In September 2016, the India Expo Centre in Greater Noida, located to the east of Delhi and part of the National Capital Region, was bustling with activity. Clinicians, embryologists, medical representatives, and an anthropologist all gathered at the convention center to attend a conference. Participants squeezed through the crowds in the corridors in their attempt to reach panels, which featured presentations of various disciplines: from endocrinology to embryology, from genetics to gynecology. Cordial greetings were exchanged here and there between colleagues who practice in different countries or just across the street.

Although conferences are frequently occurring events, this one was special. It was the 22nd World Congress of the International Federation of Fertility Societies. The fact that it took place in Delhi signaled that India had become part of a global conversation: not only as the surrogacy destination portrayed in international media, but also as an academic destination. Consider the contrast with Kolkata in the 1970s: a place where researchers like Dr. Subhas struggled to conduct IVF experiments, and a place from which a European company exported raw material. In a striking twist of medical history, hCG and other fertility drugs have since been sold back to India. Even more so, some stalls in the exhibition hall at Delhi’s World Congress were occupied by Indian pharmaceutical companies that now produce these drugs locally.¹ Almost forty years after the world’s first successful IVF procedure, it seems that India has made a mark in the world of reproductive medicine.
In the first part of this book, I laid out the conditions of possibility for this event. I traced the genealogy of India’s role in shaping global reproductive medicine from the 1960s up to the present day through three critical moments: the commodity chain of hCG from the subcontinent to Europe between the 1960s and 1990s, contestations around the first IVF experiments in the country between the 1970s and 2000s, and the emergence of a transnational IVF sector in Delhi since the late 1980s. I followed the travels of biological material, knowledge claims, medical supplies, and financial investments as vital parts that have animated global reproductive medicine. The three moments revealed how India has shaped global reproductive medicine throughout its postcolonial history in various ways: from a provider of raw material to a producer of knowledge and, subsequently, a thriving medical market.

Building on excellent accounts about the uses of IVF in different parts of the world, my goal was to demonstrate how a specific site, which is often relegated to the provincial, has had a share in the making of global reproductive medicine. I was interested to see what happens when we go beyond narratives of diffusion and instead examine India’s role in the historical formation of this medical field. In what ways does global reproductive medicine emerge from a particular locale?
How can we tell a history of reproductive medicine through India without falling into the trap of nationalistic glorification? And what are the transnational interdependencies and asymmetries that make the history of IVF an interconnected but unequal one? These queries lead to a shift in analytical perspective: from questions around the use of IVF to a concern about its making. Rather than viewing IVF in India as an application of knowledge produced in other parts of the world, I highlighted India’s variegated entanglements with global reproductive medicine.

In addition to India forming global reproductive medicine, this medical field itself has long informed the country’s history. Populations became central targets for state interventions in the subcontinent as early as the nineteenth century. Shortly after Independence, the Indian government implemented a family planning program in the name of economic development and poverty alleviation (Sur 2017). Infertility, however, long remained in the shadows of population control efforts. This changed only in the late twentieth century, owing to a paradigm shift regarding the importance of comprehensive reproductive care, the technologization and standardization of infertility interventions, and, most important, IVF’s economic profitability. In addition to population control, the health care sector in general and reproductive technologies in particular could now also be conceptualized as an impetus for economic development (Hodges 2013a). Once IVF had started to become a capitalist success, it could proudly be celebrated as part of the country’s globalized modernity and be used to mobilize an image of India not only as a health care but also an investment destination.

Even though IVF in India has indeed turned into a financial opportunity for various actors, it is important to note that gains are distributed unequally. Stories about IVF’s immense economic productivity mask the unavailability and unaffordability of services to most people. According to WHO estimates, there still is a “silent population of more than 180 million couples facing consequences of infertility” (Ombelet 2015, 106) worldwide. Countries in the global South are often disproportionately affected, as the lack of adequate primary and secondary health care may increase the risk of infertility. Despite current efforts in India to broaden the use of interventions in the tertiary sector (e.g., opening specialized public units), the IVF landscape is deeply inflected by asymmetric power relations: not only is access stratified, but medical practice differs between hospitals, and biological substances are handled according to patients’ economic status. Thus, more often than not, the practice of IVF further reproduces entrenched hierarchies and aids in cementing social inequalities.

After analyzing the formation of reproductive medicine in India historically, in the second part of the book I examined its contemporary making. Entering
hospitals and laboratories in Delhi, I tracked how various actors make IVF work as a delicate “ontological choreography” (Thompson 2005). Making IVF work means working on and with reproductive substances in conjunction with technologies, pharmaceuticals, protocols, and guidelines. Clinicians attempt to turn bodies designated as infertile into productive entities, make acceptable gametes that are understood to be improper, and manipulate embryos considered to be unpredictable. Following substances as they transform, travel, or simply elude us in IVF clinics served as a fruitful analytical tool to interlink intimate bodily processes and daily clinical life in hospitals and laboratories in India with larger social and ethical concerns.

The focus on mundane medical practice threw light on the substantial relations that reproductive medicine generates: between parents and offspring, donors and recipients, professionals and biologicals. I detailed the various kinds of connections, from the clinical to the commercial, from the epistemic to the ethical, which are summoned in daily clinical practice. While biologicals carry relational potential, they in turn are “matter related” (Abrahamsson et al. 2015). Interrogating how biological substances are constituted relationally, I tried to balance the tension of pointing to the vitality of substances on the one hand and their formation through often asymmetrical relations on the other. Although biologicals demand responsiveness and responsibility from clinicians, they are simultaneously fashioned as medically viable and ethically valuable entities for IVF.

The second part of the book further showed that as well as being a “hope technology” (Franklin 1997), IVF could simultaneously be described as a technology of discontent. Experiences of failure, fear, and unpredictability are prevalent in IVF hospitals. A sense of unease prevails when success is far from guaranteed, gametes travel uncontrollably, and medical practice demands ethnically dicey decisions. This suggests that medical technologies are “unruly” (Mol 2008, 50). “[T]hey have an excess of, sometimes unexpected, effects” (47). Similar to other technologies, IVF might bring in its wake even more unintended consequences, whose reverberations may only become apparent over time. These anxieties are certainly reinforced by the legislative void that still characterizes India’s IVF landscape.

However, global reproductive medicine in India as a complex, multiscalar, and ever-shifting assemblage will continue to change in the future. Take for example the passing of the Surrogacy (Regulation) Bill, 2019, by the Lok Sabha, which may start to regulate the commercial surrogacy sector in the future. Whether this is going to lead to shifts of commercial surrogacy procedures to the black market—as many commentators fear—or the relocation of the industry to neighboring countries, as has happened before (Deomampo 2016), or a complete standstill,
remains to be seen. Should the Assisted Reproductive Technology (Regulation) Bill, 2020, become law, which would comprehensively regulate all IVF procedures, even more questions about IVF’s future in India will arise. Or take another scenario: although IVF already oscillates between an exclusive, high-cost intervention and a low-cost alternative, it might further diversify. Global efforts to develop affordable forms (e.g., see Ombelet 2007) might extend the coverage of infertility care to a large degree. The spread of reproductive technologies beyond megacities has already become a reality. But what will it mean for the majority of India’s population, who still cannot pay for the procedure, if IVF becomes accessible? What would IVF in its “fourth phase” look like? And how might such changes translate to medical contexts in the global North that are severely affected by austerity measures?

Global reproductive medicine in India will continue to shift in form and scope. With novel political or medical formations, reproductive medicine is going to not only reproduce but also reinvent itself. Observing and thinking through these mutations will be instructive for our understanding of various substantial relations in India and on a global scale.