PREJUDICES ON IN-VITRO FERTILIZATION: EXPERIENCES FROM COUPLES STRUGGLING WITH FERTILITY OF URBAN DHAKA

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Abstract

The biomedical treatment of infertility has spread throughout the world rapidly, though the cultural understanding of its techniques stagger in various cultures and societies. The local moral ideologies and cultural urge of fertility have treated the infertile people miserably. In Bangladesh, biomedical treatments of infertility are being introduced, and many are approaching it, depending upon not only their affordability but also on various socio-cultural factors. The cultural interpretation of in-vitro fertilization (IVF) depends on various social components, like patriarchy, moral values, and belief system related to childbirth. Thus, the social exposure and moral pioneers of the recipient of treatment play significant roles in postulating the conception of IVF. This paper identifies the cultural interpretation of IVF among the infertile couples of urban Dhaka through their experience in addressing biomedical infertility treatment.

Keywords: Infertility, In-vitro Fertilization, Gender, Experience

Introduction

After the successful cases of in-vitro fertilization (IVF) in the global West, biomedical treatments of infertility spread around the world, including the Third World and developing countries like Bangladesh, India, Pakistan, etc. Many such countries of the global South are still struggling with basic health rights and are cursed with overpopulation. Though the cultural urge of these Asian countries is much pro-natal, the limited resources and state policies cannot afford primary health care for its huge population. However, in this age of globalization, technological innovations have explored the socio-cultural requirements of the people and introduced the success stories of the biomedical treatments of infertility to infertile couples around the world.

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In Bangladesh, the historical birth of the first 'test-tube' triplets achieved much media coverage in 2001, and it became a headline in the national dailies (Akhter, 2010). However, the cultural acceptance could not be measured through that excitement; even though all the success stories of IVF were published on different online platforms for couples who are struggling with infertility. It was surprising to notice that though about 15% of the married couple are suffering from infertility, among them 12.7% are women and only 5% decide to start ART, IVF in Bangladesh as prescribed, whereas a number of them fly to neighbouring countries for the same treatment. According to the Bangladesh Demographic and Health Survey (2014), each year around 16700 new patients get enrolled at different infertility care clinics in Bangladesh addressing their fertility trouble. Infertility experts in Bangladesh assume that the expense of the treatment is not allowing the infertile couple to avail of the treatment, though the plea and urge for it is remarkably high (Bangladesh Demographic and Health Survey, 2014). However, apart from poverty, there are other concerns that shape the decision for this modern biomedical treatment. Moreover, medical anthropological research (Rapp, 1999, 2011) has shown the professional scientists and medical practitioners describe only the benefits and burdens of these technological births, whereas the consumers of these technologies experience biomedical technologies struggling not only with the budgetary crisis but also socio-cultural and local understanding of conception. In the context of Bangladesh, infertile couples who are approaching biomedical treatment go through a long journey and experience technological intervention struggling with their preconceived notion of conception, thus their journey towards IVF is not an easy one. As a matter of fact, it requires empathy and responsiveness from the family and kindred.

The main objective of the study is to focus on the subjective experience of the infertile couple who are interpreting IVF. The study will also discuss how men and women act as pioneers in their decision for the biomedical treatments of infertility. The paper precisely discuss the social constrains of IVF in the context of Dhaka, the capital of a developing South-Asian country and unveil various challenges that couples face dealing with the technological trials and techniques; lastly the paper shows the connotation of socio-economic strength, gendered experience and ethical boundaries in assisting the IVF seeking people.

Theoretical Perspectives and Relevant Literature

As the biomedical treatment of infertility was introduced widely through rapid globalization, and people worldwide were engaging themselves in it, many queries

evolved regarding gender, religion, kinship, marriage, and family, which are the precise attention of anthropology and social science. Moreover, the growing number of cases of infertility provoked social researchers to address the social aspects of its treatment around the world. Yet, ART availability is still shaded and shadowed in overpopulated, developing countries like Bangladesh (Habib, 2020). In her study, Nahar (2015) conveyed that in urban Bangladesh, the quality of bio-medical treatment is inconsistent, inadequate, and unregulated. The infertility experts of Bangladesh have explained the worth of the treatment considering the high growth of infertility in the country but showed their concern in the quality and quantity of the treatment considering the population size of this developing country (Khatun et al., 2022). However, they pose that both financial and social constraints to biomedical treatment need to be disentangled for a healthier mass, keeping in mind that reproduction is a human right.

The biomedical treatments of infertility cannot be understood without analysing the technological acceptance of culture, gender, kinship, and religious practices of the society. Thus, Charis Thompson (2005) reasoned that assisted reproductive technologies (ARTs) could be understood in terms of "ontological choreography" – "the dynamic coordination of the technical, scientific, kinship, gender, emotional, legal, political, and financial aspects of ART clinics" (Thompson, 2005, p.08). Hence, the advancement and positive spared of biomedical treatments like IVF combines scientific innovation and socio-cultural adoption/ acceptance under one roof, where the sufferers of childless people can involve themselves or reject the technological conception according to their beliefs and views. Yet, the success and failure of IVF also affect the composition of biomedical treatments in certain societies. But availing the procedure of IVF potentially protects the women from the guilt of not trying for it. However, Karen Throsby (2006) argued that IVF failure and the end of treatment offer considerable possibility for rethinking normative reproductive categories and their relationship to reproductive technologies.

Much of the research engaged the way women experience the process of the treatments and only a few on male's experience. However, the nature of sufferings and coping with the trials of the long-term treatment varies from person to person. It is because the body is not only a simple biological object but also the embodiment of consciousness, the origin of intentions and various practices (Moya, 2014). Thus, many researchers have focused on how biomedical treatments are used, modified, shaped, and repelled throughout the world (Inhorn, 2006). So, the local form of policy, belief system, and social values operate the kind of treatments introduced to the specific culture.

However, these technological interventions like IVF are also considered the key to identifying people with infertility more coarsely. Margarete Sandelowski and Sheryl de Lacy (2002) disclosed the notion of infertility as a by-product of the invention of new reproductive technologies. Sandelowski and Lacy's interpretation of infertility has been considered in this to understand the attitudes toward infertility and its biomedical treatments like IVF. Karen Throsby (2006) addressed that the most devastating situation happens with IVF is when the women regardless start having self-blaming tendencies. No matter where the infertility is situated (male or female body) it is the women who blame their own bodies, not the technology, for the failure of IVF cycles. Thus, the intervention of assisted reproductive technologies like IVF provokes many women to get stuck in a vulnerable position.

However, in their study on infertility and assisted reproduction, Abdallah S. Daar and Zara Merali (2009) pointed out the sufferings of infertility and the crisis of fertility treatments in developing nations; those who are addressed for their overpopulated features are suffering from infertility problems and at substantial risk like the developed nations. They categorized the harms and sufferings of infertility and focused on the differential sufferings of infertile people from developing and developed nations. They successfully observed the pain and sorrow of the infertile people and found that the scale of suffering is intense for the developing nations; especially the women of developing nations undergo the most for not having children. Physical violence and suicide are the extreme consequences of infertility. The overpopulated discourse and lack of resources prolonged infertility treatment in many developing countries. Daar and Merali have replied to the argument of overpopulation and low resources, which appears as obstacles towards the establishment of ART in many developing countries. Like Ginsburgh and Rapp (1995), Daar and Merali (2009) also observe that the women's bodies are the locus for socio-economic and political exercises taking place, and the mechanism of fertility and reproduction is what Foucault observes as 'bio-power' exercise. Thus, the overpopulated discourse and agencies aligned the existence of infertile population and terminated them from new reproductive technologies in many developing countries. Overpopulation discourse should not resist the infertile population from ART, as it is the right of all human beings to reproduce "if, when and as often as they wish" as it was stated in the definition of reproductive health adopted by the United Nations 1994 International Conference on Population and Development. Thus, Infertility should be prioritized, and ART should be introduced with the public-private partnership in these low-resource developing countries as they explained. The disparities in infertility treatment between developing and

developed countries thus create 'stratified reproduction', as Rapp (1995) addresses. Some researchers also observe that the technology is gathered only for those who can afford it by their economic and cultural ideologies and state policies reinforce the stratified reproduction according to the socioeconomic factors of the state.

Rayna Rapp (2011) coined the term "moral pioneers" to discuss the liminal experiences of pregnant women weighing the risks of amniocentesis. Rapp observes that women considered the risk of amniocentesis harming their foetuses against the risk of not testing and giving birth to a child with a serious and/or fatal genetic condition. During pregnancy, the women had to choose whether to continue the pregnancy or abort if amniocentesis revealed a genetic disorder. However, they justified their choices using personal experience, cultural background, scientific understanding, risk tolerance, religion, and current responsibilities. Rapp concludes with the fact that every woman has a separate moral choice which she pursues. Here, medicine could not help women make the "correct" moral choice, nor was the "correct" moral choice for one woman necessarily the same for another. This research emphasizes on the subjective experience, kins approach and social networks of the infertile, who became the moral pioneers in the decision-making of bio-medical treatments, like IVF. Thus, it brings out the moral framework of the infertile to choose the "correct" moral choice of treatment.

Methods and Techniques

This specific research is a qualitative one, where the research question is basically drawing the attention of infertile couples who are approaching biomedical treatments for infertility. Thus, the subjective experience of the informants has been gathered following the case study and informal interview techniques. The interviews were open-ended to ensure in-depth information on the cases studied. In the context of Bangladesh, doing research on infertility is methodologically challenging. As, infertility is a stigmatized notion in countries like Bangladesh, the informants are much reserve to response and thus the rapport building entails more coercive efforts. Thus, the names and identities used in the research paper are pseudo name and identities. Purposive sampling was a suitable procedure to find research informants. As, most of the new reproductive treatments (IVF, ICSI, ET etc.) were introduced mostly in Dhaka, thus the research was conducted in Dhaka, though all of the informants are not from Dhaka. The details of the informants of the case studies are given in Table 1.

Table 1 : Location, problem and struggling period of the cases studied

	Name (Age)	Sex	Earning sources of the conjugal family	Home District	Specific problem	Treatment tenure	Struggling with infertility
1.	Lamia (33)	F	Both in private service	Dhaka	PCOS and several female issues	3 years	7 years
2.	Hira (28)	F	Husband has business	Mymensingh	Male infertility	3 years	6 years
3.	Musfiq (40)	M	Husband has industrial business	Dhaka	Male infertility	2 years	9 years
4.	Rena (38)	F	Husband is in private service	Dhaka	Female infertility	2 years	9 years
5.	Sopon (42)	M	Both in private service	Dhaka	Hormonal problems in female body	2 years	8 years

Source: Fieldwork

Most of the informants are from Dhaka (except for one among five cases) with good economic conditions. As, the process of IVF may require multiple attempts and each attempt may cost from 2 to 3 lacs of taka (price vary according to the condition of the female body upon which the process implied and expertise of hospitals and clinics), it is not the treatment for all in countries like Bangladesh. However, the numbers of couples who borrow money or sell out property to have these treatments are increasing day by day (Nahar, 2015). The picture of the respondents also shows that mostly female infertility is little higher than male issues, which is 60% female infertility and 40% male infertility. However, in patriarchal societies the uphold position of the males hinder many to speak on male infertility; thus, male infertility is more stigmatized compared to female infertility. However, Mumtaz , Shahid and Levay (2013) stated that women perceived more stigma than men and that being stigmatized was more painful than being infertile. Thus, in the context of patriarchal Bangladesh, the position of women in the family, social capital like her education and kindred, economic solvency of the family and moral values and believe influences the experiences of the infertile men and women differently.

Findings and Analysis

The social impacts of biomedical treatments of infertility have been addressed by many medical anthropologists and sociologists from the beginning of the century, it happened with the flourishing of the treatment worldwide. However, Bangladesh, as an overpopulated country does not have any subsidy for the expensive biomedical treatments of infertility, whereas fertility is a human right. Being a country with limited resources, Bangladesh is still working hard to provide basic health care for its people. Thus, the focus on the subfertile, primary infertile, and secondary infertile people is less prioritized in the state policy of Bangladesh. However, the cultural norms and social expectations of the wider society of Bangladesh encourage most of the people to reproduce and bring children. As the treatment dramatically travelled to the global South from the North, we observe that biomedical treatments of infertility are not for all; though it is a human right and the social meaning of pregnancy, moral ideologies of conception and patriarchy can influence the biomedical treatment of the people approaching it. Moreover, there is a sharp difference between the experience of men and women going through the IVF process.

Figure 1: Social Constraints towards IVF

Apart from economic constraints, the journey or trials of IVF have a number of social constraints. The above figure 1 summarizes the social constraints of IVF. Firstly, the patients of infertility turn blue in fear when they are suggested for IVF and even feel more stigmatized; secondly, a number of procedures and methods of IVF, like use of donor's egg or sperm, or even surrogacy, is not beyond question

in our cultural context. Thus they limit their ethical boundaries and keep searching for culturally modified ways of treatment if possible. Thirdly, infertile people never follow the medical expert's guideline or suggestion to start without researching; thus, they perform as their moral pioneers in the treatment. Last, but not least, mostly they have to pursue their thinking and decision of treatment with kins with whom they are related.

(a) Women's Burden of IVF: The case of Lamia (*case 1, see Table 1*) and Hira (*case 2, see Table 1*) shows a vivid position of women's life dealing with biomedical treatments. Lamia who was an urban, upper middle class, educated lady, has undergone IVF-ET several times. She could not share her reproductive troubles with any of her in-laws. She thought involving in-laws in the treatment could damage her conjugal relationship. Thus, her painful journey was kept hidden. She was devastated when she came to know from the doctor about her bodily anomalies and hindered from conceiving naturally. She expressed her pain of not sharing her emotional breakdowns after knowing the fact is completely different than the bodily traumas that came afterward. She reasoned that her in-laws might ask her husband to get married again if they knew that the "problem is with me*"*. However, Lamia stated that the entire process of the treatment and the uncertainty of a positive pregnancy through IVF made her anxious. As Lamia did not tell her in-laws about having ART, she continued her treatment staying at her Uncle's place, though her husband did not appreciate that at all. However, her desire to become a mother and save her marriage encouraged her to have the courage and undergone the risks and hazards of the treatment. Having PCOS (polycyclic ovary syndrome) triggered Lamia's pregnancy; however, the process of IVF depends on the menstrual cycle of the female body. As a result, Lamia often had extreme pain and distension in abdomen. Her fear of having unwanted period after ET (Embryo transplant) did not let her sleep several days. Though her husband supported her financially and kept the treatment secret from his family, but he was not with her on those sleepless, painful nights as Lamia told. However, the successful IVF helped her cheer a little (see Table 2).

Table 2: Trials and techniques used by the respondents.

Case no	Techniques	Trials	Status
1	Suppress natural menstrual cycle, ovarian stimulation, egg retrieval, sperm retrieval, fertilization and embryo transfer.	2	Conceived with twins
2	Ovarian stimulation, egg retrieval, sperm retrieval, fertilization and embryo transfer.	1	Under observation

3	Intracytoplasmic sperm injection, egg retrieval, sperm retrieval, fertilization and embryo transfer.	2	Conceived
4	Ovarian stimulation, egg retrieval, sperm retrieval, fertilization and embryo transfer.	3	Unsuccessful
5	Oral medication, suppresses natural menstrual cycle, ovarian stimulation, egg retrieval, sperm retrieval	1	On going

Source: Fieldwork

Hira has a diminutive different story from Lamia. Hira came from a rural background and had little or no idea of the biomedical treatment of infertility. It was her husband who came to know about these biomedical treatments when he was in Bahrain (worked as a labour). Hira's husband wanted Hira to conceive. In order to get the treatment, they shifted to Dhaka. He sold out some of his property for the treatment. Hiar's mother was with her. Hira was much young and had a better chance to have a successful ET (embryo transfer), she was under observation when interviewed (see Table 2). However, she feels that the treatment's total procedure made her weaker than before. She not only had a painful pregnancy, but also could not move for several months. Though her mother and husband helped her during those days, but she felt helpless and broken inside. She cried for fate and was worried about the sin they were performing through this treatment, as one of her sisters-in-law discouraged her not to go through such unnatural pregnancy, because it is like challenging Allah's will. Thus, the bodily weakness and psychological stress put her in great trauma. Once, she cried, *"*I do not want to perform any sin …whatever I am doing is to see my husband happy… I do not know whether I am right or wrong… children are blessing from Allah…"

The two cases have been stated in a condensed form to see their varied experience. However, both of them have suffered physically and emotionally. As a result, we see that the women have hope and anxiety throughout the treatment. Furthermore, they display the social and cultural dilemmas they observe and deal with. Nahar (2007) also noticed that the sufferings of Bangladesh's urban and rural women are arid by the others. According to her, infertile women suffer alone, privately, socially, emotionally, and economically. However, the patriarchal nature is embedded in the thought process of these women. Thus, women pose in an insecure position and stay in a dilemma regarding the sharing of their treatment journey with parents-in-law. The notion of patriarchy and perception of superiority enables the women's in-laws to play harshly whenever they latch any anomaly with the women's role

to be a mother. Therefore, women become vulnerable and uncertain about sharing their weaknesses and treatment trials with in-laws in this patriarchal society. As a matter of fact, they exclude themselves from the worldly atmosphere and devotedly medicalize their body in the uncomfortable trials of technological pregnancy. The experience of the treatment is not simple or easy, it requires both physical and emotional strength to adapt to the trials. Moreover, no treatment is beyond side effects. In this process, women willingly or unwillingly put themselves into the challenge to win the battle of infertility, as they believe motherhood is necessary and would be cherished by the surrounding kindred. However, women are much more considerate towards their socio-cultural pressure of motherhood; the kin and peer pressure constantly taunt them to be progressive and embrace the modern western trials to fight infertility. The influence and support of close kin are vital for these women with biomedical treatments of infertility, which is discussed at the end of the paper.

(b) Men's Differential Experience with IVF: The cases discussed above indicate the painful subjective experience of the women, whereas the men hold a separate way to interact their infertility and fight hinders in their own way. The case of Musfiq (*case 3, see table 1*) with his male infertility and Sopon (*case 5, see table 1*) with his wife's female bodily sterility poses quite common. Musfiq expressed that he was in dilemma to accept his infertility and has undergone with marital conflicts for a couple of years. His wife constantly needed him to start medical check-ups. According to his words, he agreed to start his check-up and start the treatment when his conjugality was turning to its end due to back-and-forth arguments between the couple. He agonizingly expressed his infertility and his experience of ICSI (Intracytoplasmic sperm injection), which is a form of IVF. Musfiq was very pessimistic about the treatment before the trials, however, his wife was successfully carrying fetus, when he was interviewed (see Table 2). Musfiq took a long time to understand the treatment (from the internet) and with no hope he started his trials just to calm his wife. He was blamed and humiliated for his unwillingness to start the treatment by his wife. He felt low throughout the trials of infertility treatment, even though his participation in the trials was bare minimum. However, he stated that the treatment helpful to many, though it is "a matter of great privacy" according to him. He felt accosted and excluded himself from his in-laws after knowing his bodily failure. Moreover, the constant fight with his wife hindered his mental peace and he spent a lot of money to overcome his grief, and became an alcoholic, which also threatened the treatment procedure. Similarly, Sopon also considered the biomedical treatments of infertility as private and felt

much stigmatized about their consultation with infertility experts at hospitals. He became 'rigid' and cold not only with his in-laws but also with his own family and friends. In his words,

> I became rigid and tried to avoid my social connections when I started the treatment of my wife. It was disgraceful for me... and I do not know how to handle my inner pains for not becoming a father naturally!

Nevertheless, the experience of men in IVF is not physically visible, but they go through dilemmas as they are involved in it socially, financially (in most cases) and emotionally. The entanglements of the IVF wounded them as passive victim of their situation and covertly gripped their emotion throughout the treatment journey. Patel, Sharma, Kumar &Binu (2018) compared the emotional hassle between infertile and subfertile men and women in developing countries and concluded that stigma, concealment, and discrimination among men are reported to be high. The stigmatized feeling in the search of IVF treatment is observed among the men. Infertility and its treatment also hurt male ego and wobbles their masculinity; as a result, they exclude themselves from social gathering.

(c) "Moral pioneering" in decision-making of technological pregnancy: The women and men both follow a conventional approach to the process of IVF and closely monitor the stages, trials and outcomes of the technological pregnancy. They seek for the doors to open their understanding of the treatment and then decide to jump into the procedure. Nowadays, many searches for infertility treatments on the internet and go through various advertisements for IVF. Many get the opportunity to know about biomedical treatments along with the procedures and steps of IVF through the internet, though this information do not demonstrate the social constraints, emotional journey and financial risks. As we see, Hira was unaware of the painful trials, but acted upon her husband's decision, as she mentioned. Thus, without knowing the facts of the treatment and the pros and cons of the IVF, very few embrace these expensive technological trials to get child/ children.

However, these advertisements and websites of infertility clinics are the main source of information for many infertile people. Nevertheless, in Bangladesh biomedical infertility treatment is not a treatment for all. Thus, very few clinics/hospitals share the availability of IVF and consider it as "niche treatment" as observed. In her study, Habib (2020) mentioned that doctors take time and note whether IVF could be affordable for the prospective infertile patient. It is observed that class and social exposure influence the decision-making process of the treatment. The expensive treatments like IVF are not for all in the context of Bangladesh.

Even so, many women search for biomedical treatments for infertility with a more enthusiastic approach. Similarly, Patel & et al 2018) have shown that women with overinvolved family members who had unrealistic expectations from treatments are three times more distressed than men. The involvement of the kins on fertility also has been observed in many studies, where it is observed that kins usually have a positive impact on women's fertility (Sear, 2017; Habib, 2020, 2021). Further, women's maternal relatives and their peer group are a valuable support during pregnancy. So, the situation with the infertile women is more crucial and they strive for the kind support from relatives both morally and physically. Most of the women cannot discuss their infertile condition abruptly with their in-laws. Though women's in-laws are often pro-natal, women who pursue treatments like IVF, found it unconventional and uncomfortable. So, it is observed that the patriarchal situation oppressed the women seeking IVF and play as a negative moral pioneering.

While men with infertility encounters their social surroundings with a 'rigid' behaviour and create social boundaries, concealing themselves as many studies reported. Cases observed focused on the involvement of the wives to morally boost the husbands to initiate the biomedical treatments is common in the context of urban Bangladesh. However, these women are not engaging themselves in a ground of the unknown world. The majority of them came to know much about the treatment through peer groups and the internet. The advancement of internet facilities around the country made these technologies viewed and accessed by an enormous number of people. Yet, a woman's desire to fulfil her motherhood constantly leads her to be strategic so she can convince their spouse. So, initially the women's desire to become a mother and their overinvolved relatives play vital roles in the moral pioneering of IVF.

However, the women are comparatively fragile to the condition and play the victim part of the scenario, when medicalizing their bodies. In fact, biomedical treatment made the woman's body at the centre of attention and locus to treat it (Inhorn, 1994). This fragile, victim and vulnerable condition of woman emotionally provokes them to beg for psycho-social and moral supports from their maternal relatives and with whom they can relate the most. As a result, the supportive hand of their mothers and maternal relatives help them to be pioneers.

Though both Hira and Lamia were financially supported by their husbands, they seek their mother's or maternal help in the days of the treatment to support and motivate them. However, some relatives of Hira approached negatively about the

treatment, while she sets up her own moral understanding to fulfil her husband's demand to have children with her, whereas Musfiq was convinced by his wife and tried to fulfil his wife's dream to be a mother. Thus, the infertile couples emotionally provoke each other in the long journey of infertility and its treatment if they are committed in conjugality.

The case of Rena (case 4, see Table 1) , who was suffering from infertility for 9 years, had stopped her trials for IVF after "wasting two years with immense pain and hope" she stated. She started her treatment as one of her friends achieved fruitful results of IVF with one trial only. She took financial support from some relatives to carry out the treatment and planned to sell some jewellery to repay the loan. However, her attempts of IVF went in vain and now she is struggling with hormonal issues as a side-effect of the treatment. In Bangladesh, the majority of the infertility cases, who approached biomedical treatments, have undergone through IVF though the risks of multiple pregnancies, costs and relatively unknown long-term side effects (Land & Evers, 2003; McLernon et al., 2010) of these treatments are questioned. Rena's luck was not like her friend, thus failed to accomplish a fruitful result from her trials of IVF. Now, Rena is planning to leave the country for higher education and will try to get settled abroad. So that none can put a figure on her infertile body or inflame to start the painful trials of IVF. Thus, cases like Rena are not less in the context of Bangladesh. The expensive trials of IVF and its unwanted side-effects hinder the treatments for many. So, many women do not go with the flow and medicalize themselves without understanding the aftermath of the treatments. They quit and show agency and struggle with the situation by excluding themselves and engaging their strength in other avenues of life. However, the memories and scars of IVF treatments haunt these women as their normative performance is hampered. Nevertheless, their step to escape from the 'merry go round' of treatment explains that they do not play with the flow of the doctor's will, nor do they want to act normative to society despite the fact of their inability.

It is quite comprehensible that both men and women with infertility seek treatment for their involuntary childlessness, using their own way of understanding, knowledge and capability. None start the biomedical trials of IVF without any biased awareness, into an unknown world of technological conception. Hence, following Rapp's concept of "moral pioneering", the study observes that gender, kindred, financial capability, peer group, individual personality, internet access, social exposure with modern life and technology play a role in how infertile people seek and pioneer their way through IVF.

Conclusion

With rapid globalization, Bangladeshi urban infertile couples are now well aware of this technological support to pregnancy. However, like many other developing countries (India, Pakistan, Sri Lanka), Bangladesh also experiences the effects of techno-dependent, expensive treatment of IVF, which initiates a stratified reproduction, and the opportunity of childbearing is now not a 'god's will', for those who can afford. In urban Dhaka, men and women approach differently about biomedical treatment, IVF. With a stigmatized notion, both men and women suffer and trigger their dilemmas while instigating IVF. However, men are more stigmatized to respond to the issues of infertility and IVF and feel alienated throughout the process of IVF, as women's body is the locus of the treatment and the medical sufferings and bodily challenges distress them the most. Accordingly, the sufferings of women in patriarchal settings are psycho-social, financial and physiological when they take the burden of IVF. However, the struggling journey of IVF has been addressed mostly by women who do not act simply as a passive victim of their infertility, but show agency, resistance and perform accordingly, where any positive and negative approach towards this biomedical treatment may be taken.

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