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Fertility Control: Reproductive Desires, Kin Work, and Women's Status in Contemporary India

This article reappraises the link between fertility and women's status by examining changing means and meanings of reproduction in India. It is based on data gathered during and after 16 months of ethnographic fieldwork conducted between 2005 and 2007 in Lucknow, Uttar Pradesh, India, on social and cultural contexts of infertility. Lucknow is the capital city of Uttar Pradesh, India's most populous state. Historical views of population and fertility control in India and perspectives on the contemporary use of assisted reproductive technologies (ARTs) for practices such as surrogacy situate the ethnographic perspectives. Analysis of ARTs in practice complicates ideas of autonomy and choice in reproduction. Results show that these technologies allow women to challenge power relations within their marital families and pursue stigmatized forms of reproduction. However, they also offer new ways for families to continue and extend an old pattern of exerting control over women's reproductive potential. [reproductive desires, infertility, India, reproduction, surrogacy]

> Surrogacy should be seen as an opportunity to strengthen and widen our deepest ethical concerns by questioning patriarchal norms of the family and the stigmatisation of infertility. At the very least, its miraculous potential should not be used to reinforce regressive ideas about blood and inequality or rationalise it as a way to address women's economic marginalisation. (Qadeer and John 2009)

Introduction

In this article, I examine fertility control by considering the ways women's bodies, and particularly women's reproductive potential, have been put into service of their marital families (in-laws) in India. I draw on fieldwork I conducted in Lucknow, Uttar Pradesh, North India, from 2005 to 2007, and on recent scholarship on surrogate pregnancy in India. Decisions about reproduction—from birth control to

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decisions about whether to continue a pregnancy and how to care for children—are undoubtedly longstanding concerns in scholarship about India and in interventions led by a host of governmental and NGOs over the last 60 years. My work builds on long-term social science research on marriage and fertility dynamics in India (Dyson and Moore 1983; P. Jeffery and R. Jeffery 1996; R. Jeffery and P. Jeffery 1997; Jeffery et al. 1989; Patel 1994). Here I follow scholars working on the cultural dynamics of infertility in India (Bharadwaj 2016; Mulgaonkar 2001; Riessman 2002; Unisa 1999; Widge 2001, 2005) to extend the discussion of infertility and infertility treatment as lenses through which to view how women do the kin work (Di Leonardo 1987) of negotiating family and fertility to contribute to the reproduction of their extended marital households (*sasural*) under shifting cultural and economic conditions.

Even though Indian government programs and programs run by other population and reproductive health organizations have been advocating smaller families since the decade after India attained independence from British colonial rule in 1947 (Chattopadhayay-Dutt 1995), Indian families still encourage fertility, with caveats. Couples without children, or without sons, may be perceived by others as incomplete families and as insufficient contributors to extended families' long-term viability. Patterns of preference and familial pressure often influence the course of women's reproductive lives and have very real implications for their physical and social well-being. Reproductive desires relate to the sex of children, number of children, health and ability of children, and other lesser factors such as skin color. The birth of too few or too many children, especially of too many children of the "wrong" (read: female) sex, have been viewed as reproductive disruptions (Inhorn 2007) that threaten the future continuity and prosperity of patrilineal families. In North India, reproductive ideals center on families' wishes for *aulad*, which are biologically related children, most often imagined as male (H. D. Singh 2011). Discussions of decision-making, choice, and compulsion in Indian reproductive journeys should be read within this historical and social context; reproduction involves many actors and competing pulls of duty, desire, and care.

To demonstrate the context of infertility and women's status in India, I draw from my field data to examine the story of an elderly Muslim woman who recounted a particular auspicious occasion on which her long-term household labor proved to be a poor substitute for procreation in her marital home. Her account reflects larger cultural understandings of the importance of fertility and the disruptions in social relations created by infertility. I discuss the efforts of young married women in Lucknow to cultivate strong kin ties in their extended families while working toward an appearance of appropriate reproduction through the use of biomedical infertility services. I engage the emerging literature on a recent trend in India for women to attempt to secure their families' future by diverting their reproductive potential to the procreation of foreign and domestic intending parents through gamete "donation" and surrogacy (Deomampo 2013; Majumdar 2014; Pande 2014; Twine 2011; Vora 2012).

I argue that women's bodies are still put to the service of the propagation of their larger families, but not exclusively for the direct purpose of upholding patriarchal family norms by creating new (male) bodies to reproduce a patriline (*vansh chalaana*, literally to drive or keep descent through males). In the process, women's body parts and their reproductive potential are being commodified. Their

new bioavailability (Bharadwaj 2011; Cohen 2005), not only to their marital families but also to domestic and transnational reproductive markets, creates ethical debates about assisted reproductive technologies, globalization, and citizenship. It also creates an opportunity to reflect anew on an old debate in India in general, and Uttar Pradesh in particular, that has often been described as a social problem—the link between women's fertility and their status in their marital homes (Bumiller 1990; P. Jeffery and R. Jeffery 1996).

Background

Since the early 1950s, governmental officials and NGOs working in India have created and implemented a host of programs intended to contain population growth by reducing the average number of births per woman. Although these programs have experienced numerous setbacks and scandals in their planning and implementation, the national total fertility rate (TFR) in India has indeed has been reduced by about half in less than 40 years (Ram 2012), from 4.7 in 1980 (World Bank Fertility Rate 2015). Although these national rates reveal the overall trend in fertility, more nuanced analyses of fertility across Indian states (Dommaraju and Agadjanian 2009; Dyson and Moore 1983) and across religious, caste, and class groups (Dharmalingam and Morgan 2004; Iyer 2002; Iyer and Joshi 2013; R. Jeffery and P. Jeffery 1997) reveal a more complex picture of uneven fertility change. Both the TFR and incongruity across politicized social categories have been long-standing matters of discourse and debate at local and national debates from at least the early 20th century (Ahluwalia 2008).

While pro-natalism has a long history in India, fertility preferences and goals have shifted over time toward fewer births, but with a continuing value on the birth of sons. Both of these dynamics are reflected in India's recent demographic history. Shrinking fertility rates, prenatal sex determination through technologies such as ultrasound, and continuing gender-based discrimination across the life course have exacerbated the sex ratio in recent decades, resulting in higher proportions of males relative to females, with striking variation across regions (Burke 2011; John et al. 2008; Patel 2007; Unnithan-Kumar 2010; Vlassoff 2013). For example, current data indicate that for every 1,000 male children born, only 909 female children will be born in India. In Uttar Pradesh, that number falls to 878 females per 1,000 males, while other states report figures as high as 970 females per 1,000 males in Chhattisgarh and as low as 864 females per 1,000 males in Haryana (Census of India Sample Registration System Statistical Report 2013; see also Larsen and Kaur 2013).

These patterns persist even though Indian activists including feminists, physicians, and Hindu nationalists regularly report on and disparage such practices. Despite recent international attention to the biomedical infertility sector in India due to controversial practices such as transnational surrogacy (Pande 2014), and despite the significant life disruptions occasioned by infertility, relatively little is known about the numerical prevalence of infertility within India (Jejeebhoy 1998). Stigma associated with infertility discourages people from reporting fertility problems in survey research, so available estimates may well fall below reality, yet recent work suggests that infertility affects nearly 18 million couples in India (Bharadwaj 2003; Ganguly and Unisa 2010; Widge 2005). Gaps in knowledge about the prevalence of

infertility and its effects persist even as, in several different guises, infertility services become part of the larger story of fertility control in reproducing families in India.

Setting and Research Methods

This article draws on data gathered through interviews, observation, and informal interactions I completed during 16 months of ethnographic research in Lucknow, India, primarily from 2005 to 2007. Lucknow is the capital of Uttar Pradesh, the most populous state in India. With nearly 200 million people (Census India 2011b), Uttar Pradesh alone would be the fifth largest country in the world by population (Times of India, Lucknow 2013). Located in north-central India, it has an area of approximately 241,000 square kilometers (Census India 2011a). Although roughly the same size as the United Kingdom (World Bank Land Area 2014), the state is home to more than three times as many people (United Kingdom Office for National Statistics 2014). It holds great significance in political and cultural terms at the national level. Along with neighboring North Indian states, Uttar Pradesh often lags behind other areas of the country on a range of health indicators, including, for example, infant and maternal mortality. Recent demographic data indicate that the state's TFR continues to fall, but remains above the all-India rate. Demographic indicators from 2007 put the state's TFR at 3.9 births per woman, compared to 2.7 births per woman for India as a whole (Haub 2009). The most recent statistical report from the Sample Registration System (2013) revises those numbers down to a TFR of 3.1 for Uttar Pradesh and a national rate of 2.3 (Census India SRS Statistical Reports).

I conducted semi-structured interviews with more than 50 women from a variety of religious, class, and caste backgrounds who were suffering from infertility. Interviews took place in government infertility clinics and outside of clinical spaces, and participants were recruited opportunistically rather than through a purposeful structured sample. Members of several local NGOs assisted with recruiting participants outside of clinics. In addition, I observed the work of 15 doctors specializing in gynecology and women's health, as well as the work of other medical staff members, with whom I conducted structured interviews and more informal interactions during clinic hours. Few potential respondents, selected on the basis of their attendance at the clinic or through reference by leaders of one of several NGOs, declined to participate. However, interview time in clinical spaces was limited by interruptions caused by scheduled procedures.

I conducted all interviews myself, drawing informally from an interview guide and allowing the conversation to take shape according to women's preferences and responses. To protect confidentiality, interviews with patients in infertility clinics were recorded by hand. Other interviews were audio taped. I explained the research to each participant and obtained and documented oral consent from each participant using procedures approved by the Institutional Review Board at The University of Virginia. Interviews took place in the Hindi and Urdu vernacular language common to Uttar Pradesh, and occasionally in English, according to the preferences of participants. I am fluent in Hindi and Urdu and have become familiar with local colloquial languages through years of residence in Uttar Pradesh and neighboring Bihar state, so I did not work with a translator for any of the interviews. My data also come

from material collected from newspapers, research produced by the Government of India, and Hindi and Urdu literature. The American Institute of Indian Studies and the University of Virginia provided funding for the research and provided research support, but the ultimate decisions about study design, data collection, analysis, and interpretation, and decisions about writing and publication have been mine.

I translated and analyzed field notes, audio recordings, and available documentation, and data gathered through interviews, observation, and participant observation. Outside of biomedical infertility clinics, respondents were recruited through referrals from friends, relatives, or social workers in NGOs, giving attention to including participants from diverse local backgrounds to the greatest extent possible. In biomedical infertility clinics, women presenting themselves for treatment were interviewed apart from any accompanying individuals while they waited for examination. Some interviews were conducted over several visits to the clinic for continued treatment. Medical staff in clinics provided contextual information and assisted with recruitment of participants, but staff members were generally not present during interviews. Women were informed in consent procedures that their participation was voluntary and agreeing or declining to participate in the research would not affect their treatment at the clinic. The vast majority of women recruited in clinics eagerly agreed to share their experiences.

The data presented here do not include interviews conducted in private infertility clinics (see Bharadwaj 2012, 2016; Unisa 1999; Widge 2001, 2005). I focus instead on services provided through clinics in public sector (government) hospitals, which have received less scholarly attention and have only recently begun to offer a wide range of infertility services as part of their reproductive health program, at much lower prices than in the private sector. At the time of field research, I was a doctoral candidate from the United States in my late 20s who had been married for several years to a Hindu man from Uttar Pradesh but did not have any living children or history of pregnancy. Many women with whom I interacted asked probing questions to determine these details of my status relative to their situations, and their comments often included admonishments to try for children soon. I reflect on these dynamics and their implications for the research in more detail elsewhere (H. D. Singh 2011, 2016). While important in setting the context of conversations, these dynamics did not constitute a significant barrier to field research and may have helped facilitate interactions. Finally, I draw on scholarly and popular media perspectives on new uses of assisted reproductive technologies in India to analyze continuity and change in the ways that women's bodies are used to reproduce their marital households.

Findings

Several key themes emerged through my research. First and foremost, women's fertility matters beyond the level of the individual and beyond the level of a couple—here, generally a married couple—with implications that ripple out to the extended family, whether or not they reside together. New daughters-in-law living in joint families in North India commonly become a primary source of domestic labor within their marital households, with the expectation that the distribution of labor will shift with time and with the birth of children, both of which common sense in North Indian kinship say tend to raise a daughter-in-law's status and establish her

as a member of her extended marital household. But what happens when fertility problems delay the arrival of children? And how do technological innovations promote the diversion of women's reproductive potential from producing children to secure their extended family's future to generating cash for the household?

Compensating for Infertility with Kin Work and Household Labor

I begin to answer these questions with the story of an elderly Muslim woman I have given the pseudonym Qudsia baji. *Baji* is a general term in Urdu that means "sister" or "elder sister," and is often used as a term of respect. Qudsia baji is an elderly woman I first met in 2007 through my attendance at the meetings of a ladies' organization in Lucknow. Her main focus in recalling her experiences was not on any medical or ritual intervention, but on relationships with other members of her in-laws' home. Qudsia baji recounted her contributions to running her in-laws' home in the early years of her marriage, but focused on specific occasions when she was hurt by the devaluing of her household labor through reference to her fertility status.

According to Qudsia baji, within two years of her marriage without her giving birth to a child, people in her in-laws' home, her sasural, started to talk. In Qudsia baji's narration of her reproductive history, she lived for a total of 12 years without giving birth. Then Qudsia baji became pregnant and gave birth to a baby that she believed was stillborn but later found out had actually lived for several minutes after being born. Another six years passed before she gave birth to a son, who lived. When we spoke in 2007, he was about 21 years old. In the midst of these reproductive travails, she tried at least a couple of times, unsuccessfully, to adopt a child from within her extended family. In our conversations, Qudsia baji presented herself as a person who worked hard to maintain herself and to help others, even though they often forgot her when she needed help. She focused on the difficulties she encountered after marriage and before children through problems with her in-laws, especially her mother-in-law (*saas*), her husband's sister (*nand*), and her husband's younger brother's wife (*devrani*). Although she criticized her husband for his behavior with the other members of his family, and particularly his failure, from her perspective, to vocally take issue with the treatment she received from others, she emphasized that he did not abuse her because of their childless state. Instead, he offered her comfort in private. She explained:

> He [husband] never said, "We don't have any children" or, "I'll leave you." ... One day my mother-in-law took him aside and said to him, "Leave her. ... I'll get you married again. ... " His habit is such that he never says anything to anyone, even now he doesn't say anything against his elders ... he only argues with me ... he couldn't even say to his mother, "What are you saying?" So I began to get worried. Then he said, "Why are you getting so worried? There's nothing like that, that I will leave you or get married a second time. Let her say what she wants ... there are children in the family. ... " I never had any complaints about him, but I did from every other direction. ... My methods, my manners, my getting up and sitting down ... in everything, objections were raised against me, but he never said anything.

While criticizing her husband for his silence, Qudsia baji also emphasized that she also remained silent, tolerating slights and criticisms by her husband's relatives. However, she remembered one particular incident that drew attention to her childless state in a way that hurt her more than the daily nitpicking that seems to have been a main feature of her interactions with her in-laws. It happened on the occasion of her husband's elder brother's daughter's (*jeth:* husband's elder brother; *jeth ki laRki:* his daughter) wedding. She contributed significant labor to the preparations for the wedding, including sewing, cooking, and preparing the house. She explained that she took a major role in getting everything ready for the wedding, and no one was concerned that her participation would have any negative impact on the girl who was to be married. She said:

> I didn't confront anything, I endured it. . . . What can I call myself. . . . I bore it myself. . . . The clothes worn at the time of the *nikah* [Muslim marriage ceremony] are considered to be the most important. . . . I sewed all of her clothes, all of that girl's clothes . . . at that time, I wasn't a barren woman [*banjh*] . . . putting away, picking up all of the food and supplies . . .

At the time of the marriage ceremony, when the bride was being dressed and prepared with special bridal jewelry, the wife of her husband's elder brother—her *jethani*—singled her out and asked her not to help the bride wear the large circular nose-ring (*nath*) that is a customary part of bridal attire. At a time when women offer blessings to a new bride by assisting with her final wedding preparations, Qudsia baji's jethani put the stigma of infertility front and center, saying that this girl should not get the kind of married life that Qudsia baji had. After all of the work she had done to prepare the household for the whole event, and even though many years had passed since the incident, Qudsia baji still clearly felt bitterness about her jethani's words, saying:

> But at the time of the nikah I became a barren woman. So, the girl didn't wear any silver jewelry placed by my hand . . . so I got up and left that place. Then the whole matter got spread around the household. Shaqib's wife has gone . . . now Shaqib's wife has gone, so all work has come to a standstill . . .

Without a child of her own, Qudsia baji took on responsibility for caring for other members of the extended household. In the course of daily life, her labor counted. She had carved out a space for herself in the everyday operation of the household. Being snubbed on such a joyous occasion both stung her pride and highlighted the complex and delicate nature of relationships within the sasural, particularly among the women living together there. The jethani's behavior on this auspicious occasion highlighted the limits of Qudsia baji's claims to reap the kinship benefits of her labor. Her experiences as a woman living with infertility in a joint family did not seem to lead her to question patriarchal family norms (Qadeer and John 2009), but to continue to seek ways to fulfill those expectations. Despite the insults, she stayed with the family and continued to cultivate strong ties within it. After many years, she finally succeeded in bringing a son of her own into the family.

Redistributing Household Labor for Infertility Treatment as Kin Work

During the time of Qudsia baji's struggles over labor and procreation, the technological options for dealing with infertility, pregnancy loss, and other fertility woes were limited—it was a time when there was no in vitro fertilization anywhere. Still, strategies involving shrines, holy people, plural marriage (the much-maligned co-wife), and adoption-like forms of child circulation could have brought children into her family. However, many of these strategies have low social acceptance in India, and family law limits some of them—adoption and plural marriage in particular—to members of some religious groups (Vatuk 2009; Williams 2006). For example, Muslim men, but not women, and neither men nor women of any other religious group, have been permitted to contract up to four legal marriages at a time. Until recently, only Hindus have been able to legally adopt children, although laws allowed others to become legal guardians to children (Bhargava 2005). The dynamics of fertility enhancement have undergone rapid transformation in the last few decades, with technological development as well as reform in health care delivery. In Lucknow in 2007, many women I met in government infertility clinics came there through the help of others in their households who took responsibility for managing daily chores while they visited the clinic alone, or, most often, with their husbands. Relief from domestic duties required the cultivation of good relations within the household and presented the opportunity for women to interact with their husbands conversationally and to collaborate privately in decision-making in ways otherwise not guaranteed in joint family living arrangements.

Here, the reproductive labor carried out by daughters-in-law—in the dual sense of the Hindi/Urdu word *kaam*—physical work and sexual intimacy—could both move outside of the marital home. The daughter-in-law's household responsibilities, such as preparing and serving food and cleaning or supervising hired helpers, could be redistributed to another member of the household—a sister-in-law, an unmarried daughter of the family, the mother-in-law, and/or a paid domestic worker—to facilitate her absence to visit the clinic. Clinical treatment could require negotiating sexual intimacy in a different location, but it could also involve sperm collection in a laboratory space, or a location near the hospital, for use in intrauterine insemination (IUI) or other procedures. In some cases, the "work" of procreation took place in the hospital, with the assistance of doctors, lab technicians, and syringes. However, it also required significant effort to travel to the clinic, to procure and take the prescribed drugs, and to manage relationships necessary to facilitate ongoing financial and emotional support for infertility treatment. Procreative labor is usually not only relegated to the informal sector, but rendered invisible by codes of shame and modesty or the cover of a joke. Here, working for conception requires not only time, effort, and bodies, but also money. Procedures carried out in public hospitals cost less than they would in private hospitals. Nevertheless, treatment could require the equivalent of thousands of dollars, depending on the diagnosis.

For many women I encountered in biomedical infertility clinics—the ones who made it there and were actively engaged in seeking children—their dedication to working toward getting children through infertility treatment helped strengthen bonds with their husbands. Women reported that developing close bonds with their husbands did not hinge on diagnosis of male, female, or a combination of male

and female factor infertility. Although some women referenced conflicts within their extended families, and insinuations by mothers-in-law, especially, that her son could easily get remarried, women in clinics more often pointed out the strong ties that helped them pursue treatment. Emotional arguments about the affective relationships between people and the necessity of children went beyond personal desires to experience pregnancy or motherhood, and beyond childbearing as a means of creating or salvaging a husband–wife bond. For example, Gunja, whose husband was working in the Persian Gulf, and only periodically came to visit his wife in India, felt that she had learned much about the value of children from her own experiences. She had been married while she was still completing her bachelor's degree, and she and her husband had used birth control during the first three years of their marriage. She contrasted that time, when they were always anxious that her period not be delayed, to the present, when they wished it would not arrive. She said that her own mother had passed away after her marriage, while waiting to become a grandmother (*naani*), and her father-in-law had also passed away. She argued that her child would be a king (*raja*, implies son) in both her natal home (*maike*) and her in-laws' home (*susraal*). She said, "The child is not for my happiness, it's for the happiness of others. It will certainly bring a smile to my face, but it will also bring a smile to everyone else's face as well."

While the absence of children, or an otherwise perceived lack of a "complete" family could be a threat to marital stability, laboring to achieve a semblance of appropriate reproduction (which might involve innovations such as sperm donation, kept under wraps) presented a different kind of opportunity for daughters-in-law to prove their dedication to their marital families and build relationships that could be useful in the long run, whether or not their fertility endeavors were ultimately successful. A Hindu woman named Manju, the mother of an eight-year-old daughter, came to the clinic in hopes of achieving conception, and particularly with the stated hope of getting a son. Originally from Kanpur, an industrial city about 50 miles away from Lucknow, Manju emphasized that her mother-in-law was very good and would send her for treatment even when Manju herself didn't feel like coming to the clinic, while her father-in-law bore the cost of treatment without complaint. Despite the strong role her in-laws played in her treatment, Manju focused on her eight-year-old daughter as the main force behind her treatment, saying that she would like to have a brother for her daughter, so that she would be able to tie a *rakhi* (an ornamented string bracelet) on someone on holidays like Raksha Bandhan, a day that focuses on the special protective relationship between brothers and sisters (D. Singh 2014).

Women lived in the midst of lore about the fates of childless women—that they died, disappeared, or were divorced, abandoned, attacked, and/or murdered by their husbands or other relatives (Patel 1994; Times of India, Lucknow 2007). Although a few women questioned the alleged benefits to be reaped by having children, especially in the forms of old-age economic and emotional support and companionship (Lamb 2000; Vlassoff 1990), when weighed against the difficulties of bearing and raising them these voices stood out as unusual among the women I spoke with in clinics. Trips to the clinic and the collaborative goal of overcoming infertility provided husbands and wives with an unusual opportunity—at least for those living in joint families—to get to know one another outside of domestic spaces and beyond the gaze of other members of the household. Strong ties generated through successfully

negotiating their reproductive journeys offered women suffering from infertility in its various local forms, whether lacking children in general or sons in particular, a glimmer of possibility for successful married life, even without achieving locally defined reproductive success.

Discussion: Infertility Services Advance the Commodification of Reproductive Potential

Women in Lucknow from many different backgrounds and with a variety of reproductive histories claimed the experience of infertility to be a source of significant suffering, but one undifferentiated by expected social divisions of class, caste, and religion. In general conversations about my research project that exceeded the boundaries of my formal, structured, clinical interactions, I heard again and again that women with infertility problems would go anywhere and do anything to get children, including, for example, visiting shrines of holy persons across religious boundaries. In this sense, women asserted infertility to be a unified and potentially unifying experience for women, despite significant divisions in other areas of social life.

However, research pointed to stratification of women's experiences based on different social, religious, and professional positions. These positions and the finance and relative prestige and power associated with them (or lack thereof) influenced the potential options realistically accessible to them. Commercial options in contemporary India provide new opportunities for women to fulfill or subvert familial expectations, by enhancing, reducing, or diverting their fertility. Expectations to influence, and potentially to control, women's fertility are not new features of North Indian extended families, but the means to do so and the results of those expectations are shifting with changes in the Indian economy and with technological developments in reproductive technologies that are now proliferating across India.

Whether intended to supplement a husband's earnings or secure his medical treatment, to save money for children's future school or marriages, or to improve the family's housing, women emphasize their earnings as a resource for the wider family, not for themselves. As Maya Unnithan puts it, with reference to her research on infertility in Rajasthan, western India, women's reproductive potential serves larger collective interests, while the particular form depends on circumstances (Unnithan 2013:302). In other words, their bodies may be engaged for reproducing the patriarchal family, ideally by bringing forth sons to carry on the family line and to procure material wealth. But their bodies may now be more directly put to the service of creating value through gamete donation or surrogacy. Whether this redistribution of reproductive resources amounts to a threat to a highly valued ideal of motherhood (DasGupta and Das DasGupta 2010), or a clever "cure" for both poverty and perceived overpopulation in India, or an opportunity to question patriarchal family norms (Qadeer and John 2009), commercial surrogacy and gamete donation force reconsideration of the value of reproductive labor. In her recent book, *Wombs in Labor*, Amrita Pande (2014) drives this point home through the stories of surrogates at the clinic she calls Armaan in Gujarat, western India. She cites several cases of surrogates at Armaan who had aborted their own pregnancies to pursue surrogacy, delayed their own pregnancies to "save" their bodies for

surrogate pregnancies, or thought that their bodies would be unable to sustain another pregnancy after the strain of surrogacy (Pande 2014:112–116), yet mourned the necessity of these trade-offs. Despite these sacrifices, few women who worked as surrogates were able to escape poverty over the course of several years (Pande 2014:194). Surrogates' kin work, or "kin labor," in Pande's formulation (2014:144) involves not only engaging family members for support and domestic labor but also evading or deceiving some relatives to pursue surrogacy's financial benefits.

Women seeking treatment of their own infertility in Lucknow clinics engaged in practices of selective concealing and revealing to pursue their reproductive aspirations, such as secretly pursuing treatments that transgress ideals of reproducing the patriline (vansh). For example, some women underwent intrauterine insemination with donor sperm (IUI-D), with formal consent from their partners. This method did not require disclosure to other family members and could be easily hidden from other family members they might fear would object, even while women enlisted their help to facilitate infertility treatment in general, in the name of the larger goal of ensuring successful reproduction. Strategies relating to the disclosure or nondisclosure of the details of infertility treatment are not evidence of liberation or autonomy in any straightforward sense. They were deeply enmeshed with the structures of everyday life, the desires of partners and members of the extended family, and with women's own aspirations. As with the surrogates in the studies by Deomampo (2013) and Pande (2014), I argue that pure victimhood does not represent infertile women in my study well, yet when contextualizing their actions within the familial, local, and national worlds they inhabit, neither does pure independence in decision-making about the use of infertility services, including assisted reproductive technologies.

Coverage of commercial surrogacy in India—recently banned in its transnational avatar (Dickenson 2016; Times of India, Delhi 2016)—highlights the variety of ways women's bodies may be drawn into reproductive labor for their marital households beyond the production of progeny, or aulad, and especially male heirs. Although women's reproductive labor generally can be said to have high ideological value, within certain limits, in a variety of Indian contexts, that high ideological value does not necessarily translate into high value attributed to the women who perform such labor. A variety of measures of women's health status support that observation. The examples I have given here demonstrate how the absence of fertility raises awareness of its importance—for women who would be mothers and for others invested in their ability to produce children—because fertility and children cannot be taken for granted. In surrogates' negotiations, I find not only assertion of agency and slippage of the border among ideas of decision, choice, and compulsion (*majburi*) that raises complex ethical questions (Bailey 2011), but also women's creativity in navigating sometimes through, sometimes around, family relationships to exert some measure of reproductive autonomy, even if it means extracting value from their own bodies.

Detailed consideration of how factors of class, caste, and religion influence the particular form of fertility control, and, for example, who is most or least likely to become a surrogate or be able to finance infertility treatment in conditions of stratified reproduction (Colen 1995), is a limitation of this article addressed in part by a larger project (D. Singh 2011, In prep). The work presented here demonstrates that control of women's fertility has strong historical, structural, and cultural roots in North India and that new reproductive technologies are transforming

fertility control but not unambiguously toward women's autonomy in reproduction. There is still pressure to pursue procreation, and particularly sons, but that pressure is intertwined with aspirations fostered by economic reform (Chua 2014), which remain out of reach for many.

Conclusion

What does it mean to consider potential birthing women, whether or not they are potential mothers-to-be—i.e., whether they are meant to contribute the babies they produce to their marital families or to hand them over to commissioning parents—as workers, and their reproductive bodies as objects of control by families, and sometimes by medical institutions or strangers, from which they may extract children, gametes, and ultimately, economic value? That women often labor in informal and invisible spaces, which makes them vulnerable to exploitation in various forms of reproductive labor, whether in domestic labor, kin work, care work, or intimate labors of procreation, should not come as a surprise. Indeed, it is a long-term global, but also shifting, trend (Boris and Parreñas 2010; Ehrenreich and Hochschild 2002).

In the case of India, the ways that women do emotional and reproductive labor for their families, with the aid of biomedicine and biotechnology, are changing with expectations for cash and for control over women's bodies, and particularly over a variety of aspects of their reproductive potential. The use of biomedical technologies enables a simultaneous focus on women's bodies as sources of both reproductive power and value, and away from their bodies as exclusively vessels for the vansh, or creators of aulad for their in-laws. Infertility brings diverse women together in chains of care, not necessarily of love (Meerman et al. 2001). While they connect through their intimate bodily labors, these connections tend to exacerbate, rather than alleviate, hierarchical relationships. The concentration of infertility services primarily in costly private clinics in urban areas creates issues of accessibility to treatment and potential not only to begin, but also to continue treatment, ultimately contributing to a largely unrecognized aspect of stratified reproduction (Colen 1995). Future research ought to highlight the inequalities and ethical complexities not only in transnational reproductive transfers, of which transnational surrogacy in India has become a prime example, but also in domestic reproduction. While technologies promise liberation and agency, at present they also offer a fair measure of majburi in reproduction, including ever-increasing pressure for women to acquiesce to demands on their bodies, whether or not those demands align with their own desires for children, cash, or kin.

Note

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