

## LOCATING THE OUTSIDER WITHIN: Studying Childless Women in India

*My title—the idea of an outsider within—comes from Patricia Hill Collins (1991). Like the African American women in the U.S. that Collins describes, childless women in India are outsiders within Indian society. But there is another outsider in my text. I am a white, American woman who is studying the accounts of South Indian women in a developing country. Both outsider's voices are present in this paper: my personal narrative (represented in my field notes and thoughts since returning from India 1 year ago), and a narrative about the experience of the childless women I interviewed.*

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My theme is simple: many of us strive to create a space for an absent subject in our research, in my case a space for young South Indian women to speak out about the meaning of childbearing, and what happens to them socially and emotionally, when they cannot, or chose not to. However liberatory a goal, "giving voice" to our subjects' experience happens because of our privilege. We are inevitably

outsiders in the world of an "other," especially when she differs from us in class, ethnicity, and nationality. But we can act to alter inequality in the research relationship. Beliefs about our solidarity with the women we study as feminist researchers—especially when it crosses the borders of culture and class—is not enough (Riessman, 1987). In this paper, I describe how I tried to give subjects control—not always consciously and sometimes after the fact. I also briefly present the substantive results of the effort.

I went to India on a Fulbright. The very existence of national privilege allowed the research to be done: the US government (with a small contribution from the Indian govt.) supports a number of US scholars to go there, and a few Indian scholars to come here. We can teach and research them, but few of them can teach and research us.

Everyone asks "why India?" for a study of infertility, given the perception of the population problem. There were personal reasons, and theoretical ones too. I went first in 1986, shortly after my mother's death, feeling like a motherless child,



and India offered peace and solace. I wanted to return. In another way, it seemed an ideal site to study infertility because motherhood is compulsory—her sacred duty. An Indian woman benefits from having children: they improve her status and secure a position in the family. In arranged marriages a child cements an often fragile bond between spouses. Given the cultural context, I wondered what happens when a woman doesn't conceive. How is the situation defined and managed? How do women account for being childless? How does the cultural context influence the actions women can take? An exercise in applied sociology, the project explores the relationship between meaning and action. Ways of seeing a reproductive health issue, like infertility, are closely linked to possibilities of resolution (Gusfield, 1981). I saw the research supported by the Fulbright as the first phase of a comparative study of childlessness, in cultural contexts that see and solve the problem differently.

So I entered the field (literally and figuratively) with my intellectual interests at the center, personal concerns at the margins. My career and scholarly work dictated the project (with a little help from my mother, to be sure). To the substantive topic of infertility I, if anything, brought critical eyes, developed over the years as I watched friends in the US who, with the encouragement of fertility specialists, went to unbelievable lengths (in my view) to have a biological child

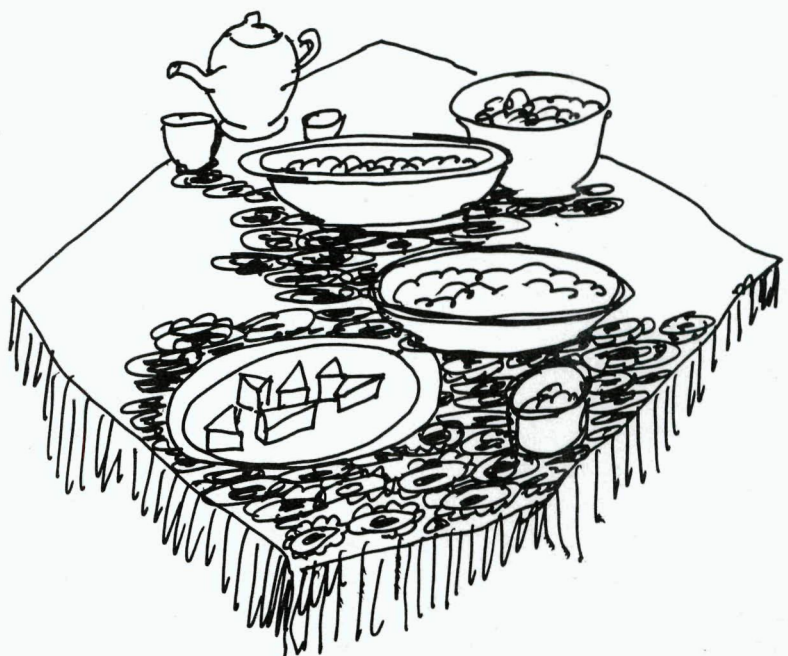
(hormones, IVF, and the like). I remember a discussion with a colleague before I left, who gently suggested I might need to develop some empathy for the desperation of infertile women, that is, for my subjects.

The research changed as I was changed by India. I began the project positioned as the distant observer who would "collect data" to "produce findings." I was an outsider in other ways: not knowing infertility myself (I have children); not speaking the language well (I did study it beforehand); not being a specialist in Indian studies (I read volumes before I left). Throughout the project, I wrestled with the contradictory pulls of privilege and marginality. As I teach my students in research classes, it is important to locate ourselves in our "scientific stories," because positionality influences what we see.

India, and the women I interviewed there, pushed me to relinquish the safety of distance. I was drawn into stories and lives as I talked to women in the infertility clinic of a government hospital, and others in their homes in towns and villages. For a period of time, I lived in a remote fishing village, helping women with preparations for a wedding and going out with the men at dawn to the sea. The focus of the research shifted too, as I learned from my subjects and the setting.

## THE RESEARCH CONTEXT

I chose to study one state in South India—Kerala, near the tip of the continent on the west coast—for several reasons. First, the state has had outstanding success in limiting population





growth (average family size in Kerala is 2 children, the smallest in all of India). In such a context, the angle of vision can be shifted to the problem in some families of infertility. Second, Kerala offers a model for India and the developing world in the availability of primary health care, which can prevent infertility, and in the education of women, which expands possible coping strategies in the face of it. Finally, Kerala has a low level of medical technology compared to India's major cities, and even neighboring states. *In vitro* fertilization and other specialized methods of assisted reproduction are unavailable in Kerala (though they are coming). For purposes of the research, the absence of high technology medical "solutions" was desirable for theoretical reasons, given that my ultimate goal is comparative. I also chose Kerala for other reasons—it is lush and beautiful and lacks the grinding poverty and pollution of other parts of India. I could see myself living there for six months (although it turned out to be difficult in some unexpected ways).

Because the study was about meaning—the explanatory models women develop to explain their childlessness, and the consequences of being childless for their lives—I chose an interpretive approach, and qualitative methods. The interview schedule (developed together with a research assistant, Liza, who is a Keralite) began with a few closed-ended questions about demographic and family information, and then moved to open-ended ones. To

cite a few examples, we asked: "What do you think are the reasons you do not have a child?" Here we encouraged women to give extended accounts of their understandings (religious, medical, and familial). There was a question, borrowed from Arthur Greil's (1991) work: "Do you ever ask yourself, why has this happened to me? How do you answer?" We asked how women were managing child-bearing difficulties, and probed for their experiences with medical treatments, ritual healing, and thoughts about adoption. Finally, there was a question and a series of probes about the reactions of others: husband, his family, her family, the neighbors. The semistructured nature of the interviews was well suited to my study issue, and they yielded the lengthy accounts of meaning and action that I was seeking.

Although the questions produced the accounts I was looking for, I was unprepared for the process of the interviews. First, there was the task of locating childless women. The original plan in my Fulbright proposal was to select women applying for adoption, but I quickly abandoned that idea when I saw the class bias in adoption agency records—families were uniformly well-to-do, and in Kerala typically Christian. (Subsequently, I learned that Indians have deep resistance to adoption.)

I eventually located two sponsors—two men who were well known in their respective communities, and who knew all the households. Chandran was

a fisherman and political activist I had met on a previous trip to India, and we had corresponded in the interim. I found him again on the beach one day as he was bringing in his boat. After greeting me enthusiastically, he took me to his village for lunch, I eventually lived there with his sister and her family, and he agreed to help me find informants—childless women to interview. These women were from rural fishing villages in Trivandrum district, at the extreme southern part of Kerala state. The other sponsor, James, located women in an urban/suburban area of Ernakulam, in the middle of the state. James had a stall on the main road where people came to get help with completing documents, and I met him through an intermediary—a local medical doctor who was the father of my Malayalam teacher. The two sponsors posed the first dilemma I faced: using male community leaders to lead me to women. I would have preferred women community leaders who could sponsor the project. I learned, however, that even in Kerala, where women enjoy higher status than anywhere in India, men have the power in the public sphere.

A third source of informants was the Infertility Clinic of a government hospital. Women (some alone, others with husbands) lined up one morning a week to be seen by gynecologists. Although I was initially reluctant to approach women in this setting—they were, after all, coming for medical care, not to help a



foreigner with her research—the clinic director's enthusiasm and my early experiences in the clinic ultimately overcame my resistance. The women wanted to talk, but doctors were expected to medically evaluate 50-60 patients in a 2 hour clinic session; they could not inquire about the life worlds of the women (Mishler, 1984). Liza and I provided something useful: inquiry about the fertility search, and supportive listening as women related the pressures they faced from family and community. It seemed a fair exchange.

Looking at the sample as a whole, I obtained roughly equal numbers of cases from the village sponsors and from the medical source. The religious distribution of the final sample of 31 closely reflects the population of the 2 districts in Kerala: mostly Hindu, some Christians, and a few Muslims. About a third of the women had family incomes below the poverty line, more had moderate incomes, and less than a third were in the upper-income group.

Ethical conundrums continued during field work. I remember one of the early interviews, with Asha, a fisherman's wife, married 10 years and without children, who lived in a thatched roof house on the edge of a waterway. The village sponsor led us to her house, on a path that criss crossed a grove of coconut palms and tapioca fields. As we were welcomed by barking dogs, he introduced my research assistant and me—"Dr. Catherine from America" (it was hopeless in

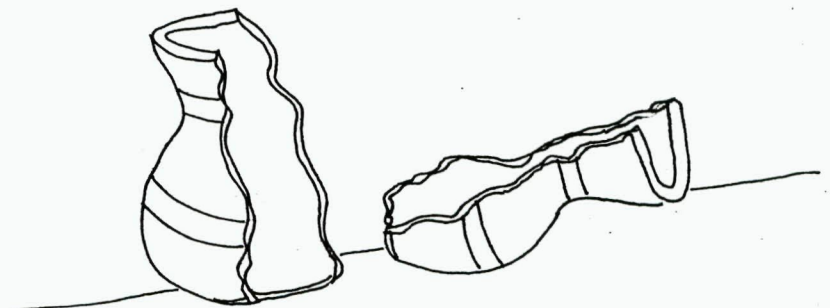
Kerala to try and use my last name, which was unpronounceable for Malayalis). The village sponsor had explained I was a doctor from America studying childless women, but the difference between a medical doctor and a Ph.D. was lost on Asha, and on other village women. Not infrequently, women asked my advice about sex, asked if I had a medicine to give them, asked if I would return to examine them. I became acutely aware of the position that research occupies in a developing country. It is illusive, meaningless even.

Asha had prepared for our visit: she wore a relatively expensive saree, and she served us tea, tapioca root, bananas. After we had eaten, the formal interview began, on the marital bed—the only piece of furniture in their one room hut. In Malayalam, Liza explained the study, asked permission to audiotape the conversation, and then she moved through the questions on our interview schedule. At points, Liza would stop and summarize what had been said in English for me, and I would suggest further areas to be probed. Although I had studied Malayalam for a year

before the trip, my language skills remained rudimentary—a great disappointment for me in the project.

Obtaining privacy for the interview and the woman's permission deviated from what I was used to in the U.S. Having sat on Human Subjects committees, I value confidentiality and a good informed consent form, and had worked to develop one for the study. Such forms are rarely used in India, and my research assistant resisted using ours (she would quickly explain the purpose of the study, but skip statements about the informants right to refuse to answer a question, and other protections). Nor could I get her to obtain the informant's signature on the form (all the women were literate). It was simply unthinkable for a village woman to refuse to talk to a foreigner of high status. To do so would violate a norm in Indian society, strengthened by years of colonial rule—acquiescing to superior authority. A consent form presupposes the notion of individual rights, and non-deference.

What did Asha, and the other 30 women we interviewed, make of the research process?





It's hard to know, but I have some ideas. A visit from an outsider, a foreigner — Dr. Catherine from America (the "richest country in the world")—and a well educated Malayali—my research assistant Liza—marked Asha's status in the community. Childless women are typically subjects of scorn in their villages. By our visit, however, the tables shifted momentarily. Neighbors peered in her door as we ate, attended to Asha with deference when, after the 2 hr. interview, she walked us back to the main road. Privilege permeated the interaction—her's at having us there, mine at the chance to be there—made possible by my nationality as a U.S. citizen and my level of education, assets that she would never possess.

I had little to give back to the women, in exchange for the time, food, and confidences they gave me. But I did offer a fleeting opportunity to tell their stories, and several women said they felt "relieved" afterwards, as if the burden of silence about an unspeakable topic had been momentarily lifted from their shoulders. They could represent themselves, and to someone who did not carry the harsh judgements they often faced in their communities.

At the end of the interview, I asked each woman if I could photograph her. Most agreed, and we mailed her a copy of the photograph. (See Behar, 1993, on photographing a subject). People were curious about what I planned to do with the tapes and the photographs. I explained that I would be

returning to America to analyze the replies of all the women, and a photograph would help me remember each person. One woman asked whether she would appear on T.V. (Her question is reasonable: America beams sit-coms, soaps, and the Oprah Winfrey Show down on India with a cable channel—Star TV—and the programs claim a substantial following.) The idea of a scholarly product—journal articles, lectures—remained a mystery to most of my informants.

Because of a continuing sense that I was exploiting the women by studying them, I made several attempts over the course of the project toward greater reciprocity. I returned to several homes at the women's request to visit and have tea. And I decided midway through the study to pay each respondent in the community sample Rupees (Rs) 100 (the hospital refused to let me pay the clinic patients for their participation). I had initially rejected the idea of payment—it felt like the rich American tipping, or like rewarding a servant—but then I discovered my 2 male sponsors expected money for their role in locating women willing to be interviewed. Giving money in exchange for service is expected in India. How could I pay the men and not the women? Especially when I heard in the interviews of their financial hardship affording the medicines doctors prescribed for infertility. The village women were grateful for Rs 100, but the urban professional women scoffed my offer, and told me to

give money to a beggar who might need it.

Paying informants was a gesture, but inequality and the underlying social relations of the research relationship persisted. Dr. Catherine—the outsider, the American—eventually left India, the developing country, transcripts in hand. Her career would see the benefits of the research, but what about the women's lives?

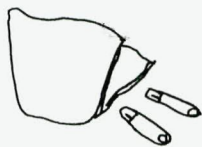
While in India, I began the process of analyzing the translated transcripts of the interviews (only 1/4 were conducted in English), and the process has continued since my return. Using the grounded theory method (Charmaz, 1990; Glaser and Strauss, 1967), I look for thematic similarities across interviews, and dimensions and contrasts within a thematic category. A more formal analysis of narrative structure is beginning for the small group of women I was able to interview in English (all professionals). I am consciously working against the western tendency to essentialize the "other" (Said, 1989). I keep the picture I took of each woman before me as I work with her text. It helps me recall our time together and avoid the tendency to objectify the subject. Yet one goal of the analysis is to interpret across subjects—to generalize about women's interpretations, and the meanings of their childlessness in the context of expectations for women in Kerala. I constantly struggle with the goal of generalizing, on the one hand and, on the other, attending to context and meaning for



individual lives.

## REASONS FOR BEING CHILDLESS

Preliminary analysis of the interviews indicates that the reasons for women's childlessness are remarkably diverse, and in ways I did not anticipate. I had begun the study with a focus on infertility, unwittingly embracing a medical definition of the study issue. The subjects taught me that the important issue is not medical, but social—not having a child.



### The Gulf wives: Infertility by circumstance

Some women suffered the personal pain and social stigma of being childless, but the problem was not infertility. These women were rarely together with their husbands. Because of high unemployment in Kerala, men migrate to the Gulf states or other places in search of jobs. We interviewed a 24 year old Muslim woman with little education who's husband worked in the Gulf "for a company" (she didn't know which one or what he did there). During the six years since their marriage, he had come back to

Kerala 3 times, to stay only a few months. She did get pregnant once, but miscarried. This is what she told us:<sup>1</sup>

R: He says I destroyed it [pregnancy] by doing all the work.

I: Have you gone outside for work?

R: No, household work itself

I: Do you have any other beliefs why you do not have children?

R: (p) I feel many things in my heart (p)

I: What do you feel? What do you think?

R: (p) Maybe because he's abroad, or maybe it's his problem. (20:7)

He stopped writing and she remarked how he had joked "I'll marry another girl."

Although this woman's situation seems particularly precarious, other Gulf wives fare better. In the absence of husbands, they learn to manage money, deal with banks, even increase their literacy (Gulati, 1993). The traditional gender-based division of labor is altered, and women enter the public sphere to a greater degree than might be possible if husbands were home.

Doctors in the Infertility Clinic were impatient with the "Gulf wives," whose problems are not medical. They referred case after case to me in an effort, perhaps, to get rid of the patient

(Mizrachi, 1986). One woman told me "the doctor said that everything is normal, nothing is wrong but (p) we must stay together." (10:4). Another said she was told they'd have a child if they had a sexual relationship (19:5). Not easy, given the economy, high rate of joblessness in Kerala, and increasing pattern of migration. In this instance, public policies shape what couples can do in their most private lives.

Going back to my apartment and laptop after these interviews, I struggled to make theoretical sense of them. Here's what I wrote in my field notes:

*Today we saw a slew of Gulf wives, phenomenon I earlier named infertility by circumstance. Discussing the issues with Leela Gulati, [an economist who studies migration] I realized that making children is one way these women can sustain idea of marriage in the absence of their men. Anxiety about fertility (which director of clinic says is endemic in Gulf wives) may represent anxiety about marriage—are they really wed?—given that they cannot enact marriage in more typical ways. Family is getting constructed by the effort to have a child, but in the absence of proximity—a necessary condition for pregnancy. (1/22/94)*

### Childless by coercion

A second group of women were childless by coercion. Husbands, responding to financial incentives offered by the government, had been sterilized during Indira Gandhi's population "emergency" in mid-'70s. Asked why she didn't have a child, one woman in the

<sup>1</sup> Transcription conventions follow: I = interviewer; R= respondent; (p) = long pause; numbers in parenthesis indicate respondent ID number and page of transcript where quote appears.



community sample said:

*He had a vasectomy operation earlier. Years before ...20-25 years ago ...But then he didn't know the after effects of it. He had no plans to get married and all. (04:2)*

But his marriage was arranged, when he was 37, to a woman 10 years younger. The interview transcript is ambiguous as to whether she thinks he knew what the vasectomy meant when he married. But the motivation to have the surgery seems clear. Asked why he had the operation, she said lowering her voice:

*Poverty ...he struggled a lot for money and all. He didn't have a father and mother. He was alone...his one hand is slightly disabled...he was from a young age sitting in a shop...He say he did it because of poverty. (04:5)*

Now, the couple have some money. Several years ago he had recanalization surgery, but it wasn't successful. The couple is Christian. We asked:

I: Do you ever ask yourself why has this happened to me?

R: ...Nothing happens without God's knowledge ...I always pray to God. Whatever is God's will, let it happen. Because I don't have children, why should I speak about this to all people, to members of the family, or to him, and destroy the peace in the family? What is the point in that? (04:6)

Spiritual idioms offer important sources of meaning that women of all religious groups in Kerala can draw on. Giving up the illusion of personal control is a lesson that western women struggling with

infertility could learn from Indian women, who see being childless as "God's will." They can appeal to a higher power for resolution: "only God will give."

Doctors in the Infertility Clinic were familiar with post-vasectomy cases, but even they were shaken by one. A clinic doctor interrupted us in the middle of an interview to introduce another couple. They were Hindus, from a scheduled caste, and the husband worked as a day laborer. When he was 14 years old and poor, he had an operation. He didn't understand its meaning at the time, but was grateful for the money the government gave him. He went on to marry—it was a love marriage—and, after 10 years and no children, took his wife to the Infertility Clinic. In the physical exam of him, the doctor found vasectomy scars. His wife, in the interview with us, cried as she said:

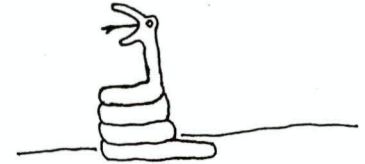
*Life is totally collapsed. What am I to do? Because of this I don't feel like living. (14:20)*

Field notes provided a place for my emotions:

*I nearly cried during the interview...I didn't realize until the middle that the woman had just found out, in the medical exam right before she saw us, that he was sterile...I could barely control my feeling—my rage—at the Indian govt. and the medical workers who carried out the "emergency" policies. I wondered if she, too, felt rage and asked. It wasn't there. (1/13/94)*

In a flashback I recalled a time when I had been pressured into a reproductive decision by physicians and other "helping" professionals—"experts" whose authority made

me feel they knew what was best. Only now could I feel angry.



### Medical and Religious Explanations

The third group of women (and by far the largest) failed to conceive because of seeming medical problems—either hers or his. Keralites have strong beliefs in the efficacy of Western medicine, and there is an extensive system of services based on allopathic principles that is available even in rural areas, in addition to Aruvedic and homeopathic doctors. So couples visited doctors, took the medicines they recommended (when they could afford them), and produced sperm and post-coital samples at their bidding.

But at the same time that women of all classes flocked to the Infertility Clinic, they resisted medical explanations for their problems. Religious interpretations were deep and abiding, and the apparent inconsistency between the two explanatory schema didn't trouble Indians. A Hindu woman visiting the clinic (post-coital sample in hand!) spoke of the curse of the Naga, or serpent. A Swami told the couple she had a curse and advised poojas, and



giving to the serpent once a month for nine months. Serpents, along with their demonic, destructive potential, are looked on as harbingers of prosperity, and there is the widespread belief in India that serpents have the power to remove bareness. To this day, the Naga—a phallic-like serpent on a stone slab, often standing on the tip of his tail with expanded hood—is worshiped by women desiring fertility in temples, and the image guards the entrance to towns along the Malabar coast (Sinha, 1978).

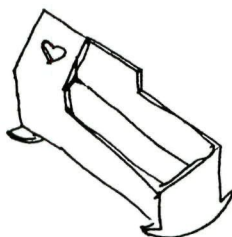
A woman we interviewed in a remote village had converted to the Pentecostal church, after her disillusionment with Naga worship, the offerings required at temples, an astrologer's recommendation to give other offerings, a laproscopic exam, two minor operations, and the recommendations of an Aruvedic practitioner to change her diet. The couple could no longer afford to pay for religious or medical cures (her husband works in a seasonal resort dependent on western tourism). She said:

*We did a lot of things and got ruined. Now we have decided we will not do like that. All these beliefs are a waste. (16:7)*

*We asked why she joined the Pentecost. She said "They are not asking any money." Her mother had gone there: "she was not mentally well (p) mad...they prayed and made her well" (16:7). Beliefs about the power of non-medical cures for seeming medical problems are now shared by east and west. As a Hindu Nayer woman put it: "both should be there, medicine and religious belief" (21:3).*

### Childless by choice

Lastly, I located a small group of the "voluntarily childless." Advantaged economically and professionally, these women are defying the pronatalism of Indian society, and choosing not to have children. They were difficult to find and the women I eventually interviewed were not from Kerala, but lived in Bangalore, South India, which some have called the most westernized city in India.



### MANAGING STIGMA

Although the reasons for childlessness varied, societal response was consistently negative. I was stunned by the degree of social pressure on women to have children, immediately after marriage, and the stigma they face when they fail to do so. Virtually all the women reported critical comments by family members and/or cruel comments by neighbors. Even when a "male factor" was causal, wives experienced blame. Neighbors gossiped and called them "machi"—an extremely derogatory term in Malayalam that has no English equivalent; it refers to a farm animal that does not breed. The woman I

spoke about earlier who's husband was sterilized at age 14 said:

*Do you know what [the neighbors] say? When there is a quarrel or something, they'll say 'machi, machi'. Because of all those problems I came here [to the Infertility Clinic]. (14:13)*

Another woman—22 years old and married only a year and a half—described how relatives used the derogatory term to her:

*Some people will say, when I am listening ...even though it is only one and a half years ...'yes, she is a machi' ...it is very upsetting. When I tell my husband, he'll say 'you pretend as if you have not heard them. People will say many things. Now we are not yet old.' (24:9)*

Though certainly not old at 22, she had come to the Infertility Clinic for a medical work up, largely due to family pressure. She has a "problem" and is expected to do something about it.

After the interviews, I filled my field notes with ruminations about "compulsory motherhood" in India, and then wondered whether and how India is different from the US. Certainly, pressures here encourage delayed childbearing, but aren't there pressures nonetheless on women to bear children? Isn't there criticism when western women fail to do so?

I constantly struggled during the field work with the issue of how to connect with the profound stigma young childless women face in their families and communities, given my position as a middle aged mother. I searched for ways to

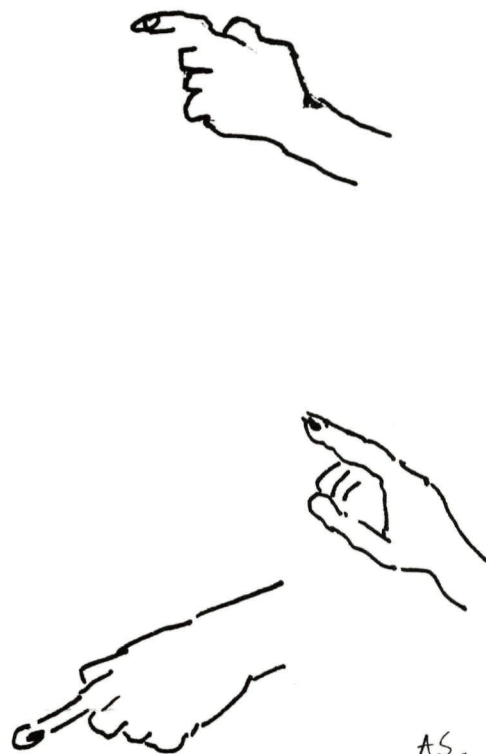


understand their experience—to develop the “imaginative identification” Barbara Myerhoff (1978) describes. A painful insight, recorded in my field notes, helped bridge the gap.

I was repeatedly asked by colleagues and neighbors, “Why are you alone?” “Where is your husband?” “Where is your husband?” Over and over again, I explained I was a tenured professor, on sabbatical, and happily single after a long marriage. But I learned that as a divorced woman and a foreigner, I was a topic of gossip in my apartment complex—seen as a symbol of western family decay, perhaps, or absorbed into images of America on the Oprah Winfrey show. (It wasn’t so funny at the time.) I was the exotic “other.” I felt terribly lonely, isolated, and misunderstood. I wrote in my field notes: “A divorced woman, like a childless one, has no place in Kerala.” During that painful moment, I didn’t feel like the privileged westerner, blessed with children. My subjects and I were both outsiders. Neither they nor I measured up. We were deviants, not living according to the rules for proper womanhood in Indian society.

## CONCLUSION

I’ve tried in this paper to give you a flavor of the process of doing research on childless women in India, and a taste of what I beginning to see in the qualitative interviews. I have displayed the scaffolding of my early ideas about the substance of the project, along-



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side my emotions as I did the work—very far from home. I have not pretended distance and objectivity, but brought myself into the “scientific story.” When we do social research, we are not robots who collect pure information (Gould, 1981), but humans with emotions, values, social biographies, and institutional locations. I hope that by locating myself in my work, instead of pretending I wasn’t there, you are better able to evaluate the situated knowledge I am producing about childless women.

My position as an outsider within India stimulated a particular perspective. Marginality—the outsider in a

culture—makes ethnography possible (as generations of anthropologists have noted), at the same time as it prevents full knowing of an “other.” The childless women I studied, because they too are outsiders within, have a distinct view. Although they would never use academic terms to describe the contradiction between ideology and action, they spoke in their own ways of family ideology on the one hand—close-knit Indian families are supposed to provide cradle to grave security for their members—and, on the other, the actions they experienced at the hands of family members. As the “others” of society who can never really belong, outsiders



threaten the moral and social order. As Collins (1991:68) says "they are simultaneously essential for its survival because those individuals who stand at the margins of society clarify its boundaries." Childless women, "by not belonging, emphasize the significance of belonging," and the mandate to be a mother.

To return to the issues about privilege I posed at the beginning of the paper, the collaboration between my subjects and me, the investigator, became greater as the study progressed, though it was never fully egalitarian. There are inevitable structural and material inequities in the research process. I left my outsider position when I returned to America, while many of my subjects (like Asha) continue to live in dire circumstances in a "third world." As Calvin Pryluck says, "Ultimately we are all outsiders in the lives of others. We can take our gear and go home; they have to continue their lives where they are" (quote in Gluck and Patai, 1991:152). Research situations are governed by inequalities and hierarchies that no amount of good will and empathy for our subjects can overcome.

That being said, what I want to do in this developing project is to make a space for an absent subject. Discourse in India (and certainly in the west about India) is dominated by ideas of population control—how to limit births. Women who cannot conceive remain invisible to view, even as individual childless women are highly visible in their communities, and

subjected to stigma and scorn. I tried in the interviews to create a space for young women's subjectivities, a place for them to speak out on the meaning of childbearing, and what happens to them socially and emotionally when they cannot, or chose not to.

Infertility is not a rare event in developing countries, although you would never know that from media representations. The World Health Organization notes that high fertility may, in fact, mask the existence of infertility in the same country. Worldwide, 8-12% of couples experience some form of infertility during their reproductive years (WHO, 1991), and rates in India are probably higher. Bringing an invisible subject into view is one way to exercise the responsibility that comes with privilege. □

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