondary infertility. She and her husband have chosen India for treatment as they came to know that treatment will be better and success rate is much high there. Exceptions are also there, for example Ismat Ara failed to conceive in India. She is still planning here at Dhaka.

I have talked with a number of IVF patients those who were treated at Singapore and India. Most of them had bad experiences at Dhaka. They found that success rate is much high there in India because, they are much cautious about every step of IVF. They also informed me that third-party donation and surrogacy is available there at a cheap price and a number of Bangladeshi patients are attempting that opportunity hiding it from the other members of their family. I came to know from them that the Bangladeshi who avail donor keep the news secret among the husband, wife and any supportive member who joins them in the days of treatment. As they were treated by the same doctor and at same hospital, others knew about their donor usages. Many couples those who are using donor/surrogacy stay there until the baby is born. Before delivering baby,

Bangladeshi citizens must have legal paper from not to claim Indian nationality by birth place. When I asked my respondent Maimuna came with successful IVF from India that how did other Bangladeshi people think of them while they were treated with third party donors. She laughed and said,

> "…you have no idea. What happens there! There are patients from various countries, such as Sri Lanka, Nigeria, and also from European countries. India provides IVF treatment at a cheap price with privacy. The patients who are going from Bangladesh are usually full of their melancholy, thus does not put fingers to other's happiness or sadness. People share their experiences with doctors they consulted, here and there…keep comparing knowledge. It seems all came with a goal to achieve…its like a huge prayer. All are praying for baby. None have time or sense to talk of others ethics or values."

Her statement indicates the very old proverb, 'necessity knows no law'. The urge of child appears in such a way that the infertile couples act as if they want a baby of their own by any means. Though the patients who were having donor gametes were practicing Muslims (as others informed), they could not think of remaining childless as science has given an opportunity. Some wanted to go to *haj* after the child born. Maimuna says that maybe they think *haj* will purify their unworthy act to religion. But, she herself reported very sympathetic for those who had third party donor. She thinks that they had no other option, as remaining childless for the whole life could not be an option to live. Unlike Maimuna's notion of third-party donor, Nipa revealed a separate view for her weak uterus. She was in Australia with her husband when they came to know about her problem. Though,

doctors over there consulted and encouraged her to have a surrogacy. She denied. She could not help herself to accept a surrogate mother for her baby. She came back to Dhaka to find further medical solutions, but failed to get pregnant. Thus, she wanted to have infertile life and imposed to divorce her husband by her in laws. Thus, not all infertile situations lead people to follow the same wave to the solution and get a baby but any means. Nipa confined herself as it was not possible to her weak womb to reproduce and she was not ready to accept a surrogate mother for her child. She rather sacrificed her matrimonial ties. However, those who travel for infertility solutions are thus often asked and pointed by others cause both socially and religiously donation and surrogacy are controversial. Thus, certainly the travelers for ART medication face more troubles than others. They belong to that group of people who thinks children are their only aspiration of living. Thus, Maimuna's optimistic notion for third party donor is justified for those infertile couples who reasons that having children is the only choice.

The couples/patients those who have travelled from villages and district towns to Dhaka for treatment had a terrific experience of living and adjusting at Dhaka. So is the case with medical tourists to suffer. It is like starting a new living for at least 3 to 4 months for having IVF. Patients going to India for treatment usually tend to live in Muslim hotels/rest house if they are Muslims. There are rest houses which remains full with only Muslim Bangladeshi couples seeking assisted reproduction. At times it is hard to get room there. Many give requisition two months before they are going to India. One Indian

infertility clinic of Chennai has an agent office at Dhanmondi, Dhaka. This office organizes the infertility treatment seekers of Bangladesh and helps them to communicate with doctors and do the paper works to go as medical tourist. The regional agent office also arranges camping when the infertility expert and embryologist of India come and visits many places of Bangladesh. Thus, they got patients from not only Dhaka but also from other districts of Bangladesh. In an interview with the manager of this regional office of India I came to know how he started this agency. He never knew of this treatment until his own sister stuck with infertility. He himself took her along with her husband for the treatment, where they had undergone with terrified problems of accommodation, food, communication, legal attentions to have IVF baby and many more. After the successful treatment of his sister, he proposed the embryologist of that Indian clinic to have a regional office at Dhaka. Now, his agency is helping the Bangladeshi medical tourists attempting assisted reproductive technologies at that infertility clinic of India.

The agency helps the logistic support and information about the treatment, thus the medical tourists are well aware of their treatment. But, not all are going to India via agency, there are many who search by their own. A part of logistic support and information there are other issues that turn an itch for the Bangladeshi women who seek treatment overseas. Firstly, it is relatively hard to have someone close to take care of the would-be IVF mother. As Maimuna had perilous days to face without her husband, who was at Dhaka at times to save his job. She had to take her mother with her. Many of the husbands could

not be with their wives while the treatment requires companion. None can afford to lose job, where more than 10 lacs is required to get treated at India. The package rate for one IVF trial is 2.5 lac Indian rupees; but the accompanying costs of medicines, injections, travelling, accommodation, food, daily necessary goods requires the rest for three to four months. Secondly, the misconception of having a third party donor at India has blamed others who have conceived without it. The majority of the assisted reproduction is still taking place using the husbands and wives semen and eggs, but the general fear, unauthentic rumors and stigma make others horrified about these technologies. Honufa also had her treatment at India and delivered baby at Dhaka. Honufa could not go to her district home, thus feel anxious that nine from her locality seen her as pregnant. Like Honufa, Maimuna also wishes to visit her ex-colleagues who humiliated her at times for not having baby. They want to demonstrate their pregnancy so that others understand they were really pregnant by IVF treatment. Thirdly, having treatment out of country where assistance is essential, turns problematic when women cannot find a suitable family person with them to live and take care during unsafe days. On a contrary, there are other charms of living in a distinct country for the same purpose. Despite all these troubles, Maimuna also admitted that while having treatment in India they have experienced a get-together party by the Bangladeshi Muslims at Eid day, where they had cultural festivals and *Biriyani* feast (which is rare in Chennai, she reported). Honufa also had some good memories which she will recall rest of her life. Both of

them made new friends (both Bangladeshi and Indian) over there with whom they still communicate over phone. They gossip on their biological changes and social experiences of having treatment abroad. They think that IVF mothers do not possess pregnancy feelings like natural others. After the baby delivery Honufa is now communicating with her fellow mates (who are Bangladeshi friends of her whom she meet at India) to know about their delivery experiences, baby's growth and many more. (more in chapter 7)

However, medical tourism for assisted reproductive technology all over the world forces the rapid globalization of the technology. But, questions the regional belief system and ethics to accept the forms of the treatment. As Bangladesh is a sunni Muslim dominating country the practice of third party donor is prohibited to keep the harmonious kinship and purity of conjugal relation. Thus, doors shut for those sunni Muslims, who had no other treatment to have their baby. The local religious practitioners solicit these helpless couple to ask forgiveness to Almighty or take care of other's child, though Islam will not accept any legal adoption, as I discussed earlier. The rapid globalization of assisted reproductive technologies and various opportunity in various regions have opened the door to medical tourism at it's widest range, but this open access to medical tourism challenges the orthodox sunni Muslim people around the world, including Bangladeshi orthodox Muslims. Bangladeshi orthodox Muslims and Islamic practitioners prohibit the third party donation treatment for infertile couples; but like Turkey, they yet did not raise voice against the medical tourism for infertile couples who go for third

party solution. As a matter of fact, it could be difficult to know who is having a third party donation as the procedure is well veiled under the supervision of the doctors and patients. And, it is an ethical issue for the doctor not to disclose patient's personal details to any other. Thus, the incidents of third party donation could be hidden in many ways, the IVF patients came from India informed.

Indeed, the assisted reproductive technology is a secret treatment in Bangladesh, as Inhorn stated, "IVF is hidden from public view in Egypt" (2003b:250). In her study Inhorn had only one respondent who proudly spoke of her twin IVF babies and said they look identical as their father and mother. Actually, most of the IVF parents are worried about the future stigmatization of their IVF babies (Inhorn, 2003b); moreover, the lacking of knowledge and keeping the treatment inside the walls of the infertile clinic lead it to misconception. The secret of the treatment has charged IVF seeker's freedom to some extent, but, the women strategically convince their family, doctors, medical associate to keep the secrets tight and induce husbands to ride the roller-coaster of the challenging treatment and control the over-all situation not only passively, but also actively. The situation, challenges, socio-economic and psychological trails of infertile life and IVF that brought it under the shed of stigma has made the IVF parents and babies extraordinary to the wider society. However, the acceptance and use of these global technologies in the Muslim, developing, third-world, overpopulated, but pronatal and patriarchal countries like Bangladesh has to be molded and altered

accordingly. Equally, anthropological research shows that these western bio-treatments has been shaped by local ethical, cultural, or religious considerations (Inhorn, 2003; Birenbaum-Carmeli and Inhorn, 2009). The next chapter has highlighted how the fear of future stigmatization influence the IVF mother's response to the wider society and revealed the way the naturally conceived people judge and related them with the new reproductive technologies, despite the reality of stigma.

Chapter 7
Relating Babies Out of Tube

As parenting is considered a socio-religious obligation in Bangladesh, both fathers-mothers and their relatives enthusiastically communicate, participate and relate them with the newborn. In Bangladesh the new mother is cherished throughout the time of pregnancy. During delivery time the tradition of keeping the new mother and baby away from the house in an *atur ghor* not only put finger to the purity pollution notion, but also creates a window to welcome them as if a new journey to family is being starting for the new mother and baby. Assisted conception is not far different from that, but the urban nature of hospitalized birth is practiced, considering the risk factors. However, emotional involvement in assisted conception varies during the early period of conception and parenthood. Assisted conception gives the mother and the father a distinct feelings and emotional attachment with the fetus which changes through the time of child bearing. The babies born through these technological interventions are reared and socialized in a dissimilar way compare to the other non-IVF babies. Though it seems that only the IVF conception differs from natural conceptions, but they also differ as parents (Owen and Golombok: 2008). The prolonged struggle for having baby develop psychological distress and imbalance mostly in mothers and sometimes also in fathers out of fear of relatedness. I have observed a number of IVF baby deliveries, while roaming around the hospital's delivery room, where I experienced the responses of new fathers and the relatives towards

the new born. Referring to the previous chapter (chapter 5) where I have narrated Honufa's father-in-law's statement after closely observing his new born grand-son, which indicated how relatives eager to relate themselves with the new member of the family. In response to that old man Honufa's mother predicts that they (Honufa's in-law) may thought that baby is not of their blood. Not only the relatives of the IVF baby this chapter also will explore the psychological bonding and functioning role of the IVF parents and the way of medicalization of the IVF baby. From the very beginning of Assisted Reproductive success the concept of 'test-tube baby' and 'doctor's baby' emerged as a silent opposition to many in the acceptance of ART babies as other normal naturally conceived babies. The concept of 'test-tube baby' and 'doctor's baby' increases the contributions of tube or doctor in producing the baby, ignoring the painful, stressful pregnancy of the women (more in chapter 5). However, parenthood in assisted reproduction comes with enormous pain of conception for the women and stress and uncertainty for both of the parents along with close kins. The following chapter will discuss on the parenting experiences of the IVF couples and their relation to IVF babies. This chapter will also discuss the attitude of the couples who naturally conceive and reproduce, who have less or no idea of the treatment procedure of assisted reproduction.

7.1 Parenthood with Assisted Reproduction

Copin, Munter and Vandemeulebroecke (1998), in their article "Parenthood motives in IVF-mother" stated that the IVF mothers and the natural mothers

have separate motives in child rearing. They explained ‘identity’, ‘motherhood’ and ‘social control’ as the motives for the IVF mothers in parenting. Whereas ‘identity’ and ‘motherhood’ play vital role as motives more according to the age and education of the mother. However, they concluded with the fact that both IVF mothers and natural mothers adjust their parenthood with their motives of parenting. Motives of parenting do not assure the emotional, functional attachment of the children-parent relationship. But, it assures the position of parents as a social identity of parenthood which may enable them to peruse and bargain in the society. One of the valid points of opting assisted reproductive technology, the IVF seekers address is their social status has been changed and women who conceived through assisted reproductive technology gains certain power and control over the family which they lost in the phase of their infertile struggle. Most importantly, the shame of barrenness shaded into the phase of happiness with the new born.

The village girl Hira was not much happy with her painful conception, moreover she did not like the commanding behaviour of the nurses at hospital. Her ignorance about the assisted reproductive technology made her confused about conception and kept her detached from the fetus, she was carrying. Whenever I asked her whether she is happy with her successful IVF, she replied that she made her husband happy, that is all she knows. As nature of natural conception and assisted conception differs, some may feel a complete exclusion from the fetus and conjugality. However, the pregnancy

with assisted reproductive technology will give the common experiences of natural pregnancy, such as nausea, vomiting etc. Thus, day by day the assisted conception appears with the natural sign of pregnancy, but the technological conception lacks the conjugal love mating, which made Hira bewildered on her pregnancy. Those who are not aware of the steps and procedure of assisted reproductive technology could feel so. Thus, the urban privileged educated women could know a lot by searching at Google and YouTube to know more about these technologies. Shapla who was an ordinary urban working woman came to know detail about IVF from internet. She was not puzzled about the treatment. One of the reasons is her lower socio-economic condition of family of orientation provoked her to do according to her husband's will, so that her natal family can survive in a good way, as I have noticed that Shapla's brother is given job by Khaibar. Being the second wife of Khaibar, she took as a responsibility to give birth of the successor of her husband's family. Shapla watched a number of YouTube videos on the treatment procedure. Moreover, she talked several times with one of her friends, the gynecologist and the IVF expert, with whom Khaibar was previously introduced. All these experiences made her easy to accept the assisted reproductive technology. The case of others who have tried IUI/ ICSI/IVF is quite similar. Honufa, Maimuna, Rehana (unsuccessful IUI, IVF), Lamia, Shapla, Rabeya (secondary infertility, decided to have IVF) and their husbands have watched videos on YouTube before starting the treatment, though the treatment varies as they told. The knowledge searched

through internet helped them to relate them with the new born fetus from the very begging of their pregnancy.

Those who had a successful pregnancy after IVF were much sensitive and aware of the baby. Both father and mother of the fetus show concern for the IVF fetus developing inside the womb. The medicines and injections required for the treatment are well maintained following the proper time-table. Honufa's mother and Maimuna's mother used to set alarm on different timing of medicines, which indicates intense care and concern for the new mother and baby compare to others who conceived. The husbands show much care and give priority to wives decisions as I observed Lamia's husband, Sohan listens to her each and every wish after she conceived through IVF, though Sohan does not agree with Lamia by all means. But, he thinks that harmonizing with IVF baby carrying wife was more important. Khaibar, Shapla's husband has given job to his brother-in-law to keep her happy in those days of her pregnancy. He also managed a number of maids and nurses at home to take care of Shapla, as he could afford. The urge to be a mother or father of a child usually keeps the IVF parents more conscious about the part and parcel of fetus development which continues after the delivery, too. It is the common nature of the successful IVF pregnant mothers to communicate and share experiences of pregnancies and fetus development. In doing so, they also ask for apathy relief as they become less visible at the pregnancy phase. Maimuna, Shapla and Honufa had IVF fellow friends with whom they were introduced at the waiting lobby of the doctors

still communicate and share the pains and pleasure of pregnancy and child rearing. Shapla who had her 2 years old daughter, still communicate with her fellow IVF friends share the difficulties in socializing IVF babies with others of the family and society. Shapla told me that three of them meet with kids on different occasions. I requested Shpala to arrange a get-together, so that I could meet those IVF mothers, too. But, her IVF parent friends didn't agree. Honufa's son is now 3 months old; she talks and compares with her fellow IVF parent friend on the weight and growth of the babies. The IVF mothers are much anxious not only at the time of pregnancy, but also after the delivery.

The gynecologists and nurses have cross-examined that IVF parents are over anxious and apprehensive. After delivery IVF mothers complain about pain on back shoulder, thigh and other parts of the body, which is common for many other non-IVF mothers, but IVF mothers assume that all the drugs (oral and injected form) they consumed are showing their side effects. Though their gynecologists disagree, IVF mothers and their close relatives predict that all drugs supporting this conception are charging pain on the mother's body, thus they wish to get more supervision and care from others. In my interview with two nurses of different hospitals, I came to know that most of the IVF mothers visits doctors more than non-IVF mothers, they show more concern on baby's movement and own physical sufferings. IVF mothers do not come alone to the doctors. Most of the time IVF mothers are accompanied with two, which can be house maid even. Both of the nurse

admitted that IVF patients are from wealthy families, thus they visit doctors more. However, an infertile woman could understand how precious the IVF pregnancy is to her. Thus, at each critical moment IVF mothers wish to see her gynecologist rather than listening to the elderly experienced women of the family. The best way the IVF mothers get relief is the consultation with her gynecologist and sharing experiences with another IVF mother. They feel that only gynecologist can relate the visible breeze between the fetus and mother, which others lack. Both Shapla and Maimuna wanted to consult doctors more frequently than their gynecologists prescribed. They got relaxed after consulting with the gynecologist, which not only indicates IVF mother's sensitivity, but also shows their rely on the doctors about their unborn baby, developing inside the womb and tries to communicate with baby's health and growth. However, not all fathers of the IVF babies are caring and protective husband and father from the very beginning of the embryo transfer. IVF fathers starts caring for pregnant wife when he notices sign of morning sickness or when the pregnancy could be visualized by ultra-sound or in physical shift of his wife's body. The IVF successful fathers with whom I meet differ in their socio-economic, professional and educational status. Some of them also experienced diversified global exposure. Thus, IVF fathers vary with their behavior and relation to the baby and it's mother. I observed young IVF father giving a shoulder massage to his 7 months pregnant wife in the waiting lobby of the gynecologist's chamber and others were feeling uncomfortable with this unfamiliar incidence, in the context of

Bangladesh. The other patients consider the couples attitude as ‘barbaric’ at waiting lobby. According to the view of wider society of Bangladesh husband and wife should not show their love and care in public places. Thus, that couple’s attitude was not well taken by the others, who were from distinct socio-economic background. I have also meet husbands, who were fired form job, some left job as they were busy as a company with his IVF pregnant wife, ignoring their own parents and sibling’s suggestion not to leave job for taking care of IVF pregnant wife. At the same time, I also came to know about husbands those do not come to visit his IVF attempting wife nor manage the treatment payment nor show sympathy to her painful effort in doing IUI/IVF/ICSI one after another in a cycle. As a matter of fact, IVF conception provides a distinct experience, where male and female go through a separate understanding of pregnancy and baby development, but in most cases both IVF father and mother eagerly wait for the baby to born healthy and safely like all other naturally conceived parents.

It is not only the technological conception that made IVF pregnancy and natural pregnancy different. There are other reasons to focus on the parenthood nature of IVF couples as they experience a long-waited baby through a painful and stressful time of infertility. It is not only their solemn, but also the social pressure and self-exclusion that made them to view things differently than others do. Owen and Golombok (2008) see that stress of infertility and it’s treatment may cause difficulties in parenting IVF babies. IVF parent are over emotional to their babies (Burns, 1990) and their

overprotection, realistic expectation from children and as parents makes they more psychologically frazzled (Hahn & DiPietro, 2001; McMahon, Ungerer, Beaurepaire, Tennant, & Saunders, 1995; Mushin, Spensley, & Barreda-Hanson, 1985; Van Balen, 1998). Some also predicted that these unrealistic expectations and burden may disrupt conjugality and may lead to psychological sufferings and marital relation. (McMahon et al., 1995). Another study on a comparative analysis among IVF twin, IVF singleton and naturally conceived couples of Sweden shows that the IVF singleton couples were most stable in their relationship during the whole study period, and the IVF twin parents also seemed more stable and satisfied compared with the control group of spontaneous conception couples. The researchers conclude that the stresses associated with IVF treatment and becoming first-time parents of twins did not have a negative impact on the couples' appreciation of their relationship and parenthood as stated by both men and women (Gunilla Sydsjö, Marie Wadsby, Adam Sydsjö and Katarina Ekholm Selling, 2008). In Bangladesh couples who succeeded with IVF twins and triples managed their living as like other naturally conceived parents did, as doctors stated and I observed. However, Bangladeshi IVF parents with triples are more sensitive and anxious on parenting and socializing three simultaneously. Though I talked with triplet's parents while visiting doctor's chambers, they did not allow to me to have a detailed interview of them.

Coping with infertility and attempting assisted reproductive technology varies, thus Khaibar's first wife divorced not to have IVF treatment, Nipa

also divorced not to have a surrogate mother. On a contrary, Marina had convinced her husband and remained infertile, passed their life roaming out of the country to avoid relatives, who make answering questions on infertility and puzzled them. However, in the context of Bangladesh, those who successfully complete the journey of IVF conception seem to make a well-balanced family with love and care. In Bangladesh, the support of relatives increases after the delivery of baby, as I experience. In case of IVF conception relatives and others known people show more love, support and curiosity. Thus, parent's responsibility could be balanced with the help of relatives; as a result, IVF parents get more compatible opportunity in their parenting. However, the IVF parents not only seek attention, pay cost emotionally, financially and physically the charges of having the precious gift.

7.2 Dealing with IVF baby

One day, while sitting and waiting for my respondents at hospitals, one of the pregnant mother were shifting to delivery room assisted by couple of nurses. One of the nurses asked her, "why are you having C-section? Your reports seems ok". The would-be mother gave a look to a relative and with hesitation answered, "…it's an IVF baby". The nurse reacted, "Oh!", indicates her seriousness to IVF conception and delivery; though IVF baby could be delivered as all other pregnancies, as I have heard of. Some of the IVF mothers have normal delivery in different hospitals and clinics of Bangladesh and experienced like other mothers who conceived naturally. In

many ways, both patients and medical associates medicalize not only the IVF conception, but also the IVF delivery and deal with the IVF baby with an over protecting nature.

Before the 20th century, pregnancy and childbirth were accepted as natural processes and treated as such. Childbirth was a social and emotional event that usually took place in the pregnant woman's home and the whole family was a part of the process in one way or another. The mortality of mothers and infants during childbirth was high (Riessman, 1983; Zwelling, 2008). With the development of obstetrics at the beginning of the 20th century and a tendency towards a decreasing mortality rate, childbirth began moving into the hospital (Mirko and Marina, 2013). In Bangladesh child birth was taken under medical supervision slowly, in a gradual development of medical facilities throughout the country. Previously, child birth was a usual eventual fact, which took place inside the home-yard under the supervision of aged and experienced motherly relatives. The midwives of rural Bangladesh took initiatives in caring and delivering babies. Now a days both urban and rural women try to consult a physician during pregnancy, thus reproduction is now medicalized with the expansion of westernized knowledge on medicine and health. Childbirth is a medical even now. The infertile couples experience the extremist form of medicalization in reproducing IVF babies. There are few sections of people who put hand in medicalizing the procedure of IVF. Both, the commoners including those who failed the treatment and the gynecologists who are not IVF experts explains the unpleasant and traumatic

experiences of IVF medical solutions and medicalize it's participant. Many of the infertile women turn the slave of medical surveillance and feel medicalized during the time of fetus development. Shapla, Honufa and Maimuna laid into the bed for the first three months of their pregnancy, though the embryologist did not suggest to do so. They were guided by the others who experienced the unsuccessful IVF pregnancies. Thus, they medicalized themselves during their pregnancy. They also believe that only that rest helped them to survive the complete risk time of tri-semester. They also suggest that a complete rest of 6 months is required for a successful pregnancy, though IVF experts have no say about this.

Shapla recalls her days lying on the bed, just watching movies and serials on television. One of her relatives discouraged her to watch *hindi* programs in that time, cause that relative think that *hindi* songs, dances and fighting scenes may make her and the fetus excited and crazy. Her physician did not ask her to lay down for a long, but her IVF friend suggested her to so. Thus, her husband, Khaibar managed three maids at a time to look after her and house. She got over-weighted, about 89 kg from 58 kg. But, the baby girls waited only 2.94 kg. She says, "Those days, I was looking like a pumpkin, and my fingers and face was red tomatoes, as I had much fruits, except papaya … doctors said to avoid papaya." I observed that as the infertile women face a long waited pregnancy via IVF they are more conscious and turns an obedient patient to the gynecologist and finds herself medicalized during pregnancy. This practice is prolonged after the successful delivery,

too as I noticed both Shapla and Honufa consult two pediatricians for their children. Shapla does not take any decision on medicines for her daughter unless she consults two pediatricians. Unlike, many naturally conceived mothers; she knows all the generic names of the pediatric medicines. Shapla and Khaibar are very much protective for their daughter. They usually do not take her out as they fear of dust and pollution. They are also worried about the schooling of their two and half year old daughter. They think that school may give pressure one manners and study, which she may not accept. In their own way Shapla and Khaibar are medicalizing their IVF daughter, showing their over protection in each and every aspect of child development.

As a young mother Honufa is also caring her son, by visiting two pediatricians each month. She knows it was not required. But, she could not satisfy herself. She is planning start her medical practice one year later, so that, she could give more time mothering the baby. Honufa told me about her husband who does not want her to practice before three years of their son. But, Honufa's mother is very anxious about her career. Honufa's mother thinks that she is over protective about the IVF baby and does not rely on anyone caring and looking after the baby, which is not allowing Hofuna to recover after the stressful IVF pregnancy. Honufa's mother assumes that Honufa requires more rest and attention as she has gone through tremendous mental and physical pain during her days with IVF, whereas Honufa feels that her baby is more precious than other naturally born babies, thus it is a special gift from Allah. It will a sin if she fails to make him smile always.

Though Honufa's mother and mother in law are capable to baby sit, Honufa's husband and Honufa herself cannot rest themselves, but caring their only son; sacrificing her career years after years from the begging of the treatment like many others. Being a non-practing doctor Honufa is more concern about her son and supporting child development utilizing her medical knowledge and pediatrician's advice. One of the medical assistant of a neo-pediatricians said that they could recognize the parents with IVF baby, as they ask more questions compare to others. Most of the IVF parents and their relatives ask questions dealing with child's physical development in the first six months and gradually understands that an IVF baby is as normal as the others. If a child is too strong at it's early age than the parents and relatives give credits to the high calcium dose given as supplements to the mothers earlier, if a child fails to show all physical ability by predictable time, then they think that it is because of the weakness of the artificial conception. Thus, the developments of the IVF babies are usually tagged with the conception and treatments done over mother's body. One of the IVF mothers while visiting a pediatrician said to me, "my mother- in law is furious to me, as I ran to doctor very often for my twins. She thinks it is waste of money. She knows all the home remedies for neo-natal care. But, they are IVF twins. They are not only precious but also expensive. I cannot take any risk. It is not like them (mother-in-law generation), having kids each year". Hence, it is understandable that the long waiting, stressful, expensive journey of the treatment made the parents overprotective and let them medicalize IVF

babies more often. According to these over protective IVF mothers, non-IVF mothering was also easier as the non-IVF conception. However, the relation with the IVF baby starts long before it takes its birth from the IVF conception, thus the overall situations are nourished and handled by various rations to the baby.

7.3 Friends in Need

"Traditionally, the pregnant women of rural Bangladesh were ignored in terms of proper diet and rest. But, now-a-days things are in change. The *sasthokormi* visits houses and ask for proper rest and food plan for the pregnant and breast feeding mothers. These days, new mothers are more privileged than previous era." Hira's mother said, while I was visiting the guest-house they rented at Dhaka. In the intensive days of Hira, her mother was with her. It was not very easy to escape from own homestead and old husband (Hira's father), but, she has no other option, but to take care of her weak daughter. Hira's mother was informed that Hira has some difficulties dealing with her productivity, which is not much true as Akhter revealed to me. However, it was Hira's mother who started sharing their painful journey to make her young daughter, 'mother', otherwise; Akhter would definitely beat and ran away from Hira , as she assumes. She also thanks Akhter, because he had given all the expenses to treat her daughter. Now, she feels that it is the upmost duty of the mother to take care of her pregnant daughter if her in-laws are not in scene. Many times Hira's mother wanted to go back

home for a week, just to see her old husband. But, could not make it, as Akhter's mother could not come to Dhaka by her own. Akhter's mother depends on her elder son and daughter-in-law, who didn't allow her to take care of IVF pregnant Hira. As they did not like Hira and Akhter having infertility treatment at Dhaka, they behaved unfriendly and shown non-cooperation in this regard. Without any help and support for the scary 15 days, many could not get positive result with IUI/IVF. Thus, Hira required some to help her on those days. But her mother was frustrated to keep her daughter alone at the rented guest-house for the successive injections and treatment, thus could not go back to own village. They have witnessed several negative cases for stress and work-load of the IVF pregnant mother, thus Hira's mother stayed as a hand to assist her daughter. She wanted Akhter's mother to come, though it didn't happened. The old lady, Hira's mother sorrowfully told me that it is she who is caring for someone else's grandson, who will be else inheritor. She was disappointed as Akhter's mother failed to come. Though IVF mothers get a complete support from their mother during high risk time and successive period, they think of in-laws care and support as the child would belong to in-laws lineage. In most cases, the mothers and relatives of the IVF mother take all responsibility during pregnancy. Both Hira and Honufa did not get any support from in-laws during those days. Where, as Lamia and Maimuna was afraid and felt discomfort to involve any of their in-laws, thus took support from mother and own relatives. The case of Lamia was interesting to notice in this regard.

Her *mami* took all responsibility as own parents live outside of Dhaka and Lamia didn't want to disclose her reproductive weakness to her in-laws. However, I find it problematic to hide from her mother-in-law, as she consulted one of popular IVF experts of the city. But, she managed with the help of her husband. Lamia has a number of inferiority complex, she was afraid as she was from middle class family of district town; and compare to her in-laws her paternal relatives are financially underprivileged. Many women having infertility treatment feel discomfort informing and involving in-laws in infertility treatment. Throughout, my fieldwork, I rarely see any women came to doctor with in-laws. Most of the women desire to visit doctor with husbands. If husbands fail to give proper time than women's first choice is their mother or aunt or sister to accompany them, visiting doctors. Some of the women had friends and neighbours to accompany doctor's visit. The discomfort comes from the traditional thinking of women's responsibility to reproduce. It does not matter, where the problem is located, the women are mostly accused for infertility, these traditional ways of thinking has hampered the trust and love between women and her in-laws, while infertile. However, it is the women's body which is scrutinized during the treatment of IUI/IVF; thus, they feel more comfortable with someone, with whom they share common psycho-biological traits.

A few cases, like Rehana will appear distinctly. Rehana has lost her parents. She has her sister, who is also an educated professional lady, like her (Rehana took leave from job). Thus, she had no other option but her husband

and in-laws to take care of her. However, Rehana did not succeed her IVF journey, but has gone through IVF twice. Apart from Iqbal, her husband, she was well cared by her mother-in-law and sister-in-law (*ja*). Iqbal and Iqbal's parents along with his elder brother's family live in separate apartments of a building, I visited. We were introduced at the hospital, when Rehana was about to lose her uterus for excessive bleeding. Rehana's husband, sister and in-laws were present at the hospital that time. They asked me to visit them at house. Rehana seemed very happy to have caring mother in law. She admitted that there are some relatives who feel bad about her not giving an inheritor yet. But, her mother-in-law and sister-in-law were friendly, cooperative and kind to her physical limitations. Rehana feels comfortable with them as they protest the gossip of those relatives and usually do not allow them to talk on the issues of infertility in front of her. Families with higher educational and financial background are more relative to adjust with infertility problems and its treatments. Thus, they become friends to daughter-in-law in those risky days of the treatment. After two successful cycle of IVF Rehana is planning to go abroad for her treatment and she wish her mother-in-law as her company over there. The reasons to have mother-in-law with her are, she is caring and coping with situations to handle; Iqbal cannot take long leave as Rehana left her job; Rehana's sister is also a professional lady and has family with kids. Thus, besides mother-in-law's caring attitude non-availability has inspired Rehana to plan so.

The assisted reproductive treatments require a friendly atmosphere for a better result. Therefore, people either asks close relative or accrue helping hand by other means. For example, Khaibar appointed nurse and several maids to take of Shapla, for the sake of the IVF baby. As, they are from affluent family, it was not much expensive to have these in a row. Otherwise, people keep on trying arranging relatives, as after the IVF cost, affording nurse for days is pricey for many. Hence, having friends during treatments depends firstly, on how the baby is related to that person; secondly, on whether the IVF mother is comfortable with that person in private; thirdly, on the availability and affordability of friends in need to the infertile couple.

Among the 23 cases I talked with 11 relatives, who played important role during the time of treatment. All the relatives were female as the women required psycho-physical support those days. Conversely, I have heard of a father who takes care and cooks for his IVF pregnant daughter, because both the mother and mother-in-law of that pregnant lady are physically unable to take care. One of the nurses told me about that old father of 67 who was physically and mentally strong enough to support his pregnant daughter who was carrying triplets. They came from some other district of Bangladesh, stayed Dhaka for the 8 months of pregnancy and went back to their home-town with the successful delivery of triplets as the nurse informed. Thus, most of the IVF pregnant mothers are accompanied with someone they can trust and love.

7.4 Categorizing 'the others'

Infertile couples both who are attempting IVF/ICSI and conceived through any form of assisted reproductive technologies have a sharp notion of 'the others'. They categorize friends and family members what to share and what not to share about their experiences of infertility and its treatments. Most of the relatives and friends are kept away from the stories of experiences of assisted reproductions. Distinct nature of relatives makes the sorrows high. Furthermore, the couples produce children naturally made the IVF conceived couple marginalized and 'topic' to gossip. As Lamia viewed that her infertility problem and IVF conception would make her feel excluded among her in-laws family, moreover, she assume that her in-laws are orthodox will not support her treatment or may insist her husband to divorce. Like Lamia, Maimuna, Maimuna's mother, Rehana, Rehana's sister, Saira and Mashhuk's interviews categories relatives with an assumption of accepting IVF babies as regular or natural ones. However, the infertile and IVF parents found that most of the relatives belong to the category of orthodox in dealing with test-tube conception. Rehana's mother-in-law suggested her, what should be said to certain orthodox relatives about the treatment she is having. So do Maimuna's mother and Kusum's mother did. Each of the couples and their intimates have some strategies to convey the news of assisted pregnancy and baby out of the tube. The orthodox relatives are known to family through their judgmental nature, their rejection on different contemporary issues.

Hence, IVF seeker's relatives are categorized broadly as orthodox and 'modern'. By 'modern' relatives the respondents identified those who know little about IVF and accept it accordingly. Though, the respondents claimed that the relatives of them who consider assisted reproductive technologies as the optimal choice of infertility and consider it as normal are 'modern', I doubt. I have experienced that these so called 'modern' relatives are orthodox and superficious in other dealing of their usual living. For example, whenever Maimuna's mother and Honufa's mother bought fishes from the market for their pregnant daughter they put lemon, garlic and green chili in the fish-bag, so that evil spirit cannot enter the house with raw fishes. So, their acceptance of IVF/ICSI does not rectify them as 'modern'. I conclude that categorizing depends on the inter-personal relation and control over relations. However, IVF seekers feel happy to have some modern relative to assist them throughout the pregnancy, with some superficial activities to protect them from evil. And, they consider 'the others' orthodox and detractor in their assisted fertility life.

Additionally, IVF seekers viewed that the assumptions of fetus development inside the tube make the orthodox people more anxious, deeming that the child development could be hampered and the mother-child utmost relation will be demolished. Thus, IVF parents think that many of their relatives will think their IVF babies as not 'natural', 'regular' and 'normal'. Similarly, Heather Paxson (2004) has explained the unwillingness of IVF parents to introduce their children to relatives with a fear that they will view their

children as abnormal. The IVF parents with triples, usually do not exhibit and communicate much, cause they fear other would easily tress them as IVF babies.

Moreover, the relatives from urban and rural social settings have dissimilar view. All of my infertile respondents admit that rural Bangladeshi people do not have any idea of these assisted reproductive treatments. Those who came from village were guided by the medical camping in different districts. Thus, the older and rural relatives have no clear ideas of the treatment, these section of relatives are not informed much of infertile couple's experiences. However, my respondents notify me that though the rural people have less idea about IVF/ICSI or test-tube, they do believe that urban doctors can do miracles. Unlike the western societies, the eastern cultures receive the notion of infertility and IVF/ICSI according to its local cultural understanding. Thus, the urban and rural people views differ (Paxson 2003). The following part will focus on the perception of the naturally conceived people on fertility and assisted conception.

7.5 The Naturally Conceived People's Interpretation

While discussing on the challenges of infertile and the IVF seekers in chapter four, I compared the social representation of infertile according to my primary respondent's (infertile and IVF seeker's) social associations with Sandelowski and Lacy's understanding. In this particular section, I consider the interpretations of naturally conceived from various socio-

economic classes. The interviews with naturally conceived people conveys distinct notions about infertility and it's bio-medical solutions. Their connotation with any infertile relative or friend has prominent effect to change their notion about infertility and assisted reproductive technology. However, most of the people were annoyed on my research topic. Some repeatedly insist me to change such a research topic as they think it could bring danger to me. Many of the naturally conceived people were surprised to know that I have compiled data from infertile couples who are attending hospitals. But, it was interesting to notice that the poor respondents were not much surprised or annoyed by my research area. They have showed their interest on it. However, the poor women have no idea about the bio-medical treatment of infertility. The only poor male respondent, who is a rickshaw-puller, knows that there are treatments, which is expensive. He also knows about the infertility clinic as his rickshaw stand is near to one of the infertility clinics of Dhaka. He has carried many couples to the clinic and heard of their pain and expenses of the treatments. He told that it is treatment for those who rides cars not his rickshaw, thus he cannot say no about the treatment. However, all of the poor respondents have knowledge about the alternative treatments of infertility and they believe that only *Allah* can forgive infertile people and bless them with children if they surrender to Islam and do accordingly. The housemaid Anu is mother of 5 children thinks a women life without children is miserable. According to her men also love children, but women are born to be mother and nourish

them with love and care. Rani, the tailor-assistant thinks it would be difficult for women to run conjugal relation without birthing children. Although she knows that sometimes the weakness could be with the husband, but women in Bangladesh have an inferior status in family, giving birth of an heir (son), could strength her position in the family. Rani relates herself by sharing her own experience. She has three children; the elder two are daughters, thus her husband and sister-in-law (with whom she stays at Dhaka) used to scold her, after the son she delivered things has changed. Her husband and sister-in-law assume that a son will be beneficiary for fathers and daughters can only help mothers cooking. Though having two daughters helped her from the title 'infertile', but it was not enough for her in-laws to cherish her fertility unless and until a son, the successor and would earner of the family had its birth. However, it is not the case with Rani, the poor tailor-assistant, one of the middle class respondent Nurjahan also admits her painful struggle with three daughters. Being a mother of three daughters is like a curse for her. Each time they prayed for son, even her eldest daughter wants a brother. Though, Nurjahan's husband loves their daughters, but he feels ashamed when others ask about son. Daughters are guest to their parents, and one day they have to send them to their in-laws, thus daughter would not help earning, according to Nurjahan and her husband. Nurjahan's husband threaten her at the birth of the third one that if a daughter is born he would divorce her. However, he did not do that, but he escaped from the family for 5 months after the birth of the third daughter.

Nurjahan feels that his escape was justified as son is important for a father to help him earning. However, Nurjahan thinks that having children is essential for happiness, specially the son. She is not well aware of assisted reproduction. She said that she heard of test-tube baby many years ago. But, now a day she does not heard of it. After the interview, Nurjahan has showed her interest about the treatment of infertility, so that she could inform her neighbor, who is trying to have baby for a couple the years. The pronatal, patriarchal society give preferences to have more children, thus search for easy conception in case of any difficulties. But, the assisted reproductive technology rested and secured by the medical authorities, and the information is provided to those who can afford it. Though it is the poorest of the poor (the poor women) who requires more children, expecting that someday these children would bring food for their old parents. The rest 8 respondents know that the treatment is available in Dhaka and there are many who go to India for infertility treatments. Among these eight respondents five have relatives or neighbors who have undergone the treatments. Thus, they are familiar with the treatment procedures, though all of them do not like the treatment. Only two of them appreciated the treatment, one is the female university teacher and another male multi-national company assistant. The rest three didn't want to talk much about their relative's decision, they have experienced that IVF children are more crazy and spoiled by the over-indulgence of parents. For example, Champa said that one of her neighbour's have IVF son, who is 17

years old now. That IVF son knows that he is precious for his parents and does whatever he wishes. He is addicted and proudly declares to his local friends about his IVF birth. Champa heard of these from her 12 years old son and the mother of that IVF son also has shared her failure to raise their only IVF son with many of the neighbourhood. Thus, one bad experience has changed Champa's view on infertility treatment, though she thinks that fruitful treatment is required with counseling of the parents, not to be over protective. Moreover, Champa and others who do not like bio-medical treatments thinks that too much drugs are used in this treatment which could be harmful for both the mother and baby afterwards. Most of the naturally conceived people have a positive attitude towards science and technology, but they are anxious of the overdose and side-effects of the drugs. Many are concerned about the alternative medication for infertility, as it costs less and does not lead anything against religion and state policy. If the Islamic notions of assisted reproductive technologies are well circulated among a vast number of people than many infertile couple will come forward and avail the treatment thinks Sinthiya, the university teacher. She expects that proper counseling is also required to accept these Western technologies of birth. But, she also stated that still assisted conception and IVF child are issues to be discuss with stigma and many feel embarrassed if someone of close relations are having it. Correspondingly, Sinthiya experienced that IVF seekers themselves feel humiliated to discuss on their treatments.

Except the two poor women, the rest informants know that there is bio-medical treatment of infertility, popularly known as ‘test-tube baby’. The people with higher education and wider social-global exposure appreciate the bio-medical treatments. But, admits the stigmatized notion of infertility and assisted conception. However, there are assumptions about the treatment, without valid experiences or examples about IVF treatments. If one example went wrong, it spreads much rapidly than the stories of success. It shows that people are more likely to escalate and discuss on the negative results of assisted reproductive technologies. They assume that any assisted intervention to fertility hinder the glorified natural conception of women. Thus, many cannot admire the bio-medical treatment, considering it as an unethical way to conceive or encumber to natural motherhood practices.

Nargis, the banker and Malek, the private job holder both belong to the middle class group ; and Abdul , the diploma Engineer who belongs to the upper-middle class know about IVF but have no relatives who has under gone the treatment. Three of them do not think that infertility treatment should be done unless proper justification is done by the Islamic authority. Like many others they also think it is a test or punishment from Allah, thus need to be dealt with patience. Three of them provided me information about their distance relatives who has successful pregnancy after *haj* and sacrifices made for Allah, but it requires time. According to them, it is only Allah’s will to give one heir at proper time. Abdul narrated his *phupu*’s

story. His *phupu* remained infertile for 17 years. She used to visit her natal house often as she remained sad. Abdul's *phupu* cried to have muddy *saree* from his grandfather. All failed to understand except Abdul's mother. Abdul's mother said that the infertile woman does not want new clean cloth; instead she wants *saree* to be mudded by her toddler. Abdul's grandfather searched *fakir*, gave *tabij* to his infertile daughter and son-in-law. Nothing worked. Abdul's *phupu* told her husband to get married again, but he didn't. According to Abdul that man was generous and kind to his *phupu*, thus did not get second wife. At last, after coming from *haj* Abdul's *phupu* conceived. Meanwhile, Abdul's grandfather expired. According to Abdul, some people of the village assume that having grandchild was his last wish which was fulfilled against the life of Abdul's grandfather. These events made Abdul think that one should not waste money in such a treatment which could be questioned at times. Going for *haj* could be more beneficiary and affordable. Infertile people must obey their own religion and try to find peace with whatever they are given naturally, as mentioned by Abdul. Like Abdul, Nargis and Malek also have other stories of infertile relatives and known people conceived through alternative medications and praying. Thus, for many of them infertility could be solved with other ways too, though assisted reproductive technologies is a choice to certain people.

The naturally conceived people people know minor about the physical risk and emotional distress of the IVF seekers, thus could not relate them as patients or heroic sufferers. More or less they possess a stigmatized believe.

They view infertile and IVF seekers as socially handicapped and cultural dupes and foils as Sandelowski and Lacy has articulated. No matter how much this naturally conceived people people know about the assisted treatment, they argue that it is natural that infertile women will be desperate to have children as the pronatatlist and patriarchal norms compel infertile women to do so. Thus, it is not unusual for theses desperate women to search Western technological solutions of their problem, though others may not favor to these technological conceptions. In a response to the question, "will you allow your children to have friends/relations who are born through assisted technological treatment?" most of them felt embarrassed and uncomfortable in answering. Many of them mumbled with hesitation, choosing friend is the kid's choice; and parents have nothing to say about it. Their inconvenient behavior and avoiding response made me suspicious their appreciation about the bio-medical treatment as well as the new babies entering world from the tube.

What so ever, the naturally conceived people people interpret the IVF parents and family keep on convincing others to normalize their situation by all means, welcoming and announcing the achievements of the IVF babies, soon after the birth. The traditional practice of *atur ghor* is no more visible in the urban context. Still, relating babies with hundreds of relations plays important part after the delivery. Thus, new parents distribute sweets among the relatives and neighbours. The IVF babies are also welcomed in the same way, but in a more lavish way. The long waiting of the parents made them to spent further more

in order to circulate the enormous joy they felt after receiving the baby. I have experienced the joy of new father, grandfather and grandmother by announcing sacrificing goat in the name *Allah* to protect the new baby. While it depends on the affordability of the parents and grandparents, I observed the new IVF parents desire to sacrifice goats at the natal village. This is one of way to relate the IVF baby with wider society, where he/ she belong. It is meant to inform that the next hire has born. As three days after delivery Honufa said, "…we are planning to sacrifice goats at his paternal natal village. The villagers need to be informed about his birth. Many of them taunt me in those days of infertility. A big feast will make all know about the rightful birth of her IVF son" Her mother replied to her, "…if your in-laws make delay I will do in at our village. I also need to inform many. We have passed hard ridiculous days." Her anger continues as Honufa's in-laws were not much co-operative during the bizarre days. However, she herself wanted to share the good news to be a maternal grandmother with her relatives and neighbour. The prolonged birth of a IVF baby thus shakes more relatives and gather more love and blessings, though many visits IVF babies and try to find the signs to relate IVF babies with it's relations. I have observed that while IVF mother and baby rest after delivery in hospital, many of their infertile friends and relatives come and visit them. These infertile friends and relatives are prospective IVF planners, who come and see IVF babies in order to accumulate mental strength and feel encouraged to have bio-medical solutions to their fertility problems. Even the doctors know that the infertile people communicate with each other,

thus in the post-delivery visits many of the IVF new parents are suggested to send their known infertile people to the doctors they consulted. As a matter of fact, I monitor that the infertile couples though undergone successful IVF keep themselves in the shell by attaching themselves with other infertile couples though they want to assimilate with wider society by sacrificing animals and distributing meat and sweets.

However, the IVF babies are still considered as 'miracle babies' (Franklin 2012). Franklin viewed IVF babies as miracles though many are normalizing the IVF conception by spreading news and commercialization. Thus, Franklin assumed of Foucault's inspection on IVF as normal considering that it "already belongs to the techniques of normalization-including, among others, those of marriage, kinship, gender, scientific progress, experimental embryology, livestock breeding, baby showers, consumer culture, and medical technology, not to mention Hollywood cinema, *Sex and the City*, Brangelina, and Mumsnet.com. But as Foucault also might have noted, this is what is useful about IVF as the condensed epistemic point of the many intersecting strands that make its logic seem so obvious and normal" (Franklin 2013: 6). Still, in the context of Bangladesh IVF conception is not that normalization process, thus the couples trying to achieve parenthood through these assisted technologies create armor and separated from others in general discussion of motherhood and mothering. Accordingly, they put themselves medicalized under the surveillance of doctors for years. Building agency requires long term experiences with doctors and IVF experts and their experienced friend's

recommendations. And, infertile couples, specially the women gradually show her resilience and agency throughout the process of IVF conception and raring of IVF baby. The process and long term experiences change women's personality in different ways, which enables them to build resilience and agency when and where required. Thus, they shape their technological treatment according to their believe system and subject of living.

Chapter 8
Conclusion

This piece of research has been done to explore the subjective experiences of the infertile men and women and their encounter with assisted reproductive technologies; where gender, class, patriarchy, belief system, socio-psychological situations were interrogated to find out their influence on the various stakeholders of the bio-medical treatment, IVF. The agony of involuntary childlessness has put both male and female in a hardship, living in family, workplace and society. The social life of almost all the married couples turned volcanic during the first phase of childlessness and it bursts into tears after the medical recognitions of fertility problem. Medical science has put the experts in such a position that an IVF specialist opt fertility problem than infertility, which enables them to treat accordingly. The stigma of infertility and social expectation of having children forced many to search for corridors of relief. On the other hand, there were many who stopped socializing themselves and could never spoke up if I didn't interrogate about their unspoken agony. Thus, I find the reasoning for talking on 'barren', 'empty' and 'sterile' life of infertile couples. The state of 'barren', 'empty' and 'sterile' do not reveal their physiological situation; it detects their miserable social living with childlessness. To escape such a painful journey, the assisted technological solutions are not the optimal choice for all. The least affordability, availability and narrow cultural acceptance of assisted reproductive technologies hinder the progress of infertile life and depress the living of men and put women's life socially vulnerable. Only a few who succeed with assisted reproduction show their trust and patience to the

expert and treatment; agency and informal secret co-operation and aggression to the naturally conceived people criticizers.

Yet, the biomedical treatment shakes infertile people in many ways. Assisted reproductive technologies are a biomedical choice for infertile couples, which provide a stressful long journey of treatment with chances of hope. The journey to these biomedical treatments console many; at the same time, it charges physical, financial, emotional and social living of childless women if they cannot successfully complete the targeted result. Thus, infertility and frequent failure with its bio-medical treatment make women’s life more vulnerable socially. Those who succeed the journey of assisted reproduction also challenge the natural and normal reproduction and face humiliation by others. However, women with infertility and IVF pregnancy show agency and play strategic role despite their dilemma and sorrowful living.

Though infertility is a medically defined reproductive problem, it is a curse in Bangladesh, where children are considered as the socially, economically and religiously valued. As, many anthropological researchers shows that infertility is socially constructed and maintained. The ideal form of Bangladeshi family comprises with a father, mother and two of their biological offspring; a boy and a girl, in urban setting. Still, majority of the rural people wish to have more children. Moreover, the ability to give children is considered as a complete woman, which is embedded in the mind of it’s women. Thus, secondary infertility is equally stressful and more stigmatized than primary infertility. Cause, secondary infertility could threat conjugal life of the woman with

children, which will be make her more vulnerable. However, unlike the west infertility is not treated as a couple problem. It is mostly the women who are accused for infertile life and took under the supervision of various medical system. The masculinity of male ego is secured by the patriarchal society and blame it's women without having proper medical investigation. However, both male and female are humiliated for their problem of infertility, but, it is the women who are more vulnerable (socially and biologically) compare to their counterpart. Accepting the reproductive problem and searching for it's solution varies according to class. However, most of them surrender to the efficacy of bio-medical solution of it, though all cannot afford the modern assisted reproductive technologies like IVF. The identification of infertility hampers the educated well off couples (specially the women) much than the poor women. Thus, the psychological stress it more visible among the educated working well-off women. But, the poor and middle class infertile people suffer the most as they lack the bio-medical treatments of infertility. Thus, despite class and gender, the situation of infertility hinders the harmony of life. However, the affluent infertile people have multiple choices to overcome their psycho-social pains of infertility, they are more capable to clutch the challenges of infertile with or without Western bio-medical solutions.

Assisted reproductive technologies has bent the living of infertile people in more devastating way that they loop in the 'stratified reproduction' struggle. These modern medical technologies are not affordable for the majority, in this third world developing overpopulated Muslim country, Bangladesh. The poor infertile people not only afford the treatment, they are also not informed about it by the

physicians. The IVF experts are not reachable to the poor infertile people, whereas children are the socio-economic capital of their old age. Though, primary reproductive problems are addressed in government fertility service centers (only in Dhaka) of Bangladesh, it is not widely informed in the root level, considering the over population and state's population control policy. Whereas, Nahar (2014) has stated the rural poor childless women are at the bottom of social hierarchy and face public stigmatization instead of hidden stigmatization like urban educated infertile women. So, the poor rural infertile women are the ultimate victim of their bio-social status 'infertile'. However, the pronatal, patriarchal society force it's infertile people to find out the solution of their infertile life according to their own means. Those who can afford ART and have desire to be parents keep on searching the best bio-medical solutions for them. Others who fail to avail the information and financial support for IVF search other private sources of treatments, like folk medicines. The population control policies hinder the most effective bio-medical solutions of infertility to the bottom class of Bangladesh, who requires children as their socio-economic support. Additionally, fertility is a human right, thus should not be obstructed by other factors, like state policy. Like many other Western countries, including US, the availability of assisted reproductive technologies has also made the reproduction stratified in Bangladesh.

The rapid growth of ART did not allow all infertile people to avail its blessing, but created 'stratified reproduction' and let the society, to observe and interpret the infertile from several viewpoints. Sandelowski and Lacy (2002) consider these interpretations as 'misrepresentations of infertile'. The interviews with the

IVF experts made me to consider that the infertile women of Bangladesh, who can afford IVF are desperately search for bio-medical solution of their infertility. These women are viewed as patients to others and doctors as well. But they do not consider themselves as patients, until they go through egg collection in order to have IVF/ICSI. The infertile couples, especially who are working urban women are often thought to be the consumers of luxurious living with immense freedom and time for their own, by their colleagues and others. Both urban and rural infertile women face social exclusion and many feel alien and terminates themselves from family and social gathering. Infertile people are interpreted as failure and responsible for the dysfunction of human normal reproduction. Though, in the West, IVF patients are considered as heroic suffers, in the context of Bangladesh, they do not experience pity and respect for going through such heroic treatments in most of the cases. Thus, they categorize relatives and avoid many about their IVF conceptions. Both rural and urban infertile people search for various folk, herbal and spiritual remedies before visiting infertility experts. Most of the patients have certain disappointments to the infertility medical centers they visit, some are also dishearten by the doctor's behavior, dealings and punctuality. Thus, patients search for the most suitable doctors of their choice, though there are a few IVF experts in the country. The prospective IVF patients are information seekers. According to the class and social status of the IVF patients, negotiation took place with the experts of IVF on pricing, trails, timing, number of embryos and privacy (of both depending on the demand).

In addition, infertile couples who decides to have IVF, have to negotiate with their parents and suffer from further challenges. Infertile life itself is stressful,

and convincing parents to accept and help for the treatment is not easy who have less social exposure. The existing belief and knowledge about fertility turn as an obstacle for many elderly people and others who have no information about these treatments like IVF/ICSI. Whereas, a positive response to the treatment from parents, relatives and friends may help the IVF seekers, especially the woman feel comfortable and psychologically stronger while compelling trails of the treatment. Mostly, the stereotype parents of the male resist to help or support the treatment. Woman get supports from mother-in-law only when they are from highly educated, urban family with global exposure. As, discuss earlier, infertility is a couple problem in the West, here in Bangladesh it is considered a female problem, thus, in most cases male visits doctors less and rejects to have pathological test, many also disagree to have IVF. Like, the would-be relations of IVF babies, these men only take these treatments assertively, if they have higher education or global exposure. Thus, the global technology is much exposed to the people who have heard of the treatment from home or abroad.

The study also unveiled the fragile conjugal relation due to infertility and it's bio-medical treatment. The fertility behavior of Bangladeshi people demonstrates that most of its people consider a marriage is made to complete a family; to have and raise children legally. The wider society of Bangladesh consider that the primary duty of the married women to conceive and give birth to children. The people explain, upbringing children as the socio-religious duty, which can bring economic solvency and security when required (Maloney1981, Blanchet 1984, Kotalova1993). Thus, any abnormalities to conceive generate tension in the conjugality. The rising tension of sexual insecurity, abandonment

and conjugal insecurity or divorce lead to social anomalies. It is the women who feel more vulnerable in this regard. Like many other societies, Bangladeshi people also try to make the male (with male infertility problem) comfortable with his shortcomings, and only very few women divorce husbands for their male infertility. The infertile men are often humiliated (directly) because, male infertility is associated with impotency, which is not medically clarified. Infertile men are called weak and inactive in mating, whereas sexual aggression of male is measured as machismo. Hence, women with infertile conjugal life are always worried about husband's socio-psychological stability and keep the secret of husband's heath problem to the wider society. This is the women who are socially vulnerable with infertile life, no matter where the biological weakness of reproduction rested. In most of the cases, it is the women who are divorced or complains about husband's extra-marital relations. Moreover, it is not only difficult to make husbands agree to visit the infertility expert, but also sometimes impossible to make them understand the efficacy and rationale of the treatment. Even, some of the husbands do not express their negative attitude towards assisted reproductive technologies in front of their wives, they keep on trying to comfy wives; be strategic and guide (indirectly) wives either to have adoption of their choice (of husband's blood line) or to keep believe on *Allah*. However, those who have started the trails of IVF are actually mostly the women who shows strategies to get information and assist husbands to get involved in the treatment. In most cases the infertile women take major steps to decide what to do next choosing or searching for a solution for their infertile living. Men are less responsive, but equally feel the stigma and exclusion. Though dealing with

the infertile identity is not similar, but the life of infertile men is not stress free. In most of the cases, men are sluggish and takes considerable time to accept the biomedical solution of infertility. It is obvious because, infertile women are haunted and taunted by other naturally conceived people women for their misfortune. Infertile women's positive and progressive nature to the assisted reproductive treatment engage them to search for the best treatment they could avail. Whereas, infertile men psychologically lose their confidence and masculinity and feel weak (both physically and mentally), when they are diagnosed as infertile, but rarely confess to others. It is not always the biological infertility, but the medical diagnosis and social identity as infertile make the couple's life vulnerable and fragile.

Assisted reproductive technologies requires time, money, immense psycho-physical patience. And, women's body is the place where the tax of reproduction is charged. Thus, those who have involved in the treatments have to get break from their usual work for a time being. Though, the medical requirement varies from one individual to other the bed rest in IVF pregnancy. But, most of the women take almost a complete bed rest during their IVF pregnancy. In this way, they define their body and treatment in their own understanding, where not the medical authority controls, but the group of friends who are also passengers of IVF roller coaster. The equivalent interests of infertile women gather them in a common ground where, they share their experiences and help each other to build resilience and show agency whenever required and define their own psycho-physical and social problems of infertility, it's bio-medical treatments.

The medical knowledge and authority has narrowed the information of assisted reproductive treatment, considering the sensitivity of it. However, many of the respondents admitted their little knowledge about reproductive health and fear about the medical authority provoke them to think hundred times before meeting a IVF expert, who seldom explains what and why (of the treatment) to the patients. However, these treatments are more easily accepted by the women who are having social and psychological difficulties for having a childless conjugal relation. Except a few most of the infertile women want to overcome her/her husband's biological failure and become IVF mother, accepting all pains and reducing control over her own body to some extent. Greil (2002) also explains in the similar way, but insists that infertile women in the USA should not be seen as passive victims (Letherby 2002, Parry 2005). Riessman (2000, 2002) and Todorova and Kotzeva (2003) make similar observations about women in southern India and Bulgaria, respectively. Thus, in most ways women actively, but strategically give endless effort to overcome the fertility problem and eagerly participate with the medical interrogation with limited knowledge.

Though, the poor and middle class people suffer the most for their infertility problem they get lesser opportunity to have assisted medications; compare to the upper class and educated women. However, few educated self-depending women are less concerned about being infertile. It need to explanation that assisted reproductive technologies are not the choice for poor infertile people, mostly for its expense. On the contrary, though affluent people are not economically insecure, not all of them deliberately accept these technological interventions. Thus, it is not always the economic solvency but the social

exposure to the medical treatments and experience with infertile couple with IVF struggle, comfy other infertile people to accept and start the treatment. Hence, comparatively a poor couple can sell their valuables or go under debt to start the treatment, but an affluent couple can get worried and guided by their embodied knowledge of reproduction and avoid the treatment and get more stigmatized than of those poorer couple who keep on trying until they are blessed with children. The number of educated, upper middle class infertile couple are rising at different infertility centers of Dhaka, who are ready to sacrifice job, time and money. However, still the bottom class infertile people neither know about the treatment nor can afford assisted reproductive technologies. And the middle class people struggle the most and become more strategic to overcome the unwarned situations of the expensive treatment of infertility.

Moreover, the existing pluralistic medical approach let the infertile women seek for other popular and folk sector apart from expensive professional sector, as classified by Kleiman (1980). Thus, in societies like Bangladesh, health care systems can be addressed as cultural systems to solve health problems, where many believe on miracles, the popular and folk sectors rather than the biomedical solution to the health problem. Additionally, most of the infertile people who seek for a solution to their problem search for other infertile couples like them who have succeed their journey with an encouraging positive result. Thus, infertile people, especially the women secretly get connected with others who are either struggling like them, or have succeeded their problem through medication. However, having these secret groups, conversing and sharing with many on their experiences are both stress solving and stress giving. Though,

infertile IVF seeking women feel these informal secret groups as tension relief space and where friends with common interest, provoke them to build agency. These informal networks also lead to give information about the expert IVF doctors, gynecologists and suitable pediatricians for their IVF babies.

These informal secret group help the IVF seekers in many ways, because, people know less about the biomedical treatments of infertility and many of them fear and hesitate to go forward. Apart from these friends, internet is the widest source for many to know more about the IVF treatment. Women's embodied knowledge with the help of these informal secret groups assist them to build agency and act not only passively, but also actively where they feel it is required. However, the authoritative power inside the clinical setting minimizes patients control over financial issues and psycho-social traumas they go through. The overall structure of hospital/clinic and the formal body of infertility centers take control over the treatment seeking couples. But, the infertile women medicalize their reproductive body with a conscious mind and soul and never stop scrutinize own body ask questions to medical authorities about her pains and worries. Women's body is the center of reproduction; thus, they show agency in all aspect and are questioned for their childless living, compare to their partners. As a pronatal society, Bangladeshi people urge to have children shortly after marriage; though in the urban sector there are few who 'take a gap' for certain period, but people want to have a fertile reproductive health; and the option to choose the timing for baby making.

Infertile couples with medical diagnosis have fewer choice to overcome their bio-social identity as infertile. There are many who cannot afford IVF (financially or physically) consider adoption for a better choice. Some infertile men are deliberate to adopt child from own lineage, in order to protect patriarchal property. I have observed, women usually do not want to adopt, they want to search for folk medication, if biomedicine is not a choice. In most cases, women strategically convince husbands agree for the assisted reproductive solutions to their infertile living. Adoption is the choice raised by the husbands, when they see no easier solution to achieve parenthood. However, adoption is not tranquil in Bangladesh. Still, there is not appropriate Muslim law for the adoption and property inheritance. In Bangladesh, there is custody (legal parental authority for certain age), but not adoption. Moreover, adoption does not carry the inner peace of a mother's mind. Giving birth of a child not only glorifies motherhood, here but also help the women's feel (physically and emotionally) associated with off springs. Though, having adoption accumulates joy to the infertility challenged couple, but it does not erase the pain of being incomplete. It was noticed that the patriarchal society frown not only at IVF but also at adoption.

The patriarchal society has an intention to come across if the normality of motherhood is challenged. The naturally conceived people of Bangladeshi patriarchal society, have immense curiosity to know more 'test tube baby', but hesitate to consider it as a solution to infertile couples. However, higher education and socio-economic class influence them to talk positively about science and western medication, but their dilly-dallied conversation limits to assume their acceptance about the infertility treatment. Anyway, women from

various class and status group wanted to know more about assisted reproductive technologies and solutions to infertility problem. It was shocking to notify that each of my respondents are related with at least one infertile couple, which is really alarming as these technological conceptions are still expensive, limited and stigmatized.

Furthermore, like Inhorn’s experience in Egypt, I observe that IVF for infertile couples is a secret treatment and are not publicly shared or discussed. The treatment seekers find their own way to get bio-medical solution to infertility. Even there are many who travel neighbouring countries for IVF, where they believe that better treatment at lower price is available. Medical tourism due to infertility has helped many to avoid curious relatives and maintain the treatment secret. The fear of third party donation is not high among the orthodox Muslims of Bangladesh. Most of the people believe that Muslim infertile couples and doctors are aware of donor prohibitions. But still, there are infertile couples (mostly men) who fear of mingling wrong semen and egg at clinics, which may be done even unintentionally in Bangladesh. However, belief system and concept of purity is strongly exhibited through avoiding donor in IVF conception. But, most of my respondents who were executing IVF did not search for religious experts at all. They were forced by their optimal desperation to become a parent of own children, through assisted reproductive technologies. Most of the IVF seekers shape their religious understanding of IVF according to their own terms. The invincible desire makes IVF seekers more pious during the days of intense treatments, but show a blunt awareness about what relatives, neighbours or religious leaders utter. As a matter of fact, infertile couples and IVF seekers are

not as excluded by the wider society as they exclude themselves to avoid negative attitude and misleading representation about them and their IVF children. These IVF seekers are more strategic than vulnerable to the patriarchal society, however, the unprivileged infertile couples are socially vulnerable and required to be addressed by the effects and efficiency of medication with affordable expense, considering child birth as a human reproductive right in the pronatal society, Bangladesh. In a society like Bangladesh where raising children are highly encouraged (socially and religiously) and marriage ties are vital and considered valued identity in practice, treatments like ART will be light of hope, sprit and courage for many who are struggling with fertility.

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Abbreviations

ART	Assisted Reproductive Technology
AI	Artificial insemination
CT	Computed tomography scan
ET	Embryo transfer
FNAC	Fine-needle aspiration cytology
FSH	Follicle-stimulating hormone
HIV	Human immunodeficiency virus
HSG	Hy-sterosalpingo-gram
ICSI	Intracytoplasmic sperm injection
IUI	Intrauterine insemination
IVF	In vitro fertilization
MRI	Magnetic Resonance Imaging
PCOS	Polycystic ovary syndrome
OT	Operation Theater
WHO	World Health Organization

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Glossary

abba	father
Allah	The creator according to the Muslims
atur ghor	Traditional Birth Place, which is separated from the house premise
aat kura	infertile
biriyani	spicy rice and meat, occasionally cooked
burkha	veiled dressing for women
chotpoti	spicy peas
chotpotiwala	seller of spicy peas
daan-saadka	sacrificing in order to be blessed by the almighty
dadumoni	grandmother
duwa	prayer
fakir	roaming priest
fatwa	rule of living as suggested by learned muslim
haj	pilgrim
hindi	a language, mostly used by Indians
hujur	Muslim honored person (teacher)
imam	leader
ja	wife of brother in-law
jagannath	the creator according to the Hindu
jannat	heaven
jin	unseen sprit, possess power

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kipta	a person who expense the lowest
ma	mother
mami	wife of maternal uncle
nofol namaz	extra prayers for good wishes
pani pora	sacred water
phupu	father's sister
pohela falgun	first day of a bangla month
Quran	holy book for muslim
raja	king
rasul	prophet
saree	women's dressing
sasthokormi	local health care giver
shariah	guidance of the prophet
sunnah	deeds of the prophet
tabij	amulet

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Check-list and Semi-structured Question

Semi-structured Question on:

Name: Age: Occupation:

Education:

Income and personal property:

Location of residence:

Period of marriage: Number of children:

Various check-list according to the categories of respondents:

Infertile women

1. Concept of motherhood and infertility
2. Planning for baby
3. Decision on medication
4. Differential experiences
5. Overall social relationship during medication
6. Knowledge of health, treatment and belief system
7. Conjugality with infertility and IVF

Infertile men

1. Importance of a child
2. Masculinity and conception on fatherhood
3. Decision on medication
4. Differential experiences
5. Socio-economic challenges of the treatment
6. Knowledge of health, treatment and belief system

Doctors

1. Infertility situation in general
2. Experiences with patients
3. Social ethics and infertility treatments
4. The procedure of assisted reproductive technologies used

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Relatives of IVF seekers

1. Relationship with the IVF seeker couple
2. Knowledge on infertility and IVF
3. Socio-psychological attachment with the treatment and belief system

Naturally conceived people

1. Importance of children
2. Knowledge on infertility and its treatment
3. Idea of technological conception and belief system