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**The Girl with the Peanut Necklace:
Experiences of Infertility and *in vitro* Fertilization in China**

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Submitted in partial fulfillment of the requirements of the degree
of Bachelor of Arts in Anthropology

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Glossary

This glossary briefly presents some medical terms used throughout this essay, including both English definitions of the words and their Chinese counterparts.

IVF (试管婴儿 – literally translate into “test-tube baby”)

– the technique in which sperm and oocytes are retrieved from the body and fertilized in a petri dish, then transferred as embryos to a woman’s womb (embryo transfer)

Embryo Transfer (胚胎移植)

– considered the last step of the IVF process, in which a fertilized embryo grown in the laboratory is transferred to a woman’s womb

ICSI (第二代试管婴儿 – second generation IVF although it was exclusively called “ICSI” by patients and doctors over its official Chinese)

– intracytoplasmic sperm injection was developed for male infertility, in which retrieved sperm is directly injected into a retrieved oocyte for fertilization

IUI (人工受精 – man-made, or artificial, insemination)

– intrauterine insemination, the procedure of using a catheter to place sperm directly into a woman’s uterus around the time of oocyte release to allow for fertilization

Surrogacy (代孕 – literally translates into replacement/substitution pregnancy)

– the carrying of a pregnancy for intended parents, in which a third-party would, for example, receive the embryo transfer rather than the individual from which oocyte was retrieved for fertilization

Sperm (精子 – the first character is the same for the words essence and vitality)

– the gamete retrieved from males, usually by ejaculation or aspiration

Oocyte (卵子 – the more medical word; although the English definition uses “egg” fairly interchangeably, the Chinese word for egg, 蛋, was rarely used by women)

– the gamete retrieved from the female with minor surgery in IVF; with the use of hormone shots, IVF patients generally grow more than one per IVF cycle to maximize the number of eggs retrieved from each cycle

Introduction

Every morning at the hospital begins with the dull, incessant ring of elevators over the scattered chatter of visitors. Cramped into three tiny elevators to full capacity, patients, family members and hospital staff shout “*chao zai le!*”¹ at each other, in hopes that the sound signaling overcapacity will stop, at last, to the elevator doors’ closing. A person steps on. *Ring*. A person steps off. Another person steps on. This remarkable pattern repeats until the elevator conductor gives a shrill remark that the lift will not move unless the weight limit is strictly obeyed.

Despite the stressful ordeal, visitors to the fertility clinic where I conducted fieldwork choose to undergo this fight for space to make their way to up the building. Although the clinic is part of the hospital’s obstetrics and gynecology department, it is housed on the 10th floor of a separate, older building, making the journey up the stairs an uninviting prospect for most.

Upon arrival, the elevator doors open to a dimly lit hallway, leading to closed doors on one end and, on the other, ajar metal doors with dented surfaces. If one arrives too early, these metal doors are closed as well. This is because the staff does not open them until 8AM, by which point dozens of patients have already amassed in the small, stuffy hallway, somewhat reminiscent of the elevator just before. Often times, visitors moved into the stairway to take a quick smoke, whether driven by boredom, anxiety or something else entirely.

On the dot, the metal doors swing open, and a nurse tries to direct the simultaneous swarm of patients and their family members to the reception desk. The nurse grabs all of their appointment receipts and disappears into the back office to pull out their files. Older patients are signified by worn out, manila folders; newer patients

¹ “超载了!” has a direct translation of “overloaded.”

are denoted by a clean and clear folder, purchased for 1RMB, with a medical history report sheet soon to be filled out by the resident in training.

Now begins the wait in the lobby.

Turquoise-colored plastic chairs face a wall-mounted television playing anything from children's cartoons to American thriller movies. Patients and their family members sit arms crossed, legs crossed, hands-clutched over their bags – a myriad of positions that often tend to degenerate slowly to laying down across three or four chairs after a three hour wait.

On one busy morning, I sat across from a 20-year old with whom I had spoken to a couple of times before. I had been there when she first came in to the clinic to consult about starting IVF and, now, she was just about to begin her hormone injections, which were required to start women on a blank slate for a timed and controlled cycle. Seeing her come in so often, I noticed that she now wore a shiny and golden peanut necklace around her neck, resting gently against her chest.

“Is that a new necklace?” I ask, curiously. I had never seen anywhere wear such an object before. “Why is it a peanut?”

“Oh, this?” She twiddled the small charm between her fingers, tugging at it slightly, giving me a smile. “The peanut (*huasheng*) is for good luck, since we're rushing to have a child. You know, like, ‘flower soon, and have many children soon’ (*hua hua sheng sheng*).²

When she explained the meaning behind it, the peanut necklace came to symbolize, for me, the intersection of tradition and state in women's perceptions of infertility. What I mean by this is that within her IVF experience, this patient embodied, at once, the effects of state regulation (the One Child Policy, for one) and of cultural

² In Chinese culture, the peanut can be understood as an auspicious symbol for fertility and the wish to have many children. This is because 花 (*hua*), the first character in peanut, means flower. The second character 生 (*sheng*), more importantly, means “to give birth”.

tradition (the Peanut, for one). Culture and individual beliefs, therefore, seeped into the fertility clinic in these subtle ways, affecting how patients made meaning of their situations. The necklace becomes capable of highlighting women's impatience with infertility and, by extension, how their pressure and anxiety in the situation came to be framed within political and traditional discourses.

In 1988, the newborn girl of an elementary teacher from rural Gansu province became the first baby born from *in vitro* fertilization (IVF) in Beijing, China (Handwerker 2002:298). Four years earlier, in 1984, gynecologist Zhang Lizhu had finally secured state-funding for research and development of the procedure under the proposal "Eugenics: The Protection, Preservation and Development of Early Embryos," a title which did not at all allude to Dr. Zhang's hope to use IVF as a viable procedure for infertile women (Jiang 2013). This proposal emerged just five years after the Chinese government announced its notorious family planning policy, commonly known as the "One Child Policy", to control the country's birth rate in 1979 (Scharping 2013).

Now, Chinese newspapers, television shows and online forums all evidence the popularization of IVF and the rise of IVF clinics around the nation. Even in foreign news, articles depict crowded IVF clinics, their full lobbies with pictures of babies plastered on white walls. I highlight these events to bring attention to the peculiar sociohistorical climate in which, from its introduction to its current popularity, IVF has developed and situated itself in China.

Using IVF as the lens, this essay introduces the dialectics at work that influence women's lived experiences of infertility and IVF in China today. Why did an antinatalist state intent on limiting births support the development of assisted reproductive technologies (ARTs) that increase births? What are the implications of this antinatalist-pronatalist dialectic? Working toward answering these questions, I aim to present the

accounts and narratives of women as they consider, undergo or end their IVF cycles. How do they perceive infertility and the pressures associated with it in relation to the state, society and family?

Infertility currently affects 15% of reproductive-age couples around the world (Vayena et al. 2002; Inhorn and Birenbaum-Carmeli 2008). Given an estimated more than 40 million couples diagnosed with infertility in China (Yan and Blum 2013), it should come as no surprise that IVF has become so popular in the nation, particularly in urban areas. Amidst a booming economy, China's emerging middle class and urbanizing population increasingly turn to IVF as women find themselves with more expendable incomes and faster paced lives.

By understanding IVF and other ARTs as "socio-technical products" (Inhorn and Birenbaum-Carmeli 2008), we can employ IVF as a useful analytical tool to study and frame the unique experiences of infertility in different global contexts. In China, women who undergo IVF have a hand in shaping the nature and societal perceptions of IVF even as the technology itself simultaneously shapes their own beliefs and lived experiences. This coevolution of the personal and the technological hints at the important relationship between the ways infertility and motherhood are understood in tandem with the ways that IVF and related ARTs are.

By looking globally, the study of IVF as an anthropological concern allows us to examine how biotechnologies taken for granted within the context of biotechnological Eurocentrism (i.e. in the Western setting) may change, or not, in other diverse settings (Inhorn and Birenbaum-Carmeli 2008:3). This is because, in part, IVF is not "immune" to culture in the heterogeneous process of technological globalization (Inhorn 2003). As we will see, understanding local encounters with IVF can shine light on cultural and historical aspects that belie unique inequalities and constraints in the face of new reproductive technologies.

Another chief concern in this inquiry, therefore, is how ARTs such as IVF are distributed in its global spread. Access to ARTs have and continue to reflect class- and race-based inequalities (Inhorn and Birenbaum-Carmeli 2008). This fact is exacerbated in countries where a lack of state-funded support for IVF puts the cost burden directly onto patients and their families (Birenbaum-Carmeli 2003; Kahn 2000). Seeing as IVF changes itself and the communities in which it becomes popularized, this technology can often reveal the underlying structures of the dynamic conceptions of infertility and kinship around the world today.

Despite this increasing anthropological interest in IVF, little work has been done on China, especially when compared with other nations with similar demand for or development of ARTs such as India or Vietnam (Bharadwaj 2006; Pashigian 2002; Inhorn and Birenbaum-Carmeli 2008). With the exception of preliminary early works (such as Lisa Handwerker's in Beijing in the early 1990s), the majority of literature concerning IVF in China has come from medical studies that do not yet provide a holistic understanding of infertility for women. This essay seeks to fill, at least in some part, the void that exists today of women's experiences concerning infertility and IVF in China.

Around the world, infertility has been shown to be "particularly important in many developing countries that place a high premium on motherhood" (Liu, Larsen and Wyshak 2003). In addition, infertility in non-Western countries place undue burdens and suffering on women, largely as a result of pronatalist norms that ostracize and blame women alone for their infertility (Inhorn and Birenbaum-Carmeli 2008:7). These pronatalist tendencies, as this essay will show, continue to be perpetuated in China today even in spite of the state's antinatalist birth control policies.

The study of infertility in China has always been confounded by the nation's notorious "One Child Policy," which has largely limited the urban population with its control of one child per family. Considering the One Child Policy, IVF's rise in China

seems, at first, to be at odds with a nation so concerned with population control. By expanding upon what Lisa Handwerker (1995:355) calls “the paradox of the problem of female infertility” in China, I seek to highlight and explain the individual concerns for infertility within a state that views population control as a top priority. What is the affect on women’s lives and bodies from the dialectic of the One Child Policy (which limits births) working against traditional norms such as filial piety (which encourages births)?

In fact, according to an old Chinese saying, “there are three filial disobediences, but having no child is the most serious one” (Liu, Larsen and Wyshak 2003). The One-Child Policy does not at all dissociate women’s status from the birth of children, especially sons, that has persisted in Chinese culture today (Qiu 2002). Rather, the combination of state and tradition changes the policy’s interpretation from “you should have one child” to “you *must* have one child” (Handwerker 1998:200). As a result, infertile Chinese women find themselves increasingly pressured by both tradition and state in a strict regulation of reproduction. This pressure, or *yali*³, is a key factor in either motivating the women to begin, continue, or, sometimes, even end their IVF cycles. For infertile women, these collisions of individual belief, culture and IVF create tensions that at once amplify and give rise to pressure in an endless cycle.

A deeper look at the means by which infertile Chinese women embody their suffering and experiences hint that IVF is capable of taking away agency as much as it is capable of creating it. As Sarah Franklin suggested, IVF is not treating infertility insomuch as it is temporarily “replacing” a single reproductive cycle (Franklin 2006:549). This substitution inevitably involves a “wholesale takeover” of women’s bodies, in which natural control is relinquished so as to obtain precise, scientific control (Franklin 2006:549). While IVF undeniably offers hope to those trying to have children, its focus on the *need* to have a child unintentionally constricts the range of acceptable life

³ 压力

courses for women in Chinese society. With its tedious timeline of steps, IVF largely remains a procedure for those who are left with no other option for a biological child. But, what about for those women who are perhaps more impatient than desperate? More pressured than committed?

Over the course of 10 weeks in the summer of 2014, I collected the accounts of women and doctors at a fertility clinic (that I will call the Reproductive Medicine Clinic, or the RMC), part of a tertiary-level, urban hospital's Department of Obstetrics and Gynecology. The RMC, thus, was a representative piece of the nation's public healthcare system, with IVF as the mediator between the technopolitical and the sociocultural. While couples visited for a variety of reasons related to infertility, most of the patients were women who come to seek IVF as a solution.

As a result, the waiting room was made up of these women, either asking about IVF, about to start IVF, in the midst of IVF, or post-IVF. Their conditions echoed each other's as they chatted casually to different degrees of scientific or personal intimacy, inevitably centered on stories about oocytes and their own infertility histories. I had the honor to sit with these women, sometimes next to them on the waiting room side, other times across from them on the clinical side with the doctor next to me. It was during these wait times, both in appointments and out of them, that I began to converse with these individuals.

This essay seeks to address the experiences of my interlocutors in describing how infertile women in China are doubly pressured by the antinatalist state on one hand and the pronatalist tradition on the other to meet the need for a child. While male infertility also plays an equal role in China's so-called "infertility crisis", this essay will focus primarily on female infertility, touching only on the male (and husband) experience tangentially.

The opening chapter delves into the making of the One Child Policy by the Chinese state, introducing its history in tandem with that of IVF's development in the nation. Next, I explain how, as a result, a stressful tension for infertile or childless women has emerged from the two-fold demands of a pronatalist tradition and an antinatalist state. What results from this antinatalist-pronatalist dialectic, in other words, is a push onto women's bodies and lives from both sides of state and tradition. The second chapter, therefore, explores how women's infertility and IVF experiences become affected and inevitably limited by these boundaries, which restrict them to certain norms – that is, meeting the One Child Policy by having *one* child, but not more and not less.

The third chapter focuses on the hospital and its role as the battleground in which women's own agency comes face to face with this two-pronged pressure from state and tradition. With the help of a community formed in the clinic, patients must often make an investment of agency to undergo IVF, in which women must temporarily give up control of their reproduction to, perhaps, gain control of their lives at large. Chapter Four addresses the role of the family for women undergoing IVF, and how filial piety influences or justifies the close involvement of husbands, mothers and, especially, mother-in-laws.

The final chapter presents five narratives of patients to compare their infertility and IVF histories. At the personal level, how do infertile and childless women truly experience the burdens that state and tradition (and by extension family) impose on them? Although dissimilar, the lived experiences of these five patients reveal the dynamic ways in which women must navigate China's antinatalist-pronatalist dialectic, hinting at nuances of the power structure in which IVF is ultimately embedded. In the conclusion, I offer questions and possible policy solutions to extend the conversation on

how IVF can become a more accessible option for women without perpetuating a stigmatized notion of infertility and childlessness.

Chapter 1 – One Child Or Bust: A History of the One Child Policy and IVF’s Rise Within It

In December of 2011, Chinese media outlets reported a wealthy Chinese couple that had become parents to eight babies through assisted reproductive technology (Xu 2011; Kaiman 2012). By the use of IVF, the wife of the couple had given birth to triplets, followed by the birth of another set of triplets and twins from two separate surrogate mothers in the following week. The couple had apparently tried to conceive naturally for many years, but had turned to IVF as previous medical attempts proved unsuccessful. This sensational story raised immediate outcry from Internet commentators and medical experts alike, calling this abuse of IVF as a blatant violation of the One Child Policy, China’s notorious birth control law that limits one-child-per-couple.

When asked about the “eight-baby scandal” in an interview with the Los Angeles Times, an obstetrics expert in Hong Kong (Kaiman 2012) responded, “from the sound of it, they just tried to have some kind of baby machine.”

Background

The World Health Organization estimates that infertility affects anywhere from 10-15% of reproductive-aged couples around the world (Sembuya 2010). With China’s population of 1.3 billion, it should come as no surprise that the nation’s IVF industry is booming. Current sources identify an estimated 40 million Chinese men and women, nearly 12.5% of the nation’s childbearing population, with infertility (Yan and Blum 2013; Huang 2014).

Although the first successful IVF cycle was performed in England in 1978, the technology itself was not introduced to China until the 1980s. At the time, both Taiwan and Hong Kong had successfully performed the procedure in the years prior to 1988,

when the first Chinese IVF baby was born in Beijing to a rural couple from Gansu Province (Qiao 2014). In the past decade, as incomes rise and accessibility increases, couples flock ever more to IVF clinics, with doctors working around the clock to address a still unfulfilled demand. In fact, according to the Chinese Ministry of Health (CMH), the number of authorized medical institutions in recent years has increased from 18 to nearly 360 institutions from 2003 to 2013 (Yang 2013; Huang 2014).

Despite being an anomaly, the “eight-baby scandal” described at the start of this chapter is but one outcome of the numerous couples undergoing IVF in China today. Chinese media maintains this continual dialogue of infertility and IVF stories with news of the nation’s current “infertility crisis”, raising questions about why infertility has become the focus of an overpopulated country with strict family planning policies.

By the time IVF was introduced to China, the Population and Family Planning Law⁴, widely known as the One Child Policy, had already made considerable social impact since its establishment, markedly reducing China’s total fertility rate to below 2.1, a level lower than replacement (Gu and Cai 2011). Just as assisted reproductive technologies began to emerge in the Chinese sphere, total fertility rates – and by extension, birth rates – had already stagnated to their lowest levels as a result of the state’s effort on population control. These restrictions on fertility have, unsurprisingly, overshadowed the restrictions *of infertility* inherently faced by couples in China. Where, then, do these opposing endeavors of state and science leave the infertile in China? Did they remain invisible amongst it all?

In this chapter, I argue that the same motivations that drove the conception and institutionalization of the coercive One Child Policy underline the development of IVF in China. The One Child Policy affects all women in China, whether of childbearing age or not, whether fertile or not. Understanding the Chinese party-state’s motives for

⁴ *Renkou Yu Jihua Shengyu Fa* or 人口与计划生育法

advancing the One Child Policy is crucial to contextualizing the development of ARTs, particularly IVF, in an antinatalist nation. The state's allowance of IVF clinics to proliferate in China, although in a manner more regulated than their Western counterparts, should not just be read as a sign of hope, but also as a sign of caution. Why, indeed, would a government so against unnecessary childbirth support, even ambivalently, the growth of IVF and its accompanying reproductive technologies?

To explore what appears to be a contradiction, I first present the circumstances and national discourses that lead to the One Child Policy, which continues to this day with little amendment. Only then, knowing the backdrop within which IVF developed, can we double back to the early 1980s, just years after this policy's initiation, to trace IVF's humble beginnings in China.

The Creation of an Antinatalist (but Modern) Nation

Population has not always been the concern of the Chinese state. Over the course of 20 years starting from the 1950s, the nation slowly abolished population studies with much ambivalence. Mao Zedong himself saw childbirth as the mark of a strong, able-bodied state, whose increase in population meant greater military resources (Zhang and Goza 2006). In fact, in the early 1970s, Maoist China saw population explosions as "Malthusian concoctions imposed on the third world by the superpowers" (Greenhalgh 2003:172). If there was a population crisis, it was neither recognized nor believed to be a detrimental issue.

Toward the end of Mao's reign in the late 1970s, however, a concern with population control began to take center stage. The first hint of this paradigm shift is the lesser-known "later-longer-fewer" (*wanxishao*) policy to promote later births and longer periods between birth for fewer births overall (Greenhalgh 2003). The pivotal shift occurred just after the third plenum of the Chinese Communist Party's Eleventh Central

Committee in 1978 – as the nation placed socialist modernization as its top priority, so did population become a concern of both state science and governance (Greenhalgh 2003:165). State birth planning and control emerged as stronger than ever before. As a result, in 1979, the One Child Policy was initiated, preventing what scientists now estimate to be 300 million births over the course of the last 40 years (Greenhalgh 2003:163). Given China's earlier position on population control (or lack thereof), what could have prompted such a dramatic change in state policy?

In an ongoing debate over the course of the 1970s, natural scientists weaved together a strong public discourse of a virtual population crisis, predicted with data and (then considered) fancy visual depictions in the forms of graphs and tables. By offering quantitative, Western models of statistical analysis, this argument ultimately brought attention to a finely crafted population crisis, positioned as urgently harmful to planned economic development (Greenhalgh 2003:172).

The goal of the policy, then, was not only about establishing a strong state, but also (and more importantly) about the making of a modern society through the use of Western science and technology (Greenhalgh 2003:164). The Chinese government hoped that, to the outside world, the policy would serve as both a show of the state's physical, coercive power and mental, symbolic prowess of scientific advancement. What culminated as the notorious One Child Policy, thus, can be understood as the inevitable policy solution of a state determined to modernize itself and its people.

As a result of this aggressive policy, China's total fertility rate dropped dramatically from 7.5 to 1.7 from 1963 to 2003 (Postan and Duan 2000; Population and Reference Bureau 2004; Zhang and Goza 2005). Even today, government propaganda continues to stress the importance of fewer high quality births, engraining the concept of one-child-per-couple into every aspect of social life (Bongaarts and Greenhalgh 1985; Zhang and Goza 2005). From its initiation in 1979 to present day, the One Child Policy

has undergone little revision, losing none of its forceful momentum. Only in recent years has the government relaxed the One Child Policy, amending and expanding the exceptions to allow a second child in cases where at least one parent is an only child (Tao 2013; Library of Congress 2014).⁵

The discussion of the making and shaping of the One Child Policy is important for understanding the role that China's antinatalist sentiments have played in coloring the experiences of women, whether infertile or not. Although infertility is not solely a woman's issue, women in China still remain largely stigmatized for either their inability to conceive a child or their personal choice to remain childless (Handwerker 1998; Martin 2006). As Lisa Handwerker observed in her ethnographic work on China's fertility clinics during the 1990s, what originated as the One Child Policy manifested itself socially as a "one child quota" for all women (Handwerker 1998:200).

Independent of women's own personal desires, the policy's ideology intersects with existing patrilineal traditions and gender roles that work to limit women's reproductive agency (Martin 2006). Infertility was and continues to be a source of suffering for Chinese couples, particularly the women of these relationships, on whom tradition places the greatest burden. Praised in state media as a technological success, the birth of the first IVF-baby in China offered a ray of hope for many of these infertile women who saw, at last, a chance to have their "one child." The question remains, however, the extent to which such media coverage perpetuates the necessity for women to have a child or otherwise face social stigma.

The Introduction and Development of IVF in China

⁵ This exception was made in early 2014 following an earlier amendment that would only permit a second child for couples in which *both* parents are the only children. This amendment adds to older exceptions, which include both parents being of ethnic minorities, rural residents whose first child is a girl, and the first child is handicapped. (Library of Congress 2014)

Just as population sciences came into state prominence, Chinese gynecologists became interested in assisted reproductive technologies, particularly IVF. Given that the One Child Policy was already firmly established by the time IVF was successfully performed in China, IVF, as a technology that *assists* with reproduction, developed chiefly in a state concerned with curtailing reproduction.

In the early 1980s, IVF caught the attention of well-known gynecologist Zhang Lizhu at Peking University Third Hospital (PUTH), who took an interest in the technology after receiving thousands of letters from infertile couples all over China, all begging for a solution to end their childlessness (Jiang 2013). These letters, mostly written by women, detailed how couples had exhausted all local resources and tried traditional treatment, but were now seeking Zhang's guidance as their final hope. At the time, IVF literature was scarce in China, but Zhang had learned about IVF technologies offered in other countries from attending international conferences. In 1982, after speaking to some of the patients, Zhang saw IVF as a possible solution for these couples, and set to secure funding to develop the procedure (Jiang 2014:31).

Zhang found funding incredibly elusive, even after teaming up with two other renowned gynecologists from Hunan and Beijing (Jiang 2014:32). The three physicians struggled with finding support for their projects during a time when the One Child Policy had just began to tighten control on the population with mass sterilization campaigns in 1983 (Greenhalgh 2003:165; Jiang 2014:32). In this sort of context, how would Zhang and her team rationalize state funding for IVF?

It was not until 1984, when Zhang re-submitted her research project as "Eugenics: The Protection, Preservation, and Development of Early Embryos", that her interests aligned with the state (Jiang 2013). The renaming of the project was crucial to shift focus away from the fertility aspect of IVF and, instead, toward the technological benefit of ensuring high-quality embryos. As part of China's Seventh Five-Year Plan,

PUTH and two other hospitals were given grants to study IVF as part of the nation's economic and scientific development goals (Jiang 2013; Toronto Star 1988). Despite how well IVF fit into the nation's aim towards high-tech modernization, the procedure still raised serious questions about possible increases in birth, going against the motives of the One Child Policy (Jiang 2014). As a result, Zhang and the other doctors involved in IVF development often had to justify their work not only to state officials, but also their coworkers (Handwerker 2002; Jiang 2014).

Regardless of these obstacles, over the course of the next four years, Zhang's team studied IVF extensively, starting from basics about the human ovum (Zhang had never seen a human egg before) and without the advice of foreign scientists (Jiang 2014). As a result, IVF was adapted and reshaped, both technologically and symbolically, for the Chinese context of the late 1980s. When Zheng Mengzhu, China's first "test-tube baby" was born in 1988, state media outlets reacted with overwhelming positivity, lauding the nation's technological and scientific success (Handwerker 1998:178). The story is covered, even today, as a modern, nationalistic success story, hailing Dr. Zhang as "our nation's divine mother of IVF" at a 20-year reunion with Mengzhu, now a college student (Lan 2008).

Contextualized within the ambitions of the Chinese party-state, IVF could not have been advanced if not for the doctors and scientists who appropriately spun their motives for patient welfare as ones of national, scientific achievements. To the statesmen who invested in the development of IVF, Zhang Lizhu's project was never about providing children for infertile couples – it was about showing off to Western eyes China's "indigenous method" of IVF design, distinct from established protocols but just as capable and effective (Jiang 2014:35). For example, Zhang devised a new, open pelvic surgery approach to recover oocytes (eggs) from patients rather than the original

laparoscopic approach in adapting the procedure to China's medical context (Jiang 2014:42).

Since Zhang's celebratory success, however, the IVF program in China has shed much of its romanticism to embrace a detached, industrialized and commercialized style. As IVF became more and more popular, creative procedures such as Zhang's initial approach have been standardized to stricter protocols, so much so that IVF babies were produced, as Zhang commented worriedly when asked, "in a manner of the assembly line" (Jiang 2014:41). In a separate article, Dr. Zhang estimates that China now had up to 10,000 children born from IVF as of 2008 (Xinhua News Agency 2008). Others articles claim that, as of 2014, as many as 15,000 babies were born from IVF in Beijing in just one year alone (Huang 2014). Chinese clinics are contributing, without a doubt, their portion of births to the estimated 5 million total from IVF around the world since 2012 (European Society of Human Reproduction and Embryology 2012). In addition, faced with inadequate regulation and an inevitable black market from the limitations of the One Child Policy, no one is even quite sure of the true extent of China's IVF boom.

Like the One Child Policy, IVF has found its place firmly in the heart of the polity by its economic and symbolic value. The IVF-baby was the manifestation of China's technological modernity. It is important, thus, to note that ARTs developed successfully in an antinatalist nation only be fitting into the state driven "modernizing" ideology. Knowing this, we must proceed with caution in assessing the state's relationship to IVF and, by extension, to the millions of patients that the technology now potentially serves in China.

Thus far, I have outlined the paradoxical yet parallel creations of China's One Child Policy and IVF program. In the next chapter, I delve further into how the state's unique positioning generates a dialectical position to that of tradition. What results from this collision of state and tradition is a heightened pressure for women, whether infertile

or not, to meet their “one child quota” as per the One Child Policy. Although entangled in a web of socioeconomic, cultural and political influences, women’s own narratives on IVF will allow us to approach a deeper understanding of the intersecting pressures and motivations at play in the reproductive realm faced by women around the world.

Chapter 2 – Pressured From Both Sides: How State and Tradition Influence the IVF Experience

Newspaper publications echo an emerging but serious infertility crisis in China. As a result, IVF has become ever more advertised in state media as a second chance for women who face childlessness. Despite its unprecedented growth, the booming IVF industry still struggles to meet a demand that is growing ever faster. The only thing longer than waiting lists is the actual waiting line of patients (mostly women) crowded in overflowing clinics. One article reporting recently on PUTH, where IVF was first successfully performed in China, described the women visiting this fertility clinic:

Some have travelled far from the countryside, where an infertile woman is looked upon with pity. One young woman's husband divorced her after she failed to conceive three years into the marriage. Others, including urban career women, appear too ashamed or embarrassed to speak. Slowly but surely, women in China who struggle to conceive are realizing there is hope out there and they do not have to helplessly suffer the intense stigma of being childless in a society that places supreme importance on having kids. (China Daily, March 2005)

Such rhetoric is immediately reminiscent of Sarah Franklin's work on IVF, in which she describes IVF as a "hope technology" that, aside from being a technical process, embodies interlinking cultural values with an overarching belief system (Franklin 1997; Franklin 2006:549). Infertile or childless women become homogenously portrayed as pitiable individuals who seek hope through pursuing IVF. Subsequently, rising infertility rates homed in on the nation's increasing concern with women who cannot reproduce (Handwerker 1995:355). As a result of this, IVF's rise in China has done little to combat the societal stigma surrounding infertility. Instead, it has only reinforced that such a stigma persists stronger than ever unless a woman has a child, through IVF or otherwise.

Past anthropological studies have shown that new technologies, particularly reproductive ones, can work as a lens to shift and thus expose previously hidden aspects of kinship and social structure (Franklin 1998:103; Strathern 1992). In this chapter, I aim to portray how conceptions and experiences of infertility may have changed with the increased availability and normalization of IVF in China. What I focus on in this particular chapter is the clash of state and tradition in influencing women's experiences. Women must therefore navigate the boundaries of bureaucracy generated by the state.

The earliest mention of the tension of state versus tradition is present in Lisa Handwerker's work on IVF and fertility clinics in 1990s China. Handwerker brought attention to "the paradox of the problem of female infertility" in a state widely concerned with population control (1995:355). Handwerker calls this issue a paradox, because even as a state concerned with birth control, China continues to place a large premium on fertility and motherhood. In the context of the One Child Policy, thus, women face a narrowed range of acceptable life courses in which both having no children *and* having too many children are unacceptable and unnatural. Despite an antinatalist policy that restricts births, China still remains a state deeply embedded in a pronatalist tradition (Scharping 2013:4).

Unfortunately, in the antinatalist-pronatalist dialectic, women's bodily ontologies become the battleground. While such ideological contradictions have raised ongoing debates in the political realm, women remain in a paradoxical position in which their reproductive bodies are regulated in a manner stricter than ever before (Martin 2006:69). On the one hand, tradition requires women to give birth to children, particularly sons. On the other, modern politics restricts them from having more than one child. Under this peculiar context, IVF is able to provide a possible solution to the problem of childlessness, but does little to destigmatize this "problem". The question, therefore, is whether women or the society in which they are embedded have greater

control over IVF. How does the increasing normalization of IVF in Chinese society affect women's state of agency over their reproductive choices, if at all?

Bound by Tradition

According to the World Health Organization (WHO), infertility is defined as the failure or inability to achieve pregnancy over the course of at least 12 months of regular, unprotected sexual intercourse (WHO 2014).⁶ While China now follows this clinical definition, infertility, up to the mid-1980s, was defined as inability for conception following 24 months of marriage (Handwerker 1995:356). Even now, the actual perception of infertility varies from patient to patient on a fairly subjective basis. In the reproductive clinic, I witnessed many women coming in to treat their infertility, but some had been married only three months, while others had been married for years. Furthermore, women often may not recognize themselves as infertile until they come face to face with medical symptoms that classify them as such.

For example, a younger woman who considered herself infertile had come in to treat her polycystic ovary syndrome (PCOS), a cause of infertility in which a woman has too many eggs maturing at once, thus hindering their development. The symptoms of PCOS include missed periods and infrequent ovulation cycles as a result. On one visit, her mother, who accompanied her, divulged that she too suffered from the same symptoms when she was trying to have her daughter (the patient). Still, she never considered herself "infertile" and luckily managed to become pregnant after a lengthy amount of time trying.

In addition to making women more aware of their infertility (and thus, the "problem" of infertility), widespread media coverage has further introduced and

⁶ <http://www.who.int/reproductivehealth/topics/infertility/definitions/en/>

normalized the option of IVF for the population. When I asked a 34-year old patient why she had decided to turn to IVF, she responded:

At first, I had fears about IVF. I thought that it was unnatural, or that something would be wrong with the child. It just seemed weird to me. I mean, think about it – the oldest IVF child in the world is only, what, 40 years old? So, we don't really know what'll happen to an IVF-child over time. But, then, I noticed everyone was doing IVF. So, it should be okay. I slowly began to accept the safety of IVF.

For this patient, IVF was not exactly a final option but a new and approved one. This sense that the procedure becomes more valid if more people are doing it builds onto a rising awareness of not only IVF, but also infertility. Thus, this “hope technology” allow women a renewed hold over their reproductive choices, while opening them up, with risk, to a new set of external influences.

In an undated video-pamphlet released by the Chinese Ministry of Health, IVF is explained at length in a two-part “audio-visual” guide, describing infertility, IVF and the guidelines that qualify and disqualify a couple (or a woman) from the procedure (56.com 2008a; 56.com 2008b). With patriotic music playing in the background, the video begins with IVF titled in Chinese (试管婴儿) with the English translation misspelled “In Vitre Fertilization and Embryo Transfer” below it. This simple mistake, as I suspect, alludes to the state's carelessness with women's reproductive lives in perpetuating and exacerbating the stigma of childlessness.

After these opening scenes, there is an extensive explanation of “normal” (正常) reproductive process, followed by the definition of infertility as “the persistence of a lack of pregnancy following two years of marriage with a normal sex life.” As China did not change their definition of infertility to the WHO standard of 12 months until the 1980s, this approximately dates the video to being released either shortly before or after IVF's first success in China in 1988. To qualify for IVF under this definition, the couple must

have gone through an extensive list of necessary tests to find out why they are infertile and failed at all other possible treatments before proving that they understand IVF and voluntarily consenting to the procedure.

Although the sperm and oocytes of both husband and wife, respectively, contribute to the development of the child, only concerns with the women's health are mentioned in a list of who cannot qualify for IVF in the video. For example, any woman with chronic organ issues, infectious disease, cancer of the ovary, uterus or breast, and most surprisingly, a history of mental illness cannot receive IVF. Despite an equal biological contribution of husband and wife, the greater and unequal restrictions placed on women only highlights the extent to which their reproduction has become medicalized by state regulation. This heightened surveillance of the woman's medical history suggests that the blame of infertility is associated more with the wife rather than the husband. While the intention of the video is to educate couples interested in IVF, it nevertheless is an example of state propaganda that further perpetuates, even in subtle ways, a tradition that emphasizes women's responsibility to provide a child.

Given this kind of literature on IVF, the label of "infertile" still remains a societal stigma that many women try to avoid, as they are assumed to bear the brunt of the blame. Traditional Confucian and Buddhist beliefs, in fact, consider infertility to be the result of a bodily imbalance, linking this inability to a lack of moral character (Qiu 2002:77). This is because Confucian morality is closely tied to the concept of filial piety, in which individuals are obligated to "extend the life of their ancestors, and make their family unlimitedly continuous from generation to generation" (Qiu 2002:77, Tang 1995:274). Out of the three ways to violate this filial piety, the greatest transgression is "being without an offspring" (Zi 1985:85).

In other words, there is no greater, moral transgression than infertility, which leaves a black mark on a person's character. While a man's infertility (*buyu*) is

mentioned hand in hand with a woman's (*buyun*)⁷, traditional texts always place the blame on the woman (Qiu 2002:77). Given this background, it is no surprise that women often keep their perceived infertility a secret even if their husbands might be at fault.

Even with China's drastic economic and political changes in recent years, its societal sphere continues to follow, to some part, traditional roles and expectations. This is particularly true in the discourse of fertility. Take, for example, the prevailing proclivity for sons over daughters. This bias extends directly from Confucianist filial piety, in which only sons are considered able to carry out the family name and, thus, continue the family line (Qiu 2002:77). This belief has persisted so strongly that, under the One Child Policy, the nation's sex ratios are currently an estimated 1.17:1 at birth, dangerously skewing the proportion of males to females to elicit researchers to ask: where are the "missing girls" (Hesketh, Lu and Xing 2005:1172; Johansson and Nygren 1991:41; Cai and Lavelly 2003)?⁸ What remains are women who try hard not only to become pregnant, but also to have a son. The One Child Policy exacerbates this issue by only giving women one shot to achieve this perceived social necessity.

Aside from son preferences, traditional beliefs on personal levels also affected women's reproductive choices. As it so happened, the particular summer I chose to do my fieldwork marked a transition period from the Year of the Horse to the Year of the Sheep in the Chinese Lunar Calendar. As a traditional saying goes, having the sheep as one's birth sign symbolizes a lifetime of bad luck. In fact, an online article titled "Chinese couples shun Year of the Sheep babies" explains that "a common folk saying" stated only one in 10 people born in the Year of the Sheep find prosperity and happiness (Lu and

⁷ *Buyu* (不育) is an "inability of insemination;" *buyun* (不孕) is an "inability to be pregnant." (Qiu 2001:76)

⁸ The sex ratio of most industrialized countries is around 1.03 to 1.07 – to put this in perspective, China's ratio in 1979 (at the start of the One Child Policy) was 1.06. Now, China's sex ratio is 1.17 at birth, meaning that there are 117 boys for every 100 girls born. When we look at an older segment of the population, this ratio rises to as high as 1.25 for some estimates, thereby doubly confirming the question of the "missing girls."

Hunt 2015). As the doctors at the RMC told me, patients at clinic had noticeably declined since late May 2014 and onwards, because a child conceived after then would be a “sheep child” rather than a “horse child”.⁹

When I spoke to my mother and grandparents about this, they confirmed this general belief, and then continued to cite close family members and acquaintances for which this bad luck proved true. In initial disbelief, I commonly asked patients I met about the Year of the Sheep. The responses I was met with ranged from concerns about having a sheep child to jokes dispelling the idea of misfortune. As one patient joked with me:

I believe in it, but I’m willing to overlook it to have a child. I’ll take what I can get. Plus, because there are less people born in that calendar year, my child will have less competition in school!

On one mid-June day during a doctors’ meeting, the director of the RMC humored her colleagues that they could finally take summer vacations for the first time in 12 years as a result of the quieter IVF season. (The next week, they began scheduling these vacations in turn.) Although this concern about the Year of the Sheep is a rather light-hearted example, it still proves that influence of tradition, working in tandem (or in conflict) with state policy to exacerbate the condition of infertility and childlessness for women.

The antinatalist-pronatalist dialectic, therefore, pressures women to hide their anxiety as they work tirelessly to solve the “problem” of childlessness. When I asked one patient about her opinion on the state of IVF today, she answered:

There are a lot of reservations about IVF in China even today. For example, when I take time off from work to come to these appointments, it’s still a secret

⁹ The Chinese New Year is usually in late January or early February. Gestational time is usually 8 or 9 months, give or take.

(*mimi*)¹⁰. I don't tell anyone about it. I have a couple of close friends that have done it, but still. How can I put it? Some people think that there's something wrong, weird or unnatural about an IVF child, or having an IVF child means that the child isn't even really the woman's. There's not a lot of understanding from most people.

As I will talk about later in this essay, visits to the fertility clinic are usually kept secret to all but the closest family. Women often lamented about having to tell their family, particularly their *popos* (mother-in-laws), for fear of shame or backlash. Even though doctors often stressed how conceiving a child was a two-person effort and, therefore, infertility could be due to either or both parties involved, female patients did not want their husbands checked for infertility until they themselves had gone through all of the tests firsts.

If the silencing of women is one way that the infertility stigma manifests, then the limited freedom of and difficult access to IVF in the public context is certainly another. This limitation can be understood in two ways. First, how women seek to use the technology becomes fashioned by traditional preferences of childbirth (i.e. a son). Second, how women *can* use the technology becomes restrained by state policy. As the Chinese Ministry of Health has largely approved IVF only in public, tertiary-level hospitals in select provinces, this difficulty becomes reality for the majority of women who walk into reproductive clinics, asking for a solution to their childlessness.

In Fashion *in vitro* Fertilization

During my time at the clinic, I encountered a wide gamut of women who asked for and received IVF. These women ranged from 20 to 51 (and anywhere in between). They had little in common but their current infertility, and even self-definitions of the

¹⁰ 秘密

condition tended to vary between patients. While what brought them to the clinic differed, what united them was their want – or need – of a child. The nuance of this seeming universality, however, became apparent when patients began to elaborate on what they expected out of the procedure. Unquestionably, some women did not care about the details beyond just having a child. Other women, though, revealed that they had come with a specific birth in mind, usually a son or twins.

In an interview with a 40-year old patient who had been in and out of IVF cycle for the past four years, she spoke of IVF's popularization amongst Chinese women:

I almost feel like IVF is very *liuxing* (流行) – it's a fashionable thing to do now, almost considered trendy or stylish.¹¹ There's a lot of talk in the waiting room about getting twins from IVF, or being able to choose the gender and have a boy. From what I see, there are definitely more and more young people doing IVF than ever before.

Her comments raise interesting questions - if a greater amount of the population begins to use IVF, is it because the technology has reached out to a previously existing and now revealed audience? Or, is it this audience being created among those who might otherwise not have considered immediate childbirth? What might women forego when IVF generates a seemingly straightforward path to fulfilling both tradition and state expectation? Why might women who are not infertile choose IVF over regular sexual intercourse? Impatience seems to be a common answer, but one should prompt why this hurry to have a child arises in the first place.

This patient's particular focus on the gossip surrounding IVF allowing for choice of a son or twins relates directly to the influence of tradition on women's reproductive agency. As mentioned earlier in this chapter, sons hold a different traditional value than

¹¹ This patient was a long-time English teacher at a private primary school for children of foreign expatriates. She spoke mostly in Chinese, but would translate some of the words she said into English. I noted these words in italics.

girls, one in which the One Child Policy's force of picking one over another always tips the scale in favor of the former. In addition to receiving, technically, two chances at having a son, twins are often favored, as multiple births have remained exempt from the One Child Policy. If a woman's first birth ends up being twins, she can keep both children without incurring the fines of the technical "second child" (Scharping 2013:142).

Other women I interviewed predicted the same trends about IVF's future as appealing to younger generations in China. The same 34-year old patient mentioned earlier in this chapter, after coming out of an unsuccessful, first IVF cycle, said:

I think in the future, more and more people will use IVF, especially very young women, like aged 21 to 25. The world is moving so fast now; the pace of life is so quick. People don't have time to go try this and that and IVF is fast, easy and certain for younger people. For example, instead of trying to conceive for three months, one IVF cycle takes only a month, and there's a 60% success rate if you're young. It's completely worth it.

Both women spoke of the technology's inevitable popularity despite their own experiences of failures with IVF. What is particularly interesting to note from both accounts, moreover, is for whom and for what IVF is considered to become most useful. Their comments reveal that a greater chance of having a son (and quickly, too) motivate many women to undergo IVF, even though they might not be infertile. The appeal to the younger and/or possibly fertile generation suggests that the technology is just as easily a tool of modern convenience as it is a need for the older, less fertile women spoken of in the media.

What IVF offers, thus, is something that natural birth often cannot offer: an expediency and efficiency in achieving a pregnancy traditionally preferred. The worry, thus, is that the country's fertile, younger women are turning to IVF at a greater rate than the infertile women. This observation is not meant to undermine the value of IVF

for infertile women, but it does hint at a chilling conformity to gender norms. This trend highlights the pressure faced by women of reproductive age, particularly married ones, to meet traditional standards that remain largely unchallenged. What IVF gives as more options for women to pursue the path of motherhood is returned as less options for women to pursue different, non-traditional lifestyles.

The suspicion, therefore, is of a state whose intentions are completely removed from the reproductive welfare of the people. Further evidence of this is present in the current restrictions and regulations placed on IVF, perceivable on the hospital level. To address these limitations, the next section of this chapter focuses on how laws and prohibitions have made IVF an agent of the state.

Regulated IVF, Regulated Bodies

While the availability of IVF technology has undeniably given many infertile women the hope to have one child, the accessibility of the technology and, in particular, the ways that it can be used, are still largely dictated by the state. In fact, many infertile women who came in seeking help still could not receive exactly what they wanted. For example, IVF cycles often proved unsuccessful in patterned ways, such as when a patient's fertilized egg failed to develop each time. For one patient whom this was the case each time, the head doctor at the reproductive medicine clinic gave this response:

Have you heard of 4th-generation IVF? It is often called SCNT-IVF as well. You take the nucleus of one egg, and put it in an enucleated (nucleus removed) egg cell of another person. You can imagine, however, how the ethics of this are in question. It was successfully performed in a Hong Kong hospital, but it is deemed illegal in [Mainland] China. Still, this procedure is something very appropriate for you, and to certain other people. Yet, to the general population, the ethics of it

are not appropriate. This is the kind of IVF that would really work for you, since it seems your embryos just don't grow well.

What the anecdote above proves is that, although knowledge of IVF advancements travels fast, putting them into practice becomes impossible in many hospitals. While Hong Kong's separate "Human Reproductive Technology Ordinance" allows this variation of IVF procedure, the case is not so in Mainland China (Ng et al. 2003). In fact, state law prohibits all IVF-approved hospitals from performing "this 4th-generation IVF". This matter is made worse when one realizes that, in spite of the 350-some IVF facilities (Qiao and Feng 2014), these IVF-approved clinics are actually few and far between for most of the Chinese population.

To get a sense of just how many state-approved clinics exist, we can take the example of Tianjin, China, the nation's fourth largest province and the location of one of the nation's central cities. As of the summer of 2014, only eight hospitals (all public) were licensed to perform IVF. Out of these eight, one had never done a single procedure even despite state approval. In fact, when I spoke to doctors in the area, only two of these approved hospitals handled the majority of IVF cases. If this case was representative of the nation as a whole, then, just what percentage of institutions that have received state approval actually regularly carry out IVF, and to what extent? According to this context, if an individual living near or around Tianjin province sought IVF, they could truly only pick between two possible locations. Subsequently, I often encountered patients, therefore, who had traveled from far away, temporarily living with relatives in or closer to the city as they underwent IVF.

This sense of unavailability, despite the representation of IVF as increasingly available, underlines the restriction such reproductive technology faces in antinatalist China. Although Beijing, Shanghai and Hong Kong have their share of growing clinics, these specific locations do little to account for need in Central or Western China. Instead

of providing IVF as a truly accessible solution, the stubbornness of the state to maintain control over women's reproductive agency has only accentuated the dialectical tensions between the antinatalist state and its pronatalist tradition.

In a separate case, a similar conversation came up, several weeks later at the clinic, with a patient whose IVF cycles had continually failed at the embryo transfer stage. The doctor diagnosed that these repeated miscarriages were the result of an anatomical or functional anomaly with the patient's uterus. When the patient asked if she could find a surrogate, the doctor responded:

I'm sorry that it will be against the law to find a carrier mother, since it [IVF] needs to be your endometrium, in your uterus, with your egg. From the perspective of technique and technology, it's not a problem – the state won't allow it.¹²

What the doctor insinuates is that, even though facilities and skills exist to carry out IVF in more advanced ways, law limits the procedure. For this patient, specifically, her chances of successfully conceiving a child from IVF would have been higher if she would have been able to receive a surrogate. The technology seems to exist for IVF to become a more successful procedure for all women in China, but the government will not allow it.

On August 1st of 2001, however, the Chinese Ministry of Health banned gestational surrogacy, thereby preventing women with endometriosis or other uterus-related difficulties from finding a third-party who could carry the pregnancy to term (China Internet Information Center 2001; Yan 2012). Not only that, but an additional law was passed outlawing the selling of sperms, eggs and embryos, as well as requiring sperm banks to be associated with approved medical institutions (Qiao and Feng 2014). This news came as part of the Administrative Principles for Assisted Human Reproductive Technology, which made illegal several IVF-related procedures that had

¹² For the last sentence, the doctor's words verbatim were: “技术上不是问题—法律不允许”.

been practiced without question many years earlier (Yan 2012). These guidelines were closely observed at the RMC, where doctors informed patients who asked that gamete donations could only proceed legally with consent from successful IVF patients who could no longer use their cryopreserved eggs or embryos.

Although doctors debated about whether the law was necessary or arbitrary, there was no denying that the state enacted them in order “to try to match human-assisted reproduction technology with the social ethics, morality and laws of China,” as a spokesman for the Ministry of Health relayed (China Internet Information Center 2001). In the same article, a doctor in support of the surrogacy ban sympathized with patients who might be hurt by the restrictions, but ultimately deferred to the state’s judgment. Strangely enough, she likened the situation to an analogy of cancer:

The cancer will deprive the patient of his life although nobody wishes that to happen. This is similar to the case of those who cannot conceive a child because of a damaged or missing uterus. They are deprived of being mothers, which is a matter of regret for the whole family. But since the state has laws and rules against gestational surrogacy, the couples should respect them. (China Internet Information Center, June 2001)

This quote places into striking perspective the antinatalist-pronatalist dialectic in China. Although tradition stresses the importance of motherhood, a matter at the core of filial piety, the state’s policies prevent women from achieving this goal, even when technological assistance provides a possible answer. Rather than place an investment in regulating surrogacy and gamete transactions, the state chooses to outlaw it completely. Women, however, have invested and continue to invest their faith and physicality to the demanding IVF procedure in order to become mothers. At the end of the day, the state’s control of IVF on the macro-level seems to overwhelm women’s control.

In the hands of the nation, IVF becomes every bit a technology of women's bodies as it is of the state's. Even today in China, only married, heterosexual couples being treated in Hong Kong can apply for surrogacy with their IVF cycles, with the procedure for surrogacy completely outlawed in Mainland China (In 2015). In addition, during my time at the reproductive clinic, patients were given a comprehensive list of requirements before they could be approved for IVF. Among many other prerequisites, these documents included the original marriage certificate, which many rural women had to get last minute from their local, family planning committee, and a *jihuashenming zheng* (计划生育证), an official approval from the government to have the first (or second, in a few cases) child. If the patient's IVF cycle succeeds, they must follow the typical protocol of registering their pregnancy with the government, using a signed slip by the doctor.

These all become examples of tight state regulation and checkpoints from the beginning to the end of the IVF process. Women must conform, therefore, to a heterosexual, married life under the One Child Policy before receiving state consent for the procedure. Under these circumstances, how useful of a tool is IVF to create new kinds of families? The answer is not at all, since the state delimits the varieties of possible families that could benefit from IVF if it was open to, say, homosexual partners or single individuals.

Although the proof of a thriving black market for banned techniques such as surrogacy in China might suggest that women are finding ways to subvert state regulations, the one million-RMB (roughly \$160,000) cost of this surrogacy transaction more than likely serves as a serious barrier for many couples who could benefit from using surrogacy (CCTV America 2015). Any circumvention of reproductive regulations becomes a privilege of the rich and wealthy and further lessens accessibility of the procedure (Yan 2012). In addition, Chinese officials have begun to tackle such abuses in

the system as of 2014, threatening even stricter legislation and even more fines to violating businesses (Ma 2014).

It is clear, at this point, that the state recognizes the IVF industry as a risky site of moral, ethical and social dilemmas. If anything, the state's tightening regulation proves that there is indeed something to be contested here, something that existing state policy cannot control. Does the loosening of state control, in this instance, suggest that IVF has eked out a chance for women to find their own agencies with reproductive lives that have been long and tightly controlled by tradition and the state?

Pushed by Paradox

As bold-lettered headlines remind us, "sterility fears" abound in China, haunting the entire nation with the problem of infertility (Huang 2014). The popularization of IVF in state media has only heightened awareness of this "problem" without engaging discussion or debate about just how valid this problem really is. Despite the implications of the One Child Policy, China's pronatalist foundations still bleed through its modern, antinatalist framework. As long as the same pronatalist tradition persists, in fact, individuals with infertility (both men and women) face tremendous psychological and social pressure in trying to meet these societal expectations (Qiu 2002:78).

Unfortunately, IVF's normalization by the state has done little to change the rhetoric of pity and shame they still experience.

The promotion of the typical, traditional family comes through in IVF's tightly regulated availability to patients, suggesting that the state may not really be caring for the welfare of these women – rather, the state cares chiefly in controlling women's reproductive cycles and *not* bettering how these reproductive cycles may affect women's lives. Although I have reserved the situation of the hospital for Chapter Four, women's strained positions are made tighter, almost literally, in healthcare providers' inability to

meet the rising demand of IVF in recent years. These crowded conditions, along with a lack of insurance funding for infertility treatment, as I will also discuss later, further demonstrate how the tension of state and tradition has generated a gap of response to women's yet unmet demands for an accessible approach to IVF that minimizes anxiety.

It is not the state's concern, in other words, whether or not women are *actually* helped in the IVF process. In reality, what has been offered is a technical solution with little change in the underlying structure. As a result, women are, at once, pushed towards IVF and subjugated to traditional gender roles and filial obligations. All the while, the pressure on women, especially infertile ones, grows ever greater. In the next chapter, to understand further this pressure that women face at a family and personal level, it is necessary to contextualize them at the site of medicalization – the hospital.

Chapter 3 – The Place of Pressure: How the Clinic Becomes Community

The hospital, as an institution, represents the manifest battlefields of war between tradition and modernization. Not to say, however, that tradition and modernization are always at odds with one another. As the last chapter shows, the two can coexist, but the antinatalist-pronatalist dialect poses unique issues and concerns for the people affected. In the case of China, the conflict of antinatalist state policy imposed upon pronatalist tradition not only complicates how women navigate IVF, but also fashions their perceptions of the procedure and infertility as a whole.

In this chapter, I first situate these tensions in their most influential location – the fertility clinic. By doing so, I additionally present an overview of IVF costs and technicalities to contextualize the medical experience in contemporary China. Given IVF's risk relative to benefit, the hospital, therefore, becomes a site of contention in which investments of agency are either returned or lost. Although the packed RMC might constrain women physically, I argue that it liberates them mentally. What can be created, as I hope the following narratives will show, is a new community in which encouragement, of women and from women, can ameliorate anxiety and pressure.

A Look at the RMC

China's healthcare system has a tumultuous but dynamic history. Although strong public health initiatives and basic healthcare reached 90% of the population by the 1970s (Ling et al. 2011:11), post-Mao China's push toward modernization disbanded this socialist system in favor of a market system in line with economic reform (Liu, Hsiao and Eggleston 1999:1349; Yip et al. 2012:833). As a result of this change, the majority of China's rural population was left without healthcare coverage. Only city residents with urban *hukou* (户口), a household registration number, and jobs received state funding

for medical care. Based on rural or urban household and passed down from mother, the *hukou* mainly determines the type and extent of healthcare coverage provided by the government based on one's rural or urban status.

No doubt, such a flawed system fomented tremendous social discontent as millions of citizens now found themselves unable to pay for healthcare. Luckily, the government realized the effects of these policy changes on the population, and, in 1997, began to reform the system (Ling et al. 2011:12). Over the course of the last ten years, the state has ushered in a new, dual healthcare scheme hoping both to better address rural need and regulate urban spending.

Although recent and current initiatives (such as community health centers established in 2007) seek to remedy these inequalities by developing (back) toward a socialist model (Ling et al. 2011:13), increased government funding has not yet remedied the shortcomings of the system. Receiving medical care continues to be expensive and difficult today (Eggleston 2010). Unequal resource distributions limit the ability of medical infrastructure to completely bridge the rural-urban divide. Public hospitals, in actuality, still provide more than 90% of the population's inpatient and outpatient services (Yip et al. 2012:834). This becomes especially true for specialized areas of medicine, under which IVF most certainly qualifies.

Although some hospitals and their departments have begun to adopt a pre-scheduled appointment system, most departments still have no such protocols. Instead, visitors who wish to be seen at clinic on a particular day must arrive early enough in the morning to "get a number" (*guahao*). As a result, the number of patients per day is largely unpredictable, and it is not uncommon for doctors to face an unexpected influx of patients. Despite closing these numbers at around 20-25 patients every day, the reproductive medicine clinic not only squeezed in patients who had connections or unexpected difficulties, but also had a general, outpatient inquiry that had no patient

cap. One time, on an especially crowded Friday, a doctor in the clinic, who I will call Dr. Mei, had joked to me:

What kind of American doctor has to deal with this? Are there this many people in American hospitals? [Pause] I think you should change to writing about the psychological conditions of doctors instead. You should forward your thesis to the Chinese government. Because of the *guahao* system, anyone thinks they can just come in and be seen immediately. That's obviously not possible.

Despite it being a relatively non-busy season, the RMC was still seeing about 100 patients every morning between three doctors, of which one was in surgery at any given time. My first week there, I was surprised to find that the clinic was open six days a week, with a morning shift of 8AM-12PM, and a (usually less jam-packed) afternoon shift of 2PM-5PM. RMC's employees had Tuesday afternoons, Saturday afternoons and all Sunday off, with the occasional exception of a patient whose oocyte extraction or embryo transfer had to fall on that day.

Even with the outpatient structure of the clinic, its nature was undeniably inpatient. As Dr. Mei later said, "what should be done as inpatient is being done in the clinic – this is why IVF is so frustrating sometimes". This is because the final steps of IVF had to time a woman's uterine-readiness for an embryo with the embryo transfer from petri dish into the womb. Prior to this, patients had to come to clinic almost daily for extensive hormone therapies and close observation of the growth of oocytes with an ultrasound.

Thus, the workday might stop, but patients' bodies do not. As a dynamic internal process convoluted with a variety of external factors, IVF is, unsurprisingly, emotionally and physically demanding to the patient and, to some extent, even the doctor. For example, even on days the clinic was "officially" closed, women were still often scheduled for procedures that could not wait until the next open day. Although I talk about this

more in Chapter Five, women must invest a great amount of time and dedication towards IVF, bounding not only their bodies but also their lives to the schedule of the technology. Decisions to undergo IVF, therefore, become an investment for both a child and one's own agency.

Even on a monetary level, the cost of one cycle of IVF can range from 20,000 to 30,000 RMB (about \$4,000 – \$5,000).¹³ What is meant by “one cycle of IVF” is an oocyte extraction and embryo transfers. Although one can freeze and cryopreserve any number of embryos for later transfer at an extra fee following oocyte extraction, women who have no successfully developed embryos, or no more following a failed transfer, must begin the IVF cycle all over again. To put this cost in perspective, consider that an IUI (intra-uterine insemination), the option considered “one level below IVF”, costs about 1,000 to 2,000 RMB (roughly \$250). Additionally, to *guahao* and see a doctor at the fertility clinic ranges from 10 to 20 (\$2.50) RMB, depending on the level of expertise, making the actual procedure of IVF itself incredibly expensive by comparison.

Many women, however, often saw this extra cost of IVF as worth it. While some had medical conditions that excluded them from IUI, many simply grew impatient with the cheaper procedure. When I asked a 37-year old patient why she ended her IUI cycles to begin IVF, she responded:

The last time was the 3rd time I had an IUI. I had a really great feeling about it. I was pretty much ready for a child, but then it turned out to fail. I wasn't pregnant after all. Since that, I thought – yeah, no more waiting, I'm going to switch to IVF.

Another 30 year-old patient I interviewed echoed her answer:

¹³ This number is from fieldnotes, but is also supported by Qiao and Feng 2014.

At first, I didn't want to switch to IVF. It sounded dangerous to me, and I'm well aware of the risks. But, I've been married for four years now, and we've waited too long for a child.

This kind of response was not uncommon for why women decided to do IVF over IUI. For many women, state regulations even required them to undergo cycles of IUI before doing IVF, although I am uncertain of just how enforced this rule was in the RMC. Despite being much cheaper, IUI's track record of low success rates (usually around 10-20%) made it far less appealing to patients.

Expenditures aside, undergoing IVF itself can be considered an investment, given that the procedure is one of chance. For a woman in her 20s and 30s, the natural rate of pregnancy is about 20%, declining rapidly during this time and dropping to about 5% in her 40s (Southern California Center for Reproductive Medicine 2015; Shady Grove Fertility 2014). During my time at the RMC, the standard success rate for IVF communicated to patients was 40%, although this also decreased to 10% for women in their 40s. Doctors calculated this statistic directly from the positive hCG test results out of all results following embryo transfer for their patients, rather than from the live birth rate. Compared to China's reported IVF success rate of 30-50% (also lower for older women), the RMC's success rates fell squarely in line with the national average (Xie 2015). Still, I encountered several previous patients, who had once again become patients, following a miscarriage or a false-positive hCG test.

As of now, there is no overarching institution that collects these IVF statistics in detail in China. Thus, it is uncertain if these IVF success rates are accurate, although they do appear inflated to some extent. For example, in the US case, the Society of Assisted Reproductive Technology maintains national statistics from all of their member clinics, comprised of 174,962 total IVF cycles in 2013 (Society for Assisted Reproductive Technology 2013). In addition to a lowering of success rates across age, live birth rates

are lower in every cohort (Figure 1). While none of this is particularly surprising, the fact that this distinction is not talked about in China might suggest certain disillusionment when patients base their judgments from solely the numbers.

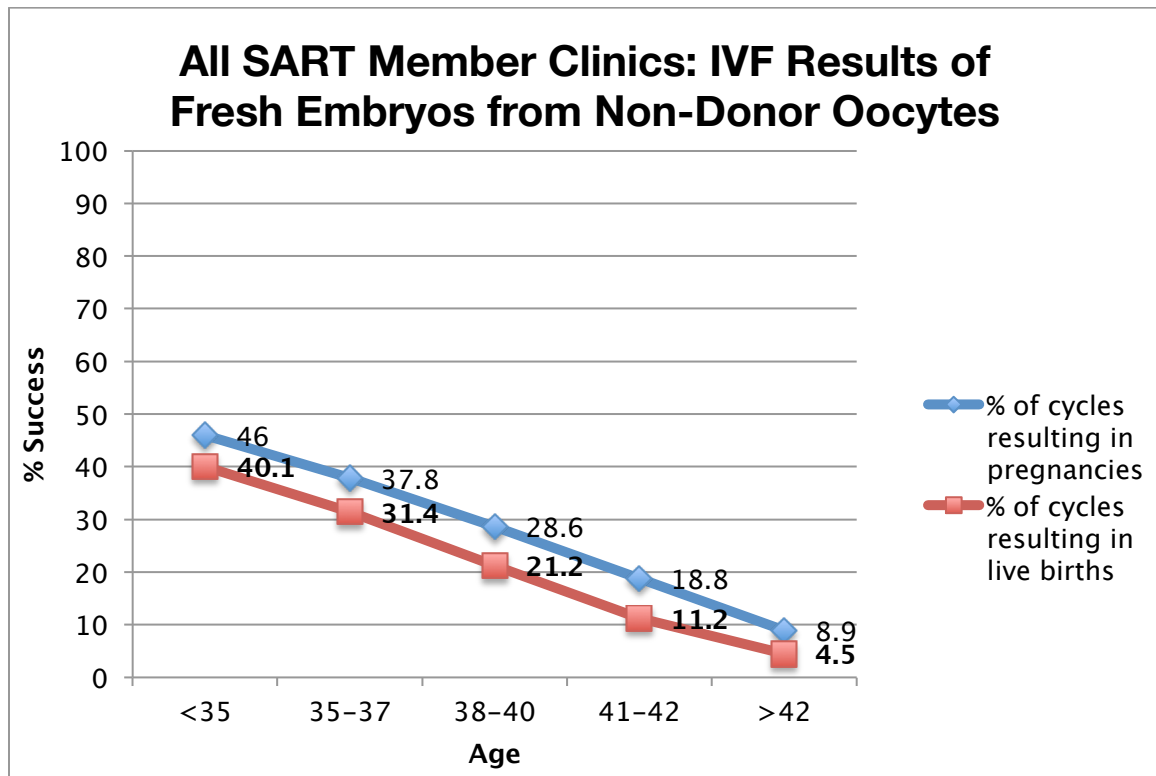


Figure 1. The IVF success rate (out of 100%) of for women in the USA, comparing rates of pregnancy vs. live births. The results are all from cases where a fresh oocyte was extracted and then later implanted (without freezing the oocyte) in the same patient (Society for Assisted Reproductive Technology 2013).

In fact, when I informed many of my interlocutors that I was from the United States, they could not help but mention to me the high success rates of IVF in the US, with an impressed attitude that they did not always hold to the technique domestically. Below, I share a couple of perceptions among patients I encountered had about IVF outside of China.

In America, you can grow eggs in another woman's uterus, right? In China, you can't do that. I think that's my problem. My uterus is not good. I could maybe have a child if I could legally get a surrogate mother.

Another woman, a 28-year old, had debated between doing IVF or not:

I don't think I'm going to do IVF in China yet. I have concerns about the procedure. For a while, I considered going to the US to do IVF there. I thought, if I'm going to get that kind of treatment, I'm going to go all the way for it.

A 36-year old patient told me, after we had been talking about the possibility of getting twins for IVF, that IVF seemed very successful in the US and Thailand, "for whatever reason." Apparently, she continued, organizations in China coordinated trips, almost like tours, to Thailand for the ulterior motive of allowing women to undergo IVF successfully there.

Given the range of speculations about success rates, permitted procedures and black market transactions, these assumptions, of course, were not always true. More than likely, they were the result of both sensationalist media and gossip online and in person. Still, they all suggest an unfounded but worrying perception of a national IVF that was inadequate in some way. For me, I always found it strange that women did not have faith in their doctors, particularly in this hospital, because the RMC would often perform several IVF procedures every day. Doctors even came in on weekends to fulfill this need. At the end of the day, I suppose, IVF was a chance-taking procedure like nearly every other medical one, and although empirical evidence might keep women optimistic, it cannot always prevent them from stressing out about the what-ifs.

From all the negatives, I would think that China's IVF clinics would not be so reportedly crowded, but this was most definitely not the case. Even though young couples have a 20% chance of pregnancy each month, many of them came after less than a year's inability to conceive (remember, the WHO and Chinese medical standard of

infertility). If a lack of patience is really what's driving more and more young people to IVF, what would drive them to undertake such an exhausting, expensive investment? The legacy of a pronatalist tradition, certainly, serves as a major factor that provides an ample amount of pressure for women to have a child soon after marriage.

Given this prevalent anxiety for a child, the RMC is never at a shortage of patients. Whether infertile or not, women take these statistical gambles, paying heavily in money, mind and body. No matter how demanding the IVF process might be, none of the women I spoke to wanted to give up what they deemed "an only chance." Whatever it was that brought the women to the RMC and kept them coming back, it was far more powerful than whatever pain the IVF procedure might have inherently carried.

Why, then, do women in China increasingly turn to IVF? What are the benefits and dangers of this trend? It is peculiar, for one, that private clinics do not receive as many IVF patients. Given China's medical milieu, one possible explanation for the influx of patients at public hospitals even in spite of the availability of private clinics might be a common distrust of private hospitals that I found prevalent in the doctors and patients at the RMC. For example, doctors who work in public institutions perpetuate this suspicion, often claiming private test results as faulty and unreliable. Still, at the end of the day, not even public hospitals are free from the scrutiny of patients.

Despite limited options within the city, the women I spoke to attributed hierarchies of capabilities to each available clinic. While their metrics for determining this list were different, it was clear that patients were willing to brave crowds and lengthy waits for what they considered the best care they could receive. Although I talk about this at length in Chapter Four and Five, the anecdote below provides a glimpse into the reasoning and calculus behind these investments of agency.

The patient is 32-years old, with one past failed IVF cycle. She had recovered 12 oocytes, from which only two had become embryos after fertilization. Unfortunately, both had failed upon transfer.

My previous attempt was done at Central Reproductive Center (CRC).¹⁴ There was such a high fail rate there when I was doing my cycle. Every day, they do about 10 IVF transfer procedures. One week, only 1 out of 8 succeeded. The next week, only 1 out of 15 succeeded. Everyone in the time frame of two weeks before to two weeks after me all had really high fail rates. It was really hard for all of us, because we all knew each other from all of the appointments and kept up with each other's progress.

Upon hearing this, the doctor immediately commented on how strange this occurrence was, because the RMC has apparently never had such a low success rate.

This patient's account required her to memorize, meticulously, the statistics of IVF outcomes at the CRC. In fact, patients often circulated and remembered these nuanced results, as well as technique and doctor-patient interactions, with fervor. Although some might have considered the information to be gossip, most women took tidbits of what they heard as the basis for decisions they made in IVF. They attributed, sometimes nonsensically, smaller occurrences or hiccups along the larger events of their medical history to unexplained failures in their IVF cycles.

Although the RMC was built for 300-500 patients a week, Dr. Mei told me, they now receive about 1,000 patients a week. It should come as no surprise, then, that the RMC's waiting room and four small clinic rooms, of which only one functionally served as the outpatient consultation room (the other three were delegated to male infertility, ultrasound and injection procedures, and special circumstances), were not enough space

¹⁴ There was another prominent reproductive medicine center in the city that offered IVF, located in a hospital that specialized in women's health. Most of the IVF procedures done in the city were between this one and the RMC.

to hold the patients who had come to visit. No more than 5 doctors, one of whom managed the IVF lab exclusively, staffed the entire clinic. The RMC owned two ultrasounds and two patient beds in total. There was a single surgery room, in which, on busier days with too many embryo transfer procedures, two patients would share at once.



Photo 1. A patient and husband at an appointment at the RMC. (photo credit to author)

During my first couple of days at the RMC, Dr. Mei once paused in the middle of seeing patients, exploding into anger at the administration that the door to the surgery room was still broken. Apparently, she had reported it for repairs almost six months ago, but her request had been lost in the bureaucracy of it all. In other instances, medicines prescribed to patients to control their reproductive cycles had even run out at the hospital pharmacy, and the clinic had to volunteer their own stash.

Despite these disrepairs and resource shortages, the doctors treated patients with respect and tried to explain the mysteries of their individual infertility problems the best they could. In return, patients respected and trusted the doctors and, even when faced

with wait times, did their best to make the most out of a long morning or afternoon. As the 32-year old patient's narrative hinted above, it was during these times of delay that women bonded with each other, forming closer ties that granted friendship and support.

Thus far, I have taken the time to describe a detailed picture of the RMC and the interactions within it, because this site is one of contention. Under the lens of IVF, women simultaneously subject themselves to meet tradition and polity on one hand and fight for control over their own reproductive and social lives on the other. It is because of this crucial dialectic that a comprehension of what it was like to be in such an environment is necessary. Only when women's efforts are contextualized can we begin to appreciate their sufferings and triumphs for what they truly are.

Crowded We Stand: The Clinic Community

With the RMC's substantial patient base, the clinic was understandably packed every day. Spots were hard to secure, even in the hospital at large, and seats at the clinic were no exception. The *guahao* system had made appointment wait times unpredictable, and many of these women found themselves waiting along with each other. Trying to fit in the most patients they could in a day, the doctors even sometimes accepted numbers from different departments, especially when a patient's case was urgent. When all of this is added together, everyone ended up being crowded together, one way or another, for most of the morning or afternoon.

In this section, I argue that the RMC's crowded conditions allow for the creation of "clinic communities," artificial families through which women can support and learn from each other during the IVF process. The commonality of women's shared IVF experiences formed a kind of "biosociality" in the clinic by which women bonded over their unique medical identities produce from their infertile conditions (Rabinow 1996). The clinic community emerged from the new biosocial identities that women formed

over long wait times and conversations about their infertility, pressure and anxiety, leading to changed meanings and relationships among the members of this community.

Although this kind of bonding makes true privacy unlikely in the RMC, very few women did not benefit, at least in some small way, from the collective knowledge that such clinic communities circulated. Many women, in fact, used these new relationships as the source for a growing repository of knowledge about IVF and all of its nuances. Therefore, while women could not escape their particular healthcare system and narrowed options, they persevered, nevertheless, to use the system's weakest link as their strongest tool.

Although the position of childlessness brought anxiety to women, the clinic's ability to bring women of the same conditions together, at least on the level of infertility, served as a point of unity for women. When I asked a 36-year old patient who had a history of two previous, failed IUI procedures how she felt about starting IVF for the first time, she told me:

It takes a lot of commitment to come to the hospital, but it is more relaxed (*qingsong*)¹⁵ than it seems like it would be from reading about the IVF procedures online. Here, how the doctors, nurses and other patients treat you make the process better. When I come here, I don't feel like I'm sick, or that I have a sickness. I don't feel like a patient anymore.

Another patient, who was slightly younger at 31 years old, talked about how she felt less anxious after coming to the RMC. When I spoke with her, she was on her 8th day of hormone injections for her first IVF cycle:

Two years ago, I was fairly afraid of IVF, but as time passed, I figured that I might as well try it. For me, nobody I know has done IVF, but when I come here, I

¹⁵ 轻松

realize that this is a common solution and that a lot of people have problems like me.

For the patient above, the clinic provided a network from which she could meet others like her and feel like she belonged. When society at large placed a huge premium on children, interacting with friends who only have children might, in fact, heighten pressure on infertile women.

These long hours in the waiting room incubated relationships that would not have formed otherwise. Although the stigma surrounding infertility silences women from talking about their conditions openly, the clinic becomes its own microcosm of open dialogue in which women are free to talk about their infertility narratives without judgment. From this perspective, it would seem, perhaps, that the crowdedness of the clinic is but another risk that women accept in an investment that could return not only a child, but also a new community.

To be certain, the high volume of patients coming into the RMC often filled up all of the waiting room seats, occasionally causing an overflow into makeshift seats in the hallway outside, across from the elevators. Although doctors and nurses tried to call in patients one by one into the actual consultation rooms, patients haphazardly walked in mid-conversation with questions, or stood close behind patients being seen out of impatience. This matter was made worse by the fact that there was only one regular consultation room, meaning that two doctors (sometimes three) and their respective patients occupied the room. On the left side of the room were several chairs placed against the wall for women who were waiting for their ultrasounds in the next room.

Thus, the lone outpatient room could hold upwards of 12 women at any time between those waiting for ultrasounds, those waiting to speak with the doctor and those currently being seen. Most patients were not actively bothered by this, because it was something characteristic of the larger medical system that they had already gotten used

to. This, however, was not the case for all patients. When I asked one 40-year old IVF patient how she felt about the matters in the RMC, she responded, leaning in closer to me:

I think it is so crowded here because a lot of people seem to have poor impressions of IVF at CRC. They don't treat you humanely there, it seems. Many patients have switched over from there. The result is that there are so many more people here. I feel like appointments here have no privacy. Conversations are so awkward (*ganga*)¹⁶, so I never want to talk to anyone in the waiting room.

The RMC had built a reputation for itself as being one of the top IVF providers in the city. Thus, patients often transferred over from other hospitals or were referred by friends. While some of these newly arrived patients were quick to form social groups, the quote above shows that some women simply found the crowdedness as a nuisance more than anything else.

Nonetheless, this lack of privacy sometimes allowed fellow patients to serve as advocates who would and could support each other during tougher times. Once, in a difficult conversation between a 33-year old patient who had become pregnant with twins following an IVF embryo transfer and Dr. Mei, a woman waiting to be seen next had been sitting close by and listening. The patient had wanted to abort one of the fetuses, but Dr. Mei had been trying to convince her to think hard about it before making such an important decision. At one point, the patient began to cry because she realized that, despite being lucky enough to have twins, she and her husband did not have the mindset and resources to care for a second child. The woman, who had been sitting to the side, quickly reached into her bag and handed the patient a tissue, reassuring her that it would all be okay.

¹⁶ 尴尬

While it is difficult to say whether these sorts of actions were nosy or caring, they were certainly not entirely meddlesome. Sometimes, they even became incredibly educational. The clinic community developed several topics of conversation, many of which included updates on women's IVF cycles, stories of success or failure, and near philosophical discussions of what a technology like IVF meant. One time, as the clinic wrapped up for the day, a couple of women who already had their appointments were sitting in the waiting room talking to each other. They were deep into a conversation about their own IVF histories:

[Woman 1]: I was at CRC before, but we found the place too technical. My family and I were also worried about the male doctor there, who heads the clinic. We just didn't like how it was there.

[Woman 2]: Yes, I agree! I hear that they use very different brands of medicine. The CRC uses Italian and other exported brands, but the RMC uses domestic brands. Their attitudes toward their patients are also not as good as here.

[Woman 3]: Still, it is hard here. I have been on so many days of hormone therapy shots that I can't even remember. Each one cost so much, too.

[Woman 2]: The shots are very painful to go through. I remember in my last cycle, I went through nearly 12 days of shots before my eggs were extracted. It's disappointing that none of the eggs extracted developed into embryos.

[Woman 1]: I don't even know why my last cycle failed. The embryos seemed to develop fine, but somehow just didn't implant well in my uterus.

[Woman 2:] You can't really blame yourself or the doctor. The technology is good, and it goes pretty far. But, you can't control luck (*yunqi*)¹⁷. The luck is just not there sometimes.

¹⁷ 运气

Over time, these conversations eased the anxieties that many women felt by mitigating their internal, self-imposed pressure. By framing IVF as a matter of not just perseverance and technique, but also luck, women were less likely to blame themselves for a complication or failure in their cycles. By shifting the conversation from a self-defeating one to a self-empowering one, RMC's clinic community provided the resource of educational and social support from the taxing realities of IVF.

While it was rare, I encountered a couple of exceptions to the clinic community's ability to lighten the pressure felt by women. These experiences often stemmed from patients who, despite facing setbacks in IVF, had made close friends in the RMC that had already "graduated" out of the procedure with a pregnancy. Take, for example, this account by a 28-year old patient, who had to wait three months to recover from a strenuous oocyte extraction procedure:

The women that had their oocytes recovered the same day as me all got embryo transfer procedures three days after, but I waited. We had gone through every step before that together, and we all have each other's numbers and keep in close contact. They are all at home now and two months pregnant, taking care of themselves. It really makes me feel like I'm missing out on something, that I shouldn't have waited.

Because this particular patient had kept in close contact with these successful patients, she found herself further pressured to prevail in her own cycle. While this raises questions about the long-term effects and durability of the clinic community (as well as its existence outside of the physical space itself), it does not undermine my previous argument that this "clinic family" proves helpful for women who are still undergoing IVF.

For this patient, keeping in contact with women who had now left the clinic served as a discrepancy from the experiences of the clinic community for most of the

other patients. When one has a child, therefore, one exits this group to become part of a new one. The clinic community might only have the power of benefit so long as all of its members share the same infertility or childlessness. In addition to remaining within it, what this patient had done was to continue reaching outside of the clinic community. The source of pressure she felt, therefore, could arguably be coming from society at large rather than from the relationships she formed with her fellow patients. After all, they now were no longer patients, but mothers.

While it is difficult to maintain connections only within the clinic community, the environment of the RMC nevertheless provides an opportunity for women to make meaning of their infertility. In this way, the RMC alleviates pressure for women by creating a safe, although temporary, space for infertile women. Although one loses privacy, one feels less alone in the demanding endeavor of IVF. Whether this is a loss or a gain often comes down to an individual value judgment. For many women I encountered, this crowdedness was a small price to pay for what could be gained, especially when considering that China's high population made a variety of places teeming with people regardless. At least in the RMC, patients found themselves in a society of childless peers.

Stepping away from the families created in the waiting room, the next chapter focuses on the families that either support or undermine the efforts of women to treat their infertility. We have talked a lot about pressure thus far, but just where is the root of these anxieties? Is it solely tradition? And, whether it is or not, who or what are the perpetrators? Family soon becomes, coincidentally, every bit an end goal as it is the start of IVF.

Chapter 4 – Fertile Families: An External Source of Pressure for Women with Infertility

It would be impossible to remove the topic of family from one of infertility and IVF. Harkening back to the first chapter, reproduction has been, and continues to be, one of the highest values in the family (Qiu 2002:77). As a philosophy and value system (Tang 1995:269), Confucianism has influenced and continues to strongly influence reproductive behavior in China. In fact, in Confucianism, family serves as the “basic unit of sociopolitical order” (Tang 1995:275). As such, the importance of filial piety perpetuates the role of a woman to bear children and, subsequently to state policy, to raise that “one” child.

Thus far, I have talked about how and where the dialectics of a pronatalist tradition and antinatalist state unfolds for women with infertility in China on a state- and hospital-level. Using IVF as a frame of experience, this chapter concentrates on their families, and what role they might play as actors within the pressures that infertile women face. Families are just as easily one’s reason for beginning IVF as it is one’s reason to end it. In addition, research has shown that, in the Confucian model, the family is the locus of moral responsibility in medical decision-making (Chen and Fan 2010; Fan and Tao, 2004). If we recognize that family dynamics manifest in complex and manifold ways, we can begin to understand societal pushes and pulls toward or away from the procedure, and just how such a conflict puts greater pressure on individual women.

In the RMC setting, coming to the hospital requires at least one family member to accompany the patient. While this family member does not enter the actual appointment room (most of the time), he or she does play a crucial role in running small errands, such as paying for tests assigned by the doctor or waiting in line at another department. This is largely due to the fact that different departments are located in various buildings or floors. For example, if a doctor assigned a patient an ultrasound, one would first have to

pay for the procedure first, but on the 7th floor (where the closest payment office is located). If a doctor ordered a blood test, a patient would have to go to a separate building for the results, and then return them back to the RMC for consultation. Even though a family member (or friend) is not required, having someone help run these small errands not only expedites the process, but also alleviates the stress of coming to the hospital for patients.

As we will see here, the significance of family manifested itself in practical and pathological ways. Although no one woman's familial circumstance was completely akin to another's, certain family members tended to have a greater influence on women's reproductive decisions than others. In this chapter, I point to two figures in particular – the husband and the mother-in-law (*popo*) – in regard to their involvement with the patient's IVF experiences. Whereas mother-in-laws can often play too present of a role in the clinic, husbands' absences also serve as a source of pressure for women. While I do not mean to belittle the agency that women have over their own IVF cycles, it would be inaccurate to completely disregard the constructive and destructive ways that families work for or against women's own reproductive efforts.

Mother-in-Law

Although women hold subordinate positions to other family members by Confucian standards, the one exception to this general rule is in becoming the *popo* of the family (Gao 2003:123) Unlike being a daughter or a wife, being a *popo* means that, first, one successfully bore a son and, secondly, one saw to the subsequent marriage of that son to further carry on the family lineage. In particular, the wife has to make sure she pleases her mother-in-law, as the *popo* is capable of swaying the family's view of her daughter-in-law (Gao 2003:121). The *popo*, therefore, commanded significant respect from and power in the family.

This chapter first focuses on the influence of the *popo* in women's experiences of infertility with IVF. Unlike husbands, who seem to have varied (though important) parts in the grand scheme of IVF, *popos* have both a greater capacity and specificity in the ways they get involved in patients' reproductive lives. In addition, their presence in the clinic almost always symbolized a close involvement with the patient's IVF cycles. Although these observations are most certainly not telling of all mother-in-laws (or mothers), they do characterize a pattern that arose at the RMC.

To illustrate perhaps an extreme case of how much in-laws, particularly the *popo*, can affect the family life of the daughter-in-law, we can look toward the experience of a 33-year old patient, from a nearby rural area. The first time I met her, she came in asking about IVF, of which she had a very faint understanding. She told the doctor that her second child had died.¹⁸ Her *popo* had threatened that if she didn't do something about this, that she and her husband should just get a divorce. The patient expressed that she wanted to do IVF, but on one condition – “if it's not a boy, I don't want to keep it.”

The next time I saw her, she explained her condition further to me. Apparently, she and her husband have an 11-year old girl and, until recently, a younger son. She was taking care of the boy when he died unexpectedly (she did not elaborate), but because she was charged with watching him at the time, she heavily blamed herself for the tragedy. Her husbands' parents, too, blamed her for the event, even when her husband himself did not. Seeing that the patient already had surgery on one of her ovaries (suggesting certain risks of pregnancy once more), Dr. Mei asked the patient why she was doing IVF rather than trying naturally.

“Not doing IVF is not an option. I *must* do IVF.” The patient responded, after explaining how her father- and mother-in-law were both incredibly angry with her for

¹⁸ Having a rural *hukou*, this patient was allowed to have a second child if her first child was female. This was the case for this patient.

the death of her son. She couldn't risk divorce, which she perceived as inevitable without a son soon.

Dr. Mei nodded, understanding, and sighed in sympathy. She asked then for the patient's original approval from the Family Planning Committee to have a second child. The patient then responded that she only had a copy, because her father- and mother-in-law have the real one and refused to give it back to her. This, she explained, was because her in-laws were determined for her and her husband to split, regardless of what the husband thought of the matter.

What the account above describes, in detail, is the power that in-laws hold in the family, particularly the *popo*. The disapproval of the mother-in-law drove this patient to the RMC, despite what she herself may have preferred. Furthermore, the IVF process became incredibly stressful and complicated for her because she did not have the approval or backing of her mother-in-law. Although this situation is rare, it does point to the fact that *popos* indeed play a great role of influence in women's experiences of infertility and IVF.

To delve further into this issue, I first contrast the two ways that *popos* find their way into the clinic, either by invitation or invasion of their daughter-in-laws' own will. Second, I explain why this latter type of involvement, inevitably, leads to greater anxiety for patients in ways that prove counterproductive. Ultimately, *popos* tend to perpetuate stigma and anxiety for women undergoing IVF, rather than to help them overcome it with IVF. While they were able to frame their reasoning as being in the best interest of their daughters or daughter-in-laws, the pressures that many *popos* placed on patients to not only come into the RMC clinic, but to also succeed in their IVF cycles often put women on edge.

In Marjery Wolf's research on family structures in Taiwan, a married woman tended to spend more time with her mother-in-law than with her husband (Wolf 1972:142).

Wolf goes so far as to call the first year after marriage for a daughter-in-law to be one of waiting, emphasizing the importance of fertility. It is not uncommon, therefore, for mother-in-laws to “[begin] asking embarrassingly blunt questions about [the daughter-in-law’s] menstrual cycle” (Wolf 1972:151).

Although Wolf’s research was done over 40 years ago, this is not dissimilar to the invested interest of mother-in-laws that manifested in the RMC. Kinship structures today still hold, to some extent, remnants of the past. For example, Wolf observed that a mother-in-law who does not receive grandchildren will eventually take direct action by bringing her daughter-in-law to a *tang-ki*, a religious practitioner who will bestow the bride with a child. At the RMC, younger women were, on occasion, brought in or, slightly more often, accompanied into the appointment by their mother-in-laws.

When I asked these women why they had the accompaniment, they sometimes said they felt intimidated by the appointment and asked their *popos* to come with them to the clinic. Most of the time, though, the fact that their *popos* came along with them was unquestioned by the patients. Interestingly enough, however, nurses and doctors often got annoyed when the *popo* seemed to take charge of the patient’s own consultation. On occasion, the RMC’s head nurse would lose her temper at a patient who insisted that her mother-in-law accompany her into the consultation room. Take, for example, what one nurse said to a 30-year old IVF patient who brought her *popo* in and responded negatively when her *popo* was asked to wait outside:

Nurse: No, family members wait outside. Do you see any other patients with family members in the room? Even if that is your *popo*, you should be able to speak for yourself. You’re here to have a child. You’re about to be a mom – you should be able to handle this appointment by yourself.

To the staff at the RMC, the mother-in-law did not need to be present in the clinic. More than anything, the patient herself, in other words, should make the primary medical choices in IVF.

Although nurses and doctors saw the presence of *popos* as meddling at times, mother-in-laws often did not see their involvement in this way. When I spoke to mother-in-laws (not frequently, but occasionally), they often saw their willingness to come to the RMC with their daughter-in-laws as a favor rather than an obligation.

[My daughter-in-law] is the one that worries the most. I'm not putting any pressure on her. I don't really care how she chooses. After all, she asked me to come here with her. Her mother doesn't care enough about her. This is a big hassle for me, because even though I'm retired, I have to take time off from my dance troupe practice to be here. I left at 5AM this morning just to get here in time. I almost feel bad coming into the clinic room. Nobody else is standing over their daughter like this.

According to her, a *popo*, in fact, would not bother herself with the reproductive life of her daughter-in-law unless such help was requested. From this perspective, mother-in-laws do not see themselves as forceful over women's agency in any way but rather supportive. It was difficult, though, for me to fully believe her words because the patient never got a chance to speak for herself. This mother-in-law, in particular, asked and answered questions from the doctor as if *she* were the patient rather than her daughter-in-law. For example, when Dr. Mei asked the patient how old she was, the mother-in-law answered "thirty-three." Surely, there must be less invasive ways to support the patient than this.

Even though the patient mentioned in the above example might have desired her *popo's* presence, some patients purposefully came alone to avoid the judgment of their mother-in-laws. This is evidenced by the reluctance of some women to let their family,

especially their *popos*, know about their current IVF cycle. To illustrate this point, one Friday afternoon, the doctor asked a patient beginning IVF to obtain a required marriage license. Being from and married into a rural hometown, the patient had to take a form to the local Civil Affairs office to get it stamped and sign. When the patient heard this, she immediately became reluctant:

Is this necessary? I'm afraid of letting my *popo* know. She's the one that takes care of these sorts of affairs in my hometown. [My husband and I] haven't told her yet. In fact, I've told my parents and they told me *not* to tell my husband's parents. I really don't want her to know, and she will if I get this form signed.

This patient's hesitation evidenced the fear that many women held toward what their mother-in-laws might think if they knew about their infertility. Although this patient might have had an extreme reluctance, other patients often mentioned their *popos* peripherally, citing the *popos'* old age or want of a child when I asked them why they had decided to pursue IVF.

Given these conflicting interests between patients and their *popos*, small fights often erupted in the RMC. In contrast to the instance of invitation I presented earlier, the mother-in-laws' insistence that patients come to the clinic often started these disagreements mid-appointment. When women were truly dragged into the clinic by their *popos*, it became fairly obvious in the body language and dialogue between the two women as the doctor asked the patient questions. The below conversation occurred after a *popo* kept asking about the success rate of IVF, while the patient herself sat in disdainful silence.

Popo: They don't really want a child. I want them to have one because I want someone to take care of them when they're older. For IVF, I heard that it's a 10% success rate. But, even if we were to do an IUI, it's also a 10% rate, right?

Patient: So...you're saying no matter what the chances are low? I keep thinking: your son doesn't really want a child. He doesn't even really care about me and what I do at all.

Popo: What are you saying? Of course my son wants a child. Who doesn't want a child? He can't just give you pressure (*yali*). He's not going to pressure you to be here.

The patient herself turned silent after that, and refused to talk for the rest of the appointment. Her complete lack of cooperation signals that even if the husband doesn't want to push his wife, the *popo* certainly feels no qualm about doing just that. Subsequently, it also raises again the question of how *popos* can negatively affect women's IVF experiences, creating more anxiety for them concerning their infertility and also turning them off from the stressful burden of the procedure.

When *popos* become overbearing about their daughter-in-laws' lack of children, the daughter-in-law's "infertility" becomes problematized, at least socially if not medically. The pressure that *popos* put on women creates the need to have a child, particularly a boy, as soon as possible. As this next anecdote will show, younger patients, especially, find themselves in contention with their *popos* over their disparate desires or the family.

On a Thursday afternoon, a 26-year old patient walked in with her husband, asking about beginning IVF. They had been married for three years and, according to the husband, had been trying to get pregnant for the past year. The doctor on duty at the time looked at their files and told them that there's no apparent reason why they haven't conceived. She told the patient that, perhaps, "there's too much pressure on you – you shouldn't be too impatient."

As if this triggered something, the patient immediately sighed, crossed her arms and responded, "you tell my *popo* that! Call her in and see what she says." After this, the

patient left the room, and I could hear a fight erupting in the stairwell between her, her husband and her mother-in-law. The three eventually came back into the clinic while the doctor and I sat there, fully anticipating a messy conversation.

Popo: What pressure (*yali*) have I given you? Look at yourself. You've been married for three years now. You're never home enough and you're always busy. You're doing too much and not resting enough, dedicating yourself to having a child, which you should have by now. I'm not giving you any pressure.

Patient: When you talk like that, my heart races. I wonder why. [Patient rolls her eyes]

Eventually, the patient had enough of her *popo's* underhanded comments about her lack of duty as a wife and left. Her husband and mother-in-law followed after her, continuing the fight again in the stairwell. The mother-in-law, then, walked back into the clinic by herself to reason with the doctor one-on-one. She pleaded:

I'm already 60. My other peers all have grandchildren. You need to know why this is important to me. My daughter-in-law is never home, she doesn't eat well, always complaining about needing to lose weight and she won't eat anything I cook her. When I ask her why they don't have a child yet, she blames my son on their inability to get pregnant. What do I do?

Rather than perceiving the patient's experiences as separate, this mother-in-law projected her daughter-in-law's infertility onto herself. The stigma of childlessness and infertility, here, extends beyond the patient to affect the family as well. Even though the patient herself did not see it this way, the *popo* burdened herself with the pressure she put on the patient. Why then, do mother-in-laws seem to invest so much of themselves into their daughter-in-laws' reproductive lives?

The answer perhaps, lies in the fact that mother-in-laws, too, are a product of an oppressive tradition of filial piety in which women are obligated to carry on the family

line by bearing children. *Popos* were, after all, newly married wives at one point in their lives. Given their prestigious position at the head of the family, *popos* become indirectly responsible for seeing that their daughter-in-laws fulfill their roles to filial piety. If so, their close involvement in patient's IVF cycles can be understood. As a result, *popos* certainly influence why women pursue IVF and how they make meaning of these experiences.

While we could blame *popos* wholly for the anxieties that infertile women face, it would be unfair to do so, as *popos* themselves might also have been subject to just this anxiety earlier in their lives. The takeaway from these experiences of patients and their mother-in-laws is the deep-rootedness of filial piety in Chinese culture. Often times, when mother-in-laws spoke about a patient's embryos or eggs, they automatically used the word "son" (*erzi*), even when the patient had not yet received a child from IVF.¹⁹ Yet, then again, some patients also spoke this way for themselves, without the influence of their *popos*.

Filial piety, by itself, is not inherently bad or oppressive – it is the combination of this tradition with various sociopolitical and economic factors (such as perceptions of needing a son to do farm work, or the One Child Policy that narrows the ways women can fulfill filial piety) that do harm to infertile and childless women. Why IVF matters here, then, is clear if we think about the ways that reproductive technology can change the context in which they are situated as the context changes it. Although IVF doesn't shut out the *popo* from having a hand in her daughter-in-law's reproductive choices, it does provide an opportunity for these women to have different conversations, with or without the *popo*, to shift authority in new ways.

¹⁹ This becomes doubly interesting when we realize that according to Chinese law, hospitals are not allowed to tell patients (or their family members) the sex of the developing embryo or fetus until the near-end of gestation, for fear of early sex-selecting abortions.

Husbands

Next, I reflect briefly on what impacts husbands might play in relation to mother-in-laws. Because of state regulations, every woman that sought IVF at the RMC required a marriage certificate. Each patient, therefore, had a husband that, either directly or indirectly, played a role in her infertility history. Sometimes, the husband's own infertility served as the primary reason for the couple to start IVF or get ICSI (intracytoplasmic sperm injection), even if the woman herself did not necessarily require it. Other times, women had more prevalent diagnoses of infertility than their husbands.

What I hope to portray in this section is the behind-the-scenes role that many husbands played for women undergoing IVF. Although husbands tried to remain supportive in the small ways they could, their physical absence served as a burden for many women. Unlike the *popos*, husbands more often took a backseat role rather than an invasive one. While their lack of a presence could be explained, in the short-term, by their role as errand-runners, long-term (and frequent) absences were often the reason women sought IVF. I do not, however, mean to paint a negative picture of the husbands of these women, many of whom did appear for crucial visits and, if not, remained no further than a phone call away. In China's evolving economic structure, however, men's increasingly migratory roles raise new questions about the husband's influence in women's experiences with IVF.

At the RMC, any patient that underwent IVF had to submit some type of fertility report for both the husband and wife. What this meant was that husbands, like their wives, had to subject themselves to medical scrutiny. The wife, however, always required a more closely-monitored "check-up" than her husband. For example, while the husband required one test of his sperm to check for motility and morphology, women had to return several times to the RMC for a short-term, monitored ovulation cycle (at least one

month, documented by ultrasound check-ups), and/or a hysterosalpingogram²⁰. Because the female reproductive system is medically less straightforward, women received the brunt of medical tests required of IVF, regardless of whether or not they were the (only) infertile party of the pair. In fact, while some men did receive prolonged infertility treatment, this was usually no more than taking a certain medicine over the course of three months to “strengthen” their sperm.

Women and men, in addition, did not even have appointments in the same room. None of the doctors who worked closely with the women in their IVF cycles had appointments with their husbands. Instead, a single, male doctor was charged with the responsibility of seeing those with “male infertility” and no one else. There was a certain amount of discomfort with a mixed-gender room, particularly in appointment rooms. While husbands occasionally accompanied women into the appointment room, nurses swiftly shooed husbands out (along with any other family members) and considered them disruptive to the room. (The many other female patients waiting to be seen in the appointment room, however, were not considered a threat to other patients’ privacy.) After talking with a few women who had IVF done elsewhere, I noted that some of them had chosen the RMC over another location because they felt uneasy being treated by a male doctor for their infertility.

At any time of the day, the RMC clinic was undoubtedly more full of women than men. As I mentioned earlier in this essay, the stigma of childlessness tended to pressure women to address and simultaneously hide their infertility. This discrepancy of population in the clinic, therefore, could perhaps be due in part to the social stigma that childless women face, as well as the burden of infertility that tradition places on women (Qiu 2002; Tang 1995). At times, women even held reservations about letting their

²⁰ This is an x-ray test of the interior of the uterus and fallopian tubes to determine that: 1) the shape of the uterus is normal, and 2) the fallopian tubes are open and clear.

husbands know about their own infertility, let alone questioning their husband's fertility. For example, during an appointment with Dr. Mei, a 40-year old patient expressed fears about letting her husband know about her beginning IVF. This, however, was ultimately linked to reluctance for the husband's side of the family, particularly the *popo*, to know.

Although this fear of telling their husbands persisted, the doctors never failed to remind women that reproduction was a "two-person job". When a female patient came in and asked to begin an IVF cycle, doctors always asked for the status of their husband's fertility and, if they didn't know, insisted that their husbands get checked before proceeding. The RMC's doctors, therefore, did a great job of dissuading women from bearing the brunt of the infertility burden, which often pressured them to keep their medical procedures and suffering silent. As a result of this, husbands quickly took at least some role early on in women's IVF cycles.

On the one hand, a lack of involvement from husbands suggested that these patients held agency over their own reproductive choices. On the other, *too* much lack of involvement suggested detached husbands from what was ultimately a two-person job. Given this imbalance, China's "infertility crisis", then, would still be painted problematically as one of infertile, childless women rather than one of the infertile couple. In this case, how can we begin to explain the absence of husbands, if at all?

At a surface level, women saw doctors mostly by themselves (with other women around them). Their husbands lacked a presence in the clinic, especially in consultation rooms when women were at closest quarters with their doctors. When we consider the clinic community (made up exclusively of women), it should come as no surprise that men were often absent from this space. For example, I would sometimes assume that women came by themselves (and they often did), only later to find that their husbands had driven them to the hospital, that they had run off to pay for a procedure on a

separate floor, or that they were sitting, crossed-arm, dozing off in a corner of the waiting room with the wife's purse in hand.

One 40-year old patient, whose husband had driven her to the clinic the first couple of times, constantly started our conversations with whether or not she had to drive to the hospital that morning:

If you ask me, the most stressful part about IVF here is finding parking. It's just impossible. Sometimes, my husband is able to drive me here and drop me off, and that's better. But now, I usually have to drive here myself.

Her story confirms how the presence of husbands makes a difference, even if in small ways, of how women perceive their IVF experiences. Although a husband's role seems peripheral at best, it is often these quotidian tasks with which they are charged. By taking on these jobs, husbands play their part in alleviating the anxiety of their wives, who might otherwise be navigating a fair bit of hospital bureaucracy. Husbands, therefore, act as short-term buffers against the pressures inherent in China's crowded IVF clinics.

While the above example outlines why men appeared absent, more often than not, husbands were *actually* so, either at work or traveling for work when women had appointments at the RMC. In addition, absences that arose from economic reasons applied to both rural and urban patients alike, for husbands would either be migrant workers in the former case, or traveling businessmen in the latter. This matter of absence presented another source of anxiety for women with whom I spoke, especially for those who mentioned that they had been married for a very long time without a child.

According to Confucianism, a wife is expected to bear a child (specifically a son) for the family within a year (Gao 2003:122). It seems, however, that changes of both social and economic structure have shifted these expectations. Although a child is still expected for women, growing employment of women (and men), as well as an increasing amount of migratory work for men, have extended the acceptable period of childlessness

post-marriage. Caused by a transitioning economy, this geotemporal gap between husband and wife, however, seems to be of a growing concern for women in China. Could IVF be the answer to these “busy” times?

Patients sometimes switched from IUI to IVF, as a matter of fact, because their husbands often worked away from the city, being gone for long periods of time. One patient, who was 33-years old and just starting her IVF cycle from several attempts at IUI, told me:

We've been married for four years, but for the past three years, my husband has worked out of the city. I think I'm childless right now, because he's been so busy. There's so much pressure (*yali*) for me to try and get pregnant in the small timeframe of when he's actually back in the city.

The patient above, therefore, perceived her husband's absence as the primary reason of her infertility. In this sense, IVF could serve as a seemingly “convenient” technology for estranged couples that have no time to try naturally.

The downfall of this convenience, however, is that IVF can only help to bridge this geotemporal gap between couples to a certain extent. A husband's availability, although not required *all* the time, still needs to be timed with not only the wife's but also the technology. Given this lack of total control, in what ways do husbands' busy schedules affect women's personal commitments to undergo IVF? How do husbands take responsibility for their absence? I ask these questions because, on numerous occasions, patients had to drop a cycle of IVF, or reschedule appointments, because their husbands could not make it into the clinic that day. Women, thus, frequently encountered delays in proceeding to the next step of IVF because husbands were not present to sign paperwork or provide sperm.

In one instance, a patient disclosed to the doctor that her husband would not be in the city for the next 10 days. The doctor, as a response, ended her cycle until he

returned because, should the patient's stimulated oocytes be ready for fertilization, the husband would be unreachable. In another case, a patient's IVF procedure was delayed because her husband would not be available for the next couple of days to provide the sperm necessary due to a business conference.

This repeated absence of husbands, however, should not take away from how influential they can become in the few instances they are directly present in the RMC. What I mean by this is that their absence did not as much diminish their power over women as it passively masked it. Although husbands were not present everyday at the clinic, they were usually present for most major procedures. In fact, when women were presented with crucial decisions that might arise during these points of their IVF cycle, they almost always called in their husbands to consult. How much say, then, do women really have over some of their most important choices when their husbands become involved in the conversation?

Considering that Confucian values still hold strong in everyday life, it is not entirely unfeasible that husbands still held their wives accountable to provide a child for the family in the name of filial piety. In fact, taking a step further, wives traditionally hold a subordinate position to their husbands, to whom they should obey without question (Gao 2003:117; Tang 1995:277). Women, therefore, could find themselves obligated to come into the RMC on their husband's insistence. Unlike that of *popos*, however, the insistence of husbands seemed equally likely for younger and older women alike.

For example, one Monday morning at the clinic, a 24 year-old patient was debating whether or not to transfer an embryo that day despite having a very high white blood cell count, suggesting a possible infection. Dr. Mei warned her that they usually advise patients with this condition not to transfer until the WBC count goes down, for fear of a risk to the developing embryo once implanted. The patient, then, decided not to

implant that day. The husband, however, who happened to be in the room, interrupted her and told her that she should really consider implanting today, regardless. His reasoning was that, otherwise, she would have to go through the hormone injection steps of IVF for at least another month. After a brief conversation, he convinced her to undergo the transfer.

To address the farther end of the age spectrum, I interviewed a 45-year old woman who had come in for preliminary IVF consultation one morning. She told me that she had been infertile for about 9 years, but her husband wanted a second child. When she told the doctor this, the doctor explained to her how risky it would be with her high blood pressure and older age. Plus, the doctor continued, she has been infertile for so long, and the procedure was very expensive. The patient responded:

Absolutely! I agree with you. I think so, too. I shouldn't be doing IVF. But, my husband won't accept it. You tell him – he won't listen to me.

The doctor then called her husband in and made clear the situation to him. He seemed to understand and left with his wife. The next week, however, the same patient came back in asking for IVF again. I can only assume what kind of conversations happened in the meanwhile between her and her husband.

Luckily, though, most patients were able to avoid these coercive decisions from husbands when doctors spoke either to the women one-on-one, or the husband. Doctors, therefore, always acted on the side of the patient, regardless of how insistent their husbands might have been. Medical practitioners worked to debunk the need for women to have a child, trying to dissuade patients from using IVF for ulterior motives. As one doctor put it:

If you want to go through with IVF, you commit yourself to keeping the child.

Nobody goes through that much effort unless they are absolutely sure they want

the child. It's not about your husband. Don't use your child to save your marriage.”

From these conversations, women could employ the doctors' support as a point of argument against their husbands. Still, the fact is that these patients seemed to lack authority over their reproductive lives in the first place. What we should aim to do, then, is seek ways for women to use IVF as a tool for their own agency rather than to *be used* by IVF as a tool against their own interests.

As this section has shown, mother-in-law and husbands (although on a lesser scale) have the ability to tilt women's reproductive decisions one way or another, for better or for worse, even if that decision might prove harmful to the woman's own health. Although this essay does not explore the impact of other family members, it should be noted that mothers of patients, as well as any other relatives, also have the opportunity to affect women's reproductive decisions and experiences. Family can prove to be just as helpful as they are hurtful, and just as supportive as they are ambivalent. The forces at play to stigmatize infertile women are multilayered, and, if this chapter proves anything, they subsequently function to pressure women in intersecting ways.

In exploring the dynamics of infertility for women, what makes IVF a useful lens, perhaps, is just this ability to expose the dialectics of different parties at work. Tradition, the state, the family and the women themselves meet at the focal point of IVF. Empowering women with doctors as advocates, IVF allows patients to better understand their reproductive cycles and their bodies. If IVF is capable of this, why, then, do women who fail in their IVF cycles continue to suffer, becoming even more constrained in their reproductive choices? The next chapter takes the discussion to the personal level by closely following the IVF narratives of five patients from the RMC. In the patients' own

lived experiences, the themes discussed thus far, such as the antinatalist-pronatalist dialectic and the role of pressure, bleed through the framework.

**Chapter 5 –
Personal Perspectives: The Experience of IVF from Five Selected Women**

Rather than pursuing specific themes, this chapter zooms in on the IVF histories of five patients at the Reproductive Medicine Clinic. With an ethnographic focus, I present the viewpoints of each woman to portray how they made meaning of their situation, how they experienced their infertility and what issues were important to them as they underwent IVF. While these women were neither the same age nor necessarily at the same stage of their cycles, they all had one thing in common – they had come (and continued to come) to the RMC to have a child.

When I first arrived at the RMC, I had expected my fieldwork to take shape through lengthy, all-at-once interviews conducted in a private space. It took me less than one day at the clinic to realize that this could not be carried out as planned. First, there were so many patients waiting in every corner that it was not possible to find a private room to conduct interviews. Every available room was already allotted to a specific task and, even then, teeming with people. The only “quiet” rooms were the ones in which doctors napped at lunchtime. Women and their family members appeared in a rush coming in and out of rooms, even though a good amount of people were still waiting all morning to be seen.

Instead, I began to develop relationships with these women during waiting times, or in the middle of an appointment when the doctor would have to step out for a private consultation or a surgical procedure. The fluidity with which doctors moved through the clinic, although not good for wait times, allowed me to converse with many of the patients. Privacy was difficult to achieve at the RMC. Given this, I deeply admired these women who were willing to share their personal stories and challenges with me as we sat down together.

I have picked these five women in hopes that their diverse yet surprisingly unifying stories can cover the spectrum of experiences and backgrounds I encountered. It is true that, amongst the five, some of these IVF experiences can be described as atypical by nature of their outcomes or circumstances. But, why do we tend to characterize any one of them as atypical? In comparing these experiences side-by-side, I aim to shift the overlying picture just enough to reveal, perhaps, glimpses of the underlying structures at work. As I wrote and finalized this essay, I worried constantly of my inability to encapsulate the individual liveliness, strength and vitality of the women I interviewed. While I could never fully represent them to readers as I met them in the clinic, I hope that this chapter will do my interlocutors justice, presenting them as fully and vibrantly as possible without reducing them to mere characters in a text.

Leewan

By the time I started my fieldwork at the RMC, Leewan, a 36-year old female patient from the city, was already four days into hormone shots for her first IVF cycle ever. She always had her hair tied up in a ponytail, bearing a tired look on her face that disappeared, usually, when she smiled. The first time I saw her, she burst into the clinic room in frenzy, worried about a fever that had flared up the day before. Her concern, in part, came from how this rising fever might affect her growing oocytes, which were to be ready for extraction in a few days. She did not have an appointment that day, but she grabbed Dr. Mei's attention in between patients.

“Should I give up this cycle? My eggs don't look good anyways, right?” She kept going back and forth about what she thought she should do. “But, if I have a fever, I'll have to give up, right? I don't want to do that.”

Dr. Mei appeared annoyed at Leewan's sudden appearance, but spoke patiently with her about her options, calming her about the fever, which could be cured with a

small bit of medicine. Leewan was advised to seek a prescription for fever medication, and left for the morning.

Later that afternoon, however, Leewan came back in a bigger fuss than before. Apparently, she had gone to a bunch of different departments (Traditional Chinese Medicine, Respiratory, General Internal Medicine) to get a prescription for her fever, but, when she told them she was undergoing IVF and feared the fever would affect her oocytes, they all refused to give her medication. According to Leewan, none of the doctors dared to prescribe her medicine out of suspicion that any possible latent damage to her oocytes or, even worse, to the (later) child would be blamed on them for prescribing the “wrong” medicine.

“Don’t think about your child first. Think about yourself first, okay?²¹” Dr. Mei looked exasperated after hearing this story from Leewan. Then, she offered to prescribe her the medicine, but Leewan kept worrying that the medicine would damage her eggs. “Think about it – I can’t give you medicine that’s bad for your child.”

Leewan broke down into tears, but seemed convinced by Dr. Mei. Still standing up from her rushed entrance into the room, she apologized to the doctor that she was just really worried. The patient sitting down, whose appointment Leewan had interrupted, handed her a tissue, telling her “it will all be okay.”

The following Monday, Leewan came back in for a checkup. Her fever had subsided, but none of her oocytes developed well enough. When I talked to her, she told me of her intent to begin another round of hormone therapy.

“It’s tough,” she said, when I asked her how she felt about starting over again. “I have to get shots on my rear, but it was more convenient for me to do it back home instead of coming to the hospital every day, so I got a nurse to teach me. I’m worried that

²¹ “你先不要想孩子 – 先想自己吧。”

I'm actually injecting these shots inappropriately, and that's why my eggs aren't good. But, then again, maybe it's my age."

A couple of days later, Leewan was once more at four days into her hormone shots. This time, she complained to me about her eggs. "They don't behave (*tinghua*). Even with all the medical guidance, IVF is so hard because you can't control this thing. Other people seem to be able to get the help they need from the treatment, and their eggs just grow the right way. Mine just don't! My eggs are so stubborn!"

On Saturday, I ran into Leewan again as she just came out of her appointment. Luckily, the RMC works half-days on Saturday and I got to speak with her just as the workday was ending. She updated me on her status, telling me that her eggs were ready to be extracted on the upcoming Monday, but they were not very good. As a precaution, she was getting ICSI done instead to up her chances because the ultrasound only showed two or three possible eggs.

"Why did I choose IVF? Well, I guess the strongest reason is that because I'm having this difficulty getting pregnant, I should be *obliged to go one extra step (duo zou yi bu)* to try this IVF procedure. For me, I'm 36 years old. Most of the pressure I feel is from myself. My family isn't pressuring me at this point. The age is there. It scares me." She paused. "When I was younger, I thought it would be okay not to have a child. We live in a modern world now, in which women don't need a child to take care of them when they're older (*yanglao*)²². I can support myself, you know? But, when I got older, I thought that these thousands of years of culture, basically all of human history, point to the fact that a child is needed for a complete life. I felt the pressure then."

I asked her, then, "what made you change your mind about children?" Her answer, in some ways, contradicted what she had said a bit earlier.

²² 养老

“At first, the pressure from my family was not even that bad. When you have family and friends constantly asking you about whether or not you have a child, though, it just hits you hard. When you go to a family gathering, like at New Year, you realize that *everyone has a child and you don't.*”

The conversation continued until it took a strange turn, when Leewan began to talk to me about her worries about having a child. While I expected it to be about medical complications from the procedure, her focus was entirely on how to raise a child properly.

“Before [this modern era], it was easier to have a child. You could have raised many children on about 300 RMB a month. Now, I make about 3,000 RMB a month, and I know it's not enough. I can't really even raise a kid if I have one, but I want one so bad now that the financial issue is not something that will prevent me from having a child. Raising a child in China now is just so difficult – if you want your child to succeed, it's going to cost money.”

The next time I saw Leewan, her oocyte extraction operation had just ended earlier in the morning. I asked her how it went. She told me she had only one egg successfully extracted this morning, and it ended up being an immature one. Leewan cupped her face in her hands and let out a sigh of anguish. Knowing that the results weren't looking good for this cycle, the doctors around her sympathized with her.

After a couple hours of contemplation on how she should proceed, Leewan expressed worries about the outcome should an embryo develop, perceiving ICSI as a procedure that “forced an egg with a sperm.”

“How will the child be?” She asked Dr. Mei. “I'm afraid this will influence the child. Is it my problem, or is the technique just not for me? Can we do something better the next time? Should I just give this egg up and start over again?”

I made a mental note to myself that Leewan, throughout all this, never directly blamed IVF for the failure. The way she had framed the words emphasized the fault on some incompatibility or incompetence with her body, rather than the technology's. Hearing Leewan's concerns, Dr. Mei made a quick call to the laboratory to find out more about the status of her extracted oocyte. She recommended to Leewan to see if the egg would develop after ICSI. If an embryo developed, Dr. Mei advised, then it would most likely be fine, because if something were wrong with the egg, it probably wouldn't develop to an embryo anyways. Leewan ultimately took Dr. Mei's suggestion without much complaint.

The next morning, I inquired with Dr. Mei about how Leewan's egg had grown over night, and whether or not she would proceed with the ICSI procedure. I learned, however, that Leewan's single egg did not survive. Leewan's first IVF cycle yielded no usable eggs. I was disappointed and wanted to follow up with Leewan about how she might have felt. Unfortunately, I never saw her again at the RMC during my time there. I thought, perhaps, she had received the updates over the phone and had decided to recover for the next two months, as many women with failed cycles do upon the doctor's suggestion, at home, before trying again.

I choose Leewan's IVF story, because she did not know why she was infertile and was about the average age for a patient at the RMC (the average age was approximately 34). Her husband, in addition, seemed oddly removed from her IVF experience. Still, Leewan's narrative highlighted for me the immense amount of pressure that women subjected themselves to in order to succeed in IVF. Although it was societal cues and the innocuous chitchat of friends and family that initially influenced her, Leewan later internalized that pressure, and more importantly, attributed the source of that pressure to herself. That Leewan felt herself obligated to pursue IVF in addressing her infertility

falls in line with “the never-enough quality” of ARTs as suggested by Margarete Sandelowski, in which women privilege quantity over quality of treatment for infertility (Sandelowski 1991:31). Leewan, in other words, felt compelled to try with IVF and, even after her 1st cycle failed, intended to return and try again until she could be successful in spite of her own fears about and anxieties brought out by the procedure.

Another concern that Leewan raises is the cost of both having and raising a child in present-day China. This is all not to mention that she is spending even more money to conceive the child in the first place. Still, Leewan appears ready to make the investment despite knowing that she doesn’t make enough to truly support a child. To undergo IVF, Leewan gave her mind and body, as exhibited by her unwillingness to treat her fever in order to benefit her could-be child, despite the immediate need to take care of her own health. How, then, does this investment become not just a monetary one, but also an *investment of agency*? What does Leewan give, of and for herself, to meet her need of a child? The next account aims to give further insight into the processes at work.

Hong

Although some of the patients I interviewed did not have a clear medical explanation of why they needed IVF, a couple of them had straightforward diagnoses of infertility in which the procedure was the only answer. A 29-year old woman with bobbed, dyed red hair, Hong had a past ectopic pregnancy in which one of her fallopian tubes had to be surgically removed. When she had recovered enough to try for a child again, doctors determined the other fallopian tube to be obstructed. As a result, Hong was infertile because there was no physiological way that her oocyte, once released *in vivo* (in her body), could meet with a sperm to be fertilized.

The first time I met Hong, she was waiting to be seen by the doctor-on-duty in the afternoon. The doctor had stepped out briefly, and I sat down next to her and

introduced myself. When I asked her why she chose IVF, she was understandably straightforward.

“I’d rather have a natural pregnancy, but I can only do IVF. I’m doing this procedure, but I feel very insecure about it. I really hope that once is enough. I just feel that IVF is doing something to my bod right now.” What Hong meant by this, as she went on to explain, was how different her eggs were growing under hormone therapy as opposed to typically. For one, she menstruated regularly every month, and, as a preliminary month of observation with ultrasound confirmed, had one egg mature at a constant and steady rate.

Perhaps because Hong’s attention to detail was so excellent, she noted that, under the ovarian stimulation, she grew unsymmetrical, oval shaped eggs that, when measured with the ultrasound, were “weird and not normal”. Hong expressed to me, then, her fear of the hormone treatment part of IVF.

“I’m afraid of these shots and these chemicals. Hospitals here are difficult, because they have a strong sense of self-preservation.” As she told me this, I was immediately reminded of Leewan’s predicament when she had come down with a fever. Both of these women expressed a dismay with the medical system that made their IVF experiences highly stressful. “[Hospitals] don’t want to be held accountable for anything that goes wrong, so I have to come all the way here just to get shots because my local clinic won’t administer the shots that Dr. Mei prescribes.”

“I overthink and hesitate on any small thing,” Hong admitted to me, identifying this trait as the source of her anxiety. “I think any little thing could affect my eggs or the quality of my eggs. Like, I worry if the shots don’t get injected correctly, something could be going wrong.”

Over the course of the next week, Hong underwent oocyte extraction, successfully recovering 8 eggs that were fertilized. Although at first she felt impressed with this

number, she heard back from the lab one day later to find that only one fertilized egg had develop into an implantable embryo.

“My heart sank. I didn’t think I would get pregnant at all after I got that call. I felt like I *must* have to repeat the whole process again. The doctors implanted that one embryo, but I don’t have very high hopes about this.” Hong left the clinic that day after the transfer procedure to go home, starting work again the next day. To put this in context, many women at the RMC took several days after embryo transfer (some going as far to not even rise from their beds for 24 hours) for hopes of IVF success. I would not see Hong again until a little over two weeks later. When I saw her again at the clinic, she greeted me with wide, bright eyes.

“Good to see you again!” She exclaimed. Hong was waiting to be seen by the doctor on duty. She held a flimsy, paper slip in her hand. Although I couldn’t tell from the way she held the sheet, I knew from past experience that the paper bore either a red positive stamp or a blue negative one as a test for pregnancy.

“Are you pregnant?” I asked, eager to hear her answer.

“Yes! You know how I didn’t think I would? A friend encouraged me to test the results anyway, so I self-tested at home nine days after transfer, and it came out negative. I put aside the idea that I was pregnant even more. But, I gave it a shot again five days later, and there was a weak positive!” She was glowing with disbelief. “My heart got so anxious, so fast. I’ve had an ectopic pregnancy before, so for a brief moment I thought – what if it’s another one? I was worried I would lose the child again. I just came and got an ultrasound. Everything is fine.”

Given her past experience, Hong had a tendency to second-guess every result she received, but it seemed that, this time, her self-doubt led her to a happy outcome. Taking just over two months, her first IVF cycle had been a relatively quick and successful one

despite rocky bumps along the way. She had already begun thinking about how this new pregnancy might affect her work life.

“The other day, out of the blue, my boss asked me if I was pregnant. I told him I wasn’t sure yet.” Hong brought this up, because nobody at her workplace knew that she was doing IVF except for her boss. She only told him because she had to take mornings or whole days off to come to her appointments at the RMC. “I am lucky, I think, because my boss understands. He knows about my past ectopic pregnancy, and told me that his daughter, too, had difficulty getting pregnant.”

That day, the doctors marked Hong down in their books as another successful IVF statistic, one of a coincidental string of positives that entire week. Even Hong, looking back, commented that she found herself lucky. The process might have been tedious while it lasted, but it didn’t seem like a long time to her. She would be free from the clinic for another couple of weeks, when she would come back for a checkup on how the embryo was developing.

“It’s not that I wasn’t thinking about getting pregnant,” Hong told me as we wrapped up our final interview. “I *wanted* to get pregnant. I just didn’t have high hopes about it.”

Compared to Leewan, Hong successfully completed IVF in her first attempt. In addition, while Leewan’s reason for infertility was undetermined, Hong’s reason was definitive and made her the “classic” patient for whom IVF was developed.²³ I do not think, however, that there was any correlation between their difference and their outcomes. As Hong herself suggested, at several points in her experience, she did not at all expect the positive outcome she received. Although women might be making an

²³ Remember, the first patients that Zhang Lizhu, the pioneer IVF-doctor in China, treated were those with obstructed fallopian tubes.

investment of and for themselves, these moves are often made with great risk. Whether they would be worth the risk or not was hard to tell.

At this point, we can already begin to see a couple of recurring concerns between IVF patients. Whereas Leewan mentioned how difficult it would be to raise a child in China's changing economy, Hong worried about how her employment might be affected by her pregnancy. These are questions that working women face in any context, not just for those who become pregnant through IVF. Still, China's economic dynamics play a significant role in influencing whether and how women problematize their childlessness. Additionally, both Leewan and Hong expressed how the hospital system's lack of accountability put them in tough spots. For one, how can we reconcile this perceived lack of commitment from doctors, when patients themselves give so much? Is this power dynamic justified, or is it a flaw of the system that women must deal with? Considering external and internal circumstances, all of these chance occasions that affect IVF outcomes, perhaps, can explain to some extent why Hong might have held back her hope despite her intense want of a child.

Although both Leewan and Hong had certain hopes about becoming mothers through IVF, the way they embodied these hopes were distinct. Unlike Leewan, Hong placed her body first, having gone through a life-threatening ectopic pregnancy years before. Women's individual lives outside of (or prior to) IVF, therefore, frame how they prioritize the anxieties associated with using IVF to deal with infertility.

The next narrative brings a rather different case than Leewan's and Hong's by highlighting how women navigate their infertility experiences. For infertile women, the IVF experience often heightens women's anxiety by subjecting them, even if only temporarily, to a set of unpredictable medical circumstances. Although the medico-technological process is never something they can fully control, we will see that patients

develop mental tactics (as with Hong) or societal ones (as the next patient will show) to deal with the pressures they face with infertility.

Yue

When I first met Yue, she was standing behind her sister, who had brought her into the RMC on a slow afternoon. Yue's sister had led her into the clinic room, having grabbed an appointment number for the general reproductive medicine doctor. Although they were supposed to be seen by another doctor, upon seeing Dr. Mei (the director of the RMC) at another desk in the clinic, the sister immediately greeted her.

"Do you remember me?" She said, taking out a photo of two boys from her purse. "I did IVF here back in 2009 and gave birth to twin boys!"

Dr. Mei stared at her, perplexed for only a short moment as she tried to recall the sister's face, and then had a moment of epiphany. "Oh, yes! I remember you. You've turned so beautiful. How are you?"

The sister updated Dr. Mei about her life, proudly handing to the doctors the photo of her two sons. Apparently, she had come into the clinic that day to sign off the five oocytes she still had frozen to be destroyed, because she couldn't have any more children anyways due to the One Child Policy. Dr. Mei asked her how her husband was doing, but the sister responded that they had already divorced. At this point, the sister diverted the attention from her life to focus on Yue, who was still standing in the back.

"This is Yue. She's only 21, but her husband is 28 already and wants a child now." I was surprised immediately by her age and the straightforward way in which she was introduced. It became clear then that Yue had come with her sister to be introduced to

the doctors at the RMC, with whom her sister already had some rapport.²⁴ “She’s hoping to do IVF here.”

Upon hearing this, another doctor in the room commented, “what are you hurrying for?” Dr. Mei, however, held her tongue. If she did have any judgments, she did not show it. When she did speak, she told Yue that if she really wanted to do the process, she should come and get an appointment another day, in the morning. IVF required a lot of different tests, Dr. Mei explained, and most of the departments that could do these tests do not open in the afternoon.

Over the course of the next couple of weeks, I would see Yue in and out of appointments. I learned that she would have to undergo at least one month of ultrasound observation, tracking the growth of her oocytes during the course of one menstrual cycle. Although she was young (or because of the fact), the doctors took care to shorten her wait time as much as possible for many of her visits. As a result of this, I never had time to talk to her at length during this time. I did notice, however, that she had a habit of biting her medical folder, which was still a clear plastic one as opposed to the thick white paper one of most IVF patients, when she stood idle for too long.

Almost a month had passed since Yue first arrived at the RMC. While her first visit was with her sister, Yue’s husband, a tan young man dressed in heavily patterned clothing, now accompanied her on most days. He, however, never came into the actual clinic room and remained outside, arms crossed, sometimes napping during long waits in the lobby.

By pure coincidence, on the day that Yue finally received a white paper folder, I had managed to interview her in the clinic room. She had just had an ultrasound and was

²⁴ It was never clarified, however, whether or not that was her sister or a cousin. In Chinese, the word *meimei* (younger sister) or *jiejie* (older sister) can mean either sister or cousin.

waiting for updates from Dr. Mei. For Yue, the change in folder type documented a momentous occasion that signaled her approval for IVF from the doctors.

As Dr. Mei began to write basic patient information and number on the top right hand corner of the folder, she asked Yue her age and her birthday. It was then that I learned Yue was only 20 years old.²⁵ She was born in 1994 and would only turn 21 a couple of weeks later. She had been married for two months. It struck me as strange, then, that the couple had, technically, only waited two of the 12 months typical for couples to be defined as infertile. Later, when Dr. Mei had finished with her appointment, I asked her why she chose IVF.

“We [my husband and I] really want a child. He has poor sperm,” She insisted, before pausing a little. “But, mostly, we can’t wait any longer.”

I must have appeared visibly confused at that point in time (belying my neutrality, my apologies), because Yue continued to give me a long list of reasons why she would undergo this procedure.

“It seems that IVF has a high likelihood of boys – and twins, too. At another reproductive medicine clinic, this one lady I talked to did IVF like 12 times there and didn’t succeed. Another one did it 8 times without success. They [the other clinic] also don’t really have boys that are born there. It’s like all girls if you look at the children that are born from IVF done there. They very rarely get a boy.” She nodded confidently at me. “Here, I feel like a lot of boys are born.”

We extended this conversation to talk about how this upcoming year was the Year of the Sheep. What this meant was that any child conceived this month or the months to come would be born between February 2015 and January 2016, making him/her a

²⁵ Earlier, her sister had said she was 21. This might have just been a mistake, although I am inclined to believe it was not, because the appointment slip that Yue had on her to be seen the day she received her IVF-folder had a reported age of 21. Her birth certificate, however, confirmed her *real* age as 20.

“sheep child.” As mentioned earlier, this zodiac animal year, in particular, was considered a bad year to be born by many couples (Liu and Hunt 2015).

I had learnt of this belief, passed down through generations, from one of the RMC’s doctors earlier when I had commented about how busy it was my first week at the clinic. The doctor’s response, surprisingly, was that it was rather *not* busy, and that I should have seen the crowd a couple of months ago. Because it would be the Year of the Sheep, she explained, “less people are coming to do IVF since it is inauspicious to have a child born then.”

Although Yue herself did not believe in this saying, she still brought it up in conversation. “I know it’s the Year of the Sheep, and the elderly all say we can’t have a child born in that year, but whatever, what choice do we have? We really want a child. IVF is our only option.”

Throughout our interview, in fact, Yue would speak as if there was no better way out of her childlessness other than IVF. When I asked her more about her husband’s infertility, she remained vague in her responses, repeatedly telling me that he had “weak sperm”. His condition, however, did not appear dire enough for her to attempt ICSI, which would address the issue of male infertility. Yue, therefore, held the burden of infertility despite what the science might have signified. Not only this, but also her attitude struck me as interesting, because she was, from the beginning, blatantly aware of how very young she was for the procedure, saying that “few people my age do IVF.” Perhaps it was because I thought of myself in her shoes for a moment, given our closeness in age, but I immediately asked her if she was scared of the procedure to come.

“No,” She paused, biting her new white folder as we leaned against a table at the side of the clinic room. “I say I’m not scared, but, of course, I’m scared.”

About two weeks passed before I followed up again with Yue, mostly because I did not see her in clinic much during this time. Although she had only obtained her

marriage license a day ago (she did not turn 21 until then), she had already taken all of the tests necessary to proceed with hormone shots for oocyte stimulation. I asked her, this time, how she was feeling and she spoke about the pressure she initially felt about being childless.

“Most of the pressure I feel is from myself, but some of it is also from my husband’s father to have a child, even if it’s a sheep child. If it wasn’t for this weird upcoming year, we wouldn’t have hesitated and tried for children even earlier.” She added more to her answer, then, when I asked her if how she felt since starting her IVF cycle.

“At first when I came here, there was a lot of pressure. I gave myself a lot of it, to be honest. But, then I realized there was no reason for that. My pressure was greater than my hope.²⁶ Now, I recognize that there is no point to feeling so much anxiety. In fact, stressing out might even have negative effects on my body and, therefore, the IVF process.”

Throughout this second interview, Yue was full of stories of the other women who came to the RMC. She had collected these anecdotes in the waiting room (much as I did). In fact, what Yue focused on most, and was most eager to share with me, were the unique and coincidental ways that certain women got pregnant. For example, she told me the case of an IVF patient who had performed a pregnancy test nine days after embryo transfer as instructed and found the result negative. Three days later, this patient saw blood and thought she was menstruating. For whatever reason, however, another pregnancy test was performed two days later, and it turned out to be positive. Yue exclaimed to me how amazing this was and how lucky that woman was now to be pregnant.

²⁶ “压力都比希望大。”

Unfortunately, my time to leave arrived too soon, and I do not know the result of her first IVF cycle. We had promised to keep in contact over email, but I have not received any updates from Yue.

I have shared Yue's (incomplete) IVF history above because she was the youngest woman I encountered at the RMC, and yet she fit in surprisingly seamlessly with the other patients. As a 21-year old, there seemed to be no obvious medical reason why Yue needed to undergo IVF, but to her, the procedure seemed necessary. If her husband's infertility was a serious factor, why did she not pursue ICSI? Is this the work of the pronatalist tradition, creating a sense of urgency in which young women fear the stigma of childlessness and carry that burden themselves? Or, are there other explanatory factors present? Although I will never know for sure whether she came to the RMC of her own volition or not, Yue's ability to successfully navigate the hospital system and build friendships in the clinic suggests that she was not completely devoid of power.

What I admired about Yue was the dynamic of her naivety at play with her maturity, the former owing from her age and the latter from her gathered knowledge of other women's experiences with IVF. She was full of contradictions, not believing in tradition but constantly thinking about it. In a way, Yue did her best to have control over her situation. Because she knew she was young, she constantly sought the guidance of the older women around her, who became, through the clinic community, her form of support. As a result, she held herself strong despite the hardships she faced, although it remains murky whether these challenges arose from IVF or prior societal and interpersonal factors.

Bing

The first thing I noticed about Bing was her beautifully patterned, well-pressed dress that made me think she just walked off a sunny cruise in the Mediterranean. She wore fancy sunglasses like a headband on top of her head.

Just as it was her turn to be seen, Dr. Mei was called away by an urgent matter. Bing folded her hands on her lap and gave me a quick smile. Knowing that she had been waiting patiently all morning, I apologized to her for the delay and introduced myself as a student from the US, researching infertility and IVF. Hearing this, she nodded and spoke back to me in perfect English.

Apparently, she was an elementary teacher that taught English for children of expatriates in the city. She told me that many of her friends were foreigners, and that she was surprised to find me interested in this clinic.²⁷ When I asked her how she felt about IVF, she told me she perceived it as a growing trend among women, particularly younger ones who hear gossip of gender-selection and multiple births. Bing had no interest, however, in becoming involved in what she thought of as “awkward conversations” in the clinic.

“I have a close friend who tried IVF for a long time. She wanted the child mostly to save her marriage. Still, none of her IVF cycles ever worked out. She didn’t want her marriage to end, so she eventually got black market contacts through her husband to receive a child by being a surrogate.” Bing continued, emphasizing the veracity of her statements. “I’m serious. This happened here *in this city*. If you have a lot of money, you can get away with this kind of thing. She told me they used another woman’s egg, with her husband’s sperm, and now she’s pregnant with his child but *not* hers.”

Since Bing disdained the gossip of the women in the waiting room, I found it interesting that she had decided to tell me this story when I asked about the state of IVF

²⁷ This sort of reaction was not uncommon. People were surprised to find that I was either studying IVF, or that I had bothered to come to China to study it. When Dr. Mei introduced me to the head doctor of the OB/GYN department, her first words to me were: “it’s just IVF – what’s there to know?”

in China. What she lacked in gossiping with other women, it seemed, was definitely compensated for in her interviews with me. She went on from the topic of IVF abuse to clarifying for me how important having a son still was to many people, even those much younger than she was.

“I don’t really want a boy; I’d rather have a girl. Girls just care more.” Bing reasoned, effectively removing herself from the majority group she just identified. “Also, I don’t want twins from IVF. I think having one child is better than having more. To me, there’s a risk of unequal treatment between two children, and I worry that they will fight amongst themselves. It’s too hard to love both at once.”

The more I talked with Bing, the more I realized that she had very different perspectives than most of the women I met at the clinic. In fact, she almost seemed to actively work against what, in her mind, was the typical image of a woman who might do IVF. When I asked her about her IVF history, she joked with me that all the nurses and doctors recognized her as an old-timer by now. Looking at her admittedly thick, white folder, Bing pointed out that she had been a patient since 2012, about two years ago. Despite becoming pregnant after her first IVF cycle way back then, she had a miscarriage as a result of a tumor on her uterus that had grown during pregnancy. She had known about this tumor before, but had decided to undergo IVF because the tumor was then small and benign.

To prevent losing another child, Bing put her concern with infertility on hold and decided to get her tumor removed first. This surgery resulted in a chronic endometrial condition in which decreased blood flow to her uterus had caused a tendency for thin endometrial lining. As a result of this, which technically made her uterus suboptimal for embryo transfer, Bing had been in and out of the RMC just preparing for her second IVF cycle. The reason I had not seen her until now was because she came in occasionally only

to check on the thickness of her endometrium, waiting for it to recover to a point when she could stimulate her oocytes again and undergo the full IVF procedure.

The second time I saw Bing in the clinic, she was sitting down in the middle of a row of women. The English book she was holding in her hands distinguished her from the women around her, who sat either in conversation with other women in the room or staring down into their own smart phones. When I asked her how she was doing, she first gave me a recommendation for “such a good English book!” before telling me that she was about to go on vacation with her husband, her sister’s family and her niece.

After finding out that her endometrium had finally looked healthy enough to begin IVF again, I remarked at her patience and willingness to set aside IVF for another month. I asked her if she was worried at all about delaying the procedure.

“For me, having a child is not that important. I don’t worry as much about having a child as I do about how *difficult* it is to raise one in China today. Most parents both have to work all day, so it’s usually the grandparents that take care of the grandchildren. The children get spoiled sometimes as a result, and parents end up fighting with grandparents over how to raise the child. It’s really a mess.”

Bing had a habit, although not because of anything she was doing in particular, of always waiting all morning to be seen by the doctors. She didn’t come often, but when she did, she found herself so often waiting that we joked sometimes about how she was still sitting there. On the third time we both found time to speak with each other at the clinic, it was almost lunch break for the doctors, but Bing’s folder was still buried under two more patients placed before her.

“Here, there’s not that many acceptable deviations from the life that ‘get married, have one child, and raise that child’ path. Pregnancy is more talked about in the US than in China. For example, in other countries, I feel like people talk more about miscarriages, or get encouraged to have more children.” Bing paused then to ask me

about Mormons, for whom she had heard actually tried to have many children in a family. She saw this as a direct foil to what it was like to start a family in China.

“The other day, I was late to work again because of these appointments, and one of the parents asked me, out of honest concern, if I was feeling okay. I felt bad hiding it from her any more, and told her that I was undergoing IVF here. But, you won’t believe what this parent told me afterward! She told me that her son, in fact, was born from IVF. She told me that she understood, and to take care of myself and hang in there.” Bing told me this instance the last time I saw her, because when she returned from vacation, I would have returned back to America. “I feel like if people could have more open conversations like this, undergoing IVF would be easier here.”

Although not the oldest patient I had encountered at the RMC, Bing was the oldest patient that had been visiting the clinic for the longest time that I interviewed. Her first IVF cycle started successfully but ended in a tragedy that derailed the course of her procedure. Despite these challenges, Bing had an incredibly lighthearted and soft-spoken demeanor. Compared to the other patients I have introduced thus far, Bing seemed far less rushed. Whether this was due to her age, her socioeconomic status or personality (or maybe a combination of all), however, is hard to say. Still, her perceptions of the way that tradition deeply affected the way women acted in IVF resonated with Leewan’s, Hong’s and Yue’s experiences. Even if Bing did not place having a child as a top priority, her perseverance in visiting the RMC even after all these years hinted at her vested interest in IVF.

Bing’s comments on how grandparents spoil their grandchildren, furthermore, touched on the influence of changing economics and Confucian filial piety. Similar to Leewan and Hong’s concerns, just having a fertile body is no longer enough – one must also have a *fertile* home, supported with finances and caretaking resources. If they are

the ones often raising their grandchildren, then mothers and mother-in-laws of patients do indeed have a personal interest in their daughters' reproductive lives. When we consider the prevailing value of filial piety, how can we rectify what is most accepted with what is most moral? In addition, given China's rapid economic development, how have obligations such as employment fallen out of place with the resources needed to support a newborn child? Thus far, the state has done nothing to address these conundrums.

Before moving on to the last and final patient in this chapter, I want to focus for a moment on Bing's closing remarks to me. Her wish for a more open dialogue on infertility, pregnancy and childlessness exemplified how women were silenced in their suffering. Despite being dynamic as a medical advancement, IVF seems stagnant in its ability to create any substantial social power for childless women. I have no doubt that IVF allows infertile women a chance (and a fulfillment, even) to have the child of which they have long dreamed. Rather, what I am suspicious about is what might be at stake to allow such fulfillment. By undergoing IVF, do women, at least to some extent, define their infertility as inherently problematic and, therefore, a flaw of the self to be solved through a modernized, state technology? I do not wish to be skeptical about IVF, as it would belittle all of the good it has undeniably performed, but I do ask these questions to challenge the insidious ways in which state and tradition have battled against women for control over IVF and, in turn, reproduction.

Shao

On my fourth day at the RMC, I met Shao, a 51-year old IVF patient from the city. At that early point of my fieldwork, I had not yet begun interviewing and speaking directly with patients, out of respect for the doctors whom I agreed to shadow for the first week (plus, I needed to learn a lot of the terminology and protocols of this particular

clinic). Thus, while I did not talk with Shao when I first met her, I did take note of her appointment.

In the middle of what I later learned was her 4th IVF-ICSI cycle, Shao had a checkup appointment with Dr. Mei, who informed her that, after more than a week of oocyte stimulation, she had only grown two or three eggs thus far. Shao's response, however, was hopeful and upbeat, and I could not detect any disappointment in her tone of voice. Throughout the appointment, Dr. Mei reminded her, in subtle ways, that she did not have a lot of eggs and that the success rate for those over 45, let alone 50, was very low. Shao just nodded, acknowledging the facts as sensible, if nothing else.

Perhaps because it was one of my first days at the clinic, as Shao left the room, Dr. Mei turned to me and said, "she's not our typical patient." Since Shao was over 50 years old, I was not surprised by Dr. Mei's statement. In a medical study on the success of IVF in women greater than 40 years of age, women over 40 years old had a significant disadvantage compared to younger individuals (Lass et al. 1998). In fact, in the same study, out of 1,087 IVF cycles started by women over 40 years of age, no women over the age of 45 had a child successfully from the procedure (Lass et al. 1998). Although Dr. Mei and other doctors at the RMC repeatedly told Shao of her low chances of success, they always gave her the final decision on whether or not to continue her on IVF— Shao, of course, insisted that she kept trying.

Over the course of the next week, I followed Shao's IVF updates peripherally, never quite getting the chance to talk to her. Every time I saw her in the waiting room, however, she was accompanied by a very pleasant, lanky, pale and white-haired elderly man sitting next to her, holding her bags. When I asked Dr. Mei about this, she told me that, in fact, Shao was married to a 74-year old foreigner from Denmark.

By the time I considered myself well versed in the clinic's medial lingo, I had luckily gotten the hang of interviewing patients during their long wait times. One day,

when Shao was sitting in the waiting room toward the end of the workday, I introduced myself and asked her if I could interview her for my research. She agreed wholeheartedly, seeing no problem with speaking to me, and told me that she would be free next Tuesday afternoon, when her husband would come for an aspiration procedure to freeze his sperm for a future ICSI cycle.

Apparently, she had received the oocyte extraction surgery two days earlier, and the doctor had recovered 4 eggs. Even the doctor herself, Shao relayed to me, was impressed by this outcome. Following the injection of these eggs with her husband's sperm, however, none of the fertilized eggs developed to the transfer stage.²⁸ The couple would have to try again.

Unfortunately, Shao and her husband were scheduled to return to Denmark next month, before another cycle could be completed. She told me, then, that she and her husband were technically citizens of Denmark, and only had a visa for China from August 2013 – 2014. Her husband, at least, could not stay for more than 90 days at a time. All four of her ICSI attempts thus far had been in China.

Wanting to try again next cycle, Shao thus asked if they could extract and freeze her husband's sperm before he left the country. In doing so, she would send him on his flight home while she canceled hers to remain in the city and undergo another ICSI cycle at the RMC. We parted ways, then, and hoped to see each other next week.

When the time came, I began the conversation by asking Shao about her thoughts on IVF, a standard question with which I prefaced most of my semi-structured interviews. What I would discover, however, is that our conversation quickly veered off path as she started to tell me more about the specific circumstances of her life that brought her to where she was now.

²⁸ For the RMC, doctors would only implant fertilized embryos if they developed to the 4-cell or the 8-cell stage. If the fertilized egg never developed to that point, the lab would discard the samples and ask a patient if she wished to start another IVF cycle.

“I’m 51 and my husband is 74. We got married when I was 43, and we wanted a child about three years after that. We lived in Denmark at the time, however, and the country didn’t allow IVF procedures for patients past the age of 45 then. We thought that was the case everywhere at first, so we didn’t bother pursuing the option further until two years ago, when we found we could do IVF in China.” During this entire conversation, Shao’s husband sat next to her, quietly nodding and smiling at certain things she would say. He held her hand firmly in his, and she would put her other hand on top of his from time to time.

Although he could not speak Chinese, her husband did speak a little English, so I asked him what he thought about undergoing IVF. He said the following to me, slowly but heartily.

“I’m not worried,” His English lagged a little as a result of not being as good as his native Danish. “My entire family, we live to be very old. My mother lived to be 95. I still have a lot of life in me.”

I looked back at Shao, whose emerging grin gave me a sense of just how confident he really was. If anything, they were in this together.

“What do other people think about you and your husband doing IVF?” I asked.

“My parents, and most people in their and my generation, think that once a woman turns 40, their child bearing days are mostly over. At 45, they’re completely over. People think that a woman over 45 should no longer think about having a child.” Shao continued to tell me that, nonetheless, her mother started looking into options for infertility treatment once Shao had informed her that she and her husband wanted a child. “We were both abroad at the time, but my mother asked all around the city for me. She went to the City Traditional Chinese Medicine Hospital first, and, of course, they didn’t know what to do at all. I asked her, then, to search for hospitals offering IVF.”

Shao, as a matter of fact, had her first three ICSI cycles at another public hospital in the city before switching over to the RMC. Although medical procedures and medicines used were slightly different here at this hospital versus the other, Shao made a point to note that they at least had one thing in common.

“Throughout the whole process, the doctors have all told us that there is little hope. Family members tell us the same thing, too, but we remain as resolved as ever to try for a child. We don’t let their opinions affect us. We’ve been through a lot and, well, we’ve learned that we can’t let what others say get to our heads.”

At this point, I seemed to have opened a sore topic for Shao, who subsequently told me particular instances in her past to contextualize her last answer. First, Shao let me know that they had never really felt comfortable, neither in Denmark nor China. When they went out, people stared at them, or they followed them and took pictures. Then, she informed me of a specific instance, back in Denmark, when a close neighbor made racist comments at her with her husband. Even worse, over the course of an undetermined amount of time back in Denmark, a close friend had periodically robbed her and her husband by, from what Shao suspected, drugging their coffees during afternoon tea and stealing tiny trinkets from their home. One day in Denmark, she came home to find all of her dictionary, vocabulary and grammar books ripped up on the floor. Shao paused then and spoke to her husband in Danish, as if updating him on what she had said and, more importantly, letting me know that this setback did not stop her from learning the language.

“Here or there, people look at me and judge. They think I’m a certain way, like a thief, a hustler, or using my husband for his money. They think I have no ability to take care of myself so I married him. I don’t fault them for thinking that, because they don’t understand or trust me. They don’t *want* to, either. We just want to have a child.” Shao

repeated this last line, with a significant but brief addendum. “In spite of all the misfortunes we’ve faced, we just want to have a child.”

I admired her perseverance. After this interview, I knew I would not see Shao again, because she would go home for two months to rest (as per RMC protocol) before starting another IVF cycle, marked by hormone shots for ovarian stimulation. In two months, I would no longer be at the clinic.

“We love each other,” Shao proudly stated. “There is no reason why we should not pursue the option of having a child, especially when it is still an option to us.”

At first glance, the combination of Shao’s life *and* medical history present an interesting case. As I worked on this essay, I struggled to reconcile the antinatalist-pronatalist dialectic with Shao’s life experiences, which seemed so fraught with difficulties unrelated to infertility. Although I have played devil’s advocate several times in this essay, questioning whether or not women were driven by their own desires or social pressure to pursue IVF, it became clear with Shao that it is absolutely, 100% the former.

What’s more, Shao’s IVF experience could not possibly be removed from her holistic life experience. After all of the hardships that she and her husband had experienced, they saw in having a child the embodiment of their intrepid commitment to each other, even in the face of continual discrimination. As long as she did not reach menopause, Shao and her husband would persevere to reach for a happiness that was, to them, a personal opportunity unaffected by externality. IVF provided them a path to this goal.

In particular, Shao’s case reminded me of the widely circulated IVF success story of Sheng Hailin, a 60-year old Chinese woman who had given birth to twins in 2010 after her 29-year old daughter died of gas poisoning. When media outlets found out about this

in 2013, it went viral. In regard to the much older couples that might use IVF as an answer to the grief of the loss of a son or daughter, one report had this to say:

“To survive and free myself of such loneliness, I decided to have another child in my old age,” [Sheng] was quoted by the newspaper as saying.... Such families [who have no children] face uncertain futures, with no one to help them through the frailties or medical costs of old age, and an unshakeable sense of loss in a culture that emphasizes family. (The China Post, December 25, 2013)

Although news outlets did not paint Sheng in a negative light, women considered past their reproductive prime, like Shao, received a certain amount of backlash and suspicion that younger patients did not. I would argue that, perhaps, Shao did not have the same traditional acceptability to solve her infertility as the younger women in the clinic did. This is not to say that the antinatalist-pronatalist dialectic did not affect her, because, as the above quote suggests, no childless couple is too old to be above needing offspring.

Regardless of a strong clinic community at the RMC, I found Shao ostracized by many of the women, who, even among those who would talk to her, would speculate behind her back on what kind of plot she had in mind to be pursuing IVF. Here Shao was, sitting in the clinic among other women who were, at least by medical diagnosis, exactly the same as her. She had undergone the same tedious tests, the same painful shots (and maybe even more), the same wait times – why was she judged, more than others, for wanting a child?

I cannot help but get the sense, somehow, that, as a 51-year old woman, Shao did not fit into the expected demographics of patients pursuing IVF, even if she was biologically able to undergo the procedure. Perhaps, then, it might be useful to juxtapose Shao with Yue, the 21-year old patient also mentioned in this chapter. Yue seemed to fit into the clinic community with ease, befriending women in their 30s and even early 40s who served as mentors. Why was Shao alienated from the other women in the clinic?

Although both women were of atypical age for the procedure, why does it seem to be more acceptable on the younger spectrum than the older?

The answer, in part, is the legacy of China's pronatalist values, whose notions of tradition in conflict with state goals of modernization reinforce their control over family life and reproduction at every turn. In line with tradition, just-married women (younger rather than older) should be having children within a year of marriage. Older women should either not be or be expected to act as such. Young women pursuing IVF does not seem particularly at odds with tradition. As an older woman, however, for Shao to be accepted, an aspect of tradition would have to be modified – that is, that older women could become mothers, too.

In fact, as China's marriage and pregnancy age shift ever older, problematization of infertility for young women might prove especially beneficial to perpetuate the pronatalist tradition. To promote IVF as a technology for older women, however, gives women the sense that childlessness is a problem, but *not an urgent one*, indirectly working against an emphasis of women to have children as soon as possible. For a woman who takes another role before that of being mother, the priority of filial piety, therefore, becomes secondary to her obligation in another role more productive than reproductive. The fear of tradition, then, is that just-married women may temporarily delay pregnancy for other pursuits. An immediate stigma of childlessness must be maintained. Rather than changing this stigma, the antinatalist-pronatalist dialectic tends to work through IVF to perpetuate this very anxiety of infertile and childless women.

Conclusion

At the front desk of the RMC, the staff maintained a tank of goldfish. The janitor, whom I befriended over the course of the summer and called Uncle Wang, would take care of these fish. Most mornings, though, I saw him cleaning out the tank to remove a fish that had recently passed away. He would continue to buy new fish for the tank, but they would keep dying, even when he tried different medicines and ways of care for the fish.

“Oh no, again, today?” I would ask, when I saw yet another fish floating on the surface of the water.

He would shrug his shoulders and point toward the surgery room, straight ahead from where the tank was located. “Whenever a patient has a successful embryo transfer, a fish has to die.” It was a joke, but I never forgot it. “Life for a life, right?”

What Uncle Wang alluded to was the give-and-take trope of “life”, which manifested itself in infertility and IVF in peculiar ways. While the fish probably did not die because a patient had a successful IVF cycle, Uncle Wang’s comment couldn’t help but remind me of the investments of agency that women made, of and for themselves, in order to try and conceive a child. These women not only dedicated their money and time, but also the whole of their emotional and physical resources to undergo the procedure.

As this essay has shown, IVF and other reproductive technologies have become increasingly important in the lives of Chinese women. This trend is not just a coincidence – rather, it is the result of the nation’s particular sociocultural, political and economic context within which individuals lives are embedded. Instead of deprioritizing childbirth for women, the One Child Policy has further dictated reproductive guidelines for women. Rather than reconciling with a pronatalist tradition, the clash of antinatalist policy with filial piety perpetuates the stigma of women’s infertility and childlessness.

In their work on ARTs, Rabinow and Rose argue that reproduction today has been made into a problem space, defining infertility as a treatable, medical condition (Rabinow and Rose 2006:208). Reproduction, in other words, becomes a site of reasonable intervention, pressuring women to work toward “fixing” themselves. In doing so, IVF patients open themselves to the modes of subjectification from state and society (Rabinow and Rose 2006:197). In “The History of Sexuality”, Foucault posits his idea that “a normalizing society is the historical outcome of a *technology of power* centered on life [emphasis added]” (1978:144). As the technology becomes increasingly popular, how has IVF helped in subjecting women into the “problem space”? If IVF can be understood as a “technology of power”, we must scrutinize the way it can affect and discipline the lived experiences of women, especially their reproduction. While IVF may increase the agency of women by providing more options to treat their infertility, the technology simultaneously narrows the range of acceptable life courses for them by reinforcing the necessity of early motherhood in the typical family.

Despite the perception of IVF as an ever more common solution to infertility, China’s strict IVF policy self-selects for the promotion of a heterosexual, one-child family for those who can afford it. The antinatalist-pronatalist dialectic contributes to these limitations by influencing the way that IVF develops. What is at stake here, therefore, is that women of all kinds will increasingly problematize their infertility and work tirelessly to solve their state of childlessness. As IVF’s influence over the population grows, so can the pressure for Chinese women (especially married ones), whether infertile or not, to have a child. The normalization of IVF in Chinese society serves as proof that the technology and the people who use it produce and reproduce each other, working to redefine concepts of infertility.

By the end of 2013, China had 358 IVF clinics authorized to conduct IVF (Yang 2013). Meanwhile, state media continues to report on overloaded clinics, filled to the

brim with patients. Current reports cite a growing rate of infertility as well, in tandem with worsening pollution and environmental conditions (Yan and Blum 2013). According to women I interviewed at the RMC, the consensus was that more and more women, especially younger ones, would turn toward IVF in the upcoming years. Given these compounding factors, what has the state done, if anything, to address this booming demand?

Rather than working on regulations to expand the access to IVF among the population, China suspended authorization for new IVF organizations as of early 2013 (Tao 2013; Yang 2013). As a result, any new hospital institution hoping to offer IVF and thus meet growing demand can no longer do so. Reports of unauthorized IVF use, surrogacy and the buying and selling of sperm and eggs have placed several currently authorized institutions under scrutiny.

Unsurprisingly, the government's failure to meet demand has spurred an emerging and thriving black market industry for IVF and related procedures. In fact, the "eight-baby scandal" mentioned at the beginning of Chapter One is just one such example among many, most of which did not catch media attention. In the clinic, more than one patient told me of the rising popularity of "IVF tourism," in which companies in China now offer fully planned excursions to countries such as Thailand and the United States, which have laxer rules about reproductive technology use.

As evidenced, even with booming IVF clinics, there still remains little, if any, state support for infertile women and men. Until these guidelines and the state approach to reproductive technologies change, IVF will inevitably remain a tool of the state even as it becomes a tool of the people. To address the banes of the IVF-program in China, the state should begin to subsidize the procedure for infertile couples that qualify. As of now, no procedures at the RMC are state-subsidized, even for patients with the national health insurance (*yibao*). The one exception, in fact, to this rule is a small loophole that the

RMC's doctors have found. When IVF patients undergo their first, general ultrasound, those with health insurance can get an appointment number from the OB/GYN department (*not* reproductive medicine) to qualify for a government subsidy. Everything else about IVF, including subsequent surgeries, hormone therapies, ultrasounds and appointments, must all be paid out-of-pocket.

If the pronatalist tradition and antinatalist tradition together require a one-child quota, couples should at least be given a chance to try for a child if nothing else can be done to ameliorate the stigma of infertility. The price of IVF, then, should appropriately reflect what people are able to make if the nation is truly suffering from an “infertility crisis.” China's median disposable income for urban residents as of 2013 is 24,565 RMB, roughly \$4,000 (Xinhua News Agency 2013).²⁹ This number must be even lower for rural residents, who were not included in this particular census. The average cost for IVF in China is about 20,000 – 30,000 RMB. What this means is that, for the average family, undergoing one cycle of IVF can potentially cost more than their disposable income.

I am uncertain if I should be more worried about this high cost of IVF or the fact that so many couples, both rural and urban, pursue IVF even *in spite* of this high cost. Given these numbers, the state should turn to shoulder some of the financial burden accrued by families in undergoing IVF. State medical insurance should expand coverage from typical OB/GYN checkups (such as natural pregnancy ultrasounds) to include not only IVF but also fertility treatments that fall outside the realm of assisted reproductive technology. If the state insists of couples meeting a one-child quota, the medical system needs to do more for infertile women, particularly those with a proven, medical need for ARTs.

Other than its costly accessibility, reproductive technologies, thus far, reinforce the idea that a family should be not only a man and a woman (husband and wife in a

²⁹ http://www.gov.cn/jrzq/2013-05/17/content_2405396.htm

heterosexual, state-sanctioned union), but also a couple and a child. The growth of IVF in China will not change this state-promoted and approved normalcy. What needs to be done, therefore, is a gradual shift towards permitting procedures such as surrogacy, and expanding the offer of IVF to couples that may not have a marriage license. This move can perhaps then start to rework definitions of kinship and the family to include homosexual couples, single mothers wanting children, and informal partnerships.

To be fair, the government might be preventing the expansion of what an “IVF couple” might look like to prevent market transactions of sex cells or surrogacy. The fear of corruption and abuse with private or market transactions therefore limit the ways that IVF can be used in China. This excuse, however, is a poor one. Rather than banning a market of sperm or egg cells and procedures for non-heterosexual, non-married couples or individuals, the government should become more active in regulating these economic transactions and working on policies that can make IVF truly more accessible, less stressful and more trustworthy of a procedure for everyone. Doing so, in fact, would actually lessen the occurrences of black market transactions of surrogacy and other procedures.

We are, however and unfortunately, a long ways off from this kind of a reality. At the crossroads of pronatalist tradition and antinatalist state, women find themselves in ever-difficult situations of reproductive concern. The responsibility of husbands remains fairly absent from the picture. So long as the One Child Policy and the Family Planning Committee, which oversees the enforcement of such laws, exert their power over women’s reproductive lives, infertility and the IVF experience in China have a likelihood of being both strictly regulated and stressful, especially for women. Even if reproductive technologies proliferate in China and become standardized, they still run the risk of becoming “technologies of power” that oppress women’s agency by their inherent link to the state.

Thus far, IVF has opened doors of possibility for infertile women, but only insofar as these women continue to perpetuate the traditional mode and values of family. In other words, IVF has unfortunately done little as of yet for the development of new and divergent paths of kinship in China. It can be, and has been, a technology that has done overwhelming good for a number of families – but, just what kind of families? What we often forget in the face of such technological brilliance is that doors open both ways. Indeed, women become actors through IVF, taking control of their own infertility, but we must take into account the presence of other actors always at influence that, too, play a role in contextualizing and framing these experiences.

It has been almost a year since I last spoke with my interlocutors at the RMC. Harkening back to the beginning of this essay, I should inform the reader that the girl with the peanut necklace is Yue, the 20-year old IVF patient mentioned in Chapter Five. To her, that dainty, gold necklace symbolized the child she sought to receive from IVF, and she invested heavily in this possibility. IVF was a hope, and it became embodied in and on her body. She saw the technology as a way out, but whether this meant from a purely medical or a stigmatized condition, I do not know. I can only hope that, by the time this essay is finished, that she found that way out.

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